



TURKEY HEALTH TRANSFORMATION PROGRAM

ASSESSMENT REPORT (2003-2011)



Health For All

Prof. Dr. Recep AKDAĞ

“Dedicated to the most precious souls and memories of the health care personnel who lost their lives in the Earthquake of Van and of Dr. Ersin ARSLAN who was martyred as a result of a nefarious attack...”

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Prof. Dr. Recep AKDAĞ

Written by
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Foreword



As the government, we believe that this country and nation deserves the best of everything. We have strived to make this ideal real for nine years. During this divine journey that we set out in order to gain a place in the hearts and minds of the nation, we rendered concrete services, created tangible achievements and solutions to cure the problems of the people. We put the Health Transformation Program into practice in order to provide our citizens the quality health services they deserve, we accomplished great things and made huge reforms.

As the poet beautifully said...

"It's important to leave behind works;

Otherwise one does not exist, ..."

This evaluation report is a brief of the steps that we took in the last nine years in health and it is also an example of success of not only the Turkish Governments but also the Great Turkish Nation. We are proud of the fact that our achievements make such a long list that can not be briefed at once and put into reports easily.

We have gained enormous experience thanks to the Health Transformation Program and our goal is to share our experience at regional and global levels. Making such progress, my country has become one of the global leaders in health.

Publishing this report, we do not only lay out the situation in the past and at present in Turkey but also we share our experience with our neighbouring countries and friendly and allied nations.

We take strength, excitement and energy from our nation and set sail for new horizons. Our slogan is “Health for All”. Remembering and undertaking our historical responsibility and consciousness for being as a leading country, we have achieved the things that could not be imagined before. Our future is rooted in our brilliant past.

We know that only dedicated and committed armies can win glorious victories which owe their existence to a number of namesless heroes and heroines. On the occasion of this report, I congratulate the compassionate and self-sacrificing physicians, nurses, health officers, technicians and all other health care personnel in Turkey and I extend my sincere thanks to them on behalf of my nation.

Sincerely,

Recep Tayyip ERDOĞAN
Prime Minister

Foreword



We have made significant progress in health since we assumed office in 2002. We have accomplished great things with the Health Transformation Program and we have made a substantial transformation.

We improved our health indicators at a rare pace and level and our success serves as a global example. We've shown with this significant transformation that we can overcome any obstacle and reach any objective.

We had no limits in service provision. On one hand we reached the hamlets of Hakkari, highlands of Trabzon, villages of Edirne, steppes of Yozgat and plains of Adana and on the other hand we extended our helping hand to the earthquake victims of Haiti, and tsunami victims in Indonesia and Japan.

Also, we share with other countries the successful implementations made under the Health Transformation Program which is highly appreciated in the international arena. International organizations such as the World Health Organization and the OECD state that other countries have a lot of lessons to learn from the health reforms in Turkey and the Transformation in Turkey serves as a model for other countries, too.

With its Health Transformation Program which is a unique model in the whole world, Turkey has become one of the global health leaders that establish the global health agenda. Turkey is not a country any more which has to keep up with the global changes, instead, Turkey acts a leader for change based on the principle of “serving the human”.

We know that we still have a long way to go. Yet, everybody should recognize that the brilliant minds which have achieved such enormous transformation are capable of making and will certainly make even bigger achievements. Besides, I am proud to emphasize that our health care personnel, all of whom are the nameless heroes and heroines in our health care system, is the main source of our self confidence and commitment. On this occasion, I extend my most sincere thanks to all health care personnel in Turkey who have recognized and adopted the spirit of transformation in health and made devoted and intense efforts since the beginning of the process.

You are the pride and joy of our nation and I am so glad that I cwork with you...

With my best regards,

Prof. Dr. Recep AKDAĞ
Minister of Health

Introduction

The health policies that have been implemented in our country throughout the history of the Republic have gone through some basic periods of change. Dr. Refik Saydam period (1923), Dr. Behçet Uz period (1946) and the start of socialisation in health services pioneered by Prof. Dr. Nusret Fişek (1963) were the important turning points. Health Transformation Program (2003) was the last of these milestones.

On the other hand, the roles to be played by the governments to ensure that the people lead a prosperous life economically and socially were highlighted during the World Health Assembly in 1977, and then in 1978 during the Alma Ata Conference, the foundations of the policy of 'Health for All in the 21. Century' were laid. In 1984, the 'Health for All Strategy and Objectives of the World Health Organisation European Region' were adopted.

Putting such global policies and objectives into implementation, unfortunately, did not go beyond a political wish for 20 years. The “Health Transformation Program”, however, which we introduced in 2003 and have been implementing since that time, is a comprehensive program that considers all of the previous actions and aims to produce the most proper solutions by encouraging participatory and democratic processes. The Transformation aims to organize, fund and provide health care services in an effective, efficient and equitable manner. Reaching its goals, the Health Transformation Program also takes into consideration the World Health Organization’s “Health for All in the 21st Century” policy, the European Union’s “Accession Partnership Document” and other international knowledge and experience.

The Health Transformation Program has human being in its center. It is essential to protect individual’s health together with community health. For this reason, “health care service that is accessible, qualified and sustainable for every one” is the underlying principle of this Program.

The 9th Development Plan, which was drafted in compliance with the goals and objectives of the Health Transformation Program in 2006, aims to facilitate access to health care services, increase service quality, strengthen the Ministry of Health’s planning and supervision role, improve health information systems, ensure rational drug and material use, and establish the Universal Health Insurance System. Most of these objectives have been achieved so far since 2003 when the Health Transformation Program was put into practice. The universal health insurance, being one of the most components of the Program, has facilitated access to health care services and increased service quality. Also a major progress has been made in health information systems, rational drug and material use and strengthening the Ministry of Health’s planning and supervision role. This report presents detailed information on all of them in its upcoming chapters. In this context, the Health Transformation Program is a complementary part of the national policy. Thanks to the implementation of the Program, national health care services have become more capable of responding to the rapidly changing and transforming health needs of the future.

The progress that we have made under the Health Transformation Program, which we developed as a unique model to Turkey based on the previous and more recent health policy actions, has been brought to the attention of the audience in some of the previous publications: “From Past to Present: Turkey Health Transformation Program, June 2007”, “Turkey Health Transformation Program Progress Report, August 2008”, “Turkey Health Transformation Program Progress Report, September 2010” and “Turkey Health Transformation Program Progress Report , June 2011”. This latest publication presents an updated and reviewed version of these progress reports with new and more recent annexes.

Remarks

The data on Turkey covered in this book are calculated according to the international definitions and standards. As well as that retrospective revisions are made accordingly.

All the figures related with the facilities and personnel of the public institutions and organisations that were taken over by the Ministry of Health in 2005 are included in the data for 1994 and 2002 which were used for the comparisons in the book.

'Classification of Territorial Units for Statistics' (NUTS) which are used by the European Union countries are used in territorial assessments.

The section titled 'Anatomy of Health Transformation Program' was prepared based on the sections of the 'Getting Health Reform Right' by Marc Roberts.

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TURKEY HEALTH TRANSFORMATION PROGRAM



ASSESSMENT REPORT EXECUTIVE SUMMARY

General Demographic Indicators in Turkey

In the last 20 years, decrease in rural population as well as a decrease of 2.1 in fertility rate together with an increase in the population over 65 years of age have been observed.

	1990	2000	2010	2011
Total Population	56.473.035	67.803.927	73.722.988	74.724.269
Ratio of Rural Population (%)	48,7	40,8	29,0	28,2
Ratio of Urban Population (%)	51,3	59,2	71,0	71,8
Ratio of Population Between 0-14 Years of Age (%)	35,0	29,8	25,6	25,3
Ratio of Population Aged 65 and Above (%)	4,3	5,7	7,2	7,3
Youth Dependency Ratio (0-14 Years of Age)	57,6	46,3	38,1	37,5
Elderly Dependency Ratio (Aged 65 and Above)	7,0	8,8	10,8	10,9
Total Age Dependency Ratio	64,7	55,1	48,9	48,4
Annual Population Growth Rate (‰)	17,0	13,8	13,0	12,8
Crude Birth Rate (‰)	24,1	20,3	17,5	17,3
Crude Death Rate (‰)	7,1	6,6	6,3	6,3
Total Fertility Rate (Per Woman)	2,9	2,4	2,1	2,1

Health Policies in Turkey from the Past to the Present

It is possible to examine health policies in Turkey in six different periods.

1920-1923 : Post-war structuring period.

1923-1946 : "Vertical organization period in which basic legislation was developed (Dr. Refik Saydam).

1946-1960 : Period in which the number of institutions increased, central management system was introduced and laws on medical professions were adopted (Dr. Behçet Uz).

1960-1980 : Structuring period in which health houses, health care centres, provincial and district hospitals were established (Socialization)

1980-2002 : Period in which theoretical reform studies were carried out.

2003-2011 : Period of "Health Transformation Programme in Turkey".

How to Design and Implement Health Transformation Programmes

According to WHO, the health care system of a country should be designed in a way to ensure the delivery of high-quality health care services for all people. This service should be effective, affordable and acceptable to the overall society. Each country is recommended to develop its own unique health care system taking those factors into consideration. While developing this unique health care system, each country has to initiate its own transformation process.

While making the political and methodological preparations of the program; a gradual, continuous policy cycle is designed that will ensure the sound operation of the transformation process of the health policies. According to that, first the problems are defined; the conditions providing the basis for those problems are analyzed; policies are developed for solving the problem; political decisions are made to implement those policies and then those decisions are implemented. After that, the outcomes of those policies, which are implemented within the ethical framework, are assessed.

The transformation process can be defined with the following cycle:



Health Policy Cycle

Getting Health Reform Right: M. Roberts et al, 2004
(adopted from)

Health transformation programme is developed and implemented using five control knobs (financing, payment, organization, regulation, behaviour) in accordance with health policy cycle.

Those five knobs cover the mechanisms and processes that need to be adjusted for improving the system performance of the transformation programmers.

A - Diagnosis

A-1 Financing:

There was a multiple and fragmented health financing system. Even most of the citizens who had health insurance could not have access to health care services.

A-2 Payment:

Health professionals were defrayed fixed but insufficient payment irrespective of the quality and quantity of the work. Physicians employed in the public sector were not paid enough. Instead, they were allowed to set up “private” practices which led to dual practice. The service procurement from the private sector was not at an adequate level to facilitate citizens’ lives. Informality, waste of resources, long waiting period and unnecessary referrals were routine practices.

A-3 Organization:

Emergency health care services had failures, preventive health care services were insufficient and some regions were suffering from high deficiencies and disparities in terms of services provided. The private practice was widespread (which led to out of pocket payments), hospitals were not maintained well, ward system was common in hospitals and hospitals were poor in terms of medical devices.

A-4 Regulation:

The health care service delivery in the public sector had a fragmented structure. Health care service provision was left to market conditions. There were extremely bureaucratic procedures in healthcare service delivery. There were no rules defining how the appointment and transfers were carried out and there was an unbalanced distribution. There was always an increasing trend when the prices for pharmaceuticals were set.

A-5 Behaviour:

Motivation of health professionals was low. Patients often preferred hospitals to be examined. Behaviour change programs for healthier lifestyles were absent. Programs aiming to change patient compliance (Direct Surveillance and Treatment etc.) were not sufficient. Organizational structure to protect patients’ rights was not in place. Patients did not have the chance to determine by which physician they would get examined in the public sector.

B - Policy Development and Political Decision

B-1 Financing

We increased the budget allocated for preventive and primary healthcare services. We made the primary health care services and 112 Emergency Health Care Services totally free-of-charge.

We put an end to being held in pledge in hospitals. We united public hospitals under a single roof. We enabled our citizens to receive service from private hospitals and medical centres through their health insurances. We began to provide emergency and intensive care treatments as free-of-charge in all private and public hospitals. We enabled the poor citizens in Turkey to benefit from health care services provided by the public sector as a whole. We introduced target-oriented management through implementing performance-based budgeting in all our hospitals.

We put the “Reference Pricing System in Medication” implementation into practice. We introduced the implementation that hospitals provide all medications and medical materials for inpatients as free-of-charge. We ensured that SSK enrolees and Green Card holders can get their medications from any pharmacies just like other citizens in Turkey.

We ensured coordination and harmony among units that are related to health financing through the establishment of Economic Coordination Board. We developed the “Global Budget Model” to finance health care services. We ensured that everyone under 18 years of age and students are covered by the Universal Health Insurance. We reduced the premium payment duration to 30 days for SSK enrolees and Bağ-Kur enrolees to receive health service.

B-2 Payment

We started to implement a model in family medicine which would involve payment based on the number of registered person.

We encouraged full time practice in public sector through performance based supplementary payment system. We introduced “manager performance” implementation which covers hospital managers.

We established the single reimbursement commission in medication.

B-3 Organization

We strengthened primary health care services with the introduction of family medicine practice. We extended the free mobile health services to all rural areas. We established the National Medical Rescue Team (NMRT) which is the greatest in Europe. We added land, air and sea ambulances to 112 Emergency Services to provide service in every corner of our country. We opened at least one Oral and Dental Health Centre (ODHC) in each province. We established centres providing free of charge cancer screening service (KETEM) in each province.

We introduced a principle for each physician to have one examination room in MoH's all health facilities. From the ward system at hospitals we passed to the room system with an inbuilt toilet and bathroom, in other words qualified room system. We activated the Health-Net system. We put latest technology devices used in modern medicine into service for our citizens at the same time with many developed countries. We increased the capacity of intensive care units, burn units and neonatal units.

We introduced mobile pharmacies implementation.

We increased the efficiency of all health facilities through service procurement.

Our Ministry underwent a restructuring process as per the Decree numbered 663.

B-4 Regulation

We included the most developed vaccines into our immunization programme. We introduced new regulations for the consumption of cigarette and tobacco products.

We introduced "Central Hospital Appointment System" at our hospitals. We ensured access to safe blood and blood products. We established "National Organ Transplantation Waiting System". We established "Patient Rights Units" in all MoH-affiliated hospitals and patients were granted the right to choose their physicians.

We established "Pharmaceuticals Tracking System (PTS)" which monitors the medication at each step it passes. We are implementing strategies towards rational drug use.

We ensured a balanced distribution of health personnel across the country following the introduction of Regulation on Public Service Obligation. We ensured that transparency and equity are observed during personnel appointments and transfers. We transferred a lot of authority to provincial organizations of the Ministry. We put ALO SABİM 184 hotline into service. We started to provide health management training via internet.

As per the Decree numbered 663; we made it possible to employ contracted personnel, encourage domestic industry towards manufacturing advanced technological products, transfer technology from abroad, scale up off-set implementations and establish free health zones and health service units abroad.

Following the adoption of "Full Time Practice Law", we ensured that physicians practice full time at hospitals and thus decreased the necessity for our citizens to go to private practices of physicians.

B-5 Behaviour

We launched “Health Promotion Programme” which is integrated into programs used to fight against chronic diseases. We introduced the implementation of “Smoke Free Air Zone”. We introduced contemporary screening programs for child health, launched the guest mother project and started to provide conditional cash transfers.

Through ALO SABİM 184 hotline service, we ensured our citizens to convey their requests directly to the Ministry, 24/7, without interruption. We developed policies to prevent violence in healthcare.

We made sure that prescribing information of pharmaceuticals is simple and easy to understand.

C - Implementation

C-1 Preventive and Primary Healthcare Services

The budget of preventive and primary health care, which was 928 million ₺ in 2002 reached to 6 billion 425 million ₺ in 2011. The resource allocation for preventive services and primary health care in 2011 (real prices) has almost increased by 2.7 fold in comparison to the allocation in 2002.

We put the family medicine implementation into practice.

We launched “guest mother” project for pregnant women who are in need.

We introduced community based mental health services which will help us perform the treatment of patients with heavy mental disorders and track them at their own living environment, if required.

Comprehensive programs have been implemented to prevent ill-health and premature deaths associated with chronic diseases. In this scope, the following integrated programs started to be implemented: Prevention and Control Program for Cardiovascular Diseases in Turkey, National Prevention and Control Program for Diabetes, National Chronic Respiratory Disease (Asthma-COPD) Prevention and Control Program, Turkey Obesity Counteracting Programme and National Action Plan, Tobacco Control Program, National Cancer Control Program, National Mental Health Action Plan.

We extended and strengthened maternal and child health services.

We extended and expanded the neonatal screening programs nationwide

Screening and Support Programs

	Target Population Reached (%)		
	1994	2002	2011
Newborn Phenylketonuria Screening	21	59	97
Newborn Hearing Screening	0	0	75
Newborn Hypothyroidism Screening	0	0	97
Newborn Biotinidase Screening	0	0	97
Free Vitamin D Supplement for Babies	0	0	96
Free Iron Supplement for Babies	0	0	96
Free Iron Supplement for Pregnant Women	0	0	96

We included the most developed vaccines into our immunization program and increased our immunization rates.

Vaccine Antigens

	1994	2002	2011
Vaccines Routinely Applied During Childhood	BCG	BCG	BCG
	Diphtheria	Diphtheria	Diphtheria
	Pertussis	Pertussis	Acellular Pertussis
	Tetanus	Tetanus	Tetanus
	Oral Polio	Oral Polio	Polio
	Measles	Measles	Hemophilus Influenza Type B
		Hepatitis B	
	(6 antigens)	(7 antigens)	
			Measles Rubella Mumps
			Hepatitis B
			Conjugated pneumococcus
			(11 antigens)

Pentavalent combined vaccine

Trivalent combined vaccine

Immunization Rates (%)

	1994	2002	2011
Immunization Rate in Turkey (%)	81	78	97
Immunization Rates in WHO European Region	89	94	94

We started to deliver “112 Emergency Health Care Services” not only in cities but also in villages. We increased the numbers of stations and equipped the ambulances with the state of-art technology.

MoH 112 Emergency Health Care Services

	1994	2002	2011
Ambulance	33	618	2.766
Ambulance Helicopters	0	0	19
Ambulance Plane	0	0	2
Sea Ambulance	0	0	4
Ambulances with Snow Pallets	0	0	224
Emergency Response Teams with Motorbikes	0	0	52
Rural Population Provided with Service (%)	0	20	100
Transported Patients	24.000	350.000	2.700.000

We established the greatest medical rescue team in Europe established in 81 provinces for which we trained 4.847 health care personnel.

We increased the number of oral and dental health care centres to 117 which was 14 in 2002 and the number of dental hospitals to 5 which was 1 in 2002.

MoH Oral and Dental Health Care Services

	1994	2002	2011
Number of Dentists	2.636	3.211	7.093
Number of Filled Teeth (thousand)	209	371	8.334
Number of Fixed Dental Prosthesis (thousand)	97	349	5.576

C-2 Diagnostic and Curative Services

We ensured facilitated access to healthcare services following the Health Transformation Program. The number of physicians per capita was 3.2 in 2002. However; this number went up to 8.2 in 2011.

Number of Physician Visits (million)										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Health Centres	69,1	79,2	82,2	105,5	121,1	146,1	121,4	123,9	84,6	-
Family Medicine	-	-	-	-	-	-	45,1	65,7	109,0	240,3
Tuberculosis Control Centres	2,0	2,3	2,4	3,1	3,0	2,8	2,8	2,6	2,4	2,2
Mother and Child Care and Family Planning Centre	3,0	3,5	4,2	5,3	4,6	6,0	5,8	5,7	3,8	0,9
Private Polyclinics	0,7	0,9	0,9	1,3	1,4	1,8	2,1	2,4	2,5	0,9
Total Number for Primary Health Care Centres	74,8	85,8	89,6	115,1	130,2	156,8	177,3	200,2	202,3	244,3
Private Medical and Specialty Centres	9,8	11,5	12,0	16,8	19,3	24,3	27,9	32,1	33,8	29,0
Hospitals	124,3	129,6	152,8	187,2	217,5	249,1	273,7	295,3	303,0	337,9
Total Number for Secondary and Tertiary Healthcare Centres	134,1	141,2	164,9	204,0	236,9	273,4	301,6	327,3	336,8	366,9
Grand Total	209,0	227,0	254,5	319,2	367,0	430,2	478,9	527,6	539,1	611,2

Number of Surgical Operations (thousand)										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ministry of Health	1.072	1.130	1.442	1.690	1.985	2.217	2.464	1.830	2.039	2.209
University	307	326	375	452	508	560	638	547	577	617
Private	219	237	260	393	580	787	1.087	1.131	1.215	1.374
Total	1.598	1.693	2.078	2.535	3.073	3.565	4.189	3.508	3.831	4.201

In 2002, 0.97% of the patients seeking treatment at hospitals affiliated to Ministry of Health underwent surgical operations whereas 3.5% of patients coming to university hospitals underwent surgical operations. This number decreased to 0.86% and 2.5% for MoH hospitals and university hospitals respectively in 2011.

We automated all MoH hospitals fully.

We increased the efficiency of all health facilities through service procurement.

We introduced “Central Hospital Appointment System” at our hospitals. Our citizens call 182 Call Centre and directly get an appointment with hospitals and physicians they want from operators, for MoH hospitals.

We initiated “Home Healthcare” implementation through which we ensure medical care and rehabilitation of the bedridden patients to be performed at home environment if possible.

In the framework of the Health Transformation Program, we renovated public hospitals with the latest technology and built more capacity. We put the latest technology devices used in modern medicine into service for our citizens at the same time with many developed countries.

MoH Diagnostic and Curative Services

	1994	2002	2011
Total Number of Beds	103.000	107.394	121.297
Number of Intensive Care Beds	209	869	9.581
Number of Burn Beds	21	35	367
Number of Qualified beds / (%)	5.584 / (%5)	6.839 / (%6)	38.272 / (%31)
USG	226	495	2.125
Computerized Tomography	35	121	446
MR	1	18	273
Dialysis	769	1.510	4.481

C-3 Pharmaceuticals and Pharmacy

We reduced prices for pharmaceuticals and brought down the prices to the lowest level in Europe. We made reductions ranging from 1% to 80 % in approximately one thousand products. We reduced the prices 250 times between 2004 and 2011.

We established the single reimbursement commission in medication. We put the “Reference Pricing System in Medication” implementation into practice.

The amount of drugs consumed reached 1 billion 720 million boxes in 2011, with an increase of 146% from 2002. During the same period, public spending on drugs increased from 13 billion 430 million ₺ to 15 billion 865 million ₺ with 2011 prices and increased by only 18%. We have used this saving on drugs to facilitate the access of our citizens to pharmaceuticals.

C-4 Institutional Structuring and Capacity Building

The number of personnel working at public healthcare institutions of the MoH was increased to 482 thousand in 2011 which was 256 thousand in 2002 including the staff recruited in the scope of service procurement. In other words, we achieved a net increase of 226 thousand staff members. However; the increase in the nine years between 1994-2002 was solely 21 thousand. In other words, the increase that we achieved in the last nine years is 11 times greater than what was achieved in the previous nine years.

While the ratio between the province where the population per specialist physician is the highest and the one where it is the lowest was 1/14 in December 2002, it was reduced to 1/2.7 in December 2011. The same ratio was decreased to 1/2.3 from 1/9 for practitioners; to 1/4.5 from 1/8.5 for dentists and from 1/8 to 1/4 for nurses-midwives.

We made great progress in health investments. We constructed an indoor space of 5.3 million m² in the last 9 years whereas an indoor area of 7 million m² was constructed between 1923 and 2002.

In the last nine years, we built and put into service 2021 health facilities in total, 554 of them being hospitals and premises and 1467 primary health care institutions.

MoH Health Investments		
	1994 - 2002	2003 - 2011
Hospitals and New Buildings	291	554
Primary Health Care Facilities	647	1.467
Total	938	2.021

D - Evaluation

D-1 Improvements in Health Indicators

Although Turkey is included among the group of upper-middle income countries by WHO, its Health indicators achieved are comparable to the ones in upper income countries.

Life Expectancy at Birth

Life expectancy at birth is considered as the most important health indicator defined by the World Health Organization. According to the report by WHO in 1998, life expectancy in Turkey was estimated to be 75 years in 2025. We achieved this number in 2009.

Life expectancy at birth was determined as 71 in 2009 for upper-middle income countries. Gained years for life expectancy between 2000 and 2009 were 2 for upper-middle income countries whereas this number is 5 for Turkey.

Infant Mortality Rate

According to the report by WHO in 1998, infant mortality rate in Turkey was estimated to be 16 per mille for the year 2025. Infant mortality rate in Turkey was 31.5 per mille in 2002 whereas it was 7.7 per mille in 2011.

Infant mortality rate for upper-middle income countries is 16 per mille. The ratio of change in infant mortality rate between 2000 and 2010 was 40.7% for upper-middle income countries whereas this ratio was 76.7% for Turkey.

Maternal Mortality Rate

Maternal mortality rate for the year 2002 was 64.0 per one hundred thousand; however we decreased this number to 15.5 per one hundred thousand in 2011.

Maternal mortality rate for upper-middle income countries is 53 per one hundred thousand. The ratio of change in maternal mortality rate between 2000 and 2010 was 30.3% for upper-middle income countries whereas this ratio was 76.9% for Turkey.

Routine Vaccination Rate

We included the most developed vaccines into our immunization programme and increased the ratio of immunization. Vaccination rate in the WHO European region was 93% in 2002 and 78% in Turkey for the same year. However; this rate increased to 96% in the WHO European region in 2011 and 97% in Turkey.

Measles

Measles incidence was 6 per hundred thousand in the European Union in 2002 whereas Turkey had a measles incidence of 11.1 per hundred thousand for the same year. However; European Union had a measles incidence of 6.2 in 2011 when Turkey had a zero measles incidence.

Turkey has not had any domestic measles case since 2008. We are waiting for the other countries to announce that they have eliminated measles in Europe too.

Malaria

Malaria incidence in Turkey in 2002 was four times as much as high as what it was in the WHO European Region. (Turkey: 14.7 per hundred thousand; WHO European Region: 3.9 per hundred thousand). We reduced the number of malaria cases to zero as of 2010. We are in the elimination period for malaria.

Tuberculosis

Tuberculosis incidence in Turkey was 33 per hundred thousand in 2002 whereas it was reduced to 24 per hundred thousand in 2011. In other words, we achieved a decrease of 27% in tuberculosis incidence.

In 2005, we already reached the targets set by the WHO for the year 2015 and even achieved better.

Typhoid

We had more than 24 thousand typhoid cases in 2002 whereas we only had 26 cases in 2011.

D-2 Protecting Individuals from Financial Risks

We provide emergency and intensive care treatment free-of-charge in public and private hospitals. Additionally we abolished extra charges applied for burn injuries, cancer treatment, newborns, organ transplantations, congenital anomalies, dialyses and cardiovascular operational procedures in private hospitals. Thus we ensured protection for our citizens' access to health care services.

Although the ratio of out of pocket health expenditures per person to total health expenses was 19.8%, we decreased this ratio to 12% in 2011.

D-3 Satisfaction with Health Care Services

Rate of satisfaction with health care services was 62% in the European Union in 2003 whereas this rate was 39.5% in Turkey for the same year. We increased the rate of satisfaction with health care services up to 76% in 2011 whereas it remained to be 62% in the European Union for 2011.

Rate of satisfaction with health care services in Romania where the public spending on health is similar to Turkey's case is 1/6 of the satisfaction rates in Turkey whereas the public spending on health in Denmark where the rate of satisfaction is the same as Turkey is 5 times greater than the amount spent by Turkey on health.

D-4 Financial Sustainability of Health Care System

We increased efficiency following the implementation of Health Transformation Programme and ensured financial sustainability. The increase in general public expenditures except for the interest rate was 92% and the increase in public health expenditures was 74% between the years 2003-2011.



OECD Reviews of Health Systems, Turkey (page 107)

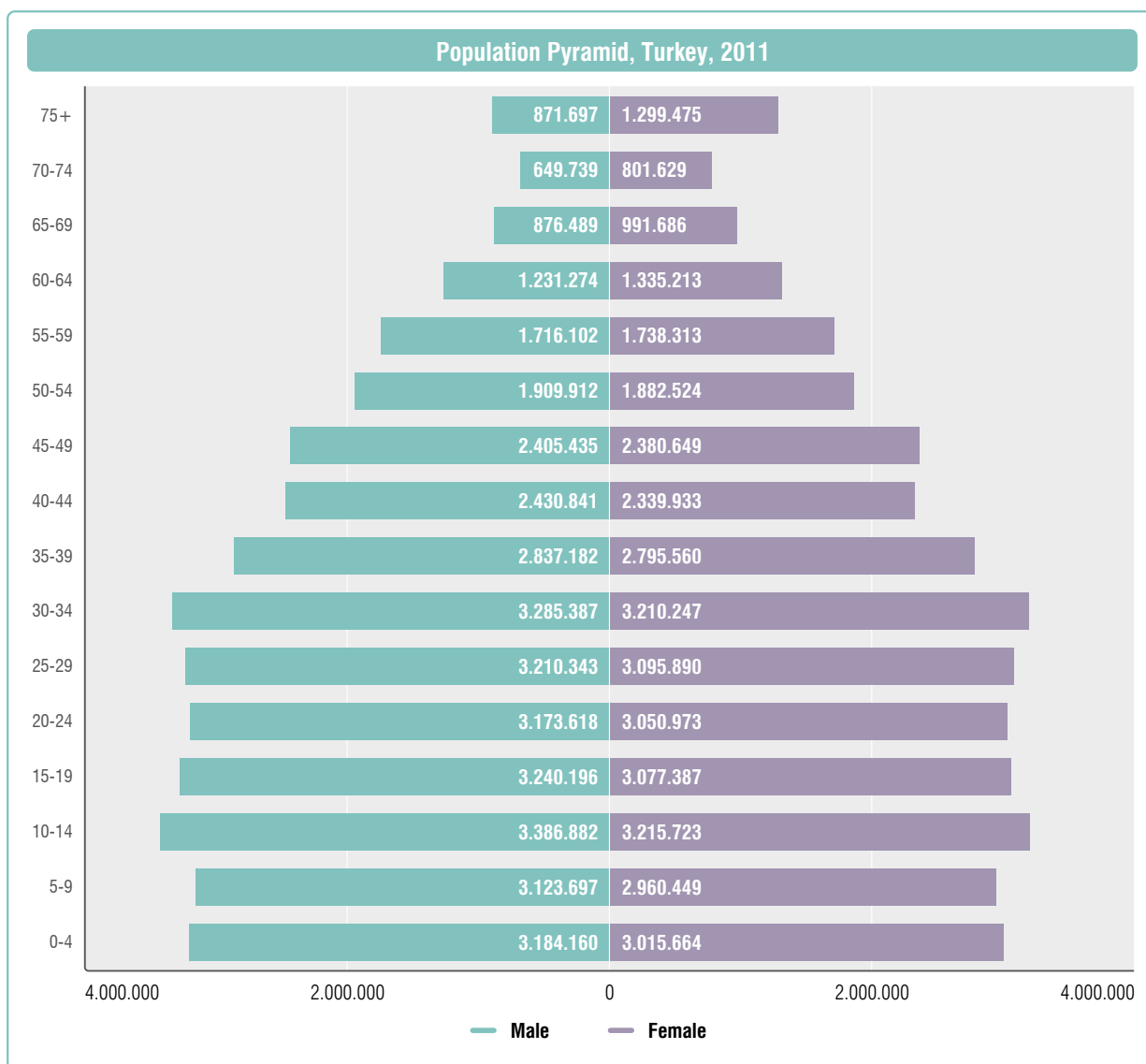
Publication Year: 2008

Published by: OECD, World Bank

*“In many ways, the content of the Health Transformation Programme appears to represent a **“textbook”** set of reforms for a health system of the type found in Turkey prior to 2003, building on the strengths of the system, yet targeting the weaknesses.”*



GENERAL DEMOGRAPHIC INDICATORS



Graphic 1
Source: TURKSTAT

Age group of 5-9 years is obviously smaller in number when compared to age group of 10-14 years. This indicates that fertility level has been on decrease. Population pyramid is getting narrower towards the older age groups. This situation shows that mortality rates have decreased in our country not only in older age groups but in all age groups as well.



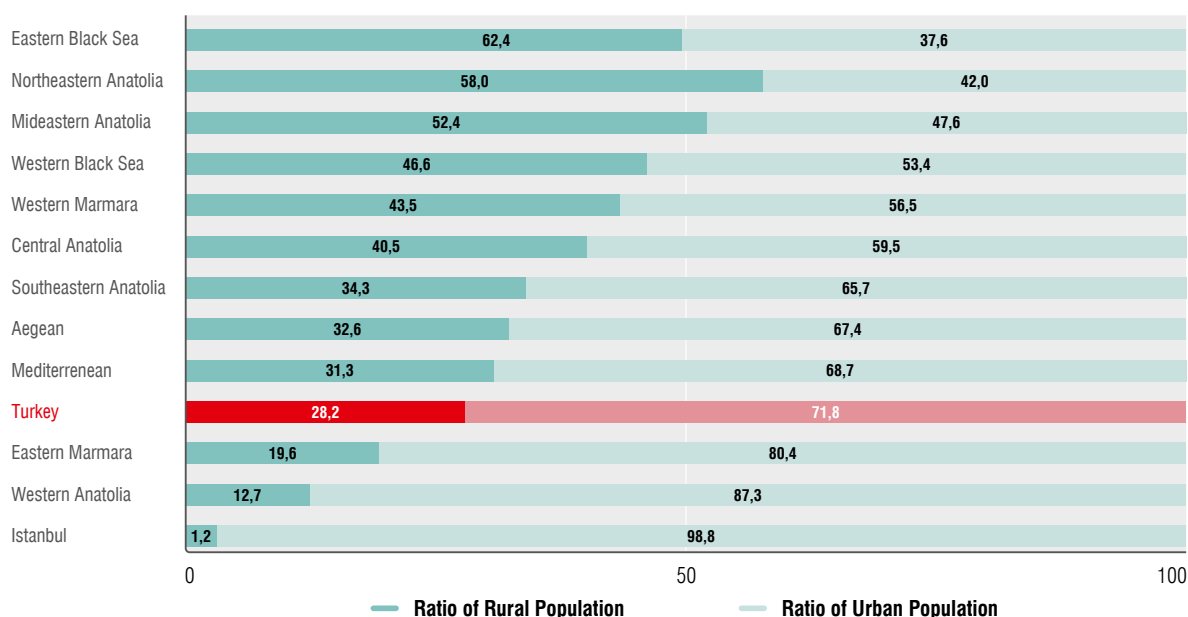
Table 1. General Demographic Indicators, Turkey

	1990	2000	2010	2011
Total Population	56.473.035	67.803.927	73.722.988	74.724.269
Ratio of Rural Population (%)	48,7	40,8	29,0	28,2
Ratio of Urban Population (%)	51,3	59,2	71,0	71,8
Ratio of Population Aged 0-14 (%)	35,0	29,8	25,6	25,3
Ratio of Population Aged 65 and Above (%)	4,3	5,7	7,2	7,3
Youth Dependency Ratio (0-14 Years of Age)	57,6	46,3	38,1	37,5
Elderly Dependency Ratio (Aged 65 and Above)	7,0	8,8	10,8	10,9
Total Age Dependency Ratio	64,7	55,1	48,9	48,4
Annual Population Growth Rate (‰)	17,0	13,8	13,0	12,8
Crude Birth Rate (‰)	24,1	20,3	17,5	17,3
Crude Mortality Rate (‰)	7,1	6,6	6,3	6,3
Total Fertility Rate (Per Woman)	2,9	2,4	2,1	2,1

Source: TURKSTAT

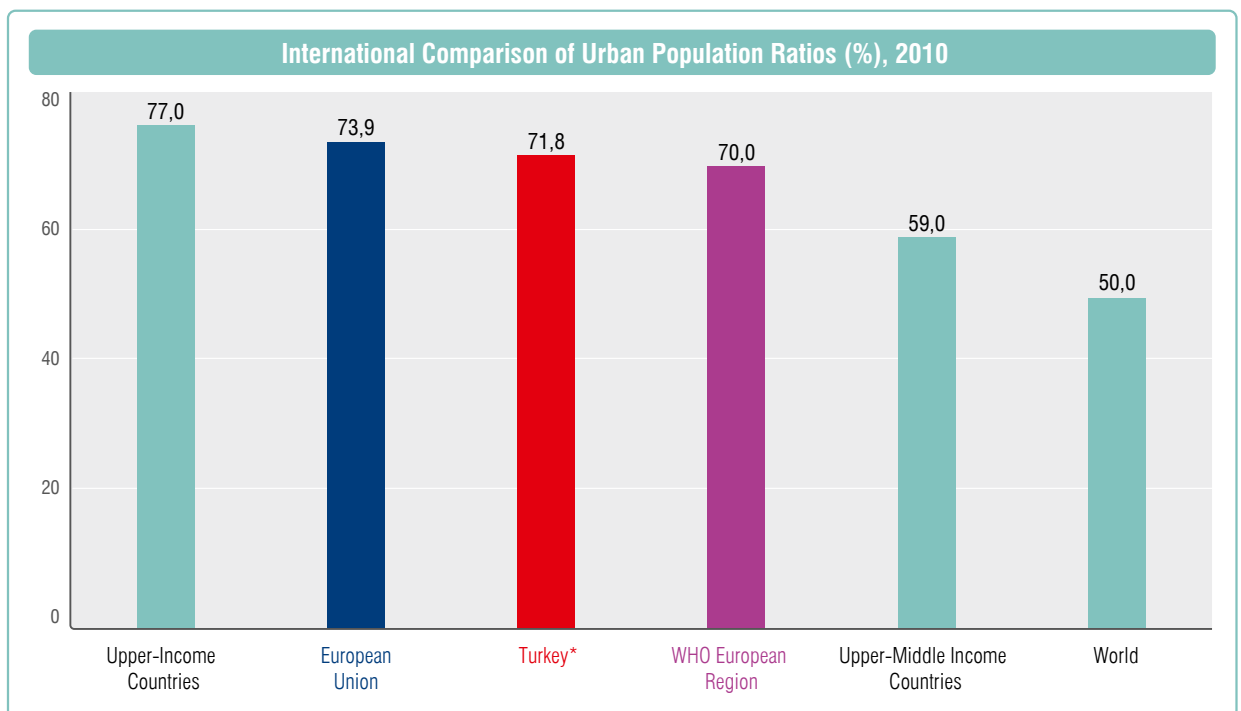


Ratio of Urban and Rural Population in Turkey (%), 2011



Graphic 2
Source: TURKSTAT

Heterogeneous distribution is observed when the ratio of urban and rural population living in various regions of Turkey is examined. Urban population living in Istanbul, Western Anatolia and Eastern Marmara regions is above the average in Turkey whereas rural population living in other parts of the country particularly in the Eastern, Northern eastern and mid-Eastern Anatolia is above the average in Turkey.

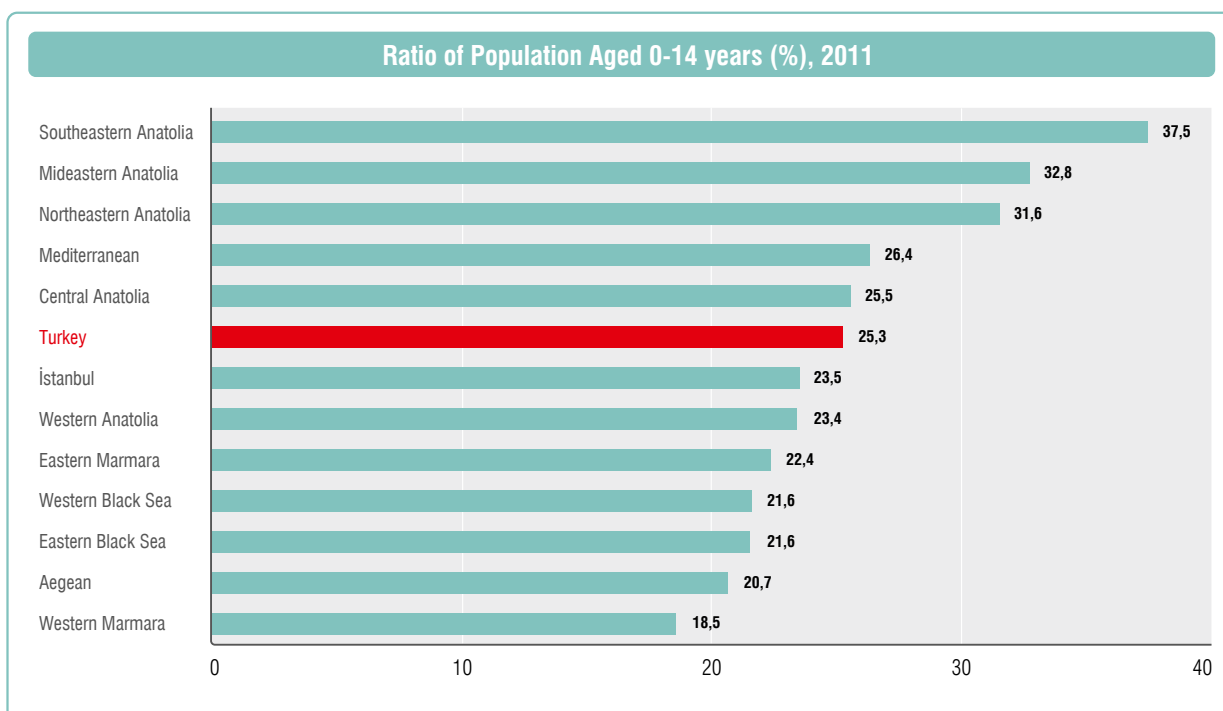


Graphic 3

Source: TURKSTAT, World Health Statistics 2012

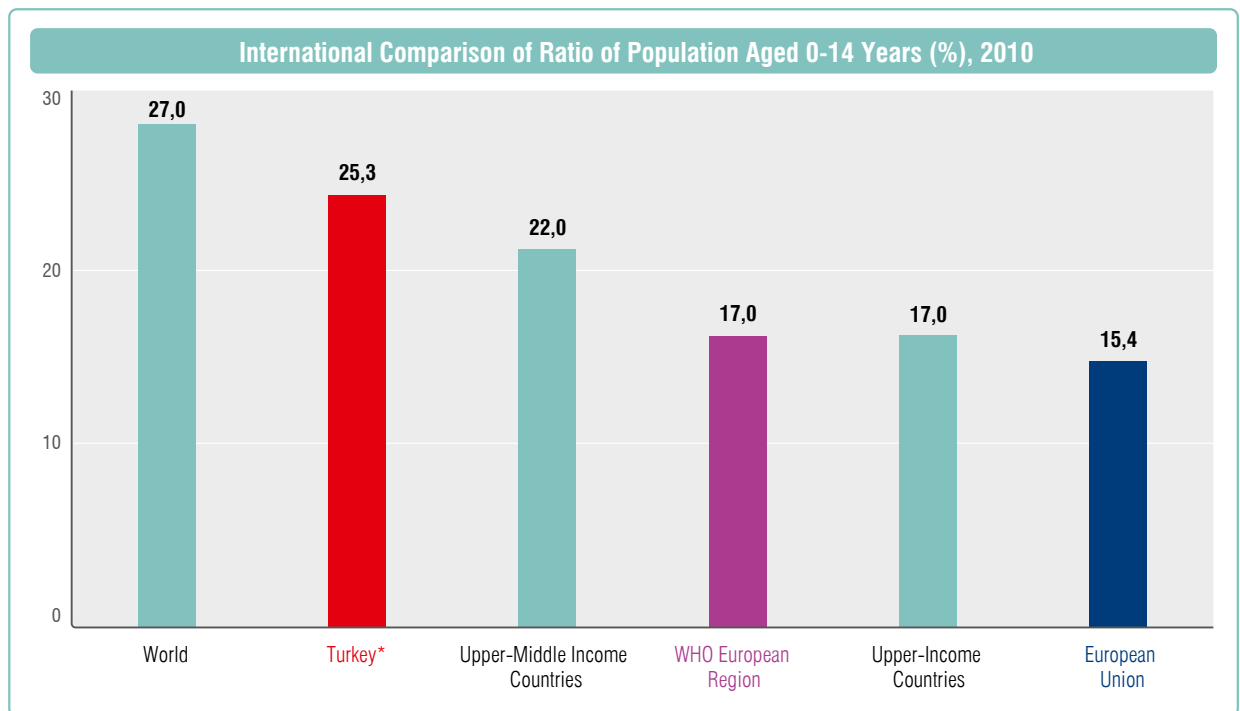
* Data of Turkey belong to the year 2011.

Urban population ratio in Turkey is a lot higher than middle and upper income countries and close to the ratio in the European Union.



Graphic 4
Source: TURKSTAT

Southeastern Anatolia has the highest child population in Turkey whereas the lowest child population belongs to Western Marmara.



Graphic 5

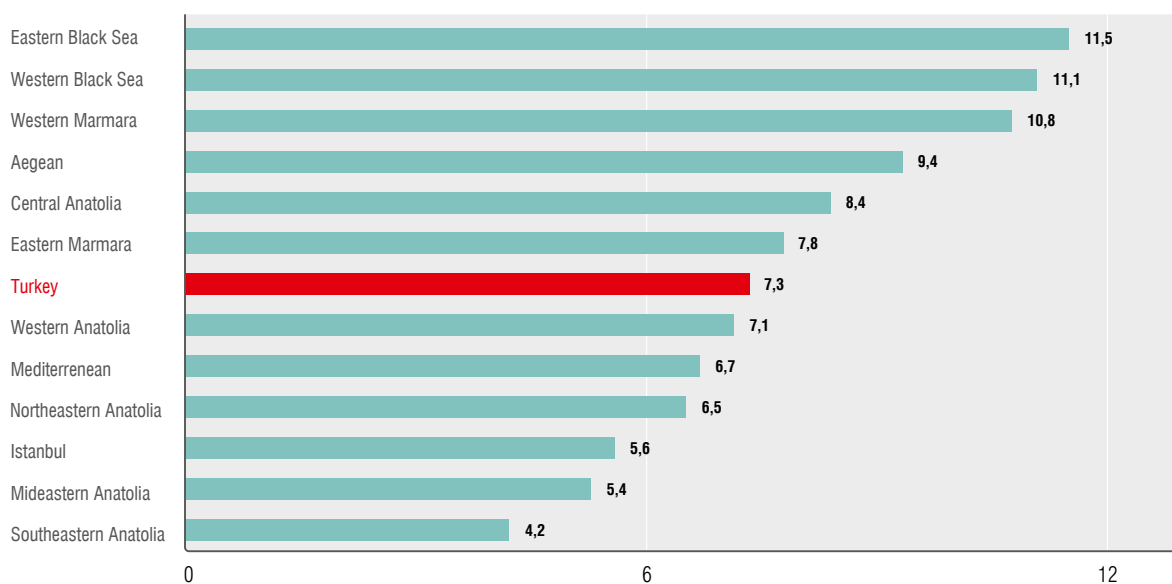
Source: TUIK, World Health Statistics, 2012

*Data related to Turkey belong to the year 2011.

Child population in Turkey is higher when compared to both middle-upper income countries and upper income countries.

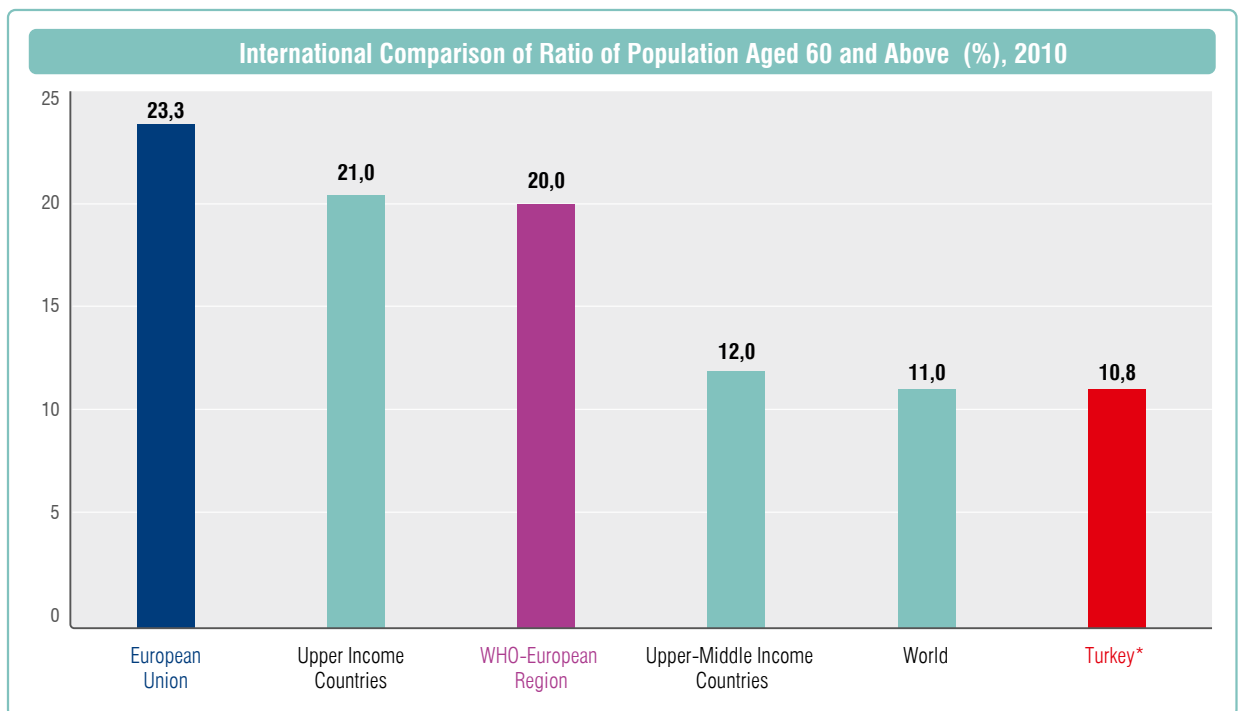


Ratio of Population Aged 65 and Above (%), 2011



Graphic 6.
Source: TURKSTAT

Eastern Black Sea region has the highest ratio of elderly population in Turkey whereas the Southeastern Anatolian region has the lowest elderly population.



Graphic 7

Source: TURKSTAT, World Health Statistics 2012

* Data related to Turkey belong to the year 2011.

Ratio of elderly population in Turkey is at the same level as it is in upper-middle income countries.



OUR HEALTH POLICIES FROM THE PAST TO THE PRESENT



Considering our health policies from the past to the present, besides the continuity of the Seljuk-Ottoman medical tradition, a cultural unity stands out in the organization of the health care services. When this structure was developed during the foundation of our young Republic, a western-oriented path was mostly followed for organizing the state and its institutions and establishing service policies. Within this process, health policies demonstrated basic preference changes in relation with the trends in the world.

Health Policies between the Years 1920-1923

The Ministry of Health was established by the Law no. 3 of 3 May 1920 after the opening of the Turkish Grand National Assembly. The first Minister of Health was Dr. Adnan Adıvar. An opportunity of regular recording did not exist in this period. The focus was mostly on healing the damages of the war and developing the legislation. The important point here is that the MoH was one of the first ministries to be established within the young state that was organized before the republic was founded and during the most difficult days of the struggle for existence. The Government of the Turkish Grand National Assembly continued to work for the institutional arrangements of the health care services even during the difficult years of warfare.

In this period, Law no. 38 on Forensic Medicine (1920) was passed.

Health Policies between the Years 1923-1946

During his ministerial term, beginning from the foundation of the Republic until the year 1937, Dr. Refik Saydam made great contributions to the establishment and development of the health care services in Turkey. According to the records we have today, health care services were provided by the government, municipality and quarantine centers, small sanitary offices, 86 inpatient treatment institutions, 6,437 hospital beds, 554 physicians, 69 pharmacists, 4 nurses, 560 health officers and 136 midwives in 1923 in our country.

In this period, the following Laws, which are still in effect, were passed:

- Law no. 992 on Bacteriology and Chemical Laboratories (1927),
- Law no. 1219 on the Practice of Medicine and its Branches (1928)
- Law no. 1262 on Pharmaceuticals and Medical and Medical Preparations (1928),
- Law no. 1593 on General Hygiene (1930)
- Law no. 3153 on Radiology Radium and Electricity Treatment and Other Physiotherapy Facilities (1937)



Health policies of the Refik Saydam era were centered on the following four principles:

1. Central execution of the planning, programming and administration of the health care services,
2. Leaving preventive medicine to central administration and curative medicine to local administrations,
3. Improving the attraction of Medical Schools in order to meet health manpower demand, opening dormitories for the students of schools of medicine, establishing compulsory duty for medical school graduates,
4. Introducing control programs for communicable diseases such as malaria, syphilis, trachoma, tuberculosis and leprosy.

Under the light of these principles;

- Health care services have been conducted with the model of “single-purpose service in a wide area/vertical organization”,
- “Preventive medicine” concept has been developed through legal regulations; the local administrations have been encouraged to open hospitals; and offices of government physicians have been established.
- Diagnosis and treatment centers have been established in district centers beginning from the places with high population (150 district centers in 1924 and in 20 district centers in 1936); physicians were banned from working independently.
- As a guide for the cities, Ankara, Diyarbakır, Erzurum, Sivas Numune Hospitals were opened in 1924; Haydarpaşa Hospital was opened in 1936; Trabzon Hospital was opened in 1946 and Adana Numune Hospital was opened in 1970.

Health Policies between the Years 1946 - 1960

“First Ten-Year National Health Plan”, which we will call the first health plan of the Republican Era of our country, was approved by the Higher Council of Health in 1946. This plan was announced by the Minister of Health, Behçet Uz, in 12 December 1946. However, before this work became a law, Behçet Uz left the MoH.

When Dr. Behçet Uz became the Minister of Health again in the government of Hasan Saka (10.8.1947/10.6.1948), the National Health Plan, which became a draft law in one and a half year, was negotiated and approved by the Cabinet and the four commissions of the Turkish Grand National Assembly. However it could not become a law due to the change in the government. The new Minister of Health, Dr. Kemali Bayazit, withdrew the plan.

Although National Health Plan and National Health Program could not be turned into a legal document or implemented in whole, majority of their ideas deeply influenced the health structuring of our country.

The inpatient treatment institutions, which were basically under the supervision of the local governments until that day, were started to be managed from the center.



National Health Plan, in the framework of the principle of bringing health organization to the villages and villagers, tried to establish a 10-bed health center for every group of 40 villages and provide curative medicine and preventive health care services together. Efforts were made to assign 2 physicians, a health official, a midwife and a visiting nurse to those centers along with village midwives and village health officers, who would work with groups of ten villages.

In 1945, there were 8 health centers; this increased to 22 in 1950, to 181 in 1955 and to 283 in 1960.

Under MoH, the Branch Management of Mother and Child Health was established in 1952. Collaboration and assistance was ensured from international organizations such as UNICEF and WHO, and a Mother and Child Health Development Center was established in Ankara in 1953.

In that period, child mortality rate was high, and also mortality caused by infections was high. This led to the intensive implementation of the policies for increasing the population. In this framework, significant progress was made in terms of health centers, delivery centers, infectious diseases centers and health human resources developments.

Average life expectancy at birth was 43.6 years in 1950-1955, 52.1 years in 1960-1965, 57.9 years in 1970-1975.

“National Health Program and the Studies on Health Bank” was declared by Dr. Behçet Uz in 8 December 1954. It was a continuation of the First Ten-Year National Health Plan and it became one of the foundation stones for the health planning and organization for our country.

National Health Plan divided the country into seven health regions, and considered establishing a school of medicine for each region and increasing the amount of physicians and other health staff (Ankara, Balıkesir, Erzurum, Diyarbakır, İzmir, Samsun, Seyhan). National Health Program foresaw a structuring composed of 16 health regions and the planning was done accordingly (Ankara, Antalya, Bursa, Diyarbakır, Elazığ, Erzurum, Eskişehir, İstanbul, İzmir, Konya, Sakarya, Samsun, Seyhan, Sivas, Trabzon, Van).

In order to establish human resources infrastructure, Ege University School of Medicine started accepting students in 1955 after Istanbul and Ankara Universities' Schools of Medicine. When the years 1950 and 1960 are compared, it is seen that the number of physicians increased from 3.020 to 8.214, nurses from 721 to 1658, midwives from 1.285 to 3.219. More than a 100 % increase was ensured for all 3 occupations in 10 years.

The number of hospitals and health centers also increased and in parallel with this the number of beds increased. The developments especially in the fields of child hospitals, delivery centers and tuberculosis hospitals were very affirmative.



While there were 14,581 beds in 118 MoH-affiliated institutions in 1950, there were 32,398 beds in 442 institutions in 1960. While those numbers were influenced by the centralization of the hospitals, which used to be under the local governments, when we look at the number of beds per a hundred thousand, we see that while there were 9 beds per a hundred thousand people in 1950, this ratio became 16.6 in 1960.

While there were such positive developments in the health institutions and the bed numbers, there were also positive improvements in the health indicators.

Tuberculosis-caused mortality decreased significantly in this period. There was also a similar positive change in infant mortality rate.

While the mortality rate caused by tuberculosis in cities and district centers in Turkey in 1946 was 150 per a hundred thousand, this was down to 52 per a hundred thousand in 1960.

Infant mortality rate was 233 per thousand in 1950, and this came down to 176 per thousand in 1960.

Both National Health Plan and National Health Program had aims such as insuring the public in return for a fee, meeting the costs of the uninsured people and the people who could not pay for treatment from a special administrative budget; establishing a health bank and financing the health expenditure from here; auditing the production of medical materials such as medicine, serum and vaccine; and establishing industrial institutions which would provide child food such as milk or infant formula.

In this framework, Biologic Control Laboratory was established in 1947 under Refik Saydam Hygiene Center Presidency, and a vaccine station entered into service. From that year onwards, intra-dermal BCG vaccine started to be produced. Whooping-cough vaccine was started to be produced in our country in 1948.

Again in the same framework, Workers' Insurances Administration (Social Insurances Agency) was established in 1946. Starting from 1952, health institutions and hospitals were opened for the insured workers. Works were also carried out in this period regarding the establishment of the Retirement Fund, thus the coverage of the social security started to expand.

In this period, legislation was also formed that set the legal infrastructure for the nongovernmental organizations and some medical occupations:

- Law no. 6023 on the Turkish Medical Association (1953)
- Law no. 6197 on Pharmacists and Pharmacies (1953)
- Law no. 6283 on Nursing (1954)
- Law no. 6643 on Turkish Association of Pharmacists (1956)



Health Policies between the Years 1960-1980

Law no. 224 on the Socialization of the Health care Services was adopted in 1961. The socialization actually began in 1963. A widespread, continuous, graduated and provincially-integrated structure was adopted, and this structure had health posts, health centers, and province and district hospitals. Vertical organizations were partially reduced, and the structures that provided different health care services were integrated under the health posts.

Law no. 554 on Population Planning was adopted in 1965. Thereby, anti-natalist policy (population control) was adopted instead of pro-natalist (rising population) policy.

“Multi-dimensional service in narrow area” approach was adopted instead of the “single purpose service in a wide area”.

While a draft law on Universal Health Insurance was prepared in 1967, it could not be sent to the Cabinet. In 1969, the 2nd Five-Year Development Plan foresaw the introduction of the Universal Health Insurance once again. In 1971, the Draft Law on Universal Health Insurance was sent to the Parliament but it was not adopted. In 1974, the draft was presented to the Parliament again but not discussed.

In 1978, “Law on the Principles of Healthcare personnel’s Full-Time Practice” was adopted. The physicians in public sector were prohibited from setting up private practices. In 1980, this law was repealed with the “Law on the Compensations and Working Principles of the Healthcare Personnel”, and the freedom of establishing private practices was re-introduced.

Health Policies between the Years 1980 – 2002

The 1982 Constitution includes provisions both regarding the citizens’ social security right and the State’s responsibility towards realizing this right. According to the 60th Article of the Constitution, “Everyone has a right to social security, and the State shall take the necessary measures and establish the necessary organization to provide this security”. Additionally, according to the 56th Article of the Constitution, “To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased efficiency, the State shall regulate central planning and functioning of the health care services. The State shall fulfill this task by utilizing and supervising the health care and social institutions both in the public and private sectors”. This article also includes a provision stating “Universal Health Insurance may be introduced by law.”

Basic Law no. 3359 on Health care Services” was adopted in 1987. However because the necessary regulation for the execution of this law was not made and some of its articles were repealed by the Constitutional Court, the law was not put into effect in full.



As the finance management in health gained importance, Universal Health Insurance came to the agenda once again in 1987. However, the legal regulations on this matter could not be realized and also in 1986 health benefits were introduced for the Bağ-Kur enrollees, thus a 3-headed structure emerged in public health insurance. The most significant outcome of this development was that three institutions had separate approaches and pricing systems for the same health care service. While some institutions covered the price of a certain service in their payment list, the others did not.

In 1990, State Planning Organization (SPO) prepared a basic plan on the health sector, and in line with this plan 1st National Health Congress was held in 1992. This “Master Plan Study on Health Sector”, which was executed by the MoH and SPO, is in a sense the beginning of health reforms.

The First and Second National Conferences on Health were held, and the theoretical studies on health reform gained acceleration. Green Card practice was started in 1992 with the Law no. 3816 for the low income citizens, who did not have social security coverage. In this way, vulnerable people who did not have the economic means to access health care services gained limited health insurance coverage.

“National Health Policy”, prepared by MoH in 1993, included 5 main chapters, which were assistance, environmental health, lifestyle, provision of health care services and healthy Turkey.

In 1998, Universal Health Insurance was presented to the Parliament by the Cabinet under the name “Law on Personal Health Insurance System and Establishment and Operation of the Health Insurance Institution” but it did not become a law. In 2000, a draft law on the “Health Fund” was presented for the opinion of the ministries; however it had no conclusion either.

The main components of the Health Reform works conducted in 1990s were:

1. Establishment of a Universal Health Insurance by gathering the social security institutions under a single roof,
2. Development of the primary care services in the framework of family medicine,
3. Transformation of the hospitals into autonomous health facilities,
4. Providing MoH with a structure that plans and supervises the health care services and prioritizes preventive health care services.

Consequently, this was a period in which theoretical studies were conducted but not put into practice sufficiently.



2003 - 2011: Turkey Health Transformation Program

According to WHO, the health care system of a country should be designed in a way to ensure the delivery of high-quality health care services for all people. This service should be effective, affordable and acceptable to the overall society. Each country is recommended to develop its own unique health care system taking those factors into consideration.

At the end of 2002, the status of the Turkish health care system made it necessary to undertake radical changes in many areas from service delivery to financing and from human power to information system. For this purpose, we have launched the Health Transformation Program in 2003. We have prepared this program by getting inspiration from past experiences, particularly the socialization of health care services, the recent works for health reform and the successful examples in the world.

It is certain that the program will seriously affect not only the present but also the future, and that it will be a significant milestone in achieving the objectives set in the field of health. MoH has shown its decisiveness for the implementation of this program and reaching the desired status in health, and has put many implementations into practice.

In this period, the steps facilitating the lives of our citizens are taken with courage and determination. In this understanding, the hospitals of other public institutions, including those of SSK (Social Insurances Agency), were transferred to the MoH.

The coverage of Green Card has been widened for low-income groups. The health care services and pharmaceutical expenses of the Green Card holders within the scope of “outpatient services” are also covered by the state now.

The VAT of the pharmaceuticals has been reduced, and the medicine pricing system has been changed. In this way, a big discount has been made in pharmaceuticals’ prices. The burden of pharmaceutical expenses both on the public and on the citizens was reduced a lot. Those arrangements have played an important role in spreading the access to pharmaceuticals.

“112 Emergency Health Care Services” are delivered not only in cities but also in villages. The numbers of stations are increased and the ambulances are equipped with the state-of-art technology. Sea and air transportation vehicles are added to the system.

Primary care services, particularly preventive health care and mother-child health care services, are strengthened; and Family Medicine implementation, which is an element of modern health understanding, has been introduced and spread out to the whole country.



Comprehensive programs have been implemented to prevent ill-health and premature deaths associated with non-communicable diseases. In this scope, national programs have been planned and implemented for certain diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory track diseases, stroke, and kidney failures.

Our indicators for communicable diseases have reached the level of the developed countries after the commencement of the Health Transformation Program.

The regions lacking building, equipment or healthcare personnel have been accepted as priority areas and the imbalances of this sort have largely been eliminated. In the last nine years, a total of 2.021 new health facilities including 554 independent hospitals and new hospital buildings were put into service. In the same period, the number of personnel working in the public health institutions has increased by 226 thousand people and reached 482 thousand people with service procurements.

A large-scale transformation program appreciated by the world has been implemented for the last nine years. Despite that, while the increase in the overall primary public expenditure was 92 % in 2003-2011; the increase in the public health expenditure was only 74%. Public resources have started to be used efficiently with the Health Transformation Program. Eventually, financial sustainability has been ensured with the medium term financial plan covering the years 2010, 2011 and 2012.

The actions are so widespread and effective that they foretell what will and can be done from now on. In 2003, the level of satisfaction with health care services was 39.5%, and this figure reached 75.9 % in 2011. As a result of this satisfaction, our people have started to demand better service and their trust and expectations have risen. It is necessary to complete the ongoing services and undertake new enterprises in order to meet these expectations. We have the determination, decisiveness and experience to make this happen.



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“In many ways, the content of the HTP appears to represent a “textbook” set of reforms for a health system of the type found in Turkey prior to 2003, building on the strengths of the system, yet targeting the weaknesses.”



ANATOMY OF THE HEALTH TRANSFORMATION PROGRAM



Health is the most fundamental building block for our lives. It is the constant denominator in every breath we take, in every step we take and in whole life. In fact all variables of life are hidden in this basic structure. Every detail we experience in a lifetime is calculated according to this constant denominator.

According to our understanding of ethics, since health is a birthright, health care services should be organized in ensuring equitable access for everyone. In line with the principles of justice and equity, all people should be provided with health assurance; no distinction such as gender, social status or social class should prevent the utilization of health care services; health care services should be easy to access; the health care services delivered should be modern and effective.

According to WHO, the health care system of a country should be designed so as to ensure the delivery of the high-quality health care services all people need. This service should be effective, affordable and acceptable by the society. It is recommended that every country develop its own unique health care system by taking those factors into consideration. While establishing its unique system, each country should also initiate its own constant transformation process.

New ideas are constantly emerging in the world with respect to transformation programs. However, it is accepted that getting health transformation right is a truly complex social phenomenon.

Reasons that Render the Health Transformation Program Essential:

1. Cost Increases in the Delivery of Health Care Services

Today, many countries face a gap between the funds they can allocate for health care services and the level they want to attain in health sector. As the economies progress, the expectations continue to grow, the countries become more democratic, and media-based images spread around the world. The costs of health care services increase in almost all countries depending on the changing demographical characteristics, developing diseases patterns and the new technology.

2. Increased Demands of the Citizens

People want to stay young and healthy as long as possible and benefit more from health care services. Health care system in many countries is under increased pressure for achieving those goals.

As countries develop, their citizens want to spend more for health. Those increasing expectations necessitate the use of more numerous and more costly services both for care and treatment. Global and social developments (films, television and Internet etc.) increase those demands. Increased expectations have caused patients to ask for the most recent and best service, state-of-the-art technology and the medicines.



Knowing that such facilities exist in other places, people have become more skeptical about the quality of service in their local health centers or smaller hospitals. People have started to prefer the regional centers and university hospitals although their health conditions do not require that.

3. Limited Payment Capacity of the Public

Governments are under pressure to meet the emerging demand created by increased costs and expectations. Although economic growth means that more financing will be supplied for health care services generally the costs and demand in the health sector grow faster. At the same time, the service providers in the health care service system struggle to maintain their income. Ultimately, the economic processes intersect with the political pressures and affect the amount of funds a country decides to allocate for health.

4. Citizens Have Started to Question the Understanding of Management in the Public Sector

Poor management in public, inadequate policies and the waste of limited sources have created skepticism about the public sector. Now the citizens analyze it more when the public sector delivers unsatisfactory service. Factors such as democratization, the increased number of non-governmental organizations, media, and internet cause the citizens to question the understanding of management in the public sector.

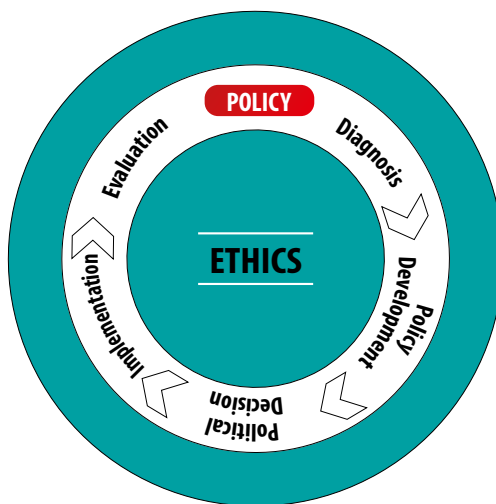
Health Policy Cycle

The Transformation Program is built on the moral understanding that aims at enabling all citizens' access to health care services in an equitable manner as the equal citizens of the country.

While making the political and methodological preparations of the program; a gradual, continuous policy cycle is designed that will ensure the sound operation of the transformation process of the health policies. According to that, first the problems are defined; the conditions providing the basis for those problems are analyzed; policies are developed for solving the problem; political decisions are made to implement those policies and then those decisions are implemented. After that, the outcomes of those policies, which are implemented within the ethical framework, are assessed.



The transformation process can be defined with the following cycle:



Policy Cycle in Health

A- Diagnosis

One of the most important steps ignored while implementing the transformation programs is the definition of the problem. How are the problems perceived? What are the social processes shaping them? Which factors determine the problem-definition of the transformation programmers? What are the perspectives of the interest groups with respect to problem-definition and solution suggestions?

Some health sector planners argue that the only thing required for defining the problems is good data. However, this data cannot fully define the problems and priorities of the health reform single-handedly. Any political decision should be based on both science and ethics. For example, in many countries women live longer than men. Whether this fact represents an inequality of the public policy which needs fixing cannot be identified just with data.

Data ensures that the discussion is carried out in a more honest manner. For this reason, the people responsible for the transformation program have a significant responsibility in understanding what is important for transformation. Otherwise, the ideology and the interest groups will dominate and shape the discussion.

One of the important uses of the data in the process of problem-definition is the benchmarking. Benchmarking in health sector reform means that a country looks at the countries, which have similar levels of income and expenditure and high health performance. Despite the differences between countries, the international comparisons can be a useful starting point for discussing the performance problems.



While defining the problems, four factors that can affect the content and implementation of the transformation program policies should be taken into account:

- **Stakeholders:** The cluster of people or groups that are included in the reform process or that can discuss the fate of the policy.
- **Power:** The relative power of each player in the political game (according to the means of each player).
- **Position:** The player's power to support or reject the policy and the amount of resources the player can spend for this.
- **Perception:** The private and public perception of the definitions of the problem and solution.

The problems should be defined by focusing on the three objectives of the health system performance:

- Health indicators
- Protecting the citizens from financial risks
- Health care users' satisfaction with the delivered health care services
- Financial sustainability of the health care system

After problems are defined by focusing on the health care system performance, it becomes necessary to make a diagnosis journey for the health transformation programs, just like a physician moves from the symptoms to the causes.

With respect to diagnosis, the fundamental strategy is "Work backwards". One keeps asking "why" until one has discovered the causes of the poor performance one wants to improve. This is not a simple task. A famous quality development specialist says that one needs to "ask 'why' for five times" in order to find the underlying causes of the diagnosis process that lie behind, beyond and under what is visible. It is necessary to study the depths in order to understand why the system behaves in a certain manner.

One tries to identify the causes of the unsuccessful results for diagnosis. This is done by examining the five control knobs of the health sector.

Five control knobs of the health sector are;

- Financing,
- Payment,
- Organization,
- Regulation
- Behavior

Those five knobs cover the mechanisms and processes that need to be adjusted for improving the system performance of the transformation programmers. Our diagnosis regarding the five critical control knobs also reveal the factors that determine the outcomes of the health care system and that can be used to change them.



Five Control Knobs Used in Health Transformation Program:



Financing

It means all the mechanisms, which ensure the collection of money that is paid for health sector activities.

Financing has a very significant impact on the performance of a health care system. It determines:

- How much money is usable,
- Who undertakes the financial burden,
- Who controls the funds,
- How the risks are pooled, and
- Whether the costs of the health care services are controllable.

Those factors help determine:

- Who has access to service,
- Who has protection against impoverishment due to catastrophic health expenditures and,
- The health status of the population.

There is no magical solution for the financing problems. All funds collected through any financing method come directly or indirectly from the citizens. The issue that every country has to make a decision on is which sources to use and to what extent they will be used.

Some specific suggestions based on political and economic theories should be taken into consideration in the light of the international experience in order to adjust the financing control knob in the most effective manner:

- Poverty constitutes a basic financial limitation by itself. Poor households may not be able to afford the health care services. If they are to have access to services, then the government should support them. If the goal is to assure equity, then the public expenditure should target the poor (this is not the case in many lower and middle income countries at the moment).



- Special financing programs should be developed for the poor people living in rural areas. Such programs enable us to use the existing expenditure in a more effective and efficient manner. In this way, we can increase the quality of health care services and decrease the impoverishment due to medical expenditure.
- As long as sufficient funds are collected, social insurance programs protect people from the financial risk at a high level. As the national income increases, the governments can enlarge this scope by providing assistance from the general tax revenues.
- If the social insurances cover the services that are not covered by the private insurances, then the private insurances can play a complementary role for social insurance towards the aims of providing better service quality.
- If a country wants its resource allocation to be cost-effective while maximizing its health status, then it should support the primary and preventive health care services with taxes.

Issues to be Considered While Choosing the Financing Strategy:

- **Socioeconomic Development**

A country's capacity to mobilize its funds is largely in correlation with its income per capita. The income determines the households' payment capacity and demand for health care services. Other important factors are tax revenues, the number of the employed people and the amount of poor households.

- **Financial Capacity**

The key question for a financing strategy is this: Is it possible to mobilize sufficient amount of money to meet the desired level of spending in the health sector? How much will be cut from the other sectors in order to increase health sector spending? Therefore, it is necessary to match the financing strategy with the objectives. While discussing the sustainability of health financing system, this topic should be at the focus point.

- **Feasibility**

The key aspect of feasibility is the administrative capacity of a country. Does the country have the necessary administrative systems and the human resources for effectively implementing a financing program? Feasibility also depends on the social acceptability of a financing program. Voluntary compliance levels differ widely both within the country and at the international level. The chances of success are much higher for the use of programs that are considered legitimate by the public.

- **Political Accountability**

The decisions regarding how and where to spend the money in democracies are the main testimony to the government's power. When considered from the perspective of the democratic politics, the citizens should be allowed to have proper control over the process. Certain features of the financing system affect this accountability. Is any person that has authority over the financing process subject to election through a democratic process? If this person is an assigned bureaucrat, then does he have any accountability?



- **Equity**

Since financing directly affects the distribution of the costs of health care services, the party that will undertake the financial burden is important. Since the use of funds directly affects the distribution of health care services, the party benefiting from the services is important. There are two dimensions to the assessment of the distribution of burden and benefit.

1. Vertical equity: Distribution of burden between the rich and the poor.
2. Horizontal equity: Justice amongst the ones at the same income level.

- **Risk Pooling**

The costs of health care services are not distributed equally in the community. Cancer affects some people and does not affect other people. The elder people experience more disease and disability conditions in comparison to the young. The people with diabetes need health care services more frequently. The uncertainty of the disease necessitates the formation of a financing strategy where the risks can be pooled.

- Mandatory social insurance coverage can provide risk pooling as long as it is universal.
- Private group insurance covers only a group of health risks.
- The out-of-the-pocket payments of the patients also provide risk pooling.

- **Economic Impacts**

Different options have different impacts on promoting or discouraging the investments, employment opportunities and labor supply. Therefore they will affect the level of the economic activities in the short and long term.

2

Payment

Fees mean the methods that are used for transferring the money such as capitation payments and budget to the health care service providers. First of all, it should be noted that no payment method is perfect (every payment methods has its own negative and positive aspects).

Although countries differ in terms of their health care system objectives and conditions, international experiences draw attention to the five critical lessons regarding the payment control knob:

- Decisions regarding the payment method should be assessed within the context of the way the system is organized, and the organization and payment should complete each other.
- Fee-for-service promotes the increase of the costs of health care services. The countries should avoid this method unless they have important reasons to do otherwise.
- The method of basic salary + bonus payment is superior only to salary payment system. The method of basic salary + bonus payment can motivate health professionals to increase efficiency and service quality. This advantage is valid especially for the specialists.



- The method of capitation payment for primary care services can support the transformation program.
- Payment based on Diagnosis Related Groups (DRGs) in upper and middle-income countries has desirable incentive effects.

3

Organization

It means the roles and functions of service providers and the mechanisms they use in health care service markets.

The transformation programmer, who wants to implement the organization control knob, should focus on four main features of the system:

- The mix of the organizations providing health care services
- The division of activities amongst those organizations
- The relationships amongst those organizations and their relations with the political and economic systems
- The administrative structures of those organizations

We should examine the “Six Keys of the Organizational Performance” in order to understand how restructuring will influence the performance of the transformation program:

- **Incentives for Organization**

- What should the organization do in order to obtain the resources it needs for its survival and growth?
- What kind of limitations or opportunities might come from the competitors, users, regulators and the ones that prepare the budget?

Powerful performance-based incentives should be established for effective transformation programs. Financing can be linked to performance with a couple of ways. For example, the budgets might differ based on the quality and amount of the services provided. Incentives can also be given to the regions or institutions that have better performance.

- **Incentives for Managers**

- How are the managers rewarded or sanctioned?
- How does this relate to the institutional performance?
- What channels of reporting, audit and accountability exist?
- What is the potential career path outside the existing organizations?



Effective transformation programs provide powerful incentives for the managers towards increased performance. The managers should be chosen, supported and paid based on their skills and managerial performances. Reporting and audit systems that establish real accountability should be prepared.

- **Skills and Attitudes of the Managers**

- What are the contributions of the managers to their works in terms of skills and attitudes?
- How are their selections, trainings and work experiences shaped?
- How do the managers perceive their works? What are their opinions of their responsibilities?

In order to carry out an effective transformation program, entrepreneurship and social responsibility that can improve transformation should be constituted among the managers. In addition, manager training programs can be taken as a precondition for certain jobs.

- **Authority of the Managers**

- What kind of decisions can managers make on topics such as prices, manufacturing processes, procurement, personnel?
- Can they hire or fire staff?
- Can they make investment decisions, or choose strategy?

The managers should have authority with respect to personnel, procurement and other important subjects

- **Incentives for Employees**

- To what extent do the rewards given to employees vary according to their performances or the institutional performance?
- What defines the payments to be made to the employees and their promotions?
- Is there any non-monetary incentive?

The former personnel management system and the weak incentives established by it should be taken into account.

Personnel management systems should be changed in a way that will reward the performance and limit the political influence and protection.

- **Skills and Attitudes of the Employees**

- What are the contributions of the employees to their works in terms of skills and attitudes?
- How are their selections, trainings and work experiences shaped?
- To what extent are the employees determined about the organization's success?

The practitioners of the transformation program often ignore the skills and attitudes of the employee. This mistake should be avoided. Recruitment structures, training systems and the personnel practices should be revised.



4

Regulation

It means the sanctions made by the state in order to change the behaviors of the actors in the health care system such as service providers, insurance companies and patients.

Types of Regulations within the Health Sector:

A- Regulating the Health Care Services Sector

B- Regulating the Health Insurance

A- Regulating the Health Care Services Sector:

A.1- Providing the Basic Conditions so that the Health Care Services Sector Can Function

- Defining and protecting the private property rights and patents
- Managing the financial status of the health care service institutions
- Protecting patient rights

A.2- Providing the Things that Private Sector cannot Do (For Equitable Access):

- Subjecting the physicians to mandatory service when necessary
- Supplying the urgent care rights of the patients

A.3- Correcting the Failures of the Health Care Services Sector:

- **Handling the External Impacts**
 - Providing free-of-charge or support programs directly by the government (vaccination and health education etc.)
- **Helping Citizens for Making Conscious Choices**
 - Regulating the accurate advertisement
 - Advertisement limitation for the physicians
- **Protecting Citizens from Unqualified Service**
 - Regulating the inputs
 - ✓ Standards on the control and use of pharmaceuticals and food hygiene (including herbal medicines)
 - ✓ Regulating the undergraduate education of the physicians, nurses and Pharmacists
 - ✓ Accreditation of laboratories and hospitals
 - Regulating the process
 - ✓ Implementing the clinical guidelines
 - ✓ Patient feedbacks



- Regulating the outputs
 - ✓ Setting standards for all kinds of medical reports
 - ✓ Building clinical supervision systems
 - ✓ Ensuring that the problems deriving from the execution of health professions are regulated by the state rather than professional associations
 - ✓ Malpractice responsibility
- **Regulating the Demand of Health Care Service Providers**
 - Regulating the labor force
 - ✓ Meeting the shortage of physicians and nurses
 - ✓ Encouraging the graduates of the foreign schools of medicine
 - Regulating the capital investment
 - ✓ Encouraging new technologies and the construction of new facilities
 - ✓ Controlling the importation of equipment
- **Objecting Monopoly**
 - Preventing monopolization of public or private sector in health care service delivery
 - Regulating the monopolistic prices
 - Defining the user fees for public and private health facilities
 - ✓ Defining reference prices for pharmaceuticals

A.4- Regulating the Issues that cannot be left to the Private Sector Understanding:

- Tobacco sales
- Blood transfusion
- Organ transplantation
- Drug abuse
- Euthanasia

B- Regulating the Health Insurance System

B.1- Defining Basic Conditions for Private Health Sector:

- *Financial arrangements for private insurance companies*
- *Sales and marketing practices of private insurance companies*



B.2- Regulations that cannot be made by Private Health Sector (Equitable Distribution):

- Risk Pooling
 - Making it mandatory for the insurance scheme to define the premiums on a community basis.
 - Ensuring that the households that have the ability to pay are included in the insurance schemes.

B.3- Correcting Health Sector Failures

- **Risk Selection:** Private insurances exercise risk pooling in order to insure the healthy people and reject the less healthy people.
- **Adverse Selection:** Mandatory insurance is used to discourage adverse selection and pool the risks amongst the elderly and the young, the healthy and the less healthy.
- **Monopolistic Pricing:** Paying a minimum premium to benefit from the health care services.

B.4- Correcting the Unacceptable Risk in Health Sector

- Uninsured People

Obliging all population to be included in the social insurance.

- Cost-Effectiveness

Regulating the benefits package of the mandatory insurance

5

Behaviour

It explains how the patient and service providers behave in relation to health and health care services.

Health system performance and health status are affected from the individual behavior in many ways. Whether the patients take their medication regularly affects the success of the tuberculosis control programs. Vaccinations affect the newborn mortality. The physicians' habits of prescribing antibiotics affect the development of microbial resistance. Drivers' habits and the use of seat belts affect the case fatality in traffic accidents. In brief, the individual behavior can have significant impacts both on the individual's health and on the health system performance. On the other hand, the behavior has its roots in the culture, social structure, habits, belief, attitudes and opinions.

Where can the behavior change knob be used within the scope of the health transformation programs? It is important to consider four individual behavior categories here:

1. Treatment seeking behaviors
2. Behaviors of health professionals
3. Patients' compliance behaviors
4. Lifestyles and behaviors protecting from diseases



1. Treatment Seeking Behaviors

The citizens' decisions about when, where and how to get treatment are an important field with respect to improving health system performance. Among the decisions that are related to the health seeking behavior are the type of the service provider (for example specialist vs. general practitioner), the level of the health facility (for example primary care facility vs. university hospital), treatment time, treatment place and the use of herbal medicines vs. chemical medicines.

2. Behaviors of Health Professionals

Among the important behaviors of the health professionals are the treatment composition, focus on the preventive care, treatment location (public hospital vs. private practices of the service providers) and patient referral.

3. Patients' Compliance Behaviors

It covers the topic of whether the patients comply with the treatment instructions given to them. Among the behaviors in this category are the use of pharmaceuticals, the execution of referral order and the treatment follow-up.

Many strategies aiming at changing the patients' compliance behavior are related to pharmaceuticals.

Examples of the behavioral change strategies in this field include the efforts made for encouraging patients to take their antibiotics properly (here the aim is to decrease the development of antimicrobial resistance) and encouraging the patients with chronic conditions to take their medication regularly and on time.

In some cases, the behavioral change strategies for ensuring compliance can be implemented with the direct correction of the individual behavior. Such practice exists in Directly Observed Therapy (DOT) for tuberculosis cases. In DOT, the health professional observe how the patients take their medication and thus they make sure that the right drug combination is taken at the right time. The behavioral change strategies are also implemented for convincing mothers to breastfeed.

4. Lifestyles and Behaviors Preventing Diseases

They are the decisions made by citizens with respect to their lifestyles and habits, which have significant impacts in preventing diseases. This category includes the individual decisions such as food consumption, tobacco consumption, and the use of contraceptives. Different behavioral change approaches should be used concomitantly so that the health transformation programs can be efficient. It is necessary to seek the ways of integrating new concepts into the existing values.

The approaches that are implemented to change individual behavior vary from less compelling approaches such as only briefing to very compelling precautions such as prohibitions.

The following four ways should be followed in order to be able to use the data, which we obtain by studying the five control knobs of the health sector, efficiently:

- **Know the Literature**

It gradually becomes easier to reach up-to-date information via international publications and internet. Take time to identify the relevant literature and to get familiar with it. There is no chance that you are the first person that faces the problems you are trying to solve or that thinks about the questions.



- **Get Suggestions**

There is national and international specialty such as WHO, OECD, which can help you in reviewing the literature and the experiences of the other countries. However, be skeptical about the suggestions. Particularly about the suggestions coming the ones that have something to sell (for example a costly computer program).

- **Make rapid assessments**

Many questions do not necessitate an important research project. There might be rapid and cheap methods to obtain reliable estimates on an important matter. Those estimates can be sufficient to attain political goals.

- **Support good researches**

Problems might occur in low-quality studies and assessments. Reliable studies provide reliable evidences. If there are a lot of topics then making mistakes would be more costly. Most low and middle-income countries make insufficient investment in health care system studies. However since those studies require time, planning and resources, they should be carried out if you really need the data.

Consequently, for a good diagnosis the health transformation team should be wellprepared, curious, attentive and eager to learn from experience.

The team implementing the Health Transformation Program should do the following four things while passing from the diagnosis stage to policy development stage:

- **Keep asking “why” until you define the variables that can be manipulated**

In health sector, diagnosis moves from the performance values of critical objectives to what generates those outcomes. This process is not always clear. Policies can cause unintended outcomes and they can be mismanaged. Individuals might claim that they have done one thing and they might be doing something else in practice. There is need for a clear and skeptical mind and generally high-level of energy and curiosity.

- **Do not jump at conclusions**

Defining the problem at an early stage depending on ideologies or prejudices is attractive. Unfortunately, bypassing the diagnosis process is not a rare situation. Identifying a wrong reason might lead to poorly-designed policies. This will not only misdirect the energy and lose an opportunity but also damage the reliability of transformation.

- **Be scientific not judgmental**

If the agencies or institutions act in a way that we do not approve we will be inclined to decide that they are the problems. Therefore it is important to stay neutral during the diagnosis process. There is need for a clear and skeptical analysis here.



- **Use figures**

It is not possible to reduce everything important to figures for implementing the health transformation program. In fact it is not possible for an analyst to have all the goodquality data he or she might want. Also it is not possible to ignore the problems that cannot be documented with figures. For instance we might not be able to get any data from the poorest and ill-conditioned areas.

Despite all these facts, data can be very useful. Data can be a control point for the prejudices and the premature decisions. Data can help support a scientific attitude. In order to use data wisely, the transformation programmers should know where the data comes from, the limitations of data, the point skipped and the assumptions.

B-Policy Development

The definition of problems is followed by the development of policies that can overcome those problems in transformation programs. In fact while the policies studied have a wide variety, they are also universal because essentially they focus on overcoming the problems and attaining the defined targets. Within the framework of this universality each society develops its own policies by considering its own conditions. International experience is assessed and successful examples are adapted to the country conditions. One should be prudent against the ideological approaches and the implementations that emphasize individual or group interests. The political, economic and cultural realities of the country are always taken into consideration. Possible implementation problems (pertaining to resources, potentials and administrative law) are taken into account.

While developing policy within the framework of Turkey's Health Transformation Program, the priority was the human centered/anthropocentric approach along with the concepts of access, quality, equity and efficiency.

Here are the Basic Principles Used in Policy Development:

- **Human-centeredness / Anthropocentrism:** This principle means focusing on the individual that benefit from the service, individual's needs, requests and expectations while planning the system and delivering service. Moving from the fact that health is generated in the family environment, the individual is considered within the framework of the "family health" concept.
- **Sustainability:** It means the principle that the system to be developed complies with the country conditions and resources and presents continuity by feeding itself.
- **Continuous quality improvement:** It means the continuous search for the better and the establishment of a feedback mechanism that will ensure learning from mistakes by assessing the system considering that the point reached in service delivery and outcomes is not sufficient.
- **Participation:** It means getting the opinions and suggestions of all relevant parties while developing and implementing the system and establishing the platforms that will ensure a constructive discussion environment. In addition, this principle aims at ensuring the uniformity of resources in implementation by including all components of the health sector in the system mechanisms and be able to use resources in a more efficient manner.



- **Reconciliation:** It means the search for common grounds by looking after mutual interest among the different sections of the sector as a requirement of the democratic management. The aim is ensuring uniformity in methods, standards and audit mechanisms and the parties' compliance with this instead of an implementation that is based on conflict of interest.
- **Volunteerism:** It is the method of ensuring that all units to be included in the system act towards defined goals without discriminating between the service provider and service receiver or between the individual and institution. The service generating and service receiving parties within the system should participate on a voluntary basis in line with incentive precautions, not on a mandatory basis.
- **Separation of Powers:** This is the principle of separation of powers that finance, plan, audit and generate the health care services. In this way there will not be a conflict of interest, and a more efficient and more qualified service delivery will be ensured.
- **Decentralization:** The institutions should be saved from the cumbersome structure established by the centralized management. The aim is to implement the decentralized management in line with the changing condition and the modern understanding. Institutions that have administrative and financial autonomy will have quick decisionmaking.
- **Competitiveness in Service:** This is the principle of de-monopolizing the health care service delivery and ensuring competitiveness amongst different service providers according to certain standards. Thus there will be an incentive environment for continuous quality improvement and cost reduction.

C-Political Decision

Health sector reform policy has certain systematic features which turns this policy into a difficult process (which makes it more difficult than all other types of policy reform):

- **Technical Complexity/ Difficulty**

It is not easy to regulate the health sector. Many pieces are interrelated and many outcomes (both intended and unintended) might occur. Designing a comprehensive Health Transformation Program is a complex technical process because health reformers turn the five control knobs in different directions. Transformation programmers generally try to design many pieces of the system at the same time, and this makes it difficult for non-specialists to understand the program's details and overall impact. Political problems might occur because of the impact of the technical problems on the sector and their complexity for the public perception.



- **Changes in the Financial Status of the Well-Organized Groups**

The efforts towards the Health Transformation Program generally cause undesirable costs to the powerful groups such as physicians or the pharmaceuticals industry. The groups might try to form political obstacles against transformation in order to protect group interests.

- **Expenditure Made for Non-Organized Groups**

The health transformation programs generally try to focus the new benefits on the disadvantaged groups (for example the poor or the rural inhabitants). Those groups are generally not well-organized and they have a few political connections. Moreover those changes do not result in the same benefit for every individual. The costs distributed amongst the low-income groups can make it difficult to mobilize the political support.

- **The Roles of the Government Actors other than MoH in the Transformation Program**

Ministry of Finance (MoF): particularly if the reform includes changes in health services financing and MoH budget,

- Social Security Institution (SSI): if the reform proposal includes changes in health care services delivery and reorganization of the public health facilities,
- Ministry of Economy or Planning: if the reform proposal includes decisions regarding overall economic growth or debt forgiveness,
- Ministry of National Education: if there are policies affecting the school health policies and schools of medicine,
- Ministry of Agriculture: if zoonotic diseases, tobacco, herbal medicines etc. are relevant,
- Industry and Commerce: Patent, market surveillance audit, medical technology policies etc,
- Council of Higher Education (CHE): if implements policies relevant to medical schools
- Local or Regional Administrations: if the reform proposal includes decentralization.

Acceptance of transformation in the health sector is not only related to the political will, it is also an issue of forming an effective political strategy. Acceptance of a reform proposal depends on the parties' willingness, interest, skills and the political strategies they used. The standing of the authority, the political power behind the implementation makes it easy for the practitioners and the people affected by the transformation to adopt the transformation. Particularly the supports of the government heads are very important. Within the scope of the Health Transformation Program, HE Prime Minister has stood behind the political decision and this has had a significant impact on implementing many profound changes and attaining achievement on those.



D- Implementation

The implementation of the Health Transformation Program includes organization tasks:

- Development of the implementation plan,
- Gathering a team to realize the plan and assigning tasks to them,
- Development and coordination of the programs,
- Motivation of the implementers,
- Providing feedback.

We have to be attentive to the holistic approach in every step to be taken for transformation. We have to develop the policy and the program by taking all actors of the health care system into account and by seeing the whole picture. Implementing the Health Transformation Program requires basically four stages each related to a component.

1. Conceptualization

The first stage is the “conceptualization”. The aims, principles, development and implementation process related to the program are presented conceptually and clarified and developed after discussions with the national and international experts of the topic.

2. Enactment

In parallel with conceptualization, the second phase to follow is the “enactment” process. Necessary arrangements are made in the fields that have acquired conceptual clarity and that need legislation (such as law, implementing regulation, and cabinet decision).

3. Controlled Local Implementations

It is known that implementing the program as a package is not a realistic approach. At this stage, limited and controlled implementations are made for some innovations and improvements, which have been formed within the framework of the program before they are rolled-out to the country.

4. Dissemination in the Country

The fourth stage is the transition to countrywide implementation. Naturally it might not be necessary to experience those four stages for all components. All stages of each component do not need to happen at the same periods of time. Some parts proceed without waiting for others and some parts needs to wait for others.



E-Evaluation

Evaluation of a new program cannot wait until this program is fully implemented. Data should be collected before the implementation for baseline, and administrative systems should be established for evaluation.

The easiest evaluation approach is the comparison of the before and after. Evaluation based on evidence should be made, and data suitable for this should be collected. Data should be standardized beforehand and should be collected as necessary. Unnecessary and unorganized data causes information pollution. Data collection method and data diversity should be as plain as possible not to harm the continuity. The gathered data should definitely be evaluated and used for the continuation of the policy.

The basis of evaluation is the aims of the Health Transformation Program. The aims of the Health Transformation Program are to organize, finance and deliver the health care services in an effective, efficient and equitable manner.

Effectiveness means the aim of improving the health status of the public by the policies to be implemented. The biggest goal in health care service delivery should be preventing human from getting sick instead of treating patients. Achievement of this goal will be indicated by the progress to be made in epidemiological indicators. Decreased maternal and infant mortality and increased life expectancy at birth are the most concrete evidences of this achievement.

Efficiency means decreasing costs by the proper use of resources and generating more service with the same resources. The distribution of human resources, materials management, rational drug use, health management and preventive medicine practices should be assessed in the framework of this principle. Including all sector sources of the country within the system and ensuring their integration increases efficiency.

Equity means ensuring that all public have access to health care services as per their needs and that they contribute to the service financing as per their financial means. Reducing discrepancies in terms of access to health care services and health indicators among different social groups, in rural and urban areas and in the east and west is included within the objectives of equity.

The assessments of the implementations that are carried out in accordance with the aims of the Health Transformation Program are measured by three performance targets:

1. Improvements in Health Indicators

The health status of the society is our first performance target. The analysis of health indicators should be made according to other countries and previous years. Those figures set the analytical basis of the health policies.



2. Protection of Citizens from Financial Risks

This is an important objective of the health sector policies and a significant focus point of the health reform policies. This protection refers to the assurance that the individual can get treatment without experiencing financial difficulties when the he or she gets sick. There should be assurance that no disease will affect the patient or family or their daily lives and put them under impoverishing burden. Such assurances can be brought forth under different models. This protection is affected substantially by the way the health sector is financed.

The scope of protection from risk can be drawn by considering the objectives such as providing that individuals can receive sufficient service regardless of their financial constraints and compensating them against any possible financial losses due to malpractices.

3. Satisfaction with Health Care Services

This means the health care users' level of satisfaction with the services delivered to him or her by the health sector. In fact, it is widely accepted that health service cannot show its effectiveness or quality by itself. However, it is not possible for a system, which does not focus on the patient or reply to his or her expectations, to get results. If the citizens admire and accept the services, this will ensure their participation in the process and obtaining results more rapidly. Therefore, policy is developed by accepting satisfaction as one of the main criteria and by taking into account how citizens assess the health services delivered.

In those assessments, issues such as the waiting times of the service receivers at the institutions they apply, the levels of complexity of the hospital procedures and processes, the time allocated for patients and patient information are taken into account.

4. Financial Sustainability of the Health System

Financial sustainability of the health system can be achieved by ensuring health financing balance. The following are the factors that influence the health financing balance in the transformation programs:

- **Reform Cost:** During the initial periods of health reforms, health expenditures inevitably increase at a certain rate. An additional cost is required in order to eliminate the shortcomings that necessitate the reform, carry out and complete the reform process successfully.
- **Supply Factors:** The way of collecting the taxes and premiums, new treatment technologies and the new treatment alternatives are the factors that affect the health service delivery and cost.



- **Demand Factors:** Demographic changes such as prolongation of lifetime and ageing population, unhealthy life styles, chronic diseases, increase in health awareness and health expectation levels due to socio-economic change are the factors that increase the health service demand.
- **Macro-Economic Factors:** Economic growth, total amount of budget allocated to health, health expenditures as percentage of GDP are the macro economic factors that affect health financing.

It is a must to keep the impact of these factors at an optimum balance in order to ensure the financial sustainability of the health system and continue the transformation program with success.

The following elements are primarily important in ensuring financial sustainability during the implementation of the transformation program:

- Having filled the health service gap substantially
- Strengthening preventive health services
- Promoting a healthy life
- Rational drug use
- Keeping the drug prices under control
- Continuing economic growth
- Implementing global budget
- Increase in efficiency by outsourcing certain services
- Implementing Public-Private Partnership model in new investments

TURKEY HEALTH TRANSFORMATION PROGRAM



A. DIAGNOSIS



At the end of 2002, the status of the Turkish health care system made it necessary to undertake radical changes in many areas from service delivery to financing and from human power to information system. In this chapter, we like to figure out “How the picture was before the Health Transformation”.



Financing

- There was a multiple and fragmented health finance system.
- There was no harmony and coordination between the relevant units (MoH, MoLSS, MoF, SPO and Treasury) of health financing.
- Actuarial balances had been disturbed completely.
- There was no correlation between the rate of increase in health expenditures and the rate of increase in national income.
- While performing health finance calculations, merely health care costs used to be taken into consideration; micro, macro and social welfare costs used to be ignored.
- Because there was no performance-based budgeting to be established for the effective and efficient use of public resources, there was no fiscal discipline, accountability and fiscal transparency in the financing of public health services.
- Because there was no “national health accounts system” enabling the monitoring and keeping of health accounts on a routine basis, it was impossible to access to the correct data on this issue.



- IMF bureaucrats had influence on the health financing policies, and they had no political accountability.
- There was neither vertical equity (distribution of burden between the rich and the poor) nor horizontal equity (equity between those who are at the same level of income) in health financing.
- One of the most important elements of health financing strategy, risk pooling (compulsory social insurance, private insurance and out of pocket payment) wasn't compatible with neither mathematics nor ethical values.
- There wasn't a social security system covering the entire population; in addition, uninsured children had been left to their fate completely.
- Including primary health care services, even the majority of insured citizens couldn't access to health services. The number of applications to physician per person was 2.7 in a year.
- The budget allocated for preventive and primary healthcare services was very insufficient.
- 112 Emergency Health Care Services were being delivered as paid services for all citizens - both insured and uninsured.
- Our very few citizens could take the advantage of private hospitals and medical centers by paying very high fees. Only high-income citizens could access to the quality health services.
- When encountering a serious health problem (cancer, transplantation, congenital anomaly, cardiovascular surgery), the citizens who are not in high-income group had to spend too much for health expenditures in so much that impoverishing their families.
- In the outpatient treatment of our citizens who are Green Card holders; tooth extraction, eyeglasses and emergency treatment costs weren't being paid, including treatment, examination and tests.
- Hospitalized patients (including insured ones) had to supply the pharmaceuticals and medical supplies on their own and most often, they had to pay additional charge.
- Setting up private business and setting up private practices were at the highest level for public sector physicians which resulted in increased number of visits to private medical offices and out-of-pocket payments of people who needed severe treatment and therefore had to go to the former state hospitals, SIA hospitals and state university hospitals.

The existing health financing system was both exposing the patient against the physician and rendering helpless. Both the health service provider and the receiver were the victims of the system.



2

Payment

- The budgets of institutions that provide and receive health service were being prepared gropingly without depending on any strategic plan
- Various social security institutions (SSK/Social Insurances Agency, Bağ-Kur/Self- Employed People's Retirement Fund, Emekli Sandığı-ES/Government Employee's Retirement Fund) were using different reimbursement mechanisms. They did not have a common model or strategy.
- Between health service provider institutions and reimbursement institutions, there was no payment schedule whose methodology and duration were determined.
- There was no payment model that was arranged for the smooth execution of primary and preventive health services.
- Because the regular mobile health service implementation was very insufficient for the citizens living in rural areas (only 20% of the population), those who live in these areas had difficulties in accessing to primary healthcare services.
- Case-based payment system which had been implemented was left to the hands of the clumsiness of the bureaucracy. Both the invoices of hospitals and their control had gone out of rationality.
- Public hospitals continuously had cash flow problem, and this was increasing the operating costs consistently.
- Irregularity had become an ordinary practice in the treatment of Green Card holders.
- Health professionals were defrayed fixed payment irrespective of the quality and quantity of the work.
- Informality in public hospitals began to be taken as normal. Hospitals neither had a regular accounting system nor did they have regular financial tracking.
- Waste of resources was being seen as a normal component of public management in hospitals.
- Because there was no rational reimbursement mechanism in public health facilities, unnecessary referrals had become a routine procedure.
- Even for insured citizens, payment of treatment and drug expenditures completely out of pocket and even informal payment had become a part of the payment system.
- There was no performance-based payment (not only for workers, but also for managers).



Organization

- Because the primary care was not strong enough, primary and preventive health care services were insufficient.
- The physicians working in the primary care weren't guided to serve in this field. General practitioners working in the primary health care weren't able to focus on their work adequately because of their working conditions, socioeconomic situations and their expectancy for specialty.
- In urban areas, especially in metropolitans, health center infrastructure was insufficient. Many primary care facilities which were established previously for special purposes such as TB Control Dispensary, Mother and Child Care and Family Planning Center had come become idle.
- Because the rate of regular mobile service delivery was very low in rural areas, the preventive and primary health care indicators in these areas had reached dramatic figures.
- Citizens were unwilling to receive the health service from primary care and they were in tendency to go to hospitals directly. Insufficiencies in primary care resulted in long waiting lists in hospitals and increased the service costs and decreased the service quality.
- Emergency health services were extremely insufficient and without coordination in cities, they were lacking in rural areas.
- Public hospitals were neglected and almost all of them consisted of wards. In hospitals, the rooms with inbuilt toilet and bathroom were so few that one can count them on the fingers of one hand.
- In public and private hospitals, some units such as intensive care units, burn units and neonatal units were almost non existing in terms of quality and quantity.
- Public hospitals were so poor in terms of medical devices. Unfortunately, even the research and training hospitals were meeting the same fate.
- In the management and coordination of hospitals, there was no approach for performance and quality even at the conceptual level.
- Hospital managers' effects on management process, procurement and personnel were limited.
- The existing health care system didn't allow the health administrators to be entrepreneurs and take initiative.
- There were no reporting and supervision systems which form accountability to Administrators.
- The most organized and coordinated activity in public hospitals was the necessity of out of pocket payment including the insured citizens and widespread setting up private practice.
- There were numerical inadequacies in man power in health sector; in addition, there were imbalances in the nation-wide distribution of the healthcare personnel.



- Instead of providing information for the whole sector, MoH was producing only statistical information in relation to its own institutions. Statistical results were not reliable because adequate organization and supervision were not insured in the collection and flow of data. These resulting data had not been transformed into information and had not been used for managerial purposes.
- In many places, health records of individuals were not better than the level of a polyclinic card; sometimes irregular files that were kept in hospitals were lost in archives. There was not an integrated system to keep the health records of individuals; in addition to this, a disease registry and notification structure had not been formed to collect and analyze epidemiological data.
- Use of information system had completely remained at the phase of record collection and storage; and for this reason, advantages such as transformation of data into information which is the main function of information, their analyses, use of this information and providing support to the management had not been made. This situation usually had turned the information systems into a workload.

4

Regulation

- There was not an efficiency-based financial management model at public hospitals.
- Because there was no effective coordination between the Ministry, SSK, university hospitals, institution hospitals and private hospitals; service and investment planning didn't use to be done in parallel with social needs.
- Health sector didn't have "Strategic Management". Because MoH concentrated upon the service delivery in its own institutions, it fell short of directing the sector and developing policies.
- MoH and SSK hospitals were acting as if they were the health service providers of two different countries. The fact that people who are under the coverage of various social security institutions such as Emekli Sandığı, Bağ-Kur, SSK enrollees could receive service only from certain hospital groups in the system in principle and this used to increase inefficiency.
- MoH and SSK hospitals had a centralist structure; material and personnel management was inflexible and irrational.
- In healthcare delivery, public hospitals were used like a conductor between the patient and the physician; private sector was addressing only a handful of people. The public saw the healthcare delivery to citizens as a favor, and left the healthcare delivery entirely to market conditions.
- There was no rational regulation in relation to the charges to be received against the service delivery of public and private health care facilities.
- Four physicians working in the public sector were sharing one examination room (for the other remaining three physicians it was impossible to meet the patients). On the other hand, citizens were waiting for hours to reach that room to get examined for a few minutes.



- Extremely bureaucratic procedures in public healthcare delivery had sickened both citizens and health workers.
- Fragmented structure of the health care system, disorganization in patient registry systems and efforts of each institution to create its own system had resulted in a complicated structure. There wasn't a medical record system to keep the regular and complete data did not exist either.
- Primary and preventive health care services were far away from meeting the needs of the country. There were only six vaccines in the vaccination program of our country in 1980 and this number just became seven in 2002.
- Smoking, which is a severe public health problem, was completely under the initiative of tobacco industry.
- Organ and tissue transplantation was a field where the citizens were completely left to their fate.
- There was no organization for the evaluation of the demands and complaints of citizens. Citizens had been left to the despair of the system.
- The services which were delivered to citizens and the obtained results were impossible to be evaluated.
- Although there were some standards that private healthcare providers had to obey during the foundation phase, no concrete steps were taken for the measurement of service results and the service process. Regarding this, there was a contradiction in terms for licensing and accreditation.
- Planning, training and use of human resources used to be performed by different institutions separately (planning by SPO, training by universities, employment by MoH and SSK); however, an effectual coordination was impossible to be ensured between these.
- Transparency and equity was out of the question during personnel appointments and transfers. Political initiative was effective in appointments, it was impossible to be protected from pollution.
- "Compulsory Public Service" implementation, which was successfully used for physicians in some developed countries of the world for the purpose of equitable access, was totally a fiasco.
- While "Compulsory Public Service" was being tried to be implemented on one hand, a planning with the Council of Higher Education (CHE) for future was impossible to be done on the other hand because the lack of physicians wasn't recognized.
- Almost every stakeholder had a wrong approach by mentioning that the number of physicians and the number of nurses are enough -sometimes they are over.
- Lack of coordination and control was the point in question in the management of health service network of central and provincial managers.
- Managers equipped with adequate knowledge and skills with respect to health policy development, health management and hospital management; and education programs to train these were so few in terms of quality and quantity.
- There were no contemporary and rational arrangements to protect the public rights in relation to intellectual property rights and pharmaceuticals' licensing, production, pricing, selling, exportation, promotion, control, research and development activities.



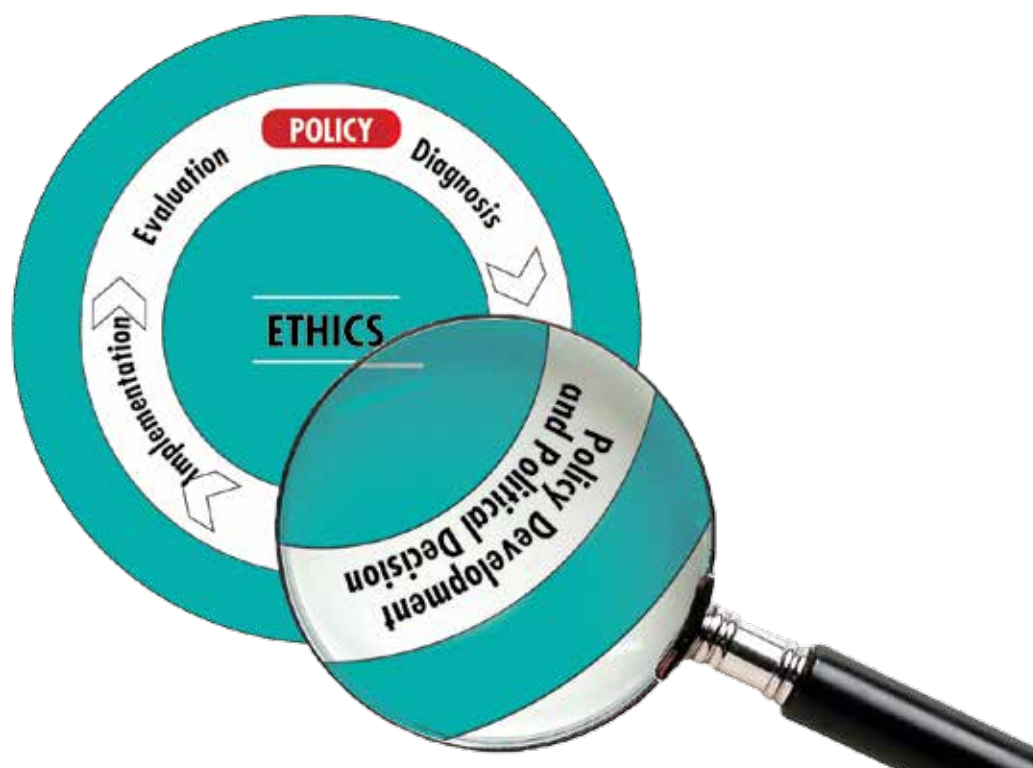
- Although the greatest target in healthcare delivery is to prevent the patients from diseases instead of treating them, the direct opposite of this procedure was being performed.
- In public healthcare delivery, the individual who would receive the service, his/her needs, demands and expectations were taken into consideration. Moving from the fact that health is produced in family environment, the individual didn't use to be evaluated within the framework of "family health".
- In public healthcare delivery, life style and prophylactic behavioral change programs were inadequate.
- "Patient compliance changing programs" that is one of the most important components of health service delivery were absent (i.e. promotion of breast milk, Directly Observed Therapy).
- In public healthcare delivery, citizens did not have option to call. A citizen could not determine by which physician he/she would get examined.
- In public health facilities, patient referral procedures were at very high rates and internalized by both citizens and physicians as if they had been a part of the treatment.
- The patients used to have a habit to go to secondary and tertiary health institution in all problems.
- Including the insured ones, citizens had accepted it as a system to go to physician's private practice in order to get benefit from public hospitals.
- Managers' efforts were insufficient to decrease the cost through proper use of resources and to produce more services with the same resources.
- Negative behaviors of health professionals against citizens were accepted as if they were "patient rights".
- There were no training programs to change the professional perceptions and behaviors of health professionals and managers.
- Motivation of health professionals especially that of physicians was low because of the existing system since they couldn't protect the professional dignity and patient rights adequately.
- There was neither right to choose physician nor patient rights unit or home care service.
- It was difficult to access to pharmaceuticals.

TURKEY HEALTH TRANSFORMATION PROGRAM



B. POLICY DEVELOPMENT AND POLITICAL DECISION





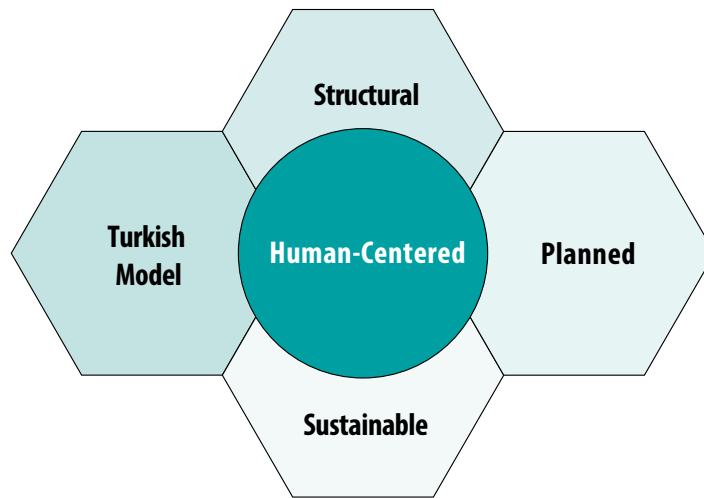
If a country wants to improve its national health care system, then strong support and commitment of the political authority will be required. Also financial and social aspects should be considered. It should be kept in mind that a number of interest groups will object to such a reform. In this circumstance, a committed and supportive prime minister, president, cabinet and parliament is essential to progress. Otherwise, no success will be made.

Transformation policy changes continuously due to the cyclical nature of the transformation process. Transformation program naturally strengthen the interests of certain groups and weaken those of others. The important thing here is to ensure that the interests of the people are not lagging behind those of the other groups. Certain groups try to influence the implementation and redesign of the transformation policy, in line with their interests. New external shocks may take place and they may change the political perceptions. Those who establish the transformation program must reassess their technical and political analysis as the transformation process moves forward. The design of the Health Transformation Program of Turkey and the implementation of the process were based on these facts.

The primary factor determining the political strategy of the Health Transformation Program was human.



Moving from those basic facts, we put the Health Transformation Program into practice in 2003. We have prepared this program by getting inspiration from past experiences, particularly the socialization of health services, the recent works for health reform and the successful examples in the world. We have assessed all the steps taken in health since the foundation of the Republic, we have reviewed the project works implemented within the Ministry and embraced the positive inheritance of the past.



We have prepared the “Health Transformation Program” considering the global developments, in compliance with the socioeconomic realities of our country, as a structural, planned and sustainable model of Turkey. We have established the program on the basis of moral approach aiming to ensure all citizens to access to health services on an equitable basis, as the people of the country with equal rights.



Financing

Preventive and Basic Health Services

- We ensure that all of our citizens get free primary health care services with the 'Law on Social Security Organisation no: 5502'.
- We increased the preventive and basic health services budget which was 928 Million TL in 2002 to 6 Billion 425 Million TL in 2011 and at real terms this meant an increase by 2,7 times.
- We made the 112 Emergency Services completely free of charge
- We rolled out the free mobile health services to all the rural areas.

Diagnostic and Curative Services

- Before the initiation of the Health Transformation Program, the first thing we did within the framework of the Urgent Action Plan was to stop the practice of holding people hostage at hospitals.
- We unified the public hospitals under one umbrella with the Law no: 5283 on the Devolution of Health Units of the Some Public Institutions and Agencies to the Ministry of Health and thus we enabled 37 million citizens insured by SSK (Social Insurance Organization), to get services from the public hospitals.
- We enabled our citizens to receive services at private hospitals and medical centers by their health insurance within the framework of the Social Insurance and Universal Health Insurance Law no: 5510
- We started to provide emergency and intensive care treatment for free in all the public and private hospitals.
- We ensured free-of-charge treatment for burns, cancers, newborn care, organ transplantation, congenital abnormalities, dialysis and cardiovascular surgical procedures at private hospitals.
- We ensured that no additional payment is charged for emergency cases, epidemics and job accidents regardless of an available insurance coverage.
- By the Law no: 5222 on State Coverage of Treatment Costs of Citizens Who Lack the Ability to Pay By Granting Them Green Card and Social Insurance and Universal Health Insurance Law no: 5510, we ensured the following :
 - We ensured that our poor people benefit from the public health services just like other citizens,
 - Their costs of examination, test, drug, tooth extraction and prosthesis, eyeglasses and emergency treatment in outpatient services are covered by the payment system,
 - They get the tooth, root canal and filling treatment services for free and
 - The retrospective expenditures of those who had an illness but did not get e Green Card although they were entitled to, are covered by the payment system.



Pharmaceuticals and Pharmacy

- We introduced the Reference Price System for pharmaceuticals.
- By the Law no: 5222 on State Coverage of Treatment Costs of Citizens Who Lack the Ability to Pay By Granting Them Green Card and the Law No: 5489 on Social Insurance and Universal Health Insurance, we ensured the following:
 - We covered the outpatient pharmaceutical costs of the poor Green Card holders.
 - We allowed the intake of pharmaceuticals from any pharmacies for the poor Green Card holders.
- We ensured that the hospitals provide the drugs and medicinal products free of charge for the inpatients as per the Health Implementation Circular.

Institutional Set-up and Capacity Development

- We promoted full time practice in the public health institutions with the performance –based supplementary payment system.
- We enacted the Law no. 5018 on Public Financial Management and Control in order to ensure effective and efficient use of public resources and financial discipline, accountability and financial transparency in the financing of public services.
- We initiated objective-oriented management by implementing performance-based budgeting.

Financial Management in Health

- We developed ‘Global Budget Model’ to be implemented in the financing of the health services of our Ministry
- We established coordination and harmony between the Economic Coordination Board (Ministry of Health, Ministry of Labour and Social Security, Ministry of Finance, SPO and Treasury) and the units related with health financing.
- In the framework of the “Social Insurance and Universal Health Insurance Law” Numbered 5510, we also ensured that;
 - Actuarial balances are paid regard to,
 - The universal health insurance premium rates of those insured by SSK (Social Insurance Organization), Bağ-Kur (Social Insurance Agency for Merchants, Artisans and Self-Employed), Government Employees Retirement Fund are equalized,
 - Our citizens receive services at private hospitals and medical centers by their health insurance,
 - Ensured that no additional payment is charged for epidemics and job accidents regardless of an available insurance coverage.
 - All the insured citizens whose illnesses can not be cured in the country get treatment abroad,
 - All the population under 18 and the students are covered by the Universal Health Insurance regardless of having insurance.



- The premium payment period required for SSK (Social Insurances Agency) and Bağ-Kur (Social Insurances Agency for Merchants, Artisans and Self-Employed) beneficiaries to utilize health services was 120 days and we decreased it to 30 days with the “Social Insurance and Universal Health Insurance Law no: 5754”.
- We established an effective, efficient and equitable health system by using the resources allocated to health in an optimum manner. While the increase in the non-interest primary public expenditures between 2003-2011 was 92%, the increase in the public health expenditures was 74 %.
- While the share of our-of-pocket expenditure for health in total health expenditure was 19,8 % in 2002, it was reduced to 12 % in 2011.

2

Payment

- We put into practice the model of performance-based payment per registered individuals in family practice.
- We introduced the performance-based supplementary payment system for the Ministry of Health staff.
- We initiated the “manager performance” implementation as a basis for payment for hospital managers
- We established the “Single Reimbursement Commission” for drugs.

3

Organization

Preventive and Primary Health Care Services

- We have enhanced primary healthcare services through family medicine that we implemented across the country.
- We have introduced the principle of an examination room for each physician in Family Health Centres.
- We have enabled the family physicians to take initiative in business and office management. Moreover, we provide payments for the family physicians to motivate them and improve their physical conditions. Through this implementation, we have improved the working environments of physicians and the physical and technical conditions of service.
- We strengthened the primary laboratory services.
- We established the National Medical Rescue Team (NMRT) which is the greatest in Europe and created emergency response capacity for disasters and states of emergency.
- We equipped 112 emergency services with land, air and sea ambulance with high standards and enhanced these services in terms of quality and quantity and made them available free-of-charge in any part of the country.
- We have opened minimum one Oral and Dental Health Centre (ODHC) in each province and totally 107 ODHC's and dental hospitals.
- We established 124 KETEMs (Cancer Early Diagnosis, Screening and Training Centres) in 81 provinces.



Diagnostic and Curative Services

- We have introduced the principle of an examination room for each clinician physician in all hospitals associated to the Ministry of Health.
- We have increased the efficiency of all health facilities through outsourcing.
- We initiated the procedures of triage and registration for all emergency departments in Turkey to ensure consistency with standards. We registered 92 % of inpatient health care facilities of the private sector, universities and the MoH by December 2011.
- We initiated full automation in all MoH hospitals.
- Through “Health-Net System”, all health information is displayed and solid decisions are taken by evaluating about 200 analyses and statistical reports in the “Decision Support System.”
- From the ward system at hospitals we switched to the room system with an inbuilt toilet and bathroom, in other words the quality room system.
- We provided our hospitals with medical devices. We have put advanced technology devices used in modern medicine at the disposal of our citizens simultaneously with many developed countries. Moreover, we have significantly increased the capacities of our hospitals in terms of intensive care units, burn and neonatal treatment.

Pharmaceuticals and Pharmacy

- We put into practice the mobile pharmacy system for the people living in rural areas with no pharmacies, in order to facilitate people’s access to medicines

Institutional Structuring and Capacity Building

- We restructured our Ministry through the “Decree on Organisations and Duties of the Ministry of Health and the Associated Institutions” numbered 663. Within the scope of this Decree Law:
 - The Ministry is assigned to make policies, determine the main rules and supervise we have constituted associated institutions to the Ministry to carry out the other functions. We established the “Public Health Agency of Turkey” for the preventive and primary health care services; “Public Hospitals Institution of Turkey” for the hospital services and the “Turkish Pharmaceuticals and Medical Devices Agency” to regulate and inspect medications and medical products.
 - We have established the Health Policies Board so as to determine the policies of the Ministry and the health system. Thus, we have separated policy making and execution.
 - We have established service units to support the new mission of the Ministry such as Directorate General of Health Services, Directorate General of Health Promotion, Directorate General of Health Information Systems, Directorate General of Health Researches and Directorate General of Health Investments.



- In addition to the “Supreme Health Council” and “Medical Residency Board”, we established the “Council of Health Professions”.
- By restructuring the provincial organization of the Ministry of Health and in addition to the Provincial Health Directorates, we allowed the establishment of the District Health Directorates. Besides, we established general secretariats in provinces in relation with the Public Hospitals Agency and established the public health directorates in provinces in relation with the Public Health Institute.
- Also, we are establishing “Public Hospital Unions” in provinces so that the affiliated hospitals are run in a more effective, qualified and efficient way. So, the unions and affiliated hospitals can be supervised by objective criteria and an accountable, professional and modern business management principles can be implemented.

4

Regulation

Preventive and Primary Health Care Services

- We have included in vaccination program the vaccines, which are used in the most developed countries in the world (haemophilus influenza type B, rubella, mumps and conjugated pneumococcus).
- Through the amendments we have made on the “Law on Prevention and Control of Harmful Effects of Tobacco Products”, we introduced new regulations with regard to the consumption of cigarette and tobacco products in order to protect the health of our citizens. There has been a great support by the public (95%) to the measures, the implementation of which started on May 19th, 2008 and which aim at prevention of passive smoking.

Diagnostic and Curative Services

- “Through the “Full-Time Practice Law”, we ensured that the physicians do not work in public and private sectors at the same time and decreased the necessity for our citizens to go to private businesses.
- We introduced “Central Hospital Appointment System” at our hospitals. This is a system where citizens call the operators at 182 Call Centre for Ministry of Health Hospitals and Oral and Dental Health Centres and get an appointment with the hospitals and physicians of their choice.
- Through the Law No. 5624 “Blood and Blood Products”, we issued new regulations to ensure easy supply of safe blood and blood products. We introduced regional blood centres. We provided all people with safe blood in compliance with the EU standards including all the stages of transfusion.
- We established “National Organ Transplantation Waiting System”. We prevented misuse and speculations. Now, we provide the donated organs to the suitable patient without waiting.
- We established “Patient Rights Units” in all Ministry of Health hospitals.
- We granted the citizens the right to choose their physician in all Ministry of Health hospitals.



Pharmaceuticals and Pharmacy

- We established “Drug Tracking System (DTS)” which monitors the medication at each step.
- We put the strategies for rational drug use into practice.

Institutional Structuring and Capacity Building

- Within the scope of “The Decree on Organisations and Duties of the Ministry of Health and the Affiliated Institutions” numbered 663;
 - We made it possible to employ health specialists to provide specialised services and contracted specialists for the tasks and projects that require special knowledge and speciality.
 - Moreover, we started to measure and evaluate the performances of the managers and the other personnel employed in the Ministry and the associated institutions.
 - We ensured the Ministry to provide free legal aid in the cases that are related with the crimes committed against our personnel during the delivery of health service or due to their duties.
 - We enabled the foreigners to work in Turkey by taking into account physician and nurse shortages. Naturally, the conditions of diploma equivalence, Turkish language knowledge and other necessary conditions will be required in order for the foreigners to work in our country.
 - Besides, we ensured the family physicians that are currently working in the field and have won the Examination in Speciality in Medicine to receive speciality training by maintaining their contracts and this implementation will continue until 2020 in order to meet the family physician needs of our country.
 - We have provided financial and other types of incentives for the development of medical devices, products, services and pharmaceutical industries that require advanced technology and we also enabled technology transfer and off-set practice from abroad.
 - We allowed for the establishment of free zones on health so as to make our country a regional attraction centre in the area of health and accelerate the flow of foreign capital and technology into the country.
 - Units of healthcare services can be established abroad with the aim of humanitarian and technical aids.
 - In addition, we have made it compulsory for the TV and radio channels to air warning, informative and instructing programmes for 90 minutes in a month for free.
- We established a more balanced distribution of healthcare personnel across the country through the State Service Obligation regulated within the scope of “Law on the Compensations and Working Principles of the Healthcare personnel” numbered 5371.
- We ensured transparency and equity in personnel employment, appointment and transfer.



- We delegated many authorities to the provincial organisations of the Ministry (authorisation and closure of primary healthcare institutions and pharmacies, licencing procedures, monitoring of marketing and consumption of medicinal products subject to control, personal procedures for the health professionals)
- Through ALO SABİM 184 hotline service, we ensured our citizens to convey their requests directly to the Ministry, 24/7 uninterruptedly.
- We put into practice Total Quality Management (TQM) in the Ministry of Health.
- We introduced distance education system via internet within the scope of health management training activities.



Behaviour

Preventive and Primary Health Care Services

- We introduced the “Health Promotion” system. Our aim is to make the people adopt correct health behaviours. Within this scope, we have been developing the following programs:
 - Increasing physical activity
 - Prevention of obesity
 - Prevention of tobacco use
 - Prevention of alcohol use
 - Personal hygiene
 - Oral and dental health
 - Prevention of accidents
 - Rational drug use
 - Mental health
 - Female health and reproductive health
 - Healthy birthgiving
 - Employee’s health and healthy workplaces
 - Healthy schools
 - Healthy environment
 - Health literacy
 - Healthy aging



- We have developed programmes for combat against chronic diseases:
 - Turkey Cardiovascular Diseases Prevention and Control Program.
 - Global Alliance Program Against Respiratory Diseases
 - Obesity Counteracting and Control Program of Turkey
 - Diabetes Control Program of Turkey
 - Mental Health Policy Strategy of Turkey
- We introduced contemporary screening programs for maternal and child health:
 - “Iron-Like Turkey Program”
 - “Program for the Prevention of D Vitamin Deficiency”
 - “Program for Iodization of Salt”
 - “Hypothyroid Screening Program”
 - “Hearing Screening Program”
 - “Biotinidase Screening Program”
 - “Hemoglobinopathy Control Program”
- We provided monetary aid to the poorest 6% part of the society on condition that the pregnant women and children are followed up.
- Through the Guest Mom Project, in areas where transportation is a problem, we provided accommodation for the pregnant women until they gave birth and thus ensured that they have a healthy delivery.
- We provided reproductive health education to 500 thousand conscripts in the Turkish Armed Forces within the scope of the Reproductive Health and Family Planning Program of Turkey.
- We have prepared the National Influenza Strategic Plan.

Diagnostic and Curative Services

- We introduced community based mental health services. We have been undertaking this service in order to provide psychosocial support to patients with severe mental disorders and perform their treatment and follow-up at home if required.
- We initiated the implementation of “Home Care Services” to decrease the duration of hospital stay and ensure that medical care and rehabilitation of the bedridden patients are performed at home, if possible.
- We introduced the “Directly Observed Therapy” for TB patients.
- Through ALO SABİM 184 hotline service, we ensured our citizens to convey their requests directly to the Ministry, 24/7 uninterruptedly.



- We established “Patient Rights Units” in all Ministry of Health hospitals.
- We introduced the right to choose physician in all Ministry of Health hospitals.
- We developed policies against violence in health.

Pharmaceuticals and Pharmacy

- We made the drug prospectuses simpler and more comprehensible.

Institutional Structuring and Capacity Building

- We introduced distance education system via internet within the scope of health management training activities.

Transformation is not only a technical but also a political process. Politics penetrates into all phases of the transformation cycle. This fact makes it necessary to develop political strategies and have political determination supporting the transformation program. We can give a few examples regarding this issue.

1. When we took office, our 37 million SSK (Social Insurances Agency) enrollees could not receive services from public hospitals. Number of annual examinations was 58 million, and the annual number for a SSK enrollee to go to a physician was 1.5. For all the SSK enrollees there were only 8 thousand physicians and only 2500 of them had an examination room. Daily average number of patients per physician was 93.

Consequently, the state could allocate only 8 minutes a year for outpatient services for the SSK enrollees. There were only 148 hospital pharmacies for the citizens to get their prescribed medications. The citizens had to wait in queues to get their medications. Only a limited number of workers could find the exact medication that their physicians prescribed.

When we made legislative amendments to unify all Public Health Institutions under one roof, those who wanted to prevent this applied to the Constitutional Court on the grounds that it was neither serving the public interest nor in compliance with the social security right. The Court, however, refused this objection.

Today, 37 million SSK enrollees, like other citizens, can receive services from 2448 hospitals and medical centres as well as 6520 Family Health Centres. The SSK beneficiaries, who were allowed to take medicines from 148 pharmacies only, are now allowed to access to any of 24 thousand pharmacies countrywide.

2. Through the Law on “Family Medicine Pilot Implementation”, we put into practice the family medicine implementation in Turkey, which is common in the modern world.

Turkish Medical Association (TMA) objected to this implementation claiming that when Family Medicine system is implemented in our country conditions, “access to health service would be impossible for a huge part of the society, it would increase unemployment further, adversely affect the personal rights and benefits of health professionals, make them unemployed”. TMA found political support for these claims from the opposition party, as well.



We implemented the Family Medicine System which we initiated in 2005 with determination and rolled it out across the country as of 2010. Currently, we are serving a population of 75 million with 20,236 family physicians. Now, people have their own family physicians whom they can visit any time and consult on the phone whenever they need without being charged. Thus, health records of every citizen can be followed-up regularly. We are still continuing to develop this new structure which can be integrated with our hospitals and consequently a proper referral chain can be established.

Through this implementation, we found out that satisfaction of citizens and health professionals increased significantly.

3. Before we put the “Health Transformation Program” into practice, almost all the physicians working at the public hospitals had their private practices at the same time. The people could only reach the physicians with out of pocket expenditures to have their serious illnesses followed up. This situation was accepted as the natural right of physicians and the fate of patients.

We introduced the ‘Full Time Practice Law’ to ensure the healthcare personnel to work full time to prevent the citizens from having to go to the private practices of the physicians. Through this law, we rearranged the working principles of the healthcare personnel working in the public sector; we issued some regulations to ensure the citizens to access to their health rights and the healthcare personnel to earn professional respect.

What were our objectives within the framework of this Law?

Through Full Time Practice, we aimed;

- To make the work load of the insufficient number of health professionals more balanced,
- To terminate the direct monetary relation between physicians and their patients,
- To strengthen the trust between our citizens and physicians,
- To facilitate patients’ access to health care services.

What did Full Time Practice Implementation bring about for the citizens and the health professionals?

- We increased the extra payments for the health professionals,
- We enabled the healthcare personnel to earn extra income for overtime work,
- We introduced an insurance system against malpractices,
- We facilitated the development of collaboration between Ministry of Health and universities,
- We rolled out “Right to Choose Physician” not only for the wealthy citizens but for all,
- We took measures to decrease the patients’ waiting time in public and university hospitals,
- We ensured that our citizens receive the most special services anytime and anywhere.



The law which passed in our Parliament was referred to the Constitutional Court and some of its articles were cancelled.

We have closely followed up this issue from the legal perspective and we will continue to do so. We believe that as a result of this rightful legal struggle, we decreased the dual working system significantly and we will remove it completely in favour of our people.

4. Through the amendments we have made on the “Law on Prevention and Control of Harmful Effects of Tobacco Products”, we introduced new implementations for the consumption of cigarette and tobacco products in order to protect the health of our citizens. There has been a great support by the people (95%) to the measures, the implementation of which started on May 19th, 2008 and which aim the prevention of passive smoking.

Regulations for the businesses such as restaurants, coffeehouses and pubs entered into force on July 19th, 2009. The said sector organizations filed a lawsuit at the Council of State for the purpose of cancellation or bending of the law. The Council of State brought the case before the Constitutional Court and the Court made a decision in favour of the law.

The ownership of our Prime Minister in this matter, our determined stance and the steps we took quickly yielded results. Before the law, tobacco consumption rate was 27,4% for 15+ age group in 2008 and following the introduction of the law, the rate dropped to 23,8% in 2012. In a very short time of 4 years, we achieved a the smoking cessation rate of 3,6%. This is a great success which is unprecedented in the world and achieved through our determination.

Healthcare in Turkey: From Laggard to Leader



BMJ, Healthcare in Turkey: from laggard to leader. 12 March 2011, vol. 342

“One of the success factors for the implementation of the HTP program is the importance of the vision and leadership to set values and guiding principles, and the determination to follow through policy implementation.”

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

1. Preventive and Primary Health Care Services

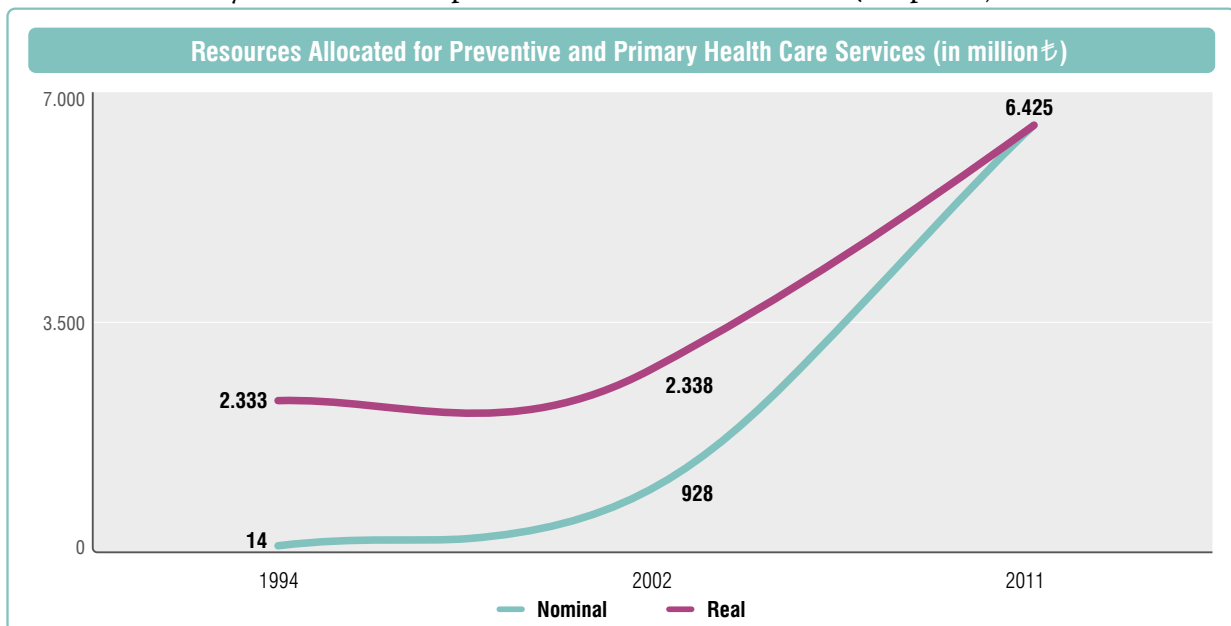
Herşeyin başı sağlık
Sağlığın başı AŞI





The Health Transformation Program aims to improve and structure the institutional position of the primary health care in a way to have authority and control over other service levels. The main focus of this transformation is to improve the conditions for the citizens in general and patients and health professionals in particular; and to constitute a starting point for innovations in this field. It is clearly observed that this program takes primary health care as the basis for service provision. A large number of activities and projects have been implemented in the field of primary health care with this approach; a multi dimensional program has been conducted. The current status was not neglected during the course of new regulations; and extensive activities for the improvement of the current status were carried out. The most outstanding feature of the Health Transformation Program is to embrace the existing heritage and to take it further as far as possible while conducting the transformation.

A campaign for preventive and primary health care was held in this period and the budget of preventive and primary health care, which was 928 million TL in 2002 reached to 6 billion 425 million TL in 2011. The resource allocation for preventive services and primary health care in 2011 (real prices) has almost increased by 2,7 times in comparison to the allocation in 2002 (Graphic 8).



Graphic 8
Source: Turkish Public Health Institute

A budget of
6 billion 652 million ₺
was allocated for preventive services
and primary health care in 2012.



1. A New Era in Primary Health Care: Family Medicine

Primary health care is a low-cost, effective and common service delivery; it provides the services of health promotion, preventive health services as well as the diagnosis, treatment and rehabilitation services of primary level together in a readily available way.



Celebrations Held on the 23rd of April, 1934

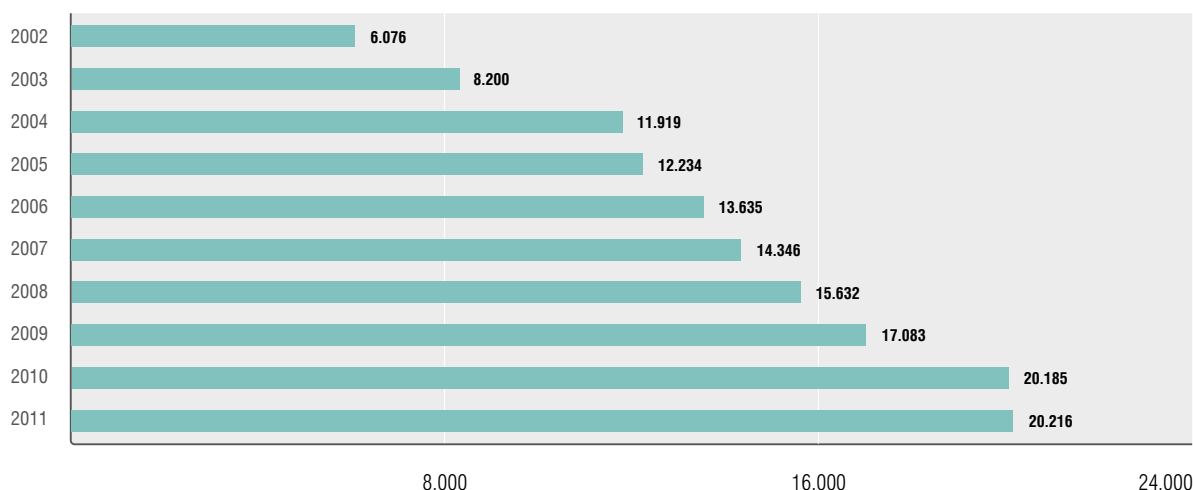
In our country, primary health care has been provided through health centers and health houses since 1960s. Providing important returns in the field of maternal and child health, this implementation has been conducted as a regional-based implementation. However, because the necessary improvements hadn't been performed in the meantime, it didn't use to meet the growing service needs later on.

Having been implemented since 2003, the Health Transformation is a citizen-centered / an anthropocentric program. This principle means that the system will take individuals' needs, their demands and expectations into consideration when planning and providing the primary health care services. One of the important components of this program is family medicine which is also the contemporary implementation of the primary health care. Family medicine is a motivating implementation, it is open to improvement and considers individuals along with their bio-psycho-social environment and as a whole from their birth to their death, and it provides the right of choosing their own physician and gives more professional satisfaction to health professionals.

A family physician is responsible for the health status and health problems of all members of the family beginning from the fetus to the eldest individual. The physician takes due precautions to prevent the individuals under his/her responsibility from diseases. In case of sickness, the physician treats them within the scope of his/her knowledge and experience.



Number of Examination Rooms in Health Centers / Family Health Centers in Turkey by Years



Graphic9

Source: Turkish Public Health Institute

For the problems of the patient that cannot be solved at primary health care level and also need specialty or special equipment to be solved, the family physician acts as a coordinator and refers the patient to other specialists, dentists or secondary-tertiary health institutions. Therefore, a family physician is the health consultant of patients, he/she is the one who guides patients and defends their rights. The family physician is generally close to the residences of families and is easy to access. The family physician knows the population for which he/she provides services in all aspects and fully evaluates the family, environment and work relations. He/she is the person with the best knowledge on the health status, living conditions of all family members and the ways to provide preventive healthcare services and health education to these individuals. Family physicians not only evaluate the individuals within the framework of disease conditions, but also evaluate patients' situation as a whole taking into consideration the risks, health conditions, psycho-social environment and other acute or chronic health problems, if any.

According to Prof. Dr. Nusret Fişek who had significant contribution to the arrangement of primary healthcare services in 1960s in our country, "Individual preventive healthcare services, outpatient and home care services should be conducted in an integrated manner. Contemporary family medicine system is the simplest example of this integrated model. Contemporary family physicians examine children periodically and vaccinate them. They train mothers on child care. They also examine elderly people and pregnant women and give advice, if necessary. They train family members on health, domestic and personal hygiene. They treat family members who get ill and refer them to a specialist or hospital, if necessary."



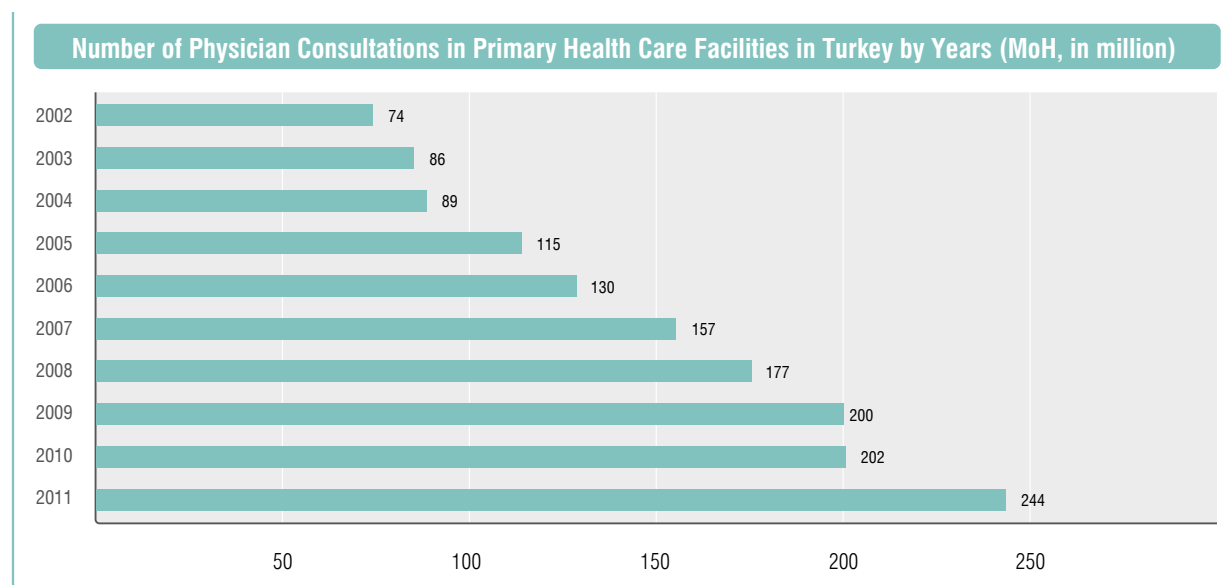
Family physicians play a role in the health care system for preventing inappropriate referrals that might cause loss of time for individuals and service providers, irregularities and unnecessary health spending. In this way, they prevent unnecessary spending, long waiting lists at secondary health care level, long queues and unjust treatment of patients (Graphic 9).

We have established a unique model of this contemporary service for the purpose of ensuring primary health care services in our country to be rearranged with a modern approach and in a manner preferable by all individuals. While forming the model, we have reviewed the implementations in many countries, taken the conducted studies into account and finally we have introduced a precise study by considering the needs and conditions of our country.

Following a period of intensive preparations, the Law on Family Medicine was entered into force in 2004. The implementation was first initiated in Düzce in September 15th, 2005. We have introduced the family medicine practice countrywide as of December 13th, 2010.

Through this implementation, we have gathered individual preventive health services as well as diagnosis, treatment and rehabilitation services of primary care under family health centers; other duties including the coordination of social preventive health services under community health services.

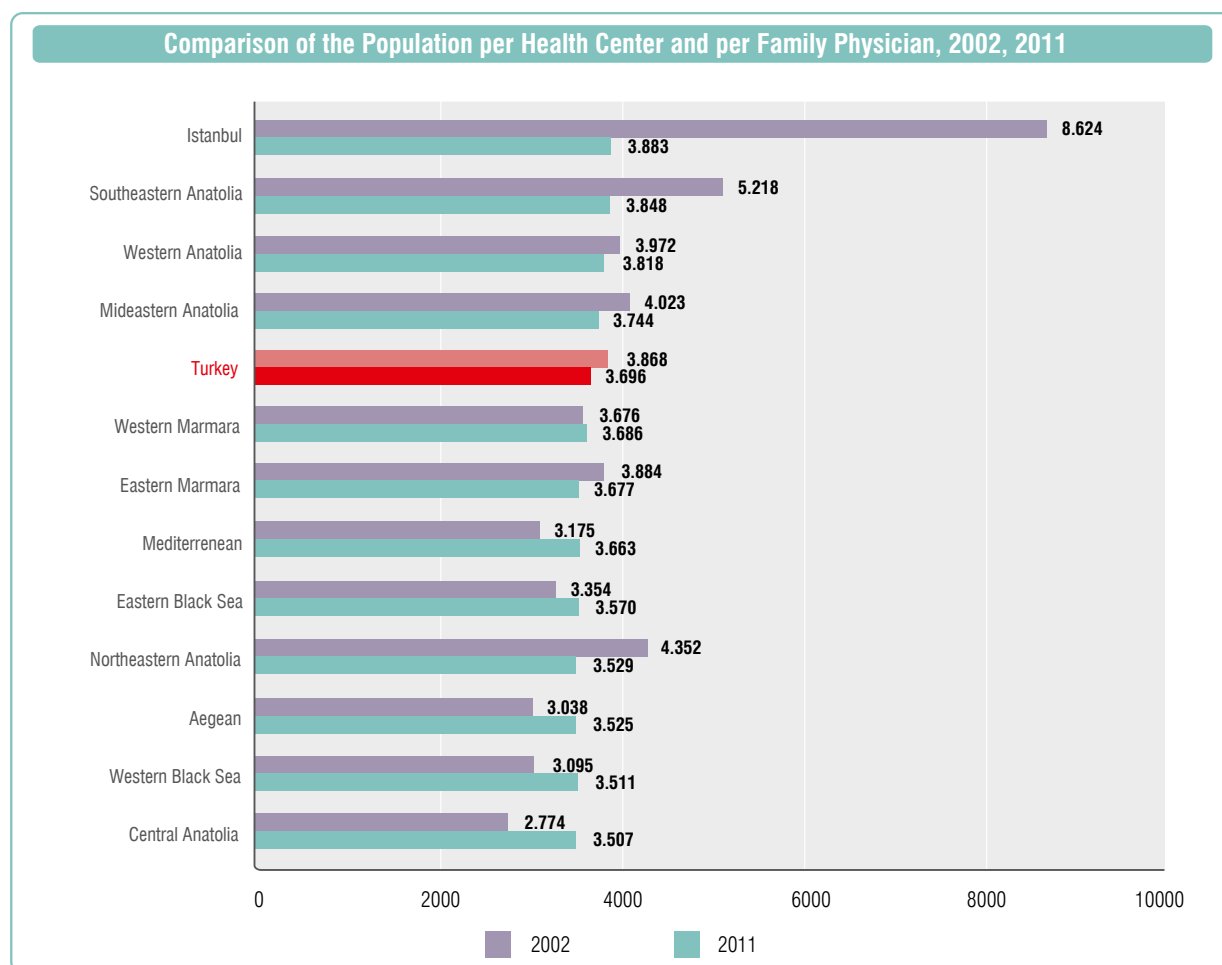
Before family medicine, 17,800 physicians were working in primary care health facilities; following the introduction of the implementation, as of December 31st 2011, totally 22,773 physicians began to provide service including 20,236 physicians in 6,520 family health centers and 2,537 physicians in 957 community health centers. In this way, we ensured our citizens to reach physicians easily (Graphic 10).



Graphic10
Source: Turkish Public Health Institute



As of the end of 2011, one family physician serves 3,696 people (Graphic 11). As obvious, we have achieved to ensure balance in population per family physician. We have planned to decrease the number of people registered to family physician gradually by years. Our target for 2013 is that one family physician will serve 2,000 people.



Graphic11

Source: Turkish Public Health Institute

We provide family medicine service completely free-of-charge for all citizens without the requirement of any social security coverage. We do not receive co-payment for this pack of services including health promotion and prevention services; examination; intervention; tests, screenings and vaccinations conducted in primary care; mobile health services and home care service.

While we were continuing to roll-out the family medicine implementation countrywide, we were also performing legislative arrangements and working to increase service quality dynamically. For this reason, we have performed various amendments on the implementation and payment regulations.



We have structured the family medicine as a willingness-based team work. Physicians voluntarily apply for the announced positions and they are signed contract for the family health center to which they were settled according to their service score. They separately sign a contract with family healthcare personnel they pull together. Midwives, nurses, health officers (community health) might become family healthcare personnel; and through an amendment in 2010, we enabled the emergency health technicians to have this opportunity, too.

In addition, when family physicians have a registered population in rural areas, we provide support to them through health house midwives. Their laboratory tests and screening services are organized by the provincial health directorates. We have also planned to support the family physicians in specific specialty fields such as psychologist, dietician, social worker, physiotherapist, child development specialist.

Family physicians periodically provide mobile health services to those who live in rural areas. Through an amendment in 2010, we began to provide home care service for bedridden patients and in place health service for those who live in places such as rest home, prison or nursery.

In addition to these; in accordance with a protocol signed with the collaboration of MoH and Turkish Pharmacists' Association in September 2009, we have introduced mobile pharmacy implementation in regions where no pharmacy is available to allow the public to take their medications prescribed by the physician for their treatment. In regions where no pharmacy is available, through facilitating the access of people to medication, we aim to serve for public health and ensure the supply medication by efficient use of public resources in compliance with deontology.

For those who serve as family physician and family healthcare personnel, it is possible to return to their previous jobs if they want. They may continue to take advantage of their rights such as promotion, appointment, retirement period while they maintain their current duties.

We pay a motivating charge to those who are assigned in the family medicine implementation.

We ensured family physicians to use initiative in work and office management. We provide incentive payments to family physicians apart from their charges for the purpose of paying the fixed expenses of the family health centers and improving their physical conditions. Through these payments, employees and service receivers attained better working conditions.

People's first recording to family physicians are done according to the nearest family health center to their residence, and later on they may choose and change their family physician without any region or time restriction.



Making Reform Happen Lessons from OECD Countries

Publishing Year : 2010

Published by : OECD

“The introduction of “family practitioner services” gave primary care doctors greater pay and autonomy and was associated with a relative shift in consultations away from hospital outpatient departments towards family practitioners, and a sharp increase in patient satisfaction with primary care.”

Training of Family Physicians

Just like in many countries of the world, family medicine was ultimately structured as a primary care specialty in our country. Family medicine specialists are the most proper people for family medicine service delivery. Since there is lack of physicians in our country in general, the number of family medicine specialists is fairly insufficient as well. When structuring the family medicine model within the framework of the Health Transformation Program, it was possible to authorize general practitioners directly to perform as family physicians just like the examples seen in some EU Countries. However, we decided that practitioners who will serve as family physicians will have to receive a standard training.

We have conducted a very heavy study in order to achieve this goal of family medicine as an important component of the Health Transformation Program. Family Physicians Counseling Committee was set up with the participation of professional organizations and academicians. The committee worked with such diligence and discipline to prepare the training curriculum for general practitioners to be assigned in the family medicine system. The program was decided to consist of two stages. In the first stage of the training, the physicians (excluding family medicine specialists) to be assigned in the family medicine will be trained for 10 days and the allied healthcare personnel will be trained for 3 days long. We have been conducting the trainings without stopping under the supervision of academicians who are the experts of the subject. As of the end of 2011, approximately 45,000 physicians and 28,000 allied healthcare personnel got their certificates after they have completed these trainings successfully.

We have planned the second stage as a long-term training on the update and improvement of professional knowledge and put it into practice. Within this plan, the physicians who have completed the first phase orientation training are subjected to the second phase training of 1 year. We have planned the second phase training so as to include 37 knowledge modules with clinical content and 3 skill improvement modules with application. We have been providing the second phase training as a combination of distance education via internet and face-to-face education.



We have initiated the second phase trainings. Through the second phase trainings, we aim to ensure all physicians completing the first phase and working as family physicians to increase their clinical knowledge level to the level of competence until the end of 2013.

Promoting the training of more family physicians on one hand, and readdressing the family medicine specialty training which is conducted as clinical rotations in 2010 on the other hand, we have changed the system in compliance with the international standards that half of the training will be given in the field.

Community Health Centers (CHCs)

We have founded the Community Health Centers in order to provide more effective and efficient health services by unifying all services at primary care level under a single roof except for preventive, diagnostic, curative and rehabilitation services. These centers give free-of-charge logistic support for priority service fields of family physicians such as vaccination campaigns, mother and child health and family planning services in accordance with the annual program of the MoH; carry out activities regarding the supervision of family physicians; and provide health services such as environmental health, judicial services, worker and occupational health, which are services of public concern rather than being individual health services. Thus, both family health and community healthcare services were unified and primary health care structure was integrated.

With the contributions of relevant experts, we have completed the “Guideline for Primary Health Care Implementation and Data Set” for community health centers. This guideline will be fairly beneficial for implementers and decision makers.

As the process moves forward, it is planned to employ family medicine specialists in family health centers and public health specialists in community health centers.

We have established a scientific committee including mainly academic members of the public health departments and aimed to improve the knowledge and experience of CHC personnel. As a result of the works conducted by the scientific committee, we have decided that the CHC personnel should be trained within a phased training. All responsible physicians practicing in the CHCs were trained at the end of the CHC first phase trainers’ trainings that began at the end of December 2008.

Satisfaction of Citizens

The Health Transformation Program is human centered/anthropocentric and considers the health service satisfaction as important. We have improved the working conditions of family physicians and physical and technical conditions in which our citizens receive service through family medicine implementation. Applying to the family health centers, our citizens meet service friendliness and well-trained personnel and receive better quality health service.

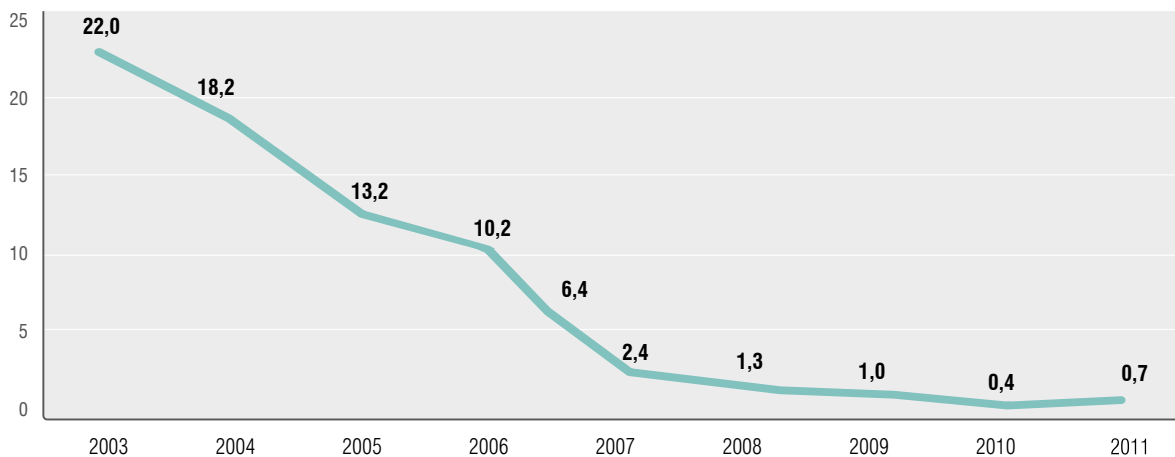
We conducted the “Satisfaction Survey with the EUROPEP Scale” in order to find out the satisfaction with primary health care services. EUROPEP Scale is an international scale which inquiries 23 parameters relevant to clinical behaviours and service organization. It is still used in 25 countries in Europe. In this study, the satisfaction with health centers was found to be 75 % in 2008 while the satisfaction with family medicine was found to be 90 % in 2011.



Implementing the Health Transformation Program, we increased the quality and efficiency of primary health care services which is reflected as an increased share of consultations and a decreased rate of referrals in primary health care services (Graphic 12).



Rate of Referrals in Primary Health Care Facilities in Turkey by Years (%)



Graphic 12
Source: Turkish Public Health Institute



Following the introduction of the family medicine system, the individuals' preference for primary health care facilities for consultations increased from 36 % in 2002 to 40 % in 2011. An increasing number of individuals prefer to receive health care services in primary care level

The Effects of the Implementation on Primary Health Indicators

This indicator is extremely important in order to indicate the reflection of implementations on health statistics and particularly to show the quality and extensivity of preventive health services. Through the implementation, the infant mortality rate dropped to 7,7 per thousand and the maternal mortality ratio dropped to 15,5 per hundred thousand. Vaccination rates rose to around 97%.

Financial Sustainability of the Implementation

We have provided better financial rights for physicians and family healthcare personnel compared with their previous situations. Through this motivating and productivity raising implementation, we made it possible to decrease the need for secondary health care service and to direct the investments to more productive and necessary fields. As we have seen the financial sustainability, we have rolled it out countrywide.

Family Medicine from the Point of Citizens

We passed from region-based system to the population-based primary health care service. Now, in the health service delivery, we see people as an individual instead of being a member of the society.

We have established easily accessible health facilities near the residence of citizens. Taking individual preferences into consideration, we have provided our citizens to have right to choose and change their physicians. Now, people may choose the physician whom they have better communications with and also they trust and reach easily.

We ensured the integrity and dynamic update of health records. We have provided our citizens an opportunity for their health records to be kept up-to-date beginning from their births and receive health service in line with their needs.

We have minimized the time and work loss while receiving health service. Citizens may receive service from family physicians by appointment and they may reach secondary health care service they need in the shortest way through the guidance of the family physician.

We have made the access to health services free-of-charge. Citizens may receive service from the family physician easily without any co-payment or presenting any documents.

Physician-patient communication is shaped on the basis of trust, respect and friendliness. The right to choose physician and also the physicians' desire to protect their patients have made a significant contribution to this process. Now, physicians are attending ceremonies such as weddings or funerals of the people in their record lists and began to take part in the family photographs. Family physicians provide health consultancy to our citizens free-of-charge.



We have extended the coverage of preventive health service through family medicine. We have also added the promotion of healthy life programs to the preventive health services such as vaccination, pregnant women and infant follow-ups, health screenings, etc. Under the responsibility of family physicians, we have been carrying out many preventive health services such as vaccinations, infant and pregnant women follow-ups, 15-49 aged women follow-ups, screening programs, Vitamin D and iron supplement support, periodical health controls for specific age groups, national disease control programs.

We have extended the coverage of health services and included the programs for the prevention of chronic diseases (particularly tobacco control, prevention of obesity, diabetes, cardiovascular diseases) and early diagnosis implementations into the coverage of health services. Now, family physicians are participating in works for the purpose of increasing public awareness and development of attitude and behavioral change in these fields.

Effective and efficient delivery of preventive health care services made it possible for our citizens to ensure the protection from diseases; it also extended the life expectancy and contributed to leading a quality and healthy life.

Some health reports which are required for starting a job, marriage, school, driving license, death certificate, etc. are given by family physicians.

We have given the responsibility of vaccination, pregnant women and infants' followups directly to family physicians. These services used to be conducted mainly by midwives previously. In family medicine implementation it is stated that the physicians who do not conduct this duty well enough are subjected to pay cut and if they continue this attitude despite warnings, termination of their contracts is considered.

Performance-based controls are done for these services; and the wages are cut back up to 20% for the physicians whose performance is low.

Family physicians update their health records minimum once a year through direct contacting the people they serve.

For the groups who have difficulty in reaching the family physicians (those who live in prison, rest home, and nursery, etc), we provide health service in place periodically.

We provide mobile health service periodically in rural regions where people have difficulty in reaching the physician. During this visit, we give vaccination to the infants if they are due, follow up pregnant women-puerperants and infants, evaluate health problems of the region, provide necessary trainings and diagnose and give treatment to citizens if they need.

We make home visits where necessary.

Family physicians coordinate the health care to be given to bedridden people who need home care.



In comparison with health centers, more cute and functional family health centers are established. The minimum standards of these centers were defined and we encourage these centers to reach higher standards.

Thanks to full time working and better recognition of the individuals, it becomes possible to allocate more time to patients. In addition, unnecessary applications to hospitals are gradually decreasing.

Family Medicine from the Point of Health Professionals

Family Medicine facilitates the following and thus improves the motivation and job satisfaction of the health care personnel:

- Contemporary primary care health service (passing from region-based system to population-based primary care health service)
- Primary care health service's becoming a specialty field,
- Professional satisfaction,
- Prestige increase,
- Motivating charging,
- Better working conditions,
- Use of initiative in work and office management
- Competition in quality,
- Continuous medical education,
- Voluntary participation in the implementation,
- Enabling willingness-based team work
- Clarification of job descriptions,
- Family physician's recognition of people under his/her responsibility and simplifying his/her job,
- Non presence of money in physician-patient relationship

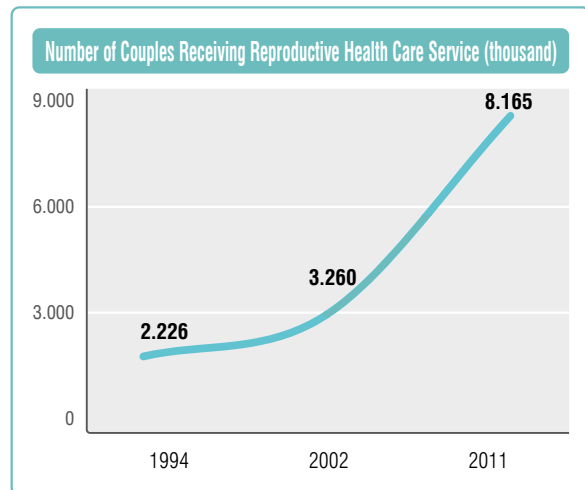


2. Maternal and Child Health Care

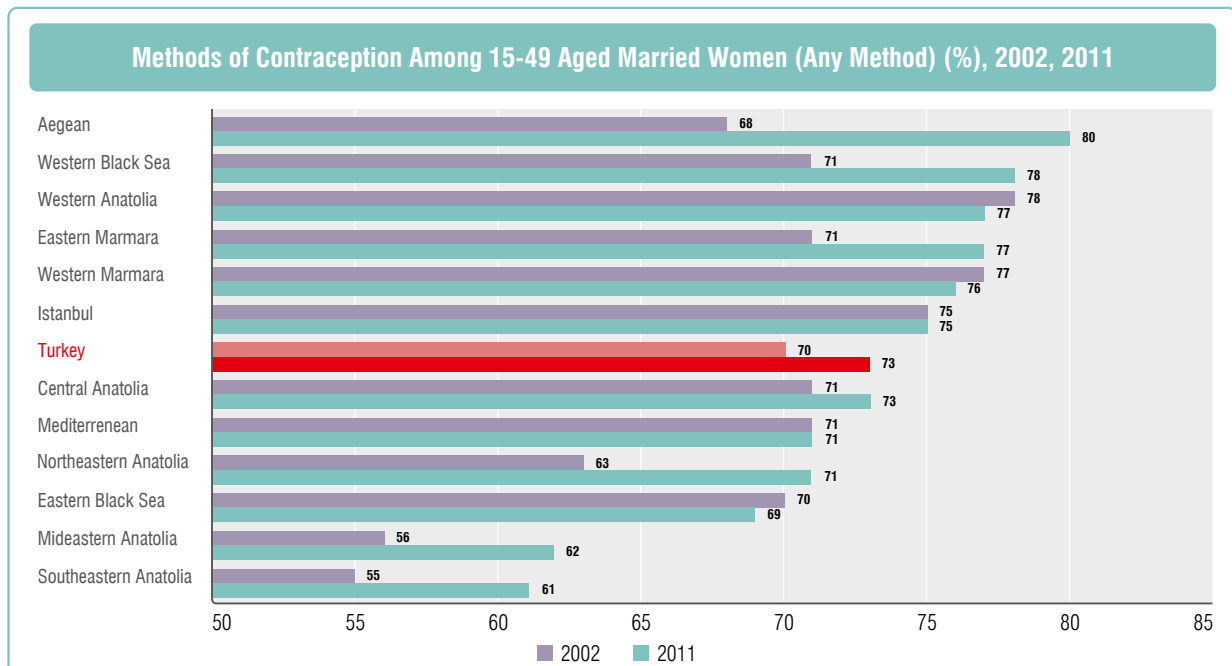
A. Sexual Health and Reproductive Health Program

Turkish Sexual and Reproductive Health Program is implemented in cooperation with the EU in order to increase the utilization and accessibility of services in the field of sexual and reproductive health, improve service quality to support the MoH-conducted studies and to strengthen the collaboration with the NGOs. Turkey's Sexual and Reproductive Health Program is conducted in cooperation with the EU. 3,260,000 couples received sexual and reproductive healthcare services from the MoH health institutions in 2002, whereas the number of couples reached up to 8.165.000 in 2011 (Graphic 13).

In preventing maternal mortality, it is important to avoid unwanted pregnancies and tell mothers to refrain from birth intervals shorter than two years. While the number of the visits made by the individuals using a contraceptive method in the framework of the reproductive health program was about 4 million in 2002, it exceeded 8 million visits in late 2011. 73 % of the women at reproductive age uses a contraceptive method (any method), which is higher than that of the WHO Region for Europe (Graphic 14 and 15).



Graphic 13
Source: Turkish Public Health Institute

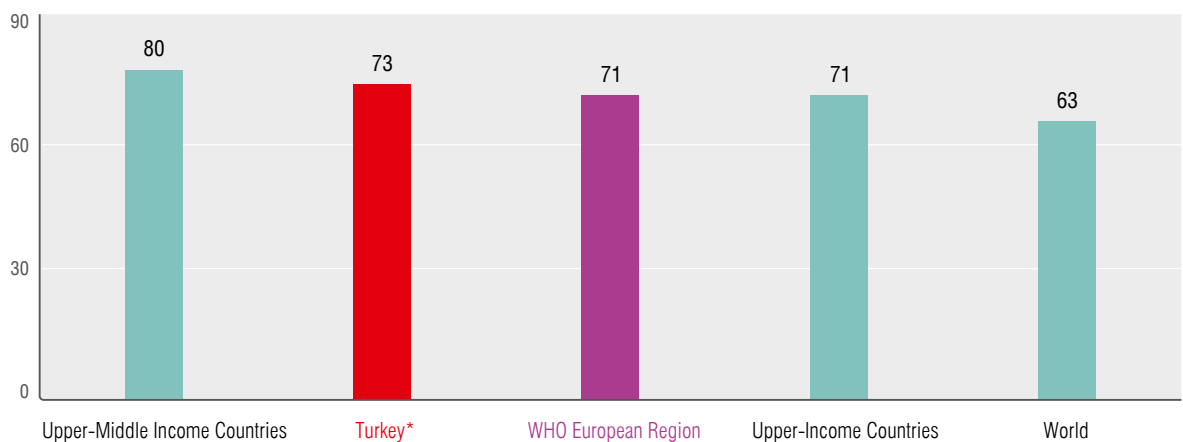


Graphic 14
Source: Turkish Public Health Institute



Also, we continue to provide in-service trainings for the health care personnel via the Reproductive Health Module Trainings in order to ensure quality service provision in the Reproductive Health Training Centers and Reproductive Health Regional Training Centers which have been rolled out in all of 81 provinces across the country under this Program.

International Comparison of a Contraceptive Method Use (Any Method) Among 15-49 Aged Married Women (%), 2010



Graphic15

Source: Turkish Public Health Institute 2011, World Health Statistics 2012

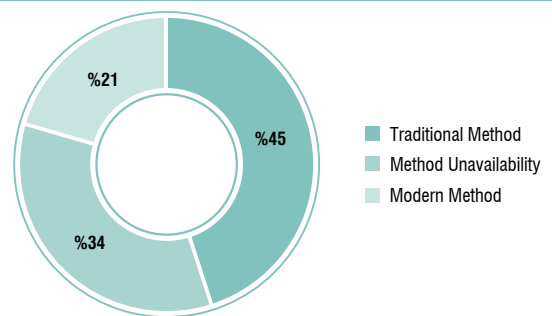
*Turkey data refer to the year 2011.

In addition, screenings are made, possible risks are detected and necessary training on kin marriage and inherited diseases is provided before marriage to men and women living in risky provinces for hemoglobinopathy (inherited blood diseases). In 2011, we provided pre-marriage hemoglobinopathy screening tests to 523,556 individuals in 33 provinces. Coverage of pre-marriage screening was %83,1 in these provinces.

Induced Abortion

Induced abortion is a surgical method applied in order to terminate pregnancy. Induced abortion, however, is not a family planning method. While modern contraceptive methods are available today, induced abortion can not be accepted as a family planning method (Graphic16).

Use of a Contraceptive Method Before Induced Abortion, 2008

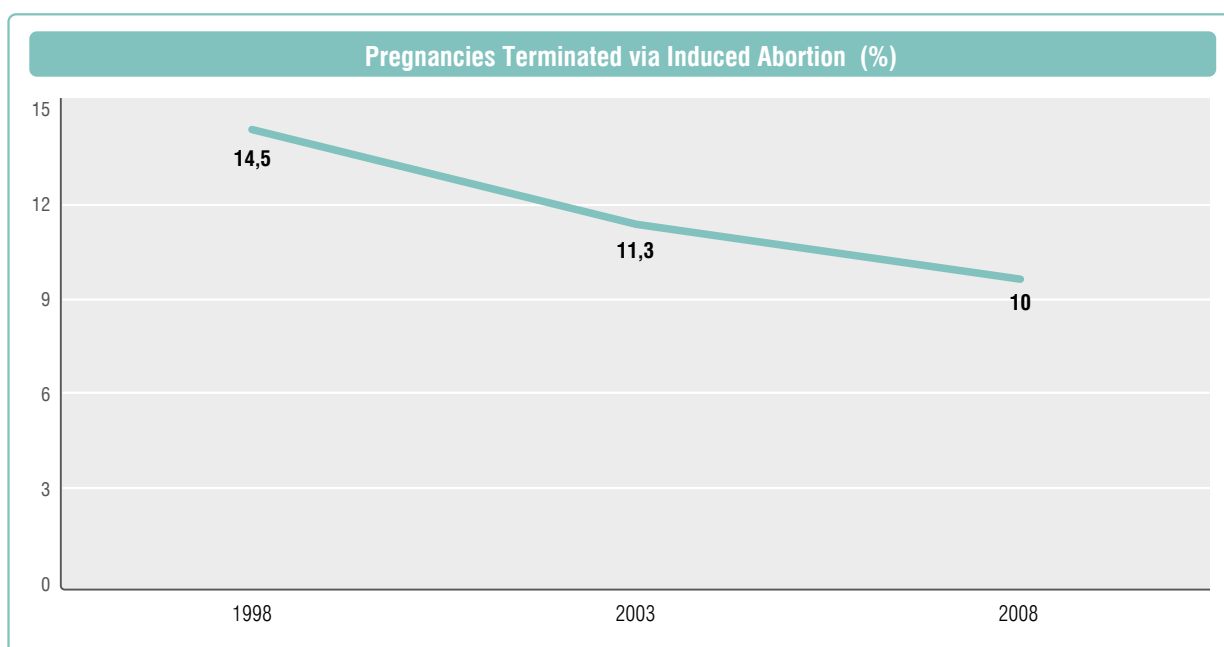


Graphic 16

Source: TDHS 2008



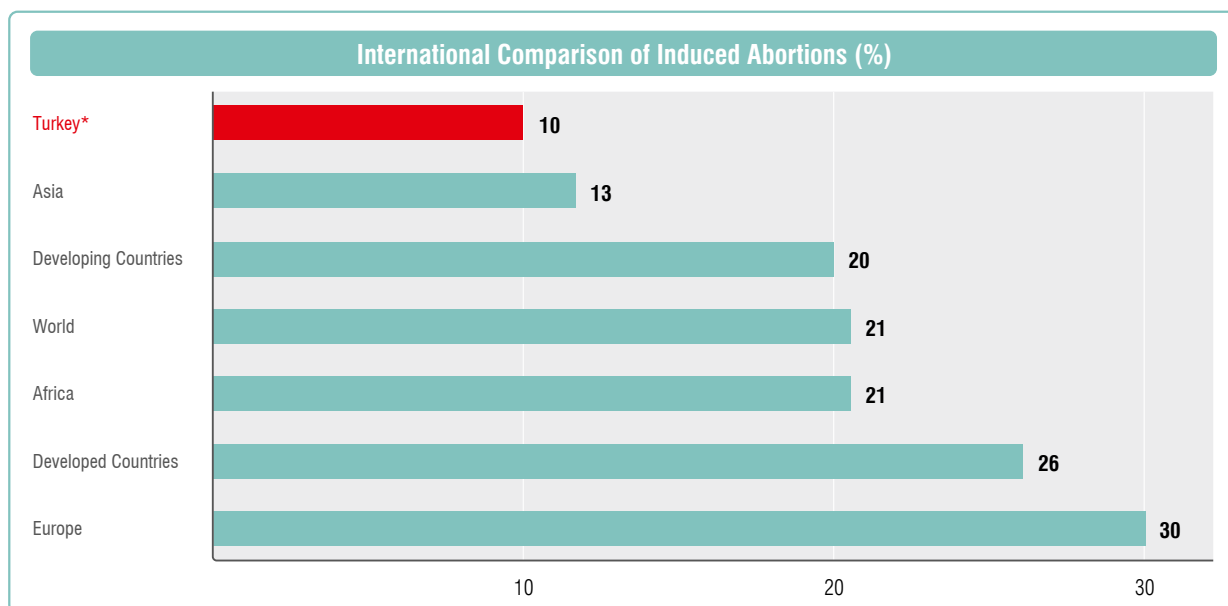
Induced abortion is allowed upon request (of a pregnant woman and her husband, if she is married) until the tenth week of a pregnancy case is completed and unless a medical risk exists for maternal health. For pregnancies after the tenth week, a medical rationale is a must. Pregnancy is terminated in such circumstances: medically absent fetal cardiac activity, miscarriage, severe fetal anomalies diagnosed by a USG or screening test (such as trizomi 18, hidrops fetalis), mental illness of the pregnant woman or pregnancy as a result of rape. Besides, pregnancy can be terminated if it causes a vital threat to maternal health, if mother has to take medicines to give harm to fetus during pregnancy or if ectopic or molar pregnancy exists.



Graphic17
Source: TDHS 2008

Implementing the Health Transformation Program, we have made significant achievements in sexual and reproductive health program. While the prenatal care ratio was 70 % in 2002, it reached up to 95 % in 2011. While more than 3 million couples were provided with reproductive health services, more than 8 million couples received these services in 2011.

While the induced abortion rate was 14,5 % in 1998, it fell to 11,3 % in 2003 and to 10 % in 2008 (Graphic 17 and 18). This is good news, yet, unsatisfactory. What need to be ensured actually is that people have access to “safe induced abortion” in case of medical requirements but induced abortion is rarely used as a method.

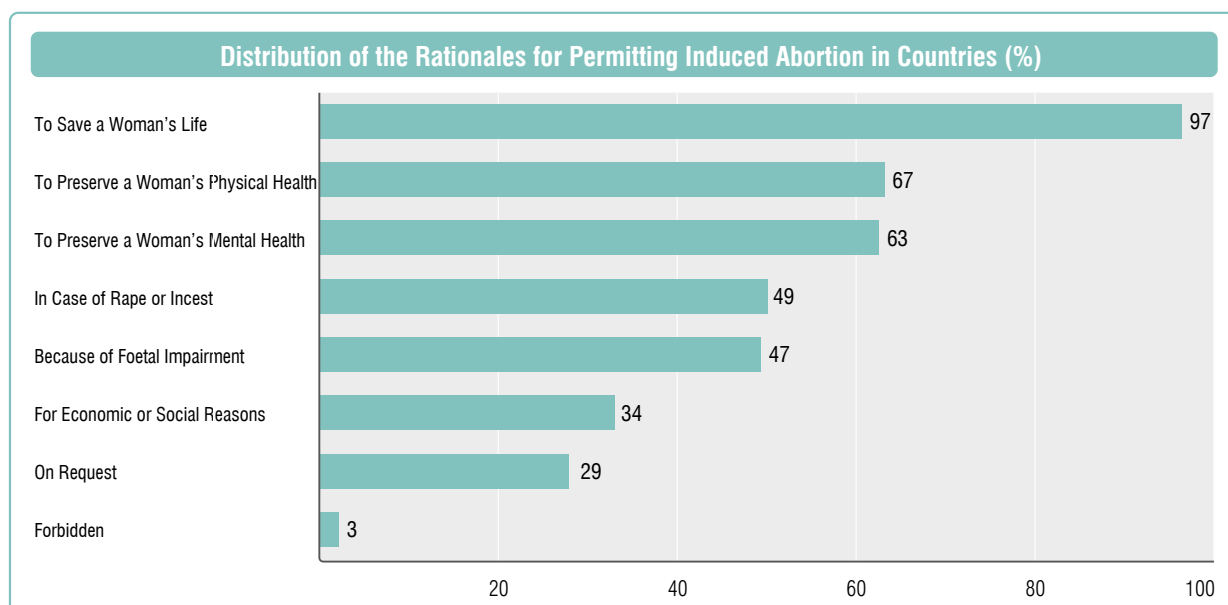


Graphic18

Source: Induced abortion: Incidence and trends worldwide from 1995 to 2008, WHO 2012

* TDHS2008

The rationales for permitting induced abortion varies from a country to another. It is completely prohibited or permitted in some countries (Graphic 19).



Graphic19

Source: UN Population Division. World abortion policies 2011. United Nations, New York, 2011

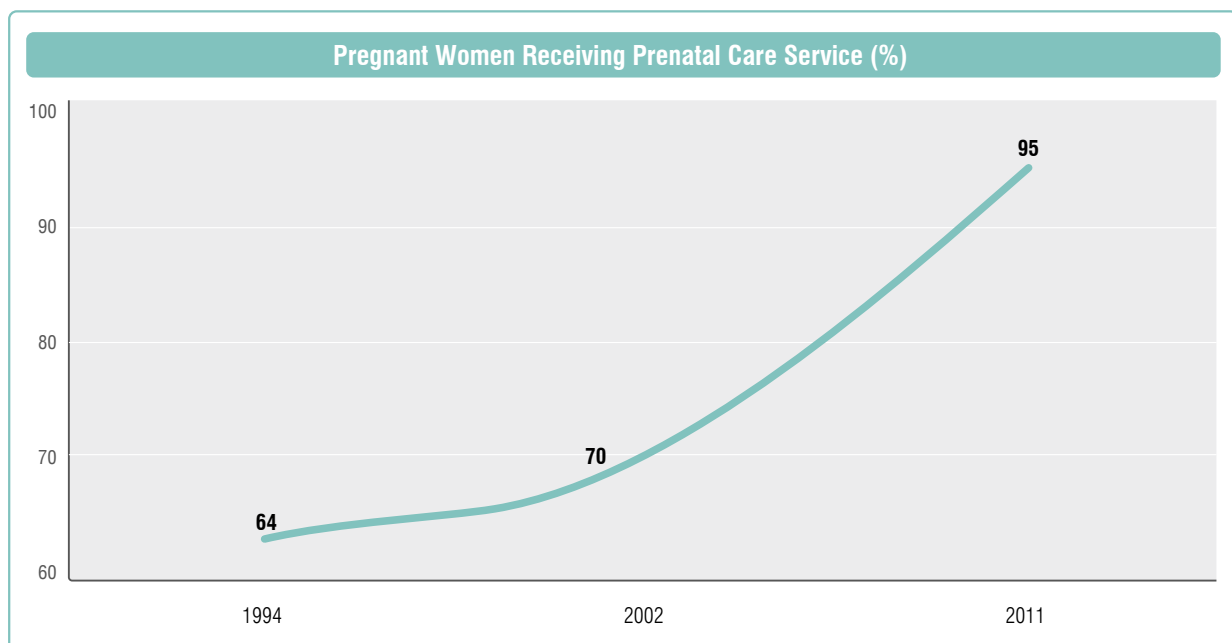


As a result, we know that living is the most significant human right and it is holy. This right can not be sacrificed for ignorance and indifference. So, we can never accept that induced abortion is used as a contraceptive method. This issue should be handled not only as a medical phenomenon but also as an ethical, a sociological and a legal phenomenon. We are formulating policies that will facilitate access to safe induced abortion but will minimize the rate of optional induced abortions.

B. Women are Getting Prepared for Pregnancy and Motherhood: Mothers Will Enjoy Their Motherhood

All 15- 49 aged women are followed up twice a year by primary care health institutions and family physicians for the purpose of informing them on fertility behaviors, determining the risky situations, diagnosing pregnancy in early period, informing on the use of family planning methods, consulting on the women health issues. Through these follow ups conducted in prepregnancy period, women are prepared for pregnancy.

According to the “Prenatal Care Management Guidelines”, pregnant women are ensured to be followed up minimum 4 times a year if they have no risk. Moreover, Risky Pregnancy protocols are prepared as well. Within this scope, we have prepared Epilepsy, Diabetes Mellitus, and Asthma Risky Pregnancy Protocols. Prenatal care rate was 80.9% in 2003 Turkey Demographic and Health Survey (TDHS), and was 92% in 2008 TDHS. According to our National Data System 2011, this figure reached up to 95 % (Graphic 20).



Graphic20

Source: Turkish Public Health Institute

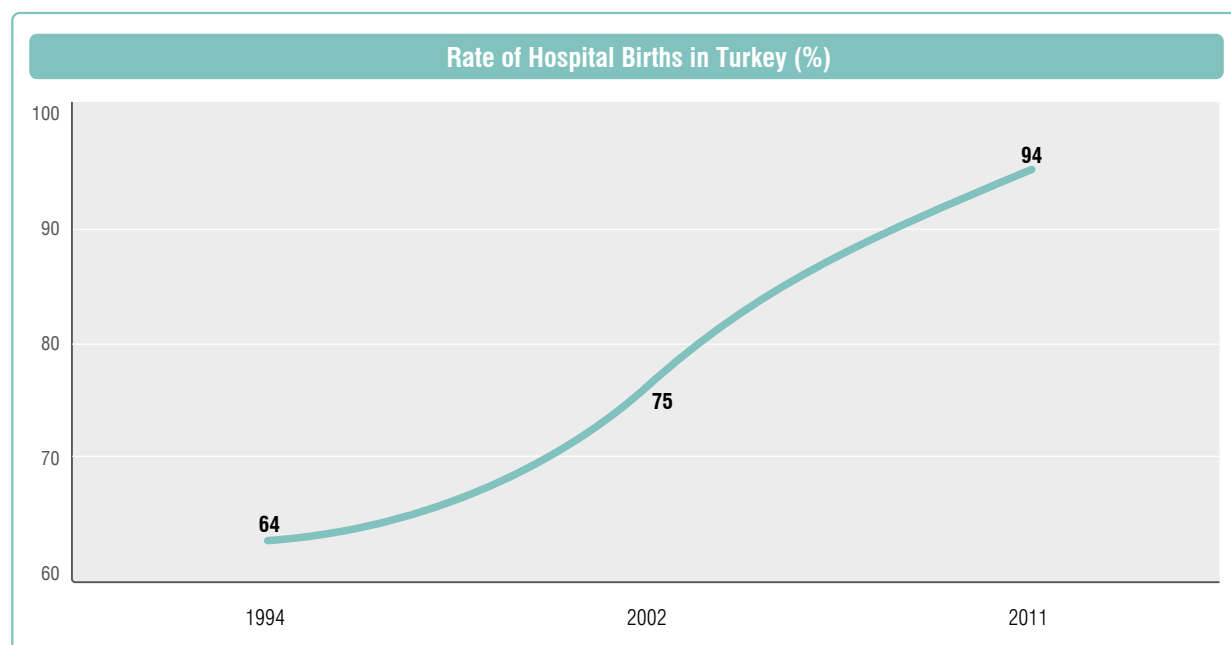
In order to meet the growing need for iron in pregnancy, we provide 40-60 mg/day iron supplement to each pregnant women beginning from the 16th week of her pregnancy and continuing for 3 months long after delivery. We provided iron supplement support to 91% of pregnant women free-of-charge in 2011.



Healthy Deliveries and Health Infants

We have initiated the Baby Friendly Hospital Program in order to decrease the maternal and infant mortality by ensuring all deliveries to be performed at hospitals under safe conditions and through follow ups of pregnant women and puerperants. Baby Friendly Hospital title will be given to hospitals that meet the defined criteria.

We monitor all hospital deliveries and caesarean rates in order to remove inequalities and to ensure each pregnant woman to give birth healthily and safely at hospitals and to ensure the caesarean rates to be at reasonable levels.



Graphic21

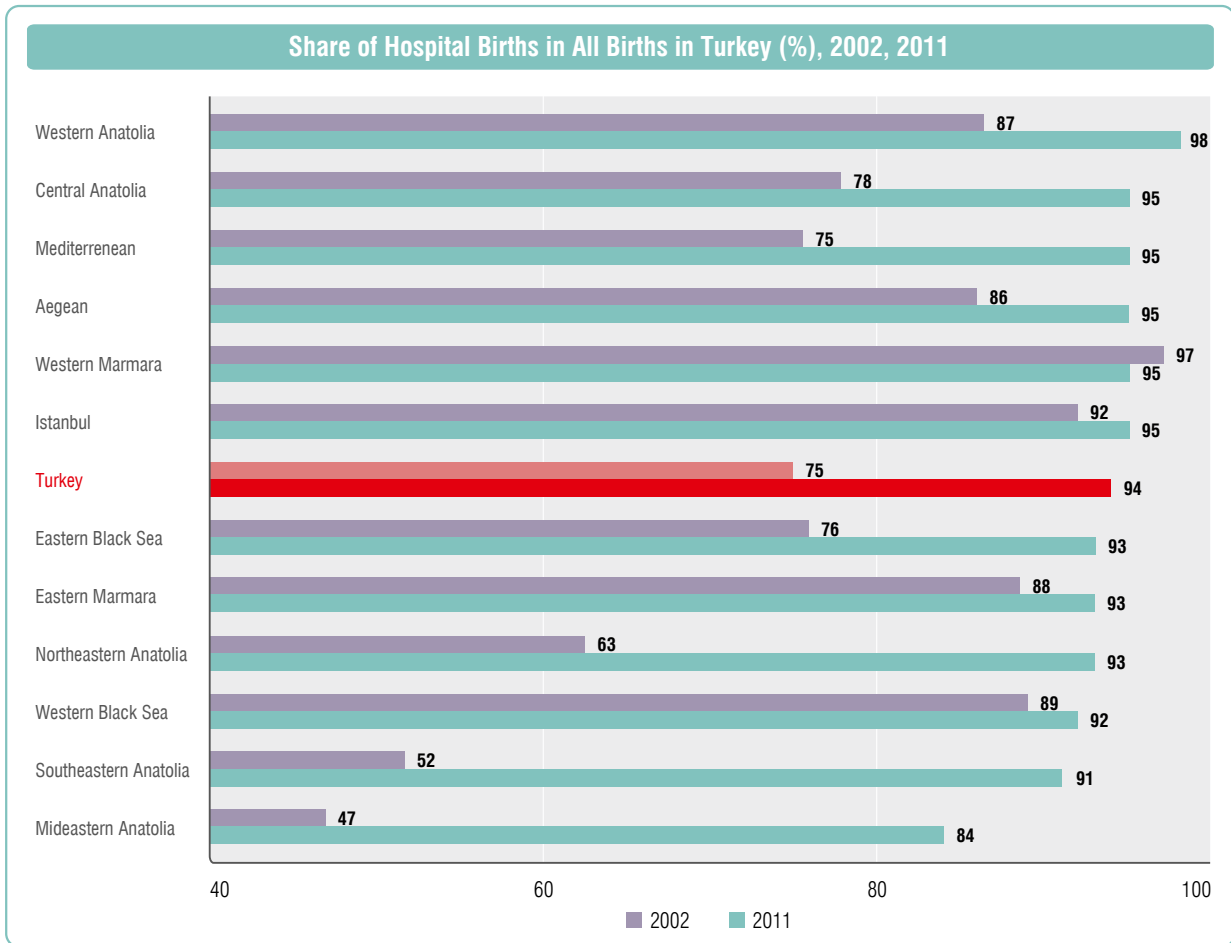
Source: Turkish Public Health Institute

Moreover, we are changing the delivery room and labor rooms into single bed units considering the privacy of patients. In 2003, almost one-fourth of deliveries were made at homes, in unhealthy circumstances.

According to 2003 TDHS data, the rate of births given in health care facilities was 78% whereas 2008 TDHS rate was 90%. However, the rate was reported to have reached up to 94 % in 2001, according to the Ministry of Health data (Graphic21, 22). Our goal is to have 99 % of deliveries made in health care facilities by 2015.

As a result of the increased rate of hospital births and fulfillment of the requirements of hygiene during birthing, we achieved to eliminate maternal (puerperancy) and neonatal (newborn) tetanus in our country which was also officially declared and appreciated by the World Health Organization in May 2009.

Emergency Obstetrical Care program works are going on with components including cross-sectoral collaboration, safe blood transfusion, safe referral, response to infant and mother in obstetrical complications.



Graphic22
Source: Turkish Public Health Institute

While our citizens could not receive necessary health care services in health care facilities a short time ago, today, we offer a monthly aid in cash amounting to 30 TRL to every pregnant women and every child in families in the poorest population group of 6 % on condition that they have regular health checks during pregnancy and in childhood. If pregnant women have births in health care facilities, we offer them an extra monetary aid amounting to 70 TRL.

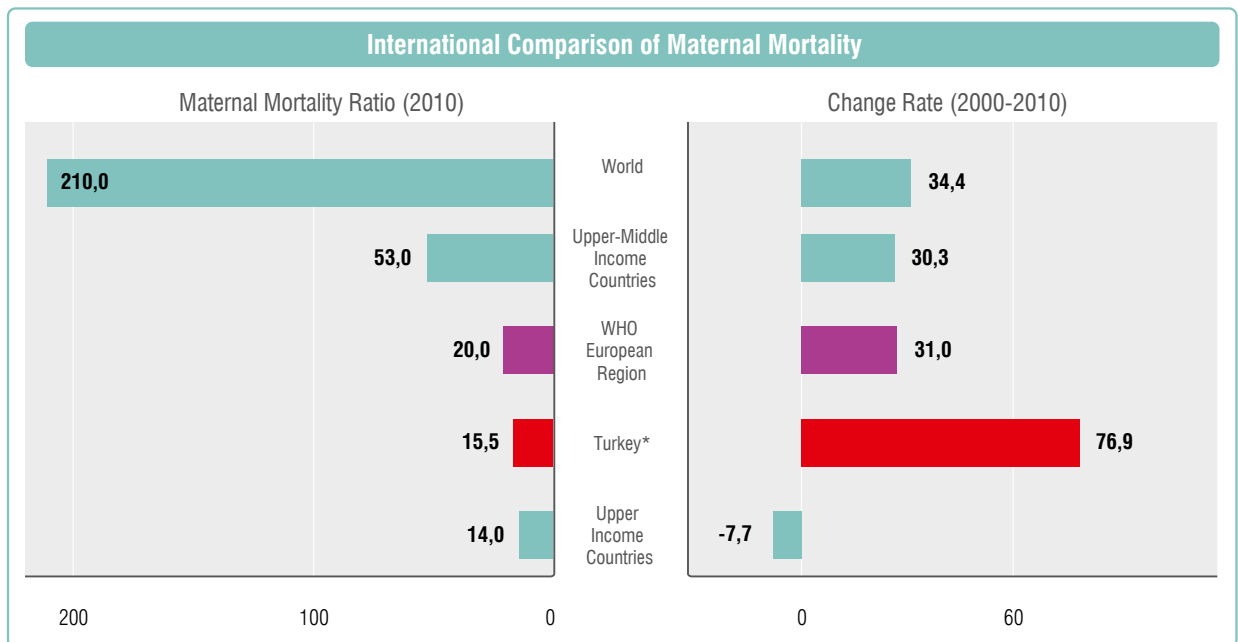
In order to reach all mothers who have given birth in outpatient health care facilities, we launched the “Conscious Mothers and Healthy Babies Program” in 2004. Under this Program, we aim to give basic training to mothers about their own health and their children’s health before discharge from hospital.



In order to prevent maternal and infant mortality caused by hemorrhage in postpartum period, preeclampsy-eclampsy and infections, we developed the Postpartum Care Management Guideline. The ratio of postpartum care, which was searched in the TDSH 2008 for the first time, was found to be 84,5 % and it was noted 90,6 % according to our national data system in 2011.

“Guest Mom Project” is another action taken under the Health Transformation Program. Accordingly, pregnant women at risk are welcome in safe settings: pregnant women living in geographically disadvantaged areas are invited to the “Mother Hotels” 4 weeks before delivery for medical care and comfortable accommodation, and those who accept this invitation are provided with prenatal and postpartum care, and taken back to homes when climatic conditions and transportation become easy. In 2011, we provided this service for 4.795 pregnant women.

The Health Transformation Program has made such an outstanding improvement in maternal mortality rate that it is beyond all comparisons with the same income-group countries (Graphic23 and 24).



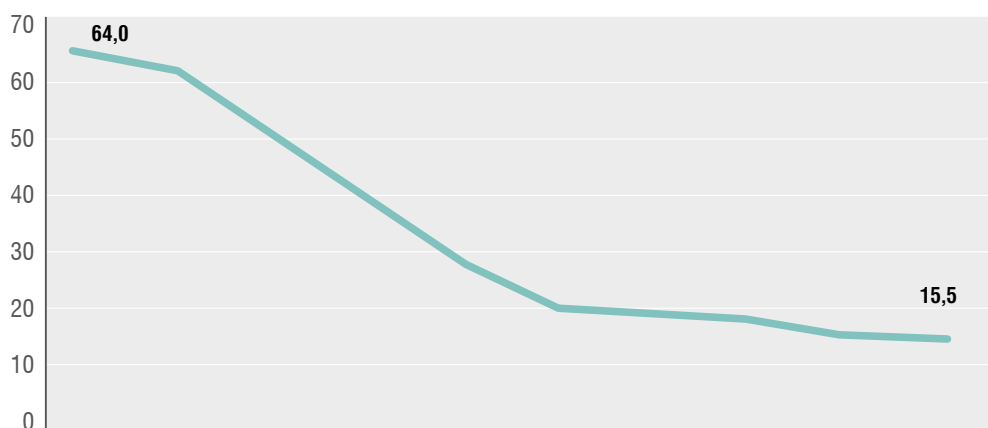
Graphic 23

Source: Turkish Public Health Institute , World Health Statistics 2012

* Turkey data refer to the year 2011 .



Maternal Mortality Ratio in Turkey by Years (hundred thousand)



Years

Maternal Mortality Ratio

2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
64,0	61,0	50,2	39,3	28,5	21,2	19,4	18,4	16,4	15,5

Graphic 24

Source: Turkish Public Health Institute



The European Health Report 2009 (page, 18)

Publishing Year : 2009

Published by : World Health Organization

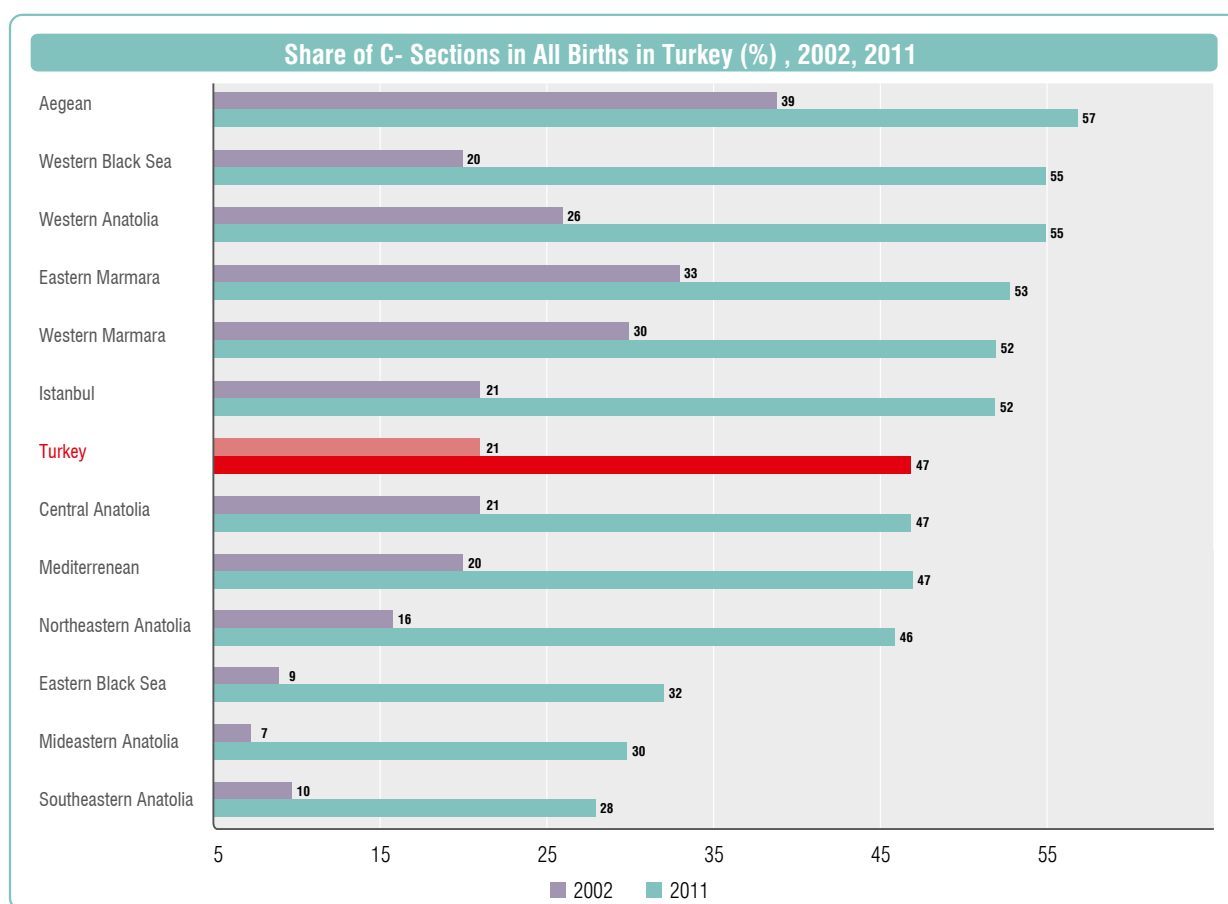
“...This progress is largely due to making maternal mortality a political priority, funding it accordingly, pursuing policies and providing services in a culturally sensitive manner.

This includes establishing pre-delivery care homes for expectant mothers near a hospital and providing land and air transport free of charge for obstetrical emergency cases, greatly reducing the distance and time needed to access appropriate and high-quality specialized care.”



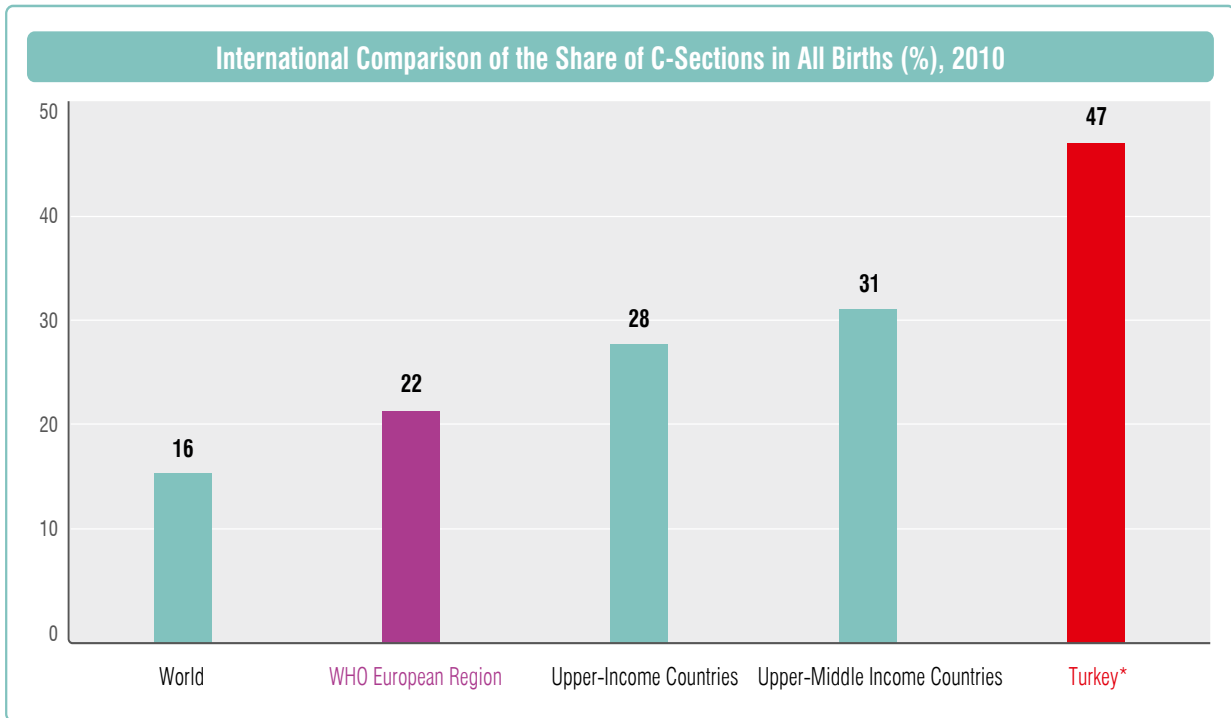
Caesarean Section

A Caesarean Section (or C-section) is the delivery of a baby with a weight of 500 grams or above through a surgical incision in the mother's abdomen and uterus. The C-section is a surgical intervention. C-section, in cases of medical indications, saves the lives of mothers and babies, and is quite effective in reducing maternal and/or infant mortality and diseases. Non-indicative C-sections, on the other hand, are known to increase maternal and/or infant disability and mortality.



Graphic 25
Source: Turkish Public Health Institute

Complications which might be encountered during or after a C-section can be listed as the risks relevant to anesthesia, bleeding and the need for blood transfusion, neighbouring organ injuries, emboli, neonatal morbidity, infant injuries, infant respiratory distress syndrome, infections (endometritis and wound infections), some psychological problems of mothers, recurrent C-sections and related risks (placenta previa, uterine rupture and abdominal adhesions).



Graphic26

Source: Turkish Public Health Institute 2011, World Health Statistics 2012

* Data refer to the year 2011.

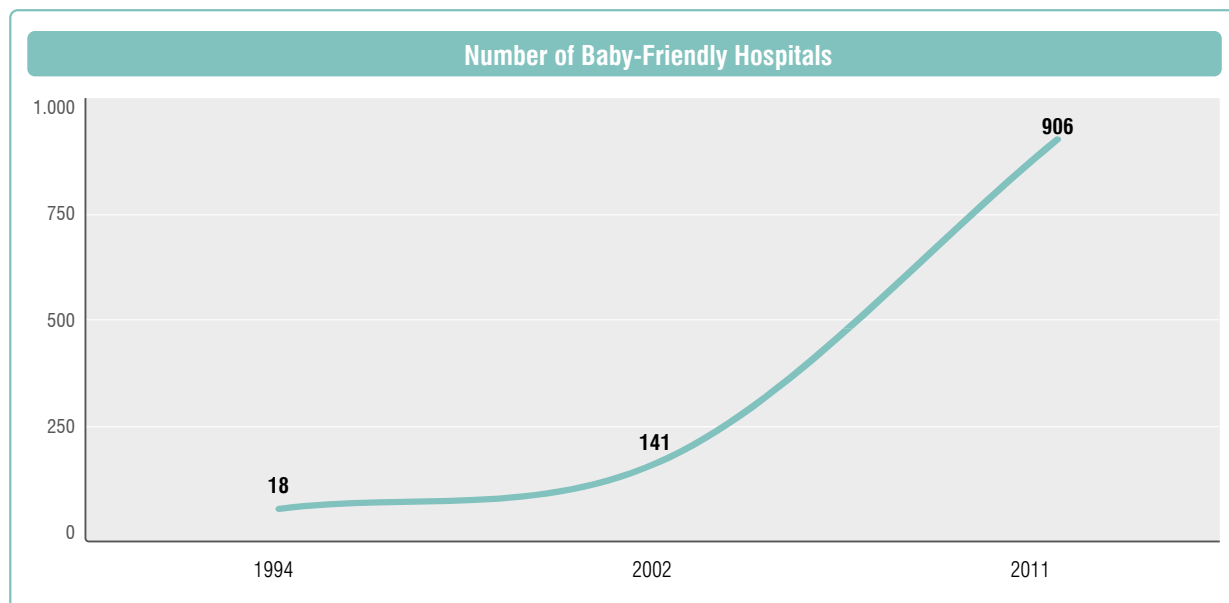
In addition to optimizing conditions for C-sections for pregnant women in case of medical indications, we also aim to minimize the number of C-sections in case of non-medical indications. Our goal is to reduce the ratio of C-sections to 15- 20 % in our country which refers to an acceptable level by the World Health Organization (Graphic 25,26).

C. Safeguarding Our Future: Mothers and Children

Feeding the babies only with mother's milk in the first 6 months and continuing with complementary foods as from the first six months in addition to mother's milk until 2 years of age prevent the infant mortality rate at around 20%. Having been initiated with the purpose of promoting mother's milk, the number of "Baby Friendly Hospitals", which was 141 in 2002, reached to 906 at the end of 2011(Graphic 27). Every infant born in the baby friendly hospitals are fed with mother's milk and make a healthy start to their life.



Today, all hospitals, which give labor and delivery service, are entitled as “baby-friendly hospitals”.



Graphic27

Source: Turkish Public Health Institute

Mother's milk is the right of every baby...

Collaborated with UNICEF, “Breastfeeding Promotion and Baby-Friendly Health Facilities Program” whose main principle is “to feed infants with mother’s milk during the first six months of their life, introduce adequate and sufficient food supplements after the sixth month and continue breastfeeding until 2 years of age” aims to prevent, promote and support breastfeeding. Within this scope, our hospitals where delivery are performed and primary care facilities which perform the follow-ups of pregnant women and infants are rewarded depending on their success rate in applying this principle and they are given the title of “baby friendly health facility” and the provinces that successful at this issue throughout the province are rewarded with the title of “baby-friendly province”.

Between 1991 and 2002, 141 hospitals and 1 province had the title of baby friendly, as of today 784 hospitals and 78 provinces have the title of baby friendly; 41 provinces took their works a step further and became “Golden Baby Friendly Province”. Now, all hospitals where delivery is performed are baby friendly.

According to the 2003 TDHS results, the rate of feeding with only mother’s milk during the first six months was 20.8%, this rate almost doubled in 2008 and reached to 41.6%. In this way, much more infants had the chance to make a healthy start to their life.

In order to protect our infants from anemia, we started providing free iron supplement to infants free-of-charge. Each year, around 1 million infants benefit from this service. We have provided iron supplement to infants exceeding 8.5 million from the beginning of the project in 2004 until the end of 2011.



The number of infants that we provided iron supplement was 1 million 285 thousand just for 2011. In 2011, we provided 3,2 million boxes iron preparations to pregnant women and mothers.

We started disseminating free Vitamin D for supporting the skeletal development of infants. We provided Vitamin D supplements to more than 8 million 500 thousand infants from May 2005 to the end of 2011. We distributed 2 million 500 thousand boxes of free Vitamin D in 2011.

Iron-Like Turkey

According to WHO data, it is predicted that approximately 30% of the world's population and more than half of the pregnant women have anemia.

Before the Health Transformation Program was initiated, iron deficiency anemia was very common in Turkey and the researches revealed that approximately 50% of the children aged 0-5 years, 30% of the school age children and 50% of the breastfeeding women had anemia.

Children most frequently develop iron deficiency anemia when they are 6-24 months old. Growth and development of children is the fastest during this period. Nutritional disorders and iron deficiency in this period has negative impact on the later mental, physical and social development of children. The easiest way to prevent such negative effects is to protect children from iron deficiency anemia.

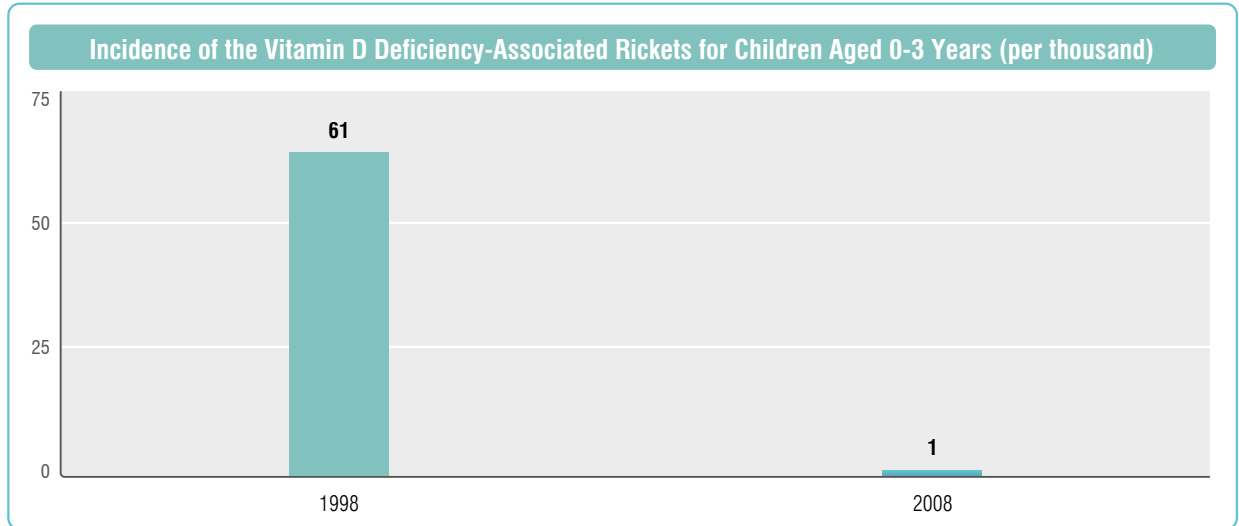
With a view to solving this significant public health problem, we started the "Iron-Like Turkey" program at national level to raise awareness about iron deficiency in the society; to feed infants with mother's milk during the first six months of their life, introduce adequate and sufficient complementary foods after the sixth month and continue breastfeeding until 2 years of age; to provide free iron supplement to all infants aged 4-12 months for protection and to offer iron therapy for infants with anemia between 13-24 months. We have provided iron supplement to more than 8,5 million infants since the onset of the program.

Following the Iron-Like Turkey program, we also undertook the Iron Supplement for Pregnant Women program and further expanded the scope of our activities. We distributed 3,2 million boxes of iron preparations to pregnant women in 2010.

In order to examine the effects of Iron Like Turkey program, "Iron Deficiency Research" was conducted in March-April 2007 with the cooperation of our Ministry and Hacettepe University School of Medicine's Department of Social Pediatrics. According to the results of this research, incidence of anemia has decreased from around 30% to 7,8 % in children 12-23 months old. This rate was 6.3 % in the research conducted in March 2011 by Gazi University. These results clearly reveal the steps we have taken to help our infants become healthier and achieve their cognitive potential.



The studies conducted by Atatürk University School of Medicine in the Eastern Anatolia revealed that the incidence of the Vitamin D deficiency-associated rickets, which used to be 61 per thousand in 1998, was noted as 1 per thousand in February 2008 for children aged 0-3 years (Graphic 28).



Graphic28

Source: Ataturk University Faculty of Medicine Rickets Survey

Support to first breath while starting life...

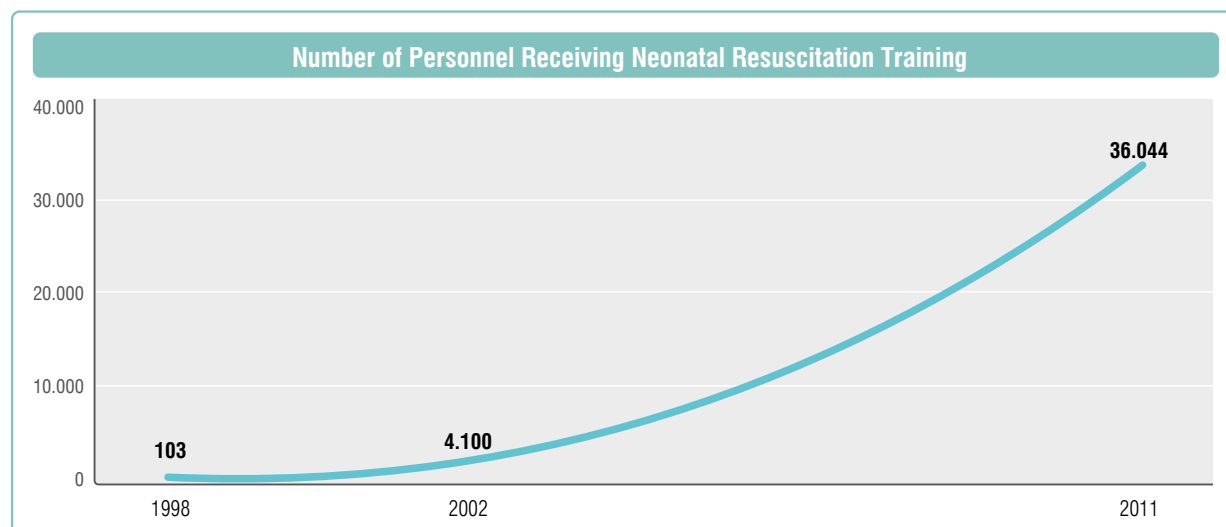
The minutes just after the delivery are crucial for providing assistance to infants in order to help them comply with the life out of mother's womb. The results of the intervention to the infant who is having difficulty in breathing during the first few minutes of the life causes lifelong results by affecting the quality of life in a direct manner.

Providing the necessary assistance and care to newborns in first minutes and establishing the fundamental resuscitation implementations could only be realized through the training of personnel equipped with the knowledge and standard implementations.

We introduced the Neonatal Resuscitation Program (NRP) in 1998; within this scope, it aims to have trained minimum one personnel available in every delivery room for the purpose of preventing disabilities and anoxia-associated deaths. Beginning with 103 people in 4 implementing courses in 1988, this journey is continuing in 1803 implementing courses with the participation of 36.044 people who serve in delivery rooms. The number of trained healthcare personnel was 4100 until 2002, and later on, the figure increased 10 times in 9 years. Apart from our Ministry's personnel, the trainees include participants of universities, military hospitals and private hospitals. Today all our units where mothers give birth have trained personnel available. We will continue to walk in this way until no infant is lost due to preventable causes.



Today, all our units where mothers give birth have trained personnel available.



Graphic29

Source: Turkish Public Health Institute

D. We are Overcoming the Obstacles through Newborn Screenings!

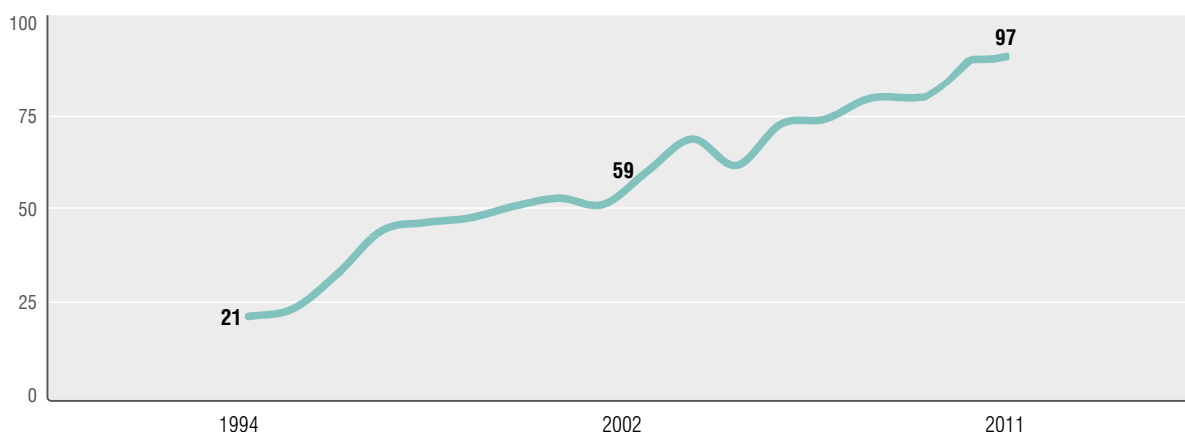
When some genetic diseases aren't diagnosed early, they cause permanent damages particularly affecting the brain tissue. Thorough the screenings conducted during the newborn period, these diseases are diagnosed early and disability might be prevented through proper treatments.

We have extended the neonatal screening program nationwide to provide a healthy beginning for the newborns. Screening for phenylketonuria, which was launched previously, was rolled-out throughout the country. Fully aware of the importance for neurological development of children, screening for congenital hypothyroid was initiated at the end of 2006 and screening for biotinidase deficiency was initiated at the end of 2008. In this way, our babies are widely protected from phenylketonuria and congenital hypothyroid, diseases that can be prevented easily when detected, but cause irreparable damages such as mental and physical development retardation when missed. 96.5% of the target population was reached in phenylketonuria and hypothyroidism screening (Graphic30). Under the Newborn Screening Program, 1,266,785 infants were screened in 2011. As a result of these screenings, treatment was initiated for 154 infants diagnosed with phenylketonuria, 2,201 infants with congenital hypothyroid (including temporary cases) and 204 infants with biotinidase deficiency.

We have completed the establishment of Newborn Hearing Screening Units in 727 hospitals in all provinces and screenings have been initiated. 959 thousand infants underwent hearing screening in the year 2011. 1,757 of these infants were diagnosed with hearing loss and taken to treatment program. For the purpose of rolling out the screenings, we have been performing procurement for the supply of hearing screening device for 200 hospitals where the screening is not performed.



Phenylketonuria Screening Rates (%)



Graphic30

Source: Turkish Public Health Institute

Can your baby hear you?

According to the data of WHO, almost 10% of the world population consists of the handicapped. It is estimated that changes in the age distribution of the population, in the pattern of diseases and death causes, and also in the content of health services and increasing industrialism would change the handicapped rates in the world. In the protection from disabilities, screening is the method which is used for early diagnosis mostly and gives the best results. Congenital metabolic diseases which are frequently associated with kin marriage in Turkey and newborn hearing losses take an important place among disability causes.

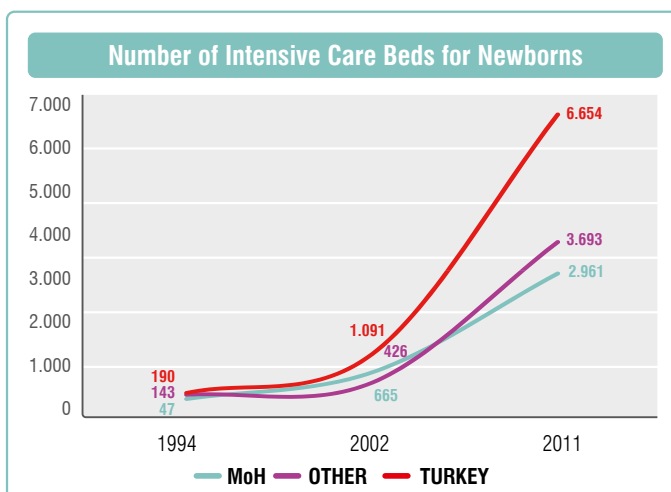
The language development of an infant stops when the baby is born with hearing loss and when this handicap is not discovered. However; the intellectual, social and psychological development of the infant slows down. We planned newborn hearing screening program "for early diagnosis of the disability in a way to ensure that the children born with hearing loss or those with hearing loss occurred in the postpartum period will take their place in the society as a psychologically and socially healthy individual without allowing the disability has an effect on the development of the child's speech and for increasing the awareness of healthcare personnel and society on the issue, as well".

The program had been introduced by the Prime Ministry's Administration for Disabled People in 2000 as a pilot project and was transformed into the national program in 2004 and its responsibility was undertaken by our Ministry in 2005. When we undertook the program in 2005, screenings used to be performed in 36 centers in 24 provinces (with a screening rate of 6.9%). Today, we have screening centers in all provinces as of 2011. We performed hearing screenings for 959 thousand infants in 2011. We diagnosed hearing loss in 1,757 of these infants and included them in the treatment program. Our screening rate reached up to 76% for 2011. Totally 727 Newborn Hearing Screening Units were established especially in 6 MoH-affiliated Child Hospitals, 51 maternal and child hospitals, 388 State Hospitals and 298 Private Hospitals, 45 University Hospitals where the hearing screenings are currently being performed.



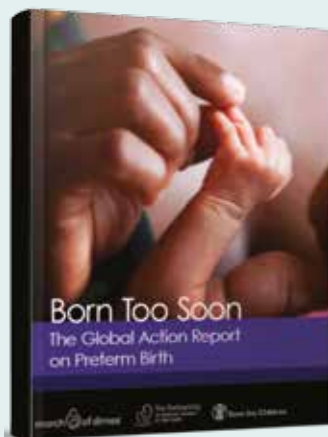
E. Intensive Care of Newborns

We raised the number of newborn intensive care beds from 665 in 2002 to 2,961 in the MoH hospitals in late 2011 (Graphic 31). We raised the number of transport incubators rose from 158 to 469 and the ventilators from 252 to 855.



Graphic31

Source: General Directorate of Health Services



Born Too Soon: The Global Action Report on Preterm Birth, 2012

Born Too Soon: The Global Action Report on Preterm Birth, 2012
Published by: World Health Organization

Some Countries Decreased Infant Mortality Rates Due to Preterm Birth in Half within 10 Years

Example from Turkey

“Turkey, an upper middle-income country, has made significant progress in health care over the past decade. Health system transformation was comprehensive, but maternal and neonatal health policies, in particular, played a central role. In fact, Turkey achieved in a decade what took 30 years in the OECD countries.”

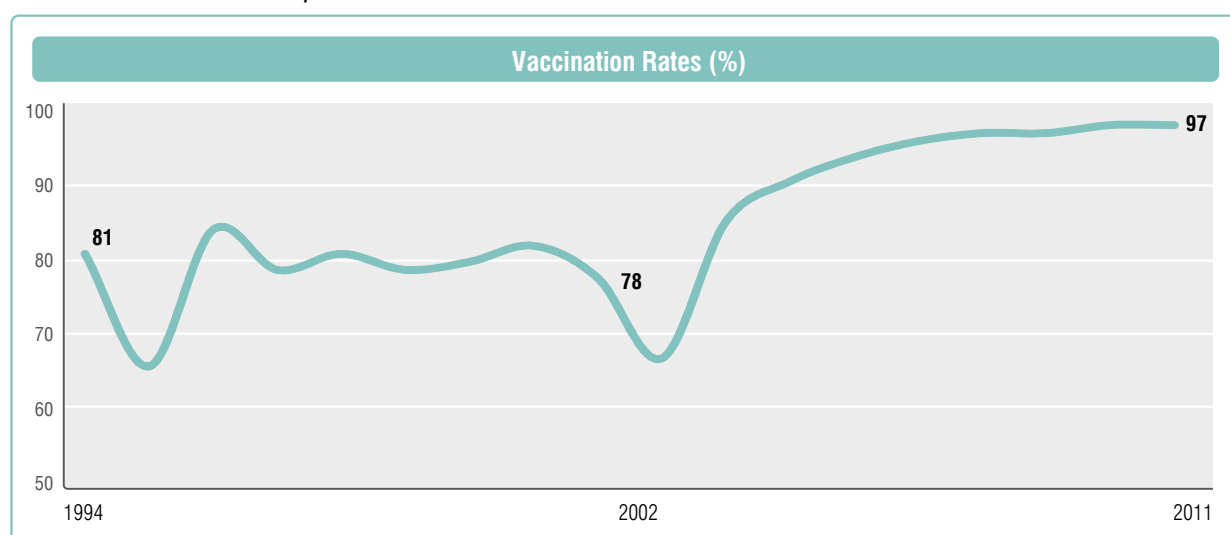
“Part of Turkey’s success was through the implementation of demand and supply strategies. There was significant promotion of antenatal care and facility births, including cash incentives and free accommodation in maternity waiting homes in cities for expectant women from remote areas. In addition, wider public health approaches were an important foundation, such as focused elimination of maternal and neonatal tetanus, breastfeeding promotion and UNICEF “baby-friendly” hospitals campaigns. Turkey invested in health systems improvements, such as systematizing referral to neonatal care with transport systems, and upgrading neonatal intensive care units, focusing on nursing staff skills and standardization of care especially for neonatal resuscitation.”



3. Immunization Programs: Vaccines

Immunization service is an important primary healthcare service which is conducted for protecting the infants, children or adults by vaccinating them against diseases before the period when infection development risk at the highest level.

The fundamental objective in immunization services is to prevent the emergence of particularly the infant and childhood vaccine preventable diseases in the society and accordingly to prevent the deaths and disabilities caused by these diseases.



Graphic32

Source: Turkish Public Health Institute

Effective and continuous vaccine implementations started in Turkey in 1930 with the law which made the implementation of smallpox vaccine compulsory. In the struggle against communicable diseases; the vaccination works which were conducted with teams established only in city or district centers at first due to the lack personnel and equipment; however, they were transformed into common and systematical vaccine implementations in 1963 when health services were socialized.

Later on, “Expanded Immunization Program” was adopted the purpose of “immunization of children against six vaccine preventable diseases until 1990” which is the objective of WHO in order to decrease vaccine preventable diseases and deaths caused by these diseases.

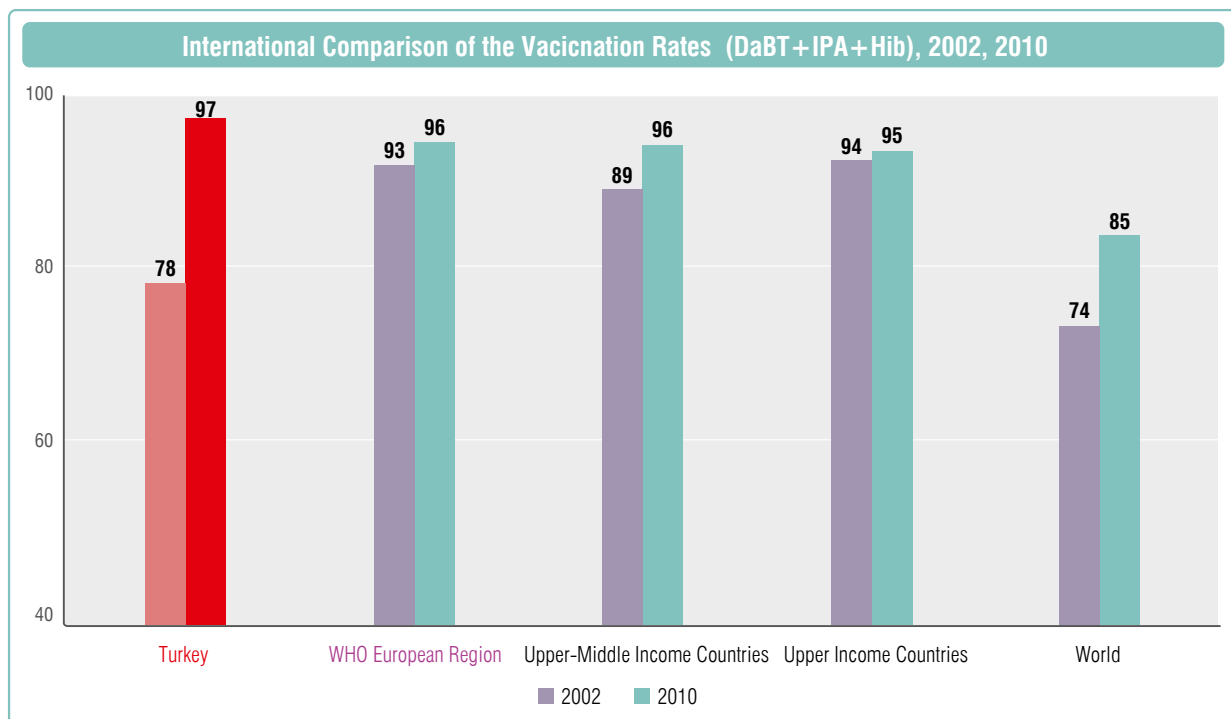
Expanded Immunization Program (EIP):

In accordance with the vaccination schedule, the main aim of EIP is to make every infant to be immunized against pertussis, diphtheria, tetanus, measles, rubella, mumps, tuberculosis, poliomyelitis, Hepatitis B and Hemophylus Influenza Type B. The term of “expanded” means that when the unvaccinated infants and children or those with incomplete vaccination are discovered, they will be vaccinated at that moment, and also it means that the implementation is performed in every place throughout the country in an equal manner.



Vaccination rate of the targeted child population was 78% across the country in 2002. This rate was even below 50% in some provinces of Southeastern Anatolia. We reached a vaccination level of 97% across the country in 2010 and sustained the rate in 2011, too. Even in those provinces with low vaccination levels formerly, vaccination level exceeded 85% in the same period (Graphic 32 and 33).

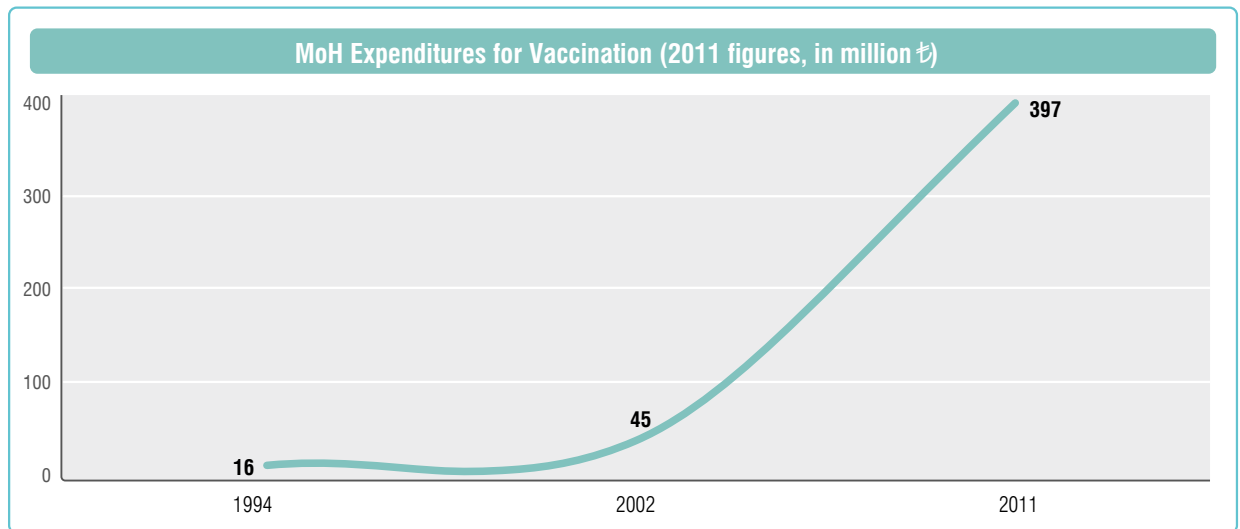
With the major progress that we made in vaccination in the last nine years, we serve as an exaple of success to the whole world.



Graphic33
Source: Global Health Observatory Data Repository, World Health Statistics 2011, 2012

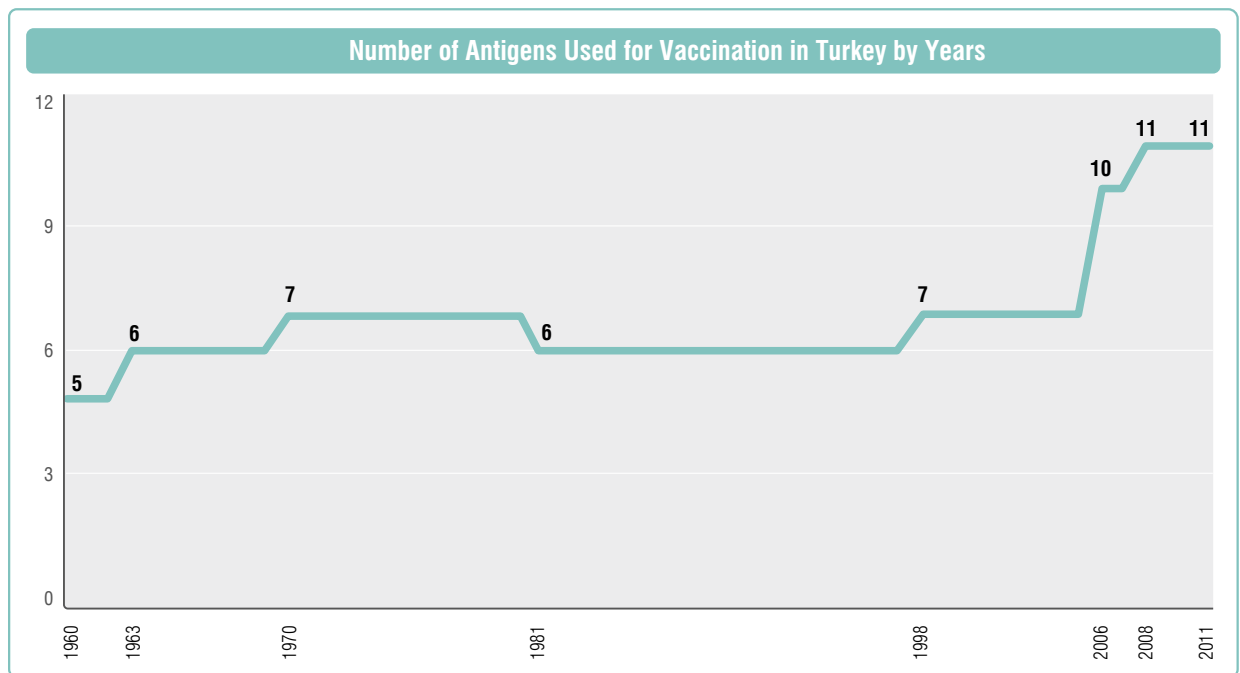
Resources allocated to vaccination increased by only 2.8 folds during the course of 1994-2002; whereas it increased by 8.9 folds in the period 2002-2011 (Graphic 34).

EIP has a dynamism that is expanding with the inclusion of needed vaccines into the program. It is conducted and developed in the direction of the suggestions and scientific support of the Immunization Advisory Committee (IAC) which consists of academicians of vaccine-related fields within our Ministry. IAC meets minimum twice a year, discuss the current developments and give suggestions.



Graphic 34
Source: Turkish Public Health Institute

5 antigens were used for routine vaccination in 1960 in Turkey and it increased only to 7 antigens in 2002, that is, vaccination was performed against 7 diseases (diphtheria, pertussis, tetanus, polio, measles, hepatitis-B and tuberculosis) before the Health Transformation Program (Graphic 35).



Graphic 35
Source: Turkish Public Health Institute



In 2006, we started to perform vaccination for Hemophilus Influenza Type B (Hib), rubella and mumps in all health care facilities across the country.

Since the beginning of 2008, we have provided DaPT-IPA-Hib vaccines (diphtheria, acellular pertussis, tetanus, inactive polio virus and Hib vaccine) as in the form of prefilled single syringe. In this way, we ensured vaccination against 5 diseases at a time. We have also ensured the filling stage of this state-of-art product to be fulfilled in Turkey.

In this way, we have provided opportunity for more vaccines to be performed with fewer injections. Immunization used to be ensured through 15 injections with 7 antigens until the age of 1 year; however, we decreased this figure to 12 injections with 11 antigens.

Moreover, we passed from whole cell pertussis vaccine to acellular pertussis vaccine through this change. Oral polio vaccine (OPV) used to be performed in the previous time and in addition to this, we have included inactive polio vaccine (IPV) into the program as well.

Through additional works, we have completed the hepatitis B and rubella vaccinations of the group aged under 21 years of age. We have completed the vaccinations for primary school cohort in 2005-2008, secondary school cohort in 2008-2009 and supportive vaccinations for risk groups identified since 2009. In this way, we have completed the 3-dosage vaccinations of those who were born after 1990 and have become the first country that substantially completed the Hepatitis B vaccinations for the group aged both 21 and under 21 years of age (approximately 26 million people) in the WHO European Region.

We have completed the “Tetanus Vaccination Days” in 2006-2007 within the scope of the Maternal Neonatal Tetanus (MNT) Elimination Program which was initiated in 1994 and reviewed in 2005. Finally, it was confirmed that our country eliminated MNT countrywide as a result of the validation study that was conducted in Şırnak province under the consultancy of WHO in February 2009.

The latest innovation that we have done in 2010 in the vaccination schedule is the introduction of quadrivalent combined vaccine including acellular pertussis vaccine implementation for the first grades of primary schools for the prevention of acellular pertussis cases which are seen frequently during the primary school period.

In conjugated pneumococcus vaccination, we passed from 7-component vaccine to 13-component vaccine. We will perform the labeling, packaging, filling and formulation stages of this vaccine gradually in our country via technology transfer.

In this way, we were involved in the group of leading countries of the world according to the evaluation of vaccination schedule and rates. (Table 2). As different from many countries, we provide the vaccination services completely free-of-charge. Our evaluations have been going on for the inclusion of new vaccines into the vaccination schedule. We have been performing operations in collaboration with the leading vaccine companies for the purpose of ensuring the production of those vaccines in Turkey in the process of including new vaccines into the vaccination schedule.

We have improved the surveillance of the vaccine preventable diseases. Until 2005, we collected the polio-excluded vaccine preventable diseases as clinical diagnosis. However, we started to collect them as firm cases via laboratory support under the strengthening of communicable diseases surveillance.



Table 2. Childhood Period Vaccination Schedule (2011)

	At Birth	End of the 1st Month	End of the 2nd Month	End of the 4th Month	End of the 6th Month	12th Month	18-24 Months	1st Grade in Primary School	8th Grade in Primary School
Hep-B	I	II			III				
BCG			I						
DaPT			I	II	III		R		
PCV			I	II	III	R			
MMR						I		R	
DaPT-İPA								R	
OPA					I		II		
Td									II

R: Recall (Reinforcement)

We have been conducting works to roll-out adult vaccinations. We provide vaccines for defined risk groups of adult pneumococcus, influenza, hepatitis A, chicken pox under the SSI's Health Implementation Communiqué.

Recent Improvements in the Turkish Childhood National Immunization Program, The Turkish Journal of Pediatrics, 2010

“Childhood National Immunization Program is one of the main elements of basic health services and has an important role on national health status.”

“Turkish Immunization Programme conducted by the Ministry of Health used to cover such basic vaccinations as BCG, TDAP and polio until 2005. The change in the MoH policies and close cooperation with Immunization Counselling Board resulted in improvement not only in quality of vaccinations and vaccination rates but also the number of covered pathogens (Table 3).”

“Turkish Immunization Programme is currently in an equal or a better state when compared to the European countries. On the other hand, vaccination must be made a priority and an integral part of the health policies of the state to ensure sustainability. Political determination, multi-sectoral cooperation and awareness are vital issues.”



As a consequence, vaccination percentages in our country increased not only in number but also in respect of the vaccines that are used. In 2002, immunization was ensured against 7 antigens (6 antigens were used in 1980); however, we increased this number to 11 antigens by adding the modern vaccines into the schedule (Table 3). We pay attention to the use of quality and safe products. We have brought the vaccination schedule in force in our country to the level of developed countries.

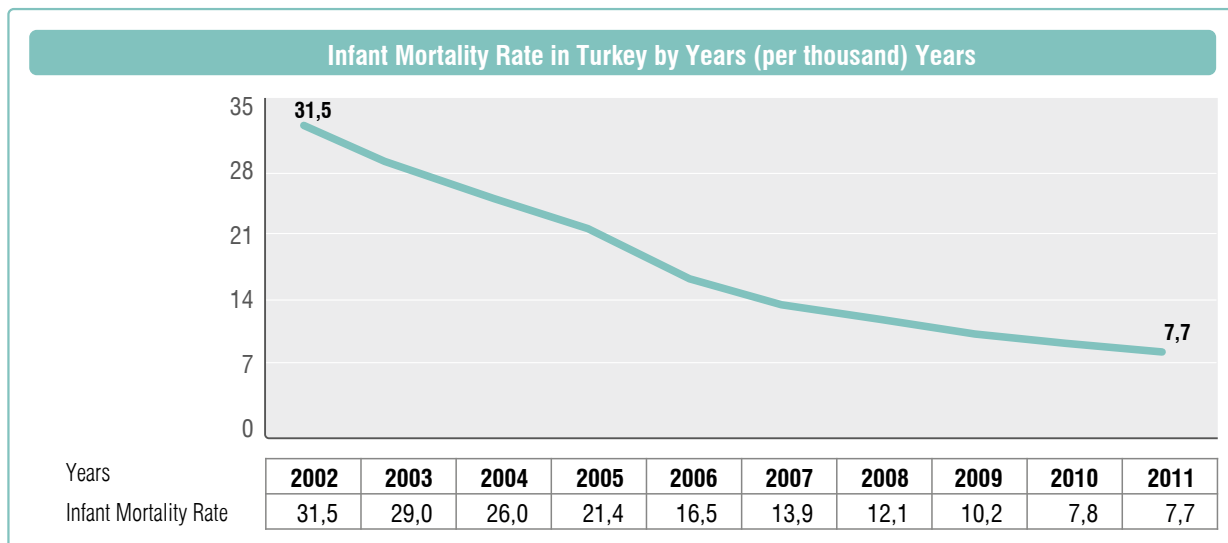
Table 3 Vaccine Antigens Used in Turkey By Years

	1994	2002	2011	
Vaccines Routinely Applied During Childhood	BCG	BCG	BCG	
	Diphtheria	Diphtheria	Diphtheria	
	Pertussis	Pertussis	Acellular Pertussis	
	Tetanus	Tetanus	Tetanus	} Pentavalent Combined Vaccine
	Oral Polio	Oral Polio	Polio	
	Measles	Measles	Hemophilus	
			Influenza Type B	
		Hepatitis B	Measles	
			Rubella	} Trivalent Combined Vaccine
			Mumps	
			Hepatitis B	
	(6 antigens)	(7 antigens)	Conjugated pneumococcus	
			(11 antigens)	



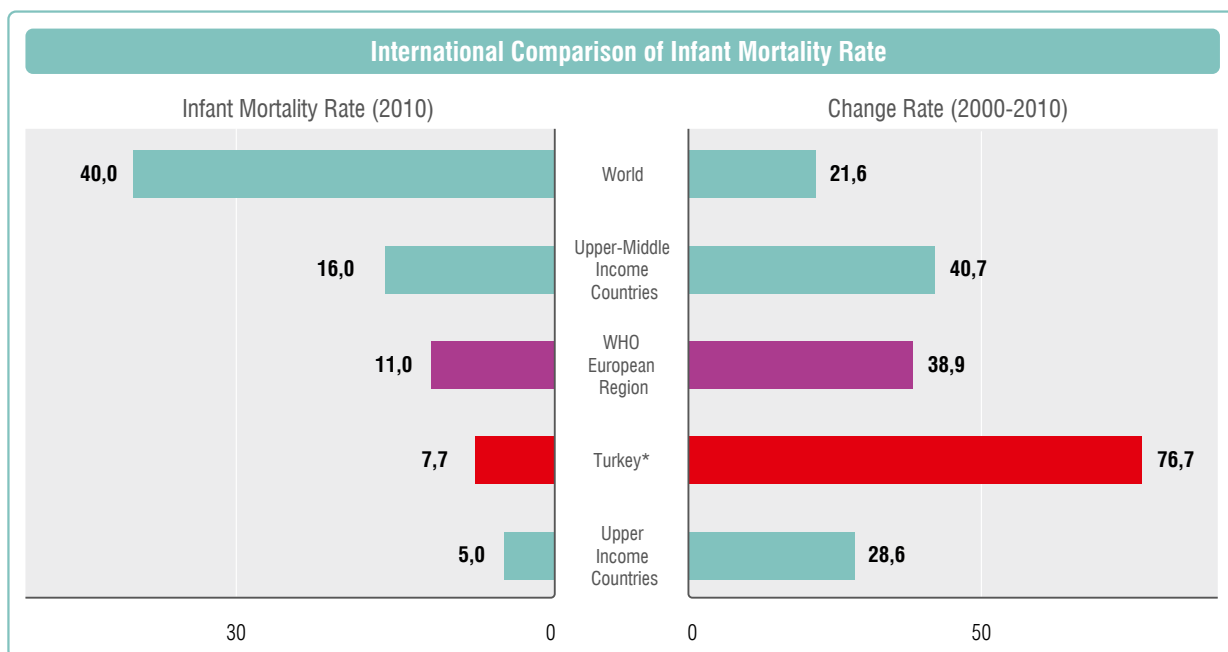
Healthy Generations and a Healthy Future...

According to the Turkey Demographic and Health Survey (TDHS), the infant mortality rate which was 28.5 per thousand in 2003 and 12 per thousand in 2008 was reported 7.7 per thousand in 2011 according to the MoH data (Graphic 36 and 37).



Graphic 36

Source: 2011 Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012"; Other Years Turkish Public Health Institute



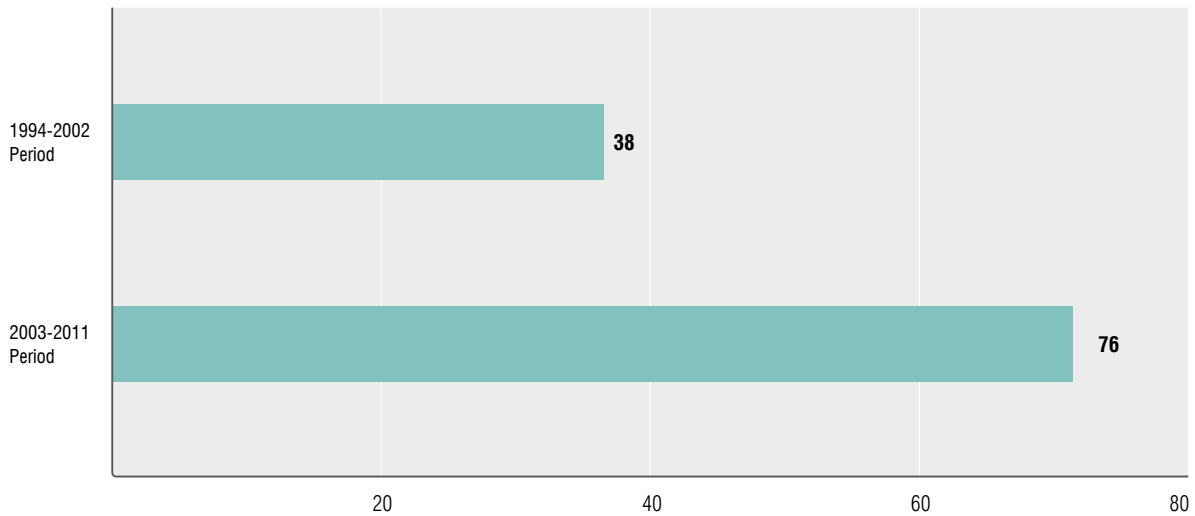
Graphic 37

Source: Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012", World Health Statistics 2012

* Turkey data refer to the year 2011 .



Change Rate in Infant Mortality Rate in Turkey by Nine-Year Periods (thousand)

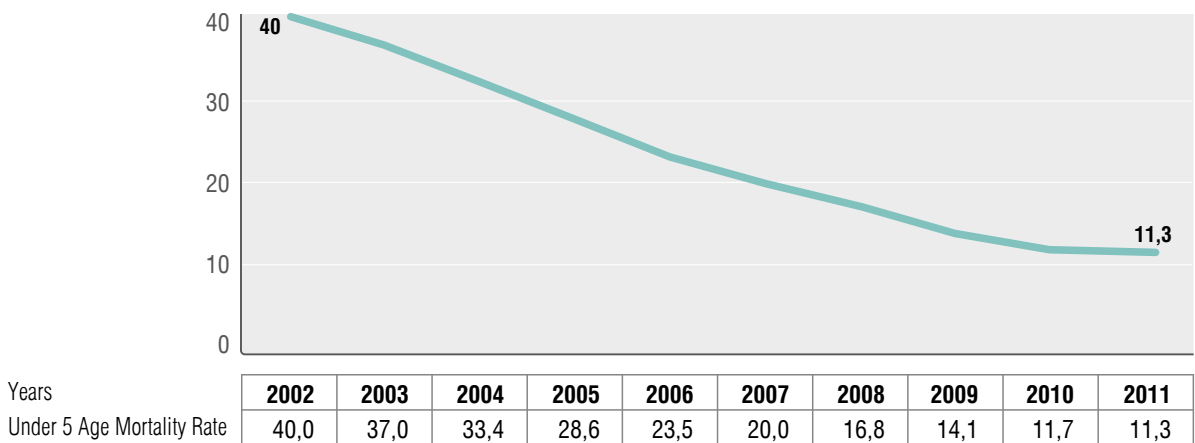


Graphic 38

Source: 2011 Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012", Other Years
Turkish Public Health Institute

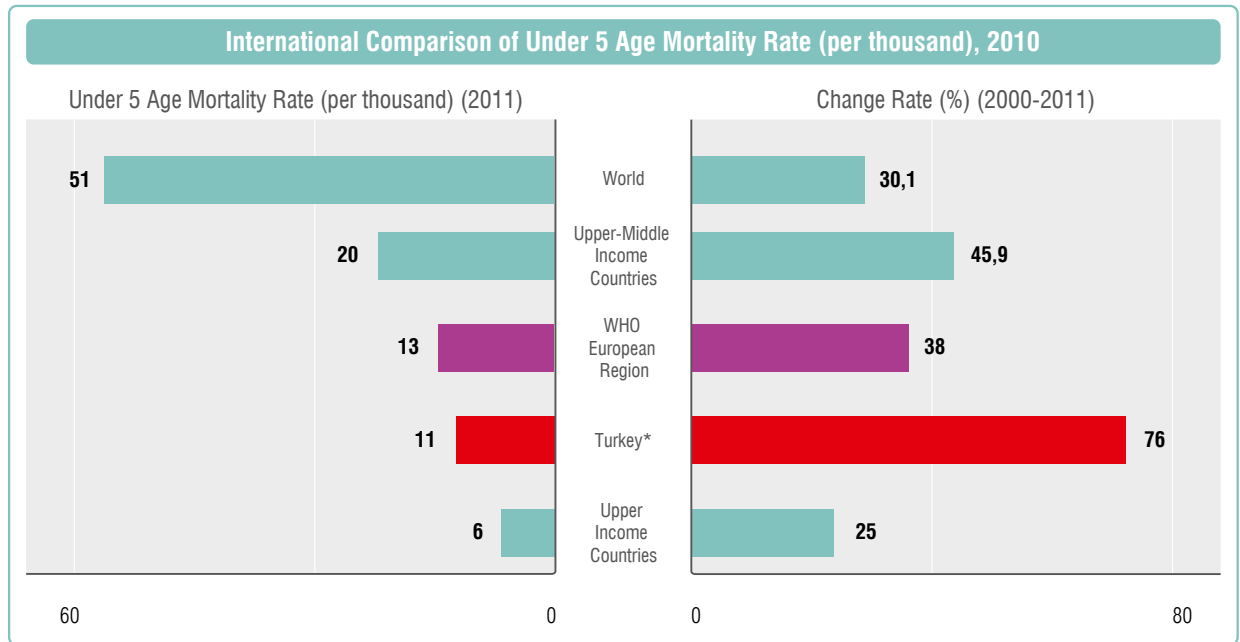
Infant mortality rate decreased by 38 % in 1994-2002. In 2003-2011 period, in which we were in power, however, the rate of decrease was noted 76 % (Graphic38).

Under 5 Age Mortality Rate in Turkey by Years (per thousand)



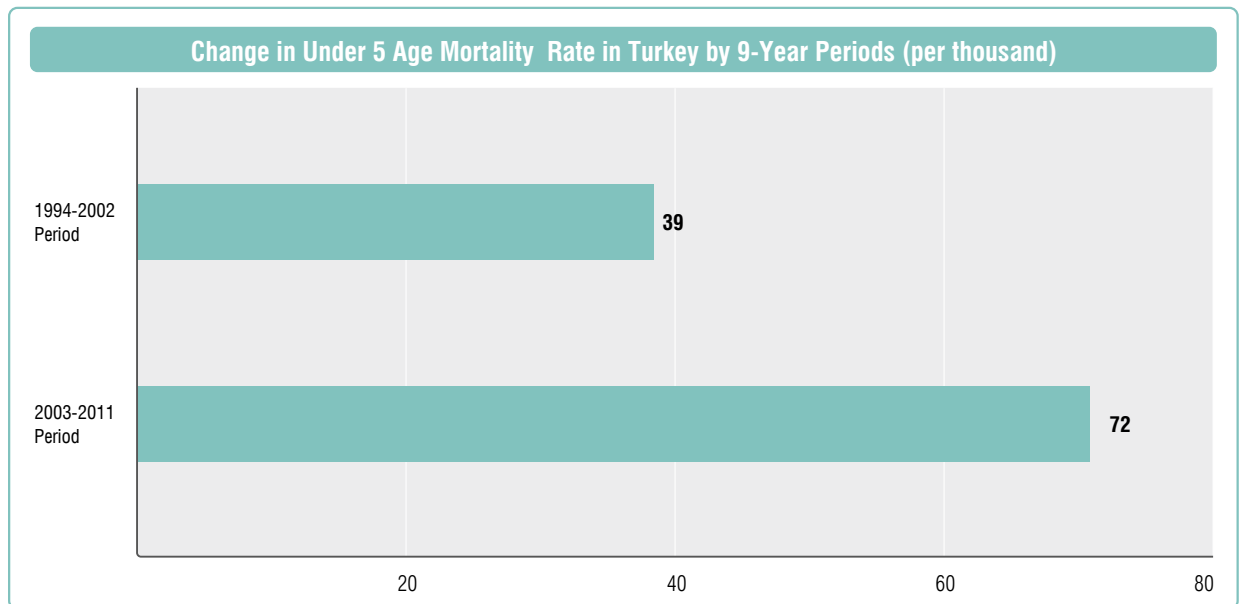
Graphic 39

Source: 2011 Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012", Other Years
Turkish Public Health Institute



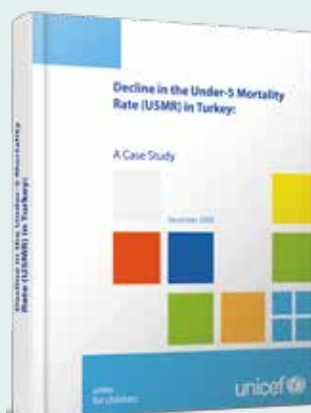
Graphic 40

Source: Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012", Unicef, WHO, The World Bank, UN, Levels & Trends in Child Mortality 2012.



Graphic 41

Source: 2011 Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012", Other Years Turkish Public Health Institute



Decline in the Under-5 Mortality Rate (U5MR) in Turkey: A Case Study

Decline in the Under-5 Mortality Rate (u5mr) in Turkey: A Case Study

Year of Publishing : 2009

Published by : UNICEF Institution

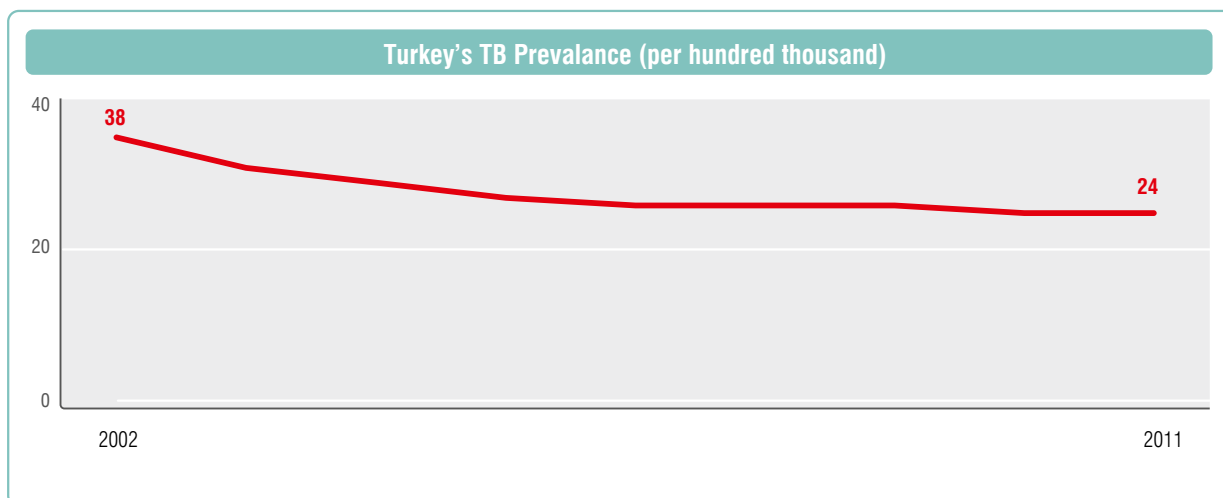
“Increase in neonatal care directly contributed to the pregnant women’s giving birth in health institutions and in the custody of health personnel, qualitative and quantitative developments in neonatal intensive care services and survival of children.”

“Focusing on health strategies and planning and comprehensive and effective public health campaigns on family planning, immunizations, neonatal resuscitation and children survival have significantly contributed to decrease in infant mortality rates and under 5 mortality rates subsequently.”

4. Effective Struggle Against Communicable Diseases

Tuberculosis

WHO implements a global control program for tuberculosis and in Turkey we have a parallel National Tuberculosis Control Program meeting the same standards.



Graphic 42

Source: WHO HFA Database July 2012



Within the framework of the Millennium Development Goals, the WHO's "World Health Assembly Decision" No. 44.8 and "Stop Tuberculosis Strategy", goals of tuberculosis control across the world have been determined.

According to the "WHO Global Tuberculosis Control Report 2012" data, the incidence of tuberculosis in WHO European region, also including Turkey, was 56 per hundred thousand, whereas the incidence was 24 per hundred thousand in Turkey in 2011.

The goal of WHO for tuberculosis incidence is to halt the increase and reverse the incidence until 2015. The incidence rate of tuberculosis has decreased over the years in Turkey and it has dropped down to 24 per hundred thousand in 2011 from 33 per hundred thousand in 2002. On the other hand, we achieved to reduce the TB prevalence from 38 per hundred thousand in 2002 to 24 per hundred thousand in 2011 (Graphic 42).

Successful tuberculosis control activities under the Health Transformation Program enabled the "Millennium Development Goals" and "Stop TB Strategy Goals" to be reached before 2015. Moreover, Turkey has become a country capable of "following multi drug resistant cases for two years and reporting the treatment outcomes" since 2005.

As a result, Turkey has reached and exceeded the 2015 targets set by WHO as of 2005.

Measles

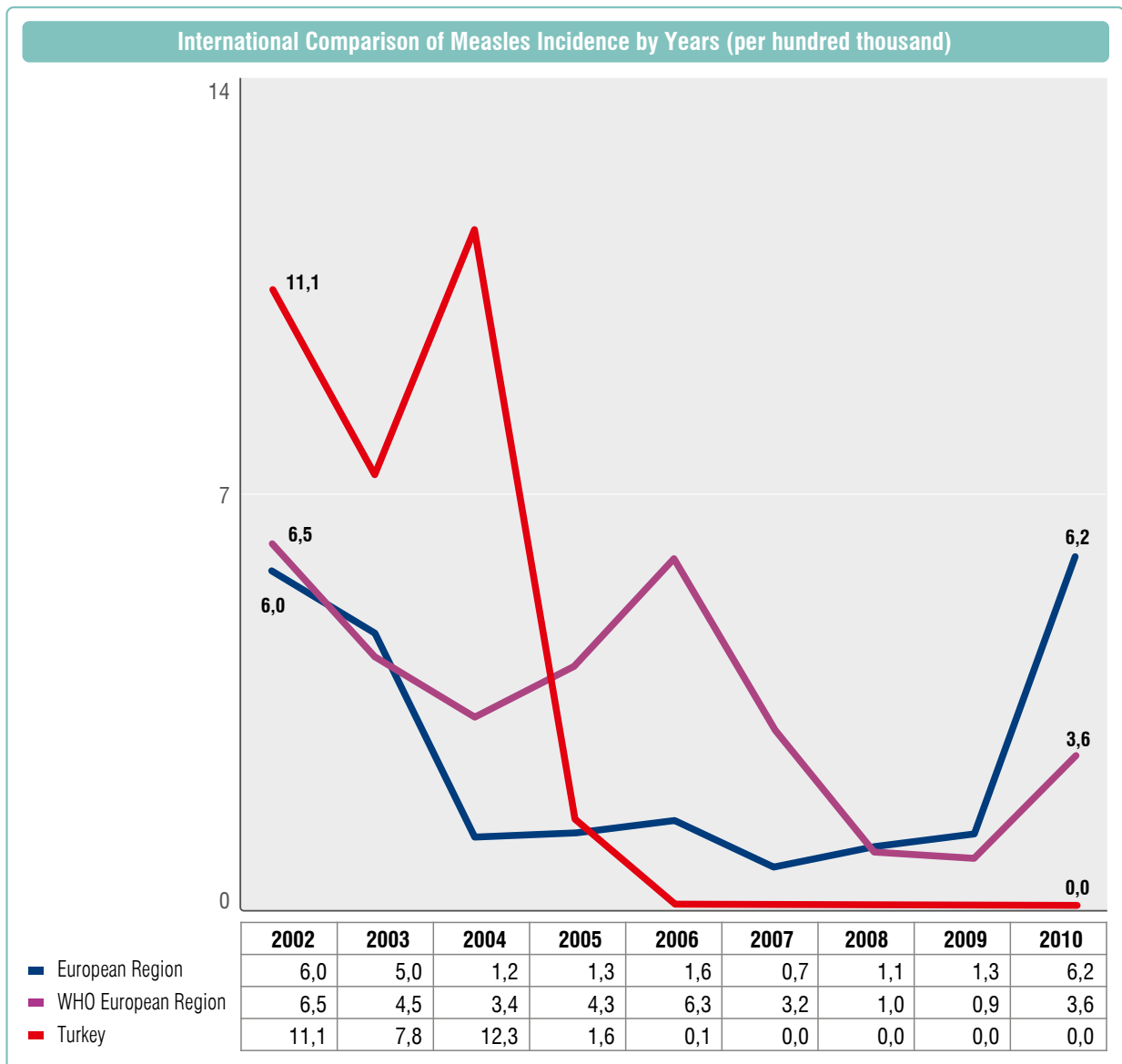
In parallel to the WHO European Region Measles Elimination goal, we aimed to eliminate measles and rubella and to achieve control over congenital rubella syndrome until the end of 2010 and put this goal on the agenda. Yet, the WHO Europe revised its goals considering the situation of other countries and revised the date of measles elimination as the year 2015.

Upon consideration of the high rate of morbidity and mortality from measles in Turkey and the developments and experiences in the World and the European region in the recent years, Turkey has initiated the "Measles and Rubella Elimination and Congenital Rubella Syndrome (CRS) Prevention Program" covering the period 2002-2010. The aim of the program is to eliminate measles and rubella, prevent CRS and maintain the current levels reached. Our target is to halt domestic virus circulation in Turkey until the end of 2010 and to prevent the import of new measles viruses from other countries into Turkey and prevent deaths from measles as of 2010.

Important developments have been achieved in routine vaccination, as one of the most significant strategies for elimination, and the vaccination rate has exceeded 90% which has been around 80% for years. Measles vaccination rates were 98%, 96%, 97%, 97% , 98% and 98 % respectively for the years 2006, 2007, 2008, 2009, 2010 and 2011.



We aim to keep this rate above 97 %. Considering the epidemiology of measles in Turkey, all children aged 9 months-14 years were vaccinated by a supplementary dosage of measles vaccine in the period 2003-2005 and the vaccination coverage reached 96%. In this framework, we vaccinated approximately 18,5 million children. It stands as the vaccination activity with the largest target group in the history of the Republic and Europe.



Graphic 43
Source: WHO HFA Database, Turkish Public Health Institute



Following the supplementary vaccination activity, case and laboratory-based measles surveillance was initiated. The number of measles cases was 30,509 in 2001, but it was reduced with the vaccination activities and 34 and 3 cases were diagnosed respectively in 2006 and 2007. In 2008, 2009, 2010 and 2011 and in the first six months of 2012, no domestic cases were reported (Graphic 43). 226 cases were diagnosed in the last 4.5 years and all of them were imported cases (out of country) or related with imported cases. Thus, the period of elimination has started. Now, our target is to prevent the settlement of measles viruses coming from other countries in Turkey.

Before the Health Transformation Program, the rate of vaccination against measles was not satisfactory in our country. In some places, it was even 10-20 % which led to measles outbreaks in every 3-4 years. The number of cases was almost 20-30 thousand. The biggest outbreak was noted in 2004 (with 8,927 cases). Since that time, our intense efforts for vaccination have yielded positive results. Considering the past trend of the measles outbreaks, a peak was expected in 2007-2008, however, we stepped into a period of measles elimination and we have not had any domestic cases since that time (Graphic 43). Now, we are at the stage of measles elimination. We are waiting for other countries in the WHO European Region in order to certify the measles elimination.

An Era of Measles-Free Turkey

We have realized the WHO's goal "Eradicating Measles" within the scope of measles control in our country. Now, our goal is to halt domestic virus circulation in Turkey.

Within this scope, we organized a widespread vaccination campaign between the years 2003-2005. Under the scope of School Vaccine Days, all students attending primary education were targeted in 2003, whereas pre-school children, first grade primary school children and the children aged 6-14 not attending school were targeted in 2005.

We vaccinated 18,217,000 children within the framework of the campaign. The vaccination rate of the campaign was 96,2%. The campaign was the vaccination activity with the largest target population in the history of the Republic and Europe.

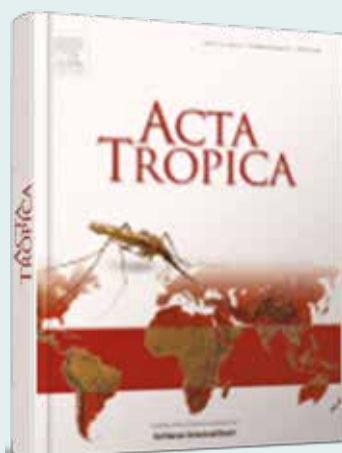
As a result of the campaign and subsequent vaccination activities, the number of domestic measles cases, which was 30,509 in 2001, has been zero since 2008 (Graphic 43).

Considering the measles outbreaks seen in many European countries in recent years, the WHO postponed the European Region elimination target to the end of 2015. For this reason, our country, which has already reached the elimination target, is waiting for the other countries in WHO European Region for certification.



Malaria

The intensive studies of the Ministry in the field of communicable diseases have given fruitful results. Great success was achieved in the field of malaria control. The number of malaria cases was over 10,000 in 2002 and it dropped down to zero in 2010. Malaria, which is no longer a significant problem for our country, is in the process of elimination. Turkey, together with Tajikistan, was selected the most successful country in WHO European Region.



Malaria in Turkey: Successful control and strategies for achieving elimination, Acta Tropica, 120 (2011) 15 - 23.

“Number of malaria cases has regularly decreased during the Health Transformation Program since 2003. It is decided that the conditions to eliminate malaria have been created in Turkey and to make a programme change with the name of “Turkish Malaria Elimination Programme.”

“With the initiation of the Health Transformation Project in 2003, access to patients became easier and mobile teams were created in addition to the “Active and Passive Surveillance” activities in the provinces with communicable diseases and bloods were taken from people in villages when required, the bloods were analysed within the same day and those identified as ill were treated and insecticides were applied in the area.”

“Since 2005, drugs of patients have been administered by the malaria personnel personally and thus the treatment was completed.”

“Determined policies and successful activities of the Ministry of Health were very effective in decreasing the number of malaria cases and free of charge access to service continues widely.”

“Malaria Control Programme of Turkey’ that enabled the country to reach the elimination phase in 2010 may set an example for similar countries on malaria control owing to its successful results. It is believed that this effort will guide those working on malaria control, researchers and decision makers, in terms of its scope.”



Water and Food-Borne Diseases

For the control of water and food-borne diseases and for the prevention of outbreaks,

- For the purpose of ensuring the diagnosis and notification of the agents of water and food-borne diseases in the notification system, we have included them into the notifiable agents of Group D.
- We initiated the daily surveillance of diseases with diarrhea throughout the year as of 2010. We have introduced the works of Early Warning and Response System (EWRS) for the purpose of monitoring water and food-borne diseases.

Sexually Transmitted Diseases and HIV/AIDS

HIV/AIDS is in low endemicity in Turkey. Although it has a low prevalence in our country, we conduct studies aiming to prevent HIV/AIDS and closely monitor the HIV/AIDS cases in the light of the scientific and recent developments.

As the MoH, we conducted a project titled HIV/AIDS Prevention and Support Program of Turkey for a period of 2.5 years initiated in 2005 in cooperation with the Global Fund. Under this Project, we worked in cities where HIV/AIDS patients are predominantly reside. We established Voluntary Counseling and Testing Centers. We prepared guidelines. We delivered trainings on counseling and testing to health professionals working for these centers. We also conducted training projects so as to increase access to preventive HIV/AIDS services, to raise awareness and to provide information.

With the aim of providing scientific support to activities conducted for the control of Sexually Transmitted Infections, we set up “Scientific Committee of Sexually Transmitted Infections (STI)” for the first time in the year 2010. The aim of the Scientific Committee is to ensure that current developments on the struggle against STI are transposed into our national policies; to provide technical and scientific support on diagnosis, treatment and follow-up protocols; to recommend efforts to raise social awareness and to make recommendations to National AIDS Commission in the field of HIV/AIDS. Within the Scientific Committee, we set up sub-committees on “Standard Diagnosis and Treatment for HIV/AIDS and other STI”, “Surveillance”, “Voluntary Counseling and Testing Centers”, “National Action Plan Update, National Objectives and Strategies Update, Legislation Update”, “Monitoring, Evaluation and Raising Awareness”.

Activities Conducted for Pandemic Preparedness

a. Preparation of a National Action Plan for Pandemic Influenza

We have conducted preparedness activities for possible pandemic influenza in our country in line with the recommendations and guidance provided to Member States by WHO since 2004. There is a committee of 60 people representing academicians and several agencies and organizations. Our National Pandemic Plan is one of the most comprehensive and well-prepared examples in European region.



b. Preparation of Provincial Pandemic Plans and Pandemic Preparedness Exercise

As set out in the Pandemic Plan which also functions as a framework for the preparation of local plans, preparation of Provincial Pandemic Plans by Provincial Health Directorates was completed within the same year.

We built a website, www.grip.gov.tr, so as to strengthen communication both in interpandemic and in pandemic periods and to explain the policies and implementations of the MoH in an effective manner.

c. Avian Influenza Response Activities

Becoming a current issue in the global agenda since the 2000s, avian influenza has been one of the main motives of pandemic preparedness activities conducted in our country. The first outbreak among poultry in our country was detected in Balıkesir/Kızıksa in 2005. In cooperation with the Ministry of Food, Agriculture and Livestock (MoFAL), we prevented the disease from affecting our people as a result of our efforts. On the first days of 2006, it was found out that severe respiratory tract infections detected in Ağrı were due to avian influenza. 4 out of 12 human cases of avian influenza unfortunately passed away in this period. We developed effective measures that we had taken. Although there had been several other animal outbreaks detected until 2008, we avoided the occurrence of new human cases. Within this period, our efforts in cooperation with the MoFAL were closely followed by international health authorities and appreciated as case studies.

d. H1N1 Pandemic Response Activities

We started to work upon reporting of suspicious influenza cases detected in Mexico in March, 2009. We convened Pandemic Monitoring Board and assessed the overall situation. We set up a Pandemic Executive Committee among the members of Pandemic Scientific Committee with the aim of helping them execute their works at more frequent intervals in quick decision-making processes.

With the occurrence of pandemic H1N1 cases, we put into practice measures delaying the entry of the disease in our country. We achieved to keep the number of cases at the lowest level during summer months by maintaining these measures. Within this context, we introduced health checks at land border gates, airports and seaports. With the mentioned time saving efforts, we had meetings for the procurement of pandemic H1N1 vaccines and made initial settlements with relevant companies on the procurement of 43 million doses of vaccine. However, we only used 3 million doses of vaccine. We also stored an additional 3 million doses of vaccine as a precautionary measure. We paid a total of 32 million Euros for 6 million doses of vaccine we procured. We did not make any further payment other than that. We continued to struggle against H1N1 cases that started to escalate in our country in autumn months. We prepared and distributed informative banners, posters and brochures for our citizens, we prepared informative video clips and communicated them to the public by means of national channels. We steered the works to limit the effects of the diseases by preparing case management algorithm, establishing H1N1 polyclinics, increasing the capacity of intensive care units and building diagnostic capacity with new laboratories.



Despite all efforts, 656 people unfortunately passed away due to pandemic H1N1. Modeling and seroprevalence studies conducted both in pandemic and post-pandemic periods show that 15-25% of the society was affected by the disease.

Seasonal Influenza Control Activities

We procured vaccines every year starting from the year 2006 for the vaccination of health professionals with high risk of influenza. We distributed them to provinces and vaccinated health professionals free-of-charge. With the inclusion of influenza vaccine in Health Implementation Communiqué, we vaccinated those over the age of 65, those living in nursing homes; adults and children with chronic pulmonary and cardiovascular system diseases including asthma; adults and children with any chronic metabolic disease including diabetes mellitus, chronic renal dysfunction, hemoglobinopathy or immunodeficiency or receiving immunosuppressive therapy and children and adolescents between 6 months and 18 years of age receiving long-term acetylsalicylic acid treatment.

Communicable Diseases Notification System

We have rearranged the Communicable Diseases Notification System and introduced the implementation of the new system as of 2005. We have rearranged the diseases included in the system and their notification patterns.

With this study;

- We have updated the notifiable communicable diseases list. We have determined the number of notifiable communicable diseases as 51 which used to be 36.
- We have introduced standard case definitions; in this way, we have ensured the notification of infectious diseases to be in compliance with the case definition criteria specified in the published guideline as well as the solid findings (evidence based) which are obtained from the laboratory rather than clinical observations (opinion based).
- We have introduced groupings according to some characteristics in the notification of diseases.

We have established four groups for the notifiable communicable diseases and categorized them as Group A, B, C, and D. These groups and their notification properties are presented below:

Diseases in Group A: These are the diseases which have to be notified by all institutions in the health care system beginning from primary care. For the patients who were diagnosed according to the standard case definitions and laboratory criteria by the physician, the notification will be done according to the algorithm defined in the notification system.

Diseases in Group B: In accordance with various decisions particularly WHO's 1969 dated International Health Regulations, in this group, we have included the diseases to be notified when they are doubted.



Diseases in Group C: In this group, we have included the diseases which have to be notified by the secondary care and superior health institutions.

Diseases in Group D: As different from other groups, it describes the notification of “infection agents”. This is an important innovation which requires the inclusion of laboratories into the direct notification system for the first time. The purpose is to obtain information on the etiological agents of some communicable diseases which maintain their importance as a public health problem at present and to conduct further epidemiological researches on these where necessary.

- We have included some infection agents into the notification list, as well. We have ensured the defined infection agents to be notified from the relevant laboratories.
- We have ensured laboratories to take part in the system directly or indirectly.

We published the “Regulation on the Principles of Surveillance and Control of Communicable Diseases” on the Official Gazette dated 30 May 2007 which we have prepared for the purpose of ensuring the harmonization of notification of communicable diseases with the Acquis Communautaire during the EU harmonization process.

5. Crimean Congo Hemorrhagic Fever (CCHF) Disease

We had blood and serum sample analyses performed at Pasteur Institute in 2003 upon reporting of cases progressing with suspicious clinical manifestation to our Ministry. CCHF was confirmed as a result of the analyses.

We set up a Scientific Committee of Crimean Congo Hemorrhagic Fever under the MoH after the diagnosis of the disease. We took measures required for the disease and determined the works to be performed from then on. The same Committee regularly convenes every year and makes recommendations on necessary assessment and plans.

From 2003 when it was first detected until now, Crimean Congo Hemorrhagic Fever Disease has continued to pose an important public health problem in our country between April and October with the increase in the temperature due to activation of ticks which are carriers and contaminants of the diseases.

The area affected by the disease has expanded in recent years and sporadic cases are reported from almost all regions of our country.

It is important to avoid human contact with ticks for prevention.

Within the framework of reducing tick population down to an acceptable level in places where the risk of disease exists, periodic disinfection of livestock, primarily bovine animals, by the MoFAL is ongoing.



Within the struggle against CCHF:

- We distributed tick removal cards to be used in case of tick attachment. We envisaged that the use of this card by the public will increase their awareness about the immediate removal of ticks from the body.
- Patients are needed to be referred to a higher level healthcare facility in cases which require a closer follow-up and treatment. We set up regional centers in 16 provinces for the patients to be referred.
- We formulated immune serum to be used for the treatment of patients. We use them for the treatment of some patients under this study. According to the results of this study, we aim make the use of serum widespread.
- We detected the areas where CCHF cases occurred and analyzed tick population in these areas. We found out that ticks carrying disease factor belongs to Hyalomma family.
- Moreover, we drew a map of our country showing areas with ticks and CCHF cases based on this data.
- We built a web-based reporting system for reporting CCHF disease. We continue to conduct case-based surveillance.
- We contributed to the efforts aiming to develop vaccines for effective protection against CCHF.

6. Struggle against Chronic Diseases

In the twentieth century, factors such as increase in the level of education and income in the world, change of dietary habits, control of communicable diseases resulted in the increase of life-expectancy at birth.

Although longevity is something desired, it has led to an increase in non-communicable diseases (chronic diseases). The increase in the ratio of elderly population to pediatric population has resulted in the shift of health problems in society from childhood diseases to non-communicable diseases seen in the elderly population.

Chronic Diseases are the Root Causes of Mortality in almost All Countries: It has been estimated that 35 million people died from chronic diseases in 2005. 60% of all mortalities is due to chronic diseases. Unless any measure is taken, it is estimated that 388 million people will die from chronic diseases in the next 10 years.

The Poorest Countries are the Most Affected Ones: While only 20% of mortality caused by chronic diseases occurs in high income countries, 80% of mortality caused by chronic diseases occurs in low and middle income countries, where most of the world population lives.

Risk Factors are Extensive: Frequent and preventable risk factors are underlying reasons for main chronic diseases. Most of chronic disease mortality occurring in men and women at all ages in every corner of the world can be explained by these risk factors. The most outstanding ones of these risk factors are:



- Unhealthy diet,
- Physical inactivity,
- Smoking.

Although there are many diseases in this disease group, risk factors and protection strategies are common for most. All these risk factors are influenced by economic, social and political environment, gender and behaviors. Thus, it is easy to make suggestions, but it is difficult to put measures into practice. Although it is believed that habits like healthy diet, regular physical activity and cessation of smoking are proper, they are among habits that are difficult to change. This is why health promotion activities are important.

Preventive care is an effective approach in the struggle against non-communicable diseases. For instance, cardiovascular disease risk is reduced by 50% two years after cessation of smoking. Moreover, blood pressure and high level of cholesterol can be prevented with measures such as encouraging healthy diet and reduction of salt consumption.

Application of available information has ensured the achievement of significant progress in the life expectancy and quality of life of middle-aged and elderly people in several countries. For instance, mortality rate of cardiac diseases went down to 70% in the last thirty years in Australia, Canada, England and the USA. Middle income countries like Poland have also made significant progress in recent years. Such achievements are fulfilled with the implementation of comprehensive and integrated approaches for both the society and individuals and concentrating on underlying common risk factors and some special diseases. Total number of lives saved thanks to these achievements is very high. 14 million deaths from cardiovascular diseases were prevented only in the USA from 1970 until 2000 according to the estimations of the WHO.

Struggle against risk factors causing chronic diseases could only be successful through national policies and long-term strategies. Non-communicable diseases must be included in the agenda of all layers of the society. Practices such as healthy diet, increase in physical activity, and reduction of tobacco use require the participation of all sectors. All sectors have roles and responsibilities in the protection and promotion of health.

Considering the effect of chronic diseases on lifetime and quality of life and increased level of pecuniary and intangible costs, the significance of programs to change lifestyle will be better understood. Taking risk factors under control, reducing diseases requiring hospitalization, expensive therapeutic and surgical procedures including other fundamental measures, and decreasing labor loss and deaths associated with such diseases will contribute in the improvement of health status and economic burden.



WHO, in 2008, adopted a draft plan covering the years 2008-2013 for the prevention and control of non-communicable diseases and set out the following objectives:

Objective 1. To enhance priorities given to non-communicable diseases within the scope of global and national development and to integrate the policies of all government units with the prevention and control of such diseases.

Objective 2. To develop and strengthen national policies and plans for the prevention and control of non-communicable diseases.

Objective 3. To increase responses to reduce shared modifiable main risk factors for non-communicable diseases, tobacco use, unhealthy diet, physical inactivity and harmful alcohol use.

Objective 4. To encourage conducting researches for the prevention and control of noncommunicable diseases.

Objective 5. To promote partnerships for the prevention and control of noncommunicable diseases.

Objective 6. To monitor non-communicable diseases and their determinants and to evaluate improvement at national, regional and global level.

We developed action plans and struggle approaches with the aim of protecting health and preventing early deaths within the scope of chronic diseases control program and we planned and started to implement national programs primarily on cardiovascular diseases, diabetes, chronic respiratory tract diseases.

WHO indicates that the rate of chronic diseases rapidly increases and that they will impose the largest work load in front of health care systems in the future. Moving from this point, we reviewed our structure for chronic diseases and established two new departments in order to work on chronic diseases and health promotion.

A. Prevention and Control Program for Cardiovascular Diseases in Turkey

Deaths from cardiovascular diseases have a tendency of decreasing in developed western countries whereas they increase in developing countries. However, the number of cardiovascular diseases increase in developed countries with the aging of society and the elongation in life expectancy, and the burden associated with these factors is not reduced.

Cardiovascular diseases have a significant share in the disease burden created by noncommunicable diseases and the positive thing about these diseases is that they are mostly “preventable”. WHO reports that prevalence of cardiovascular diseases could be reduced by half with the control of blood pressure, obesity, cholesterol and smoking.

EU and WHO opened “European Heart Health Charter” for signature with the aim of significantly reducing cardiovascular disease burden in European Region and reducing unfair and unequal practices among countries.



National signing ceremony of European Heart Health Charter was held on December 2007 in Ankara and the Charter was undersigned by the Minister of Health and the chairmans of nine specialty associations.

What needs to be done within this framework is to develop prevention strategies for “preventable” cardiovascular diseases and to make plans for individuals and the society as well as providing treatment options for those who are diseased. Moreover, a comprehensive prevention and control program for cardiovascular diseases should include high-risk strategy approaches including human resources planning for secondary and tertiary prevention, technology, medical device management, medication management, rehabilitation, palliative treatment and home care services, emergency treatment services, surgery, surveillance and researches, financing and intersectoral cooperation and future practices.

Within this framework, MoH, in cooperation with non-governmental organizations, prepared and put into practice “Prevention and Control Program for Cardiovascular Diseases in Turkey, Strategic Plan and Action Plan for the Risk Factors” which is an integrated, community based program designed based on three main risk factors (tobacco, obesity and physical inactivity).

The objective of this plan is to prevent cardiovascular diseases by reducing main risk factors in the struggle against cardiovascular diseases and to ensure control in this area for a healthier Turkey. The plan aims to ensure the following so as to prevent main risk factors for cardiovascular diseases in Turkey;

- Reducing the use of cigarette and other tobacco products,
- Preventing unhealthy dietary habits and overweight and eliminating physical inactivity,
- Informing the society on cardiovascular diseases,
- Ensuring that people pursue a high quality life in terms of health by increasing awareness in society, making positive and lasting behavior changes on main risk factors.

Having completed “Prevention and Control Program for Cardiovascular Diseases in Turkey, Strategic Plan and Action Plan for the Risk Factors”, we felt a need for a national program involving other approaches for secondary and tertiary prevention of cardiovascular diseases.

We drafted “Strategic Plan and Action Plan for Secondary and Tertiary Prevention in Cardiovascular Diseases” including high risk strategies for secondary and tertiary prevention as a complementary to the first plan prepared.

We also updated the “Strategic Plan and Action Plan for the Risk Factors” under this study and reformulated it in the framework of the “Strategic Plan and Action Plan for Secondary and Tertiary Prevention in Cardiovascular Diseases.



This plan comprises the following main points:

1. Risk Factors, Protection and Prevention
2. Organization, Human Resources and Training
3. Emergency Treatment Services and Cardiopulmonary Resuscitation (CPR)
4. Medication Management
5. Device Management
6. Pediatric Cardiology
7. Cardiovascular Surgery
8. Cerebrovascular Diseases (Stroke)
9. Rehabilitation, Palliative Treatment and Home Care Services
10. Surveillance, Researches and Future Practices
11. Intersectoral Cooperation
12. Monitoring and Evaluation

B. National Prevention and Control Program for Diabetes

WHO estimates that more than 180 million people across the world are diabetic and 1,3 million people died from diabetes in 2005. 80% of deaths from diabetes occur in low or middle income countries. WHO indicates that deaths from diabetes will increase more than 50% in the next 10 years unless action is urgently taken.

International Diabetes Federation (IDF) predicts that there are 285 million diabetic patients in the world. Considering the fact that 7 million people is added on to the diabetic patient population very year, it is expected that this figure will exceed 350 million in the next 10 years. According to the estimations of 2010, prevalence of diabetes in the adult population between the ages of 20 and 79 is 6.6% in the world. This figure is calculated to be 7.8% in the year 2030.

Disease manifestations also change as the level of development increases in our country. While communicable diseases were priority in health agenda 20-30 years ago, noncommunicable disease groups have gained significance today. Morbidity and mortality of non-communicable diseases have increased by elongation of lifespan, changing life styles and stress factor, dietary habits and other environmental factors.

Diabetes, in addition to being a chronic disease by itself, is also a common cause of many other chronic diseases. Therefore, it would be a correct approach to regard diabetes as both an individual chronic disease and a risk factor. We developed the “Strategic Plan and Action Plan for Diabetes Prevention and Control Program of Turkey” with the active participation of all related sectors.



Response Activities in the field of Diabetes

We established diabetes polyclinics/centers in 16 provinces in 2003 (Afyonkarahisar , Aksaray, Balıkesir, Bartın, Edirne, Erzincan, Kahramanmaraş, Kayseri, Kırıkkale, Malatya, Muğla, Nevşehir, Ordu and Van) under the “National Diabetes Program”. In the same year, we published the “National Diabetes-Obesity-Hypertension Control Program”, too. This program is a result of rearrangement of policies on the struggle against diabetes and diabetes management in parallel with relevant strategy and action plans of the WHO and in line with current struggle techniques. We completed the strategy document aimed at the objective of diabetes control and held workshops on middle and long term action plans, and implemented our action plans in the framework of the “Turkey Diabetes Prevention and Control Program” in February 2011.

We Conducted the Following Studies in Cooperation with Non-Governmental Organizations

- Turkish Diabetes, Hypertension, Obesity and Endocrinologic Diseases Prevalence Study (TURDEP-II)
- Turkish Pillar of Prospective Urban and Rural Epidemiological Study – PURE Study
- Diabetes Control Project of Turkey (“You Steer Diabetes” Campaign)
- Trainings on Updates in Diabetes and Case Discussions
- Diabetes Discussions Training Project
- Diabetes 2020: Vision and Goals Project

C. National Chronic Respiratory Disease (Asthma-COPD) Prevention and Control Program (2009–2013) Action Plan-GARD

With all relevant agencies and institutions in our country, we joined in the GARD-The Global Alliance against Chronic Respiratory Diseases, established under the leadership of the WHO to struggle against chronic respiratory diseases. The 3rd Plenary Assembly of GARD was held in Istanbul on May 30-31, 2008. “GARD Action Plan of Turkey”, which was presented in this meeting as a draft, is the first action plan prepared in the World on this matter and we continue to implement this plan actively. GARD Turkey structuring is also a model practice as it brings together public and civil society under an effective struggle platform. We conduct the program especially in coordination with National Tobacco Control Program and carry out strategic actions for the control of COPD and asthma.

We carry out the program based on five main points:

- **Within the scope of introducing the program to the public**, we built a web page at the address www.saglik.gov.tr/GARD which is available at the website of the MoH for having the program adopted by the public and introducing thereof. We broadcast on television channels short movies prepared with the aim of raising awareness on chronic respiratory disorders. We established GARD Provincial councils so as to complete structuring of GARD Turkey and they started functioning.
- **Within the scope of preventing disease development**, we prepared, published and distributed a book titled “Approach to Air Pollution and Climatic Change of Turkey from the Point of Health”



- **Under the activities of early detection and prevention of disease progression**, we prepared and published “In-Service Training Module – Trainer Guide for Primary Care Physicians in the Diagnosis and Treatment of Asthma and Chronic Obstructive Pulmonary Disease”. We have given training for trainers to 133 chest diseases specialists so far, who later trained 4.380 family physicians via in-service trainings. Our objective is to give in-service training to all family physicians by late 2013.
- **Within the context of effective treatment of diseases, prevention of complication development, delivery of rehabilitation services for these diseases, organization and expansion of home care services and we prepared a report thereon**, we held Home Care Workshop in November 2010.
- All these works are actively monitored under **monitoring and evaluation** and both workgroup activities and monitoring and evaluation works are addressed at the annual meeting of General Assembly. We held II. Ordinary General Assembly participated by provincial representatives and all stakeholders in Ankara in December 2010 and we updated the action plan.

D. An Effective Approach in the Struggle against Cancer: Early Diagnosis Saves Lives

Cancer is the second most common cause of death after cardiovascular diseases both in our country and other countries of the world; therefore it is an important public health issue.

The most significant type of cancer which may be prevented by primary prevention is the lung cancer; and it is the most prevalent type of cancer both in Turkey and the rest of the world. Successful struggle against tobacco will help eradicate particularly lung cancer and other types of cancer such as larynx, bladder, pancreas, cervix, pharynx and oral cancers.

In early 2000s, 6 million people developed cancer in the world each year; however 24 million people will be down with cancer until the year 2030 if cancer continues to spread with such speed. 17 million people will die of cancer in the same year; and 75 million people will be living with cancer by the year 2030.

The picture of cancer in Turkey will be more or less like this: if cancer rate keeps the same, 360 thousand more Turkish people will be diagnosed with cancer in 2030. Minimum 250 thousand people will lose their lives due to cancer every year. In 2030, total 1,3 million people will be living with cancer. Thanks to the measures that we take for cancer control, we estimate that 120 thousand people will be diagnosed with cancer in 2030, minimum 90 thousand people will die from cancer in the same year and total 300 thousand people will be living with cancer.

In the scope of the fight with cancer, we developed a national cancer control program for 2009-2015. This program, which is implemented together with the World Health Organization officers, consists of 5 topics and the progress made regarding these topics are briefed in the following.



Our national cancer control policies and Cancer Early Diagnosis, Screening and Training Centers (KETEMs) were presented as a model in the WHO Cancer Report 2008.

D.1. Cancer Registration

We established a new active cancer registration method which follows a certain population quintile representing the country. We established registration by new regional representative characteristics and achieved significant improvements in determining the incidence of cancer in the last couple of years.



Turkish Model in Development of Cancer Registry

N. Kibria, M. Spires, M. Kaufman, F. Stillman*

*Johns Hopkins Bloomberg Public Health School,
Public Health Specialists

“While only 8-10% of world population is followed up in terms of active cancer registry today, this ratio has been increased to over 27% in Turkey. Moreover, there were only 2 cancer registry centres before the Health Transformation Programme and the number of these centres went up to 12 after the transformation owing to the intensive efforts of the Ministry of Health. The success of Turkey in cancer registry increased even more when the centres were accredited by IARC (International Agency for Research on Cancer) in terms of their data reliability and completeness.”

“As the Ministry of Health provided long-term support, cancer registries were used correctly and appropriately and NGOs also provided adequate support, the model in Turkey became successful.”

“Turkey gradually established the population-based cancer registry centres and ensured that awareness is created by the public authorities and led the comprehensive national cancer control programme and as a result of all these activities, contributed to lessen the burden of cancer on the country.”

“High quality data collected in Turkey by the cancer registry centres were used in order to shape the policies and allocate the appropriations and other preventive measure resources. Lung cancer is the most common cancer type among men in Turkey. So the Ministry of Health took an important step in 2009 and prohibited the use of tobacco and tobacco products in all indoor areas.”

“As is seen in the Turkish example, the countries need a sufficient resource support, political support, good cooperation with the associated stakeholders, local actors and national and international agencies in order to have an efficient cancer registry system.”

“Establishment and improvement of cancer registry centres in Turkey may serve as a model for the countries that have limited resources and fight against other health and financial problems related to cancer.”



The number of active cancer registration centers established in eight provinces in 2008 was increased to 12 by 2011 and thus we included almost 27% of the whole population in follow-up in terms of cancer development while it is approximately 8 % of the population in the world . In addition, we started to establish active cancer registration centers in Istanbul and Mersin provinces in 2012. Turkey has become an important country with this coverage range in cancer registration in its region and in the world. Two of our registration centers were accredited by International Agency for Research on Cancer (IARC) of the WHO and the data were published in the book titled “Cancer Incidence in Five Continents”. The quality of our cancer data was routinely evaluated every year and raised to international standards. On the other hand, some developing countries take Turkey as a model considering the point we have reached in cancer registration system. Public Health Specialist from John Hopkins Cancer Institute made an on-site visit. They appreciated the current situation of cancer registration and published a scientific study pointing Turkey as a model for many other countries.

D.2. Cancer Prevention

The most effective cancer control policy is primary prevention, namely eradication of the factor causing cancer. There are activities of the MoH on this matter conducted at national and regional levels:

- **Nationwide Cancer Prevention Activities**

Our country has become one of the countries that best implement MPOWER strategy which is suggested by the WHO as a result of activities on indoor smoking and tobacco controll.

A significant activity undertaken by the MoH on the struggle against tobacco in 2010 was that the MoH started to cover the costs of smoking cessation units and smoking cessation treatments. We established a total of 434 smoking cesstion policlinics including 79 polyclinics at KETEMs (Cancer Early Diagnosis, Screening and Training Centers) and 309 polyclinics in other health care facilities as of December 2011. Including 44 physicians and 165 health care employees at KETEMs a total of 601 physicians and 457 health care employees give service to people in these polyclinics.

Under the “Stop-Smoking Support Program”, we purchased and disseminated 250.000 pieces of varenicline and 110.000 pieces of Bupropion – medications for quitting smoking - to the people without any charge in line with the Cabinet Resolution in 2011. 114.000 people achieved to quit smoking as a result of this implementation.

Another important problem is obesity. Unfortunately Turkey precedes European countries on this matter. We initiated obesity screenings at all KETEMs.

Another issue that has been discussed significantly in recent years is electromagnetic waves, mobile phones and base stations. In order to cease the concerns of our citizens on this matter, we published an implementing regulation in cooperation with 5 ministries. Moreover, we set up an Advisory Board on Electromagnetic Waves under the roof of the MoH so as to provide the most accurate information to the public in a short time.



- **Regional and Scientific Activities**

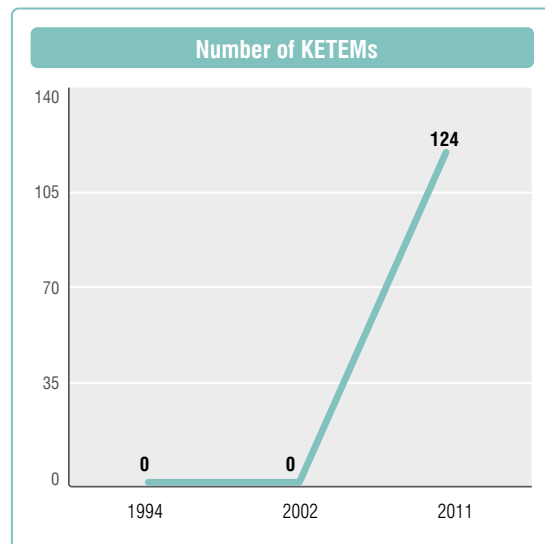
In addition to nationwide cancer control activities, regional cancer control activities are ongoing both at scientific and institutional levels. We can list our activities as follows: Kocaeli Dilovası Cancer Follow-up Studies, Post-Chernobyl Cancer Researches in Eastern Black Sea Region, Nevşehir Mesothelioma Early Diagnosis Studies, Studies on Heavy Metal Accumulation in Turkish Waters, Study on Biphosphenol Level in Baby Bottles, Researches on Early Diagnosis of Gastric Cancers and Oncogram Development.

D.3. Cancer Early Diagnosis, Screening and Training Centers (KETEMs)

Moving from the principle “Early diagnosis saves lives!”, we have organized screening and public training programs for breast, cervical and colorectal cancers under the KETEMS which were founded in 2004 first and are 124 in number today (Graphic44).

Our objectives are:

- To reduce deaths from breast, cervical, colorectal and skin cancers and to increase the health level of the society,
- To raise awareness about cancer in the society by providing relevant information to the men and women included in the target group for screening,
- As for cancer screenings, we reached 30 % of the target population per year and we aim to reach 70 % of the population by 2015.
- To decrease the number of cancer cases diagnosed at later stages
- To reduce the number of new cancer cases.



Graphic 44
Source: Turkish Public Health Institute

Screening services are provided free-of-charge to citizens unable to pay for the service.

We also integrated family physicians into the cancer screenings and established a system which is capable of monitoring people periodically.





Pallia-Turk: Turkish Model in Community-Based Palliative Care Services

Opioids for Cancer Pain: Availability, Accessibility, and Regulatory Barriers in Turkey and Pallia-Turk Project, *Journal of Pediatric Hematology/Oncology*, 2011;33:S29–S32

Turkish community-based palliative care model: a unique design, *Annals of Oncology*, 2012;23,3:72-74

“Palliative care services were ignored for many years in Turkey. The patients could not access the active drugs for cancer pain even in their last days. They were refused by the hospitals and sent back their homes hopelessly, during their difficult times.”

“Ministry of Health aimed to present palliative care for all citizens as a human right through the Health Transformation Programme. For the first time in the world, palliative care was reduced to the primary health care level and the aim was to ensure that all the citizens reached the most basic treatments within the shortest period of time. Moreover, the idea was to provide community-based palliative care services to all citizens across the country via family medicine.”

“Ministry of Health accepted palliative care as a life quality marker. Home care services were created in order to meet the basic needs of patients at home. When compared to other countries, Turkey has rapidly put into practice the community-based and primary palliative care services that serve for a crowded population in a very wide area.”

“First palliative care centres of the country were established. Planning efforts for the Palliative Care Services continued until 2023. The patients were not only provided with physical symptom controls but also moral and financial support. Relaxing care services such as private rooms, hobby rooms, playing rooms, special physiotherapy and massage rooms were planned for patients and patients’ relatives.”

“Pallia-Turk Project can be a model for the provision of individual- based palliative care services in countries with a crowded population and large surface area.”



D.4. Cancer Treatment and Palliative Care

Any type of modern and state-of-the-art opportunity available in developed countries in the field of cancer treatment is also available in our country and there is no need to go abroad for cancer treatment any more. The MoH now uses detailed plans which are prepared in cooperation with all units for every type of investment. Therefore, we listed all investments to be made in the next 10 years under the Oncology Vision Study. All treatments of cancer patients are provided free-of-charge in our country.

The Pallia-Turk Project was launched as a pilot Project at 3 hospitals in 2011. We aim to establish total 197 palliative care centers including 57 centers at hospitals and 140 centers in primary health care facilities by 2015.

We fulfilled the procedures that are necessary to import morphine tablets which are not available in the domestic market and we plan to start domestic production in 2013.

This Project is closely monitored by many international organizations and our actions under the Project, our joint visions with regional stakeholders and our plans for the future have been published and discussed in prestigious journals.

D.5. Patient Advocacy and Awareness Programs

We pay great attention to patient rights in recent years. With the support of the MoH, 24 associations of cancer patients and patient relatives came together and formed a federation. We integrated officials of this federation working under the name Hand in Hand against Cancer Platform into Cancer Advisory Board of the MoH. Thus we provided officials of the federation the opportunity to directly communicate any of their problems to the MoH officials. Therefore patients have taken an active role in the development of health policies. Besides, we delivered almost hundred trainings titled “Patient Schools” at every corner of the country. Many questions were answered by the experts during these trainings such as “What is Cancer? How should we eat when we have Cancer? What is Chemotherapy?”

Under the Health Transformation Program, we accelerated our cancer awareness activities. The national awareness program, which we have been conducting with the slogan of “We are aware of it, we will beat cancer” for a year’s time, created significant impacts on the people nationwide.

We also continue to conduct our awareness activities at international platforms. Turkey chaired Asian Pacific Organization for Cancer Prevention in 2010. The MoH became an official member to Union for International Cancer Control (UICC) in the same year. We also became a member to International Agency for Research on Cancer (IARC). Turkey will be the Research Center for Eastern European Region of IARC. We also chaired Middle East Cancer Consortium (MECC) in 2008 and became the Co-President of Black Sea Countries Coalition on Breast and Cervical Cancer Prevention in 2010.

We published “International Handbook of Cancer Prevention 2010” detailing cancer problems and cancer control activities ongoing in Asia Pacific countries.



E. Mental Health

We drafted mental health action plan in line with the “National Mental Health Policy” prepared in 2006 with the purpose of improving mental health services.

E.1. Community-Based Mental Health Services:

The aim of community based mental health services is to provide psychosocial support to patients with severe mental disorders and to ensure the delivery of their follow-up and treatment integrated with home care services, when necessary.

We decided to establish centers that will function under the responsibility of mental health specialists, which are affiliated to mental health hospitals of the MoH and to general hospitals having psychiatry clinics or mental health specialist.

We designate the centers considering the demographic structure and epidemiologic characteristics of the population they will serve. We may establish more than one center in provinces where needed. Services of the center are limited to the region where it will deliver service.

The Center identifies patients with severe mental health disorders residing in the area they serve for by using the records kept by family physicians, psychiatry clinics, district governorship, provincial directorates of family and social policies and other agencies and organizations; and add up to its own database.

We identify psychiatric and social profiles of patients who continue with their treatments at the center by using data forms and scales and archive patient files in compliance with the relevant legislation after the end of service.

We collect and evaluate necessary data considering demographic characteristics of the population served with the aim of making necessary interventions and service plans.

If the patient followed moves to somewhere which is under the responsibility of another mental health center, we send necessary information and documentation about the patient to this center which is located in where the patient has moved.

We allocate a patient transportation vehicle to be used for the transport of the team assigned to deliver mobile services by the Center or of patients when needed.

The staff of the center consists of one mental health and disease specialist, one social worker, one psychologist, one nurse, one driver, one occupational therapist or one qualified instructor, one medical secretary, administrative and technical staff, one cleaner and security staff.



We inaugurated a mental health center in May 2008 in order to serve as a model for the transition to community based mental health service model at Bolu İzzet Baysal Mental Health and Diseases Hospital and started to develop the system. We decided that community based mental health model should be extended nationwide based on the positive results of the pilot project. We drafted an ordinance on the operations of these centers to be started. We also worked with SSI so that our patients could make use of these services under social security. We have already put 50 centers into service in 44 provinces. Once the said centers are extended nationwide, we plan to have total 236 community mental health centers.

Application and Admission of the Patient to the Center:

- The center identifies patients with severe mental health disorders in the area under its Responsibility and contacts with these patients or their families by phone.
- Necessary information on the center and practices is provided and the patient is invited to the Center.
- Patients who are unable to come to the Center are visited at home and their health conditions are assessed and they are invited to the centers.
- Patient's condition, who will receive service, and the service to be delivered are decided at the Center. Follow-up and treatment plans are drafted and patients and patient relatives are informed about them.
- Patients, who could not be brought to the Center although they are visited at home, are assessed by a relevant specialist at home and then the patient is either invited to the Center or followed at home based on a program in coordination with home care health service unit according to the result of assessment.
- Patients in person or patient relatives may request to utilize services of the Center. In case if such a request, the condition of the patient is assessed in terms of suitability with the services delivered and treatment responsibility by the mental health specialist who diagnosed and planned the treatment of the patient or by a specialist in charge at the center.
- Patients or patient relatives, who have applied, are given a reasoned explanation if the result of application is negative.
- When the admission of the patient to the center is approved, this situation is documented by a health committee certificate. Family physician is informed about the patient admitted to the Center.
- The scope, duration, plan and program of the service to be delivered at the Center is decided by the treatment team presided by the responsible physician and patients and patient relatives to receive the service are informed.



- In case patients or patient relatives do not approve the treatment plan suggested by the Center, risks that may occur are explained to patients or patient relatives if the treatment plan is not applied. A written statement is asked if the service is still not accepted. If written statement is not given, the relevant staff makes an official report of the situation.

In addition to opening community based mental health centers, we adopted a national strategy to provide service for patients with mental health problems at general hospitals rather than establishing isolated mental health hospitals. We made a planning for beds and started to increase the number of beds throughout the country which are allocated to patients with mental health problems. We appointed a psychiatrist to each province in line with this strategy. As a result of all these activities, the public has now Access to mental health services in the province they live, which used to be given in 8 regional hospitals in the previous years.

Preventive mental health services constitute a significant part of mental health services, especially for risk groups. In this context, the MoH conducts programs focusing on special groups.

E.2. Response Services for Child Abuse and Child Neglect

Childhood conditions should be considered as important precursors of adult mental health disorders which may be more important than the risks experienced in adulthood. Physical, mental and social health of an individual for a lifetime is closely related to brain development. Brain is mostly developed during pregnancy and in the first five years of life.

In addition to brain development, skills, learning capacity, social skills and character of an individual, which will be used for a lifetime, are also mostly developed in these years. The society should first be aware of the significance of rapid development process of the brain and support the development of children in this period so as to preserve the health status of individuals for a lifetime; to raise more skillful, intelligent, successful and capable individuals; to reduce increasing level of violence and criminality; to reduce socioeconomic disparities down to a reasonable level. Therefore, it will prove to be useful in the long term for individuals, society and health care systems to support mental health of children and adolescents. Considering this sensitivity and needs, we set up “Branch Office of Child and Adolescent Psychiatry” in 2005 with the aim of enhancing child and adolescent health, preventing mental health problems and integrating these services with Primary Health Care Services.



We started to spread out the “Program on Supporting Psychosocial Development of Children (PSPDC)” throughout the country in 2005. The aim of this program is to integrate methods supporting psychosocial development with primary health care services, to support the child during pregnancy and in the period of 0-6 years of age when the development is the fastest and to make sure that healthy generations are raised in physical, social and mental terms. Infants and children may face some risk factors in the period of development as is known. Under the program, risk factors monitored during this period are poverty resulting in malnutrition, growth retardation, mental disorders of parents, violence, and child neglect/abuse.

Integration of primary health care services with monitoring and evaluation of mental and social development of the child, we monitor pregnant women and children at primary health care with a biopsychosocial perspective. We provide trainings on the mentioned program to midwives, nurses and physicians working for primary health care. Trained midwives/nurses interview with the mother and father starting from the pregnancy period and monitor the child; provide fundamental information on nutrition, family planning and harms of smoking and observe the risks. Midwives/nurses who determine cases with risks will refer these cases to physicians. The physician will apply the treatment plan and if needed refer the patient to secondary health care or organizations that could provide support to the patient.

Child abuse and neglect are at the top of traumatic fields that damages children the most. Child abuse is described as conditions that the child is made to face by those who are responsible for looking children or by other adults and these are conditions which are not accidental and may impede physical, emotional, mental or sexual development of the child or harm physical or mental health of the child. Failure to meet necessary requirements for the health, physical or psychological development of the child is defined as “child abuse”.

Child abuse and neglect are very serious social problems which are not truly known in the world. It is also a health problem bringing an important level of economic burden on the society with physical, mental and psychological disorders it leads to because of workforce loss, long-term and repetitive investigations and treatment.

The MoH started to work so as to eliminate shortfalls in the field of services provided to children who are abused or neglected and first addressed the children who are sexually abused.

It is known that used children are assessed by law enforcement officers, judicial authorities and health care organizations separately. The child is exposed to repeated questions on abuse and is psychologically affected by this in a negative way. Moreover, people interviewing children at these organizations are mostly those who are not trained on interviewing with a view to be cautious about the mental status of the child.



We started to work in January 2010 so as to eliminate these shortfalls with the participation of the Ministry of Justice, Ministry of Education, Social Services and Child Protection Agency (SSCPA), Ministry of Interior and the Presidency of Religious Affairs under the leadership of the MoH. We set up “Child Monitoring Center” (CMC) in Ankara as a pilot center. The aim of “Child Monitoring Center” is to serve for public institutions while handling sexual abuse cases; to meet all requirements of these institutions by making them fully available for the child and to protect the child from a traumatizing process for the second time within the system.

The mentioned center started to operate on 18 October 2010. There are 1 Forensic Medicine Expert, 3 Social Workers, 2 Psychologists, 1 Psychological Counselor and 1 Nurse at the Center and a lawyer assigned by the prosecutor and the bar association assesses the case at the center. Representatives of Social Services and Child Protection Agency and law enforcement are also present at the center and procedures to be applied concerning the child, including social assessment, are executed via the Center. In 2012, we will open Child Protection Centers in Bursa, Diyarbakir, Gaziantep, Kayseri and Samsun provinces. The child is not referred to another organization within judiciary process and traumatization for the second time is thus minimized.

E.3. Fight Against Autism

Autism is defined as a developmental syndrome appearing before the age of three and characterized with significant deterioration in social interaction and communication and notable limitation of interests and tasks.

An intensive special training program is recommended in the early period in the treatment of autistic patients with unknown etiology. Primary health care services which are mostly utilized by the public in the early diagnostic period are important. We developed child protection protocols with the aim of ensuring monitorization of all children between the ages of 0-6 within the framework of specific standards and we included “Guidelines on Monitoring and Supporting Development” module, which will enable early diagnosis of autism, into child protection protocols. In this module, we screen for signs such as eye contact that will help us make an early diagnosis of autism.

Within the framework of the “Program on Supporting Psychosocial Development of the Child”, we provide trainings on early detection of any developmental disorder including autism to midwives, nurses and doctors working at primary health care closely with mothers and children.

Cases considered to be risky or suspicious at primary health care should be assessed by the relevant specialists without losing time. Therefore we inaugurated the first “autism excellence center” of Turkey in Ankara Yenimahalle State Hospital in March 2011 which will provide training in this field, assess the case both in psychiatric terms and in terms of comorbid auditory and genetic problems as well as delivering services which are very important in rehabilitation processes under a single roof, such as speech therapy. We completed trainings of the staff who will work at the Center. The Center also functions as a training clinic.



Another progress we have achieved in the field of diagnosis is that we translated diagnostic tests into Turkish, which are considered to be golden standards in the diagnosis of these diseases in the world (ADI and ADOS). Coordination between the MoH and Ministry of National Education is required in the fields of rehabilitation and training. Early special training is the most important treatment rehabilitation method with proven efficacy in autism. With an intensive rehabilitation-training provided in early childhood (ages of 2-6) for children who are diagnosed with autism, we aim for ensuring that these children could continue formal education with their peers in the future. We continue to cooperate with the Ministry of National Education on this matter.

F. Elderly Health

According to data of 2011, population over the age of 65 constitutes 7,3 % of the general population. Life expectancy at birth gradually increases in Turkey. Life expectancy at birth was 70 years in 2000, however life expectancy at birth increased up to an average of 75 in total in 2009, increasing up to 72 and 77 for men and women respectively.

We translated into Turkish, published and distributed “Diagnosis and Treatment Guidelines on Elderly Health” prepared for primary health care physicians with the contribution of specialists working in this field in our country and “Age-friendly Primary Health Care –PHC- Centers Toolkit” so as to improve the quality of health care services for the elderly who have special health requirements and to meet these requirements at the level of primary health care services. We prepared the books titled “Elderly Health Guidelines for Trainers” which is to be used for training the elderly on health and “Nutrition for the Elderly” which is a guideline for a healthy diet for the elderly. The MoH is also one of the active stakeholders of the “National Action Plan on the Status of the Elderly and Aging in Turkey” prepared under the leadership of SPO and SSCPA.

7. Health Promotion

Individuals must have adopted healthy life habits in order to sustain a healthy life. Individuals who are well-nourished with a proper diet; having regular physical activity; abstaining from bad habits that may harm his/her health and having health checks to keep healthy, will be able to further promote his/her health.

Health promotion is a process where people are enabled to increase their control over their health and promote their health. Health Promotion is described as the integration of health training provided with the aim of making behavioral changes in the protection and promotion of health with all types of support given on the basis of organization, economy and environment.



The first strategic objective of the Strategic Plan indicating the objectives of the MoH between the years 2010-2014 is “to protect the community from health-related risks”. In the subparagraph of this strategic objective, the following objectives are emphasized: to enhance the control capability of citizens over their health and to ensure their active participation in decision-making processes on matters that may influence their health so as to protect individual’s health and to enhance health level. Under health promotion, we support promotion, informing and awareness-raising activities as well as programs on protection from risk factors.

Health promotion activities;

- Help to reduce early mortality and disability,
- Address leading risk factors and underlying health determinants,
- Help to strengthen sustainable health care systems,
- Place health care in the heart of a large-scaled development agenda.

It is important to develop behaviors that will ensure a healthier life at any point in life. Important steps to this end are raising awareness in such a way to develop healthy life behaviors in the society (reduction of tobacco and alcohol use, prevention of obesity, promotion of physical activity, hygiene, healthy dietary habits etc.) and increasing level of knowledge, ensuring that individuals assume responsibility on their health care and participate to decision-making processes.

We aim for the adoption of a lifestyle that will ensure the sustainability of mental, physical and social well-being by raising awareness of individuals and gaining sufficient level of knowledge to make an accurate decision on their health and improving factors and social determinants that influence health directly and indirectly.

All factors that may influence the course of life have a potential of making positive/ negative impact on the access to a healthy life. Therefore, it is needed to raise awareness of other sectors apart from healthcare on these matters and to activate multisectoral health responsibility. Starting from the moment when health care services are needed, elimination of obstacles is needed to ensure access to all services needed in proportion to the needs, in line with the needs, equitably and on time. The obstacles before the access to services required are bureaucratic, financial and regional differences, lack or imbalance of service supply and being among the disadvantaged group.

The ultimate aim of health care policies to be implemented is to increase the level of health care and therefore welfare and happiness level of the society. While trying to achieve this aim, the top priority principle is to prevent people from becoming sick and to meet their expectations for a healthy life. The level of achievement for this aim will be demonstrated by the progress that will be achieved on fundamental health indicators. The most tangible indicators to this end are the reduction of maternal and child mortality and increase in the life expectancy at birth. Participation of individuals in decision-making processes on their health care, respectability, effective communication and access to social support networks during treatment constitute important milestones of a people oriented system.



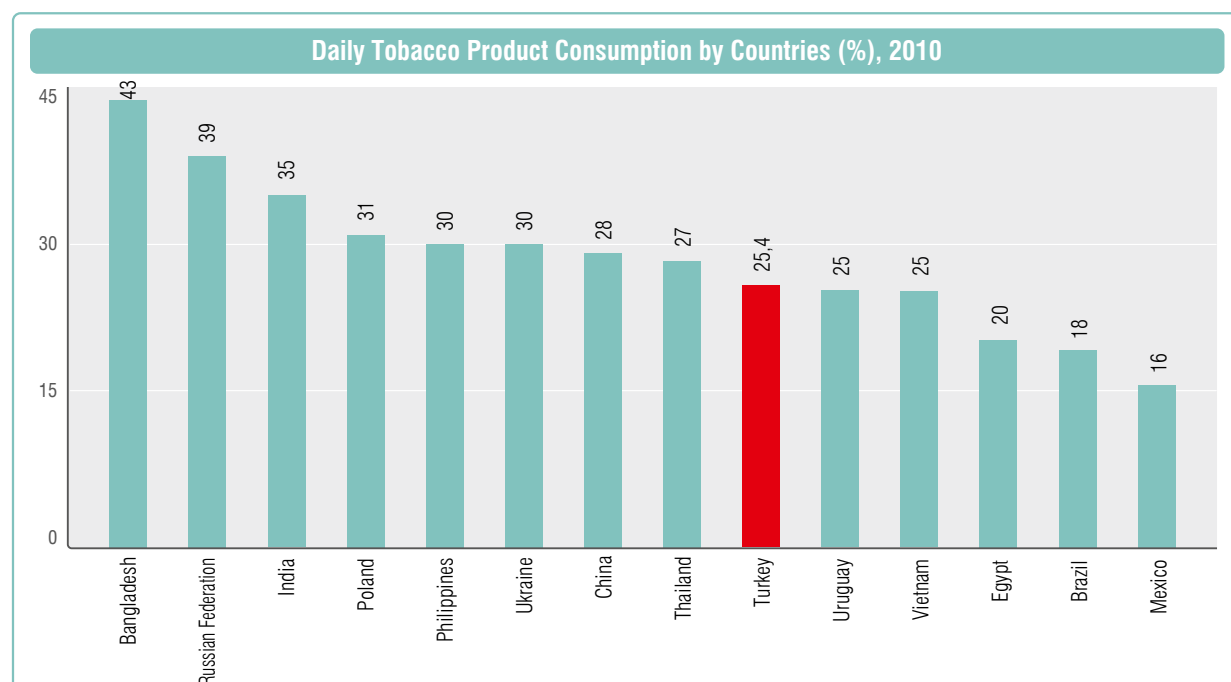
The aim of health promotion is to ensure that a large proportion of the society implements proper health behaviors. Health promotion practices improve personal choices and social responsibilities of individuals and it means the process where people will ensure the promotion of their own health.

Activities of the MoH under “Health Promotion”:

A. Struggle against Tobacco, Alcohol and Substance Addiction

The Biggest Step in the Fight against Risk Factors; Smoke-free Air Zone

Smoking is a significant public health problem in our country. Smoking leads to more than fifty health problems starting from the prenatal period and resulting in mortality during childhood and adulthood. It is one of the leading preventable causes of disease and mortality. 1,3 billion people in the world and 16 million people in our country smoke and 80% of these people is in developing countries (Graphic 45). Around 100.000 people in our country die from diseases caused by tobacco use.



Graphic45

Source: WHO Report on the Global Tobacco Epidemic, 2011



Our country ranks the third in Europe and seventh in the whole world for tobacco consumption; and the addiction rate is calculated to be around 40% among adult men. Tobacco consumption plays a major role in many diseases, particularly cancer.

The first implementation aiming to promote health was achieved by an anti-tobacco campaign, the “Smoke-Free Air Zone” campaign. We managed a successful health promotion activity and addressed millions of people in each of the steps aiming to achieve changes in awareness, attitudes and behaviours. It is also confirmed by scientific studies and the process is still continuing. With the program which is progressing in phases, we emphasized that the law introduced regulations aiming to protect and promote the health of all of us. We were justified by our foresight that our people would not wish to harm others and our messages were appreciated by the people which claimed that smoking in indoor places would give harm to secondhand smokers.

Minister of Health Recep Akdağ signed the “Tobacco Control Framework Agreement” in 2004 prepared by the WHO and already undersigned by 171 countries; and the “National Tobacco Control Program”, prepared in line with the Agreement in question, was declared by our Prime Minister in December 2007. In accordance with the program, amendments were made in the Law No.4207 on the Prevention and Control of Harmful Effects of Tobacco Products and new regulations were introduced for the consumption of cigarette and tobacco products. There has been a 95% support to the measures, the implementation of which started on May 19th, 2008 and which aims the prevention of passive smoking.

Turkey ranks the third in Europe and the sixth in the whole world for tobacco control activities and the comprehensiveness of national regulations and sets an example for other countries.

WHO awarded H.E. Minister of Health in 2008 and H.E. Prime Minister of the Republic of Turkey in 2010 for the “Struggle against Smoking”.



The MoH makes efforts to establish smoking cessation polyclinics and increase their number and to disperse medication for smoking cessation free-of-charge under the control of physicians for current cigarette addicts as well as taking measures to prevent starting to use tobacco and tobacco products. The MoH also took ALO 171 smoking cessation hot line into operation in October 2010.

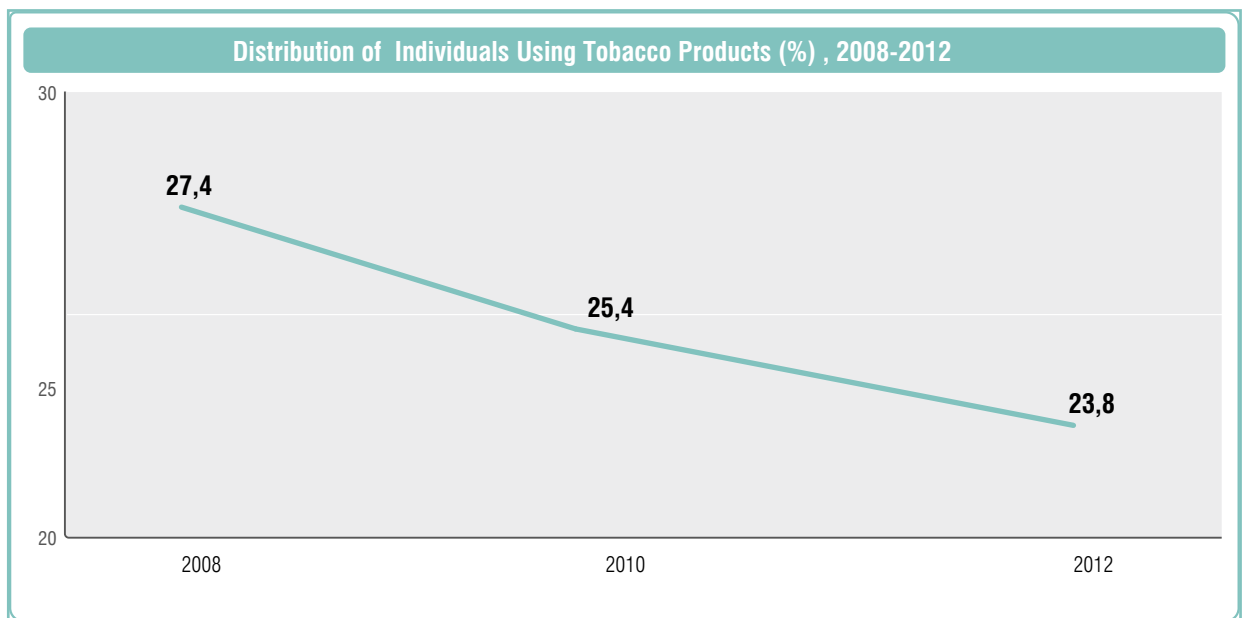


According to measurements of indoor air, the particle amount was found to have decreased;

- By 57 - 97% in public areas
- By 75% at hospitals
- By 89% at shopping centers
- By 78 - 90% in private businesses.

Specialists of Marmara University investigated admission rates of 11 diseases including asthma attacks, upper and lower respiratory tract infections to hospitals in Istanbul, affiliated to the MoH, between 19 July 2009 – 1 July 2010. There was a reduction of 20% in admissions due to respiratory tract infections and asthma attacks.

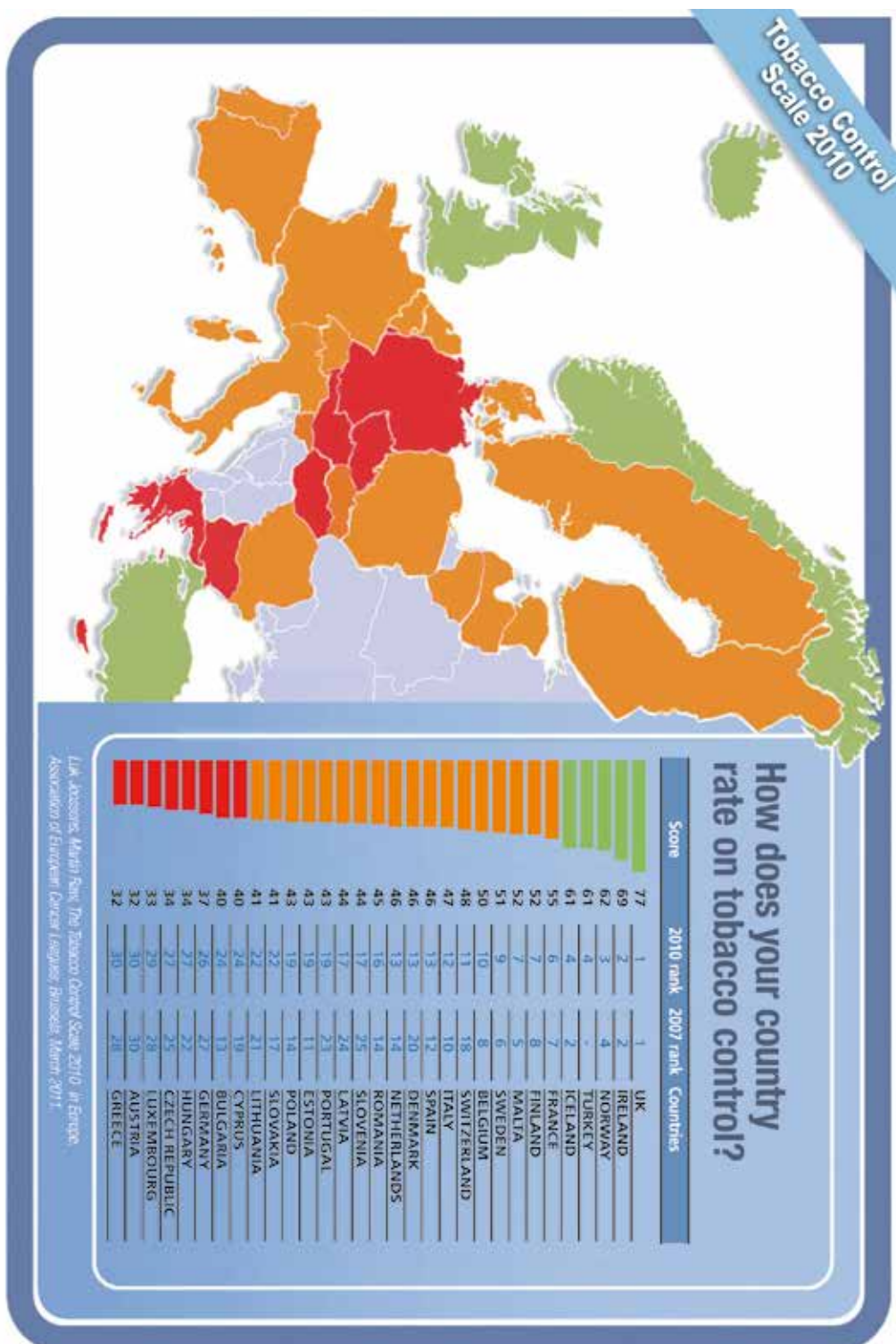
The rate of smokers from 32,1 % in 2003 to 23,8 % in 2012. The smoking rate was reduced by 8,3 % (Graphic 46).



Graphic46

Source: MoH National Burden of Disease and Cost-Effectiveness Study, Household Survey 2003, TURKSTAT Global Adults Tobacco Survey 2008, TURKSTAT Health Survey 2010, TURKSTAT Global Adults Tobacco Survey, 2012

Applications to 112 Emergency Health Care Services in Ankara in 2010 due to smoking-related diseases were reviewed by Turkish Society of Public Health Specialists (HASUDER). Emergency applications due to cardiac and respiratory diseases and stroke especially in men have reduced after the enforcement of the law as expected. There has been a reduction in applications due to cardiac and respiratory diseases in women.





“MPOWER A Policy Package to Reverse the Tobacco Epidemic” was prepared by the WHO in the light of international experience with the aim of functioning as a guideline for countries in their efforts to lead the way for tobacco control. Our country is one of the leading countries in that it has put all components of MPOWER strategy into practice.

Luk Joossens, Belgian specialist of European Cancer League, mentioned at European Tobacco Congress held in Amsterdam on 27-29 March 2011 that Turkey ranks the fourth among 30 European countries. Turkey was appreciated by its successful practices in the field of tobacco control.

We have completed 98 components out of 100 of MPOWER policy package by now. We are aiming to complete the remaining two components (having pictorial warnings on at least 50% of the surface area of cigarette packages and prohibiting “brand sharing” as a type of advertisement) and to become the first country in enforcing the whole policy package of MPOWER in the world.



Tobacco Control in Turkey, Story of commitment and leadership

Year of Publishing: 2012

Published by: World Health Organization European Regional Office

“Turkey faces a serious tobacco epidemic. Nearly 16 million of the nation’s adults are smokers. Smoking is the most important public health challenge and preventable cause of mortality in the country. Beyond health hazards, the economic burden of tobacco use is equally enormous. Smokers spend nearly US\$ 20 billion annually on tobacco products – four times the annual budget of the Ministry of Health. Turkey, a country with a high prevalence of smoking and important tobacco production, has taken bold and courageous steps in tobacco control in recent years. Driven largely by Government leadership and policy initiatives, Turkey is now considered a “model country” in tobacco control at both regional and global level, emerging as a leader in Europe in terms of policy measures such as taxation and the introduction of smoke-free indoor public places. The implementation of a comprehensive tobacco control law in Turkey has already saved thousands of lives and encouraged countries around the world to follow the Turkish example.”



Alcohol and Substance Addiction

Alcohol and substance addiction is known to create many negative effects on an individual's health. Also it is clear that alcohol addiction causes, in addition to a number of health problems, some social problems such as murder, divorce, rape, domestic violence and traffic accidents.

Strategic objectives of Health Transition Project include the protection of children and youngsters from the harmful effects of alcohol. We drafted National Alcohol Control Program and Action Plan to this end. We aim to raise the awareness of society on protection of children and youngsters from harmful effects of alcohol with National Alcohol Control Program.

B. Contact Water and Soap

We implemented the "Contact Water and Soap for Your Health and Get Protected From Diseases" campaign in order to raise public awareness for the significance of regular handwashing and hygiene.



C. Love is the Best Medicine

Any kind of transformation and improvement in health care services certainly reaches its goal if supported by positive perceptions and attitudes of health care personnel. Therefore, health care personnel's self-esteem and respect for their jobs – together with their raised awareness for the significance of health care services in the lives of people – build positive working culture. We implemented the "Love is the Best Medicine" and "So Glad We Have You" campaigns in order to establish a good communication between health care personnel and patients.

D. Healthy Diet and Physical Activity for a Healthy Future

Struggle against Obesity

Obesity is defined as "abnormal or excessive fat accumulation that presents a risk to health" by WHO. 15-18% of body weight in adult men and 20-25% in women is composed of adipose tissue. Obesity develops as this rate exceeds 25% in men and 30% in women. Obesity in the world gradually increases like an epidemic.

Obesity is a chronic disease associated with many factors which reduce the quality of life. Today there is no other disease in the world which increases so rapidly and affects individuals and communities. Therefore, policies are developed and national action plans are drafted on the struggle against obesity across the world.



Mostly caused by malnutrition and physical inactivity, obesity is the second most common reason for preventable deaths following smoking. Obesity related health expenditures constitute 2-7% of all health expenditures in developed countries.

Despite gradually increasing obesity epidemic, “WHO European Ministerial Conference on Counteracting Obesity” was organized by the WHO Regional Office and hosted by Turkish government on 15-17 November 2006 in Istanbul and solution offers on obesity epidemic were discussed during the conference.

The mentioned conference was held with the participation of 500 participants including senior officials of relevant Ministries such as agriculture, education, sports, transportation and social security and of public sectors, representatives of non-governmental organizations, specialists, representatives of international organizations and members of the press. During the conference participated by H.E. the Prime Minister of Republic of Turkey Recep Tayyip ERDOĞAN, Minister of Health Prof. Recep AKDAĞ and the WHO Regional Director for Europe Dr. Marc DANZON undersigned “European Charter on Counteracting Obesity” on behalf of participant countries.

We prepared “Healthy Diet and Active Life Program of Turkey” with the aim of struggling effectively against this disease, which has an increasing prevalence in our country and affects our children and youngsters; enhancing the level of knowledge of the society on the struggle against obesity and encouraging

them to adopt healthy diet and regular physical activity habits and thus reducing the prevalence of obesity and obesity related diseases (such as cardiovascular diseases, diabetes, hypertension, musculo-skeletal system diseases) in our country (Graphic 47 and Table 4, 5).

We built our communication campaign on three main pillars which are learning our body-mass index, eating less and making physical exercise. 78 % of the population recognized the campaign, 32 % of the population started to make physical exercise and 29 % of the population started to eat less as a result of this campaign.



Table 4. Availability of Physical Exercise Performance Among 12 and 12+ Aged Individuals by Sex (%), 2010

	Female	Male	Total
Physical Exercise Unavailable	76,5	67,6	71,9
1 or 2 Times a Week	7,7	11,5	9,7
3 Times and Above a Week	15,7	20,6	18,3

Source: Turkey Nutrition and Health Survey 2010



Several public institutions and organizations, universities, private sector and nongovernmental organizations etc. have carried out different programs, projects and training activities. With this program, we aim to include activities conducted in our country into a planned schedule and make them measurable, traceable and to achieve collaboration.

“Healthy Diet and Active Life Program of Turkey” embraces a large-scale and multisectoral approach.

National program involves 4 main headings, 11 goals, 21 objectives, 37 strategies and 115 activities. The scope of the program involves achievement of political will and determination at national and local level; raising awareness of the society on adequate and balanced nutrition and physical activity by using different tools under preventive health care services; taking measures for the diagnosis of obesity and monitoring and evaluation activities.

Under the mentioned program;

- We set up Executive Board on the Struggle against Obesity, Scientific Advisory Board and Coordination Committee under the MoH and Adequate and Balanced Nutrition and Active Life Board under Governor’s Offices in 81 provinces. We also established “Obesity Units” under Health Directorates.
- We also included relevant data on Obesity Monitoring into Family Medicine Data System with the aim of identifying obesity status of individuals and thus we gained access to data of individuals like Body Mass Index (BMI), waist circumference, hip circumference.

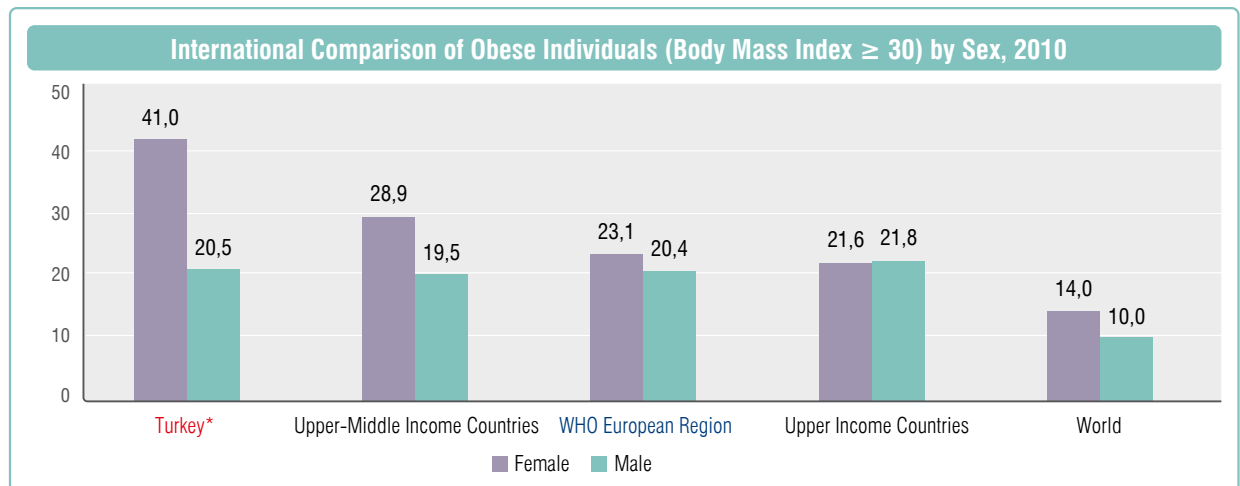
Table 5. Body Mass Index Percentages in All Age Groups

Age	Male				Female				Total			
	Slim	Normal-weighted	Over-weighted	Obese	Slim	Normal-weighted	Over-weighted	Obese	Slim	Normal-weighted	Over-weighted	Obese
19-30	2,8	59,0	30,5	7,7	8,1	56,0	22,2	13,8	5,1	57,7	26,9	10,2
31-50	1,1	31,7	42,9	24,4	1,3	22,2	34,5	42,1	1,2	27,1	38,9	32,8
51-64	1,7	26,1	41,4	30,7	0,2	7,0	28,3	64,4	0,9	16,4	34,8	47,8
65+	1,8	27,5	45,9	24,8	1,1	15,0	30,4	53,5	1,4	20,7	37,4	40,4
Turkey	1,8	38,7	39,1	20,5	2,7	26,6	29,7	41,0	2,2	32,9	34,6	30,3

Source: Turkey Nutrition and Health Survey 2010



- We ran the “National Project on Monitoring Growth in School-Age Children” at elementary schools in 26 provinces as an indicator of adequate and balanced nutrition in cooperation with relevant Ministries and universities.
- Salt consumption in our country is three folds higher than the recommended level. Excessive salt consumption causes the increase of blood pressure and plays an important role as a risk factor in the occurrence of many diseases such as osteoporosis, renal diseases, gastric cancer and primarily cardiac diseases and stroke. We introduced a national program in 2011 so as to reduce salt consumption for gradually lowering salt consumption level in our society with a multidisciplinary approach in protection of public health and prevention of disease occurrence. The amount of salt used in bread baking was also reduced by the Turkish Food Codex Regulation on Bread.
- We started to work on the production and consumption of whole wheat bread which plays an important role in healthy diet and the quality of the flour used in bread baking was increased by the Turkish Food Codex Regulation on Bread.
- We put a website into service, www.beslenme.saglik.gov.tr, which is prepared based on scientific facts in order to provide a source of information on nutrition for the society. Our citizens are able to access the most accurate and updated information on nutrition on this website.



Graphic47

Source: World Health Statistics 2012

* Turkey Nutrition and Health Survey 2010



E. Other

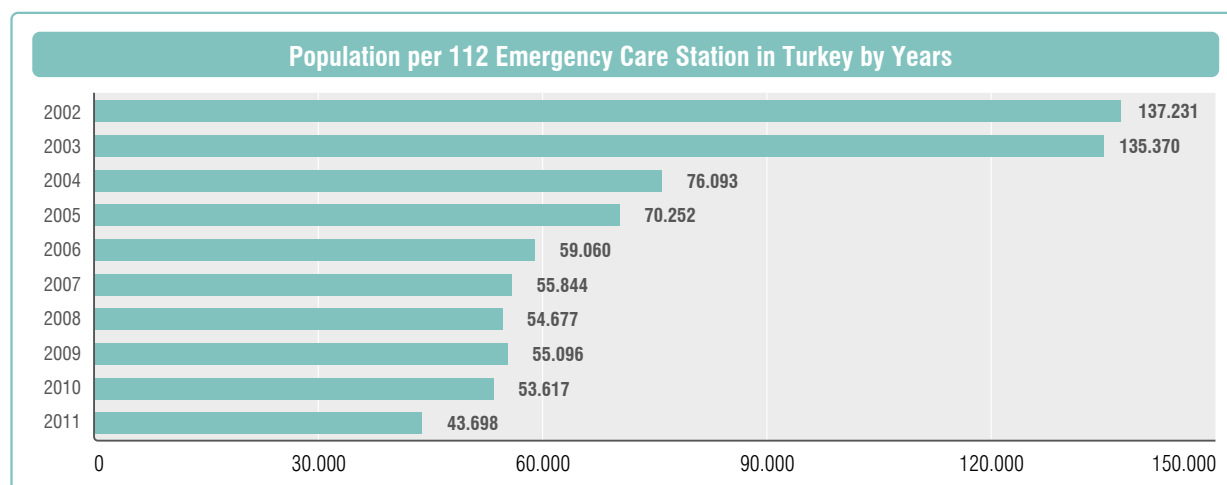
We run communication campaigns in order to inform people about the health care services expanded in scope and improved in quality under the Health Transformation Program, and to guide people how to benefit from these services efficiently. We ran communication campaigns in order to introduce and promote the family medicine implementation and home health care services.

Also we have expanded our vaccination program which aims to protect our children from communicable diseases and included new vaccines. We informed people with communication campaigns in parallel.

8. A New Era in Emergency Health Care Services

Emergency healthcare service is an important public health matter. It is very important to reach the place of incident, to perform the first intervention and to ensure transportation to a health institution as soon as possible in cases of emergent diseases and injuries.

We live in an era when “112 Emergency Health Care” services are provided extensively not only in cities but also in villages (Graphic 48). We deliver the air ambulance service free-of -charge, which is provided in the most developed countries of the world. No healthcare institution, including private hospitals, charges a fee for diseases that require emergent or intensive care.



Graphic 48

Source: General Directorate of Emergency Health Services, Population: TURKSTAT



In the last nine years, our capacity to transport emergency patients has improved by six folds. We are fully aware that in emergency cases, every second is important. We can now reach 94 % of the cases in urban areas in the first ten minutes and 96 % of the cases in the first thirty minutes in rural areas.

The number of fully equipped ambulances for 112 Emergency Health Care, which was 618 by the end of 2002, has reached 2766 by the end of 2011. Our ambulances have improved not only quantitatively but also qualitatively. All our ambulances were brought to compliance with the EU standard TS-EN 1789. The number of emergency stations, which was 481 by the end of 2002, reached 1710 in nine years. The target has been accomplished in Emergency Health Services. We are now capable of providing emergency services in every corner of the country.

224 “ambulances with snow pallets” are at the service of the public as of December 2011 in regions with transportation difficulties due to the geographical and climatic conditions. We also added 35 more ambulances carrying multiple patients, where at least 4 injured patients could be carried while lying, in cases of major accidents and social events.

Moreover, we established emergency response teams with motorbikes for replacement in cases the standard ambulances fail to reach the place of incident due to insufficient street width and traffic congestion. Experienced personnel who received training on advanced motorcycling skills were assigned in these teams. 52 motorbike teams continue to provide services as of December 2011.

4 sea ambulances, which were put into service in the year 2007, continue to serve in Istanbul, Çanakkale, Balıkesir and Gökçeada.

In 2008, we put into implementation the air ambulance system for the first time in Turkey, which is only available in developed countries. We deployed 19 ambulance helicopters in 15 provincial centers as of December 2011 which are supposed to provide service countrywide.

Besides, since April 2010, we also started transporting emergency patients or injured citizens inside Turkey or from abroad by our two ambulance planes. One of the ambulance planes is turbojet and for long distance flights, whereas the second one is a turboprop propeller driven plane (capable of landing at airports with short runways). Turbo jet ambulance plane has a flight range of 5.300 km. and turboprop ambulance plane has a flight range of 3.500 km and both planes are equipped with medical equipments for transporting two lying patients and making any medical intervention under intensive care conditions. Newborn babies could also be transported thanks to transport incubators available at the planes. Ambulance helicopters have a flight range of 450 km and serve for the transport of emergent cases between hospitals. They descend to highways in cases of car accidents, respond on the scene and transport people to hospitals. They also rescue people who are in urgent need of help when stuck in a mountain. As of December 2011, the number of patients transported by ambulance helicopters and ambulance planes was 10.509 and 2.012, respectively. By the end of December 2011, 118 Turkish citizens were transported to Turkey and 5 foreign tourists were transported to their countries.

While the number of citizens utilizing 112 Emergency Health Care Services was 350 thousand in 2002, 2,7 million people utilized the service in 2011. This number represents a 7,7 fold increase in comparison to the figures of 2002.



Only 20% of the citizens living in rural areas benefited from 112 Emergency Health Care Services in 2002, whereas today all citizens living in rural areas utilize this service.

Healthcare Organization in Disasters and National Medical Rescue Teams (NMRTs)

“We realized the Healthcare Organization in Disasters Project in our country in order to respond to possible disasters, primarily earthquakes that may happen. We established adequately trained and equipped teams with a view to providing medical rescue services within the shortest possible time; ensuring the fastest and safest transportation of patients or injured citizens in the disasters and organizing the professional management required in such circumstances. The fact that 95% of Turkey is located in the earthquake zone underlines the importance of specializing and being well prepared in this field.



Under the project, we delivered basic and complementary trainings to 4.847 voluntary healthcare personnel assigned in NMRTs established in all provinces under the control of the Ministry. We already have the largest national medical rescue force of Europe.

We are proud to state that these teams, highly capable of responding to disasters even outside our country, performed their duty in Iran and Pakistan earthquakes, Indonesian earthquake and tsunami disaster, and most recently Haiti earthquake and Pakistan flood disaster.

Subjects of NMRT Trainings

- Triage
- Disaster Psychology
- Stress Management
- Wreckage Works
- Alternative Splints
- Crush Syndrome
- General Overview of Disasters
- Disaster Epidemiology
- Stretcher Placement and Transportation
- Communication
- Basic and Advanced Life Support
- Protection from the NBC Attacks
- Strategic Team and Conflict Management
- Psychological Support and Intervention to Shock
- International Signs and Signaling System
- Fixation, Identification, Packaging of the Patient/Injured
- Terms of Reference of the Medical Team and Legal Dimensions



The Largest Medical Rescue Team in Europe

We set up the “Department of Health Organization in Disasters” in 2004 with the purpose of reducing death and injury rates to acceptable levels in disasters, particularly in earthquakes, through the provision of medical rescue services in the shortest extent possible by well-trained and properly equipped voluntary teams; transport of patients/injured citizens in the fastest and safest way; provision of emergency treatment units and treatment services after transport and establishment of professional management organization required for all works. In a period of two years, we delivered basic training to 2643 personnel assigned in the National Medical Rescue Teams established in 81 provinces on voluntary basis. We delivered training to a total of 4847 NMRT personnel by the end of 2011.

Medical rescue teams are engaged in field exercises as well as basic theoretical and station trainings and are always on call. National Medical Rescue Teams are a source of pride since they were established and some of the rescue activities undertaken by them in Turkey and abroad are the following:

Homeland

Zümürüt Apartment Building Collapse in Konya (2004)
Explosion in Diyarbakır Military Housing (2006)
Intam INTAM Building Collapse in Bursa (2006)
Airplane Accident in Isparta (2007)
Buiding Collapse in Konya-Taşkent (2008)
Railway Accident in Sivas (2008)
Railway Accident in Kütahya (2008)
Helicopter Accident in Kahramanmaraş (2009)
Helicopter Accident in Bolu – Kırıbrıcık (2009)
Elazığ Earthquake (2010)
Rize Flood (2010)
Simav Earthquake (2011)
Van Earthquake (2011)
Avalanche in Rize Ovit Mountain (2011)
Explosion in Ostim in Ankara (2011)

Abroad

Earthquake in Iran, Bam (2003)
Earthquake in Pakistan (2005)
Sudan Humanitarian Aid Organization (2007)
Flood and Landslide in Afghanistan (2007)
Earthquake and tsunami in Indonesia (2009)
Haiti Earthquake (2010)
Pakistan Flood Disaster (2010)
Transport of the injured from Iraq
Transport of the injured from Israel



One of the most important aspects in cases of disaster is the coordination between rescue teams and organizations in the efforts to reduce the impacts of disaster. Moving from this requirement, we set up Health Disaster Coordination Center (SAKOM) in the MoH in late 2009 with the aim of responding to disasters or any extraordinary incidents immediately and reducing mortality and disability by ensuring coordination with all organizations. We keep track of disasters and extraordinary incidents that occur within the country and abroad for 24 hours and respond to them immediately. We simultaneously monitor 16 national and international news channels with this system, watch breaking news on internet and check earthquake monitors for 24 hours with our connection to Kandilli Observatory. Long distance calls could be made with HF radio systems at the center equipped with the state-of-the-art technology and we could also make live calls by means of video teleconference with provinces.

We also introduced a system which could detect emergency call signals received from air and sea vehicles and emergency signals from mountaineers and research and rescue teams and find their position and location.

We provided 44 Mobile Urgent Response Units, each of which involves 8 tents, for preparedness for disasters and extraordinary circumstances. Each of these units is comprised of 6 tents of 60 m², a connection platform of 30 m² and a decontamination tent of 30 m². Installed by inflating in a maximum of 10 minutes and the first patient could be admitted in 15 minutes. Total area of use for each unit is 400 m². We also provided 16 field hospital tents that could serve under severe climatic conditions. These hospitals involving decontamination units needed in cases of chemical events are allocated to central cities of the region. So we increased our preparedness capacity for disasters across the country.



2011 Van Earthquake







**Assessment of Health Systems' Crisis Preparedness, Turkey
(Page 32, 35, 46, 47, 53, 54)**

Assessment of Health Systems' Crisis Preparedness, Turkey

Year of Publishing : 2010

Published by : World Health Organization

"One of the biggest strengths of the Turkish response system is the provision of very advanced medical equipment and the planning for emergencies at each level."

Turkey has increasingly focused on preparedness and risk reduction activities and has developed substantial response capacity and capability for emergency medical systems before and within the hospital."

"The set-up and availability of emergency logistics and support functions, including the ability to set up temporary health facilities, clearly represent one of the strengths in Turkey."

"Turkey will provide assistance for preparedness to international disasters and for response communities to create norms and standards by sharing its experiences."

"Turkey has a high level of political commitment to crisis preparedness and the proven capacity to respond to national and international disasters. The emergency response system has a strong legal framework; it is adequately staffed and well-equipped."

"Because of Turkey's unique position, with its broad experience in disaster situations and its advanced disaster and emergency management system, the country could play a leading role in training and research related to disaster risk reduction at global level."

"From their numerous international and national operations, Turkey has amassed vast experience in delivering medical aid in disaster situations. This experience should be shared and used for joint capacity-building activities in the WHO European Region."



9. Oral and Dental Health Services

The Strategic Action Plan on Preventive Oral and Dental Health

Oral and dental health is a factor directly affecting the health of an individual. Unless preserved, oral and dental health leads to several diseases. As is the case in all health related matters, preventive measures are generally acknowledged for oral and dental health diseases rather than treatment.

Under preventive oral and dental health services;

- We drafted a “Monitoring Plan for Preventive Oral and Dental Health Care” with the aim of monitoring oral and dental health of expectant mothers, mothers during pregnancy and of the baby in the uterus until adolescence so that oral and dental health awareness is raised in the society. This Monitoring Plan is a part of the “Action Plan for Preventive Oral and Dental Health Care”.
- We aim to make sure that regular dental check-ups and preventive dental practices are adopted as a lifestyle in order to improve oral and dental health awareness of the society.

Dental caries and gingival diseases are important problems of oral and dental health of the society and affect the quality of life of all age groups. Lack of awareness of individuals on oral and dental health adds a social dimension to the problem. Therefore, the most effective method of prevention is the primary preventive service given on community basis.

Dental caries and gingival diseases are diseases, which people may be exposed to for a lifetime, so preventive methods should continue for a life time as well. Dental caries and gingival diseases are likely to be reduced with the effective use of preventive methods.

We drafted “Preventive Oral and Dental Health Strategic Action Plan and Implementation Program” with the aim of providing information and training to the public on the significance of oral and dental health, preventive dentistry practices and acquiring the habit of regular tooth-brushing; following up oral and dental health of the target group and minimizing the rate of dental caries and dental treatment given.

We aim for a society without dental caries with preventive oral and dental health services. We continue to conduct the following activities to achieve this objective :

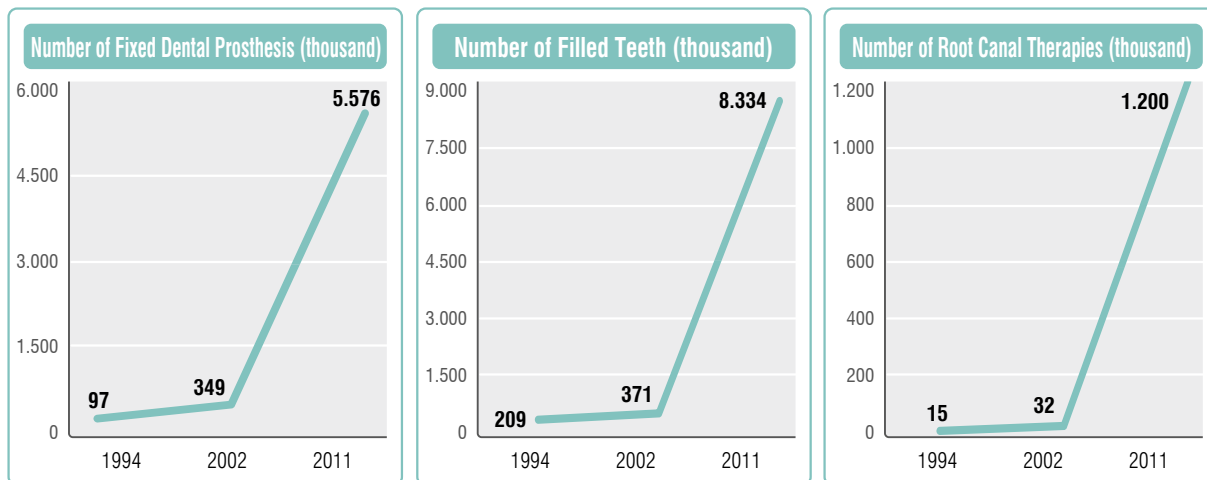
- Understanding the significance of and improving public awareness on oral and dental health,
- Monitoring regularly oral and dental health of the mother and the baby under preventive oral and dental health services starting from expectant mothers,
- Making people be aware of and act in line with their own health and health-related problems and pay attention to their oral hygiene (acquiring the habit of proper and regular tooth-brushing, making dental flossing more common),



- Acquiring adequate and balanced dietary habits, understanding the significance of the relation between oral hygiene-nutrition-caries and acting accordingly,
- Having regular dentist check-ups,
- Understanding the significance of preventive dental treatments (Fluorine use and fissure sealants),
- Increasing efficiency and availability of preventive oral and dental health services. In this scope, we identified our target groups by prioritized risk groups:
 - Parents of 0-3 aged children,
 - Age group having 6-age teeth
 - Pregnant women
 - Disabled people.

We aim to monitor these target groups closely in the framework of the “Periodic Consultation Guideline” developed for family physicians.

In 2011-2012 education term, 2,840.186 students in primary health care schools received oral and dental health care trainings and screened for oral and dental health.

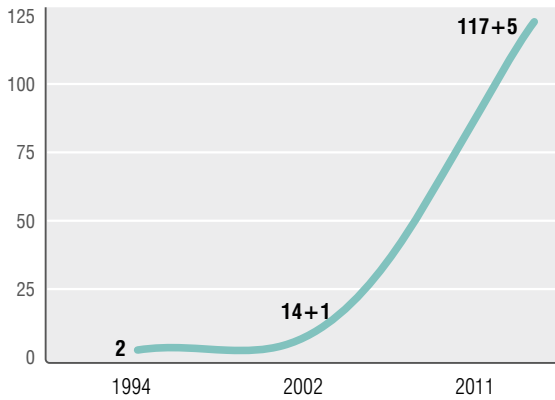


Graphic 49, 50, 51
Source: General Directorate of Health Services

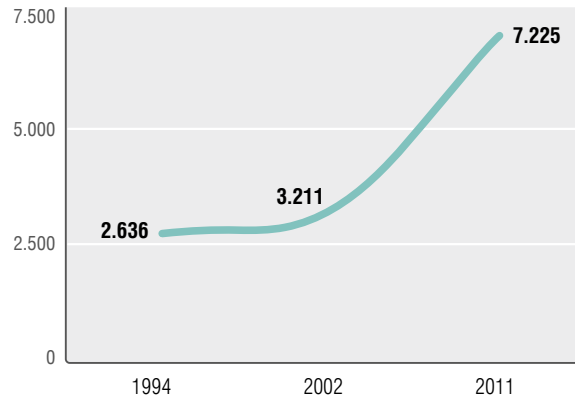
In the context of public oral and dental health care services, we increased the number of Oral and Dental Health Centers from 14 in 2002 to 117 in 2011 and increased the number of dental hospitals from 1 to 5. We offer oral and dental health care services in 81 provinces. While there were 1.475 active dental units in the MoH facilities in 2002, the number increased to 6.169 in 2011. The number of dentists increased from 3.211 in 2002 to 7.225 in 2011. So, we facilitated access to oral and dental health care services for our citizens (Graphic 49-54.)



Number of Oral and Dental Health Centers



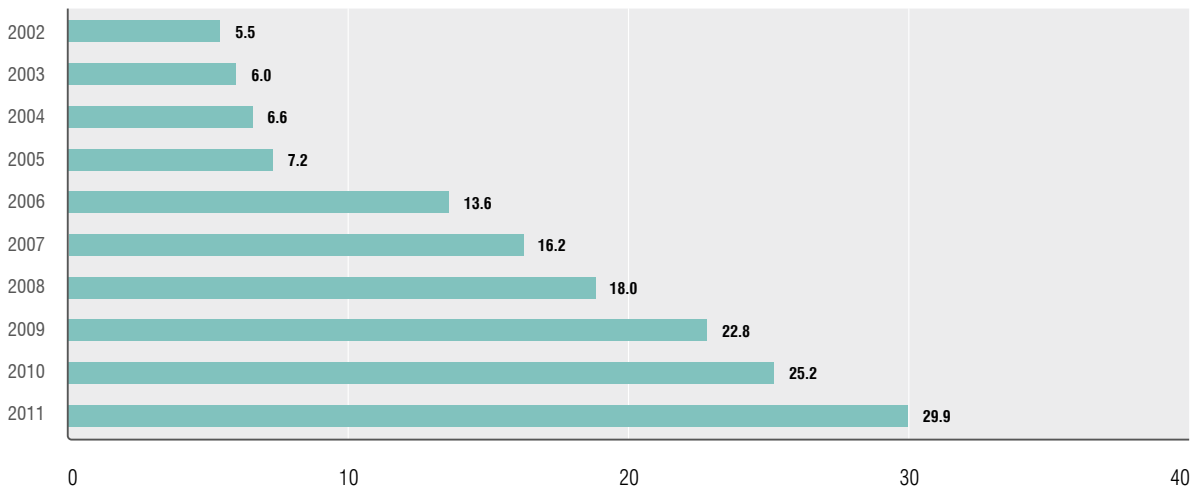
Number of Dentists in the MoH



Graphic 52, 53

Source: General Directorate of Health Services

Number of Oral and Dental Health Center Visits by Years, MoH, Turkey (million)



Graphic 54

Source: General Directorate of Health Services



10. Healthy Environment, Healthy Human

• Survey on Health Profile of Villages in Turkey

We introduced “Healthy Villages Project” with the aim of providing necessary conditions in villages as well as urban areas for environmental and public health, which are the fundamental elements of Preventive Health Care Services. We aimed to identify current status of villages with the mentioned Project and to develop policies in cooperation with relevant organizations and institutions on the problems of villages based on accurate, healthy data obtained.

We conducted the “Survey on Health Profile of Villages in Turkey” covering 34.110 villages in our country. We identified specific characteristics of villages such as: inclination of village territory, presence of swamps and dumpsites, exposure to natural disasters, sources of income, residential, land, territorial and climatic characteristics of the village, the number of health care organizations in the village, the number of public personel working in the village, seasonal migration; presence of seasonal migration and health conditions in the sites of seasonal migration. We also evaluated drinking and potable water of the village in a separate questionnaire. We also analyzed many other things such as network and water pipeline, presence and convenience of resource saving areas, presence of and convenience of water tanks with proper health and safety conditions, necessary analyses and chlorination of water.

We questioned and analyzed health status of villagers, existence of important health problems affecting health in the village, and the causes of diseases, disability, mortality and poisoning cases resulting from these problems, if any.

We also inspected the conditions of public places in villages for construction, proper use, enlightening, heating, maintenance and cleaning.

• Water Safety

Water is one of the substances of vital significance for human beings. However, human health may be endangered in case that water, which is indispensable for human health, is not safe and reliable and major public health problems may rise.

Drinking water has a vital importance for human beings to maintain their lives. Adopting a holistic approach for drinking waters from the spring to the point of distribution, we introduced “Water Quality Monitoring Program” with the aim of monitoring them in such a way to include water treatment, water distribution system, taps, water tanks and water pipes.

Quality of water is analyzed in the data collection system created for drinking-potable water in two ways: inspection and control. Both types of monitoring involve chemical, physical and microbiological parameters. However, inspection also involves almost 52 parameters including radioactivity.



We take necessary corrective measures and impose utilization limits if incongruity with any of these parameters is observed during inspection and control. We inform the customers in cases of incongruity and make the necessary warnings. We publish incongruent analyses results on the web pages of provincial health directorates in order to inform the public.

11. Employee Health

According to data of the International Labor Organization, around 250 million and 160 million people in the world are exposed to dangers resulting from occupational accidents and occupational diseases respectively. 11 million new occupational disease cases occur every year in the world according to the data obtained from WHO and 700 thousand of these cases die from occupational diseases.

A majority of employees in our country are not able to access to fundamental occupational health and safety services adequately. Therefore, it is required to integrate delivery of current health care services with occupational health services so that occupational health services become effective, widespread and accessible.

Restructuring and development of services are involved in the field of National Occupational Health and Safety as a policy and the following are among such services: occupational health and safety measurements by improving measures for occupational health and safety of employees, revelation of occupational diseases, practice of workplace physicians, consultancy, training services, hospitals specialized in occupational diseases and inspections

We drafted an action plan on the services we will provide on occupational health between the years 2010-2014. Moreover, we included some components of this action plan into strategic plan of the MoH. These objectives are as follows:

Objective 1. To extend the scope of occupational health services in such a way to cover all employees in our country.

Objective 2. To identify the actual dimension of occupational health problem in Turkey.

Objective 3. To reduce mortality and morbidity of occupational diseases.

We developed “Primary Occupational Health Model” in cooperation with WHO so as to maintain and spread out occupational health services in an effective, accessible and qualified way and to integrate them with current health services.

A cooperation protocol was signed in the field of “Occupational Health and Safety” between the MoH and the MoLSS in April, 2010. Under the protocol, we cooperate on drafting a national policy and action plan on preventive occupational health services, prevention and early diagnosis of occupational diseases.

The MoH and the MoLSS enacted an implementing regulation and thus enabled Community Health Centers to serve the practice of workplace physician.



12. Climatic Changes

Climatic changes are one of the most important global problems that the world is faced with in recent years. Moreover, they pose a serious threat for public health. Recent studies show that the impact of climate changes on the increase of global disease burden and mortality is high.

As is the case across the world, people living in our country are also directly affected by severe climatic events such as temperature extremes, flood, storm and rise of sea level and are indirectly exposed to changes occurring in the quality of water and food, ecosystem, agriculture, industry, residential areas and economy. This exposure poses a significant threat on public health from the point of communicable diseases, vector-borne diseases and diseases caused and influenced by temperature extremes.

We drafted a report titled “Health Impacts of Climatic Change in Turkey” in order to assess the impacts of climate change on public health in Turkey. In line with this report, we drafted “Action Plan on Health and Climatic Change” with the aim of minimizing health impacts of climate change.

TURKEY HEALTH TRANSFORMATION



C. IMPLEMENTATION

2. Diagnostic and Curative Services



The significance of preventive health services is not disputable. However, receiving essential treatment in the right place and at the right time is also very important for patients. Health right is an indisputable and urgent human right.

1. Eliminating Discrimination in Health: Uniting Public Hospitals under a Single Roof

The principle of efficiency, one of the objectives of the Health Transformation Program, is defined as “efficient use of resources to reduce costs and produce more services out of the same resource”. It is emphasized that the distribution of human sources, management of materials, rational drug use, health administration and preventive medicine will be assessed under the scope of this principle and that efficiency will be improved by including and integrating all sector resources of our country into the system.

We aim at mobilizing all resources allocated for health service provision to serve for the public by “uniting all hospitals under a single roof” in the abovementioned framework. In this period, we have lifted obstacles preventing the access of patients to the hospitals by transferring SSK hospitals to the MoH and thus, we have eliminated discrimination among our citizens. In this way, hospitals which suffered from unbalanced workload in the past were opened to all patients regardless of whether they were covered by the SSK, Bağ-Kur, Government Employees Retirement Fund or Green Card.

Most people, who had difficulty in accessing healthcare services formerly, now have the opportunity to utilize these services. Uniting SSK and public hospitals, which is an equitable implementation, not only created different alternatives for people but also granted SSK beneficiaries the right to utilize healthcare services, which they could not in the past although they paid premiums and were covered by the insurance system.

Table 6. Number of Total Consultations at Hospitals in Turkey by Years and Sectors (million)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ministry of Health	110	114	135	165	189	210	217	228	235	254
University	9	10	11	11	13	15	18	19	20	24
Private	6	6	7	11	16	24	39	48	48	59
Total	124	130	153	187	218	249	274	295	303	338

Source: General Directorate of Health Services



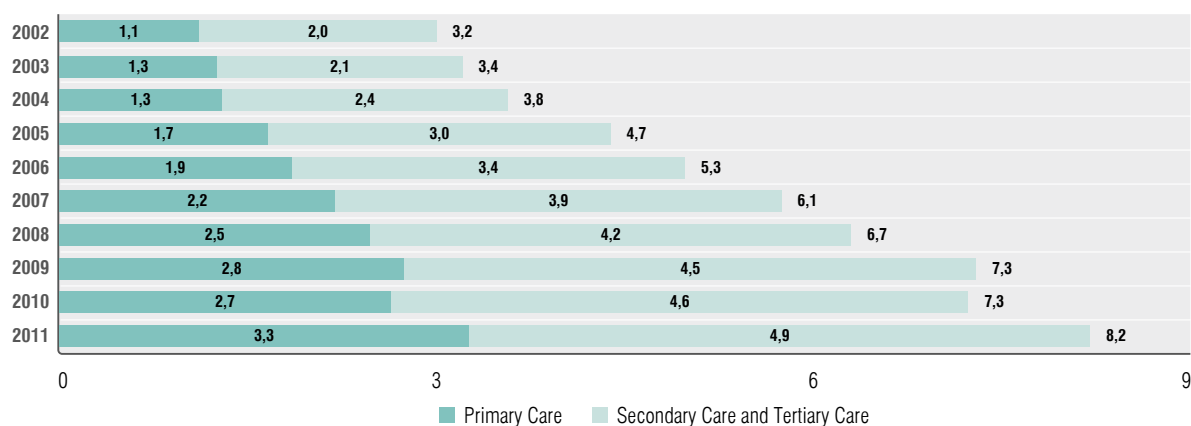
Table 7. Number of Per Capita Consultations at Hospitals in Turkey by Years and Sectors

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ministry of Health	1,7	1,7	2,0	2,4	2,7	3,0	3,0	3,1	3,2	3,4
University	0,1	0,1	0,2	0,2	0,2	0,2	0,3	0,3	0,3	0,3
Private	0,1	0,1	0,1	0,2	0,2	0,3	0,5	0,7	0,6	0,8
Total	1,9	1,9	2,3	2,7	3,1	3,5	3,8	4,1	4,1	4,5

Source: General Directorate of Health Services

With the Health Transformation System, access to health care services have become easier for people in Turkey (Table 7-9). While per capita physician visit was 3,2 in 2002, it increased to 8,2 in 2011 (Graphic 55; Table 6).

Number of Per Capita Physician Visits in Health Care Facilities in Turkey by Years



Graphic 55

Source: General Directorate of Health Services

Table 8. Number of Inpatients in Turkey by Years and Sectors (thousand)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ministry of Health	4.170	4.278	4.860	5.042	5.303	5.675	5.960	5.935	6.361	6.775
University	782	838	922	1.026	1.165	1.263	1.386	1.463	1.509	1.607
Private	556	619	659	909	1.220	1.782	2.338	2.504	2.658	3.054
Total	5.508	5.735	6.441	6.977	7.689	8.720	9.684	9.902	10.528	11.437

Source: General Directorate of Health Services



Table 9. Total Number of Surgeries in Turkey by Years and Sectors (thousand)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ministry of Health	1.072	1.130	1.442	1.690	1.985	2.217	2.464	1.830	2.039	2.209
University	307	326	375	452	508	560	638	547	577	617
Private	219	237	260	393	580	787	1.087	1.131	1.215	1.374
Total	1.598	1.693	2.078	2.535	3.073	3.565	4.189	3.508	3.831	4.201

Source: General Directorate of Health Services

2. Opening Private Hospitals' Doors to Everyone

The Health Transformation Program envisages to incorporate all sectoral sources related to health in our country into the system and thus to ensure harmonization and enhance efficiency. Uniting hospitals under one roof was a concrete step taken to this end.

Another important step is the inclusion of private sector investments to the system allowing patients to receive services from these institutions under the coverage of their own social security. Now, all sources in the country, regardless of being public or private sources, serve to the public. Public hospitals compete with the private sector for service provision, which increases the quality of service; this effect will become more pronounced over time. The fact that private healthcare facilities opened their doors to patients covered by public insurance has alleviated the workload of public hospitals.

Thus, the provision of healthcare services is facilitated by sharing the excessive workload, which was mostly undertaken by public sector in the past, with private healthcare institutions. In addition, registered work was encouraged in private sector. As a result, the shares allocated for the public over the values produced also increased. Today, the sector is supervised more carefully. On the other hand, private health sector gained a new momentum with this implementation. Significant number of investments has been made in this field. We have imposed limitations to additional fees charged by the private hospitals in order to protect the patient. We began to provide emergency and intensive care treatments as free-of-charge in all private and public hospitals. We have provided free-of-charge health care services for burn injury, cancer and infant treatments, organ transplantations, congenital anomaly, dialysis and cardiovascular surgical operations. These recent implementations direct the majority of the private hospitals to a transition towards becoming public hospitals. Private hospitals are in the process of adapting themselves to this process. On the other hand, the claim that the Health Transformation Program led to privatization and specialist physicians are deployed in the private sector is absolutely unreasonable. To provide an evidence, 48,8 % of specialist physicians was working at public hospitals in 2002 and this ratio did not diminish in 2011. On the contrary, some small increase was noted and it became 49,4 %.



3. Decentralized Management of Hospitals

Transfer of authority to hospitals, flexibility in management, and further autonomy over resource allocation and performance-based supplementary payment for personnel from revolving funds increased efficiency in hospitals. Healthcare institutions started to become patient-centered service institutions.

In order to alter the cumbersome structure of public hospitals, obstacles preventing the purchase of particularly imaging services as well as many other medical services from the private sector were lifted, and the service structure of the hospitals started improving rapidly.

Thus, unnecessary waiting periods for imaging and other diagnostic tests were shortened substantially. Differences in management models and weaknesses of management were removed by uniting all SSK hospitals and public hospitals under the MoH's roof and new implementations.

Establishing data-processing infrastructures at all hospitals, we registered all services. Public hospitals do not have to wait for allocations for long years any more. Today, service equipment and tools are supplied without putting burden of investment on public sources and the cost can be incurred by the revenues of public institutions.

Hospitals in Turkey, which gain more autonomy each passing day and have already decentralized in management, are gradually becoming autonomous public institutions. These developments are considered to be the first steps of privatization by opponents of the Health Transformation Program; however, the Health Transformation Program does not have such a goal.

4. Restructuring in Hospital Services

In the framework of the Health Transformation Program, we have renovated public hospitals by the latest technology and we have built more capacity. We began to service procurement as public-private partnership model in public hospitals. The number of magnetic resonance imaging (MRI) devices, which was 18 at all public hospitals in 2002, was increased to 273 in 2011, whereas the number of computerized tomography (CT) devices increased from 121 to 446, and the number of ultrasonography devices increased from 495 to 2.125. There are also similar increases in private sector and university hospitals (Graphic 56, 57 and 63; Table 10)

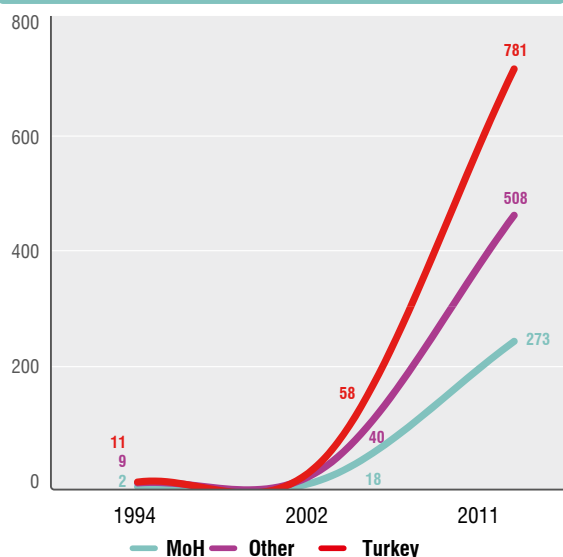
Table 10. Number of Medical Devices in Inpatient Treatment Facilities in Turkey by Years

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
MR	58	99	149	199	310	410	517	647	697	781
CT	323	376	446	509	593	675	759	838	904	1.088
ECO	259	338	391	453	518	598	689	791	881	1.181
USG	1.005	1.164	1.309	1.493	1.699	1.900	2.117	2.283	2.436	3.775

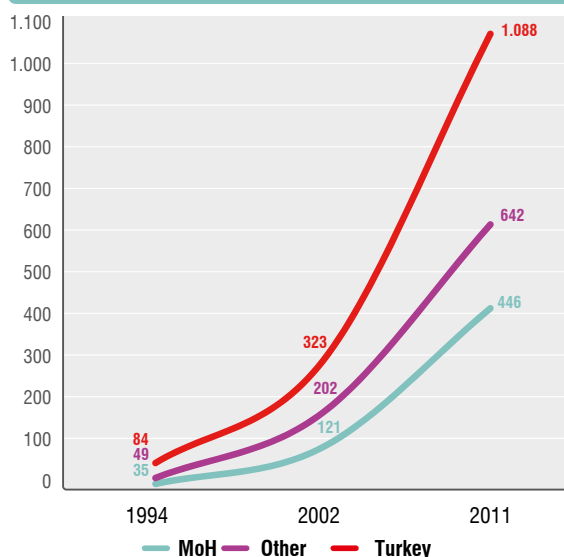
Source: General Directorate of Health Services



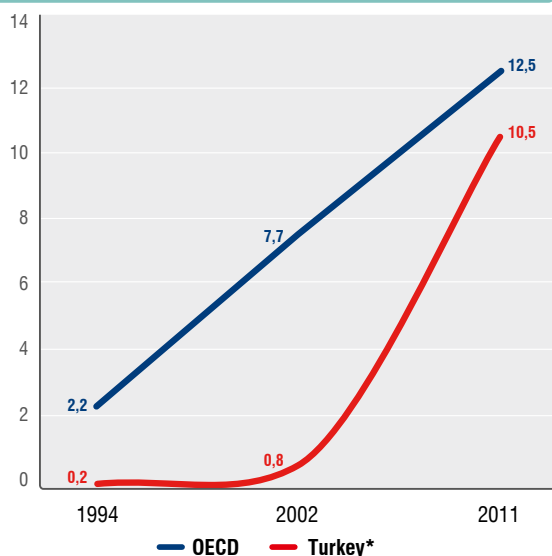
Number of MR Devices



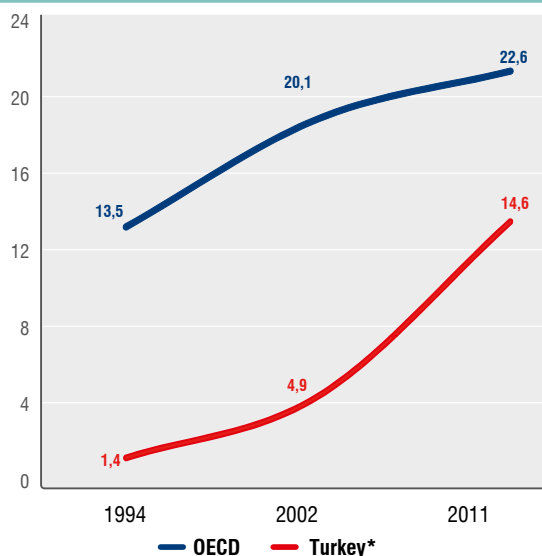
Number of Computerized Tomography



Number of MR Devices per Million Population



Number of Computerized Tomography Devices per Million



Graphic 56,57, 58, 59

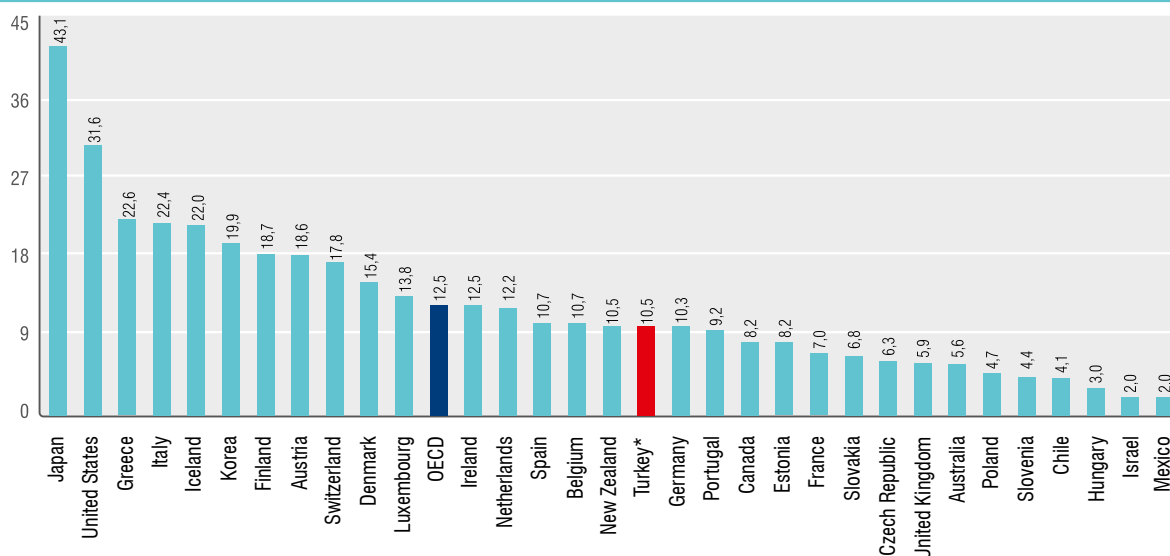
Source: General Directorate of Health Services, OECD Health Data 2012

* Turkey data refer to the year 2011

The claim that the MR and BT devices are in excessive supply in Turkey does not reflect the real situation. While the average of MR devices per one million population is 12,5 in the OECD, it is 10,5 in Turkey. As for the average number of CT devices per one million population, it is 22,6 in the OECD while it is 14,6 in Turkey (Graphic 57-60).



International Comparison of the Number of MR Devices per Million Population in Inpatient Health Care Facilities, 2010

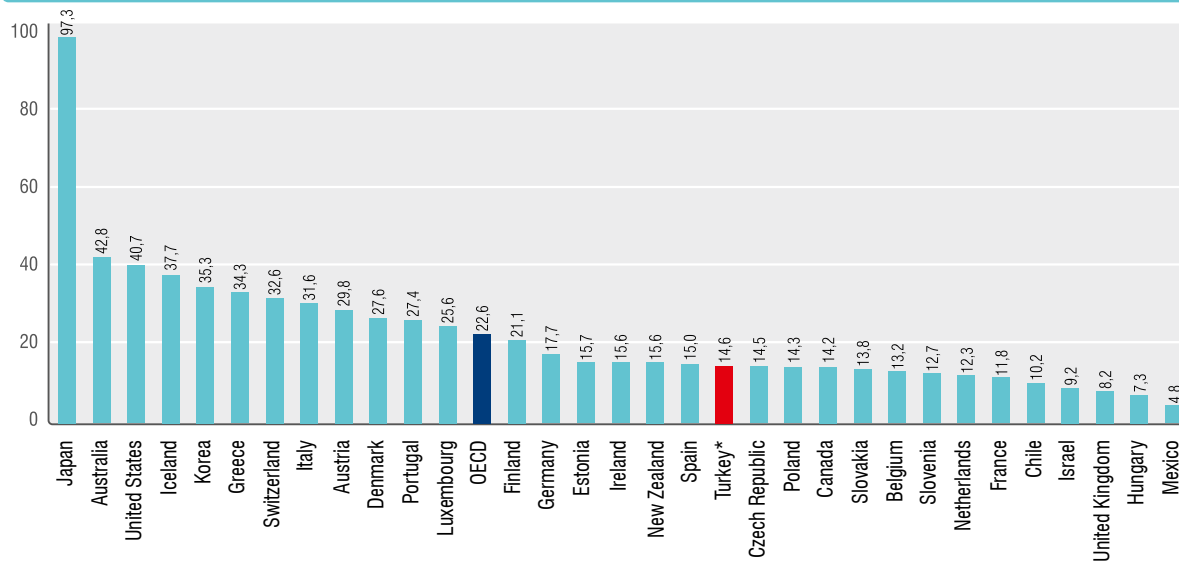


Graphic 60

Source: General Directorate of Health Services, OECD Health Data 2012

* Turkey data refer to the year 2011

International Comparison of the Number of CT Devices per One Million Population in Inpatient Health Care Facilities, 2010



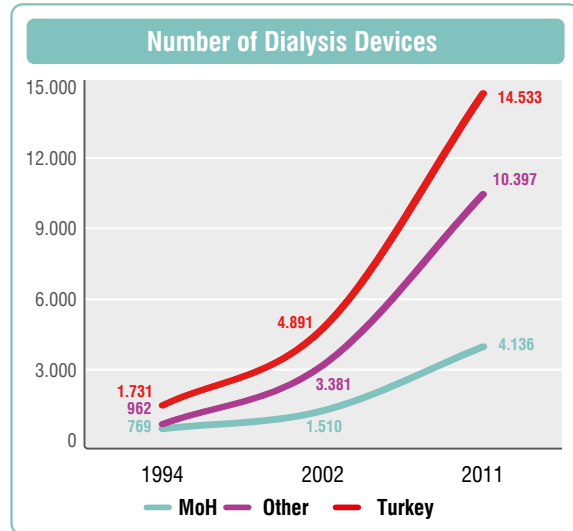
Graphic 61

Source: General Directorate of Health Services, OECD Health Data 2012

* Turkey data refer to the year 2011



The number of dialysis machines was 1,510 in 2002, whereas it increased to 4,481 at the end of 2011 (Graphic 62). The number of hemo-dialysis devices has been increased approximately three times more. Regular and sufficient treatment services are provided to hemo-dialysis patients. In this way, life expectancy of chronic kidney patients is extended substantially in Turkey. For the reason, the number of patients increased from 23,255 in 2002 to 53,576 in late 2011 in dialysis program. The need of kidney transportation is also increased substantially with this positive development.



Graphic 62

Source: General Directorate of Health Services

Today, dialysis patients are taken to hospital from their house and to their house from hospital. No payment is requested for this service.



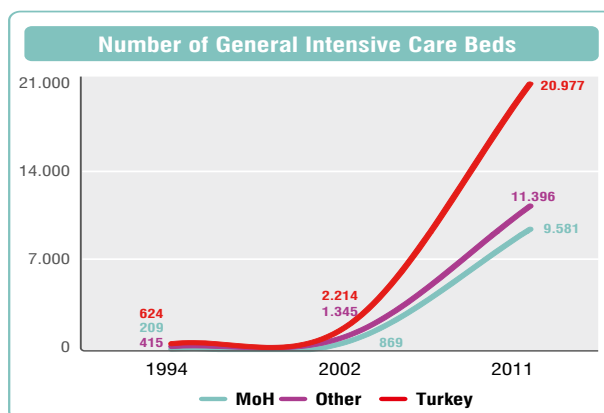
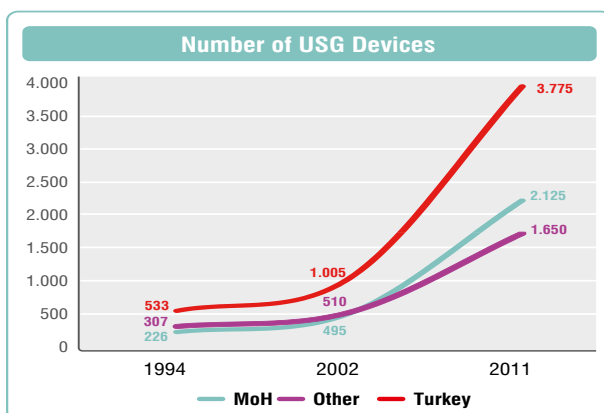


Table 11. Number of Medical Devices in Inpatient Treatment Facilities in Turkey by Years

	Cyberknife			Robotic Surgery		
	MoH	Other	Turkey	MoH	Other	Turkey
2002	0	0	0	0	0	0
2011	3	4	7	3	9	12

Source: General Directorate of Health Services

We increased the number of intensive care beds, which was 869 in 2002, to 9.581 in late 2011, indicating an 11 fold increase (Graphic 64). We provided and put into use a number of high-technology devices (Table 11). So, we equipped our hospitals with modern technology (Graphic 56-59, 62-63).



Graphic 63, 64

Source: General Directorate of Health Services



5. Patient Rights

A. SABİM (Call Center of the Ministry of Health)

We established the SABİM in 2004 to identify problems in health care system and solve them immediately on site and in the fastest way possible.

We give organizational relations service via the SABİM. We respond to individuals' requests for information. We bring direct solutions to problems which people encounter during the functioning of the health care system.

We inform the Ministry of Health management about most recent developments and amendments through the requests of individuals.

Calling the phone number of SABİM (184) for a problem occurred in any process of health care system is activating an auto-control mechanism. An application recorded by SABİM Operators is sent to related provinces SABİM after being evaluated by SABİM Analyzers (Graphic 65). This application is analyzed in the most accurate way by SABİM Analyzers.



Touching People's Lives with SABİM (Communication Centre of Ministry of Health)

We have devotedly replied the calls of our citizens in the last 10 years approximately even if with regard to the issues that are not directly related to our field of interest. We turned into a solution centre contributing to the solution of various problems of citizens.

SABİM is a health communication centre, we aimed at contributing to the solution of the encountered problems in their all aspects with the principle of "not saying no to the citizen. "The following application of a citizen is an example of social and medical support."

Extending a Helping Hand to the Family in Borçka!

(Date of calling SABİM: 23.03.2011)

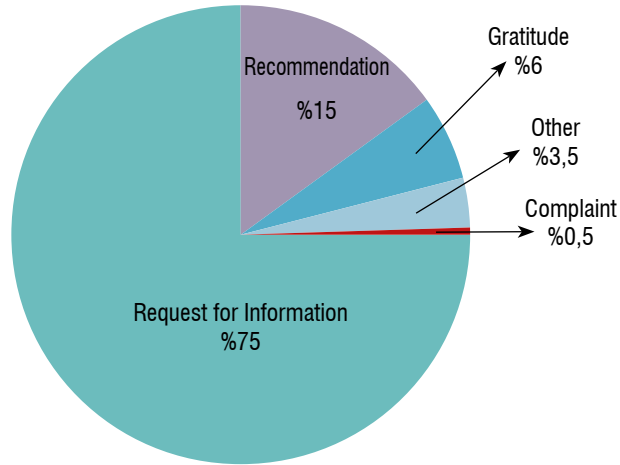
Problem: The person who called SABİM told that living conditions of a family with 8 members living in Aralık village of Borçka district in Artvin were very poor. Moreover, there was a bedridden patient in the family and it was impossible to take care of that patient under those unhealthy conditions. That person asked for help for that family.

Solution: After this issue was communicated to SABİM, firstly, the situation of the family was assessed at home by the health care team. The bedridden patient was provided homecare services. At ordinary conditions, SABİM could finalize the application after providing the health care services. However, social problems of the family needed to be solved. Mayor of Borçka Municipality was met with and the physical conditions of the house were improved and the house was cleaned. Food and financial support was provided by the Municipality. Afterwards, SABİM made an application to Borçka Assistance and Solidarity Foundation and completed the necessary procedures to ensure regular aid support to the family.

The application file was closed after all these needs of the family were met. Moreover, the situation of the family is still followed up.



Rate of Applications to the SABIM (%)



Graphic 65

Source: General Directorate of Health Promotion

B. Patient Rights Unit

We aimed to offer a health service system in which the patient is informed at any stage of treatment process, the patient consent is received, which provides necessary treatment service without making any discriminations and violating patient rights, gives a chance to patient to choose his/her physician and hospital and protects patient privacy sensitively. Thus, we launched Patient Rights Unit in accordance with related legislation in all public hospitals.

Our citizen is notifying his/her demands in writing or orally to patient rights units which we established to provide the right to receive service, and the necessary assistance and remedial actions are made in accordance with patient demands.

Members of the Patient Rights Board consist of the following:

- Chair of Patient Rights Board: Deputy Head Physician
- Supervisor of Patient Rights Unit
- Supervisor of the Personnel Unit
- Representative of Non-governmental Organization engaged in patient rights
- A citizen determined by Governor's Office
- Member of Provincial General Council





- Patient's lawyer (if available)
- Union Representative authorized in public institution in accordance with the Government Union Law no. 4688

How "Patient Rights Unit" operates:

- Complaint reports received by the Patient Rights Unit are delivered to Board Members within one day.
- Information is requested from the personnel reported within one day.
- Personnel shall respond to the Board within two days.
- Responses requested from personnel shall be reported to Board Members within one day at the latest.
- Comments of persons other than Parties (if necessary) shall be given by any member authorized by Board Chair. Comments given shall be reported again to members of board within one day. Board decisions shall be taken by secret voting and majority of votes. Administrative action shall be taken to personnel proved as defective in accordance with related legislation by the Patient Rights Board of Hospital. Decision taken shall be reported to patient by Supervisor of Patient Rights Unit. Patient is informed about next legal process and what he/she can do.

C. Your Right to Choose Your Physician

We formulated and introduced "the right to choose a physician", which is one of the most fundamental patient rights, in 11 hospitals in September 2004. We put "the right to choose a physician" into practice in all hospitals and Oral and Dental Health Centers (ODHC) by late 2010 (Graphic 66).

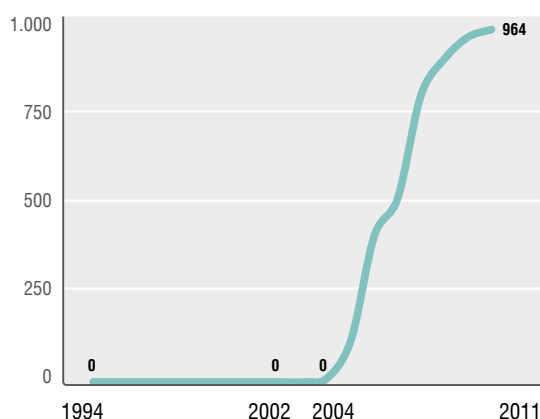
How do patients choose a physician?

- We are preparing lists to inform citizens about examination days and the working hours of physicians.
- We are putting up boards including physicians' name and specialties at the entrance of polyclinics.
- We are publishing general information about physicians on web sites of hospitals.
- We are informing citizens about "the right to choose a physician" through secretaries in polyclinics.
- We are providing screens on the doors of polyclinics in order to show numbers of patient queues.
- With the Central Hospital Appointment System (CHAS), we facilitate getting appointment for patients.



**YOU CAN CHOOSE YOUR PHYSICIAN
IN OUR HOSPITAL**

Hospitals Offering the Right to Choose Physicians and the Number of ODHCs



Graphic 66
Source: General Directorate of Health Services



6. Implementations for the Security of Employees

We have turned the measures we took and the practices we initiated against the attacks against medical staff into a “Programme for Protecting the Medical Staff.” We developed an “Action Plan for the Health and Security of Employees.”



We initiated the White Code implementation. With this implementation, we ensured that the security officers who are closest to the crime scene are rapidly sent there.

We made it compulsory for the health managers to notify the violence incidents. We established the hotline of “ALO 113 White Code” so as to ensure the notification of violence incidents against medical staff. Moreover, we created the website of www.beyazkod.saglik.gov.tr for notification. We increased the number of cameras in hospitals and now we conduct a real time, preventive and close follow up in hospitals except for the private areas.

We ensured that required measures are taken for the security of patients, patients’ relatives and medical staff in emergency services. We established “Committees for Security of Employees” in hospitals and we also established “Employees’ Rights and Security Units” to work with these committees.

We ensure that a criminal case is filed against those who resort to violence against medical staff. We introduced the implementation of legal aid for medical personnel who are the victims of violence, for the first time in the public sector.

We ensure the patients who were previously engaged in any type of violence to be examined in appropriate environments.

We’re establishing specially trained units to provide the sensitive information that may cause tension among the patient and the patients’ relatives. We are informing the citizens via the specially trained personnel in health institutions. Medical staff is provided with training on basic security, communication and stress management.

Citizens are provided with the informative materials on those who are prone to violence, through health institutions, other public institutions and organizations and media. We keep on saying “Love is the best medicine” by increasing our media campaigns.



7. Identifying and Grouping the Roles of Hospitals on an Institutional Basis

A-1 Group General Training Hospitals: General inpatient healthcare institutions, which are authorized by the Ministry to provide training in at least five branches as per legislation and assigned training cadres accordingly and which provide tertiary level treatment and rehabilitation services, conduct training research activities and train specialists and subbranch specialists, are classified as A-1 Group Hospitals.

A-1 Group Subspeciality Training Hospitals: This group includes branch hospitals which hold training and research hospital status and meet the following criteria;

1. To have training and research hospital status,
2. To have tertiary level intensive care and/or newborn intensive care units as required by its field of specialization,
3. To provide tertiary level emergency services in the branch and/or branches required by its field of specialization,
4. To establish Training Planning and Coordination Board.

A-2 Group General Hospitals: General hospitals located in provinces with regional health centre status or in provinces that are attached to these centres; which do not have training and research status and meet the following criteria are classified as A-2 Group Hospitals:

1. To serve as secondary inpatient healthcare facility in provinces with regional health care status (e.g. Erzurum) or in provinces with sub-regional centres attached to these centres (e.g. Erzincan, Bayburt, Ağrı, Iğdır, Artvin, Ardahan and Kars),
2. To have 6 and more specialist physicians for at least the following four branches of internal medicine, general surgery, gynaecology and obstetrics and paediatrics each (except for the settlements that have hospitals on the related branches) and to be able to separately assign physicians on-call/duty for emergency branches,
3. To have the capacity to accept and provide treatments for extremely ill and highly risky patients; and to accept and treat the patients with complicated problems,
4. To have tertiary level emergency services,
5. To have tertiary level intensive care units,
6. To be able to meet the needs for examination, treatment and imaging services required in line with the status of the hospital within the institution or by outsourcing the service.

A-2 Group Subspeciality Hospitals: All branch hospitals lacking training and research hospital status are classified as A-2 group branch hospitals.



B Group General Hospitals: A General hospitals which are not included in A-1 and A-2 Group hospitals, which are located in strengthened districts or in general hospitals in provincial center and classified as B-Group hospitals should meet the following criteria.

1. To be located in provincial center or strengthened district center,
2. Capacity to assign physicians on-call/duty from its pool for emergencies in internal medicine and surgery branch on 24-hour basis.
3. To have at least secondary level emergency and secondary level intensive care units.

C Group General Hospitals: C group includes the general hospitals classified according to the below listed criteria.

1. To be located in strengthened districts or smaller districts connected to district centers strengthened under health region planning,
2. To have specialists in four major branches and specialists in minimum two additional branches,
3. To have at least primary level intensive care unit and primary level emergency department.

D Group General Hospitals: This group includes general hospitals with minimum 25 patient beds and located in strengthened districts or smaller districts connected to district centers strengthened under health region planning and which meet the following criteria:

1. Under the four major branches; to have minimum one specialist planned for each branch and more than one specialist including the family physician,
2. Under the existent specialties; to provide specialist level polyclinic examination services and specialist level follow-up and treatment of hospitalized patients,
3. To provide emergency healthcare services within the primary level emergency service setting,
4. To have an operating room, post-operative recovery room, dental polyclinic, delivery room, observation room with monitor,
5. Capacity to structure dialysis unit according to the needs.

E Group Hospitals: E-Group hospitals are the integrated district hospitals with less than 25 patient beds. Diagnosis and treatment services are provided in the same setting with primary care in these institutions.



8. Triage and Registration at Emergency Departments

“Communiqué on Rules and Principles of Emergency Service Provision in Inpatient Healthcare Facilities” was enforced following its publication in the Official Gazette No.27378 of October 16th, 2009.

The communiqué applies to all emergency departments, emergency polyclinics and units providing services in public and private inpatient healthcare facilities.

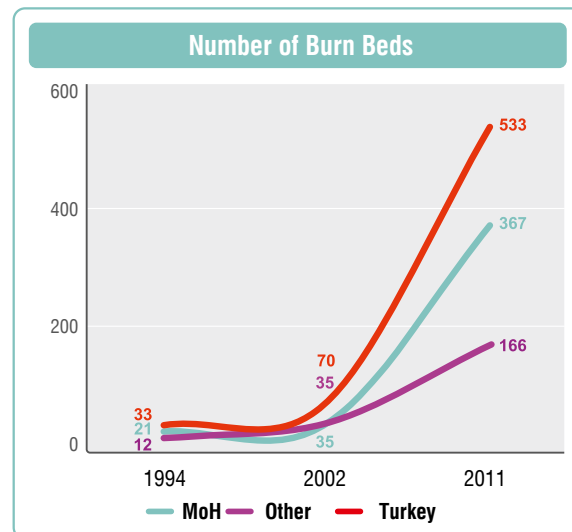
We initiated the restructuring process by defining the minimum personnel and service criteria, physical conditions and ease of transportation, minimum standards regarding materials and medical technological equipment in the communiqué. We put into practice patient triage and color coding system at emergency health services. We made regulations for emergency call services in order to provide emergency departments to 24 hours uninterrupted service at specialist level. We have provided an effective coordination between 112 Emergency Health Care Services and emergency departments of hospitals.

We started to undertake triage and registration in all emergency departments across Turkey according to their compliance with standards in line with the communiqué. We registered 92 % of inpatient health care facilities of private sector, universities and the MoH by December 2011.

The registration process is continuing for health care facilities which asked for time extension in order to remove their shortcomings and restructure their physical conditions. We are planning to complete the registration procedures by late 2012.

9. Restructuring in Burn Treatment

Due to the fact that burn patients are susceptible to infections and other secondary problems, they need special care and attention. When the Health Transformation Program was first initiated, there were only 35 burn beds in the MoH hospitals. By the end of 2011, the number of burn beds in the MoH hospitals rose to 367, accounting for a total of 533 burn beds countrywide (Graphic 67). The number of burn beds in the MoH hospitals increased by 10,5 folds in comparison to 2002. We put into service the MoH Kartal Burn Treatment Hospital for the first time in 2009 in Istanbul.



Graphic67
Source: General Directorate of Health Services



10. Prevention of Hospital Infections

Despite the developments in medicine, hospital infections are an important health problem all over the world. Hospital infections might cause deaths if they are severe, and they pose a great threat especially for patient safety and health professionals, visitors, non-health professionals and public health. By taking measures, it is possible to decrease the frequency of hospital infections, which bring a financial burden to the country's economy by extending the patients' length of hospital stay.

Hospital infections pose an important problem in our country as well. Despite the fact that serious studies have been undertaken in the developed countries on hospital infections for the last 50 years, except for the studies of the relevant specialty fields on the issue, the studies and administrative support in our country were insufficient. Under the MoH, we began to work and study in this field in September 2004. We have carried out the works and studies in line with the opinions and decisions of "Hospital Infections Scientific Advisory Board", which is composed of experts of the field from various schools of medicine and training and research hospitals.

We provided legal support needed for many years by invoking "Regulation on Infection Control in Inpatient Healthcare Institutions" published in the Official Gazette No. 25903, dated 11.08.2005 in order to regulate principles and procedures regarding to duty, authority and responsibilities of the infection control committees which carry out works in the field of prevention and control of healthcare related infections in inpatient healthcare institutions. We continue our works and studies on the basis of implementing this regulation.

Today, infection control committees carry out activities in all inpatient healthcare institutions in accordance with Regulation.

One of the important tools for improving the quality of service delivery is to train sufficiently-qualified human resources required for service provision. In accordance with the relevant Regulation, all inpatient healthcare institutions are obliged to assign an infectious diseases and clinical microbiology specialist per thousand beds as the infection control physician (preferably having a national/international certificate). They are also obliged to assign one of their nurses holding infection control nursing certificate, issued by the MoH, as the infection control nurse per two hundred and fifty beds. We certified 527 infection control physicians and 1.063 infection control nurses with national certificates by the end of 2011 through infection control trainings conducted since 2007 up to the present. We prepared "Hospital Ventilation and Control Guide" with the efforts of the Scientific Advisory Board. As a result of our serious studies in the field of hospital infections, we have been able to reach national data and develop national policies since 2006.



As per the relevant Regulation, hospital administrations are obliged to submit their annual activity reports, including hospital infection rates and surveillance results, to the MoH no later than the end of February each year. With the support of the Scientific Advisory Board, the MoH developed “National Hospital Infections Surveillance System” in order to collect hospital infection data in a single center, to analyze the data and provide feedbacks, and to develop policies for the prevention and control of hospital infections. In this way, we determined “Hospital Infections Surveillance Standards” with the support of the Hospital Infections Scientific Advisory Board and we notified all hospitals about them.

Moreover we published “Safe Practices for Total Parenteral Nutrition Guide” in order to help decrease hospital infections by standardizing the current and future Parenteral Nutrition units in hospitals and increase the service quality of the institution.

We have collected the latest hospital infection data in accordance with international standards and analyzed by using web-based “National Hospital Infections Surveillance Network (NHISN)” developed under the MoH and opened to public access in August, 2007. Hospitals enter NHISN by using the passwords provided by the MoH, and reach their own hospital infection data. We obliged all inpatient treatment institutions of the MoH to join NHISN in May 2008. Today, we can access infection rates and frequency of resistant microorganisms of 1.019 inpatient healthcare institutions over NHISN, except day hospitals.

Within the scope of “Health System Performance Assessment in Turkey” carried out by the MoH in cooperation with WHO, one of 42 indicators chosen in accordance with data quality is surgical site infection rates. Today, we have the most developed surveillance system in EU countries. The quality level of data that we obtained is comparable with data of the United States of America. The development we have reached in the last five years is equal to the one which developed countries have reached approximately in fifty years.

11. Central Hospital Appointment System (CHAS)

CHAS is an implementation through which patients can dial the Call Center 182 in relation with the Oral and Dental Health Centers and get an appointment from the hospital and physician they choose through real-time operators.

The objectives of CHAS are as follows:

- To shorten the queues at hospitals and to increase the citizen/patient satisfaction through better planning of resources at hospitals (efficient and effective planning of work force and equipment use).





- To increase the efficiency and quality in the provision of health services through the measurement of resource use and distribution at hospitals; efficient and effective implementation of work force, use of machines and equipment use,
- To provide assistance to development of health policies through CHAS data.

We generalized the CHAS in 2011. Also we enabled online appointment via the CHAS. About 200 thousand citizens get their hospital appointments through the CHAS per day, which refers to 24 % of all medical consultations.

12. Home Health Care Services

We are providing qualified, effective and accessible health care service for bedridden patients in their own homes under home health care service provision. In addition, we are reducing the costs of healthcare services by preventing unnecessary use of hospital beds.





Services Provided by Home Health Care Units:

- Examination and Consultation Service,
- Nursing Services,
- Laboratory Services,
- Preparing Health Board Report – Renewing Expired Reports,
- Prescribing pharmaceuticals to be taken with Health Board Report,
- Procurement of Medical Devices and Equipments and Allocation to Use of Patients by debit,
- Rehabilitation, Education and Support Services,
- Oral and Dental Health Care Services for the Patients under Home Health Care Services.

13. Planning for Cardiovascular Surgery (CVS) Centers

Our population is expected to increase by 13 % by 2023. Moreover, population growth rate of aged 40 and above, considered to be under risk for coronary heart disease, is expected to constitute 40 % of the whole population due to the aging matters.

According to the number of patients with cardiovascular disease might increase. Even if the increase is prevented, service access should be facilitated for these patients. Therefore, we are carrying out works and studies to prepare a national plan in line with the National Heart Health Policy.

Under the scope of regional health planning, we have planned to establish cardiology and CVS centers to operate 7/24 in 26 provinces. We started our works with the support of 7 coordinator hospitals. We organized training activities for relevant personnel in the said 26 provinces and we have almost completed trainings. Now, we have provided to CVS services in 43 centers established in 21 provinces by the end of 2011. Today, CVS services, which require such advanced technology and team-work, are provided to our patients at CVS centers in their neighborhood.

In CVS centers, at least 6 CVS specialists are working and there are 5 inpatient intensive care services (tertiary level) and 10 inpatient care services.

We aim to achieve a diagnosis in the earliest time to a patient suffering heart attack and provide a cardiologist and internal specialist in 90 minutes and start medical intervention by the right specialist.



14. Blood Services

We started to establish reconstructing regarding the blood service units in Turkey with the Law no. 5624 on Blood and Blood Components enacted in 2007. The MoH assigned the Turkish Red Crescent (KIZILAY) for the collection and distribution of blood, except for emergencies. Regional structuring is carried out by Red Crescent across the country with the support of the MoH. Having established 15 Regional Blood Centers and 56 Blood Donation Centers, Red Crescent supplies safe blood through the Transfusion Centers in hospitals. In the transition period, the infrastructure of the Red Crescent was completed and the blood transfusion centers at hospitals having high blood use ratios were licensed as Temporary Regional Blood Centers (TRBC). While there were 84 TRBCs in 2010, the number was noted as 58 in 2012. As the Red Crescent completes its infrastructure and meets the blood transfusion needs of the hospitals, the TRBC figures are revised on yearly basis. In order to ensure the supervision of blood service units and enforcement of the Law on Blood and Blood Components, we have organized Supervisor Training to 213 healthcare personnel from all provincial health directorates of the country and physicians with experience of blood banking.

We have organized campaigns with the involvement of non-governmental organizations in order to underline the importance of blood donation and raise awareness about blood donation in the society. As a result of these efforts, trainings and briefings with Red Crescent, we increased the amount of blood donation, which was 326,337 units in 2002, to 1.276.211 in 2011. This way, we have prevented our citizens from running from pillar to post in order to find blood and blood components in emergencies. In addition, we have prevented wasting of blood components which are so valuable.

15. Organ Transplantation Services

In all of kidney transplantation centers throughout the country, data of the individuals waiting for transplantation have been registered to National Organ Waiting List of the MoH.

In the past, only registries for patient waiting for kidney transplantation and cadaver donor allocations were carried out by National Coordination Center of Organ Transplantation (NCC) on the basis of these registries. We generated Organ Transplantation Information System including data of all organ transplantations from living and cadaver donor (kidney, liver, heart, pancreas and small intestine) throughout the country and data of patients waiting for organ. This system is primarily followed by organ transplantation centers, regional coordination centers (RCCs) and NCCs.



Organ transplantation is the only treatment method in terms of transplanting some kinds of organs. Solution cannot be found for some liver and heart chronic diseases which do not have any alternative treatments such as dialysis, if an organ isn't found; patients could lose their lives in a short time.

This situation underlines the importance of increasing organ donation and cadaver donor organ supply for organ and tissue transplantation services. One of the most effective ways to shorten the waiting period for organ transplantation is to increase the number of brain-death notifications and cadaver organ donations.

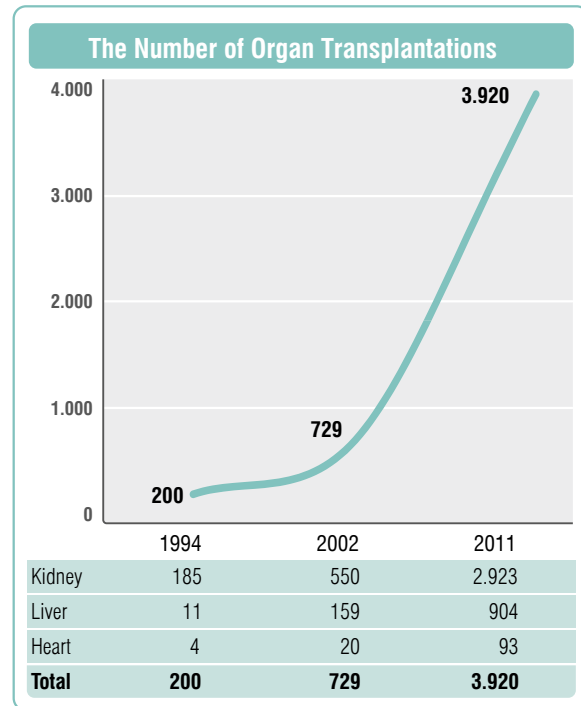
9 RCCs in Istanbul, Izmir, Ankara, Adana, Antalya, Samsun, Diyarbakır, Erzurum and Bursa are performing cadaver donor organ allocation in coordination with NCC of Organ and Tissues Transplantation, which they belong to. We are also using the MoH ambulance airplanes to supply organ from cadaver to patients. We opened Kidney Transplantation center in 62 hospitals, liver Transplantation Center in 42 hospitals, Heart-Lung Transplantation Centers in 16 hospitals with certify to public access by granting license to them.

In 2011, we identified the criteria related to composite tissue transplantations.

16. Tissue and Cell Transplantation Services

We put into service the Bone Bank (Atatürk Training and Research Hospital) and the Tissue Bank for Musculoskeletal System (Ankara University) in order to provide tissue required for institutions and organizations working in the field of organ and tissue transplantation services throughout the country.

We have granted new licenses to increase the number of tissue typing laboratories which are very important in organ and bone marrow transplantation services and provide rapid tissue typing in every region. In this way, we have increased the number of tissue typing laboratories to 32 throughout the country.



Graphic 68
Source: General Directorate of Health Services



In our country, suitable donor cannot be found; as a result of this the number of bone marrow transplantation is limited with 2 thousand people when it shall be approximately 4 thousands in proportion to our country population per annum. More than 2 thousand people wait for transplantation every year. Donors are mostly nonrelative persons in bone marrow transplantations, and most of the bone marrows may be obtained from abroad.

International surveillance is done to find a suitable bone marrow as the number of donor is less than 40 thousand in Turkey. Suitable bone marrow which is found through international donor surveys is procured by SSK and thus, it makes life easier for patients waiting for bone marrow. We increased the number of transplantation centers by giving a permission and license to new centers in order to provide active transplantation centre in each region and improve service provision. There are 53 transplantation centers in total 17 of which are pediatric and 36 are for adult by December 2011.

We took place among the leading countries in the world by allowing mesenchymal applications in line with scientific criteria in Graft Versus Host Disease (GVHD) cases in stem- cell field. In Ankara University, an experimental treatment of spinal cord injury was performed on 10 patients through a study that we empowered.

We increased the number of eye banks to 19 in order to augment the number of cornea obtained from cadaver donors and reduce the number of patients waiting for cornea. In addition, we also increased the number of corneal tissue obtained from cadaver by implementing the plan of connecting tissue source centre to each eye bank.

Turkey Stem Cell Coordination Centre (TÜRKÖK)

In order to prevent the controversies on stem cell treatments and stem cell which gained importance in recent years, TÜRKÖK was established and put into action. The followings are targeted:

- Developing international standards ,
- Gathering the coordination of centers regarding the transfer of hematopoietic stem cells under one roof,
- Performing works for increasing the number and capacity of the centers,
- Ensuring regular data flow from centers,
- Analyzing the collected data and detecting the shortages of centers,
- Performing works to determine the quality control and standards of centers,
- Through the establishment of “National Bone Marrow Bank” and “Cord Blood Bank for Non-kin Transplants” , decreasing the treatment expenditure for the patients, to whom hematopoietic stem cell will be transferred,



- Ensuring the coordination for supplying hematopoietic stem cell for the patients who are waiting for the transfer through screening the cordon blood donated to National Non-relative Cordon Blood Bank and by voluntary donors in Turkey with various HLA-typing,
- Ensuring the coordination for supplying hematopoietic stem cell, in the shortest time, from the banks abroad for the patients who are waiting for the transfer, but for whom voluntary local donors can't be found in Turkey,
- Obtaining 250,000 registered voluntary donors with various HLA-typing from many different geographical regions of Turkey until 2013,
- Obtaining 50,000 cordon blood donations in total until 2013,
- Establishment of "Regional Coordination Centre", at first step, in 29 health regions in order to reach the targeted number of voluntary donors,
- Establishment of "Voluntary Donor Centre" at required number to be determined according to the findings of Region Coordinators,
- Establishment of National Non-relative Cordon Blood Bank and cordon blood collection centers (cordon blood donations from the MoH, universities, foundations and private maternity hospitals),
- Starting the accreditation process and ensuring the integration and coordination of hematopoietic stem cell centers with international institutions such as European Marrow Donor Information System (EMDIS), Bone Marrow Donors Worldwide (BMDW), The World Marrow Donor Association (WMDA), European Group for Blood and Marrow Transplantation (EBMT),
- Completing the trainings and certification activities of personnel working in all centers,
- Meeting all establishment costs and having a capacity to meet operational costs without getting any additional allowance until 2013,

17. Replantations

In cases in which limbs or part of limbs is damaged as a result of accidents or similar reasons, sewing up the severed limb in a short time is very important and this intervention may take several hours. A problem in replantation applications is caused due to the lack of coordination between health institutions for referring the case to suitable center and the shortcomings in organizations.

Applications of replantation in deficient and unauthorized centers have negative consequences such as losing a limb.



In the past, patients who applied to hospital with their own means for complicated hand injury or amputation had to run from one hospital to another due to the fact that they were not informed well or were sent from hospitals without being stabilized and also patients referred to via 112 Emergency Health Care Services had waste of time due to challenges in finding appropriate health center. This loss of time caused delays in taking the patient into operation and irreversible losses concluded with patient's permanent disabling due to lack of coordination.

We made region-based planning in order to carry out replantation applications in a widespread and effective way throughout the country. We have developed guidance algorithm to these centers for emergency complicated hand injuries and amputation cases and we launched it in Istanbul at first step. We authorized and conferred responsibilities to 112 Emergency Health Care Services Command and Control Center for implementing and carrying out this algorithm delay-free. We will have extended this implementation gradually until the end of 2012 throughout the country.

Today, replantations are performed with an annual average of approximately 1000 applications. The number of micro-surgeries applied with complicated hand injuries is around 4600. 168 plastic and reconstructive surgeons and traumatologists and orthopedicians have sub-branch specialty degree in hand surgery and wWe are planning to increase this number to 300 when relevant studies and works on giving sub-branch specialties to plastic surgery and orthopedic specialists are completed.

As a result of our works, we have prepared a list of centers capable of replantation applications in public and private sector. Today, we have provided treatment capacity for complicated hand injuries and amputations in university hospitals, private hospitals and the MoH hospitals from 22 provincial centers. Ensuring proper coordination of this capacity, we can provide timely Access to these centers for individuals. Health care facilities also including private ones do not charge fee from patients for intervention.

18. Traditional, Complementary and Alternative Medical Practices

Traditional, complementary and alternative medical practices are often performed in our country and in the world.

With the Decree Law No. 663 and Dated November on the "Organization and Tasks of the Ministry of Health and Affiliated Agencies", we established the Department of "Traditional, Complementary and Alternative Medical Practices under the General Directorate of Health Services .



With the restructuring, we aim to standardize and describe the implementation methods of approaches proved to be curative scientifically, to certify the relevant trainings and qualifications of practicers, to identify their responsibilities and to inspect practices.

As the Ministry of Health, we make plans and regulations on the applicability of traditional, complementary and alternative medical practices in compliance with scientific, professional and ethical principles.

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

3. Pharmaceuticals and Pharmacy



1. New Era in Drug Price Policies

One of the leading findings about drugs considered while forming the Health Transformation Program was that drug prices and also the increases in prices were not evidence-based in the past. The MoH is responsible for determining the relevant norms and standards about drugs and pharmaceutical services on behalf of the public. It is also entitled and obliged to carry out inspections in the program and encourage rational drug consumption in cooperation with other relevant institutions and organizations.

As for drug pricing, the program clearly emphasized the need for developing a method mutually agreed by all parties. We have eliminated all the disturbance and negative aspects and put drug pricing under the light of transparency with the “Decree on the Pricing of Medicinal Products for Human Use” of 2004. Thus, we reduced prices significantly and brought down to the lowest level in Europe. We made reductions ranging from 1 % to 80 % in approximately a thousand products. Additionally, we contributed to the sustainability of price reductions with “reference price monitoring”. We monitored price changes in reference countries in three-month periods and the price reductions, if any, we reflected in the prices in our country.

In order to relieve the burden on Public Finance, we established a Reimbursement Commission and we launched “Single Reimbursement System” under the leadership of the MoF. With the consensus of the reimbursement institutions, we laid down the rule that prescribed medicinal products will be reimbursed on condition that their price is not higher than 10% of the cheapest equivalent drug

With this practice, the firms manufacturing the drugs that remain out of this circle have voluntarily reduced their prices in order to benefit from the reimbursement system. Eventually, we have achieved a significant saving for public finance.

We reduced the VAT rates for drugs from % 18 to 8 % and we provided another outstanding decline in drug prices.

We laid down the rule “When a generic of an original product has been marketed, the price of the product may not exceed 60 % of the current market price (both for the original and the generic product)” by another radical amendment in “Decree on Pricing of Medicinal Products for Human Use” in 2009.

The reductions in price made by Social Security Institute have also decreased the cost borne by the public for medicinal products. As the Government, made investments out of our gains that we achieved as a result of our resolutions and eased the access to medicines.



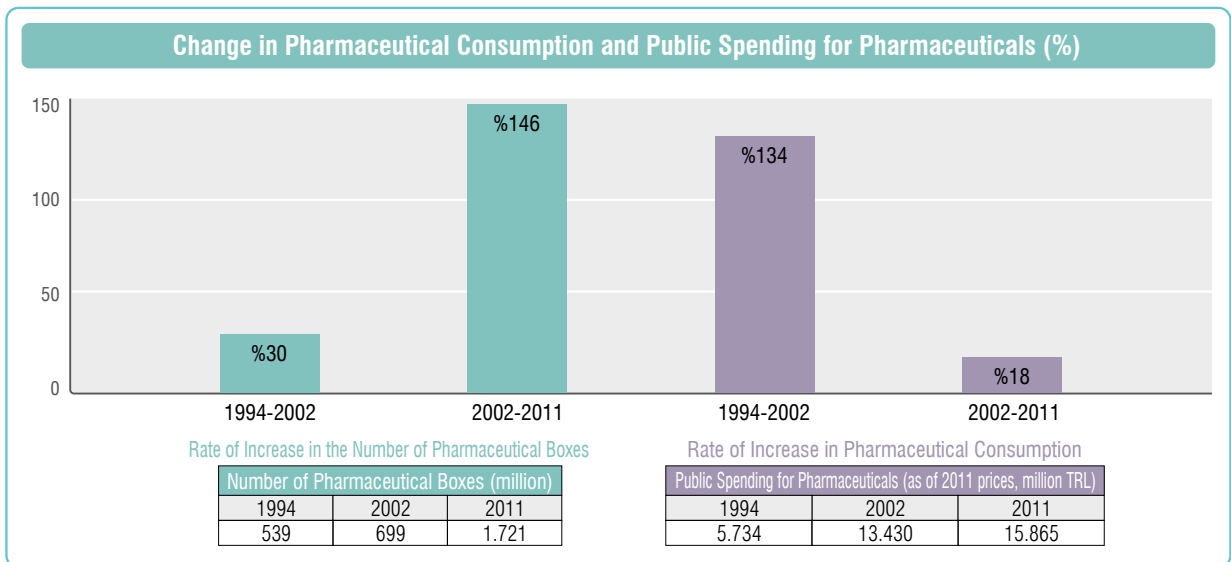
2. Opening Pharmacies to Everybody

We eliminated obstacles preventing our citizens (particularly SSK enrollees and Green Card holders) from accessing drugs through the reductions in drug prices were directly reflected to our citizens. Within the course of the Health Transformation process, decisive steps were taken to ensure easy and economic access to drugs and the result of those steps are observed by the public very closely.

People insured by SSK, who could obtain their drugs only from a limited number of hospitals, some of whom could not obtain their drugs from SSK and had to pay out of their own pockets, we have provided them to be free to obtain their drugs from the pharmacy of their choice like other Turkish citizens. We amended the Green Card legislation to cover the provision of outpatient treatment to Green Card holders and allowed these citizens to supply their drugs from the pharmacy of their choice.

With all these practices, we eliminated the discrimination among citizens that previously prevailed in the health care system.

3. Drug Consumption



Graphic69

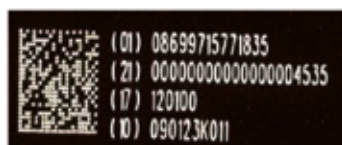
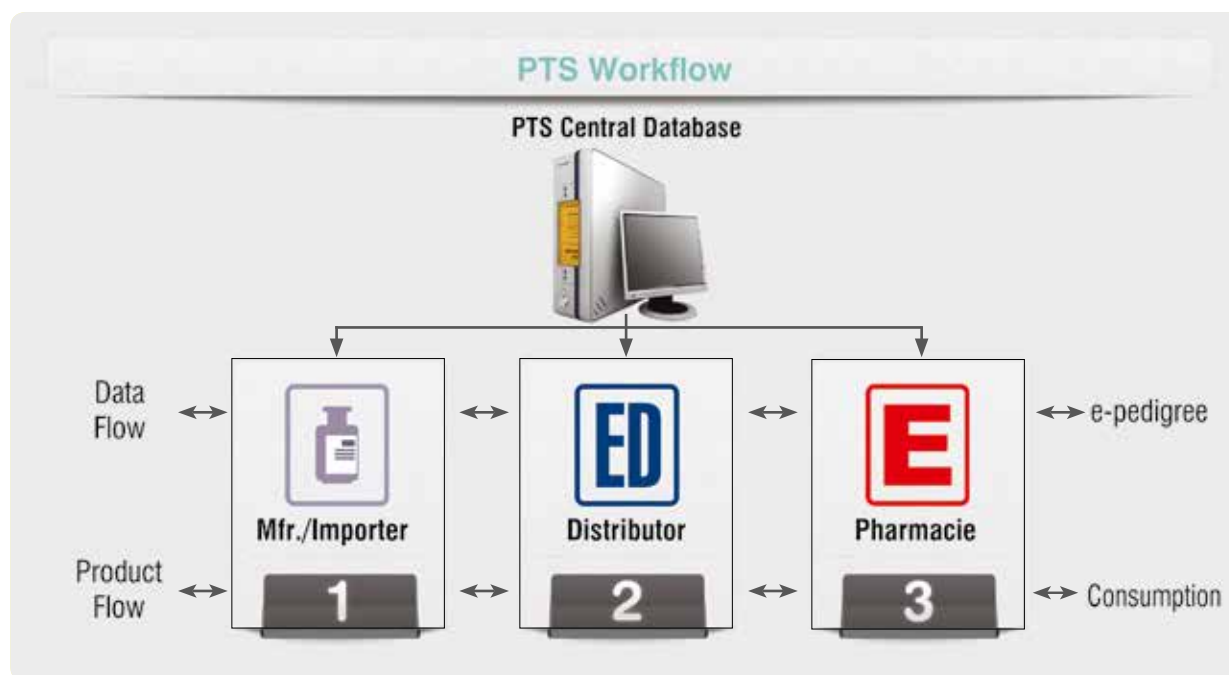
Source: Turkish Pharmaceuticals and Medical Devices Agency

The amount of drugs paid by the public sector reached 1 billion 720 million boxes in 2011, with an increase of 146 % from 2002. During the same period, public spending on drugs increased from 13 billion 430 million TRL to 15 billion 865 million TRL with 2011 prices and has increased by only 18 % (Graphic 69).

We have used this saving on drugs to facilitate the access of our citizens to drugs as mentioned above.



4. Pharmaceutical Tracking System (PTS)



“Pharmaceutical Tracking System”, known as PTS, defines an infrastructure that was established to trace each unit of pharmaceuticals in Turkey. PTS is another form of the structure defined as “Track & Trace” in literature and applied to pharmaceuticals. Ensuring the serialization of products, square code is used to ensure tracing of the products; and tracing of them is ensured through the notifications to the central database from each point where the pharmaceutical is passed.

Production of high-quality pharmaceuticals, distribution and storage of them by considering the quality conditions are among the duties of the MoH. PTS is primarily designed to contribute to the aim of on-site detection of problems that might occur in the quality of pharmaceuticals and for rapid response. Through the developed system, all pharmaceuticals in the market are registered with a tracing number on box basis and it is ensured to trace them in each stage from production to consumption.

Thus, corrupt practices regarding the drug clippings are prevented, and it becomes almost impossible to find counterfeit and unregistered drugs in the market. In addition, for the pharmaceuticals which were put on the market, in any condition that might emerge afterwards and might expose threats to public health, it would be possible to know where exactly each pharmaceutical is and it would be ensured to collect them easily.



PTS that we put into practice in Turkey took its place in the literature as a system connected to a “Central Database” which was introduced for the first time in the world. As of 1 January 2010, we obliged the existence of square codes on drugs and their notification to the system by their manufacturers/importers for all products. As of 1 July 2010, we closed down clipping-cutting procedure at pharmacies, and the products began to be sold by being notified to the PTS. All reimbursement institutions began to perform their pharmaceutical payments by checking them over the system. In addition to these, we have included hospitals in the scope of the tracking system and began to follow the products which entered the hospitals.

5. Rational Drug Use

Unnecessary and improper use of drugs is still a serious problem affecting treatment costs and public health both in our country and rest of the world. Thus, training and raising awareness of health professionals and public on rational drug use is very important.

Drug is effective but only if it is used properly. However, unfortunately 50% of drugs have been prescribed, sold and applied inappropriately as WHO mentioned so many times. More than half of patients cannot reach drugs properly. Unfortunately, there are serious problems in tracking drug use in many countries. This also makes it difficult to access the accurate data.

According to definition of WHO, rational drug use is; “obtaining the appropriate drug in suitable duration and dosage, at the lowest price and with ease according to the clinical findings and personal characteristics”. Thus, we can identify the principles of rational drug use as;

- Being based on true diagnosis.
- Choosing the appropriate drug; prescribing it in suitable dosage and in suitable way within the scope of treatment plan and using it in suitable duration.
- Measuring the success of treatment; monitoring side effects and patient compliance.
- Measuring drug interactions if more than one drug is used.
- Considering effectuation and cost of treatment.

We established Department of Rational Drug Use in order to extend principles of rational drug use throughout the country in 2010.

We planned the methods to be implemented as short, medium and long-term ones in order to raise awareness of public and health professionals and provide information to them on this issue.

We made the pharmaceutical prospectuses easily understandable. We ensured that people could easily understand any information on the pharmaceuticals consumed.

Strategies are needed to activate the utilization of resources considering the continuous increase of health expenditures based on demographic, social and economic reasons.



Projects to be carried out will provide not only savings on health expenditures but also a positive public health development. Responsible people in this field shall have sufficient knowledge and opinion to develop understanding of rational drug use.

Our strategies in rational drug use

1. Raising public awareness and consciousness.
2. Carrying out periodic assessment and evaluation to determinate the validity of methods to be implemented.
3. Including rational drug use in curricula of primary education.
4. Including program for rational drug use in curricula of medical and pharmacy faculties.
5. Preparing diagnostic treatment guidelines.
6. Transforming Updated Diagnosis and Treatment Guidelines into e-guide.
7. Providing web based accession to Drug Guidelines of Turkey.
8. Protecting principles of rational drug use in medical congress and including a session in this respect.

Today, we achieved the goal of “at the lowest price and with ease” which is one of the items in rational drug use definition of WHO. There are milestones need to reached for remaining items in relevant definition. We aim to make rapid progress in this field.

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

4. Health Information System



1. E-Transformation in Health: National Health Information System (NHIS)

National Health Information System (NHIS) which is one of the main components of the Health Transformation Program is one of the significant phases of the reforms we put into practice. We have developed national standards in health information systems through this programme and thus we have established an effective information system framework.

In NHIS, citizens can individually access their health information. Registries start from the prenatal period and cover all stages of life. The system has a fast communication backbone covering the whole country and it also allows the medical image transfer. On the other hand, it is also possible to register the manpower, movables and immovables, administrative and financial data of the institutions and organizations providing health care services, through this system.

Main goals of e-Health Projects can be summarised as follows:

- Ensuring the health data standardization
- Establishment of data analysis support and decision support systems
- Acceleration of data flows between e-Health stakeholders
- Creation of personal electronic health registries
- Ensuring resource savings and increasing efficiency
- Supporting scientific activities
- Acceleration of national adoption of the e-Health concept

2. E-Health Implementation in Turkey

A. Health-Net

Health-NET is an integrated, safe, fast and expandable information system which aims to improve efficiency and quality of health services by collecting all kinds of data produced in the health institutions in line with the standards and generating information adequate for all stakeholders out of the collected data. In other words, it is a health data banking model where personal health data of all citizens are registered in a central structure. It has a safe communication backbone with a high-bandwidth. It intends to enhance efficiency and quality in all health systems.

Health-NET collects sufficient data for determination of problems and priorities, taking measures, planning sectoral resources and investments and assessment of the quality of health service delivery in health sector and processes these data.



Health-NET consists of 3 main components. These components are National Health Data Standards (NHDS), Health Coding Reference Dictionary (HCRD) and web services.

Main features of the Health-NET infrastructure are as follows:

- It is able to transfer standard data from various softwares of health institutions.
- It has a decision support system that can access information on burden of disease, health expenditures, demographic analysis and all other necessary information.
- It follows and reports the indicators shared with international organizations (WHO, EUROSTAT, OECD).
- It allows for international data exchange within the framework of the relevant legislation.
- It enables the citizens to access and manage their health registries.
- It rapidly reaches information through early warning systems.

A.1. National Health Data Dictionary (NHDD)

As information becomes more important each day in the globalised world, the need for accurate information also increases. Many international standards are being developed especially in health informatics field. These standards establish rules with regard to the method to be followed during the phases of definition, transfer, storage, protecting confidentiality and analysis of data.

Firstly, we initiated the efforts for NHDD development activities for data standardization.

It is critical to define, classify and measure the data for the correct management of health services. The data to be collected should be defined before establishing a health information system. A standardized structure will enhance the data collection quality, decrease the repetitive and incorrect data and ensure proper use of the collected data. Unity of concepts will be ensured with this structure and integrity, accuracy, reliability and consistency will be enhanced.

We analyzed various health information systems in NHDD analysis activities and looked into the type of data produced by various units and the type of information required in the decision mechanism. We have also gone through the statistics compiled for the World Health Organization, EUROSTAT and OECD.

The most important function of NHDD is to create the basis of “interoperability.” Therefore, we took into consideration the following criteria while including new data element in the dictionary:

- Whether it can be used for the purposes of policy development, monitoring, evaluation, inspection, statistics, analysis and reporting
- Whether it useful for obtaining other information or not,
- Whether it is a data which should be included in the patient file or not.



- Whether it is a data that the physician needs to rapidly reach in electronic, environment or not, even if it is required to be included in the patient file,
- Whether the data to be included in the dictionary is required to be entered and recorded by the physician in the information system or not.

NHDD is a cluster of standards where the data is defined in line with the national and international standards, all health information systems are used as reference and the unity of terminology is ensured between the stakeholders.

We have made plans that take into consideration the requirements of all the stakeholders who plan and provide healthcare services, are suppliers in service provision, use this service and pay the service fee and, the education institutions educating manpower for the health sector. We published the National Health Data Standards (NHDD) as a result of the analyses we carried out with all the stakeholders.

We have defined 261 data elements, 46 data sets and 41 data packages in version 1.1 of NHDD. We presented the conceptual and technical explanations together while defining the data element and stated in detail the conceptual meaning of each data element and the features they should have.

We have expanded the scope of NHDD Version 1.1 and updated it according to the changing and developing needs of the health informatics sector. We published NHDD draft version 2.0 in March 2012 to receive the opinions of the relevant authorities. This draft version covers more than 400 data elements and more than 60 data sets.

A.2. Health Coding Reference Server (HCRS)

Health Coding Reference Server (HCRS) is a reference and sharing system, which brings the health information system standards and coding systems together, shares these with open technologies (XML web services) and easily update them. The goals of HCRS are as follows:

- To contribute to making the system have a monitorable, measurable and more easily manageable structure by bringing all coding and classification systems used in health informatics together
- To create a common coding standard in the information systems used in public health institutions and private health institutions
- To eliminate the data mismatch in data exchange and provide an interoperable ground

Some of the standards included in HCRS are as follows:

- Diagnostic classification system (ICD-10)
- Drug codes
- Clinical Codes
- Health institution codes
- Possible diagnosis criteria
- Vaccination codes



A.3. Web Services

The other component of the Health-NET project is the web services that are separately opened for “sending schemes” which are used to collect data from the field and are defined in NHDS. The aim of these services is to collect the data from its source and transfer them to the Health-NET database.

We have developed the necessary communication in HL7 standards. There is an intense interest and effort for transitioning to HL7 V.3 throughout the world.

B. Tele-Medicine

Tele-Medicine means provision of healthcare services at a distance. Tele-Medicine is provision of such services as radiology, pathology, biochemistry and electrocardiography (ECG) by specialist health institutions through information and communication technologies.

The aims of the Tele-Medicine Project are as follows:

- To collect the medical images of and information on the patient in a common electronic environment
- To create a safe and rapid electronic environment only for the related physicians to examine and report
- To create a paperless and filmless hospital by moving the procedures to the digital environment
- To use information and communication technologies in the provision of healthcare services at a distance
- To hold a consultation
- To ensure exchange of information and experience among the physicians
- To diagnose correctly and rapidly
- To enhance the quality of patient assessments
- To decrease the hospital costs and enhance efficiency
- To increase patient satisfaction

Through the tele-medicine project, we can assess the medical images at a distance. Our main objective in this project is to hold consultations with experienced radiology specialists, use imaging device capacities to the fullest in hospitals with sufficient technological equipment and devices and provide services in place for the citizens who live in the regions where these opportunities are limited.

Medical images are transferred to the imaging data centre authorised by the Ministry through the SB-Net (SB: Ministry of Health) in accordance with DICOM (Digital Imaging and Communications in Medicine). The images collected at the imaging data centre are reported by the radiology specialists in the reporting centre. Then these reports are recorded in the Tele-Medicine database and the physician or the health institution in need of these images or reports can access them within the framework of their authorities.



PACS (Picture Archiving and Communication System) was established in more than 300 hospitals, particularly in training and research hospitals, within the scope of the project and so we have made substantial savings in film printing and archiving. Thus, we have taken significant steps towards the paperless hospital.”

C. Electronic Health Records (EHR)

Electronic Health Records (EHR) is a safe information system where the health data of citizens are kept in health institutions and can be shared through SB-Net based on certain criteria. EHR covers a wide range of information from demographic information to examination and from chronic diseases to immunization.

The citizens and the physicians will initially have access to the following records in EHR Project:

- Examinations
- Prescriptions
- Infant and child monitoring
- 15-49 aged women monitoring
- Pregnant monitoring
- Puerperant monitoring

Moreover, there will be certain areas in the system where citizens can enter their information. The citizens will be able to record the measurements they do and the family physician or the other doctors monitoring the patients will also see this information if required. The implementation will provide web-based, mobile and web services.

3. Institutional Resource Planning Systems

Institutional Resource Planning Systems are the systems that ensure efficient use, planning and management of resources and analyse them in the light of data.

Institutional Resource Planning System uses the Core Health Resource Management System (CHRMS). CHRMS is a system developed to monitor the personnel, movables, our institutions and other health institutions. It consists of the following components:

- Human Resources Management System (HRMS)
- Material Resources Management System (MRMS)



A. Human Resources Management System (HRMS)

MSHR is used to carry out the personnel procedures in the central and provincial organizations of the Ministry accurately, rapidly and in line with the legislation in force. The system includes all of the personal rights of employees such as appointment, personal record, promotion, salary and accrual.

Moreover, we have prevented time losses in post for many procedures. For example; procedures for appointment of new personnel can be conducted collectively owing to this system. Notification documents on these appointments can automatically be created in Electronic Document Management System (EDMS). 81 provincial health directorates and more than 1000 institutions can instantaneously see these appointments through MSHR.

All authorised users can see all the calculations we make about the implementation of State Service Obligation (SSO) in MSHR.

We ensured the participation of provincial health directorates in resource planning processes through this system. Now, provincial health directorates make demands by taking into account such parameters as existing buildings, facilities, devices and population by using the 'personnel planning and demand form'. Various reports are being produced by making spread sheets with the data in CHRMS and transferring them to Decision Support System (DSS).

B. Material Resources Management System (MRMS)

It is the system that follows the resources in the stocks of all institutions associated with the Ministry, monitors the prices of the movables, and identifies the excess stock and the debit of the inventory stock (integrated with HRMS). It consists of such sub-components as Inventory Information System, New Materials, Storage (Depot) Information System, Durable Movables Information System, Transportation Means Information System, Medical Devices Information System, Maintenance and Repair Information System and Company Information System.

All users can see the hospitals with excess stocks and what these stocks are in Turkey through MSRS. When the hospitals go out to tender to purchase a new product, they firstly query these stock excesses and can ask for the products that are stated to be excess in the other hospitals instead of purchasing them. Thus, we prevented the unnecessary purchases and the extravagance. Moreover, the prices and quantities of purchased products are also followed by all expenditure units. As a result, we can easily compare the price differences between the procurement of the same or similar products.

Spread sheets are prepared on the basis of MRMS data and transferred to Decision Support System (DSS) daily and various reports are created.

Moreover, data can be transferred to MRMS from Hospital Information Systems.

MSRS has been actively used since 2007. This system is one of the biggest electronic material storages in Turkey and around the world.



4. Decision Support Systems (DSS)

DSS is a systematic structure established to ensure data use during planning, determining the strategies and taking critical managerial decisions. It ensures that the data to be used by the management during decision making process are collected, stored, analysed and can be easily accessed.

For example; population per specialist physician by provinces are shown both numerically and graphically and the provinces with specialist physician shortages in various branches can easily be seen.

As the Ministry, through this system, we aim at collecting the data directly from its source in accordance with the standards in electronic environment and reporting them to the users at any level through DSS-Geographical Information System (GIS). For example; the provincial health director in his/her province and the Head of Public Health Institution in the whole country can momentarily see the changes in the numbers of communicable diseases diagnosed in family health centres on the map and ensure that necessary measures are taken.

Our Ministry collects substantial amount of various data. Use of decision support reports integrated with the Geographical Information System will serve as an early warning system in many fields particularly in contagious diseases and outbreaks. We will complete the integration of DSS-GIS that will help the managers take appropriate decisions easier, by the end of 2013.

5. Other Implementations

A. Electronic Document Management System (EDMS)

We have established the EDMS in the central organization of the Ministry to exchange documents and information in electronic environment and manage this information instantaneously on the internet.

We have standardized the processes related to our intra-institutional and inter-institutional correspondences through this system. Moreover, we minimized the resources used for correspondence (paper, photocopy, toner, man power). Our project plan on establishment of EDMS in all our provincial organisations is ready and we will ensure that all correspondence between our institutions takes place electronic environment by the end of 2013.

By doing this, we also prevented the problems encountered in physical environment. We can also implement electronic archiving in EDMS. The biggest benefit is saving time. As well as that there are various reports on document flows in the system.



B. Safe Electronic Signature

We made Safe Electronic Signature integration in the Electronic Document System to maintain document and information exchange electronically, to instantaneously transfer and manage the documents via internet in the central organization of the Ministry. All personnel with signature authority in the central organisation and the provincial organisations of the Ministry are provided with e-signature. Once e-signatures are acquired by the staff and user habit is established in the organisation, we plan to end the paper correspondence and ensure mobile signature integration by the end of 2013.

C. Data Bank for the Disabled

Data Bank for the Disabled is aimed at collecting information about all disabled citizens in Turkey in one centre, recording them in database and producing various reports. These reports will specify the degree of disability and facilitate the access of disabled persons to their rights.

Moreover, the obtained information is shared with the General Directorate of Services for the Disabled and the Elderly under the Ministry of Family and Social Policies via web services. All hospitals authorised as per the relevant law to issue medical board report for the disabled are included in the project.

D. Investment Monitoring System (IMS)

Investment Monitoring System (IMS) is aimed to plan the financial resources of our Ministry according to the needs, distribute them among the units and use and monitor them. The system consists of the sub-modules of Investment Information System, Building Information System and Direct Procurement Procedure.

By the help of this system, we can follow the investments, investment proposals, construction works, building repairs and structure and revised procedures for facilities. Besides, we can follow any immovable starting from the tendering process until completion via Investment Information System and even after the completion. In addition to real estate investments, we also recorded civil defence infrastructures of buildings such as fire extinguishing systems.

Building Information System includes information on provinces, names, ages and the results of earthquake resistance tests of the buildings of the Ministry. We can also follow the physical features, ownership information and lodging information with regard to the buildings by this system.



E. Private Healthcare Institutions Management System (HIMS)

Private Healthcare Institutions Management System (HIMS) is the system monitoring the Private Healthcare Institutions licensed by the Directorate General of Health Services. This system provides for online monitoring such information as identities, licenses, devices, ambulances, equipment, laboratories, personnel, communication and service capacity distribution of private healthcare institutions. For example; the records of the physicians of a private healthcare institution have to be made via HIMS and meanwhile, the verification procedures are automatically conducted through Physician Data Bank.

HIMS has been in use since January 2010 and the system is still being developed. We follow private hospitals, branch centres, medical centres, polyclinics, optic establishments, private practices, orthosis-prosthesis and audio application centres, laboratories and similar institutions through the system.

F. Physician Data Bank (PDB)

Physician Data Bank includes the brief information on credentials and education of all physicians across Turkey. This data bank makes it possible for the physicians to see their personal information and for the institutions to access to this information electronically and to share this information via web services within the legal framework

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

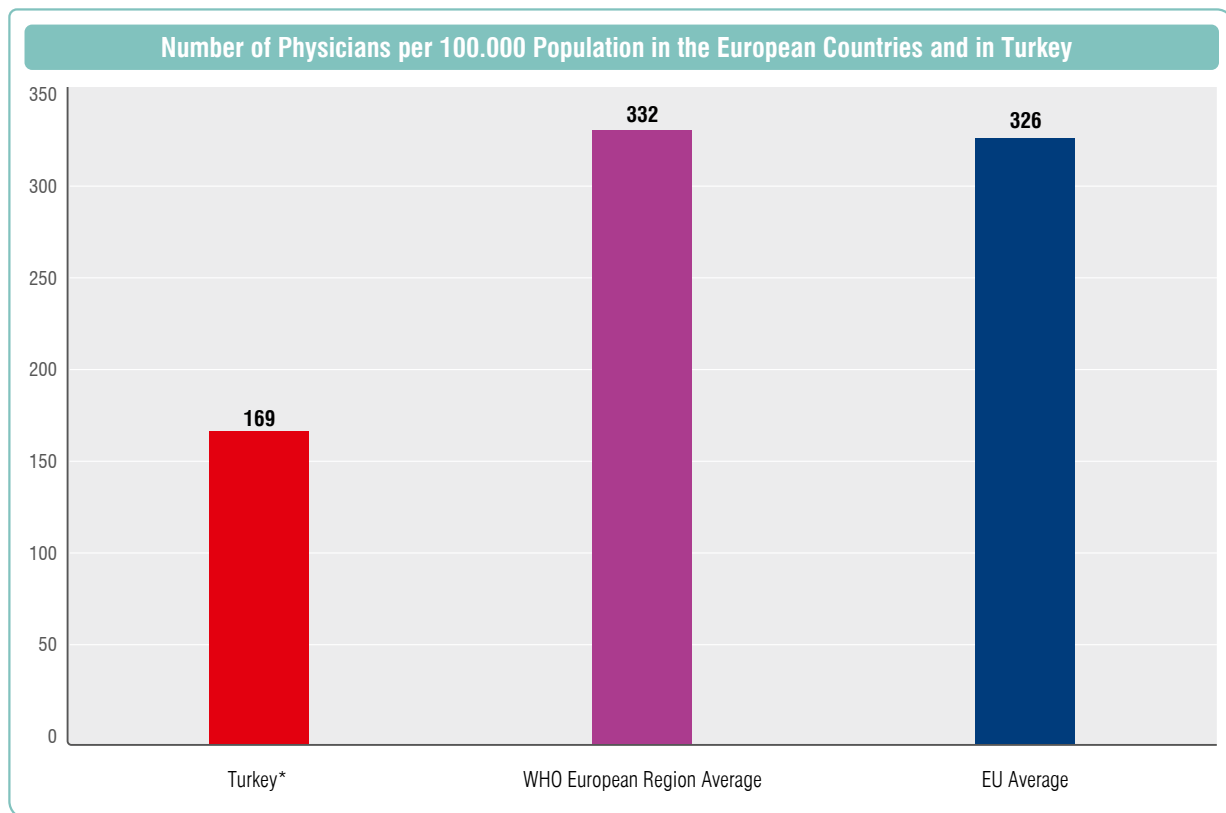
5. Institutional Structuring and Capacity Building



1. Human Resources for Health (HRH)

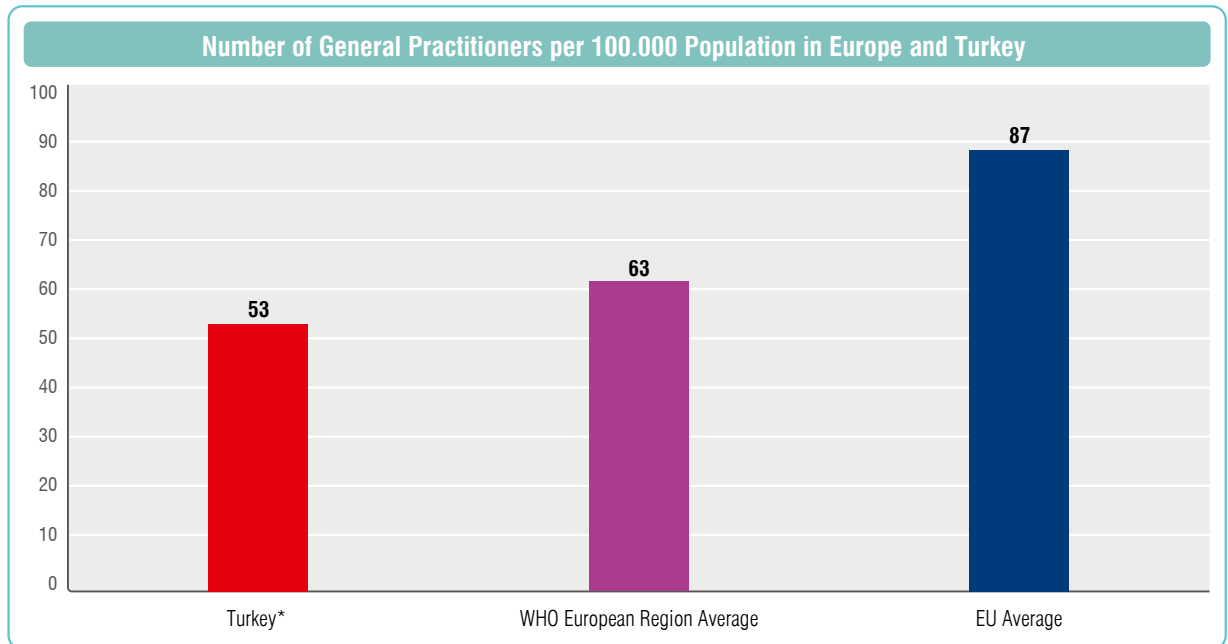
A. Determining the State of HRH and Planning Solutions

Before the Health Transformation Program, there were significant inaccurate approaches to HRH in Turkey. The misconception that the “number of physicians is too much” has always been on the agenda. There was a similar approach to the number of nurses as well. As of December 2011, the total number of physicians is 126,029 and the number of physicians per a hundred thousand population is 169 in Turkey (Graphic 70). It is important to raise the numbers, particularly of the physicians and nurses, without compromising education quality in HRH (Graphic 70-74, 76- 81). In terms of the number of physicians per hundred thousand, Turkey ranks at the bottom of the WHO European Region (Graphic 70-74).



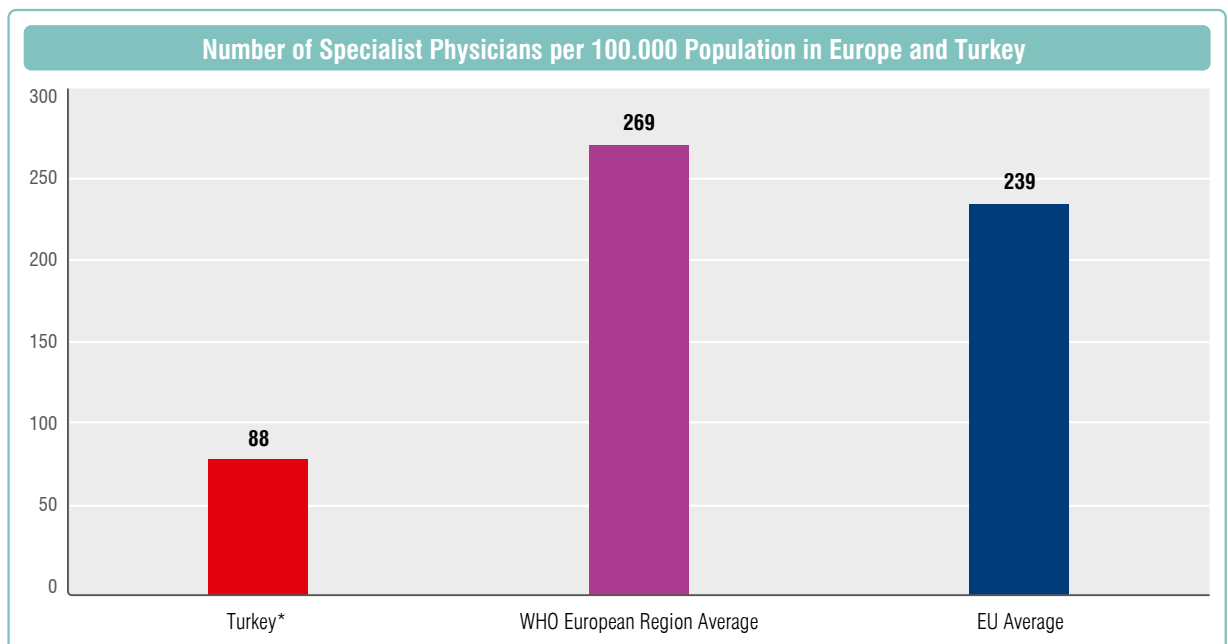
Graphic 70

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012



Graphic 71

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012

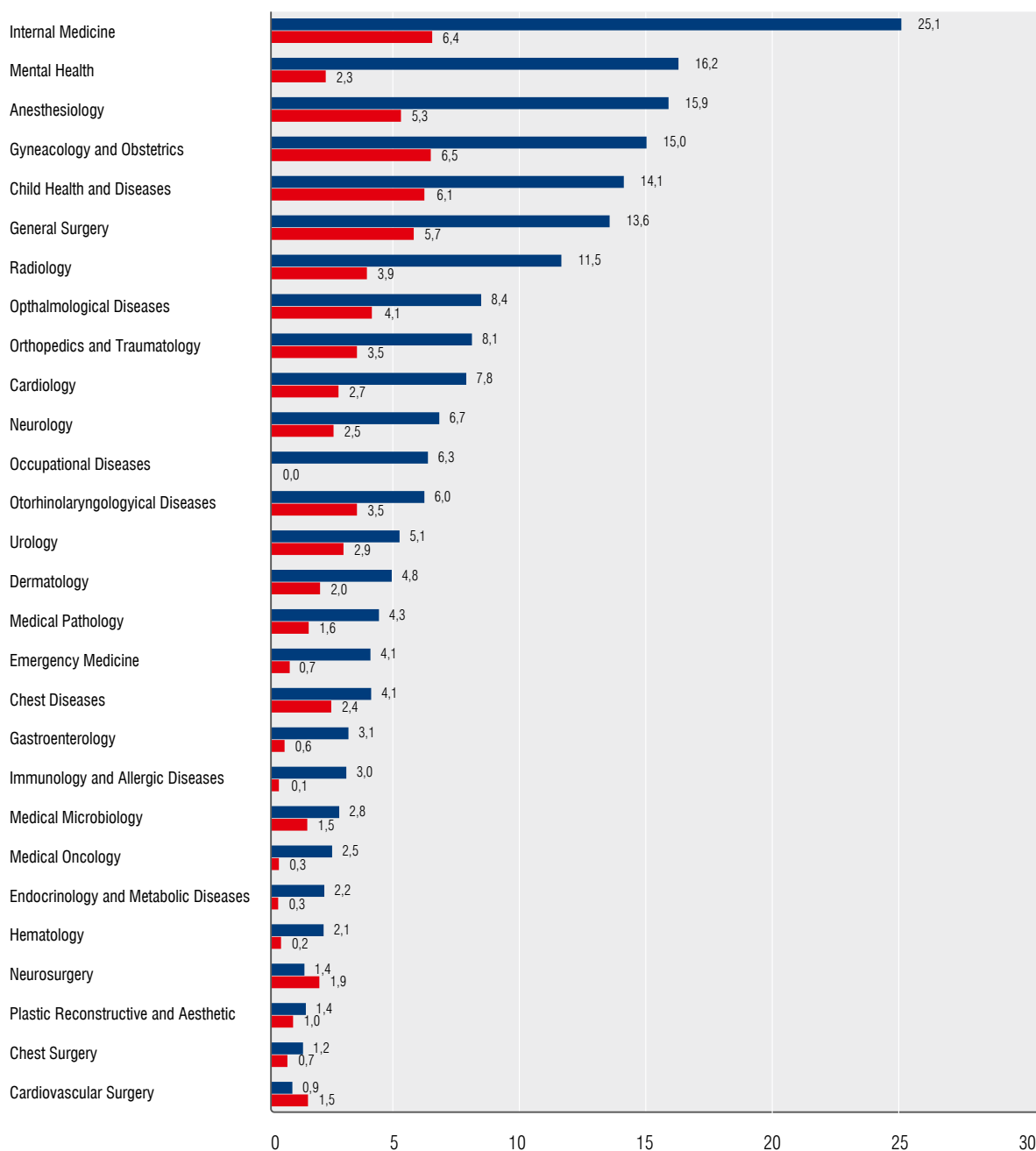


Graphic 72

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012



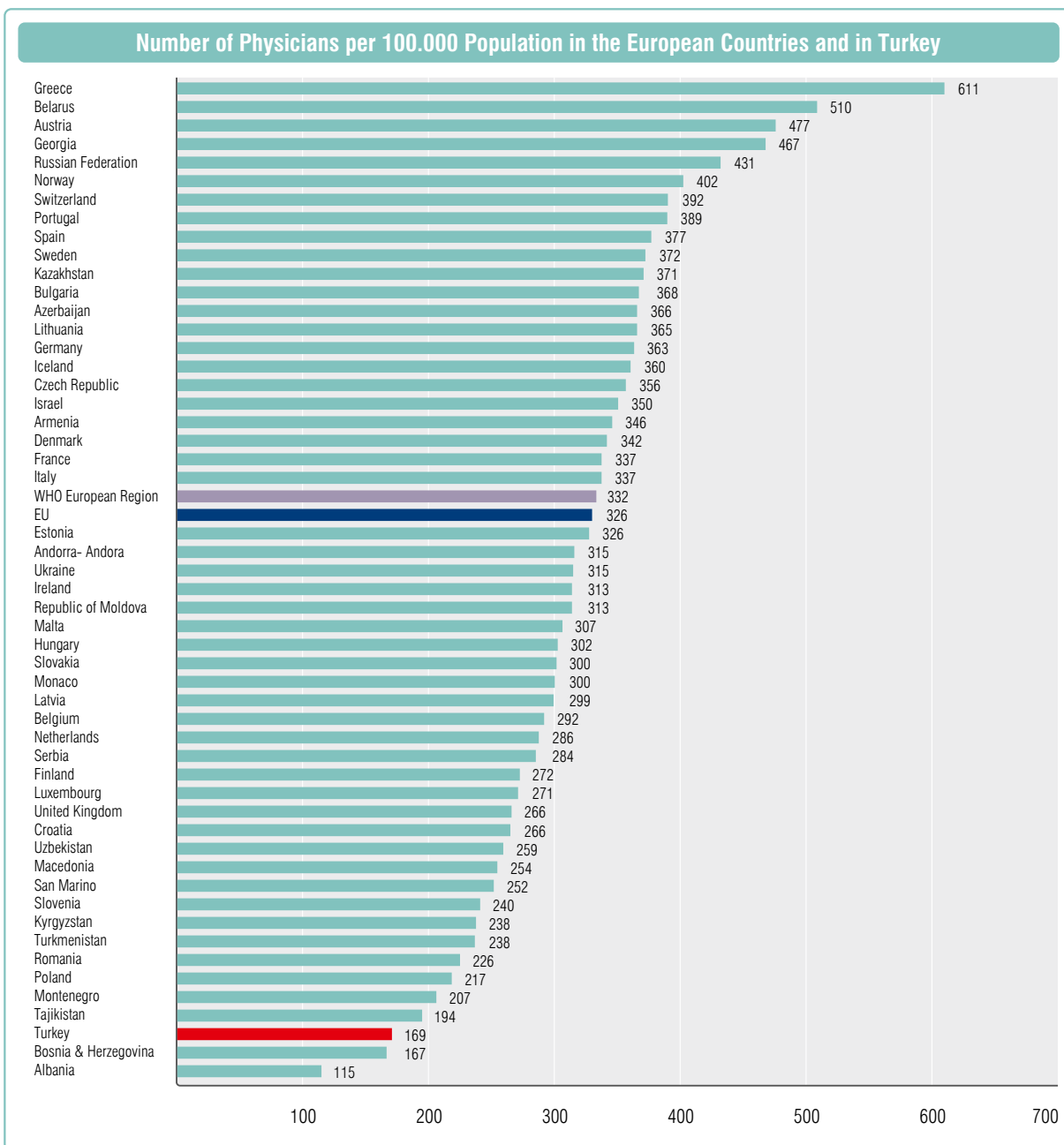
Number of Specialist Physicians in Selected Branches per 100.000 Population in the EU Countries and in Turkey



Graphic 73

Source: EUROSTAT, Physicians by medical specialty

We have substantial deficiency of personnel in all branches other than brain surgery and neurosurgery (Graphic73).

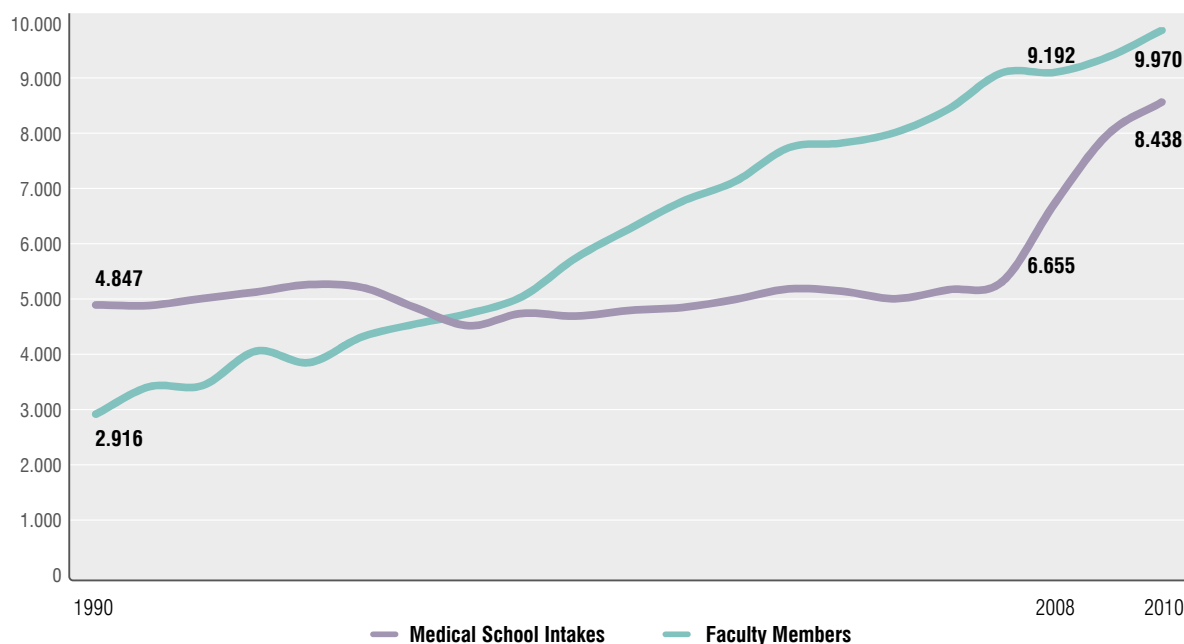


Graphic 74

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012



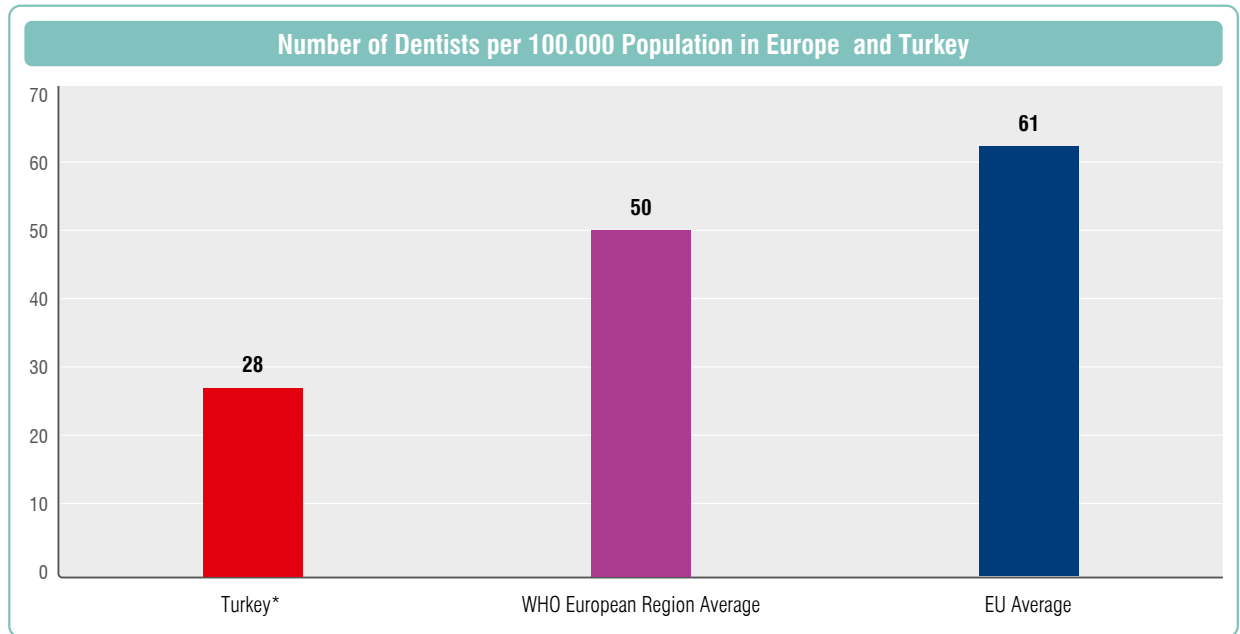
Number of Medical Faculty Members and Medical School Intakes in Turkey by Years



Graphic 75

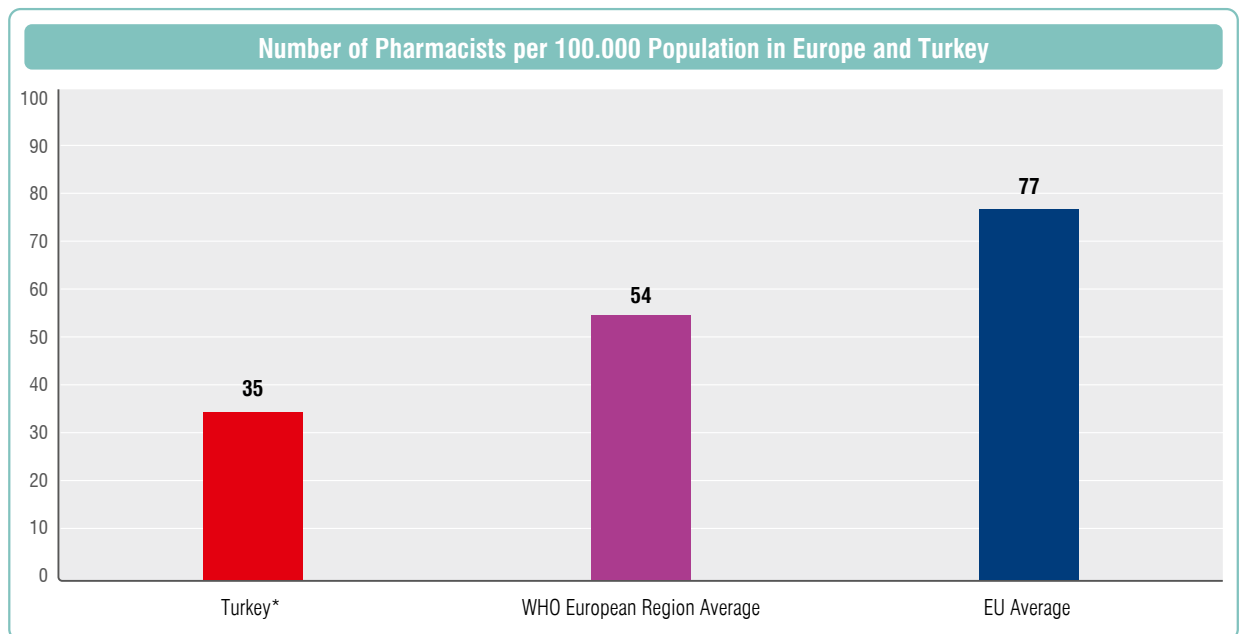
Source: HEC Higher Education Statistics

In Turkey, there are 41.664 students enrolled in schools of medicine and the total number of faculty members is 9.970 as of late 2011 (Graphic 75). The number of faculty members per student is 4. The number of faculty members is sufficient in our country but it is out of the balanced distribution. To achieve the balanced distribution, the number of faculty member should be balanced in line with the requirements while creating new quota for a new school of medicine or regulations.



Graphic 76

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012

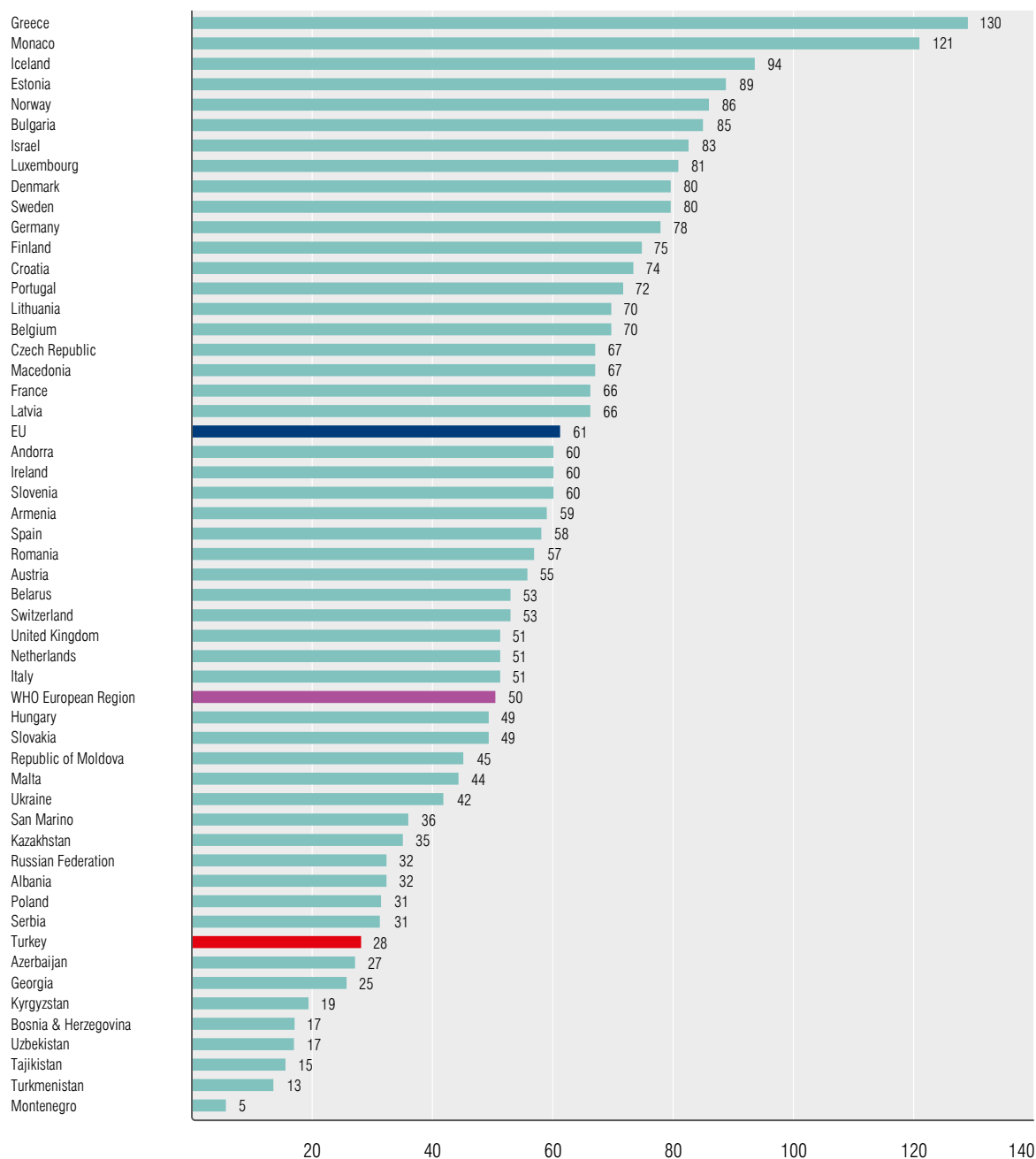


Graphic 77

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012



Number of Dentists per 100.000 Population in the European Countries and in Turkey

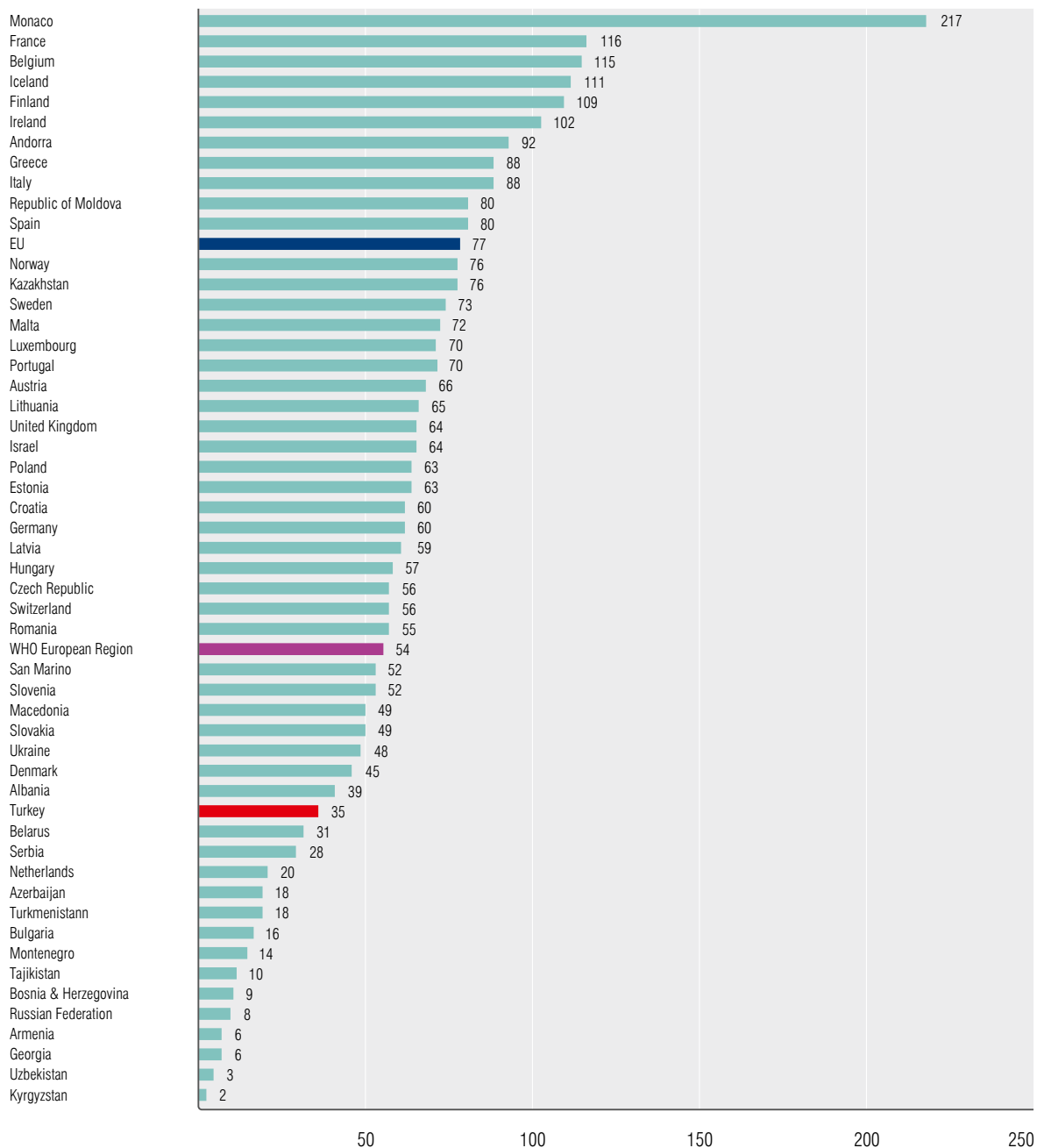


Graphic 78

Source: General Directorate of Health Services, World Health Statistics 2012 (*Data dated 31.12.2011 were taken as the basis for Turkey), WHO/European HFA Database, July 2012



Number of Pharmacists per 100.000 Population in the European Countries and in Turkey

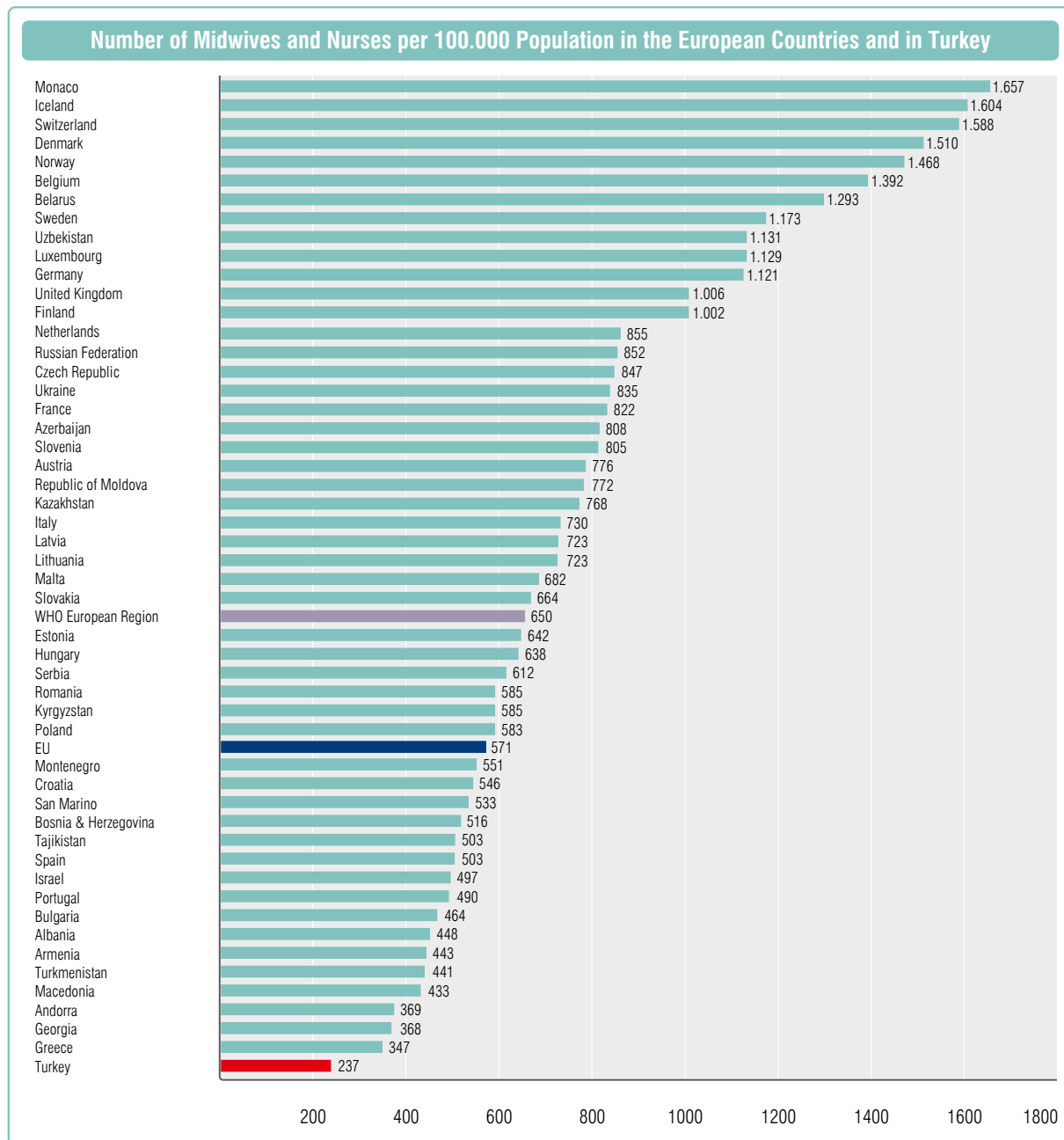


Graphic 79

Source: General Directorate of Health Services, World Health Statistics 2012 (*Data dated 31.12.2011 were taken as the basis for Turkey), WHO/European HFA Database, July 2012

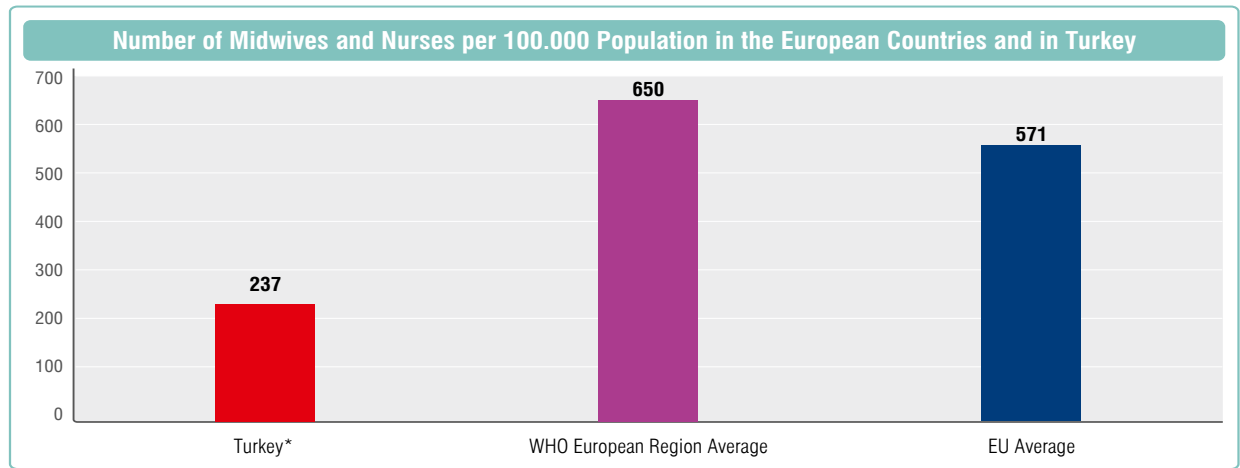


The case is not so different for nurses, physiotherapists and many other health employees. The needs of our population and increased demand for health care services do absolutely require increasing the supply of physicians and nurses. Yet, the quality of education should be preserved and even improved.



Graphic 80

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012

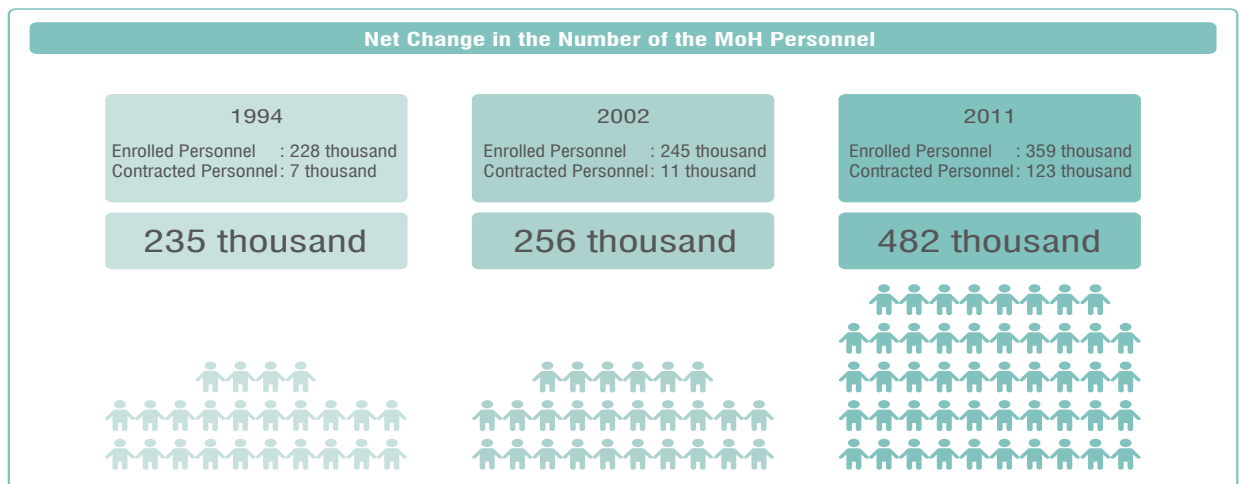


Graphic 81

Source: General Directorate of Health Services (*Data dated 31.12.2011 were taken as the basis for Turkey), World Health Statistics 2012

B. Breakthrough in the Health Human Resources Employment in the Public Sector

We increased the number of employees which was 256.000 including outsourcing in 2002 in the healthcare institutions associated with our Ministry, to 482.000 by the end of 2011. In other words, we obtained a net increase of 226.000. The net increase in 9 years from 1994 to 2002 was only 21.000. In other words, the employment we have created in the last 9 years is 11 times more than the one in previous 9 years (Graph 82). We started to employ personnel based on new employment models in health facilities and regions deprived in terms of health personnel for years. To this end, the Law numbered 4924 was put into effect in 2004 and developed a new employment model on contractual basis peculiar to the Ministry of Health. This model is used to employ people on a voluntary basis and the personnel who are covered by this Law upon their consent gain higher financial rights compared to other personnel of equal position. Moreover, after a contract period of 10 years, the personnel earn the right to become permanent contracted personnel.

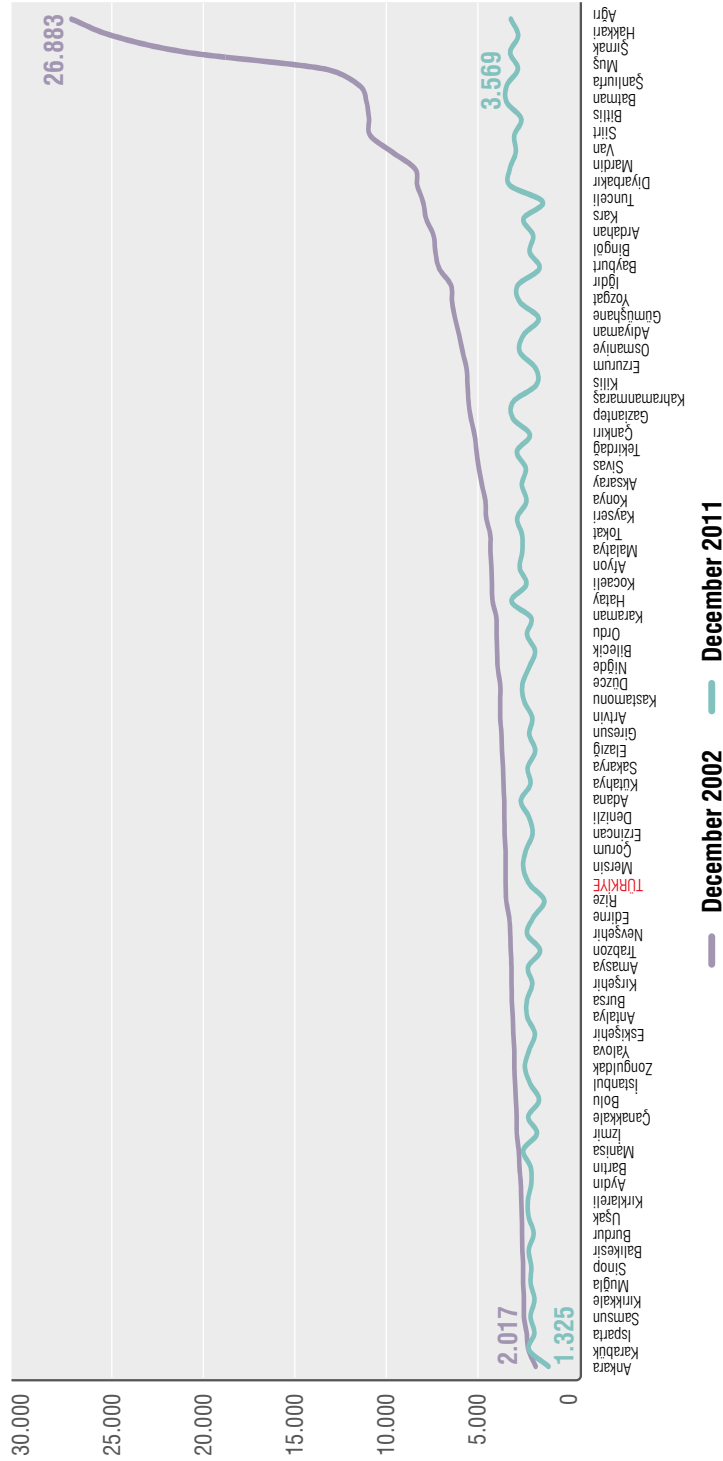


Graphic 82

Source: General Directorate of Health Services



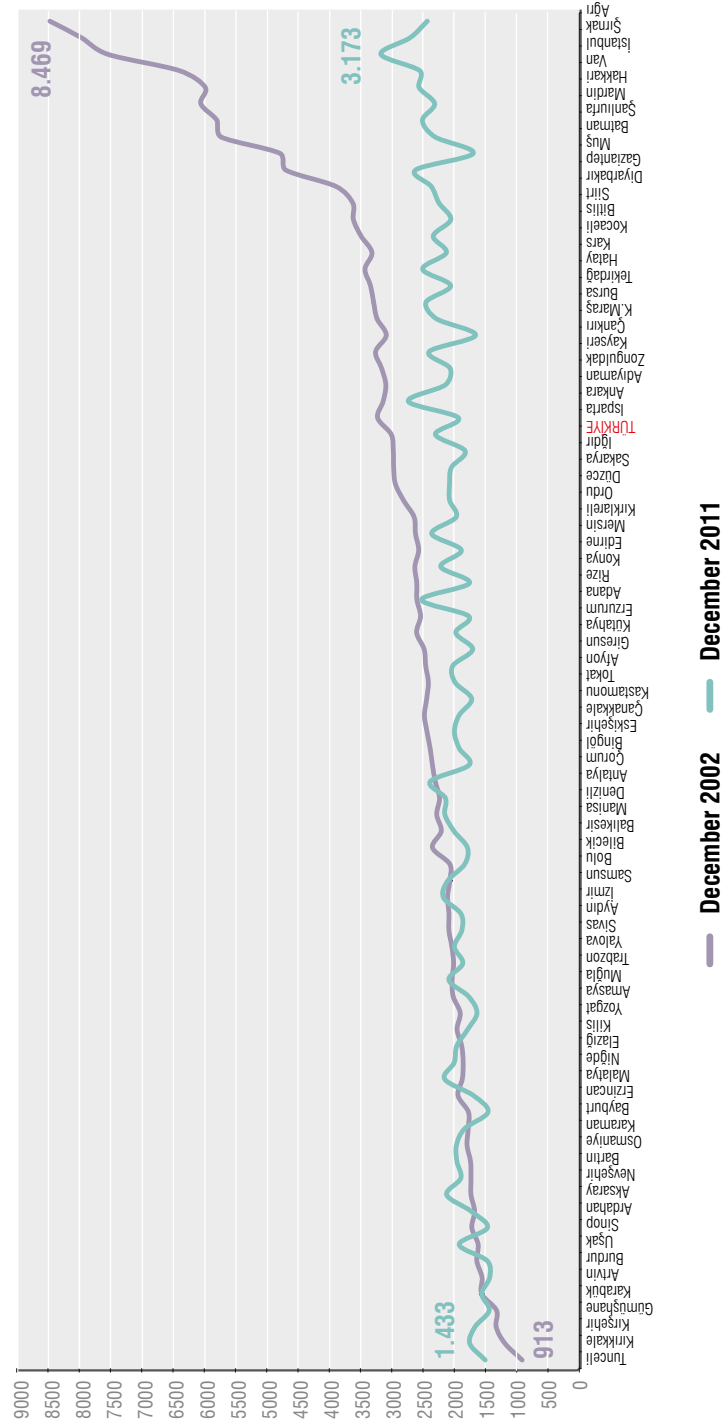
Population per Specialist Physician 2002-2011



Graphic 83
Source: General Directorate of Health Services



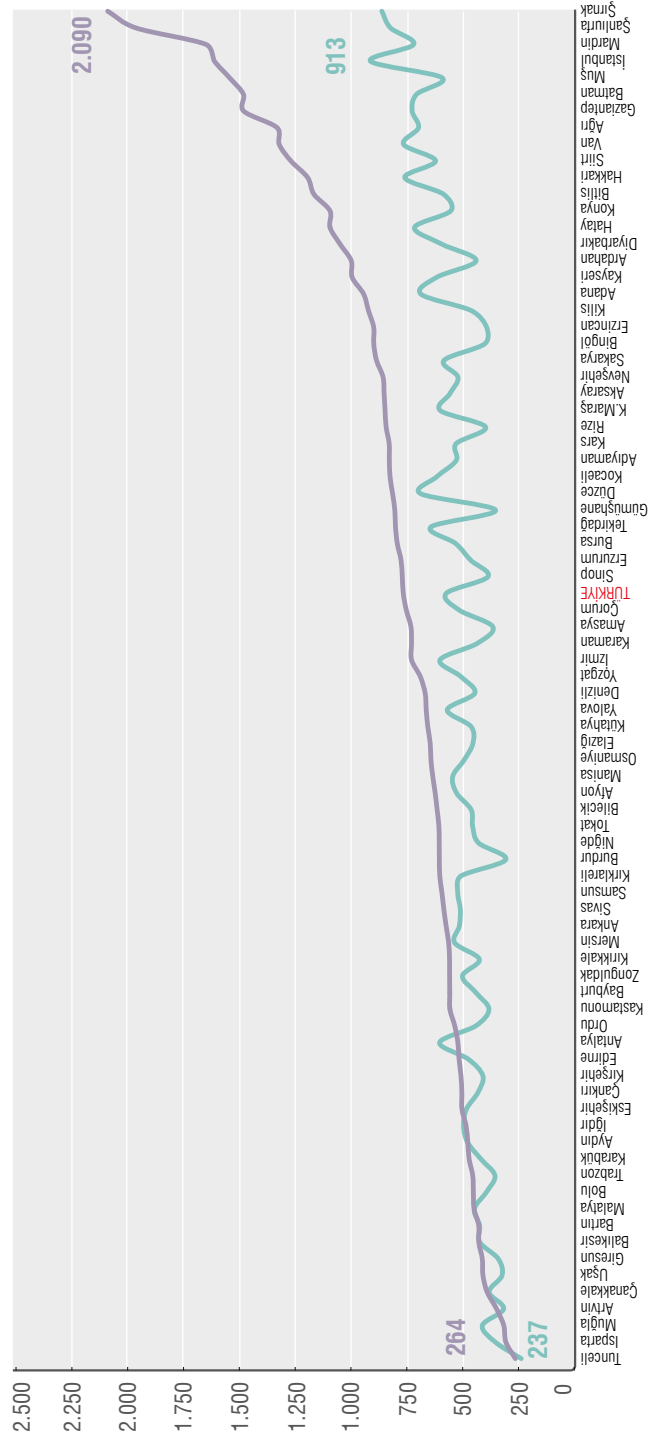
Population per General Practitioner, 2002-2011



Graphic 84
Source: General Directorate of Health Services



Population per Midwife-Nurse, 2002-2011

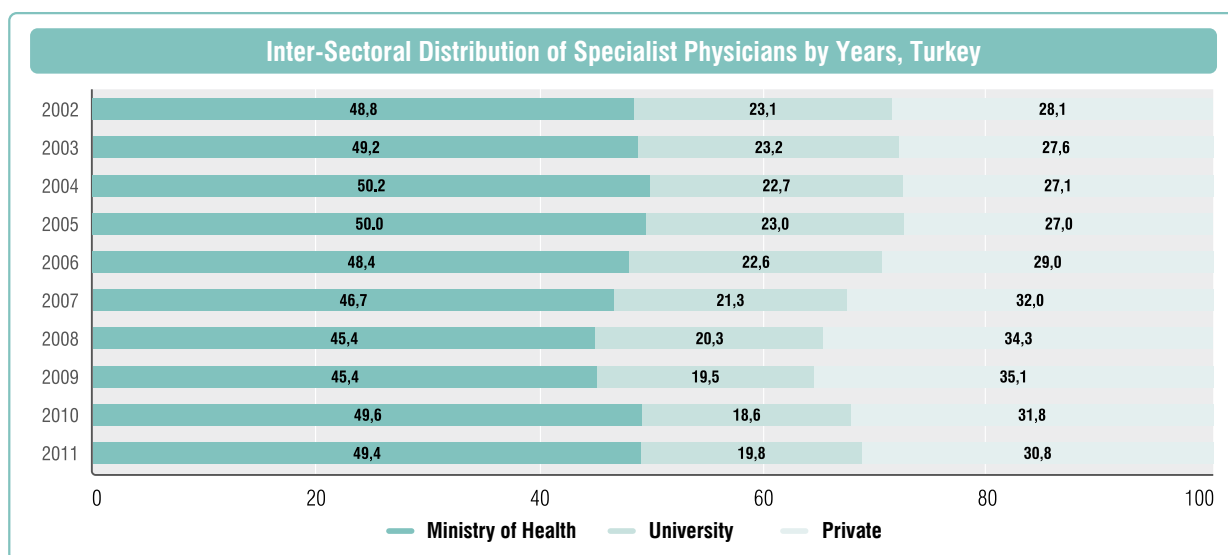


Graphic 85
Source: General Directorate of Health Services



While the gap between the best and the worst province in terms of the population per specialist physician was 1/14 in December 2002, we reduced it to 1/2,7 in December 2011. Similarly, the gap dropped from 1/9 to 1/2,3 for GPs, from 1/8,5 to 1/4,5 for dentists and from 1/8 to ¼ for midwives and nurses (Graphic 83-85).

While ensuring inter-regional balance in the public sector on one hand, we also protected the balanced distribution between the public and the private sector. The claims that the Health Transformation Program gave rise to privatization and the specialist physicians were transferred to the private sector are unreasonable; while 29,5 % of the specialist physicians practiced in the private sector in 2002, the figures was noted 30,8 % in late 2011 (Graphic 86) .



Graphic 86
Source: General Directorate of Health Services

The other type of employment applies to the personnel who are assigned for cleaning, data processing, security and catering services that are provided through service procurement. The number of these personnel rose from 11.000 in 2002 to 123.000 in 2011.

C. Transparency in Personnel Appointments

It is known that imbalanced distribution of personnel was one of the most important problems in our country in the previous period. One of the priorities of the Health Transformation Program is to bring regional disparities in personnel distribution down to acceptable levels, to determine realistic standards for titles in personnel employment and plan human resources accordingly and to establish an objective and equitable system for appointments and transfers.



We enacted the Law No. 4924 allowing employment of contracted personnel in order to encourage personnel to work in priority development regions. This way, we encouraged more personnel to work at less developed regions with more severe problems of personnel shortage.

There is already a shortage of physicians, and it is difficult to employ them in the less developed regions, since most of them like to work in metropolitan cities. Within the sense of providing accession to health care services for everyone, we put into effect the subsidized compulsory public service for physicians. Taking the former deficiencies and mistakes in the compulsory public service implementations into consideration, we made a new and sustainable arrangement which has more acceptable, identified, separate work periods and higher payment policies according to different deprived regions.

In order to prevent nepotism in personnel appointment and ensure more balanced distribution of healthcare personnel to all the MoH healthcare facilities, we prepared Regulation on Appointment and Transfer in a different understanding. According to this regulation, specialists, general practitioners, dentists and pharmacists are appointed by a computer-based lot, and other personnel are appointed by a central examination conducted in accordance with general provision.

Personnel appointment and transfer proceedings are based on the “service points” that depend on the characteristics the region they are employed and the duration of employment. We launched a more strict supervision system for excuses. Use of service points and computerized lottery for appointments put an end to favoritism and nepotism pressures on politicians and bureaucrats as well as some unjust proceedings and speculations. Thus, we have achieved a marked success in the equal and balanced distribution of healthcare personnel across the country.

D. Healthcare Personnel Training

We attach a great importance to the training of health professionals of all levels, current managers and management trainees. We organized regional training events on technical topics on the one hand and systematic health management trainings online by the General Directorate of Health Researches for resource in an efficient, effective and collaborative way, on the other hand.

D.1. Distance Education

We aimed to provide education to all healthcare personnel particularly managers, management trainees and specialists through the Distance Health Education System (Turkish abbreviation is USES), which is an online distance education system of the latest technology in order to improve efficiency and service quality in all MoH institutions by the General Directorate of Health Researches. You can visit the training page on <http://www.uses.gov.tr>.



More than 10,000 students including more than 1000 managers have so far received these trainings. 6000 of these students are still continuing various education programs. Around 4000 certificates have so far been granted to health professionals educated under various education programs in line with the ultimate goals.

We continue the second round of Health Management and Administration Distant Education Certificate Program by attendance of 465 new participators since 2009 which is prepared with an academic perspective on the basis of graduate programs and its first round was completed successfully by 256 of the 590 participants in total. We prepared education content with the contributions of leading academicians and provided to management level personnel and management trainees in the MoH institutions and organizations.

We are providing orientation trainings to family physicians to be assigned in primary health care and other healthcare personnel to be assigned in family medicine. We have prepared curricula, produced most of the education materials and initiated trainings for the second term of professional education program, which will last longer and will be conducted through USES for the most part. We have also continued to update training materials in parallel to the education. We will have completed this training program by December 2013. Also we are continuing to update training materials in parallel with the training program.

D.2. In-Service Trainings

We updated and revised the “Regulation of In-Service Training of the MoH” which came into force in 1986. We put the new regulation into force on 11.12.2009.

By the new regulation;

- In-service trainings are started to be planned and carried out in an effective cooperation and collaboration with relevant units.
- We saved time and sources by combining trainings which have the same content and are organized separately by different units.
- We ensured that in-service trainings are carried out based on plan and programs in line with national development goals through objectives, missions, authorities, responsibilities and requirements of the MoH.
- We ensured that in-service training events are carried out in line with central planning by provincial health directorates.
- We began to use an evaluation principle during and after trainings in order to detect whether the expected results of the trainings are achieved at the end of the in-service trainings.
- We increased the number of in-service training programs and the personnel trained.



D.3. Certified Trainings

Many certified training programs were conducted in our country until 2010 for healthcare personnel.

There were no established standards on principles and procedures regarding the renewal of certificates and there were variable practices for certified trainings conducted in professional fields of health by many other public and private institutions, primarily the MoH and universities.

With the aim of eliminating shortfalls in practice, preventing variable practices in certified trainings and bringing a specific standard to certified trainings, we put into force “MoH’s Implementing Regulation on Certified Trainings” on 21.08.2010.

With this implementing regulation

- ✦ We regulated principles and procedures on certified trainings to be delivered by the MoH, Turkish Armed Forces, universities, public agencies and organizations and private law legal entities and real persons in order to be equipped with Professional competencies based on special knowledge and/or skills to be applied in the postgraduate period in the field of health.
- ✦ We make sure that scientific committees constituted by the experts of the fields settle the scientific and technical content, principles and procedures of certified trainings as well as all certified training fields.
- ✦ Certificates to be granted by the end of the trainings to be conducted according to this implementing regulation will be registered and recorded by the MoH.
- ✦ All certified training programs and training centers are regularly audited in line with the criteria set by scientific committees.
- ✦ We plan to deliver specific health care services by certified personnel with the aim of providing a more effective and quality health services.

D.4. Database Provided by TÜBİTAK ULAKBİM

Serving under TÜBİTAK, ULAKBİM (Turkish Academic Network and Information Center) started to facilitate the access of training institutions to information by providing National Licensing for databases as from 2006 with the purpose of facilitating the access to information of training institutions in Turkey which grant diplomas. Training and research hospitals affiliated to the MoH and providing trainings were also included in this service.



E. We Meet at the Meeting Point for Health (MPH)

We established a platform in which we can have direct contact with all health care employees: “Meeting Point for Health (MPH)”. Through this portal, the health care employees can directly contact Mr. Minister without any barriers or filters.



Our aim is to improve employee satisfaction with a mechanism to deliver the criticisms, suggestions, questions and problems of healthcare personnel directly to the headquarters of the MoH. Establishing a 360-degree communication and opinion sharing, it ensures transition from a communication environment where only rules are transmitted between agencies and their employees to a communication model where more informal and friendly relations could be established.

The web page address of the Meeting Point for Health (MPH) is www.sbn.gov.tr. Questions and suggestions of healthcare personnel are first assessed by MPH team and messages are conveyed to relevant units. Feedback is given to healthcare personnel in the shortest extent possible on messages reviewed by the experts of the field.

Healthcare personnel are able to reach H.E. the Minister of Health via MPH and communicate their questions, problems, opinions and suggestions to him. In addition, healthcare personnel are able to share their exchange notices in a safe medium, to keep abreast of current events and to share their success stories with their colleagues. At the sametime, recent information on congresses and conferences, job and career opportunities in health, appointments, personnel safety and etc. is presented at the MPH.

Between March 2011 – November 2012, 41.000 messages were received via the MHP.

Approximately 80-100 messages are received per day and the distribution of these messages are as follows:

- 32 % - direct contact with Mr. Minister
- 2 % - “I have an idea” messages (projects developed by the health care personnel), and
- 66 % - “I need a solution” messages.

2. Health Services Planning

A. Health Care Service Planning

In most of the developed countries, the healthcare systems are structured so as to cover the whole population in the framework of quality standards and equality principles. While the approaches might differ, the financing and organization responsibility of the health services is shared between the central and provincial authorities. However, the central government is the main determinant in general.

In Denmark, the local administrations and the municipalities plan the health regions under the supervision of the government for health planning. In the UK, national and regional planning is directed by the central government with the participation of the local administrators. In France, regional health associations plan the hospital service within the framework determined by the central government. In Germany, state governments plan the hospital capacities in the framework of the national and regional legislation. In Canada, the planning is under the responsibility of the regional administrations, but the national framework is taken into consideration in some cases.



In Canada, France and Germany, the hospital planning covers both the public and the private hospitals. In fact, the private institutions are subject to permission within the scope of the planning in order to expand their activity areas. On the other hand, countries like Denmark and the UK limit their plans only with the public hospitals.

We have taken opinions from the provincial organization by the MoH during the Works on the regional health plans. We paid attention to the reviews and findings of the central organization in provinces, demographic and geographical structure, region under coverage and distance to the center, transportation, local needs and existing health inventories.

We have planned reference hospitals/campuses in order to meet the needs for health training, institutional guidance and reference center in their regions. While before the Health Transformation Program, the delivery of health service was structured with the induction method from bottom to up as health house, health center, district hospital, provincial hospital and regional hospital; we have adopted the deduction method by taking the reference center as the basis with this planning.

We have identified 29 health regions by taking the health requirements, geographical structure, patient flow, accessibility, socio-economic structure of the region into consideration.

In this respect, we have identified specific health regions, provinces to act as the health centers of their region in each health region and sub-regions of these central provinces in accordance with service provisions throughout the country. It is important to define the service provision roles of the inpatient healthcare facilities, which are already planned or at the phase of investment planning in the sub-regions, strengthened districts and smaller districts. The issues of classification according to the roles and restructuring according to the health requirements and expectations of the target population are also important.

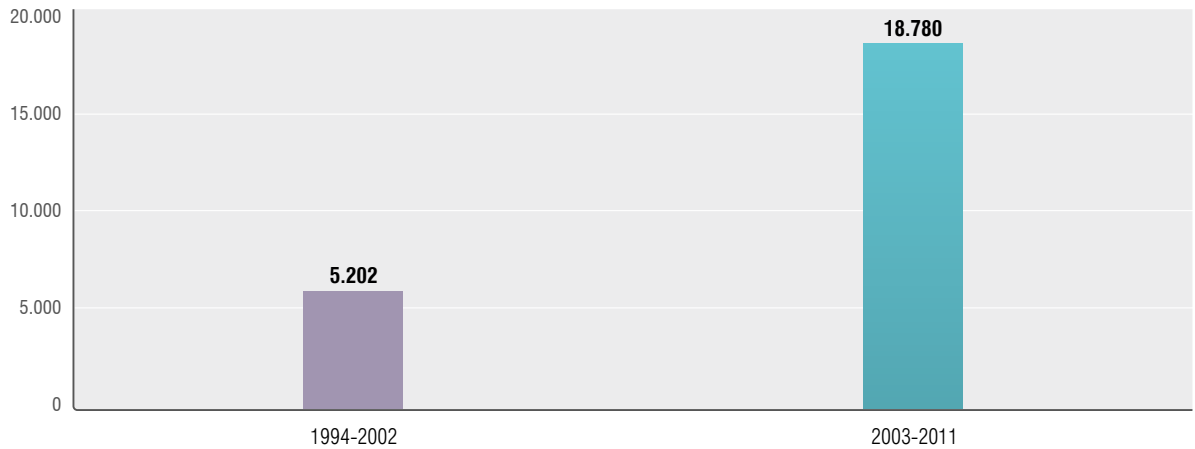
We have made these planning at country level based on the population rate; we have also made regional distribution upon consideration of the adequacy of the physical environment, number of personnel, existence of tools and equipment and the regional disparities among specialty service units (such as ICU, CVS Centers).

B. Rationalism in Investments

We have created a detailed health inventory with the Health Transformation Program by reviewing all the health investments. We have re-planned public health investments. We have reevaluated the financial, medical and technical analyses of investments. We have carried out these planning procedures on-site at the level of districts, provinces and regions together with the local administrators. We have begun to utilize investment budgets more logically by re-arranged projects in accordance with the priority and importance level and investment budgets (Graphic 87).



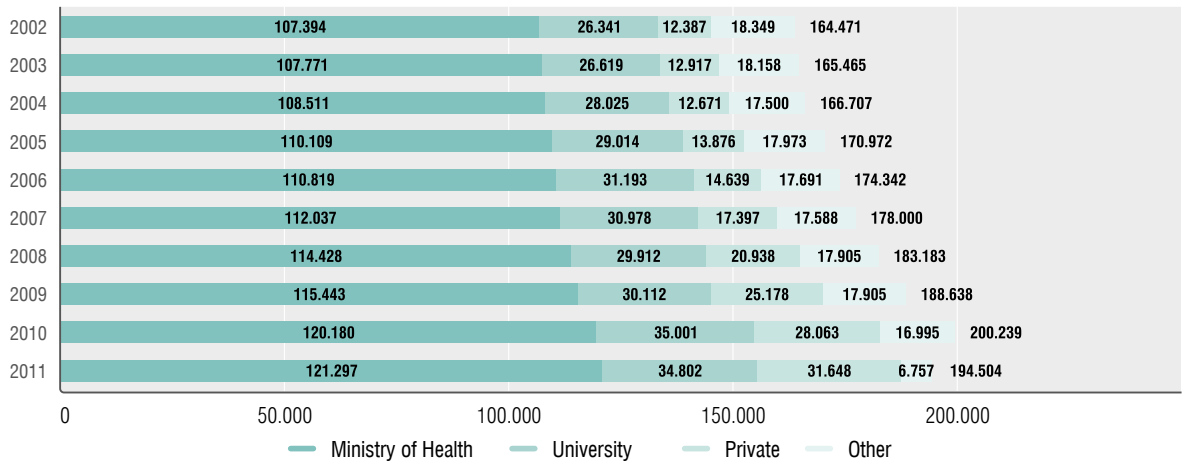
Expenditures for Health Investment and Hardware and Vehicle Purchase (by 2010 prices -million TRL)



Graphic 87

Source: Ministry of Finance Budget Final Accounts

Number of Patient Beds in Turkey by Years and Sectors



Graphic 88

Other: Municipality Hospitals

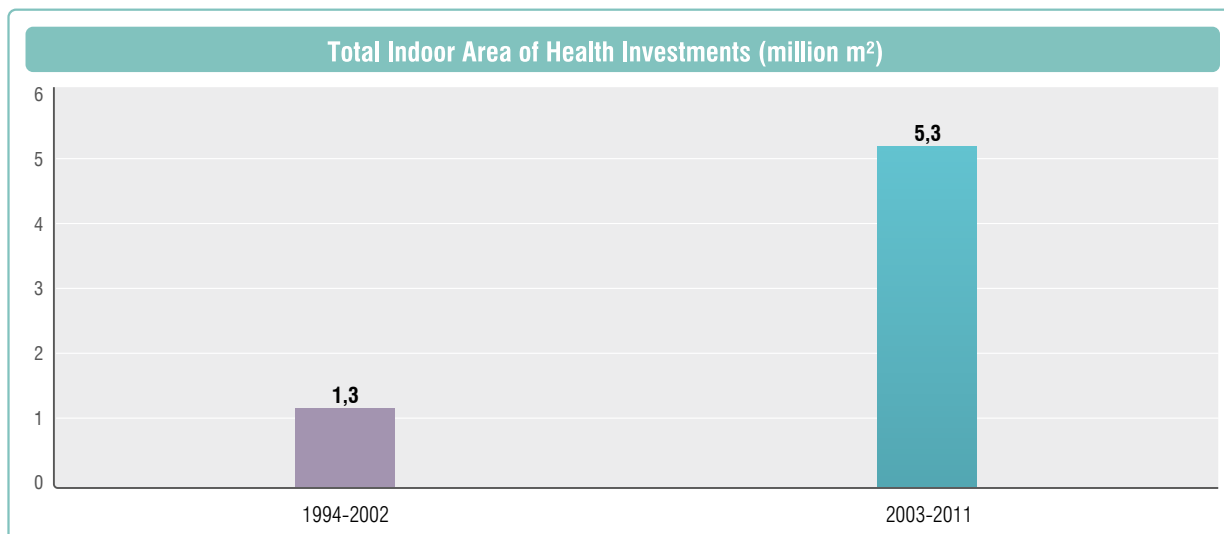
Source: General Directorate of Health Services

“We prepared the legislation which will enable investments to be made through public private partnership for the construction of new “patient centered” hospital buildings and hospital campuses and for the revision of some old buildings.

In fact, the number of beds per 100 thousand people in Turkey is 260 and this figure seems sufficient in the framework of the new tendencies in the world. However, we are replacing the existing beds by qualified beds. We will continue the investments by establishing modern structures accompanying this (Graphic 88).



We have made major progress in health improvements. In the 80-year period before we came into power, 7 million m² indoor area was built and 1,3 m² was put into service in the previous 9-year period. However, we built 5,3 million m² indoor area (Graphic 89).



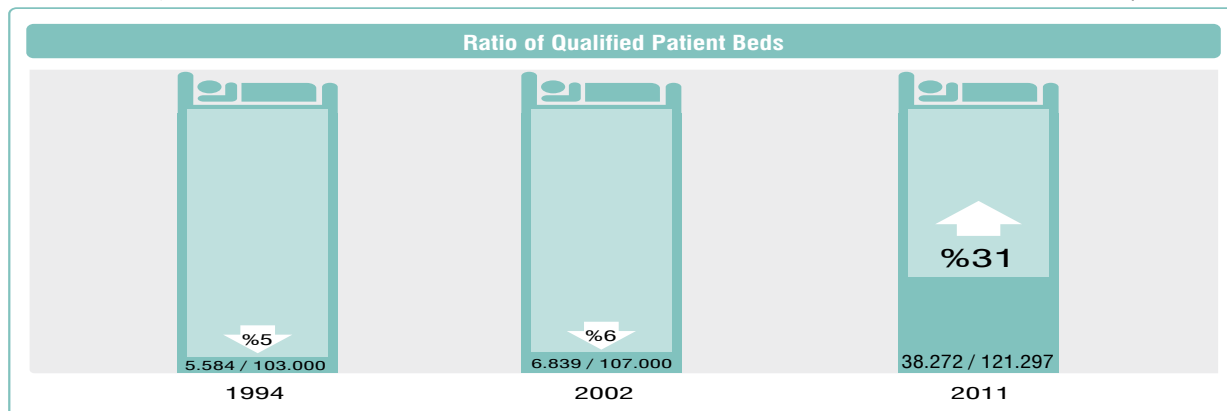
Graphic 89

Source: General Directorate of Health Investments

In the last nine years, we have built and commissioned 2,021 health facilities in total, 554 of them being hospitals and additional building and 1,467 primary health care institutions to public. We have completed constructions waiting for a rebound for years. The number of new patient beds went beyond 38 thousand with the inpatient treatment facilities in the last nine years. 80% of the patient rooms constructed during this period have bathroom, toilet, television, refrigerator, telephone and companion seat and are in the class of “qualified patient bed”. The remaining 20% are not included in the class of qualified patient beds due to the projects initiated in the past, about to be completed and not allowing technical revisions. Therefore, the percentage of patient beds with bathroom and toilet in the total number of patient beds rose from 6% to 31% (Graphic 90).



The ratio of qualified patient beds is 100 % in the investments completed after 2003 and recently started.



Graphic 90

Source: General Directorate of Health Services

During the period 1994-2002, 291 hospitals and new blocks were constructed, whereas in the period of 2003-2011, we have completed and commissioned 554 hospitals and new blocks. We have achieved similar level of success in primary health care facilities. During the period 1994-2002, 647 facilities were constructed, whereas in the period of 2003-2011, we have completed and commissioned 1467 new facilities (Table 12).

Health Investments (in number)		
Health Care Facilities	1994-2002	2003-2011
Hospitals and New Buildings	291	554
Primary Health Care Facilities	647	1.467
Total	938	2.021

Source: General Directorate of Health Investments

3. Efforts to Minimize Bureaucracy and Maximize Transparent Management in Health Care Facilities

Public health, public security, public order and implementation of other governmental policies can only be achieved by implementing regulations. However, implementing regulations increasingly cover broader scopes, get increasingly complicated and as a result operation costs rise.

Efforts that are made to minimize bureaucracy and ease administrative procedures pave the way for a reform process, which refers to intervening in this process, accelerating the flow of administrative procedures, alleviating the burden of harmonization with public sector regulations on individuals and business organizations and preserving the principle goals of regulations in fact.

With the amendments we made, we aimed delivery of public services in a rapid, qualified, simple and low-cost manner by developing an efficient, effective, accountable, transparent and individual statement-based public health management (Table 13).

We put the "Public Service Inventory Data Entry Program" into use in order to monitor and evaluate the public service inventories of the MoH departments and units. We gathered all information on intramural process and procedures - as well as information on public services - of the MoH central organization, provincial health directorates, population health centers and health center presidencies in this program.



Steps Towards a Simple and an Effective Public Service Delivery

Request of Information and Documents

- Do not request documents already available in the institutional records.
- Do not request notary attestation, just see the original and get a copy.
- Do not request copy of the birth certificate, criminal record, and residence entry and health record but receive just a personal statement instead.
- Do not request any documents until the final stage of the procedure.
- Do not request documents already available in other facilities' archives and get into contact with them.
- Take just a copy of a document not the original.

Correspondence

- Avoid unnecessary correspondences.
- Put a deadline to correspondences and stick to it.
- Make correspondences electronically.
- Reduce the number of officers putting signature and initials and eliminate interim ranking officers.
- Review the incoming document in the presence of the applicant/visitor and let him or her makeup deficiencies at the very moment.
- Issue a receipt form for the incoming document.
- Handle and conclude the request relevant to the incoming document on due time set by the service standards and notify the positive or negative result to the applicant/visitor.
- In case of a negative result, inform about the rationale and the contact information of the next authority.

Devolution of Power

- Provide the service in the closest neighborhood of the service receiver.
- Join services all under one roof.
- Devolve power downwards in central organization units.
- Devolve power from central units to rural units.
- Devolve power to downwards in rural organization.

Disabled People's Access to Service

- Construct ramps for wheelchairs in service buildings.
- Construct lifts in service buildings if possible.
- Establish a separate service counter or appoint a companion for disabled people if possible.
- Provide proper signboards for disabled people.
- Construct and properly design restrooms and bathrooms for disabled people.
- Arrange disabled parking spaces properly.
- Put a call button and appoint a reception officer for disabled people on the ground floors of high service buildings with no lifts.

Service Standards

- Identify service standards for all facilities.
- Clearly describe the requested papers and forms.
- Make a clear commitment for service delivery calendar and stick to it.
- Indicate primary and secondary application units with contact information against any problems in routine service delivery.
- Announce service inventory and standards in print in service buildings and on the web page of facilities.

Source: General Directorate of Health Services



We asked all provincial health directorates, health group presidencies/population health centers, hospitals and oral and dental health care centers to set their service standards especially for the services which are directly provided for people. We developed an inventory of services given in all central and rural organization units of public facilities. In this regards, we had the affiliated units develop tables indicating the services offered, the documents and information required and the time period of necessary processes and procedures. Later, we duplicated these tables in soft copy and hard copy; we hanged the prints on service buildings and we published the electronic tables on the web pages of health care facilities. These tables also guide people to application process and procedures and competent authority on condition that they cannot receive the services guaranteed.

We also incorporated family physicians into this process. Depending on the effective date of the family medicine implementation, we asked family physicians to complete the process by 2011.

We made amendments to about 30 implementing regulations in the framework of the secondary and tertiary legislations which the MoH is responsible for implementation.

Thanks to legal amendments made in this regards, we managed to simplify bureaucratic process and procedures. We alleviated the burden on bureaucracy and simplified the management for delivery of services which are repeated for almost thousands of times during a year's time.

4. Restructuring the Ministry of Health

One of the components of the transformation programme we carried out was to strengthen the planning, administration and inspection capacities of the Ministry of Health. To this end, we have restructured the organisation of the Ministry. We have put the human in the centre during restructuring process as we always do in every step we take and we pay attention to the expectations of our citizens and the health sector. Moreover, we examined the theory and practice in the other country examples. With the new organisational set-up, our aim was to make the institutions effective, efficient, transparent and accountable at contemporary norms.

What Have We Done with the Decree Law?

A - New Structure of the Ministry

In the new organisational set-up, we have assigned the duties of policy-making, identifying the main rules and conducting the supervision and control duties to the Ministry. In addition, we have set up new institutions attached to the Ministry to carry out the other functions. These institutions are as follows:

1. Turkish Public Health Agency conducting the preventive and primary healthcare services,
2. Turkish Public Hospital Agency conducting the hospital services,
3. Turkish Medicines and Medical Devices Agency responsible for determining regulations and inspection on medicines and medical products.

New organisation of the Ministry and the associated institutions will be completed in a year at the latest. Public hospital associations will also be established during this process.



A1 - Central Organization of the Ministry

- ✦ We have established the Health Policies Board so as to identify the policies of the Ministry and the health system. Thus, we have separated structures of policy making and execution.
- ✦ We have established service units required by the new mission of the Ministry such as the Directorate General of Health Services, Directorate General of Health Promotion, Directorate General of Health Information Systems, Directorate General of Health Researches and Directorate General of Health Investments.
- ✦ Besides, we have maintained the High Council of Health and Board of Medical Specialities that are among the permanent boards of the Ministry. Moreover, we have constituted the Board of Health Professions. This board will deliver opinions on professional matters such as identifying the curriculum, professional field and branches and employment plans for the health professions. It will also conduct professional competency assessment and identify the ethical principles.

A2 - Provincial Organization

- ✦ We have restructured the provincial organization of the Ministry and allowed for establishing district health directorates in addition to the provincial health directorates. Moreover, we have established public health directorates in provinces for the Public Health Agency and general secretariat for the Public Hospitals Agency.
- ✦ We are establishing Public Hospital Associations at provincial level in order to operate the hospitals associated with the Public Hospitals Agency more efficiently, effectively and a better quality. Besides, we are introducing a professional and contemporary management and operation system that can be inspected and is accountable according to the objective criteria, for the associations and the associated hospitals.
- ✦ General secretariat is the top decision making and executive body in the association. There are Departments of Medical Services, Administrative Services and Financial Services under the General Secretariat. Health facilities of the association are managed by the hospital directors. The Directorates of the head physician, administrative and financial affairs and healthcare services directorates are associated with the hospital director. Positions of deputy head physician and deputy director are established at the number determined by the General Secretary on condition that the norms and the standards specified by the institution are not exceeded, Specialised staff and office clerks are employed to carry out the office services in the General Secretariats in line with the position of the contracted personnel in the General Secretariats.

B - Personnel

- ✦ We have allowed for employing health specialists in order for the services to be carried out by specialised staff and contracted specialists for the works and projects that require special knowledge and speciality.
- ✦ Moreover, we have started the implementation of measurement and evaluation of the performances of the managers and the other personnel employed in the Ministry and the associated institutions.



- We have introduced the performance-based supplementary payment also for the personnel working in the associated institutions we have recently established.
- We have ensured that the Ministry provide free attorney services within the scope of the cases on crimes committed against our personnel during provision of health services or due to their duties.
- In addition, we have created lecturer cadres for clinic chiefs and clinic chief residents so as to make the clinics in our hospitals more efficient. We have appointed the existing clinic chiefs and clinic chief residents to lecturer cadres.
- We enabled the lecturer cadres in the Ministry to be used for the appointment of the academic staff in the health institutions used jointly with the universities, to academic cadres.
- Considering the physician and nurse shortages, we have made it possible for the foreigners to work in Turkey. However, the conditions of diploma equivalence, speaking Turkish and other necessary conditions will be required for them to work in our country.
- Moreover, we have provided the opportunity for those who are engaged in doctoral studies in faculties of dentistry to continue their education by receiving a salary at the same time in the cadres of the Ministry.
- In the new organisational set-up we have retained the acquired rights of our current personnel and have not allowed any unjust treatment against them. Within this framework, we decided to appoint those whose cadre titles did not change to the Ministry and the associated institutions with the same cadre titles. On the other hand, we have appointed those, whose cadres were removed, to the cadres of Ministry advisor or researcher and ensured that they are paid compensations if there are financial differences between their new and old cadres.

C - Family Medicine

- We ensured the family physicians that work in the field and have won the Examination in Speciality in Medicine to get speciality training by maintaining the contracts and this implementation will continue until 2020 in order to meet the family physician needs of our country.
- The medical residents in family medicine are given the opportunity to conduct their field training as family physicians.
- The period that family physicians and the family health personnel spend under contracted status will be taken into account in their employee status while they are continuing these services and adaptation will be ensured.
- Family physicians will receive positive performance based on their success in health promotion, prevention, monitoring and control of diseases and they will be paid accordingly.

D - Investments

- We have provided financial and other types of incentives for the development of medical devices, products, services and pharmaceutical industries that require advanced technology and we also enabled technology transfer and off-set practice from abroad.
- We allowed for the establishment of free zones on health so as to make our country a regional attraction centre in the area of health and accelerate the flow of foreign capital and technology into the country.



E - Miscellaneous Developments

- Healthcare service units can be established abroad for the purposes of humanitarian and technical aid.
- The people and the institutions authorised to provide health services can provide voluntary and free health services for social purposes.
- We have made it compulsory for the TV and radio channels to air warning, informative and instructing programmes for 90 minutes a month for free.
- We have introduced the condition of having a license to open a health institution in order to more fairly determine the investor to make health investment according to the planning of the Ministry.
- Moreover, we made it mandatory to provide training on sanitation for the employees in workplaces related with food production, sales and cleaning services. The people with contagious diseases and other certain health problems shall not be allowed to work in these workplaces until they recover so as to protect the public health. We have introduced the reference price implementation in dental clinics instead of price tariffs so as to enhance the service quality and protect the citizens financially.
- We have also introduced consensual settlement procedure between the parties to solve the legal disputes, which stem from the practice of health professions, within a short period of time and without pursuing legal remedies.

5. Health Policies Board

Health Policies Board consists of eleven members, the Undersecretary and the deputy Undersecretaries who are assigned to carry out the main duties of the Ministry on health system management and policy making.

The board members are assigned by the Minister from among those who have at least a bachelor's degree and eight -year business experience. Term of office is two years and the members whose term of office has expired can be assigned again.

The Undersecretary or one of the Deputy Undersecretaries that he will assign chairs the board.

The board may invite universities, professional organizations, trade unions, non-governmental organizations and directors or experts from the associated institutions or departments of the Ministry to receive their opinions in the meetings.

Advisory board and commissions can be established under the board so as to carry out activities and deliver opinions on scientific matters and issues that require specialization in the area of responsibility of the Ministry.

Personnel from the Ministry and the associated institutions and universities, other public institutions and organizations and the private institutions and organizations or foreign experts can be assigned in the advisory boards and commissions.

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

6. Cross-Border Health Care Services and the European Union



1. Dynamic and Friendly Foreign Relations

We have intense cooperation with many countries also including those that we have cultural bonds. We signed Cooperation in Health Agreements with various countries in order to build a legal basis for such cooperation. While we had 39 Cooperation in Health Agreements with 33 countries in 2002, today we have 97 agreements with 56 countries.

Signing such agreements, we put further emphasis on the exchange of personnel, knowledge and experience in health, direct and close contacts among scientific institutions and supporting commercial enterprises in private sector between countries.

Recently, we have developed cooperation in health with many countries such Sudan, Yemen, Afghanistan, Palestine, the Balkans, Central Asia and the Caucasus including the following activities:

- Technical support to developing health care systems,
- Educating and training healthcare personnel in Turkey or in that country,
- Organizing congresses and seminars,
- Performing surgical operations

The WHO European Ministerial Conference on Counteracting Obesity, 15–17 November 2006, Istanbul, Turkey was organized by the WHO Regional Office for Europe in collaboration with the European Commission, hosted by the Turkish Government and chaired by Prof. Dr. Recep AKDAG, the Minister of Health. Prof. Dr. Sabahattin AYDIN, the MoH Undersecretary, was elected as a member of the WHO Executive Board for three years. Prof. Dr. AYDIN is the fourth Turkish scientist, who has been assigned in the WHO Executive Board since 1948. On the other hand, the Minister of Health of Turkey acted as chairman in the 56th European Regional Committee Meeting in Copenhagen which welcomed the Ministers of Health and high-ranking officers from 53 European Regional Member Countries. Prof. Dr. Recep AKDAG, the Minister of Health, acted as the vice chairman in the 63rd World Health Assembly Meeting which was held on 17-21 May 2010 with the participation of 193 member states.

A. Education and Training

We provide health care personnel (doctors, nurses, health officers and technicians etc.) from many countries with short and long-term education and training either in scope of the Cooperation in Health Agreements or upon requests of the Ministry of Foreign Affairs and Prime Ministry-affiliated TİKA Presidency. Education and trainings are given in the MoH central organization and in the MoH-affiliated Training and Research Hospitals.

At the end of these education and training activities, foreign health care personnel put the knowledge and experience they gain in Turkey into the use of their nations. Turkish delegations, which make visits to these countries, witness that these foreign professionals offer health care services in their homeland more successfully and productively and that they make further progress in their career.



Such studies contribute to both HRH capacity development in these countries and advertising Turkey.

B. Patient Treatment

In the framework of the Cooperation in Health Agreements that we signed with Afghanistan, Albania, Azerbaijan, the TRNC, Sudan and Yemen, we allow transfer of a certain number of patients, who cannot be treated in their countries, to Turkey for charge-free treatment. Besides, we provide treatment for foreign patients if requested by the Ministry of Foreign Affairs.

In addition, we will be providing charge-free treatment for a certain number of patients from Iraq and Mauritania once the Memorandum of Understanding on Cooperation in Health signed with Iraq and the Cooperation in Health Agreement signed with Mauritania comes into effect

C. Pharmaceutical and Medical Supplies Aids

Also we give pharmaceutical, medical device and supplies aids to other countries upon the requests and recommendations of the Prime Ministry-affiliated AFAD Presidency, Ministry of Foreign Affairs and the Prime Ministry-affiliated TIKA Presidency.

D. International Health Care Facilities Supported for Repair-Construction Works, Medical Supplies and Management

- **Sudan Kalakla Turkish Hospital**

We restored Kalakla Turkish Hospital, which was built by Turkey in 1996. We equipped the hospital with medical devices and equipment, which were provided by Turkey, and re-opened to service in 2007.

- **Sudan Darfur Nyala Saharan Hospital**

General Directorate of Turkish Red Crescent built the Saharan Hospital in Nyala. Healthcare personnel are supplied by the Turkish MoH. In addition to this, we are working on pharmaceuticals and medical equipment supply to Sudan.

- **Sudan Darfur Nyala Hospital**

A 150-bed capacity hospital to be built by the Prime Ministry and the Administration of Turkish Cooperation and Development (ATCD) will come into service in late 2012.

- **Southern Sudan Juba Training Hospital**

We equipped the Operation Theater, Gynecology-Obstetrics, Pediatrics and Imaging Units of Juba Training Hospital with our national resources at all



♦ Republic of Moldova - Autonomous Territorial Unit of Gagauzia

Turkey grants financial, technical and humanitarian aid to the Republic of Moldova - Autonomous Territorial Unit of Gagauzia and recently Turkey has provided 3 hospitals located in Ceadir- Lunga, Vulcanesti and Comrat with medical devices, equipment and supplies.

♦ Ethiopia

We re-equipped the gynecology-obstetrics, pediatrics and newborn clinics, imaging center and operation theater of the Black Lion Training and Research Hospital in Ethiopia with medical devices, equipment and supplies which we provided from Turkey.

♦ Pakistan

Following the flood striking Pakistan, we provided 7 hospitals in the region with medical devices, equipment and supplies and sent the equipment in an aid plane on 21 and 28 January 2011. A technical team of the MoH is still continuing its work in the region.

♦ Somali

In the framework of our continuing humanitarian aid to Somali, we give service with 2 saharan hospital in Mogadishu. We continue to meet pharmaceutical, medical device and medical supplies of these hospitals.

E. Joint Health Weeks

We celebrate the joint health weeks with our counterparts in line with the cooperation agreements and protocols that we signed.

Scientists, specialists and professionals, who take the chance to come together on the occasion of the Joint Health Weeks, exchange views and look for the ways for maximizing the existing cooperation.

We have celebrated the joint health weeks with Afghanistan, Sudan, Yemen, Nahcevan, Iraq, Syria, Mauritania, Republic of Moldova the Autonomous Territorial Unit of Gagauzia and the Turkish scientists, health specialists and professionals have organized joint conferences and workshops in these countries, and the Turkish doctors have performed joint surgical operations and health checks with foreign colleagues so far.

F. Empowering Health Care Systems

“Health Systems Empowerment” is a subject of priority in the WHO agenda. In this regards, we give technical support and counseling services to Macedonia, Afghanistan, Sudan, Kosova, Libya, Moritanya, Syria and Iraq with the aim of communicating the experience and knowledge to other countries, which we have obtained as a result of the actions that we have made under the Health Transformation Program. Also we gave technical support and counseling services to Syria and Iraq.



G. International Aids in Disasters and Emergency Cases

Being the Turkish MoH, we give specialized personnel, medicines, medical devices, equipment and supplies aids to the countries and regions suffering from disasters (earthquakes, tsunami, floods etc.) in cooperation with other public organizations in Turkey such as the Turkish Red Crescent, Prime Ministry-affiliated General Directorate of Emergency Events, the Turkish Ministry of Foreign Affairs, Turkish General Staff and the Prime Ministry-affiliated TIKA Presidency.

In this framework:

- Since December 2003, we have sent a health team consisting of 81 members to Bam, Iran which was stroke by an earthquake.
- In January 2005, we sent 14 health care employees accompanying the Turkish Red Crescent to Aceh, Indonesia which suffered from the earth quake and tsunami striking the Southern Asia.
- In January 2010, we established a mobile hospital and appointed health care personnel in Haiti after the earthquake within the scope of support intended by our Government.
- In August 2010, we started humanitarian and medical aid to Pakistan that suffered from flood and we established 2 mobile hospitals, appointed health care personnel and sent medical devices, equipment and supplies to Pakistan. 2 Turkish hospitals are still functioning in Pakistan.
- We did not look on the humanity tragedy in Somali. In our 2 saharan hospitals running in Mogadishu, we give health care services to people there and we also equip the hospitals with pharmaceuticals and medical supplies.
- We treated the Libyan injurees at our hospitals. Coordinated by the Prime Ministry-affiliated ASAD, we transferred 575 Libyan people to Turkey and provided them with necessary treatment. We sent medicines and medical supplies there. Also we are trying to establish a Physical Treatment and Rehabilitation Center in Misurata province.
- We neither did nor reject the Syrian asylum-seekers who escaped from their countries due to the conflicts and attacks. We offer health care services to about 25.000 asylum-seekers.

2. Efforts in the EU Negotiation Process

Once the negotiations for accession to the EU were officially started, Turkey took yet another turn in harmonization of national legislation with the EU legislation. In this context, the Turkish MoH is charged with “Protection of Health”. The efforts that Turkey has made for EU harmonization are briefed as follows:

A. Phase for Protecting Consumers and Health

In the context of Protecting Consumers and Health, we made regulations on legislative harmonization, projects and action plans, communicable diseases, blood and blood components, tissue-cell and organ transplantationsi tobacco, alcohol and susbtance addiction, electromagnetic fields, cancer, physical activity and mental health.

* The power to make regulations on electromagnetic fields was devolved to the Ministry of Environment and Forestry.



The studies, which we conducted in relation with the closing criteria of “Protecting Consumers and Health”, are briefed in the following:

A.1. Communicable Diseases

In the process of accession to the EU, Turkey put emphasis on the surveillance and control of communicable diseases and made an impressive progress.

We published the “Regulation on the Surveillance and Control Principles of Communicable Diseases” in 2007. We updated the regulation in accordance with the EU legislation. We aligned our legislation with that of the EU.

In this context, we updated the disease notification system, made case descriptions for standard notification and harmonized our system with the international disease Networks in order to join the EU and WHO more effectively with regards to data share. We took some important steps to improve relations with the European Center for Diseases Prevention and Control (ECDC) which is the primary authority of communicable diseases surveillance and control in the EU. We benefited from the EU’s technical support, knowledge and experience in communicable diseases. For example, we received technical support from the ECDC in fight with the recently emerged diseases such as swine and avian influenza.

We published the “Strategic Plan for Strengthening the Communicable Diseases Surveillance and Control System in Turkey”.

A.2. Blood and Blood Products

We issued the Blood and Blood Products Law in 2007 and the Blood and Blood Products Regulation in 2008, and thus we completed legislative harmonisation. We published the Blood and Blood Products Guideline in July 2009* and we updated it in 2011. We regulated the technical conditions for the quality system of the blood related facilities, with the new legislation. We created service units that meet the conditions to ensure more efficiency in blood services and we also licences these units. Moreover, we accelerated the activities to make the regional blood centres operational.

We authorised the Regional Blood Centres (RBC) to collect the blood from the donor, test, prepare, store and distribute it with blood donation organization and Turkish Red Crescent to establish Regional Blood Centres. Turkish Red Crescent has created 15 Regional Blood Centres and 56 Blood Donation Centres and it meets the needs for safe blood provision through the Transfusion Centres established within our hospitals. We have issued a Temporary Regional Blood Centre (TRBC) license for 1 year for the transfusion centres of hospitals, which have high rates of blood use and whose blood needs cannot be met by the Turkish Red Crescent, until the time Turkish Red Crescent completes its infrastructure. While the number of TRBC was 84 in 2010, we reduced it to 58 in 2012.

* Blood and Blood Products Guideline was prepared on the basis of European Directorate for Quality of Medicine and Health Care (EDQM) Guideline. EDQM has updated its related guideline. Inter alia, we have initiated the activities to update the National Blood Guideline.



We have organized campaigns together with the non-governmental organizations in order to increase the sensitivity of citizens for blood donation and to emphasise its importance. Owing to the conducted activities, training sessions and briefings; blood donation went up from 326.337 in 2002 to 1.276.212 units in 2011.

The use of whole blood, which was 60 % in 2002, was reduced to 5 % in 2011. The Ministry of Health took an important step by issuing the new blood regulation and established regional blood centers system. So, we replaced the exchange method with voluntary, regular and unpaid blood donation which is essential to access to safe blood and covered all stages of blood donation in the EU standards. In the new system, all stages of blood donation and transfusion is closely monitored and severe reactions are notified to the Ministry of Health. The Ministry of Health organizes comprehensive training programs for access to safe blood and regulates technical requirements for the quality systems of blood centers.

So, our citizens can more easily access safe blood in modern facilities based on volunteerism.

A.3. Tissue and Cell

We completed the studies on the “Implementing Regulation on Human Tissues and Cells and Quality and Safety of Relevant Medical Facilities”.

With this Regulation, we set the EU standards for all processes and procedures relevant to human tissue and cell transplantation including immunization, supply, labeling, registration, monitoring, testing, packaging, storing and distribution.

So, we set the highest quality and safety standards to protect human being's life and regulated basic principles of tissue and/or cell centers, supply facilities and test laboratories for establishment, management, personnel and service infrastructure and supervision.

As known, tissue and cell transplantation is a curative method which can save life. Therefore, these efforts made direct contribution to promoting the health of people in Turkey.

B. Phase of Intellectual Property Law

Intellectual property rights refer to literary works and the rights of literary work owners producing works in industry, science, literature and art fields. The MoH is interested in pharmaceutical patents with regards to industrial property rights. In our country, industrial property rights are registered by the Turkish Patent Institute.

Pharmaceutical patents concern the MoH with regards to outcomes because pharmaceuticals are the products of a long-term and high-cost research and development process. Therefore, a “pharmaceutical patent” has a specific significance for encouraging and boosting innovations in the pharmaceuticals sector. Besides, the Ministry of Health supports the R&D studies and innovations in pharmaceutical sector. The Ministry of Health both supports innovation and implements its specific policy to prevent misuse of the Intellectual Property Rights through strategies like “ever greening”.



C. Phase of Environment

Under this heading, we conducted studies on drinking water, swimming water and biocides.

C.1. Implementing Regulation on Drinking Water

The MoH issued the “Implementing Regulation on Waters for Humanitarian Consumption” and harmonized the national legislation with the EU legislation. The safety of water consumption and the physical inspection of the quality of manufacturing facilities are regulated in this framework.

At the same time, this Implementing Regulation allows the MoH to monitor, inspect and report drinking waters. In case of need, the MoH is authorized to impose necessary sanctions.

C.2. Implementing Regulation on Swimming Water Quality

As a part of the MoH efforts aiming to empower the quality of swimming water monitoring, a project, which was developed in relation to the “Implementing Regulation on Swimming Water Quality”, was approved by the EU and the project will be started in 2012. Besides, we collaborate with the Ministry of Forestry and Environment pertaining to the regular monitoring of swimming water quality and taking precautions when necessary.

C.3. Implementing Regulation on Biocides

We successfully completed an EU project on biocides in 2008 and issued the Implementing Regulation on Biocides in 2009. After the project was completed, we gave trainings to 200 biocides control personnel.

D. Right of Establishment and Freedom to Provide Services

Right of establishment and freedom to provide services is one of the four freedoms of “Single Market.” Within the framework of this chapter, the Member States must ensure that Right of establishment and freedom to provide services in anywhere in Europe is not hampered by national legislation. Special rules are introduced with regard to mutual recognition of professional qualifications and diplomas in order to facilitate practising certain professions. A harmonized curriculum must be followed for the recognition of the professional qualifications in an EU Member State.

Professional qualifications and their mutual recognition between the Member States is very important in this phase. EU splits the professions into two groups and implements two separate systems for the groups within the framework of this phase.

The first group of professions is the professions for which minimum training conditions, curricula and course durations are regulated clearly and there is an obligation to implement them uniformly in all Member States. These are the doctors, nurses, dentists, midwives, veterinarians, pharmacists and architects. The system of “automatic recognition” of professional qualification is implemented for the abovementioned professions in the EU.

** The strategy defined as “ever greening” means that reference (innovative) medicine producer has different characteristics of the same medicine protected through continuation patents. While this strategy is in favour of the reference medicine producer, it causes adverse effects for equivalent rival products such as to be kept away from the market and the public not being able to access to the medicine.



We harmonised with the EU curriculum and minimum period of education in the professions of doctors, nurses, midwives, pharmacists and dentists with the enactment of the “Regulation on Identification of the Minimum Educational Conditions for the Curricula of Doctors, Nurses, Dentists, Veterinarians, Pharmacists and Architects” which our Ministry contributed to during preparatory work and which was prepared by the Council of Higher Education.

The second group of professions within the scope of this phase is the professions for which there are no regulations such as minimum educational conditions for pursuing the profession in the EU. Each Member State is free to draft its national legislation concerning these professions.

Within this scope, 26 professions that are currently practised but not regulated are regulated with the Law dated 6225 that entered into force in 2011. These are the professions of clinic psychologists, physiotherapists, audiologists, dieticians, language and speech therapists, podologists, health physicians, anaesthesia technicians, medical laboratory and pathology technicians, medical laboratory technicians, medical imaging operator/technicians, oral and dental health technicians, technicians of dental prosthesis, medical prosthesis and orthosis technicians operating room technicians, forensic science technicians, audiometry technicians, dialysis technicians, physiotherapy technicians, perfusionists, radiotherapy technicians, pharmacy technicians, occupational therapists (ergotherapists), occupational therapy technicians (ergotherapy technicians), electro-neurophysiology technicians and mammography technicians.

E. Phase of Free Movements of Goods

Phase of Free Movements of Goods includes issues on regulation of many wide ranged and closely related areas. The phase also includes horizontal issues such as standardization, accreditation, market surveillance and control and common regulations on commercial products and lifting the customs duties, equivalent effect taxes and amount restrictions.

We completed harmonization on toys, detergents, medical devices, medicinal products for human use, cosmetics, special purpose dietary food, market surveillance and control, unregulated field notification procedure and good laboratory practices.

Within the framework of negotiations, the Ministry of Economy is responsible for the coordination on the Phase and the activities related to the opening-closing criteria and preparation of the position documents are carried out by the Ministry of European Union Affairs.

5 opening criteria are specified for the Phase; the third criterion is directly related with our Ministry and is as follows; “Turkey must present an action plan including the intermediate objectives to ensure the required harmonization and implementation for the “horizontal and procedural measures” including pharmacy products.”



Ministry of Economy, the coordinator of the Phase, conducted activities related to the opening criteria in 2007 and prepared an action plan. Our Ministry submitted a general plan including the legislative harmonization on medicinal products for human use within this framework as it is also stated in the said criterion.

F. Efforts Made for Developing the Market Surveillance and Control (MSC) Infrastructure in 2003-2010

MSC refers to the control of government agencies over the movements of related products within the market in order to monitor if these products comply with necessary laws and legislations in both pre-marketing and marketing stage, and to impose necessary sanctions if not.

Although the MoH has been functioning as a control authority in order to protect public health for long years, the notion of “controlling within the framework of the EU harmonization” is somewhat new in Turkey.

Responding to this recently emerged need, the MoH issued the “Implementing Regulation on the Principles of the Market Surveillance and Control Activities of the MoH” on 25 June 2007.

With the MSC, we developed a system which targeted top-level protection of human being’s health and safety by keeping people away from unsafe and non-standard products in the market and immediately and effectively taking the precautions required.

In the context of the MSC, we have strengthened the laboratory infrastructure, trained and certified the controlling personnel, coordinated controls and conducted activities to determine and impose necessary sanctions in case of inconformity so far.

Also, being the MoH, we undertake the control over medical devices, cosmetics, toys and detergents. In 2009 and 2010, we issued a surveillance and control legislation for bleachers, pool chemicals, and air aromatizing products, sanitary pads and diapers.

With the Decree Law No. 663 on the “Organization and Tasks of the Ministry of Health and Affiliated Agencies”, we re-defined the MSC among the tasks of the Ministry of Health. In this scope, we made changes to our organizational structure for a more effective MSC.



G. EU Projects

The EU-funded projects, which the MoH conducted in 2003-2011, are listed in the following:

“Public Health” is the top priority field, for which the MoH has received support from the EU so far.

Turkey and the MoH took some significant steps in harmonizing the national legislation with that of the EU through conducting the below listed studies in 2004, 2005 and 2008:

- Strengthening the Epidemiologic Surveillance and Control System for Communicable Diseases in Turkey-I
- Strengthening the Epidemiologic Surveillance and Control System for Communicable Diseases in Turkey-II
- Communicable Diseases Surveillance and Control Project-III

Pertaining to the EU for the “Empowering the Blood Supply System Project” in 2008, made efforts to approximate the national quality and safety conditions to the EU norms.

Medical procedures relevant to tissue and cell are rapidly advancing. New opportunities come into the stage for many diseases which were incurable in the past. In this regards, the Harmonization for Tissue and Cell Project aims to establish quality and safety standards, and to minimize infection risks in surgical procedures this way. By implementing the Harmonization for Organ Transplantation Project, similarly, we aim to establish quality and safety standards in organ transplantation, as well.

With the “Reproductive Health Program” of about 60 million Euro fund, we made efforts to increase the institutional capacity in Turkey and we supported the NGOs with grants.

The “Project of Support to the Turkish Feasibility Assessment Agencies” (2002-2007), which had five different beneficiaries, aimed to support the infrastructure of MSC laboratories and to train the laboratory personnel for detergents, medical devices and toys, towards which some severe progress had been already made. Under the Project, we provided equipment supply for medical devices and detergents and trained the personnel.

In the framework of the “Project of Strengthening the Capacity of Ministries in Turkey for Market Surveillance and Control Activities in Certain Fields” (2006-2008) is another EU-funded Project which is jointly implemented with five ministries pertaining to strengthening the MSC activities. Under this Project, we developed a MSC strategy, established a surveillance system, and trained personnel and auditors.



We carried out the “Safety of Toys Project”, supported within the framework of the EU Leonardo da Vinci Occupational Training Program with the participation and contributions of various universities and private sector companies under the guidance of the Refik Saydam Hygiene Center Presidency (RSHCP) in 2007-2008. We carried out this Project, which had approximately 500.000 Euro budget, jointly with Spain, Portugal and Italy. With this Project, we raised the awareness of trainers, who are in charge of training 0-14 aged consumers, toy manufacturers, importers, dealers, auditors etc. for safety of toys and child health. We informed consumers of proper toy selection methods and risks of toys; we informed actors in the sector of technical guides, scientific researches, reports and standards particularly. We implemented two other projects for safety of toys and we conducted studies to ensure access to safer toys for children.

Besides, we conducted the “Good Laboratory Practices (GLP) Project” in cooperation with the Ministry of Forestry and Environment and the MARA. The Project, which was started in June 2006 and concluded in 18 months, aimed to empower the administrative and technical capacity of Turkey to harmonize the national legislation on GLP with that of the EU and we developed a new legislation.

Finally, we adapted the RSHCP Control and Research Laboratory to the EU standards under the “Quality Control Tests for Human Vaccines and Sera Project” in 2007.

H. Legislative Harmonization

We harmonized our legislation with the EU acquis on public health issues such as medical devices, medical products, cosmetics, detergents, tobacco and tobacco products, toys, biocidal products, communicable diseases, health professions, blood and blood products, tissue and cell, and strengthening laboratory infrastructure.

We made fundamental changes in the organisational structure of the Ministry on the basis of the “Decree on Organisations and Tasks of the Ministry of Health and the Affiliated Agencies” numbered 663. We established “Turkish Drug and Medical Devices Agency” and “Turkish Public Health Institute.” Moreover; we implemented the two measures that we promised as the Ministry in the “National Programme of Turkey for the Adoption of EU Acquis” published in 2008.

We continue our activities on legislation in parallel with the updates in EU legislation with regard to the aforementioned product groups and fields.

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

7. Multi-Dimensional Health Responsibility



1. Public-Private Partnership

With the aim of providing people with more effective and qualified health care services, we introduced the Public-Private Partnership model by designing huge investments such as metropolitan hospitals and benefiting from the private sector's capital and experience in service design and management in such big hospitals.

Adopting this model, we will be able to construct the new hospital campuses which are necessary for Turkey.

Why Hospital Campuses?

Regarding improving the efficiency of health care services in our country

In order to;

- Generalize the wide of range of health care services to the whole country,
- Complement regional development in health dimension,
- Improve the quality of health care services, and
- Ensure cost-effective health service delivery.

Pertaining to the needs of the population:

In order to;

- Achieve to reach the adequate quantity and quality of patient beds,
- Provide regions with comprehensive health service delivery with specialized teams,
- Apply new technologies in diagnosis and treatment,
- Adopt and establish new concepts in curative services such as day-surgery, day-hospital etc.

Pertaining to the needs of patients

In order to;

- Reduced length of stay in hospitals,
- Diminish patient transfers and referrals,
- Minimize hospital infections,
- Maximize patient safety, and
- Increase patient satisfaction with health care services.

Pertaining to the needs of the health care personnel

In order to;

- Increase employee safety and satisfaction,
- Increase labor force and service quality,
- Increase health service performance.

2. Public Institutions

A. Cooperation with the Prime Ministry-Affiliated Housing Development Administration (TOKİ)

We collaborate with the Prime Ministry-affiliated Housing Development Administration (TOKİ). Following the protocol signed between the MoH and TOKİ, we had the TOKİ build new health care facilities. So, we further improved the MoH's capacity of physical infrastructure without placing a burden on the Treasury.



One-third of the construction works, which are already conducted or are still being conducted by this protocol, are paid in cash while the second one-third are financed with estate sales and the last one-third are financed by a deferred payment plan to be paid in installments.

Some parts of the estates of appropriation are owned by the MoH and the other parts are owned by the Treasury. Also, nationalization is considered and applied as an option while developing the current lands stock.

Making these efforts with these resources, we bring modern structures to the national health care sector, which comply with the contemporary hospital vision. The new hospitals, which are built with this understanding, have a modern architecture, qualified one or two-bed patient rooms, closed parking spaces and landscaped spaces. Moreover, the health care facilities to be built under this protocol will be smart buildings that allow effective utilization of advanced medical and technological instruments.

Under this protocol we have completed 40 projects with a bed capacity of 7.776 on 1.383.700 square meters. Construction continues for 132 projects with a bed capacity of 20.130 on 3.657.295 square meters. In addition to that tender process continues for 52 projects with a bed capacity of 9.105 on 1.379.742 square meters and we also plan to implement 166 projects with a bed capacity of 19.670 on 3.547.600 square meters.

B. Cooperation with the Council of Higher Education (CHE) and Universities

Number of physicians is very insufficient in Turkey. Turkey ranks 52 out of 53 countries in WHO European Region in terms of number of physicians per 1000 population. While the number of physicians per 100.000 population is 326 in WHO European Region, it is 169 in Turkey. In other words, the number of physicians in Turkey per 100.000 people is only half of the number in WHO European Region.

Turkish Medical Association is mainly responsible for the low number of physicians in our country. For decades, Turkish Medical Association has alleged for ideological reasons that the number of physicians in Turkey is sufficient. Moreover, it succeeded in affecting the pre-2003 administrations through this ideological approach which is not based on scientific evidence. Unfortunately Higher Education Board was also under the influence of this ideological approach until 2008. For example; while the number of students enrolling in medical faculties was 5.367 in 1983, it was, after 24 years, 5.253 in 2007.

Our country suffered a lot due to this ideological approach of Turkish Medical Association for decades. As the number of physicians is very insufficient, obviously the workload of our physicians is very high compared to their colleagues in Europe. However, we have to solve the health problems of our citizens with our physicians in this country. From time to time, undesirable situations can occur due to the intense workload of our physicians. As the problem is insufficiency of absolute number of physicians, it will take time to completely solve this problem. The ideological attitude of the Turkish Medical Association on the basis of intense workload of physicians is definitely an irony.



Unemployment of Health Care Personnel

Journal of Society and Physicians, March-April 2006,

Volume: 21, No: 2

Published by: Turkish Medical Association

“The outcome is, to express gently, is “oversupply of health care personnel”. It means “unemployment”. According to the TMA, one of every five physicians is supposed to lose his job if things are the same in 2020, too”.

Health care personnel play an important role in raising the health status of a population and continuing living in good health. For this reason, the quantity and education of health care personnel, together with training facilities and service facilities where health care personnel receive trainings and offer services, are very important, too. Therefore, adequate number of health care personnel should be educated and trained in a way meeting contemporary conditions, requirements and criteria, and a sound workforce planning and a balanced personnel distribution should be managed afterwards. In this context, the MoH launched a close cooperation and coordination process with the CHE in 2007 and student’ quota for higher education in health has been raised since then (Table 13).

We jointly prepared the human resources report. We collaborate with universities and we will soon reflect the products of these efforts on education, research and management.

Table 13. Comparison of the Student’s Quotas for Health Education at University

Department	2006-2007 Quota	2011-2012 Quota
Faculty of Medicine	4.953	8.880
Faculty of Dentistry	1.072	2.271
Faculty of Pharmacy	1.009	1.509
Faculty of Nursing	4.348	11.680
Faculty of Midwifery	1.350	1.927

Source: Council of Higher Education (CHE)



We paved the way for joint use the MoH's and its affiliated agencies' health care facilities and the university-affiliated health care facilities, in addition to ensuring cooperation between the MoH and universities.

As of the end of 2011, the MoH has protocols signed with 14 universities for joint use of facilities and cooperation.

C. Cooperation with the Ministry of Education (MoE)

We implement programs and projects in order to raise awareness for health status of school age children. We make use of a variety of communication instruments such as CDs, brochures, booklets, theaters etc. We started the Nutrition-Friendly School Project and the School Diabetes Program. We made arrangements for school cafeterias and we are still trying to encourage school cafeterias to offer healthy menus to children. We designed and implemented a program with physical education teachers to prevent obesity and encourage physical activity. We added new courses to the curriculum and increased the hours of physical exercise course (3 hours a week in the 1st-3rd grades and 2 hours a week in the 4th-8th grades) in order for children to adopt the habit of physical exercise. On the other hand, we give trainings to teachers, students and families in primary schools by using health nutrition modules developed in the framework of the "Life with Healthy Nutrition and Physical Activity Program".

We implement the "White Flag Project" which indicates the quality of schools in terms of hygiene.

D. Cooperation with the Ministry of Food, Agriculture and Livestock (MoFAL)

Recognizing the need for a multidisciplinary fight with and control over zoonotic, vectorborne and parasitery diseases, the MoH works in cooperation with the MoFAL. In this regards, the population of ticks, which are biological vectors responsible for circulation and transmission of the Crimean-Congo Hemorrhagic Fever Disease, should be reduced to an acceptable level. With this aim, we have collaborated with the MoFAL in the fight with ticks also including but not limited to funding and we provide necessary support to the MoFAL. In the fight with rabies, we get engaged in joint studies and actions with the MoFAL in both central and rural organization levels.

We continue our fight with rats in order to control and prevent Tularemia. As for Anthrax, we gave trainings to veterinaries under the "Identifying the Molecular Epidemiology of the Bacillus Anthracis Infection and the Antibiotic Susceptibility of Isolates in the Anthrax- Hyperendemic Areas in Turkey" project. As for the Avian Influenza, we organized and gave public trainings supported by joint communication strategies and training materials. We performed joint exercises for personnel training. We are still conducting surveillance studies on domesticated poultry.

We collaborate with the MoFAL in order to prevent food-borne poisoning and other food-borne disease outbreaks, as well.



E. Cooperation with the Ministry of Environment and Urban Planning (MoEUP) and the Ministry of Forestry and Water Affairs (MoFWA)

With the MoEUP and the MoFWA, we take joint actions for the following:

- Protecting water resources by clean water supply
- Preventing or minimizing noise and air pollution
- Inspecting and facilitating operations and management of industrial facilities and all other commercial enterprises for optimum health and peace of people
- Fighting with all harmful agents that can threaten public health such as garbage, wastes, fertilizers and vectors etc.
- Having a strict control over environment polluters to natural resources
- Giving timely and effective environmental health care services in case of disasters.

F. Cooperation with the Ministry of Defense (MoD)

In the framework of close cooperation with the Turkish Armed Forces, we have launched reproductive health and family planning trainings for male, who perform military services in the army. Beforehand, we gave “training for trainers” to 4.000 military health care personnel and facilitated them to give reproductive health trainings in all troops. So, every year 500.000 young men, who obtain basic information on reproductive health and family planning, go back home after military service. Since 2004, we have trained more than 4 million soldiers until 2011 this way.

G. Cooperation with the Ministry of Family Affairs and Social Policies (MoFASP)

We co-worked with the Administration for Disabled People and jointly made arrangements for identifying disability criteria, classification and health committee reports to be issued for disabled people. We have conducted and are still conducting joint studies in disabled people’s access to health care facilities and services, home care services etc.

We worked on establishing and managing the data bank for disabled people.

H. Five Partite Cooperation in Health Financing (Undersecretariat of Treasury, Ministry of Finance, Ministry of Development, Ministry of Health, and Ministry of Labour and Social Security)

We established the Commission for Monitoring and Evaluation of Health Expenditures in order to systematically monitor, evaluate the health spending and develop the necessary strategies.

The stakeholder institutions are informed about the developments in health spending and the Ministry of Health regularly provides information to management of economy.

Public health spending and the payments to be made to the health service providers are identified through the data prepared by the Commission. The Commission makes analysis on the development of health spending and new policies are determined as a result of these analyses if it is deemed necessary.



Joint activities are carried out based on consensus on global budget transactions, fixing the prices within the framework of Health Implementation Communique (HIC), identification of the drug prices and preparation of investment plans for healthcare services.

I. Cooperation with the Ministry of Labour and Social Security (MoLSS)

We work with the MoLSS on regulations about occupational diseases and establish the legislative framework and information technology infrastructure. As well as that, we also cooperate on with the MoLSS in drafting legislation on Workplace Medicine in compliance with the macro health policies of Turkey.

3. International Organizations

A. Cooperation with the World Health Organization (WHO)

The Tallinn Charter states that health care systems are interrelated and therefore a consistent approach, which contains well-coordinated actions on more than one system functions, is required to improve performance, and the experience indicates that a single function or a program alone is less likely to guide to the reaching the results desired (Tallin Charter).

Our Ministry maintains the cooperation with the World Health Organization through “Biennial Collaborative Agreement (BCA) signed between the Government of Republic of Turkey and the Worlds Health Organization European Regional Office” every two year. In 2003, we had continued to implement the 7 projects included in the agreement covering the period between 2002-2003. We have conducted 61 projects in total within the scope of 4 cooperation agreements between 2004-2011.

Within this scope, we made the “Health System Performance Assessment (HSPA)” together with the World Health Organization in 2011. Turkish health system is being evaluated comprehensively, systematically and transparently by the World Health Organization via the “Health System Performance Assessment.” Improvements in performance require a consistent and an integrated approach between different elements of the health system.

The system’s performance, as a whole, is something more different and complicated than just adding up individual performance of each of the system functions and/or components. Health system performance assessment, therefore, should go beyond making individual performance assessments for each of the functions and components. It should be carefully monitored and evaluated to what extent the system responds to the ultimate objectives (better health status, better financial protection, further satisfaction etc.) and contributes to these objectives.

HSPA is also important in that it is an analytical process which makes use of complementary informative resources in order to assess the performance. Performance indicators are supported by policy analysis, complementary information (qualitative assessments) and reference points (trends over time; local, regional or international comparisons; or comparisons by standards, objectives or comparators) in interpretation.



The topics of the “Health System Performance Assessment” can be listed as follows:

- Good Health
- Fairness in Financial Contribution
- Healthy Life Styles and Environment
- An Effective Coverage for Health Care Services: Access, Quality and Utilization
- Improving Efficiency in Service Delivery
- Strengthening Primary Health Care Services
- Resource Generation for Information Technology, Health Systems Infrastructure and Resource Generation, Distribution and Sustainability Improvement for Health Human Resources
- Revenue Collection, Universal Health Coverage and Financing Improvement,
- Enhancing Health System Management and Leadership

B. Cooperation with the UNICEF

In cooperation with the UNICEF, we have been implementing two programs which are “Encouraging Breastfeeding and Baby-Friendly Health Care Facilities” and “Preventing Iodine-Deficiency Diseases and Salt Iodizing Program”.

“Encouraging Breastfeeding and Baby-Friendly Health Care Facilities”

We encourage mothers for breastfeeding with “Maternal Support” groups and “Mother to Mother” groups, which have been recently established in Turkey for the first time. We select mothers among all others, who visit primary health care facilities and are capable of sharing their knowledge and experience with other mothers, or mothers, who can act as community leaders in this field, and assign them as facilitating mothers after they are trained by health care personnel. Also, we give mother supporting trainings to many NGOs and facilitate them to convey the MoH’s message to the entire population to encourage breastfeeding and raise awareness among mothers in all related subjects.

“Preventing Iodine-Deficiency Diseases and Salt Iodizing Program”

The most devastating effects of iodine deficiency are observed in the following risk groups: fertility-age women, pregnant women, infants and children. The most common devastating effects can be listed as growth retardation, difference in intelligence among peers (minimum 13.5 point difference), diminished cognitive ability and school achievement, increased risk of abortion and still birth among pregnant women, and goiter/thyroid disease in all ages and both sexes.

We are continuing information campaigns in order to eliminate



C. Cooperation with the OECD

We work in close cooperation with the OECD. The OECD reviewed the major reform actions taken since 2003 within the framework of the Health Transformation Program implemented in Turkey and published the “OECD Health System Reviews: Turkey” book - an assessment report.

4. Media and Public Relations

A New Communication Approach and Communication Coordination Unit

Adopting a new approach, the Health Transformation re-built and adapted public relations to the contemporary norms while re-organizing the health care system in a modern way with minimized bureaucracy. This renewed, accelerated and extended system needed a new way of communication and PR, as well. In order to respond to this necessity, we replaced the traditional working methods of the MoH's Office of Press with those of the newly established Communication Coordination Unit and considered communication as a whole. So, we regarded all health care employees in 81 provinces (including rural and deprived areas) across the country; national and local media personnel; all public and private facilities and all people, who became the focus of service delivery under the Health Transformation Program, as inseparable components of the system and we planned our activities based on this principle.

7/24 Active and Accessible Communication for Health

Abandoning traditional methods of public relations and communication, we built the Communication Coordination Unit and shaped its activities on the basis of “equity, transparency, speediness and effectiveness”. Recognizing that health is a vitally important matter, we considered that hiding truths from people would not only harm personal values but also professional norms and ethics. We established a new, clear and friendly language for public and media. We used media as an effective education tool for people by adopting transparent and productive communication strategies and we created an environment of mutual trust in order to benefit from media for preventive health care services in the future.

A Healthy Communication with All Stakeholders in Health

We replaced unilateral communication with multilateral communication. We transformed the heavily bureaucratic, plodding and static structure into a fresh, friendly and dynamic one. We left the older and conservative approach, which merely followed the agenda, and we adopted a new and dynamic approach, which supports getting involved, taking initiative, informing-feed backing, monitoring and evaluating.



A Working Office for Health Reporters in Our Coordination Unit

We attached utmost importance to co-work with all parties within the media. We launched new activities for new phenomena which have recently emerged from new communication technologies. We made new arrangements in order to provide more comfortable work settings for media actors. We allocated a special working office equipped with a telephone, television and computer for health reports in the Coordination Unit. Regardless of official work hours, we responded to any kind of requests of the media for information, new documents, visitors etc. Today, the MoH's relations and communication with the media are based on this friendly, equitable, transparent and effective approach which reflects our consciousness about the media and public confidence and respect to us.

Getting and Giving Information

The MoH Communication Coordination Office produces and offers 7/24 services with its competent communication assistants. The basic work principle of us could be best defined as "Getting and Giving Information".

We re-designed our system based on this principle. We completely renewed our technological infrastructure. We started 7/24 newspaper, web site and television follow ups and evaluated all news in health simultaneously.

We supported, witnessed and shared with public all steps taken to reflect the activities under the Health Transformation Program.

Health advocacy means advocating social policies that support health and collecting scientific information, sharing it with the media and public and raising both public and academic awareness for health is essential to achieve this. From this perspective, we took even bad news about health status, health sector and

5. Cooperation with Non-Governmental Organisations

We attached importance to cooperation with non-governmental organizations (NGO). We met with the NGOs and other stakeholders and received their opinions before we put the Health Transformation Programme into practice. We also exchanged ideas and took their solution suggestions into account in implementation, monitoring and evaluation stages.



We adopted a decentralized and human-based approach complying with performance measures rather than a central, hierarchical and centralised management. The concepts of having multi-actors, dialogue and communication were brought up through this approach and thus the Health Transformation Programme was adopted and owned by many people.

Good governance that emerged as a result of cooperation and the dialogue has ensured that the feeling of responsibility is adopted by not only the state but also the people and the people also have a say through NGOs in the decisions taken.

In this scope, we have conducted activities with the authorised trade union for the health professionals, which is our legal interlocutor on behalf of the health professionals in the meetings of Institutional Administrative Board. Moreover, we have held numerous events in recent years such as symposiums, workshops, panels where solutions were sought for the problems of the health sector. Some of these activities are as follows;

- **Symposium on Hospital Management and Full-time Law (October 2009)**

All issues related to the financial management of hospitals, legal aspects of the Full-Time Law which are binding for the relevant parties and its effects on the efficiency of health services, wages and personal rights were discussed in detail during this symposium.

- **Symposium on Health Vision (March 2010)**

Personal rights and working environments of the health professionals were discussed and “Security of Health Professionals”, “Violence in Health”, “Performance Systems” and “Various Employment Models in Health” issues were addressed in this symposium.

- **Workshop on Performance System in Health (October 2011)**

Performance system was assessed in this workshop and criticism and suggestions that were raised during the implementation of the system were discussed.

- **Symposium on Respect for Labor and Zero Tolerance for Violence (September 2011)**

Various aspects of violence in health and solution suggestions were discussed in the symposium. Representatives of trade unions and medical association, jurists, academicians, members of NGOs representing the patients and their relatives were present in the symposium. “Violence, Media and Health”, “Extent of Violence in Health” and “Preventive Processes and Expectations against Violence” were also evaluated.

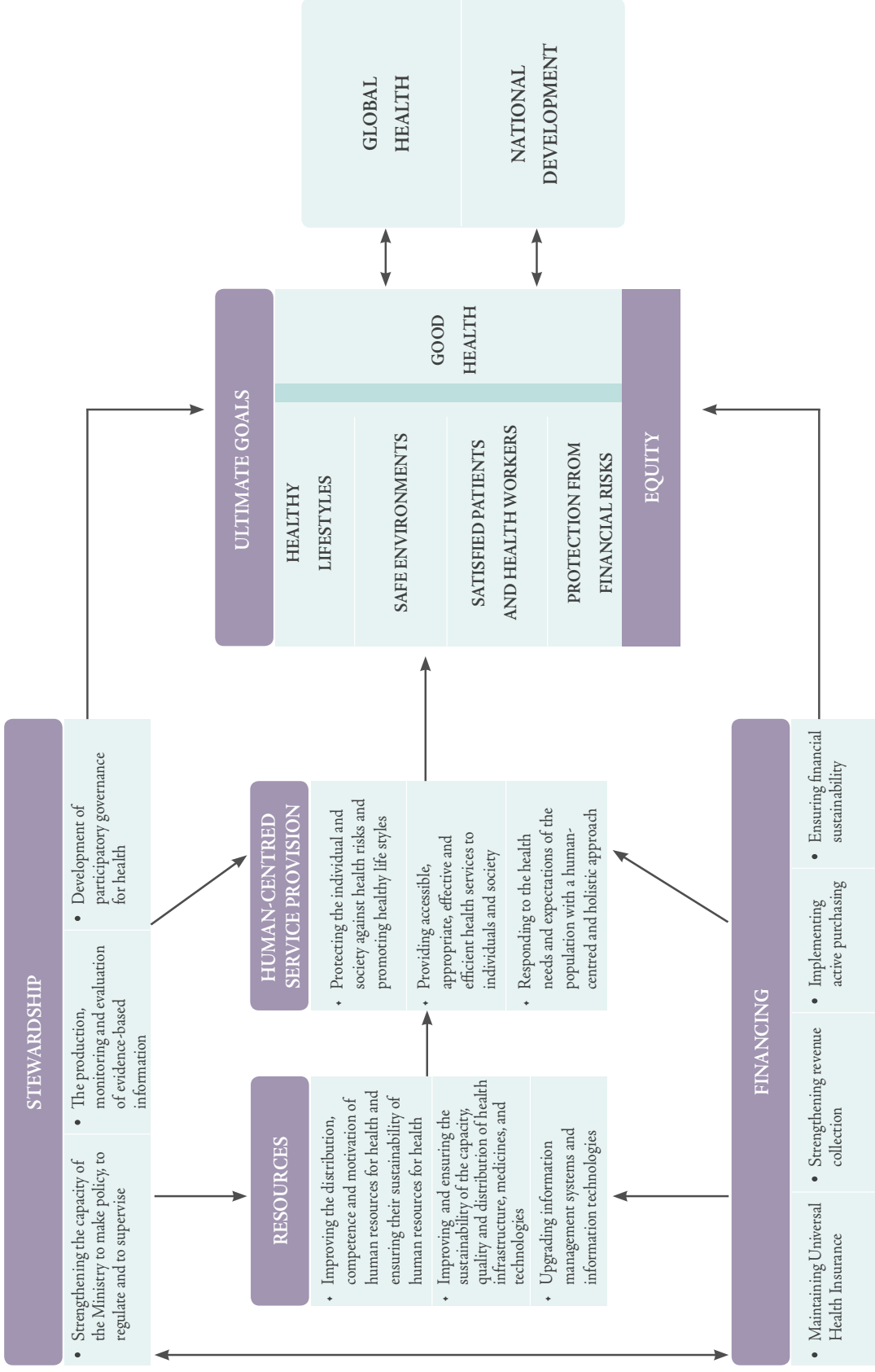
TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPLEMENTATION

8. Strategic Management, Performance and Quality in Health Care Services

Turkish Health System Strategic Map





1. Strategic Management in Health Care

Strategic management could be defined as identifying objectives and targets of an organization and managing the whole organization. Strategic management is not planning the management just for once but an organization's renewing its objectives and targets in parallel to the changing and evolving world.

Strategic management is comprised of two basic stages: "strategic planning" and "strategic control". Strategic planning could be defined as putting the strategies of implementation into a formula while strategic control could be defined as the whole entity system which is essential to implement strategies properly and reach the results targeted. The components of strategic management could be categorized under strategic planning (mission, vision, targets and activity plan) and strategic control (implementation, measurement and evaluation).

Regarding strategic management, first we developed the MoH Strategic Plan 2010-2014 in consistency with the senior policy papers and the MoH strategy. Later, we prepared yearly performance programs including performance targets, indicators and activities relevant to the implementation of the plan. Based on the strategic map, which was previously developed in scope of the Turkey Health System Performance Assessment, we prepared the MoH Strategic Map and identified objectives and indicators..

Strategic Map

While establishing an association between the strategic map and strategic plan, we developed the strategic map based on critical success factors, methods and ultimate goals. We handled the functions of stewardship, resources and financing as the critical success factors and we handled the function of service delivery in the context of methods. We associated the critical success factors and methods with the objectives-oriented strategies.

In the context of the ultimate goals, we dealt with life styles and environment, effective and comprehensive health care services, fairness in financial contribution and good health level. While linking the ultimate goals with the strategic plan, we also linked the interim goals / sub-goals with the ultimate goals and ultimate outcomes. The following topics are included in this map:

A. Key Success Factors

A.1 Stewardship

The MoH acts as the superior authority which undertook the stewardship function for protecting and promoting population health. In this scope, the MoH is authorized to establish necessary rules, develop plans, make supervision, and manage monitoring evaluation and guiding.

In addition to these primary tasks and responsibilities, the stewardship function of the MoH is complemented by also some other components such as strengthening the health sector, raising the awareness of other sectors for health responsibilities, enabling coordination among sectors, amending laws and regulations according to health needs and technologies, and using health care management information systems and decision support systems.



A.2 Sources

The implied physical infrastructure basically consists of developing infrastructure such as the buildings, hardware, supplies etc, which are necessary for reaching the target level of health care service delivery, making it sufficient in terms of quality and quantity, and ensuring responsiveness by enabling people have access to the health care services they need.

In parallel with the scientific and technological developments, it is necessary to ensure that the human pharmaceutical products and medical devices are sufficient countrywide and distributed in a balanced manner. Rendering this technical potential safe and easily accessible makes a significant contribution to the qualified health care service delivery.

In order to protect public health and ensure that the people in need can receive qualified health care services, ensuring that there is sufficient trained healthcare personnel that will work throughout the country and ensuring a balanced distribution have a significant place in health policies. The motivation of the existing health professionals and encouraging the professionals in this field are important elements of achieving sustainability.

Increasing speed, convenience and credibility by using information technologies in health care service processes, establishing national and international comparable data standards, ensuring rational source use and secure data flow, building secure data pools for service delivery and service receivers, and developing prospective decision making system for policy makers gain importance with increasing momentum.

A.3 Financing

The system financing covers an area where revenues are collected, consolidated in fund pools, distributed among service providers within the active procurement process for the delivery of necessary services and thus used in investments to provide resources.

It is necessary to develop health financing resources, to consolidate and manage them efficiently in a common data pool, to ensure the delivery of accessible, qualified and satisfactory health care services and maintain its financial sustainability.

A.4 Efficiency

Efficiency is the reduction of costs by using the resources properly and thus generating more services with the same resources. The main elements of the target-oriented use of available resources are obeying the principles of efficiency without making concessions during the infrastructure investments, human resources distribution, material management, rational drug use, health management, and preventive medicine implementations; and ensuring that all health-related resources of our country are included in the system and integrated.



B. Methods

B.1 Service Delivery

It is important to develop behaviors towards a healthier life in the process of almost all kinds of relations in every point of life. The important steps towards this are raising awareness in public in a way that will develop health life behaviors (such as protection from tobacco, alcohol addiction, healthy diet, physical activity habit), increasing the level of information, taking responsibility of your own health, and ensuring individuals' participation into decision making processes.

The essential responsibility areas of public health are reducing risks through preventive health care services (such as immunization, screening programs) for improving the health status of the society, preventing the emergence of diseases, executing public health services in a widespread manner, preventing the progress of diseases and ensuring the collaborations of the relevant sectors in those fields.

Moving from the fact that health is formed in the family environment, family medicine implementation has been introduced to address the individual within the framework of the concept of "family health", ensure its ownership and constant monitoring in terms of health and make the primary care services the coordinators of the health care service delivery. In this way primary care services are strengthened and made attractive both for the service providers and service receivers.

The priority responsibility area is ensuring of effective and qualified delivery of health care services in their diagnosis, treatment and rehabilitation process by focusing on evidence-based medicine practices, scientific data, patient and worker safety, by using proper technology and by protecting patient rights.

In the processes from the manufacturing of pharmaceuticals and medical supplies to their consumption, it is necessary to set standards, prioritize quality, develop costeffective supply methods and provide the necessary infrastructure for ensuring financial protection while reaching those products.

C. Ultimate Objectives

C.1 Healthy Life Styles and Environment

Many factors outside health including our preferences, habits and our living environments affect health lifestyle.

The underlying objectives of accessing a healthy life style are ensuring health care services that protect public health, raising awareness in individuals and providing them with the knowledge that will enable them to make the right decisions on their health, improving the factors and social determinants that affect health directly and indirectly and adopt a lifestyle that will ensure the continuance of the mental, physical and social well-being. All factors that can affect the course of life have the potential to make positive/negative contributions to this access. Therefore, it is necessary to raise awareness in sectors other than health sector and mobilize multi-sector health responsibility.



C.2 Effective and Comprehensive Personal Health Services

Ensuring individuals' access to all kinds of health care services aiming at a healthy life style is a priority function of the health system. Starting from the moment when the need for health care services arises, it is necessary to remove all kinds of obstacles (such as the bureaucratic and financial obstacles in front of access to necessary services, regional differences, insufficiency or imbalance of service supply, inclusion in a disadvantaged group) when necessary and ensure timely and equitable access to all necessary services according to the needs.

C.3 Equity in Financial Contribution /Protection from Financial Risk

Ensuring that the people who need health care service can benefit from those services as per their needs and that they contribute to the financing of those services as per their means is a requirement of equity.

It is necessary to eliminate the discrepancies between different social groups, rural and urban areas and different geographical regions in terms of benefiting from health care services and ensure overall improvement in health indicators. Among the prominent targets of the social systems are including all citizens within the social security coverage, decreasing the share of out-of-pocket household expenditure in total health expenditure, and

C.4 Good Health Level

The ultimate goal of the health policies to be implemented is to increase the health status and thus the welfare and happiness status of the individual within the society. While pursuing this goal the priority principle is to prevent people from getting ill and meet their expectations for a healthy life. Attaining this goal will be indicated by the progress made in the basic health indicators. Decreasing maternal and child mortality and increasing life expectancy at birth will be the most concrete indicators for this.

When the systems focus on meeting the expectations of the service providers or service financers and when the adjustments develop in this way, the expectations of the service receivers, who are the reason of state of all those services, cannot sufficiently be met. During the delivery of health care services, system's ability to meet the health care needs of the service receivers and also meet their non-health expectations is an important factor that ensures the service receivers' satisfaction and indicates the system's success.

The important cornerstones of a human centered/anthropocentric system are responding in a timely and effective manners starting from the moment when the need for health care services emerges, arranging the health facilities ergonomically for the service receivers and providers, rolling out the facilitating life spaces for the disadvantaged groups, protecting personnel privacy, giving the right to choose service provider, ensuring their participation in the decision processes about their own health and ensuring dignity, effective communication and access to social support networks during treatment.

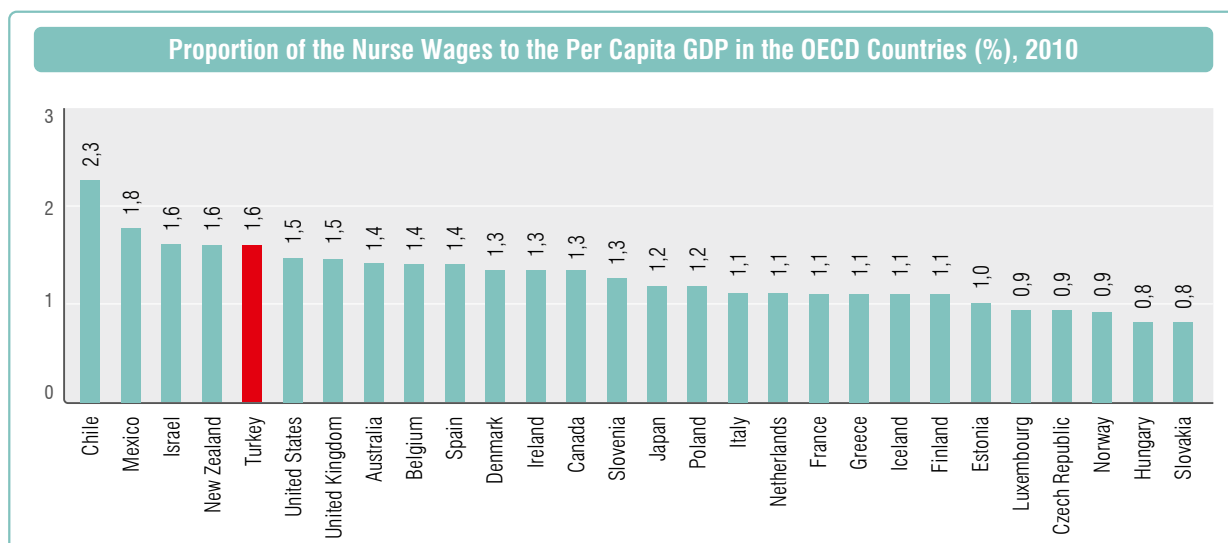


The Ministry of Health supports the Strategic Management principles with the Score Performance Assessment System for the following purposes:

- We ensure that all departments and units of the MoH have their own key performance indicators and we support coordination. So, the whole MoH organization acts by adopting the same goals and objectives.
- We have been transitting from traditional evaluation techniques to strategic performance assessment which is a systematic and fair assessment technique.
- We link the MoH strategies to the budget.
- We monitor the performance criteria of the MoH departments and units, intervene in the process in case of a shorcoming or a problem, and help these departments and units to make self-assessment of their performance.
- We establish a common language in strategic management within the organization.
- We monitor the process, the points needing improvement, measurement results and actions, and we ensure continous development and progress.

2. Performance-Based Supplementary Payment

Before the Health Transformation Program, hospital personnel received very limited financial benefit from the hospital revenues raised by the services which they produced at hospitals. Since no systematic approach did exist in the past, which directly associated additional payment with performance and service production as it is today, service efficiency, registration or reimbursement did not mean more than an isolated problem for only few managers, and registration did not become a formal and regular procedure as necessary. To brief the payment method used in the past, supplementary payment was capped with maximum two-times of the basic salary and health care personnel did not even reach the cap in most of the time. In 2002, the supplementary payment cap for specialist physicians was 915 ₺ in 2011 figures and it was 281 ₺ for other health care personnel in 2011 figures again. However, the caps range between 150 % and 800 % of basic salaries depending on occupations and working conditions today. In 2011, supplementary payment was reported 4.275 ₺ in average for specialist physicians 791 ₺ for other health care personnel. Graphic 91, 93 and 94 makes a comparison of the wages of nurses and physicians with that of the OECD countries. Making measurable service descriptions is a must in order to motivate health care personnel, improve efficiency and quality in service production and supply. Performance management puts emphasis on various performance criteria to achieve it. These criteria do include but are not limited to the following: satisfying patients, reaching a better health status, conforming to a welldefined and qualified health service delivery process and meeting the norms described for infrastructure, human resources capacity and materials-equipment.



Graphic 91
Source: OECD Health Data July 2012

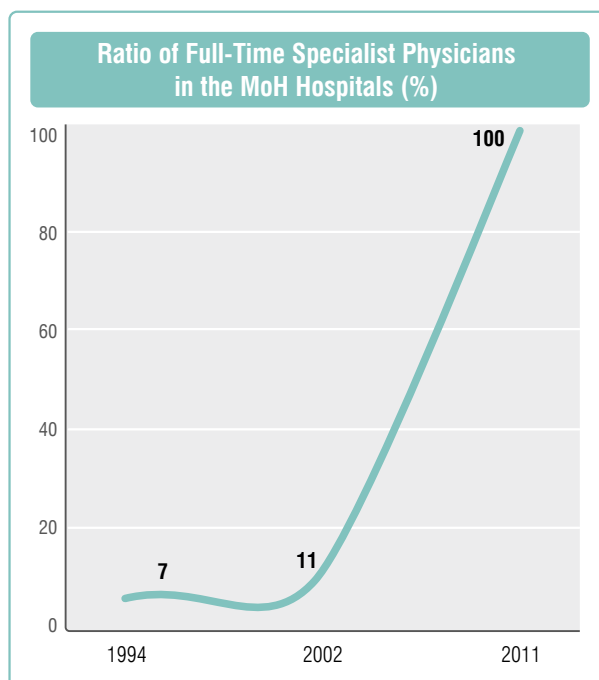
The Health Transformation Program declared that performance indicators would be identified and performance-based payment systems would be improved in Turkey. This newly developed system required many new implementations and initiatives. Firstly, we associated work with income and established a system in which time and potential could be exploited more effectively because it is more equitable if service providers get a share of revenues in proportion to their involvement in and contribution to service production. In addition to this principle, we have witnessed in the process that such additional income facilitates more efficient use of time and potential, as well. Firstly, this application sets out hospitals services in Turkey should become measurable firstly and the measurable hospital services should be evaluated and reflected on service producing personnel secondly. In training and research hospitals on the other hand, not only services that are directly provided for patients but also scientific trainings given to medical residents and scientific researches/studies and publishing are accepted as the performance criteria, which encourages and awards medical residency training and scientific studies.

The most outstanding features of the system are the awards given to primary health care facilities by their locations (if they are located in deprived areas) and the performance criteria applied to preventive medicine services.

As a result of the performance-based supplementary payment system, working hours have been voluntarily extended in most hospitals and operation theaters have become available for surgical operations for longer hours. Most specialist physicians closed down their private offices and preferred full-time practice at hospital, which has helped to alleviate the workload of hospitals that has been raised due to the increased demand for better services. While 11 % of specialist physicians worked on fulltime basis in public hospitals in 2003, the percentage is reported 100 % today (Graphic 92). So, the efficiency of physicians, who are already in undersupply in Turkey, has increased in public hospitals.



- We implement the performance-based supplementary payment, which refers to a bonus paid in return for the wellquality services produced in health care facilities, as an instrument that improves service supply and efficiency.
- It has proved to be a significant instrument which increased motivation in responding to service demand.
- It is mainly subsidized by preventing leakages within the system, providing equipmentat lower costs and diminishing waste.
- It has contributed to a routine registration system. While only 20 % of the hospitals had automation systems in the past, today 100 % of the hospitals have automation systems.
- Waiting lists have been outstandingly shortened.
- Examination time allocate for patients has been extended.
- Number of referrals to upper levels of health care has been normalized.
- Monitoring income-expenditure balances of health care facilities has been attached further attention.
- Our fight against “informal payments to health service providers” has become easier.



Graphic 92
Source: General Directorate of Health Services



Making Reform Happen: Lessons from OECD Countries

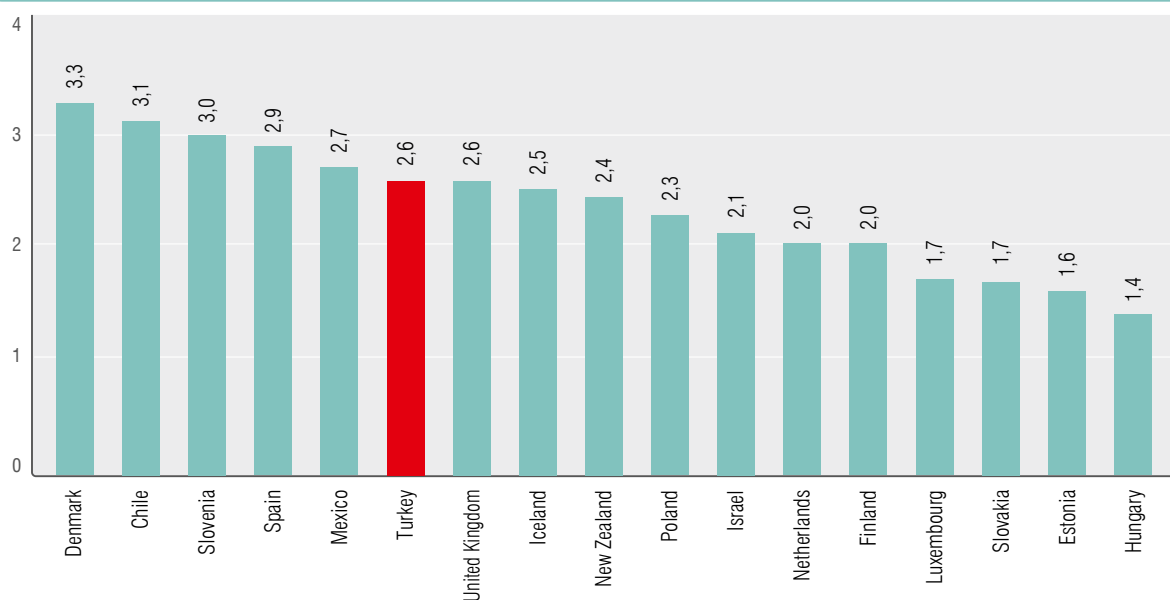
Year of Publishing : 2010

Published by : OECD

“In Turkey, significant prospective increases in doctors’ pay, combined with new performance incentives, helped to ensure that many individual doctors co-operated enthusiastically with the reforms, despite vociferous opposition from the Turkish Medical Association.”



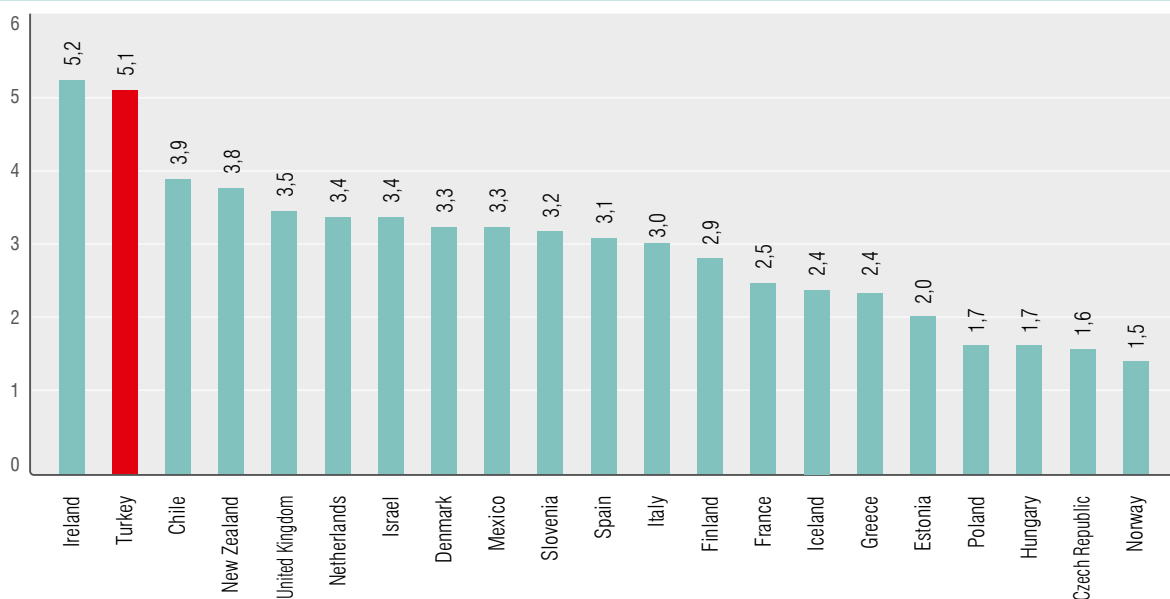
Proportion of the GP Incomes to the Per Capita GDP in the OECD Countries (%), 2010



Graphic 93

Source: OECD Health Data 2012

Proportion of the Specialist Physician Incomes to the Per Capita GDP in the OECD Countries (%), 2010



Graphic 94

Source: OECD Health Data 2012



Practitioners are provided with more opportunities for income through the Family Medicine practice. While the average income of a practitioner was 1735 TRL in 2002 according to 2011 figures, it increased to 4.122 TRL in 2011 with a real increase of 138%.

Specialist physicians earn more income through performance-based supplementary payment systems. While the average income of a specialist physician was 2.665 TRL in 2002 according to 2011 figures, it increased to 6.563 TRL with a real increase of 146% in 2011.

According to OECD Health Statistics Yearbook 2011, Turkey ranks second among OECD countries with 5,1% as percentage of specialist physicians' wages in GDP per capita and Iceland ranks first with 5,2% .

Manager's Department Performance

We developed a financial sustainability-based model and put into use in March 2010 in order to measure the performance of health in the MoH-affiliated health care facilities including head physicians, deputy head physicians, hospital managers, deputy hospital managers and head nurses. In addition to financial indicators, we also identified some new administrative priorities that managers should consider while performing their tasks. Therefore, the Manager's Department Performance is evaluated in two parts. The first part could be considered as the primary factor and the second part contains the correction factor which is used to remove discrepancies among hospitals and managers.

- Parameters of the Fundamental Factor:
 - Regularly paying bonuses to personnel in order to secure the institutional dynamism and offer better services,
 - Establishing and protecting a structure compatible with the accepted quality standards,
 - Criteria indicating that the performance objectives identified by the MoH are fulfilled.
- Some parameters constituting the adjustment factor:
 - Development level of hospital location
 - Age of hospital,
 - Hospital financial ratios (endorsement).

In our model, calculations are made on monthly basis, every manager's performance coefficient is identified, the coefficients identified are associated with managers' payments and reflected on supplementary payments to be given in that month.



To brief, a systematic evaluation model was designed by considering service quality, sustainable borrowing plan, sustainability of making timely supplementary payments, availability to reach the previously identified performance objectives and all other parameters in integrity. These indicators also laid out the priorities of managers. This evaluation system, which is the first example in Turkey, will contribute to more effective and positive outcomes. The OECD states in its report 2008 also other countries can take so many lessons from the Turkish experience.

3. Quality and Accreditation

One of the primary objectives of the Health Transformation Program is to ensure continuous quality improvement in health care services in Turkey. With this aim, we developed and introduced a performance-based supplementary payment system which is unique to Turkey. As the second stage, we carried out the Institutional Performance and Quality Development study. So, we put into effect a much more comprehensive system for hospital evaluation which is based on health service access, service infrastructure, process assessment, patient satisfaction measurement and analysis of targeted performance.

Quality criteria serve as the main parameter of the Performance and Quality Improvement study. We developed these criteria on the basis of international practices, needs and the MoH strategy. We revised the quality criteria list, which consisted of 100 items initially and re-prepared a new list of 150 items in 2007. Making another revision to the list in 2008, we re-arranged these criteria with regards to structure, design and methodology. We made up a new Service Quality Standards Set which consisted of 354 standards and 900 sub-components. In 2009, we developed and declared the “Service Quality Standards for Private Hospitals” which contains 388 standards and about 1.450 sub-components.

When developing the Service Quality Standards, we held talks with analysts, hospital quality directors and many specialists from other health-related fields, and asked for their views and recommendations. Also, we carefully considered different institutional structures, problems and country-specific conditions in the light of the national and international references.

The guidelines, which we published together with the Quality Standards, serve not only as facilitators for health service providers but also as schedules helping for on-site assessment of the implementations.

In addition, we see that the efforts made to raise the quality of health care services worldwide are rather based on national quality and accreditation systems when we consider examples from various countries on the world. The needs, priorities and expectations of national health care systems and financial burden originating from the international accreditation systems obliged many countries to establish a national quality system. The United Kingdom, Canada, France and Denmark are the leading countries having established national quality systems in health.

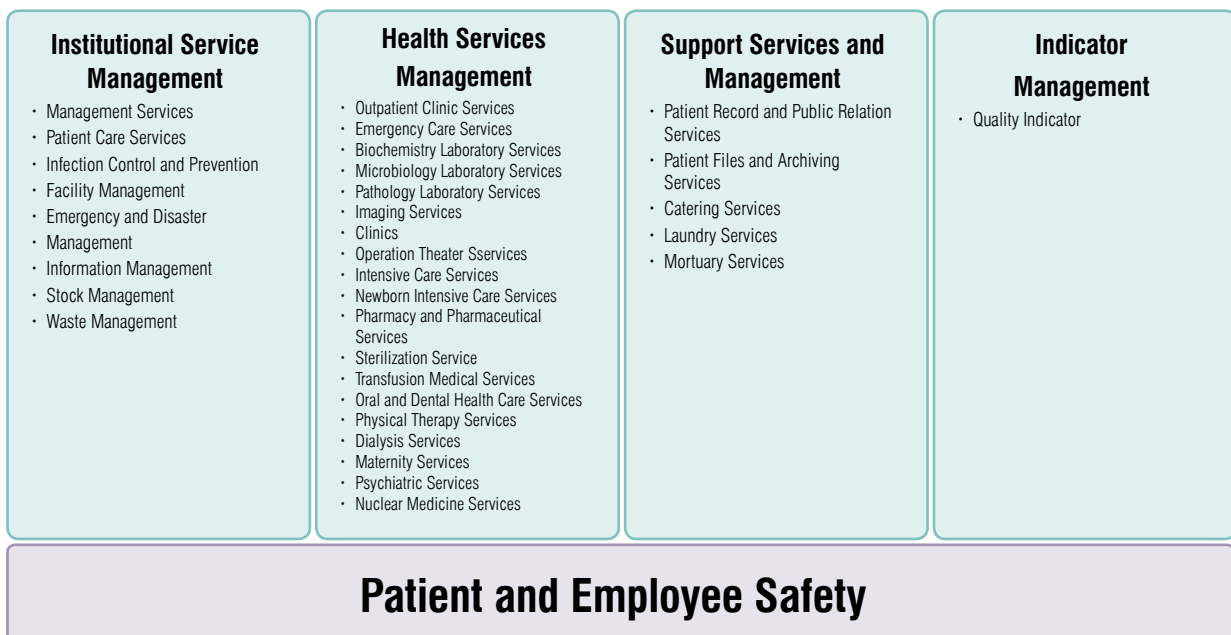


While establishing a national quality system in health in Turkey, public and private hospitals were first evaluated by two different sets of standards. However, we developed the “Hospital Quality Standards” later in order to approximate service standards of hospitals regardless of their types (public, private or university), to pave the way for exchange of experience among facilities and to well establish a national quality system in health. In the upcoming period, we will draw a conceptual framework for these.

Hospital Service Quality Standards

We targeted to follow a scientific method while developing the standards included in the “Hospital Service Quality Standard”. In this framework, we paid attention to the following objectives and principles:

- A. Assessing the standards, associating them with each other and developing a sizing structure within an organization,
- B. Developing and designing the standards according to this sizing structure,
- C. Carrying out validity and reliability studies of the established standards,
- D. Developing a specific coding system to monitor and analyze the standards,
- E. Following a specific rule and strategy to rate the standards,
- F. Developing an index of descriptions,
- G. Developing informative tables.





A. Development of Sizing Structure

In sizing, we located the standards on a model having 5 vertical and horizontal dimensions and designed the model to cover all aspects of a facility. Institutional Service Management, Health Care Services Management, Support Services Management and Indicator Management were located in the vertical dimension while the Patient and Personnel Safety was located in the horizontal dimension. So, we developed a sizing structure specifically for country.

B. Developing Standards

While developing the standards, we reviewed national and international resources including the Service Quality Standards of public and private hospitals; and considered four strategic objectives by respecting the country's needs and conditions. In addition, we received the feedback, views and recommendations of field observers, hospital quality directors and a variety of specialists; and gathering them all with our in-depth experience we piloted the standards. In terms of quality, we paid strict attention to approaching the issue with a conceptual perspective that minimizes wasting and maximizes costeffectiveness, efficiency and satisfaction.

C. Validity and Reliability of Standards

In order to assess the applicability and understandability of the standards at hospitals, we piloted the standards at 24 hospitals of different types in different sectors in different provinces.

D. Developing a Coding System

We developed a coding system and aligned the standards accordingly with the aim of establishing a statistical record system and ensuring follow-up of the standards in measuring to what extent these standards are met at hospitals. So, the codes that we associated with the standards will also allow data processing and comparisons among hospitals. Besides, coding will also give some practical information to users about the dimensions of the vertical and horizontal standards.

E. Developing a Scoring System

We developed a system to score the standards. Accordingly, the standards are scored by certain rules and a certain strategy; they are compared to each other and scored by a certain categorization. An integral, a well-balanced and a weighted design is essential to this scoring system.

F. Developing an Index of Descriptions

As for the implementation and evaluation of the standards, we developed an index of descriptions in order to establish a common language between implementing and evaluating parties.



G. Developing Information Tables

While implementing the standards, we identified the standards which are not valid for a facility due to institutional characteristics and/or application. We do not score these standards in the evaluation process.

Result

We used a scientific methodology while setting these standards. This study is regarded as an innovation since it paved the way for developing a standard set including sizing, standard development, validity and reliability, coding, scoring, description and information tables. The set is quite better than it was in the past with regards to effectiveness and quality. The standard set contains total 295 standards and 1.058 evaluation criteria, and 480 standards and 1.640 evaluation criteria are used in hospital evaluation.

In the Turkish health care system, we have made very immense efforts resulting in an impressive progress so far in order to establish a national health care system which aims to promote population health and to offer the same quality services for all service providers by improving service quality; supervises and rates all health care facilities by using the same standards; targets continuous improvement; and respects employee safety and satisfaction as much as patient safety and satisfaction under the guidance and stewardship of a superior authority. “Hospital Service Quality Standards” are in the heart of this process which is designed by a scientific and proper methodology and these standards raises acceptability within the system. “Hospital Service Quality Standards” will continue to contribute to the national health care system.

National Quality System, which we have established as a result of the afore-mentioned studies and efforts, is eligible for improvement and scientific studies, technological developments, feedback, experience and country needs will continue to be the factors that support and enrich our strong commitment and immense efforts in the future, as well.

TURKEY HEALTH TRANSFORMATION PROGRAM



C. IMPEMETATION

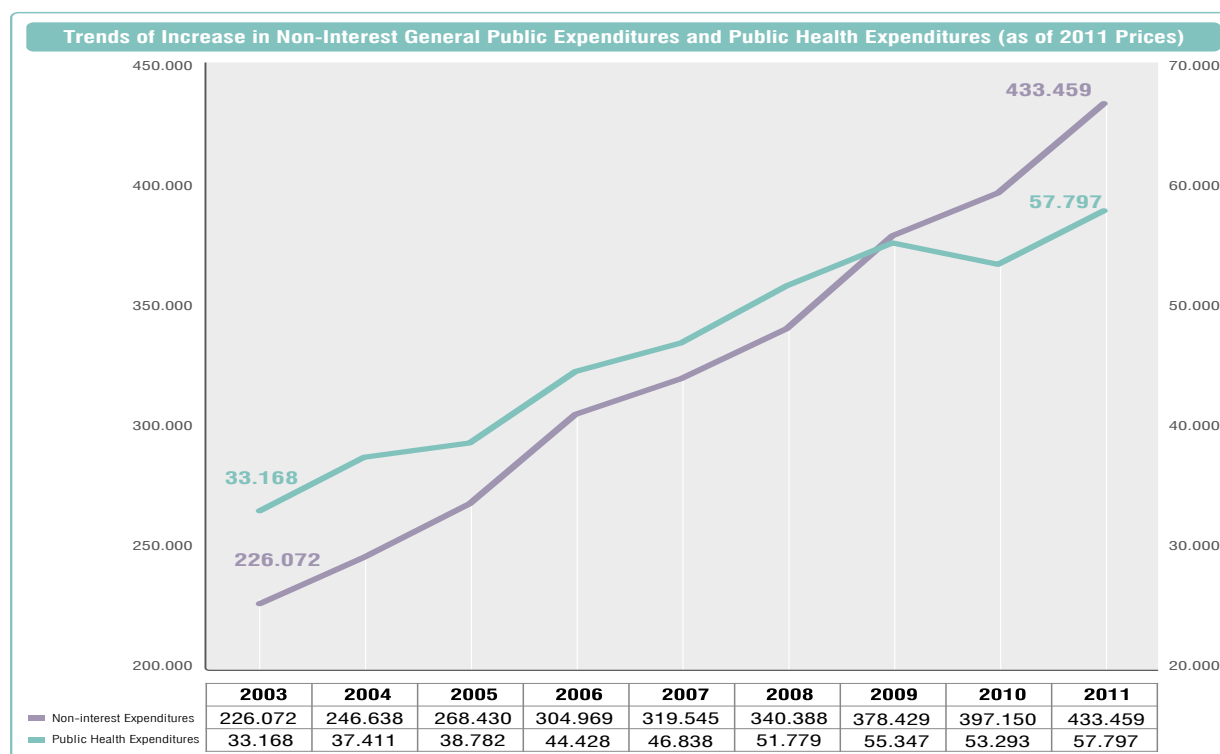
9. Financial Management in Health



1. Health Expenditures

When we have a close look at provision of health care services in terms of quality and quantity, that the resources could not be used in an effective, efficient and rational way prior the implementation of the Health Transformation Program is easily noticed.

The Health Transformation Program has ensured optimum use of resources a productive and equal health system.



Graphic 95

Source: TURKSTAT, Ministry of Finance, Ministry of Development

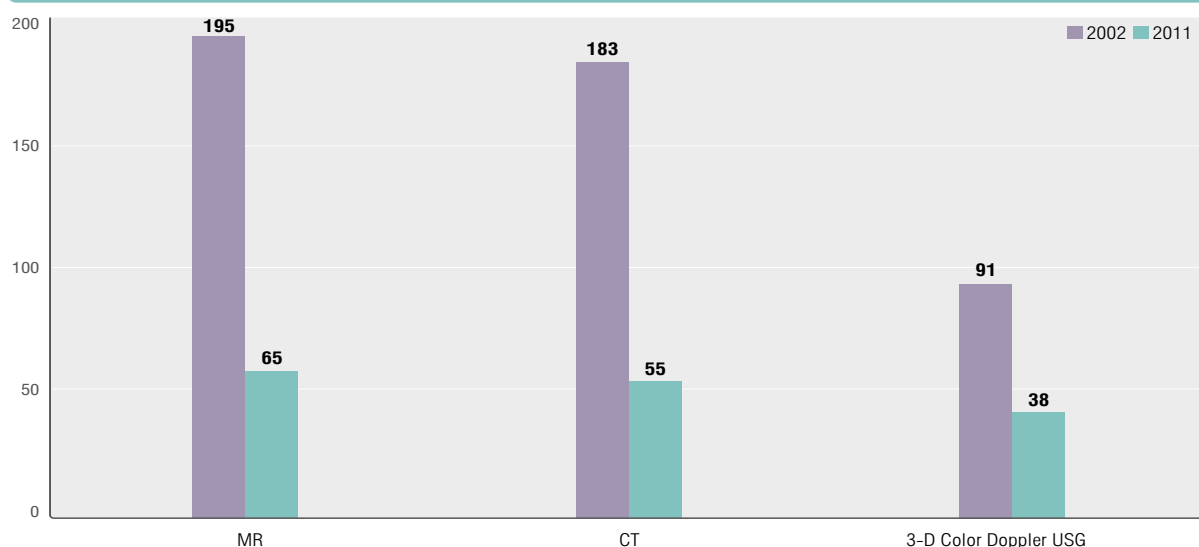
The increase in general public expenditures except for the interest rate was 92% and the increase in public health expenditures was 74 % between the years 2003-2011 (Graphic 95). The figures in the table prove that health expenditures did not dramatically increase with the introduction of the Health Transformation Program. Additionally, the proportion of out- of- pocket health expenditures to total health expenditure per capita was 19,8 % in 2002 and decreased to 12 % in 2011.

The average number of people consulting to a physician was increased by 2,6 folds in the last nine years. That the obstacles in reaching medicine and health care services under the scope of the Health Transformation Program were abolished had a great impact in forming this table.

High technology increases the cost of health care services is a well known fact. However, as a result of the cost-effective policies we have been implementing, we prevented high costs likely to result from high technology use. (Graphic 96).



Graphic 96 Radiologic Imaging Prices (as of 2011 prices, in ₺)



Graphic 96

Source: General Directorate of Health Services

The quantitative and qualitative improvement of health care services can be achieved by continuing the optimum use of resources and increasing the resources allocated for health (in proportion with the financial opportunities of our country) (Table 14-16; Graphic 97-102).

Table 14. Share of Public and Private Health Expenditures in GDP by Years (%)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Public	Turkey	3,8	3,8	3,8	3,7	4,0	4,1	4,4	5,1	4,6	4,4
	OECD	5,9	6,1	6,1	6,1	6,1	6,1	6,3	7	6,9	-
Private	Turkey	1,6	1,5	1,5	1,8	1,8	1,9	1,7	1,4	1,2	1,0
	OECD	2,4	2,4	2,5	2,5	2,5	2,5	2,5	2,7	2,8	-
Total	Turkey	5,4	5,3	5,4	5,5	5,8	6,0	6,1	6,1	6,1	6,1
	OECD	5,4	5,3	5,4	5,4	5,8	6,0	6,1	9,8	9,7	-

Source: TURKSTAT, OECD Health Data 2012

While the share of the public health expenditure in the GDP was 3,8 % in 2002, it increased to only 4,4 % in 2011. That is, the share of the public health expenditure in the GDP was only 0,6 % as a result of such an enormous and a radical change offering full satisfaction.



Table 15. Per Capita Out-of-Pocket Health Expenditure (Purchasing Power Parity in USD) and Its Proportion to Total Health Expenditures (%)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Turkey	92	87	105	141	162	178	147	120	117	113
	%19,8	%18,5	%19,2	%22,8	%22	%21,8	%17,4	%13,0	%13,0	%12
OECD	385	410	436	454	471	505	529	562	569	-
	10,7	%18,7	%18,9	%19,0	%18,7	%18,9	%19,0	%19,9	%20,5	-

Source: TURKSTAT, OECD Health Data 2012,2009,2010 and 2011, General Directorate of Health Services

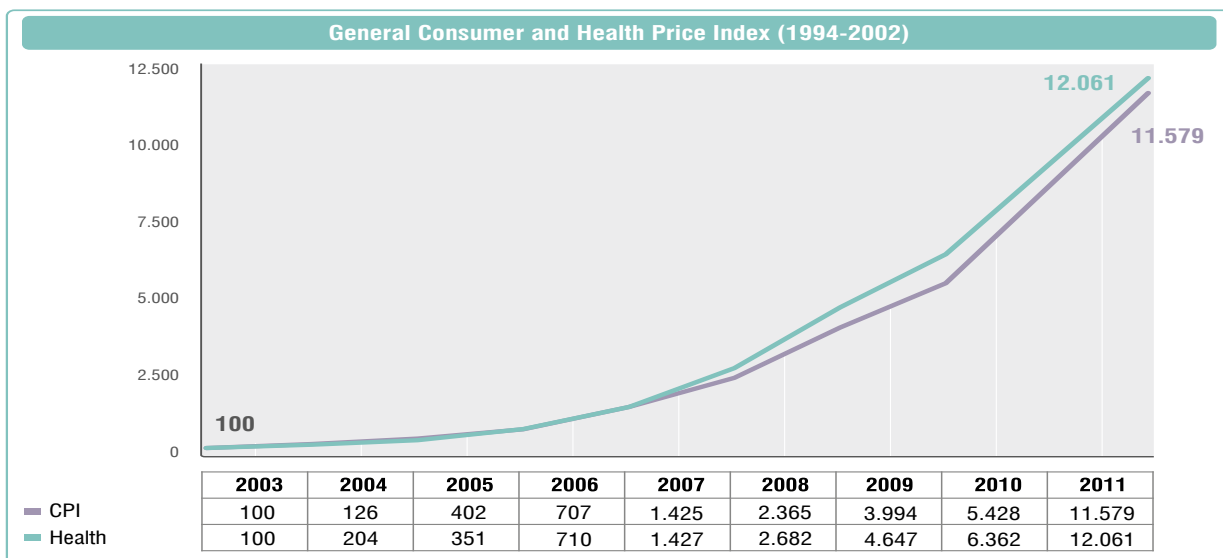
We decreased the proportion of the per capita out-of-pocket health expenditure to the total health expenditure from 19,8 % in 2002 to 10,7 % in 2011.

Table 16. Per Capita Public and Private Health Expenditure (Purchasing Power Parity) (in USD)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Public	Turkey	330	339	390	422	505	552	667	730	713	769
	OECD	1.565	1.632	1.737	1.825	1.946	2.050	2.224	2.380	2.357	-
Private	Turkey	136	132	157	200	234	262	246	196	193	181
	OECD	612	635	677	712	762	813	846	945	981	-
Total	Turkey	466	471	547	622	738	813	913	926	906	950
	OECD	2.178	2.293	2.442	2.565	2.736	2.890	3.101	3.325	3.338	-

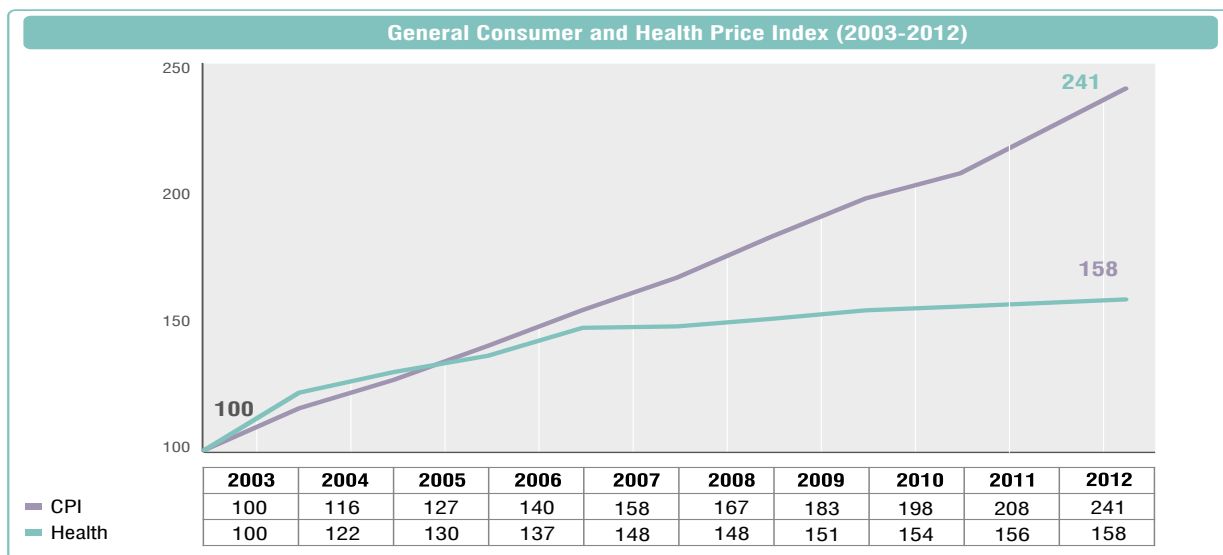
Source: TURKSTAT, OECD Health Data 2012,2009,2010 and 2011, General Directorate of Health Services

While per capita public and private health expenditure was 466 PPP USD in 2002, it was reported 769 PPP USD in 2011. The OECD average, on the other hand, is 3.4 times higher than that of Turkey.



Graphic 97
Source: TURKSTAT

The price of health product and service, which cost 100 ₺ in January 1994, rose to 12.061 ₺ in December 2002. In this period, the increase in the prices of health products and services was 104 % of the general increase in prices.

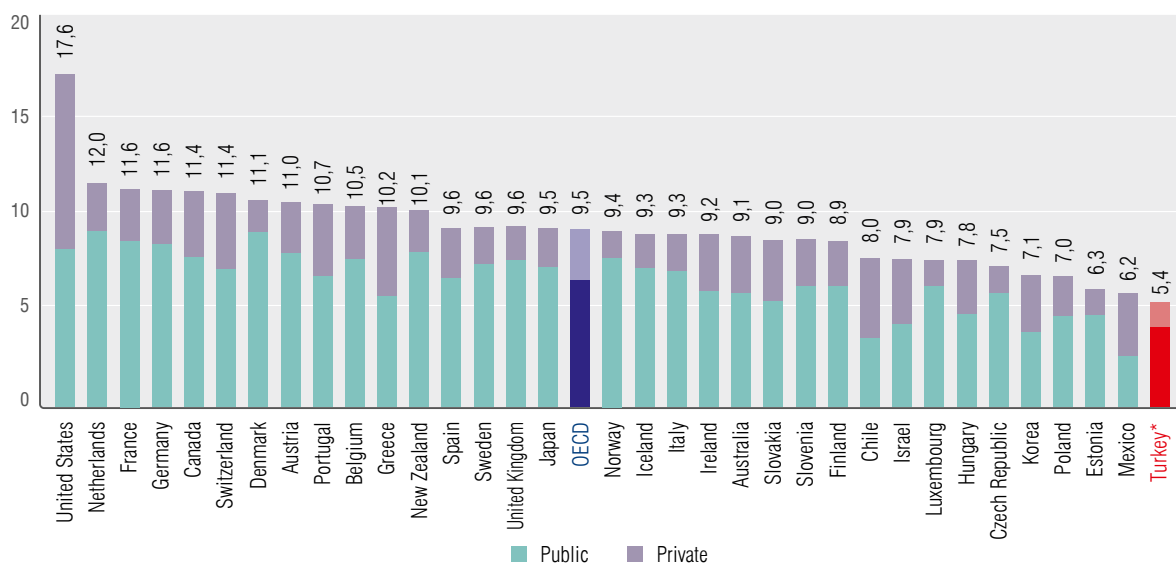


Graphic 98
Source: TURKSTAT

The price of health product and service, which cost 100 ₺ in January 2003, rose to 158 ₺ in October 2012. In this period, the increase in the prices of health products and services was 41 % of the general increase in prices.



OECD 2010 (Share of Total Health Expenditures in GDP in the OECD Countries, %)

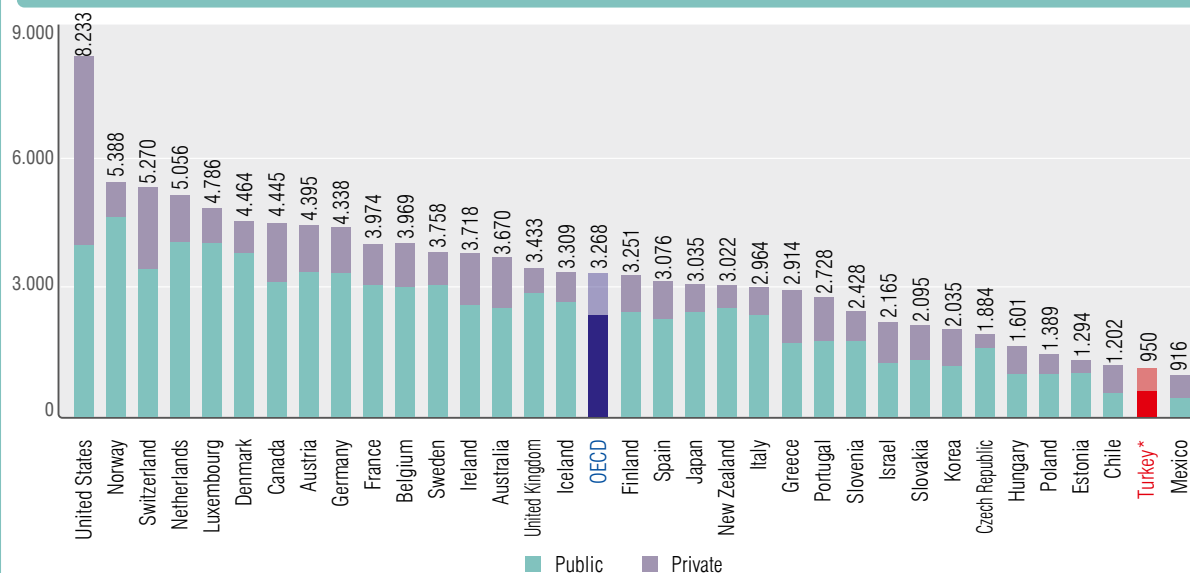


Graphic 99

Source: OECD Health Data July 2012

*Turkey data refer to the year 2011.

Per Capita Total Health Expenditure in the OECD Countries (PPP USD), 2010



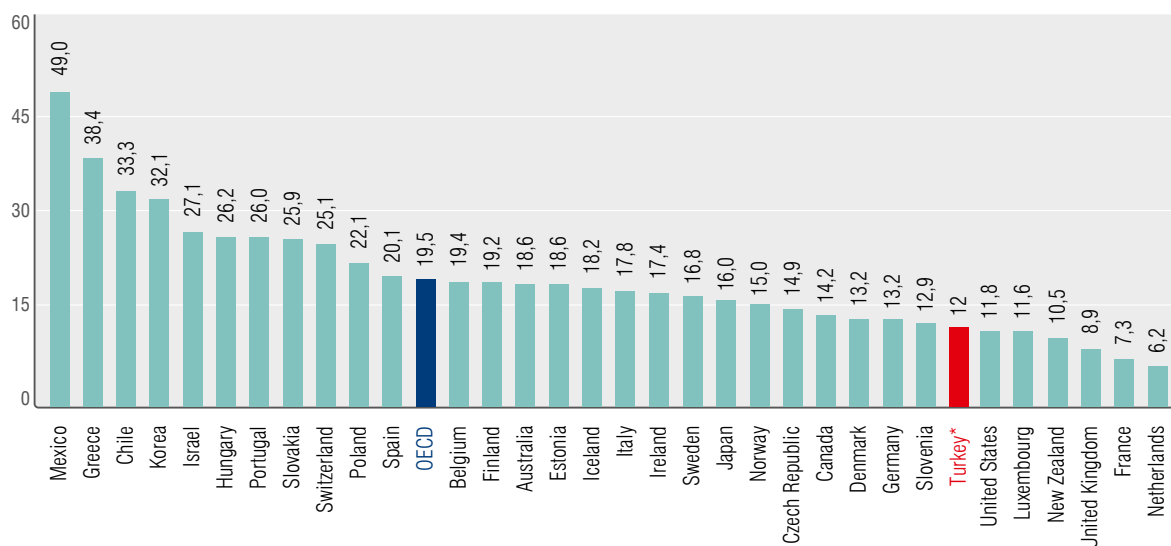
Graphic 100

Source: OECD Health Data July 2012

*Turkey data refer to the year 2011.



Share of Out-of-Pocket Health Expenditure in Total Health Expenditure in the OECD Countries (%), 2010

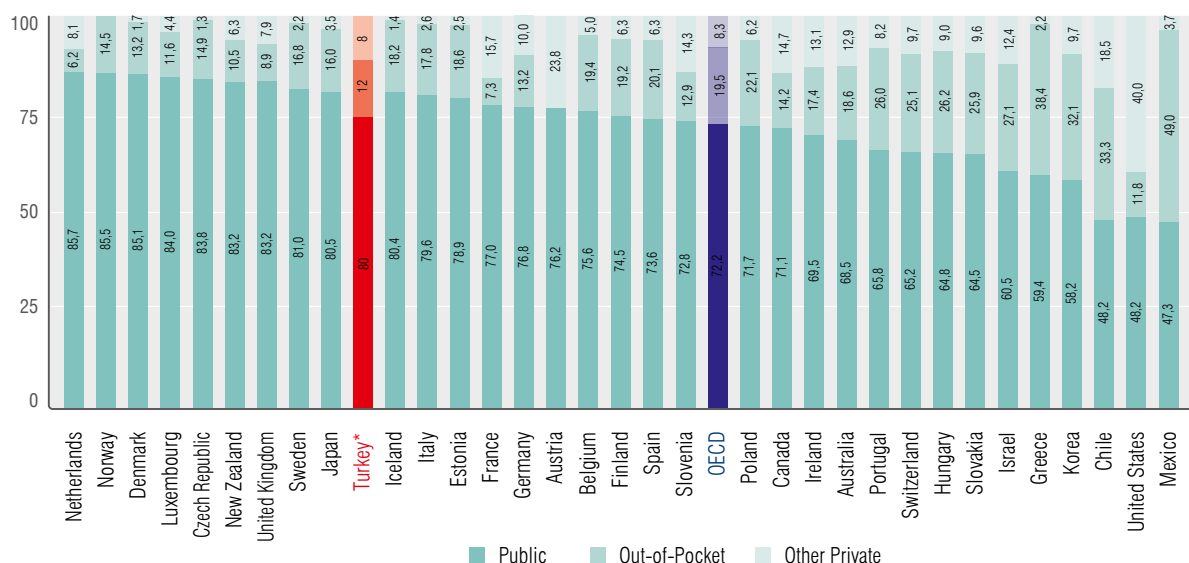


Graphic 101

Source: OECD Health Data July 2012

*Turkey data refer to the year 2011.

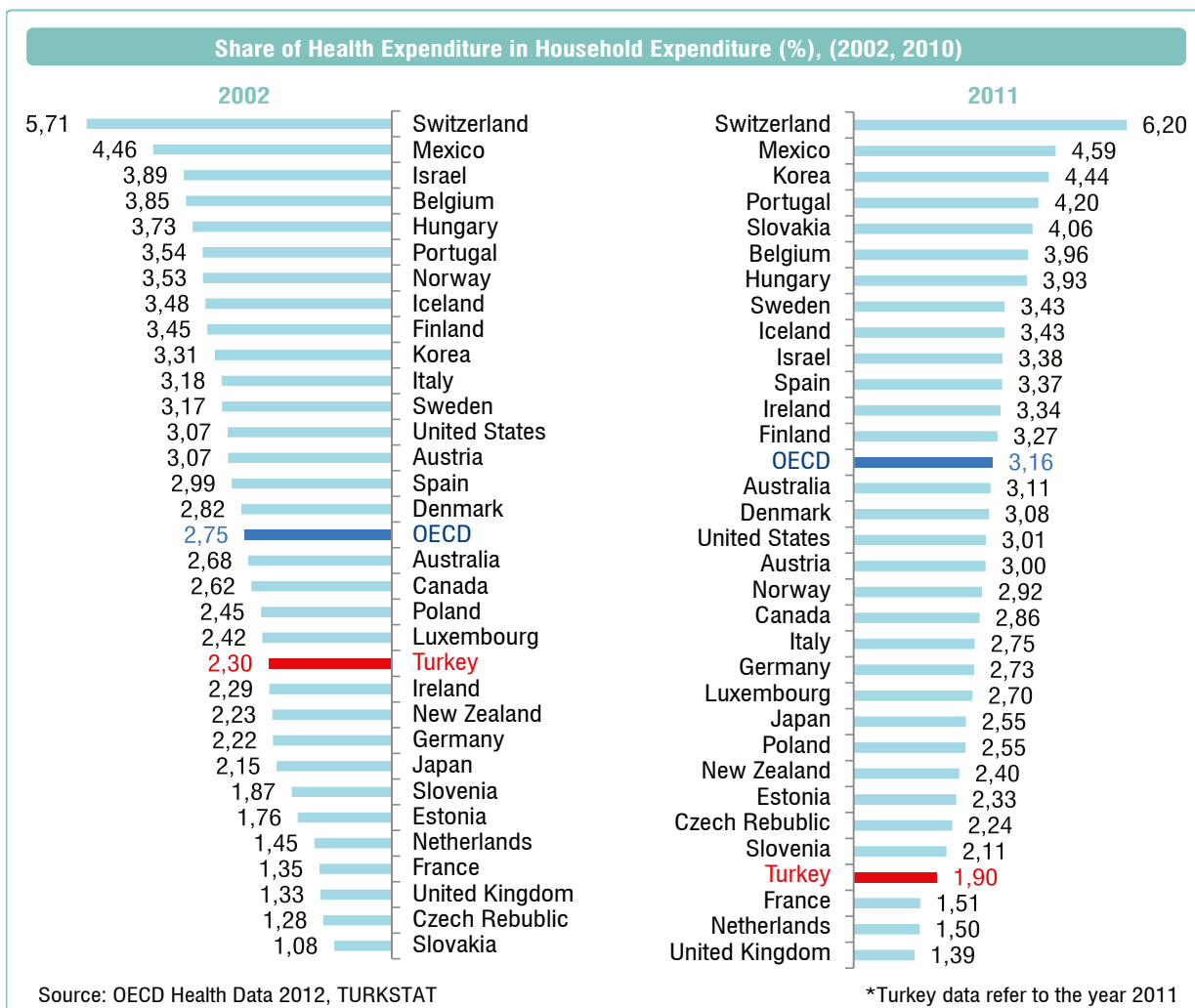
Ratios of Health Expenditure in the OECD Countries by Financing Type (%), 2010



Graphic102

Source: OECD Health Data July 2012

*Turkey data refer to the year 2011.



Graphic 103

Source: OECD Health Data, TURKSTAT

*Turkey data refer to the year 2011.

While the share of health expenditures in the household expenditures was 2,75 % in the OECD in 2002, it was reported 2,30 % for Turkey. In 2010, the share of health expenditures in the household expenditures increased to 3,16 % in the OECD but we decreased it to 1,90 in Turkey (Graphic 103).



A. Middle-Term Financial Program

The Middle Term Financial Program was established in order to ensure efficient and productive and economic use of resources as well as accountability and financial transparency.

The purpose of the Middle-Term Financial Program:

- To determine resource allocation in terms of strategic objectives,
- To ensure that the sustainability of improvements implemented in the economic and social area in Turkey is guaranteed,
- To provide consistent objectives and policies for sectors developed under the scope of macro policy privileges.

The program is open to improvements and changes with a perspective of three years and is renewed every year in accordance with the results of the annual executions and changes the country went through. Program implementations and improvements likely to affect the program are regularly monitored and assessed. The financial sustainability of the Health Transformation Program is continuing to be successful, thanks to the economy, finance and planning method managing the 2009 financial crisis and the post period successfully.

Health-related part of this program is about issues to ensure provision of health care services with an improving quality and financial sustainability. This program provides a budget for a period of three years. Thus, the optimum use of sources by sectors is ensured.

B. Monitoring Health Expenditures

Systematic monitoring and assessment of health expenditures and improving relevant strategies with the aim of cost effectiveness and quality are included among the precautions to be taken in order to ensure effective and productive use of public resources. We founded the Commission on Monitoring and Assessment of Health Expenditures in order to fulfill all these objectives. This commission carries out analyses with regard to the improvement of health expenditures and new policies are determined as a result of these analyses.

2. Management of the Global Budget

We developed “The Global Budget Model” in 2006 to finance health care services provided by the MoH.

The Global Budget means the prospective receivables in return to the services to be provided for a fiscal year- in other words means the expenditure cap and targets.

We aimed to keep health expenditures under control by limiting the total amount to be allocated for health care services in accordance with the Global Budget.



A. Situation prior to the Global Budget

Financing of services used to be based on invoicing system.

People under the coverage of the Social Security used to apply to a primary care facility with a health record book and a medical visit form or a patient referral paper.

Green card holders used to apply with their green cards.

People with no social security used to pay for their treatment costs out-of-pocket to obtain primary health care services.

As a result of the examinations carried out during the primary care, a copy of the examination request form displaying examinations and tests carried out after the submission of a medical visit form, patient referral form and medical record book as well as the copies of tests used to be kept in the facility concerned while the originals used to be sent to the provincial health directorate. The provincial health directorate in question used to separate these papers forwarded by the primary care service institutions and used to invoice them by calculating the amount on the basis of reimbursement and per person. The invoice prepared for reimbursement institutions was accompanied by copies of other relevant documents too and each copy of the documents was also kept in the relevant file as well and these invoices and attachments used to be mailed to reimbursement institutions. As a result of the examinations carried out during the secondary health care, the examination request form displaying examination and tests carried out after the submission of a medical visit form, patient referral form and medical record book as well as the copies of tests used to be kept in the facility concerned while the originals used to be sent to the reimbursement institutions along invoices issued.

On the other hand, inspecting invoices in reimbursement institutions was a big work of load. It was nearly impossible to inspect invoices on time.

B. Implementation Stages of the Global Budget

- Determination of the Global Budget Amount: It starts with a protocol signed between the MoF, the MoH and the MoLSS (SSI). The followings are included in the protocol:
 - The total amount to be allocated for the MoH in return for the treatment services provided for people under the scope of SSI and Green Card holders and people whose treatment costs are paid from the general budget,
 - The date and the extend of amount to be paid and the reimbursement institution to pay,
 - Other issues (like the treasure share).
- The Global Budget Execution: “Lump sum price procurement of services specification” is signed by SSI and the MoH. On the other hand, the total amount specified in the protocol is applied by allowing payments for green cards determined on a monthly basis and for SSI allocation it is paid in advance.



- Determination of Allocations Surpassing the Global Budget and Cancellations: Every year a cabinet decree is passed in order to subtract the amount surpassing the amount determined in accordance with the reconciliation by the Global Budget. Principles and procedures with regard to cancellations of amounts surpassing the Global Budget are agreed on the basis of a cabinet decree, and these amounts are subtracted from the receivables of the MoH.

Table 17. Public Accrual - Allocation and Cancellation Figures per Year, 2004-2011 (as of 2011 prices ₡)

Year	Accrual	Collection	Cancellation
2004	10.659.000.000	9.306.000.000	1.352.000.000
2005	10.807.000.000	7.940.000.000	2.868.000.000
2006	13.321.000.000	11.491.000.000	1.831.000.000
2007	13.973.000.000	12.524.000.000	1.449.000.000
2008	15.039.000.000	12.495.000.000	2.545.000.000
2009	15.630.000.000	13.700.000.000	1.930.000.000
2010	15.577.000.000	13.544.000.000	2.033.000.000
2011*	15.811.000.000	14.204.000.000	1.607.000.000
TOTAL	110.818.000.000	95.204.000.000	15.614.000.000

Source: Presidency of Strategy Development

Between the years of 2004–2011, the cost of the services provided by the institutions of the MoH was 111 billion ₡ for the SSI (including green cards); however 95 billion ₡ of this amount could be received (Table 17). Approximately 14% of the cost of the services provided by the MoH for SSI was subtracted in the last 8 years.

C. Global Budgeting for the Primary Care

We took the first step towards the Global Budget through the Article 4 of the Law No. 5597 and dated 08/03/2007 and the Additional Clause- 2 included in the Law No. 5502. We formally started to implement the Global Budget for the primary care services and signed direct service procurement contracts with payment institutions.

We made sure that all the services provided in primary care service providers are free-of charge regardless of whether they are under the scope of the Social Security Execution Communiqué.



We also ensured that the health reports submitted to obtain licenses granted by primary care health institutions and establishments, health reports for driver licenses and getting married, blood type determination, blood sugar measurements are free-of-charge as well.

With this implementation we made it easier to access to primary care services and diminished paper work.

In addition to creating positive impacts on people, we also diminished bureaucratic procedures and paperwork among public institutions and establishments. We ensured that sending invoices and their justifications to reimbursement institutions and keeping copies, referral papers, health record books and invoices came to an end beginning from the health care centers.

Via this implementation we ensured that public institutions could plan their financial future. Via the implementation of the Global Budget, we decreased costs and accelerated the procedures in relation to budget and reimbursement.

In order to make sure that institutions spend in parallel with their incomes, we implemented effective stock management and took measures by determining standards for service procurements. We have decreased the expenditures of our institutions by applying a treasure share of 1% in the Global Budget in 2009, 3 % in 2010 and 1 % in 2011 formerly determined as 15% in the law.

In the same way, we made savings:

- Mail expenditures
- Personnel's working time in dealing with such transactions
- Unnecessary loss of time for healthcare personnel resulting from paperwork
- There is tremendous saving in terms of work force as inspection process in reimbursement institutions came to an end.

D. Distribution of the Global Budget to Hospitals

With the aim of de-stressing our Institutions financially, we started to plan accruals determined by the Global Budget. Formerly, plans used to be made taking only invoice production into consideration. Instead of this, we initiated the approach of making plans based on the personnel burden of hospitals, the size of the area it serves for and the number of inpatients and outpatients.

These parameters concerned are as follows;

- **Outpatient income:** Outpatient institutions can meet their minimum expenditures if they receive 75% of their accrual. For this reason, the rate of outpatient institutions to allocation is applied as 75%.



- **Inpatient income:** As the rate of allocation of accrual was 90%, the Global Budget, this rate is directly reflected on the inpatient income. Since the proportion of collection to accrual would be 90 %in the global budget for 2011, this proportion would be reflected on the revenues to be obtained from inpatient treatments.
- **Extra burden of personnel for the institution:** This parameter is applied in order diminish the difference between institutions due to payments for personnel expenditures from the revolving fund.
- **Closed area expenses:** This parameter is applied in order to ensure balance between institutions in terms of expenses due to closed areas (electricity, rent, heating, etc).
- **Building maintenance expenditures:** This parameter is applied in order to ensure balance between institutions in terms of expenses due to building maintenance expenditures.
- **Bundle procurement:** It is applied to encourage hospitals appointed for bundle procurement. For these institutions 1% of extra allocation is allocated.
- **Commitment in terms procurement:** It is used in order to encourage hospital carrying out procurements procedures for other institutions as well. Each hospital linked to these institutions receives an extra payment of 2 per thousand of the accrual.
- **B1 Type 112 I Emergency Health Care Services Integrated Station:** B1 type integrated 112 Emergency Health Care Services stations receive an extra payment of 1 per thousand of the accrual as they constitute an extra expenditure for the institutions they are integrated.
- **Diagnosis Related Groups:** It has been carried out taking DRG implementation developed by the MoH into consideration since December of 2010.
- **Stock Record Order:** If the institution has an irregular stock record, a reduction from the accrual by 1% is envisaged.
- **Harmonizing with Hospital Roles:** It is envisaged that the accrual of institutions failing to harmonize with the roles of the hospital would be reduced by 1 %.



3. Financial Standards Development and Regulation Procedures

A. Determining the Number of Personnel to be assigned for Personnel-Based Service Procurements

In order to determine the number of employees to be assigned under the scope of service procurements, we initiated a dynamic system which can be modified in parallel with income, service provision, patient potential, the size of the facility and the number of current contracted and permanent personnel in accordance with the new health care service provision model improved under the scope of the Health Transformation Program.

With this regulation we brought some limitations with regard to determination of the number employees not affecting the performance and service provision of the institution in question.

With the aim of making a reliable estimation of the number of employees to be assigned for service procurements in accordance with the new criteria established and the aim of following-up these estimations on a provincial basis, we developed web-based “Determination and Follow-up of Employee Number” and sent it to our institutions.

Our institutions can determine the number of employees they can hire for a period of six months based on their criteria and performances via this program. These data can be instantly controlled and followed up by the MoH, Provincial Health Directorates and institutions. Additionally, this system also enables access to information about the number of personnel in parallel with service procurement, educational background of such personnel and their salaries.

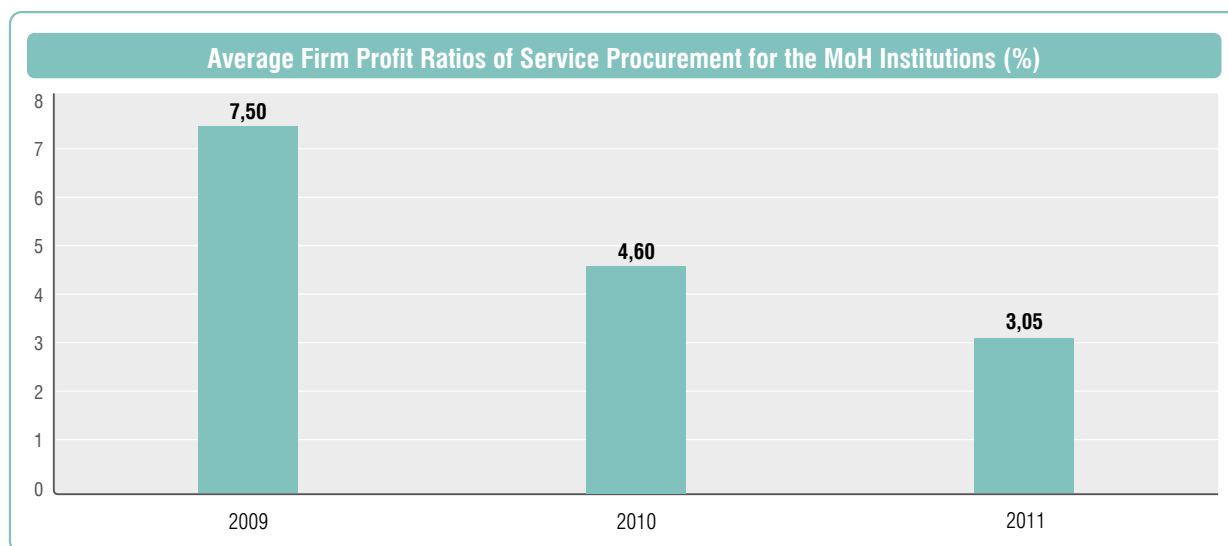
B. Profit Ratio to be Allocated for Contractors for Personnel-Based Service Procurements

In accordance with the provisions of Implementing Regulation on Service Procurement Tenders published by the Public Procurement Agency, determination of the profit ratio to be allocated for Contractors for Personnel-Based Service Procurements is subject to the administrations of institutions on condition that the profit ratio does not exceed 20% in parallel with the quality of the work.

Through the regulations implemented between 2009 and 2010, we limited the maximum profit ratio to be Allocated for Contractors for Personnel-Based Service Procurements to 8% initially and then to 5 %. The maximum profit was applied as 5 % in 2011.



After this regulation we reduced the profit to 3,05 % in 2011 which was about 7,5 in 2009 and 4,6 in 2010 (Graphic104).



Graphic 104
Source: Presidency of Strategy Development

We enabled the MoH to get rid of a burden of 60 million TRL in 2011 thanks to this regulation.

C. Wages for Employees Hired For Service Procurement

Employees, hired for service procurement tenders based on personnel employment in accordance with the secondary legislation published by Public Procurement Agency, are paid the gross minimum wage. As a requirement of the services provided, payment of an amount more than the gross minimum wage is subject to discretionary power of the administration as long as the relevant provisions are included in the bidding document and contracts.

The fact that the institutions (even the ones in the same province) linked to the MoH is likely to determine different amounts of wages results in inequalities and disturbance among employees.

We developed relevant regulations in order to envisage an equal wage schedule for employees to be hired in accordance with the service concerned, educational background and the certificates.

D. Determination of the Time of Payment and Regulation of the Payment Processes

The issue of suppliers being informed of the time of payment by the administration and the payment schedule planned being applied properly is one of the most important factors in assuring appropriate conditions while meeting the needs and efficient use of resources.



Through the regulation we have been implementing, we ensured that payment schedule is stated in bidding documents and the time of payment is not to exceed maximum 90 days in accordance with income generating of the institution and cash flow. We also ensured that institutions with a good financial status determine an earlier payment time and payment papers are forwarded to the relevant accountancies forthwith in order to avoid delays during inspection, admission and accrual processes.

In order to ensure that health care needs are met by health institutions and the satisfaction level is increased to the maximum level, we initiated stock implementations based on provision of products of high quality, low stock level and low cost.

4. New Implementations Initiated under Stock Management

A. Implementations of Management System for Resources of Supply (MSRS)

MSRS is a web-based information management system improved to ensure efficient use and updated follow-up of resources (medicine, medical devices, consumables and Office equipment) possessed by the units included in the central and provincial organizations of the MoH.

There are several modular structures for resource use and follow-up within MSRS. With this model, we established a combined resource management system including an Inventory Information System, Storage (Depot) Information System, Durable Mobile Information System, Transportation Means Information System, Medical Devices Information System, Firm Information and Health Care Centers Supply Procedures.

With this system having been implemented since 2008; several books, documents and tables required to be prepared in accordance with the financial legislation started to be prepared electronically. Additionally, with regard to accountability of works and procedures to be carried out by our units, we diminished potential errors and risks to the minimum level by automating record and reporting systems.

Prior to MSRS, as in the other public administrations, the portables of the institutions of the MoH used to be followed-up by movables officers through hard copy record.

In parallel with this, financial data such as properties, consumption and stock of an institution could only be obtained at the end of the terms by closing the accounts.

Additionally in order examine properties and supply procurements of an institution or in order to find out which units received the items purchased before, the relevant books and registrations had to be examined by authorities. This procedure took a lot of time and the information obtained from these books was subject to an extra estimation process as well.



After the implementation of MSRS, all records started to be kept electronically and most of the books, papers and tables were abolished. Thus we started to prepare electronic records and reports of accountability.

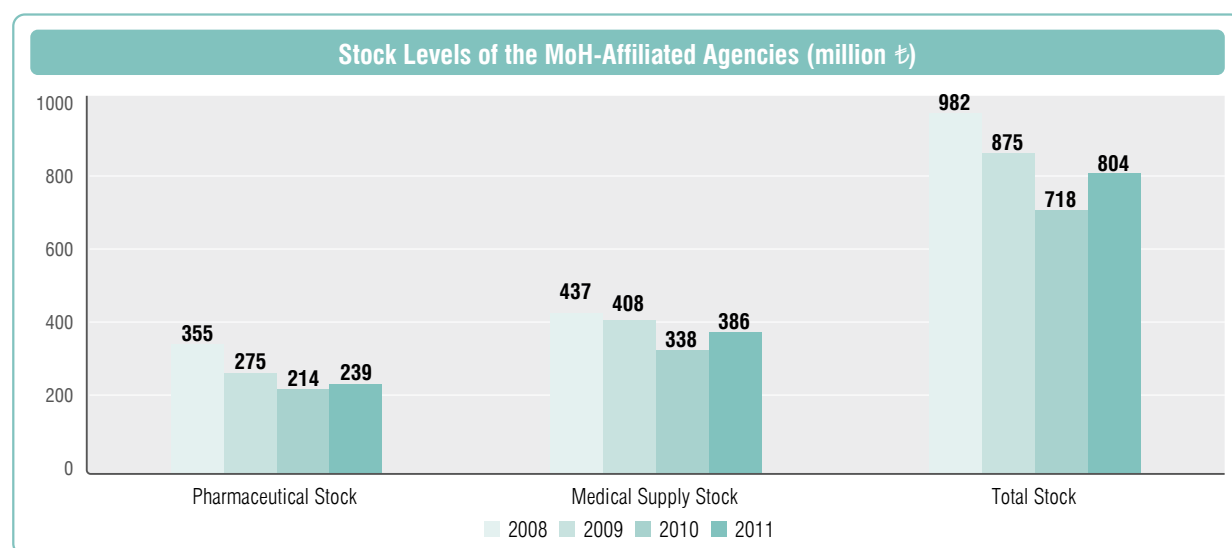
MSRS implementations have enabled us to follow-up an institution's medicine and medical consumables stock, fuel oil consumption, stationary items and data about from whom, when and through what method replacement parts are purchased via detailed and consolidated reports through web.

B. Maximum Stock Amount (MSA) Implementation

In order to continue provision of health care services in case of ambiguity of demands in the field of health, institutions are supposed to keep their stock at a certain level.

Under the scope of the Health Transformation Program, we agreed that all the medicine and medical consumables are provided by the health facility concerned in order to ensure satisfaction for patients and their acquaintances. Due to all these improvements, an increase was observed in medicine and medical consumables stocks.

We introduced new regulations in the field of stock management in order to maintain a sustainable financial structure. Within this respect, in order to minimize risks such as expiration and deterioration as well as provision and stock costs, we limited stocks to a period of three months by initiating "Maximum Stock Amount Implementation" for medicine and medical consumables (Graphic 105).



Graphic 105

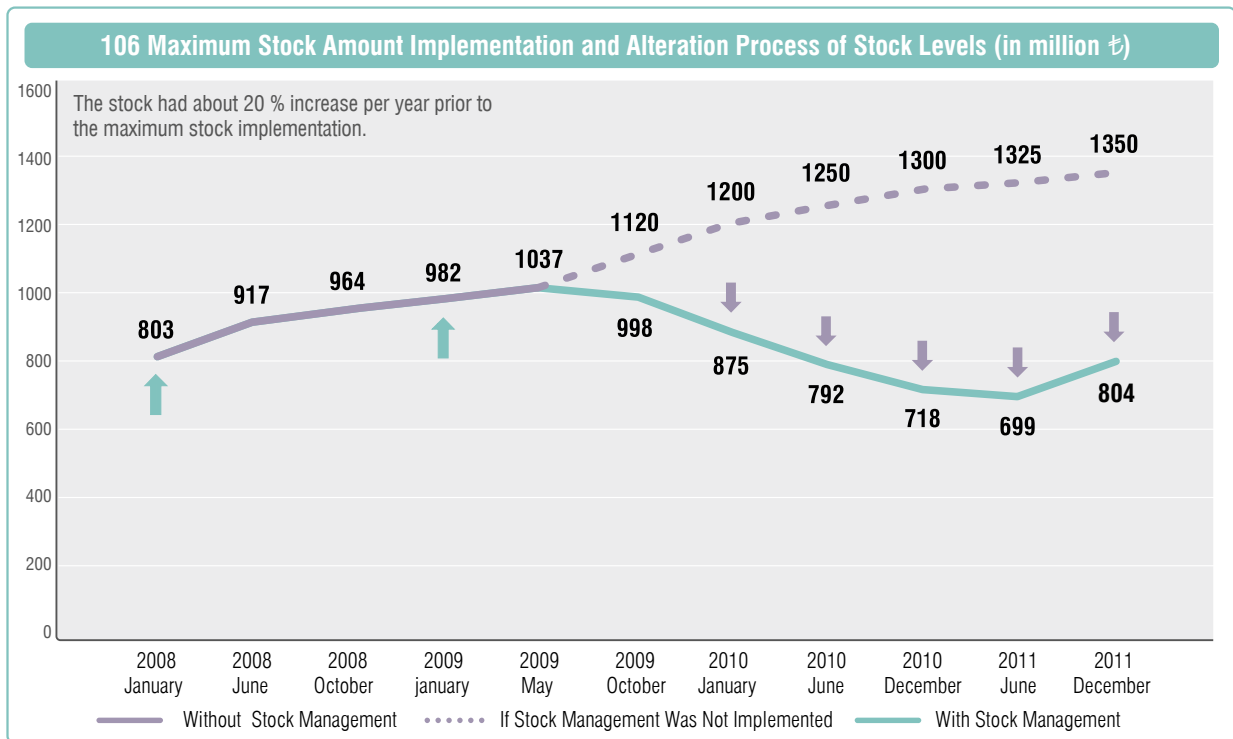
Source: Presidency of Strategy Development

Via the maximum stock amount implementation, we ensured that acceptance of goods are maintained in a way not to exceed a period of 3 months in accordance with the needs and shorten maturity periods by controlling payment requirements as well.



Prior to Maximum Stock Amount implementation, stock levels tended to increase more than 20% annually. By May 2009 with the initiation of this implementation, we prevented stock increases and decreased the stock levels, which were 1 billion above to 718 million ₺ at the end of the year 2010 all over Turkey. Yet, our stock capacity increased by 11 % in 2011 due to the increased capacity of the health care facilities, joint use of hospitals with 11 universities and meeting the costs of prescribed medicines and medical supplies from the hospital stocks (Graphic106).

We are aiming at decreasing maximum stock levels more for some specific items in order to ensure effective and efficient use of resources.



Graphic 106
Source: Presidency of Strategy Development

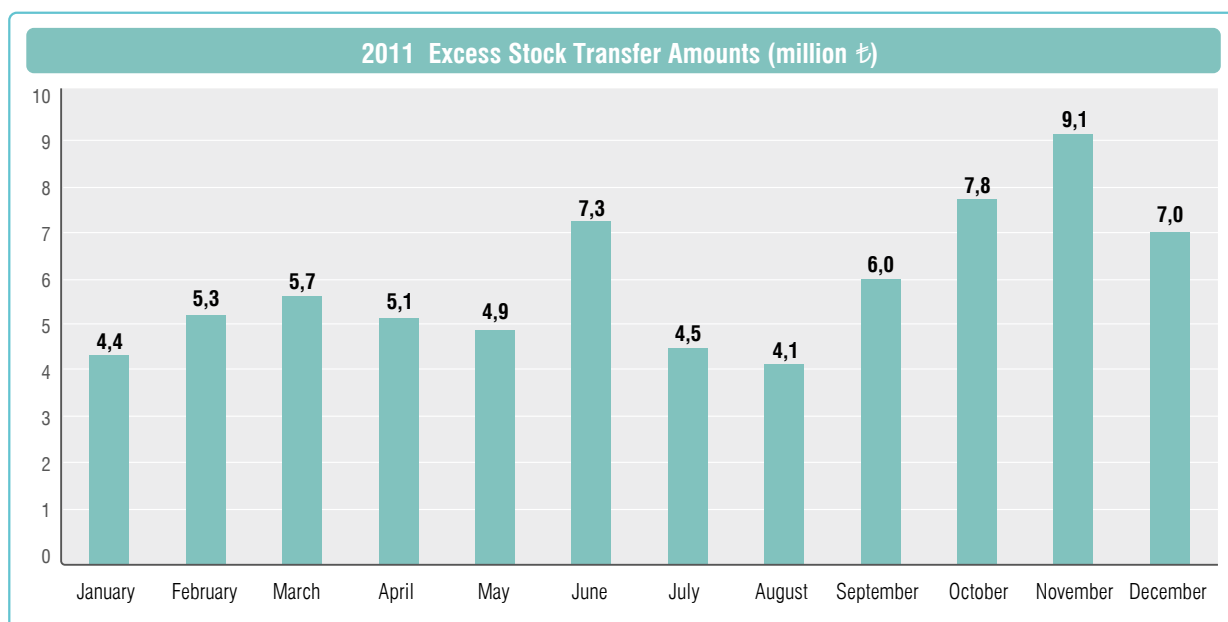
C. Requirement of MSRS Questioning Prior to Tenders and Provincial Stock Pool

Needs for medicine and medical consumables playing a significant role in service production expenditures have a negative influence on financial structures of institutions as well as on provision costs.

We improved “Excess Stock Portables Module” and “Surplus Portable Module” in order to transfer 3- month surplus medical supply or medicine or movables unlikely to be used due to reasons such as expiry, being old-fashioned and deterioration to an institution in need free-of-charge or with a charge.



In accordance with the provision places of products needed by institutions, we require MSRS questioning Prior to tenders to try to meet the need from the supply included in the excess stock or surplus modules preferably.

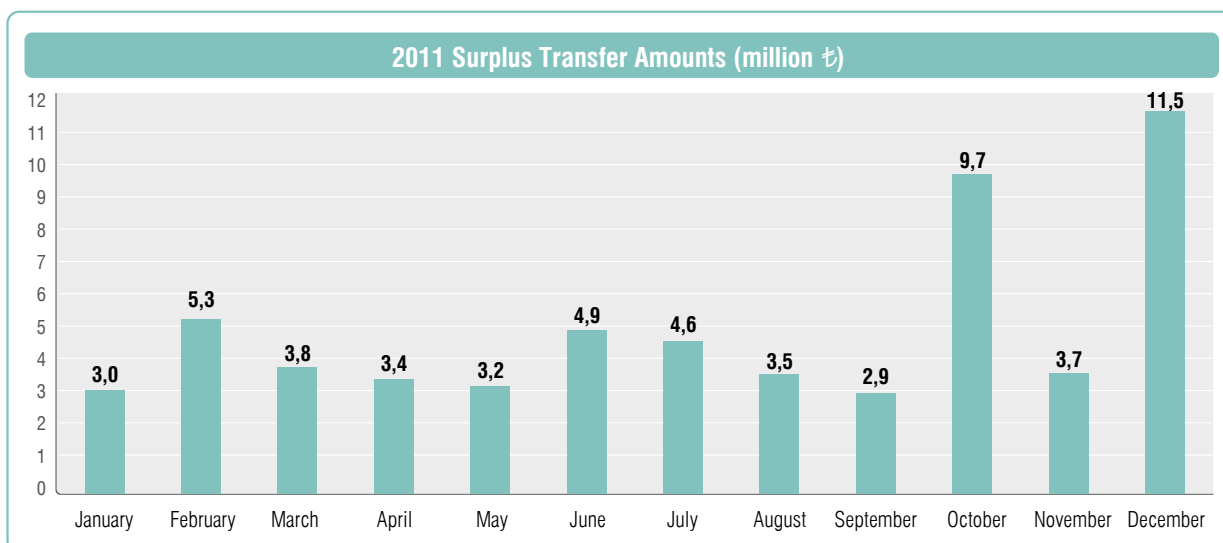


Graphic 107
Source: Presidency of Strategy Development

Under the scope of this implementation, we decreased the excess stock supply transfer, which was 71,1 million ₺ in 2011 (Graphic 107).

According to the consumption data of medicine and medical consumables registered in MSRS, it is required to determine annual needs and maximum stock amount implementation automatically transfers products above three month of need into the excess stock module and submit it to information of other hospitals. For example, if a hospital's need for an A item is 1000 count, this hospital can only have 250 count of this item at most in accordance with the maximum stock amount implementation. If the hospital purchases 300 count of item A, 50 counts will be automatically transferred into excess stock module and submitted to information of other hospitals.

Goods and materials provided as required by service production but turned out to be extra for a reason are described as surpluses. In order support the efficient use of resources, we ensured that products included in Surplus Portable Module are transferred free-of-charge.



Graphic 108

Source: Presidency of Strategy Development

A surplus of 58,7 million ₺ in 2011 was transferred (Graphic 108).

One of the modules to be questioned in MSRS prior to tenders is “Supply Procurement Questioning Module”.

Administrations are enabled to access to information such as “of whom, what, from whom, when and how much” via this module and to decide about tenders based on better data through approximate cost estimations.

As a result, we use MSRS questioning as a significant means in order to transfer excessive public resources to other institutions in need and to decrease stock levels as well as economic procurement implementations.

D. Stock Analyses

The main purpose of stock and procurement analyses is to provide medicine and medical consumables required by service production through an economic procurement method.

Under the light of the information obtained through MSRS procurement method, we could analyze procurement and stocks regularly.

E. Establishment of Provincial Stock Coordination Teams and Provincial Stock Pools

As a sequence to the implementations applied in the field of stock management, we established “Stock Coordination Teams” in every province in order to render stock management efficient in the provincial level and to keep supply transfers under coordination at institutional level.



Stock coordination teams function in order to review stock practices at institutional level, to control annual needs, to prevent procurement of products which are already included in the provincial stock pool and create awareness for administrations by analyzing procurement practices.

We required institutions to meet their need from the provincial stock pool primarily before trying to purchase their needs under the control of stock coordination unit.

F. Establishment of Commissions for Determination of Needs

We established the “Commissions for Determination of Needs” in order to control appropriateness of demands for procurement of medical consumables, medicine and similar goods as well as services by our institutions and to control amounts of demands.

This commission ensures that needs of institutions are provided trying to avoid unnecessary bureaucracy. This commission decides on the followings;

- Whether a product agreed to be provided via supply procurement could be reimbursed as well as the amount to be purchased and their maximum prices,
- The maximum price that could be obtained for a certain product considering the payment by reimbursement institutions in accordance with the quality and the scope of the service to be purchased,
- Whether it is possible to meet the need at a lower price by investigating alternative products,
- Whether there is a possible method (donation, transfer from other institutions, renting, procurement) for the provision of the alternative supply or service needed.

We ensured that such commissions function as a control instrument in order to maintain financial sustainability of institutions.

5. New Methods Developed for Provision of Needs

We implemented new methods under the scope of public procurement legislation in order to provide the urgent needs of health care institutions at a minimum cost in terms financial sustainability.

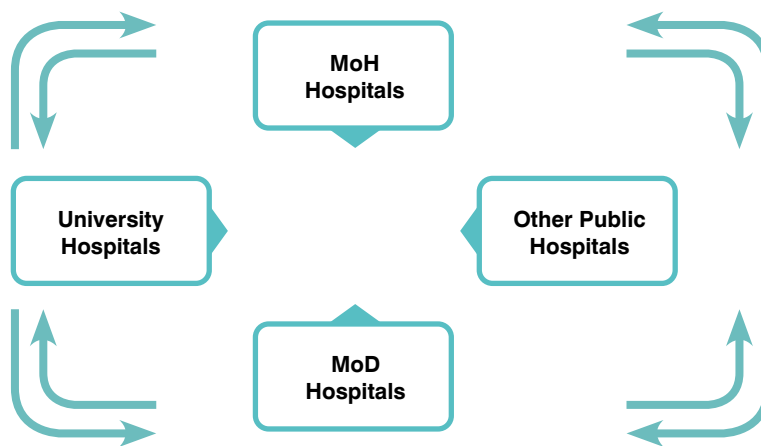
A. Enabling Public Hospitals to Exchange Goods and Services between Each Other

So that the unutilized or surplus goods and fixed assets which are owned by the Ministry of Health-affiliated revolving fund institutions are not wasted, we enacted the relevant legislation in order to ensure that the unemployed resources are transferred to the demanding institutions free-of-charge or at a value to be determined.



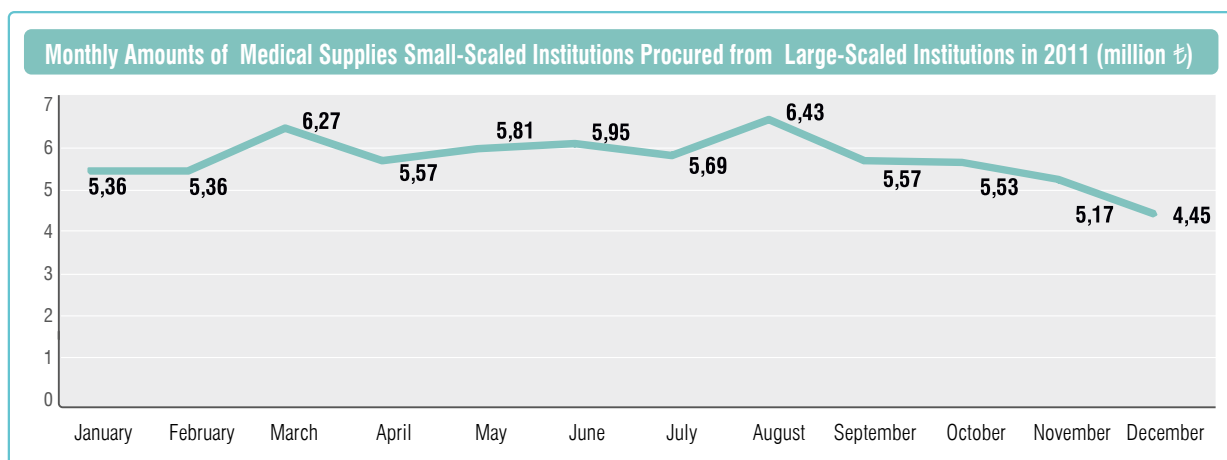
We expanded this regulation in order to include all public health institutions. We provided the opportunity to obtain the diagnostic and treatment services which cannot be carried out by health institutions and establishments in other health institutions and establishments linked to other public administrations.

We activated the unemployed resources of the MoH hospitals, university hospitals and other public hospitals with this regulation.



B. Meeting the Needs of Small-Scaled Hospitals by Large-Scaled Hospitals

In parallel with the regulations in the relevant legislation, by the second half of 2009, the needs of Small-Scaled Hospitals with a limited procurement capacity are met by Large-Scaled Hospitals. We simplified procurement procedures of institution and decreased stock costs.

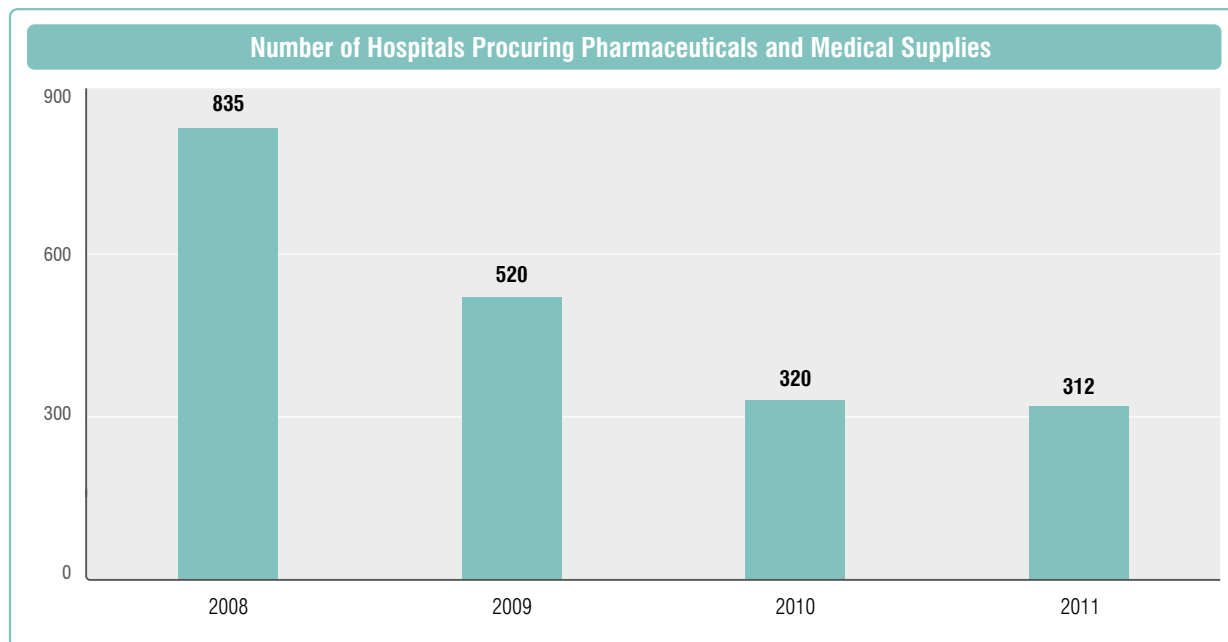


Graphic 109

Source: Presidency of Strategy Development



Through these implementations we decreased the number of hospitals purchasing medicine and medical supply from 835 to 312 (Graphic 110). We enabled a purchase of 87,5 million ₺ of medicine and medical supply by larger institutions on behalf of small sized ones in 2011 (Graphic 109).



Graphic 110

Source: Presidency of Strategy Development

C. Bundle Procurement through a Framework Agreement

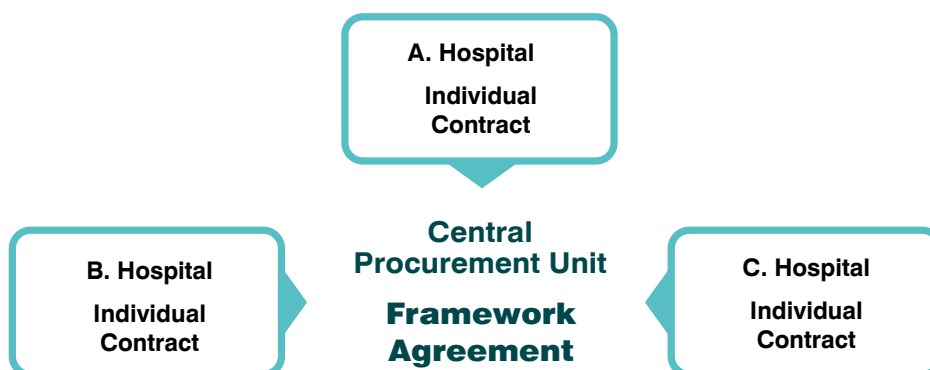
We initiated the relevant legal arrangement in order to ensure that procurement of services and goods needed by health service providers is carried out through a framework agreement.

Framework agreements are a significant method which contributes efficient stock management of public administration enabling rapid procurement of needs from pre-defined providers.

The most important aspect of framework agreements is that they do not load another burden on administrations for procurement. Additionally, in a framework agreement period (this period might go up to four years), it is not necessary to call for tender for each procurement and candidates are not required to submit their papers again and again to prove their compatibility.

The MoH started to benefit from framework agreements on a large scale in order to meet the needs.

We made it obligatory to use framework agreements in order to meet the needs for medicine and medical devices on a provincial basis via an ordinance published by the MoH in 2009 and we gave instructions in order to ensure that such procurements are handled by Provincial Health Directorates or Central Procurement Units established in hospital with capacity to regenerate procurements within the province concerned.



After we necessitated the use of framework agreements, we held information meetings about the legislation on framework agreements for the personnel employed in central procurement units established in 81 provinces and for representatives.

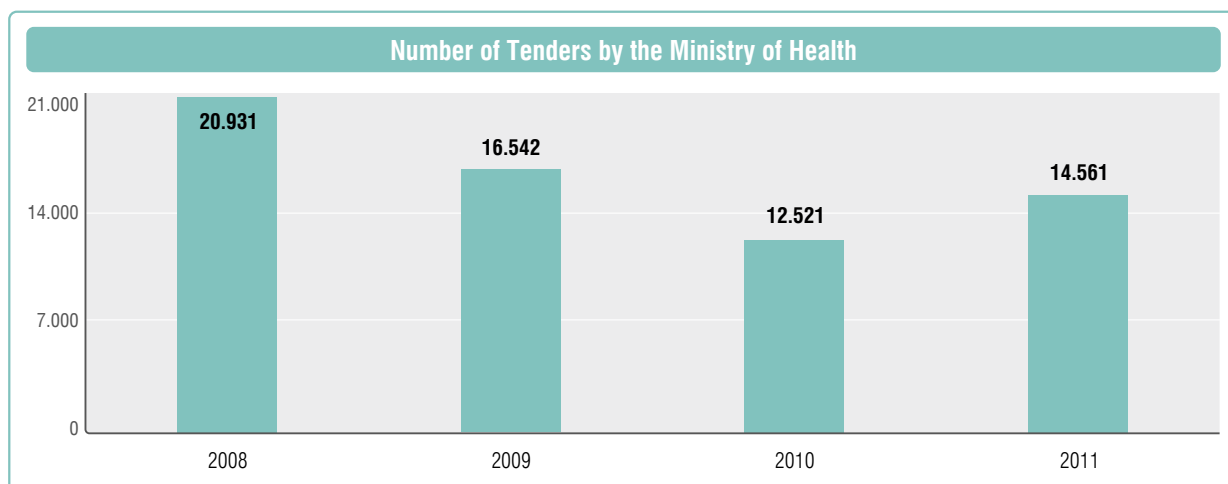
We aimed to increase the rate of the use of framework agreements in order to meet the need of our institutions by implementing the relevant legislative alterations to remove the problems resulting from the current legislation via regulating legislations by promoting the participation of candidates into framework agreements. While the share of framework agreements in total contracts was 11,3 in 2010, we increased it to 18,3 in 2011.

D. Meeting the Needs of Laboratory Service Providers through Bundle Procurements

With the aim of meeting laboratory needs in an economic and efficient way, we necessitated bundle procurement of laboratory needs of 629 institutions by Provincial Health Directorates with an insufficient procurement capacity and low budget through a regulation we developed in 2010. The implementation continued in 2011 and the laboratory needs of 629 institutions were met by bundle procurements.

Via the regulations initiated in 2009 and 2010;

- a. We decreased the costs of provision and stocking.
- b. We ensured the establishment of common terms of references.
- c. We increased procurement capacity of our institutions.
- d. We encouraged competitions for the tender to be held.
- e. We decreased the number of tenders (Graphic 111) (We saved 21 million ₺ just from the fund allocated for advertisement in 2009-2010).



Graphic 111

Source: Presidency of Strategy Development

E. Facilitating the Provision of Needs for Research and Development

Under the scope of paragraph (f) of the Article 3 of Public Procurement Law No. 4734, we described all the procedures and methods for all kinds of service procurements with regard to the research and development activities to be carried out in the field of health by the MoH institutions. The research and development services to be carried out in the field of health care can be purchased from the sector through bargaining or direct provision method based on the principles defined by the MoH and directly from public institution and universities based on the principles of the relevant protocol. In return for the services obtained from public institutions and universities carrying out the research and development activities needed by the MoH, we allocate 1 million ₺ financing for each service thus contributing to improvement of research and development activities, an obvious deficiency in Turkey.

6. Establishment of Financial Management Information System

Provision of better services by hospitals and other health institutions and establishments depends on appropriate and timely use of limited hospital revenues and current resources. With the aim of maintain financial sustainability of our institutions, a liable information system was need to be established and improved along with the legislative regulations.

In parallel with appropriate management of current resources and revenues, we established the Uniform Accounting System in 2004 and we improved other web based finance management means as well.

A. Uniform Accounting System

Via Uniform Accounting System, we rendered the electronic momentary follow-up of financial situation of hospitals as well as the administrator, relevant personnel and accounting units and central users. We enabled the follow-up debts and receivables of our institutions. We decreased work load of accounting units via Uniform Accounting System. We established the relevant infra structure for the procedures included in the responsibilities of accounting authorities.



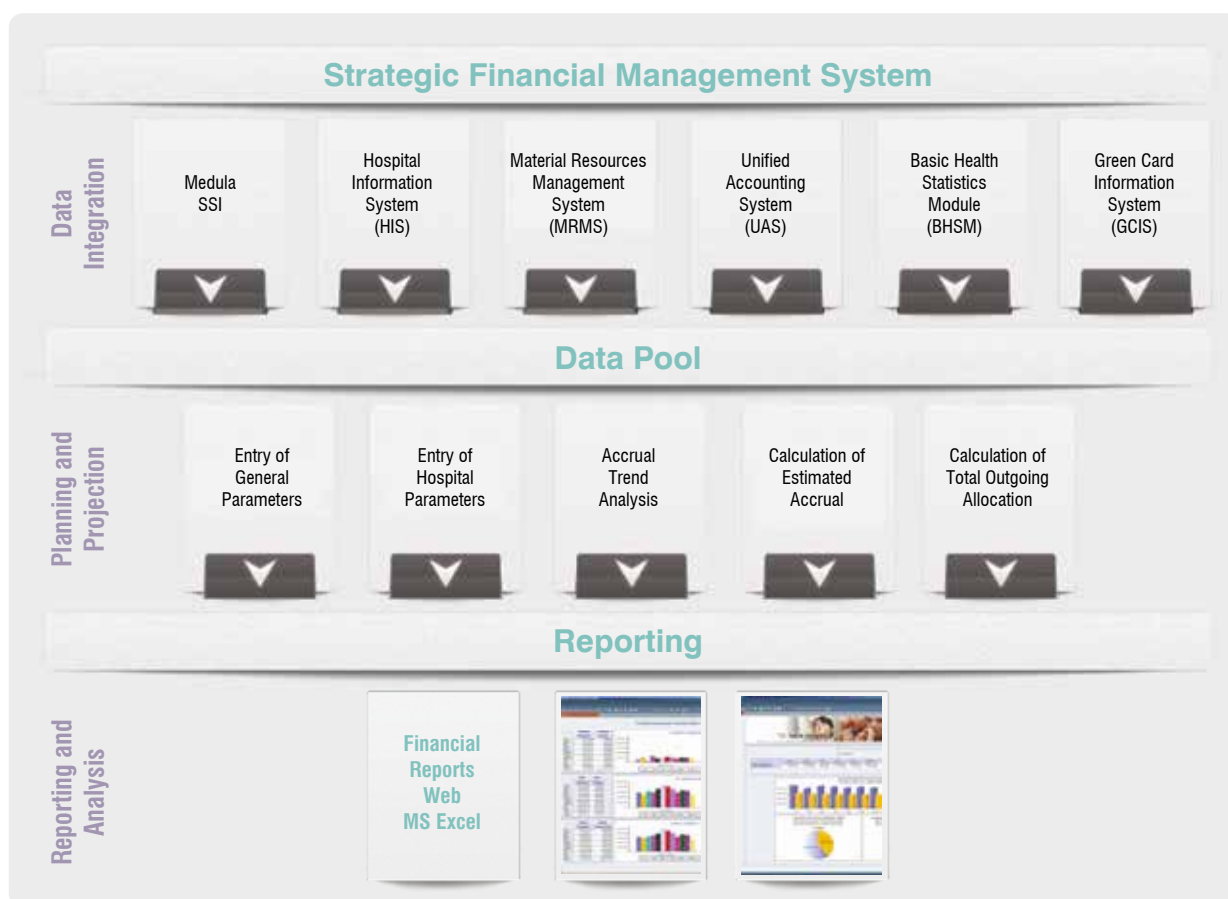
B. Budget Program for Revolving Fund Institutions

We ensured that our institutions could establish their budgets for every fiscal year by providing with revenue and expenditure estimations. We followed up their budget regenerations and kept their revenues and expenditures under control. We avoided high expenditures especially through determination of investment budget in accordance with the financial structures of institutions in terms of budget implementations. We accelerated the process of procurement of services and goods by introduction web based budget transactions.

C. Strategic Financial Management System

We started to develop the system in order to carry out all the financial work and transactions of the MoH, and to analyze and review the situation of institutions, to determine their financial risks and to put forward recovery proposals reporting the determinations found out.

With the aim of ensuring an effective planning and projection process, we established a fast, accurate, multi-dimensional, flexible and modular infrastructure maintaining integration of current systems based on a single resource.

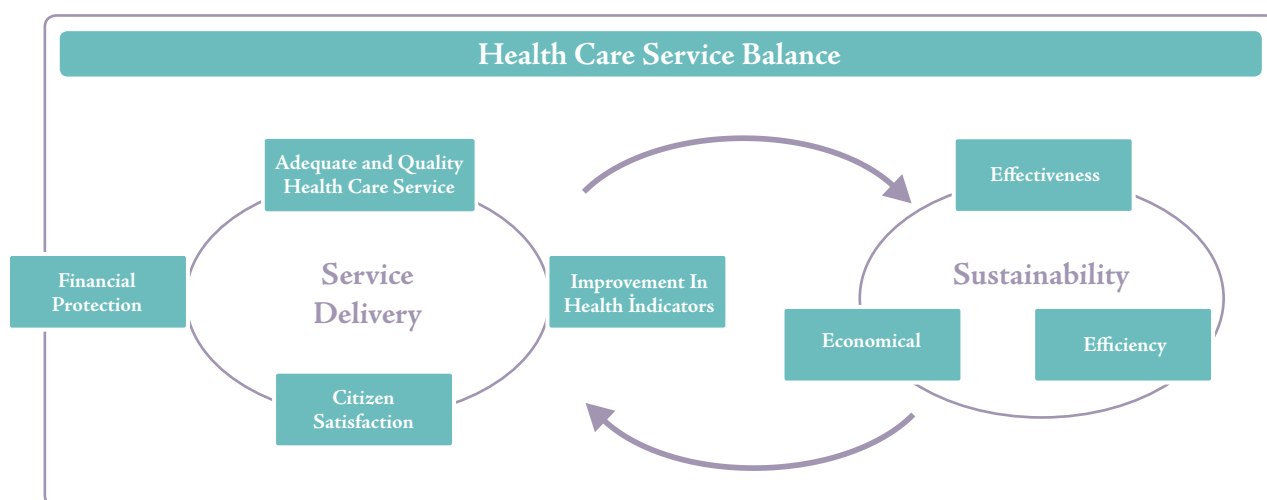




7. Risk Management and Financial Analysis

A. Financial Risk Management of Institutions

The main purpose of the regulations implemented under the scope of the Health Transformation Program is to sustain adequate and high quality health care services in way to improve satisfaction-based health indicators under the coverage of financial protection. Achievement of this objective is undoubtedly possible by effective and efficient use of resources as revolving fund institutions.



In parallel with this purpose, we carry out financial risk analyses by assessing our revolving fund institutions in terms of their financial data and we follow up their risk situation through five different grading system (Table 18).

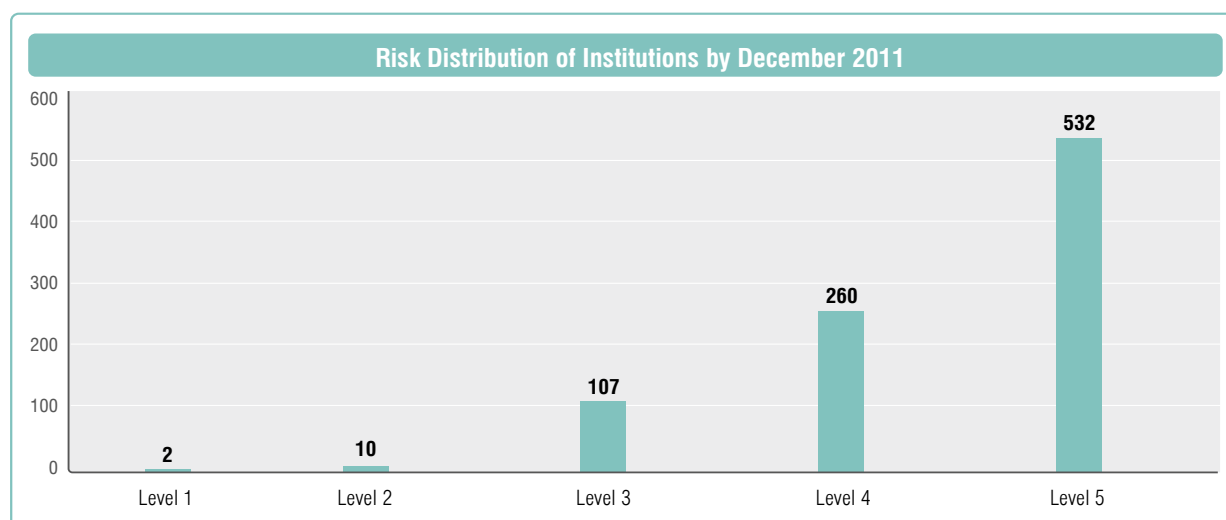
Table 18. Risk Estimations of Revolving Fund Institutions by December 2011

Criterion	Institution	Level
Institutions where the ratio of total net debt to average accruals is 2 and above	2	Level 1
Institutions where the ratio of total net debt to average accruals is between 1,5 and 2	10	Level 2
Institutions where the ratio of total net debt to average accruals is between 1 and 1.5	107	Level 3
Institutions where the ratio of total net debt to average accruals is between 0.5 and 1	260	Level 4
Institutions where the ratio of total net debt to average accruals is below 0.5	532	Level 5
Total Institution Number	911	

Source: General Directorate of Health Services



Under the scope of risk analysis, we assess each institution in terms of their budget balance and resource management based on their service production revenues and debts. In this respect, we graded institutions with a total debt equal to twice as much of their monthly service production revenue as level 1 risk (Graphic112).



Graphic 112

Source: Presidency of Strategy Development

B. Financial Analysis Reports and Financial Action Plans

The institutions followed-up in terms of their risk analysis through financial tables are determined before they constitute a high risk level and financial analysis meetings are held with the administrators of such institutions.

We review the performance of service production and revenue- expense regenerations of institutions and analyze such data in comparison with the data coming from other institutions with the same role during these meetings. As a result of these meetings held, we prepared “Financial Analysis Reports” and “Financial Action Plans (FAP)” specific to each institutions in order to maintain a more effective and efficient use of resources with the aim of ensuring financial sustainability by eliminating potential financial risks.

Additionally we followed-up the items included in the analysis reports and action plans along with the periodical regenerations and held consultancy meetings with the administrative body concerned.

C. Financial Management Meetings

Under the scope of financial assessments, we held regular “Financial Management Information Meetings” for hospital managers.

Within this respect, we also conducted training and information meetings about the new regulations implemented through the changes in financial legislation for hospital managers playing an important role in management of institutions and for chief physicians especially playing a role in expenditure.



We tried to make a difference with the use of financial tables and implementation results in terms of revenue and expenditure balance in order to maintain financial sustainability of institutions during these meetings.

Additionally, in order to follow up regulations implemented with the aim of ensuring an efficient financial management, we continued to carry out these training and information meetings every three months.

COSO PYRAMID



D. Establishment of an Internal Control System

D.1. Regulation in Accordance with Public Financial Management Control Law No. 5018

Under the scope of the Public Financial Management Control Law No. 5018, we aimed to establish an internal control system based on the Integrated Control Frame (COSO) model in accordance with our public management system and the international standards and EU implementations. We started the works with regard to establishment of the Internal Control System in the Directorate of Strategy Development in 2009 as a first step in accordance with this model in order to ensure effective services, to produce administrative and financial reports and to increase efficiency and to align such services with the law and regulations in effect.

As a second step, under the scope of Public Internal Control Standards prepared by the MoF, the MoH put Internal Control Standards Harmonization Action Plan in effect on 30.06.2009.



D.2. Provincial Evaluations: Inch by inch Eighty One Provinces

Works carried out based on on-site assessment of implementations enabled observing the services provided by the personnel of the MoH on-site, one of the most common organizations of Turkey.

Mr. Minister and field coordinators made a total of 2,4 million km during their field visits which have been carried out since 2006 in a more inclusive and detailed way. This estimation is equal to going around the world more than sixty times.

We visited eighty one provinces without any exception. We carried out more than one evaluation in several provinces. We discussed the problems of these provinces with local administrators. We shared tasks in order to find solutions. We transferred health administrators already assigned in a province to another province; hence we gave them a chance to review other institutions and make comparisons. Therefore provincial assessment studies were also regarded as in-service training opportunities. We are so proud to see satisfaction of our people as a response to all these efforts.

Basic Benefits of Provincial Evaluations:

- **Intellectual follow-up**

All the information and statistics obtained during field studies were compared with the ones obtained from the next field study to the province concerned.

We questioned if the items instructed during the previous visit by arranging monitoring reports in the subsequent field visit were actualized or not.

Thus we set the idea of monitoring the instructions given during the field visit and ensured that the improvements would be accelerated.

- **In-service training**

We transferred health administrators already assigned in a province to another province; hence we gave them a chance to review other institutions and make comparisons.

Thus, the Health Transformation Program provincial health services were also regarded as in-service training opportunities.

- **Encouraging search for solutions**

We paid attention to suggestions from personnel during both the visits and the evaluation meetings. We promoted sharing and declaration of deas. We encouraged our personnel to be a part of the solution rather than the problem.



- **Exchange of experiences**

Through these works we enabled health administrators exchange their experiences with each other. We assigned 1640 people from the central organization of the MoH and 2580 people from provincial administrators at different times for Field Assessment Studies.

- **Communication and consultation**

We ensured that administrators from across the country meet with each other and share the problems they encountered and try to find a solution in consultation with each other. We carried out “Provincial Assessment Meetings” in every province at least twice and founded an understanding to find common and participative solutions.

- **Horizon broadening and institution scanning**

We visited 19350 hospitals, 2850 dental clinics and 30500 primary care service providers in order to enable administrators to evaluate cases happening other than in their own institutions.

- **Standardization**

We made our institutions understand that they were not alone and the importance of establishing a standard with other similar institutions. We established a “common language” and a “common vision”.

Under the scope of the Health Transformation Program, we evaluated 260 provincial health care services since 2006. Mr. Minister attended 171 of these visits. Additionally field coordinators visited hospitals 19.350 times, Oral Dental Health Care Centre 2.850 times and primary care centers such as health centers, tuberculosis control centers, mother and child care and family planning centers, public health care centers 30.500 times and carried out on-site assessments.

TURKEY HEALTH TRANSFORMATION PROGRAM



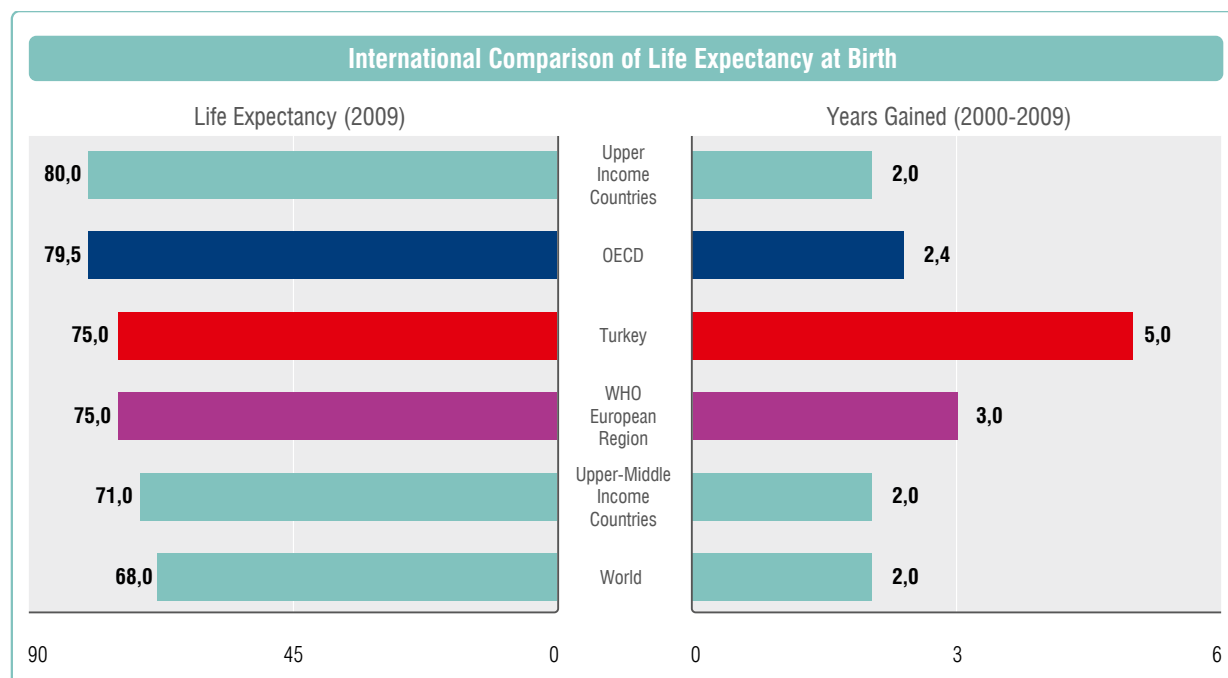
D. ASSESSMENT



1. Improvements in Health Indicators

Although Turkey is classified among the mid-upper income countries by WHO, health indicators of Turkey have reached a comparable level with upper income countries

A. Life Expectancy at Birth



Graphic 113

Source: OECD Health Data July 2012, World Health Statistics 2011



Turkey Health System Performance Assessment (Page 13)

Year of Publishing: 2011

Published by: WHO, World Bank

“There has been a major continuous and linear improvement in life expectancy at birth in recent years in Turkey (2003-2010), with the gap between Turkey and rest of the European Region narrowing quickly. Improvements in life expectancy at birth were greater in Turkey than in the rest of the Region over the period of implementation of the HTP.”

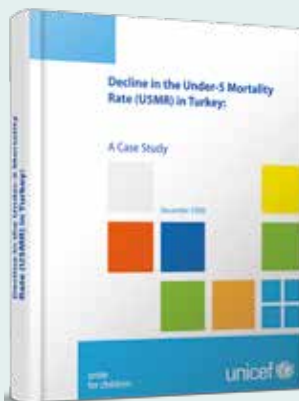


B. Infant Mortality Rate



Graphic 114

Source: Istanbul University, Marmara University, Yildirim Beyazit University "Infant and Under 5 Age Mortality Survey 2012", World Health Statistics 2012", Other Years Turkish Public Health Institute



Decline in the Under 5 Mortality Rate (U5MR) in Turkey: A Case Study (Page 4)

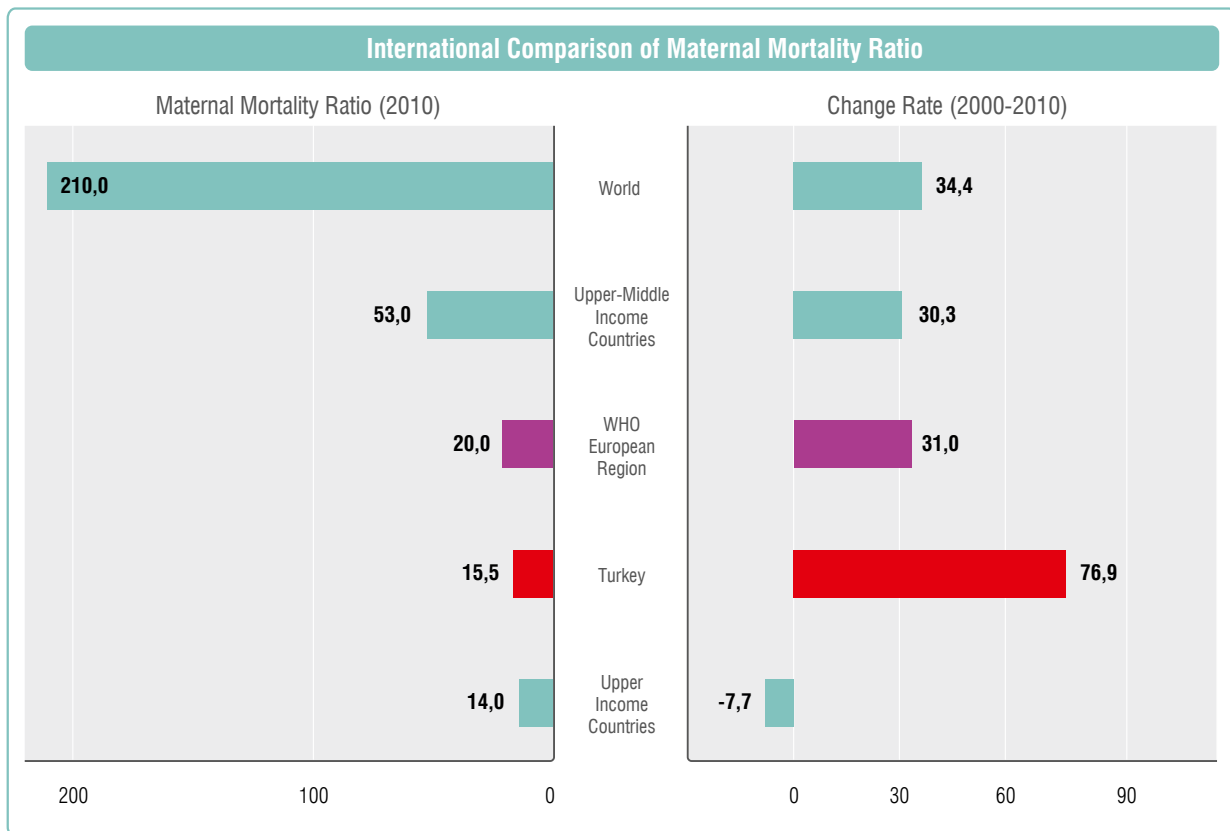
Year of Publishing: 2009

Published by: UNICEF

"Improved prenatal care, increased number of women giving birth in health care facilities in the attendance of skilled health care personnel and improved quality and quantity of neonatal intensive care have directly contributed to the survival of newborns and children."



C. Maternal Mortality Rate



Graphic 115

Source: Turkish Public Health Institute , World Health Statistics 2012



The European Health Report 2009 (Page 18)

Published by: World Health Organization

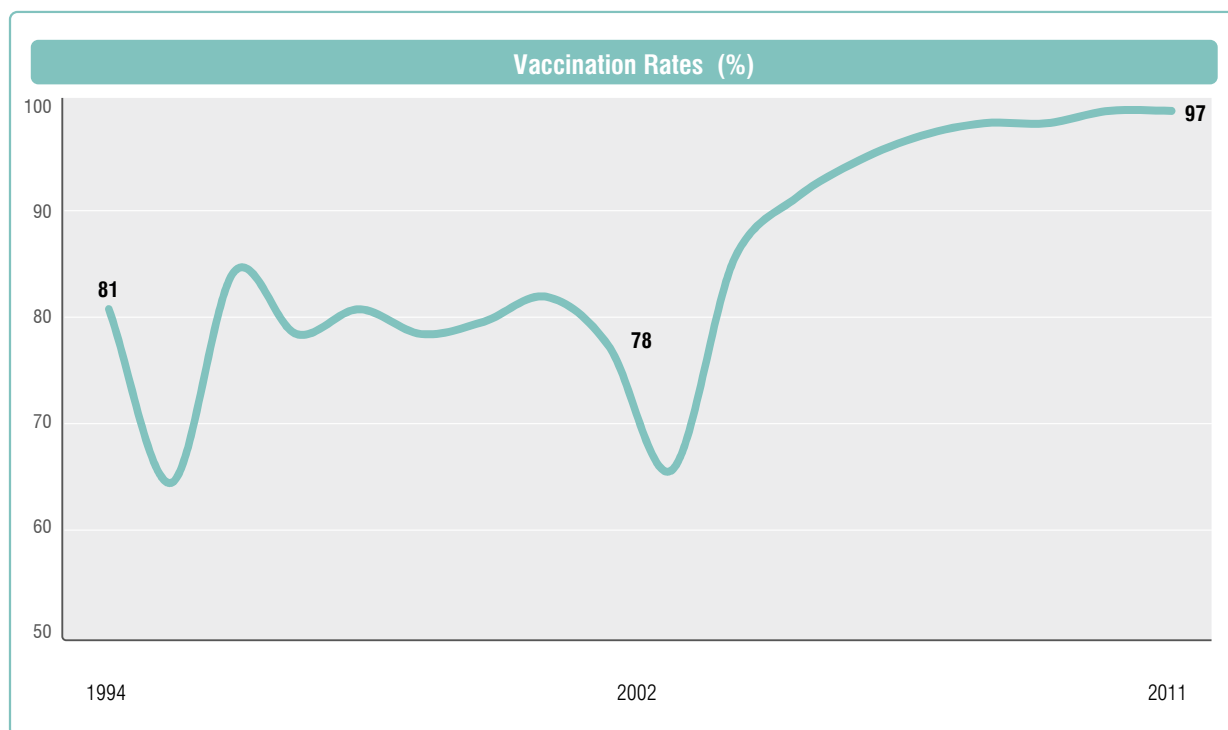
This progress is largely due to making maternal mortality a political priority, funding it accordingly, pursuing policies and providing services in a culturally sensitive manner.

This includes establishing pre-delivery care homes for expectant mothers near a hospital and providing land and air transport free of charge for obstetrical emergency cases, greatly reducing the distance and time needed to access appropriate and high-quality specialized care."



D. Routine Vaccination Rate

Turkey is one of the countries setting an example in terms of baby vaccination variety and vaccination rates it achieved.



Graphic 116
Source: Turkish Public Health Institute



Recent Developments in the Childhood National Immunization Program of Turkey

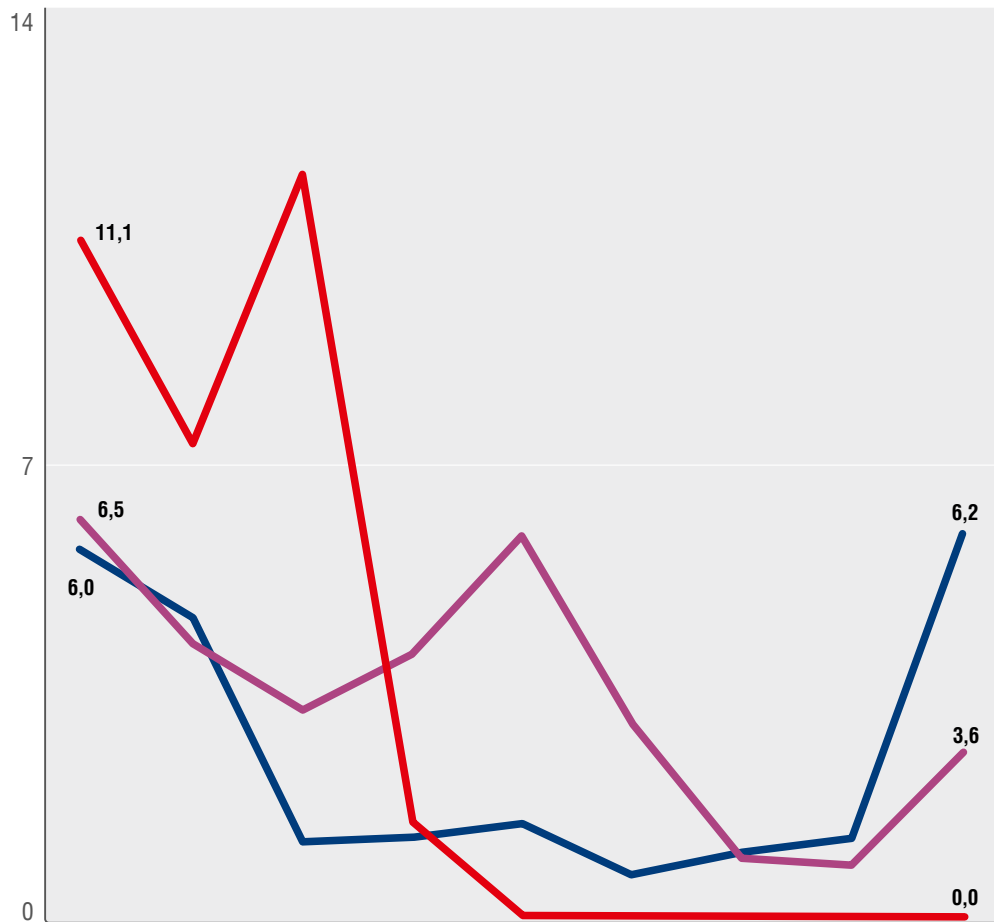
The Turkish Journal of Pediatrics, 2010

“Now, the Immunization Program of Turkey is equivalent to or better than the programs in the other European countries. Yet, immunization should be a priority and an integral part of the government policies for health for sustainability. Political commitment, multi-sectoral cooperation and awareness are of vital significance.”



E. Measles

International Comparison of Measles Incidence by Years (in 100.000)



	2002	2003	2004	2005	2006	2007	2008	2009	2010
European Union	6,0	5,0	1,2	1,3	1,6	0,7	1,1	1,3	6,2
WHO European Region	6,5	4,5	3,4	4,3	6,3	3,2	1,0	0,9	3,6
Turkey	11,1	7,8	12,3	1,6	0,1	0,0	0,0	0,0	0,0

Graphic 117

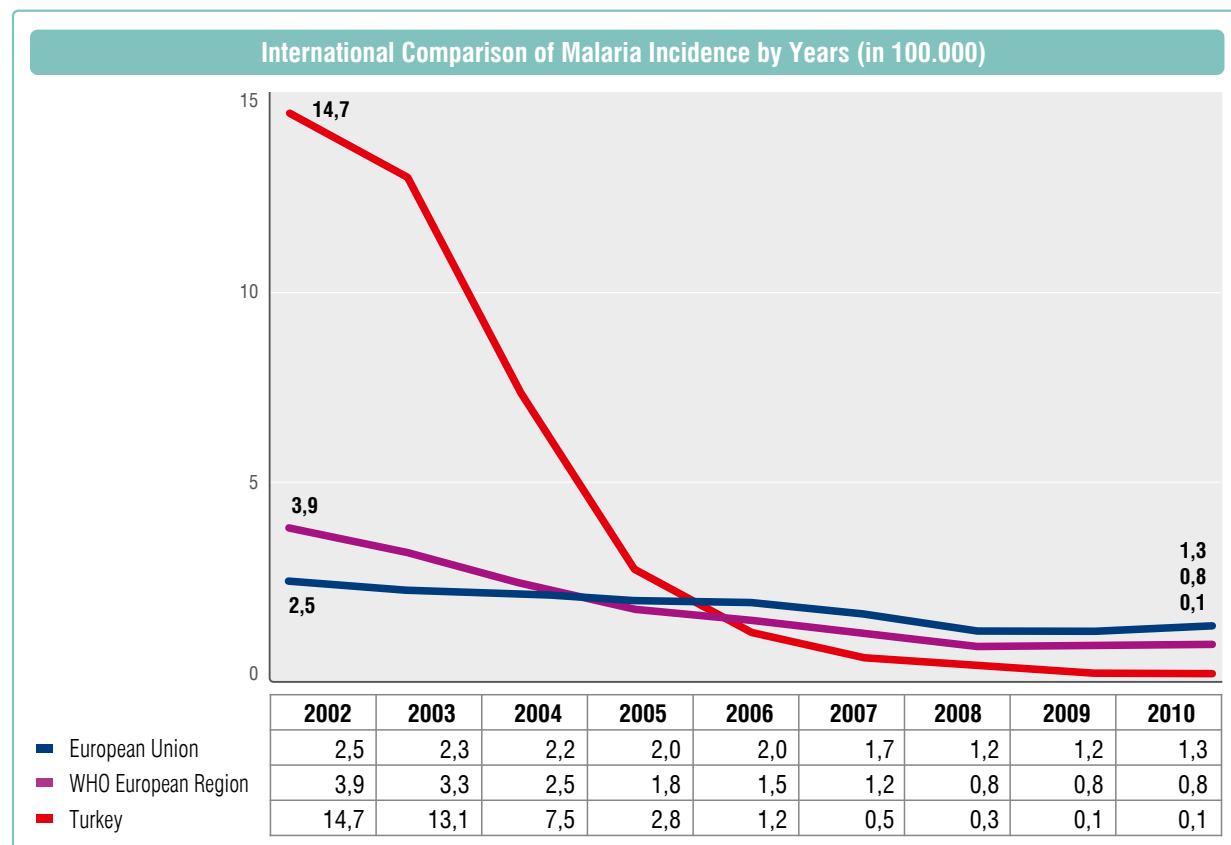
Source: WHO HFA Database, Turkish Public Health Institute

Measles has not been observed in Turkey since 2008.

We are waiting for the other countries in order to declare that measles has been eliminated in Europe.

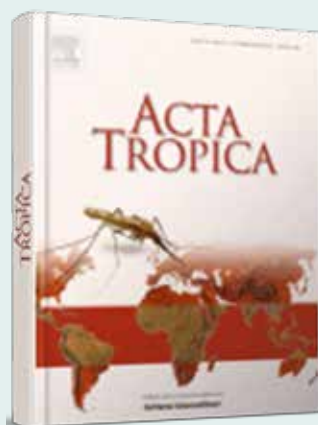


F. Malaria



Graphic 118

Source: WHO HFA Database, Turkish Public Health Institute



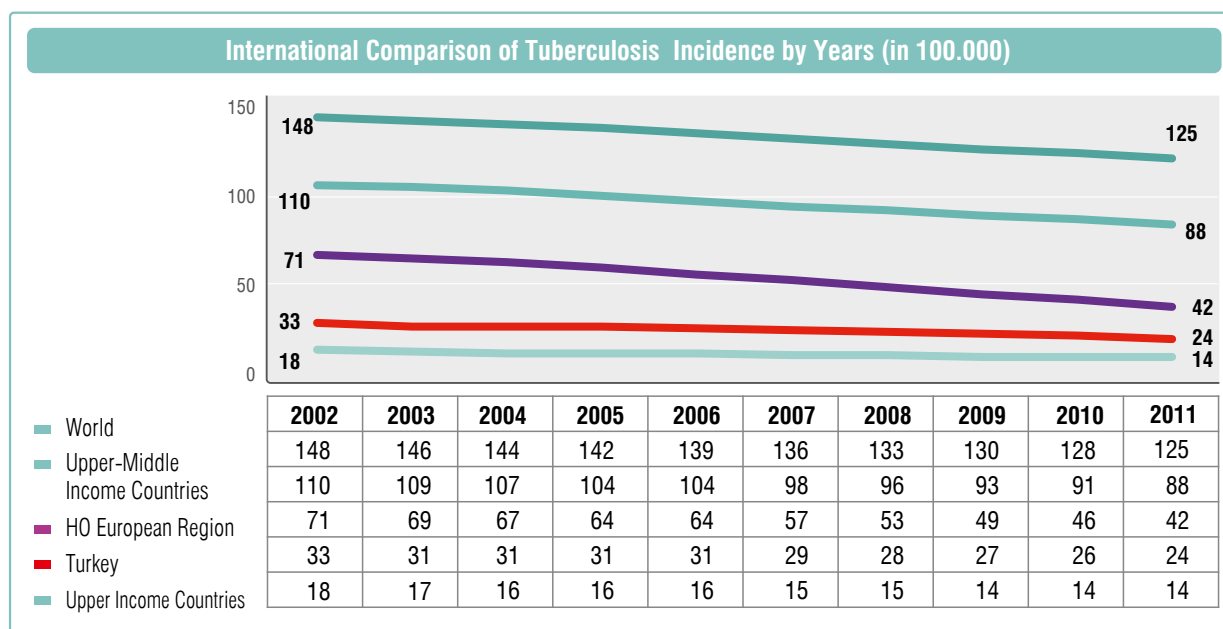
Malaria in Turkey: Successful control and strategies for achieving elimination

Acta Tropica, 120 (2011) 15 - 23.

"The Malaria Control Program has been so successful in Turkey that it gave way to pass to the elimination phase in 2010; it is also a successful experience for similar countries. In terms of its content, it is considered that this study will guide malaria control program workers, researchers and decision makers."



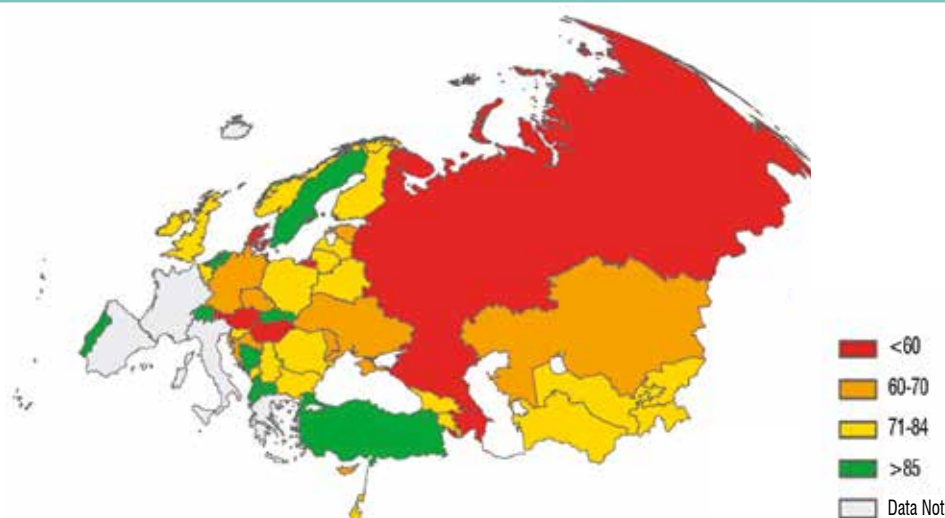
G. Tuberculosis



Graphic 119

Source: WHO Global Health Observatory Database

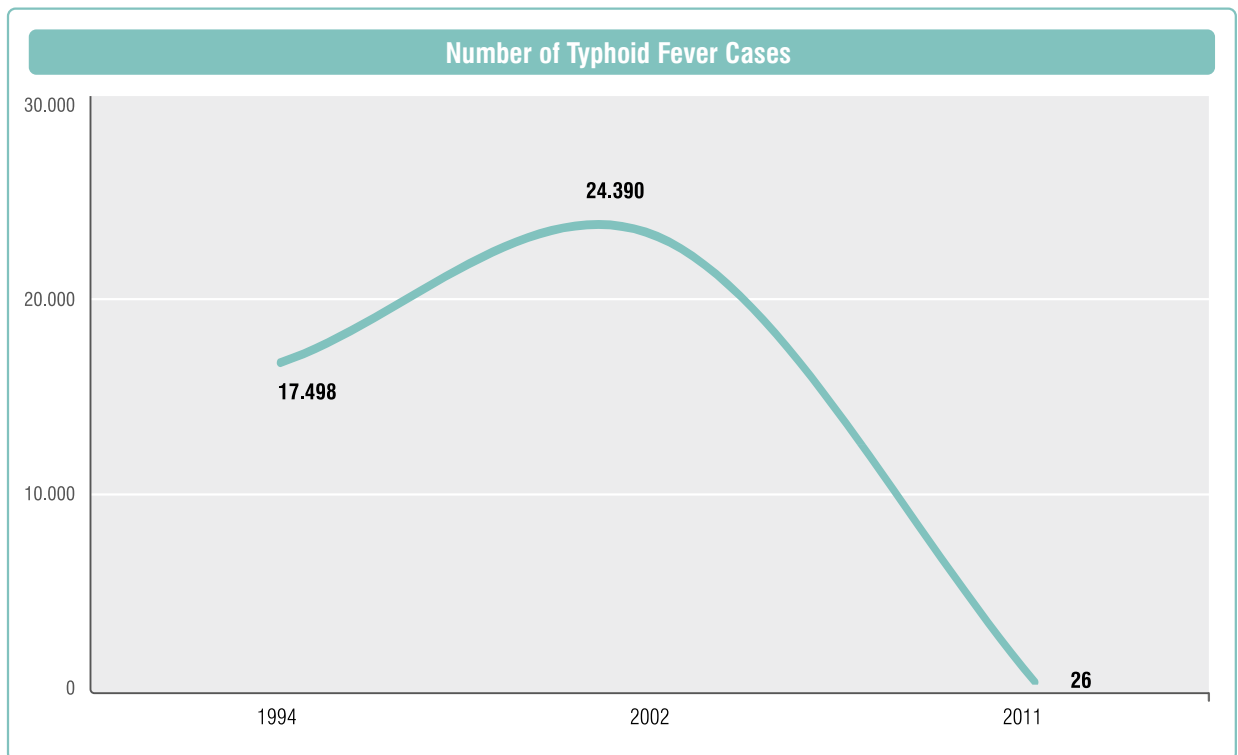
Treatment Success Rate in Recently Diagnosed Pulmonary Tuberculosis



According to the European Tuberculosis Surveillance Report 2009, only 9 out of 53 countries in the WHO European Region achieved 85 % success rate. Turkey ranked the third, having success rate of 91,6 % .



H. TYPHOID FEVER



Graphic 120

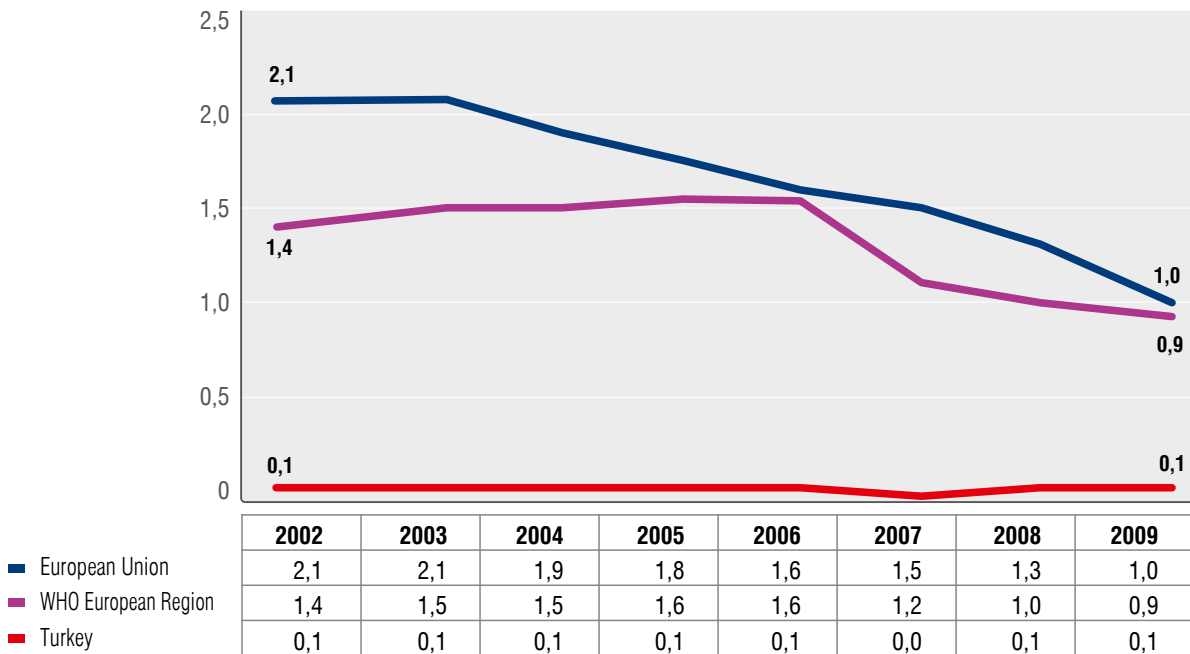
Source: Turkish Public Health Institute

In order to achieve this, we cooperated with the MoEUA and the MoFWA, and municipalities and special provincial administrations and gained significant improvements in microbiological safety of drinking waters. On the other hand, completion of infrastructure for drinking waters and roads in villages via KÖYDES project is another factor contributing to this success.



I. AIDS

International Comparison of AIDS Incidence by Years (in 100.000)



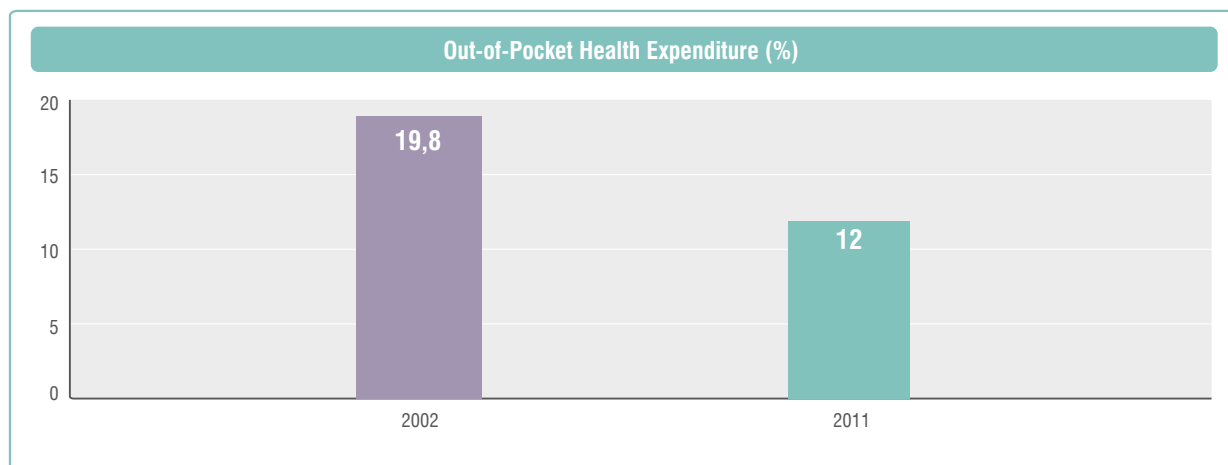
Graphic 121

Source: WHO HFA Database, Turkish Public Health Institute

“In Turkey, HIV/AIDS is at low endemicity. Although the HIV(AIDS prevalence is low in our country, we monitor scientific and up-to-date developments, make efforts for prevention and follow up the cases.”

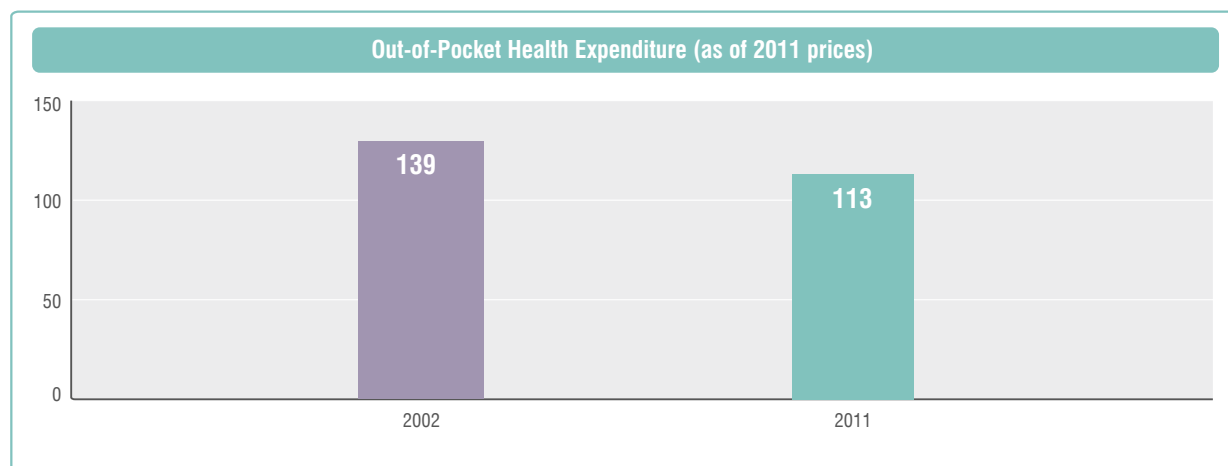


2. Protecting People from Financial Risks



Graphic 122

Source: TURKSTAT, General Directorate of Health Researches, 2011



Graphic 123

Source: TURKSTAT, General Directorate of Health Researches, 2011

We provide emergency and intensive care treatment free-of-charge in public and private hospitals. Additionally we abolished extra charges applies for burn injuries, cancer treatment, newborns, organ transplantations, congenital anomalies, dialyses and CVS procedures in private hospitals. Thus we took access to health care services under protection.

For the low-income groups within the population, we expanded the coverage of the Green Card for treatment and pharmaceutical costs. We removed the obligation to visit private practices for people and prevented impoverishment due to catastrophic health expenditures.



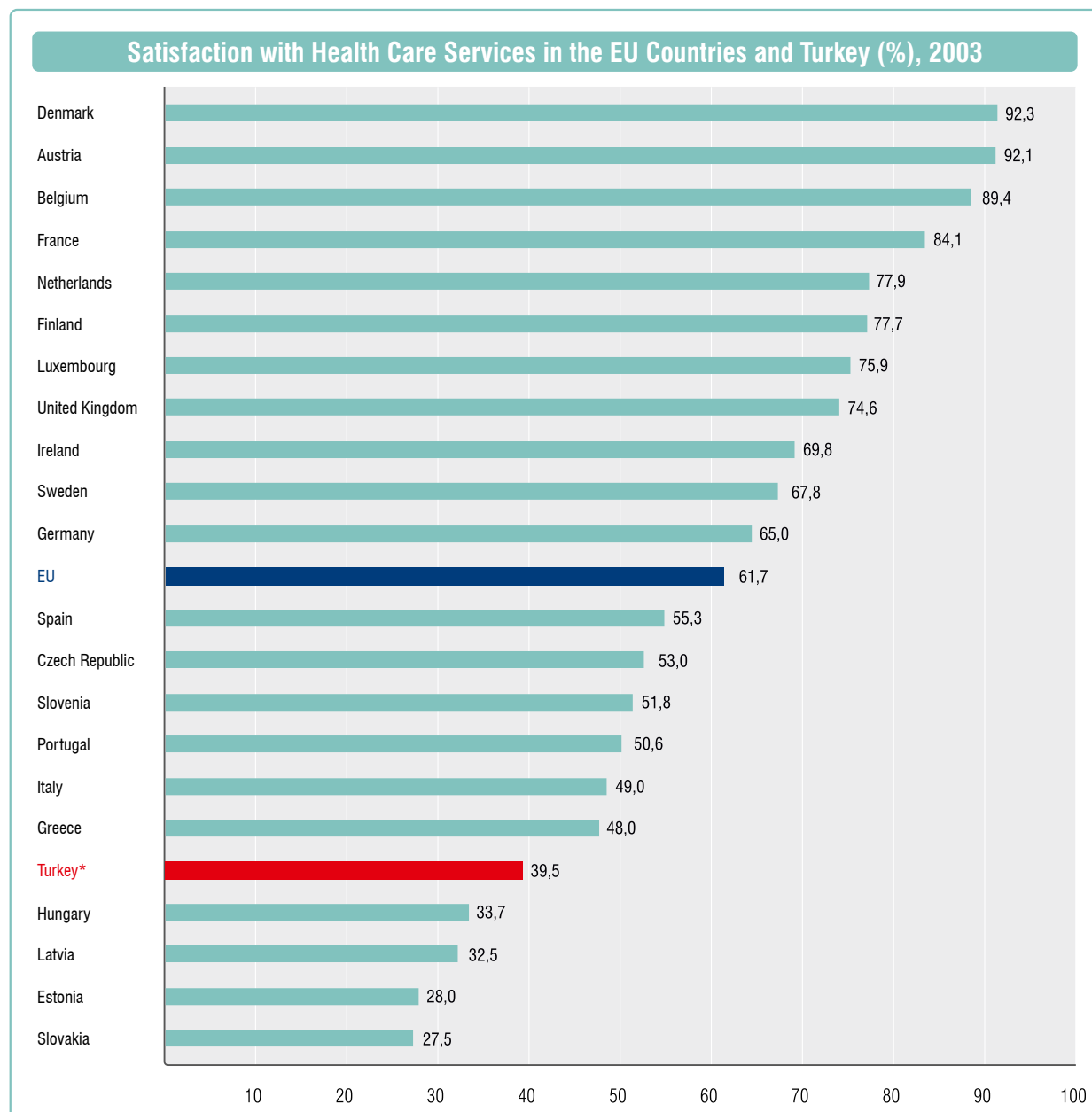
OECD Health Systems Review Report 2008
TURKEY (Page 65):

“Nevertheless, based on the overall information available from the latest national health accounts and Household Budget Surveys, it appears that the Turkish health system performs quite well in terms of equity and financial protection, both in absolute terms and relative to other countries.”



3. Satisfaction with Health Care Services

According to the life satisfaction research conducted by the TURKSTAT, satisfaction rate for health care services was 39.5% in 2003. It increased by 36,4 points and reached to 75,9 % in 2011.



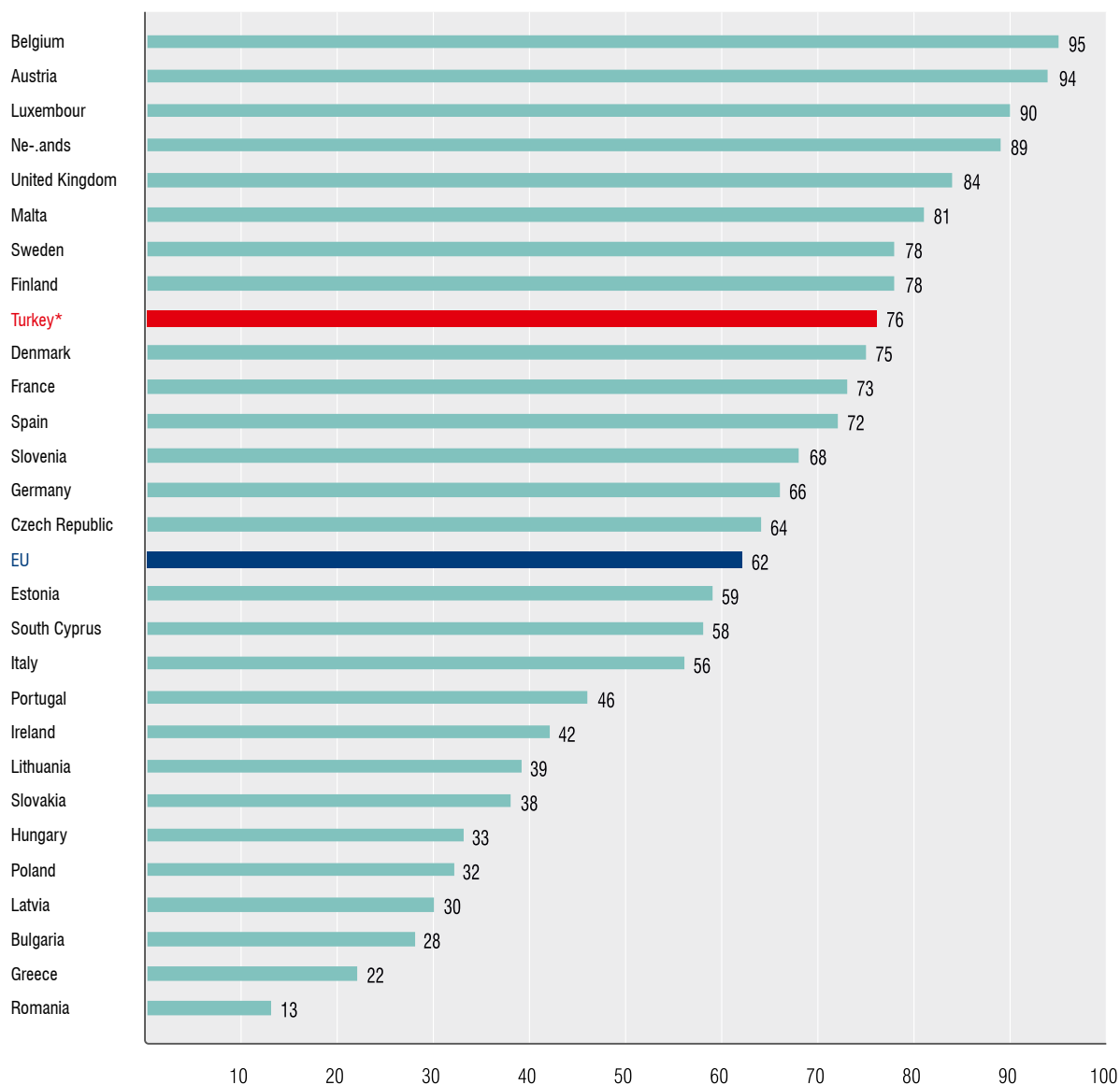
Graphic 124

Source: Global Health Observatory Database, Bulletin of the World Health Organization 2009, 87: 271-278.

*Turkey "TURKSTAT Life Satisfaction Survey "2003"



Satisfaction with Health Care Services in the EU Countries and Turkey (%), 2011



Graphic125

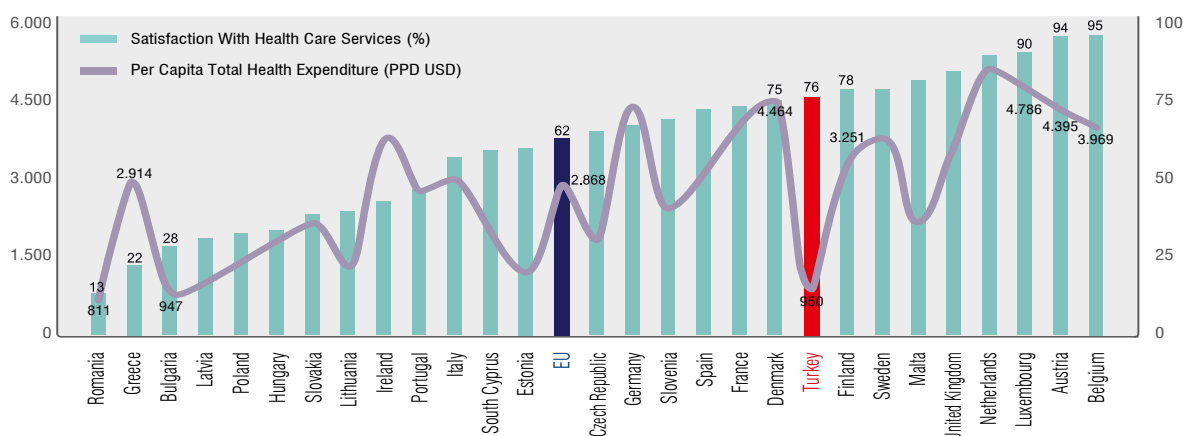
Source: European Commission Social Climate Report 2011

* Turkey "TURKSTAT Life Satisfaction Survey 2011"

While the satisfaction with health care services was 62 in Europe in 2003, it was 39,5 % in our country. Yet, we increased the satisfaction with health care services to 75,9 % in 2011, which was reported 62 % in Europe.



Satisfaction with Health Care Services % and Per Capita Total Health Expenditure (PPP USD), 2010

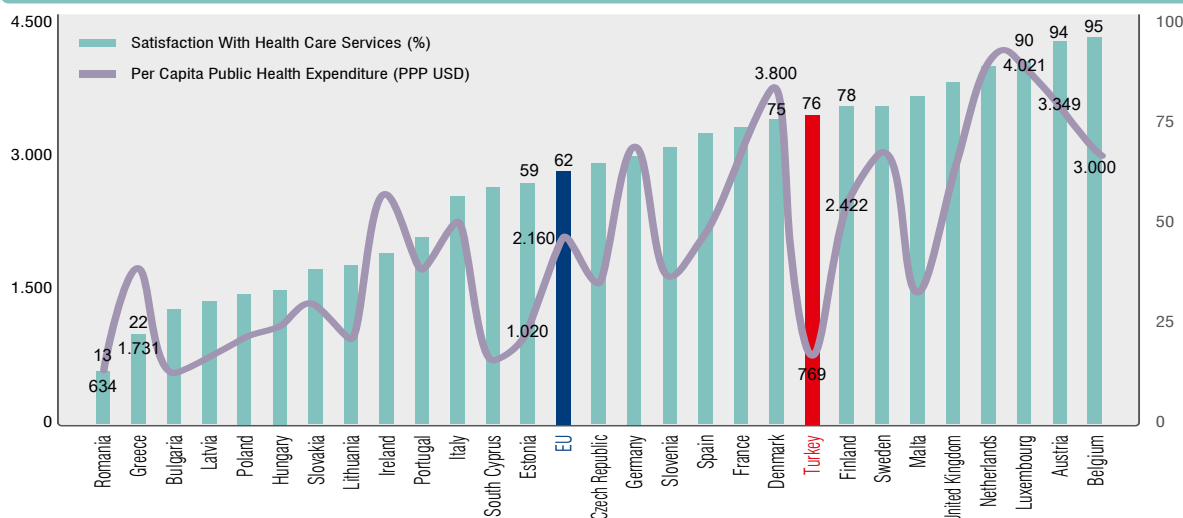


Graphic 126

Source: OECD Health Data, European Commission Social Climate Report 2011, TURKSTAT Life Satisfaction Survey 2011

In Romania, where per capita public health expenditure is similar to that of Turkey, satisfaction with health care services is 1/6 of the satisfaction in Turkey. On the other hand, Denmark, which has the same satisfaction ratio as Turkey, has 5 times higher public health expenditure than Turkey.

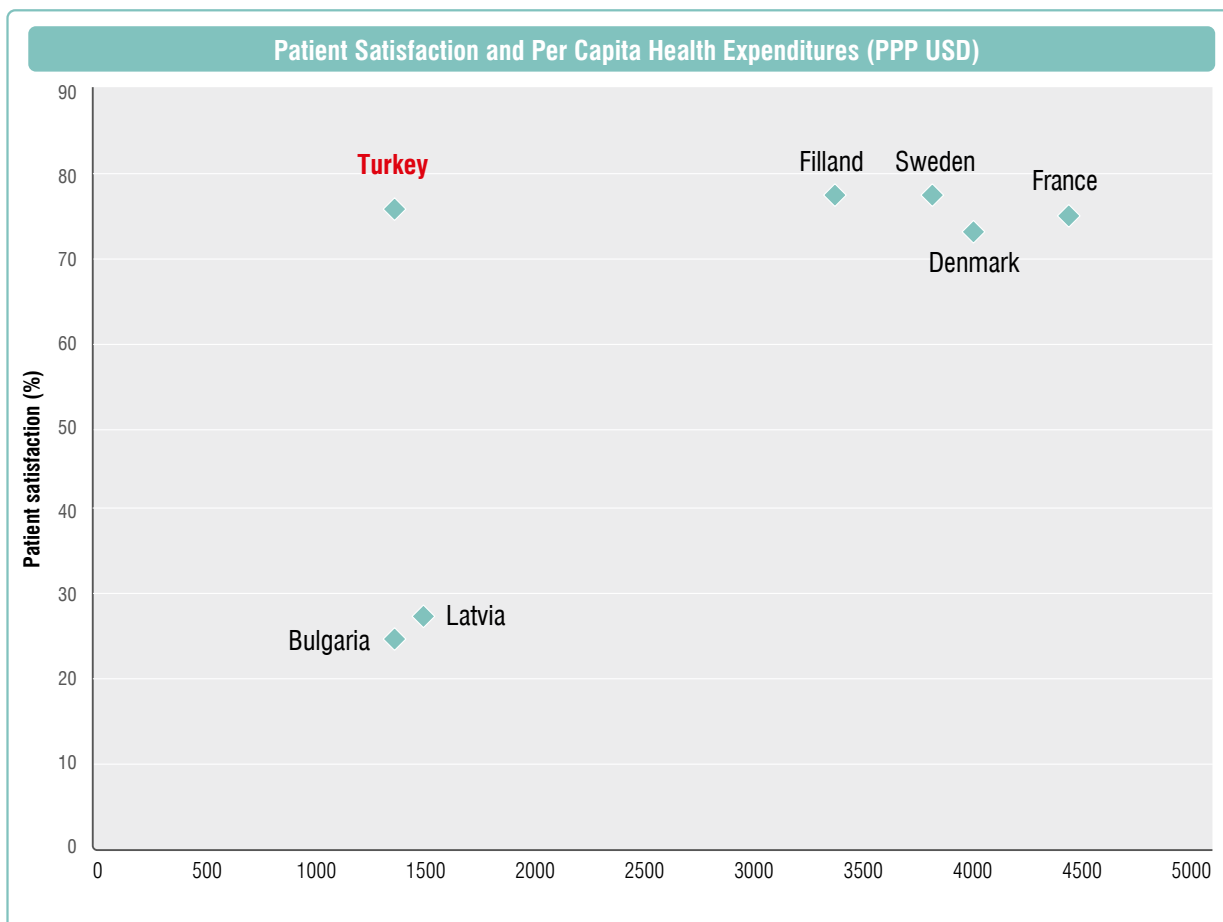
Satisfaction with Health Care Services % and Per Capita Public Health Expenditure (PPP USD), 2010



Graphic 127

Source: OECD Health Data, European Commission Social Climate Report 2011, TURKSTAT Life Satisfaction Survey 2011

In Romania where per capita public health expenditure is similar to that of Turkey, satisfaction with health care services is 1/6 of the satisfaction in Turkey. On the other hand, Denmark, which has the same satisfaction ratio as Turkey, has 5,7 times higher public health expenditure than Turkey.



Graphic 128

Source: OECD Health Data, European Commission Social Climate Report 2011, TURKSTAT Life Satisfaction Survey 2011

Turkey obtained 5 times more effective results than similar countries in terms of patient satisfaction.

Turkey obtained 3 times more effective results than similar countries in terms of the association between per capita health expenditures and satisfaction.



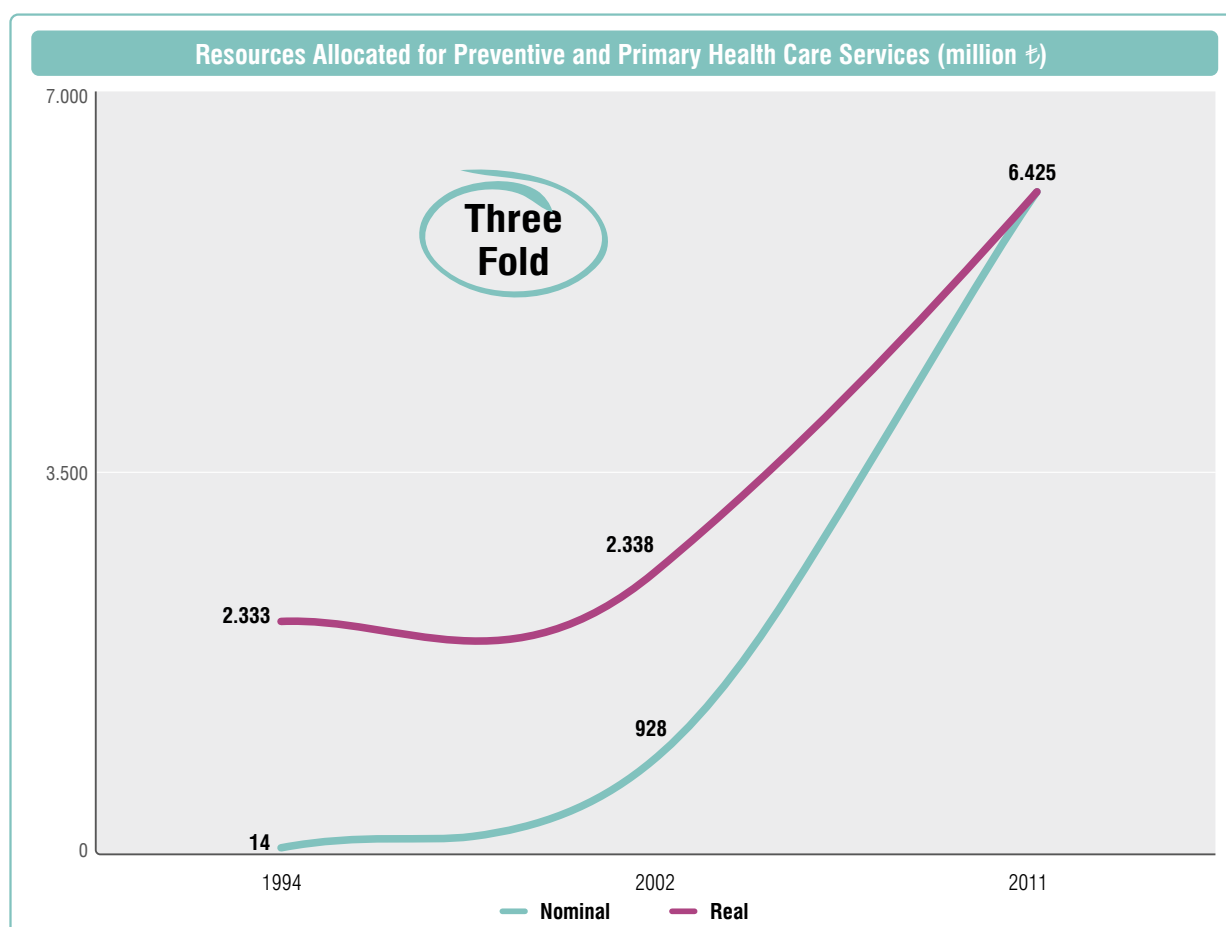
“Health system reform is a perpetual process. At this early stage in its implementation, Turkey appears to be one of the few middle-income countries to be implementing a “big bang” reform effectively.

The HTP represents both an important improvement in Turkey’s social welfare system and a “good practice” example for other countries struggling with the same issues.”



Financial Sustainability of the Health Care System

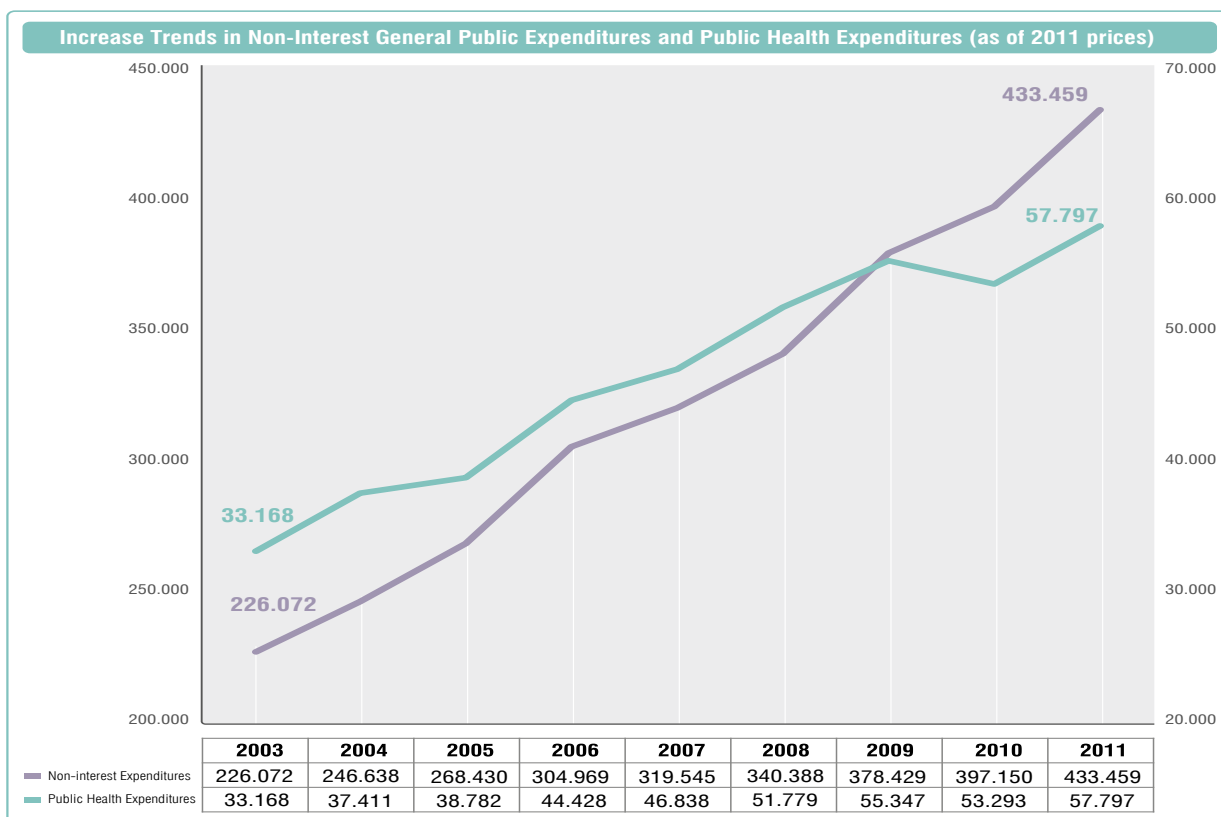
We removed the undersupply of health care services to a large extent. We absolutely removed the deficit of medical technology and we can provide medical technology at low costs. We increased personnel motivation. We increased efficiency through service contracts. We empowered preventive health care services. We encourage healthy living styles.



Graphic 129

Source: Turkish Public Health Institute

The medicine prices are under control. Global budget is implemented. We use the Public-Private Partnership Model in recent investments. The country's economic growth is continuing.



Graphic 130

Source: Ministry of Finance, Ministry of Development, TURKSTAT

We increased efficiency and ensured financial sustainability with the Health Transformation Program. The increase in general public expenditures except for the interest rate was 92% and the increase in public health expenditures was 74 % between the years 2003-2011.



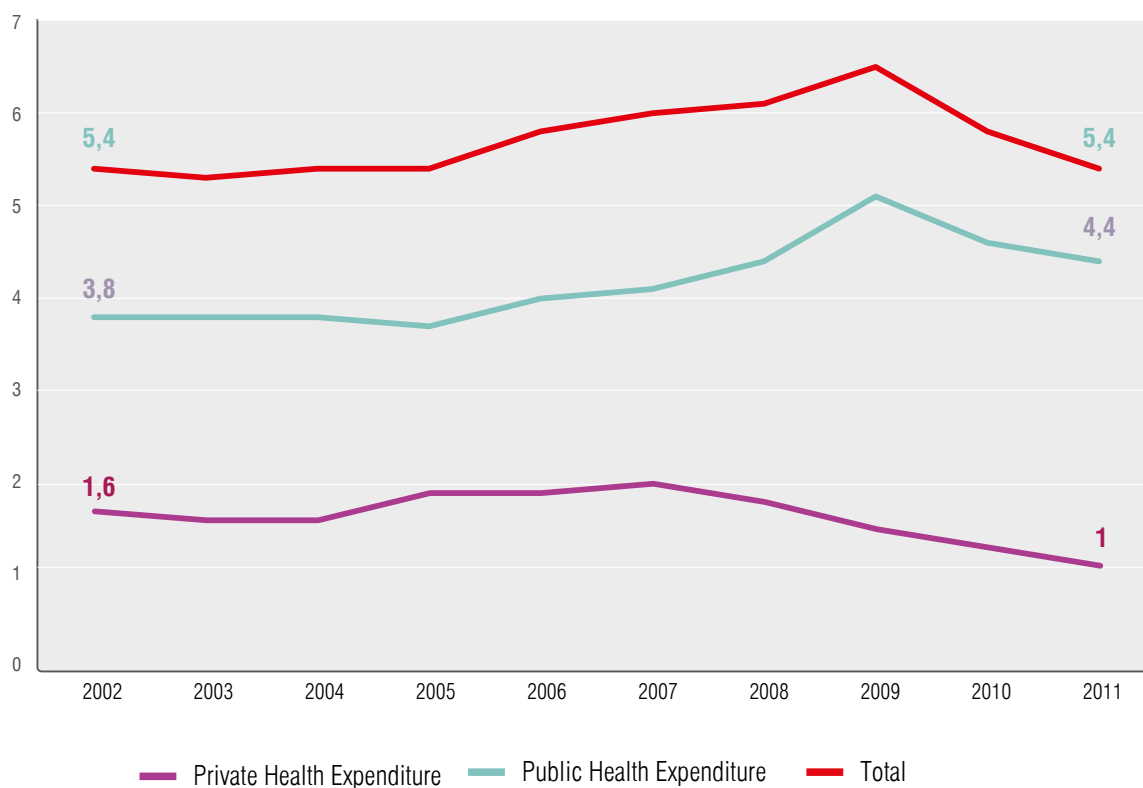
Health System Performance Assessment (Page 18), 2011 Turkey Year of Publishing : 2011

Published by : WHO, World Bank

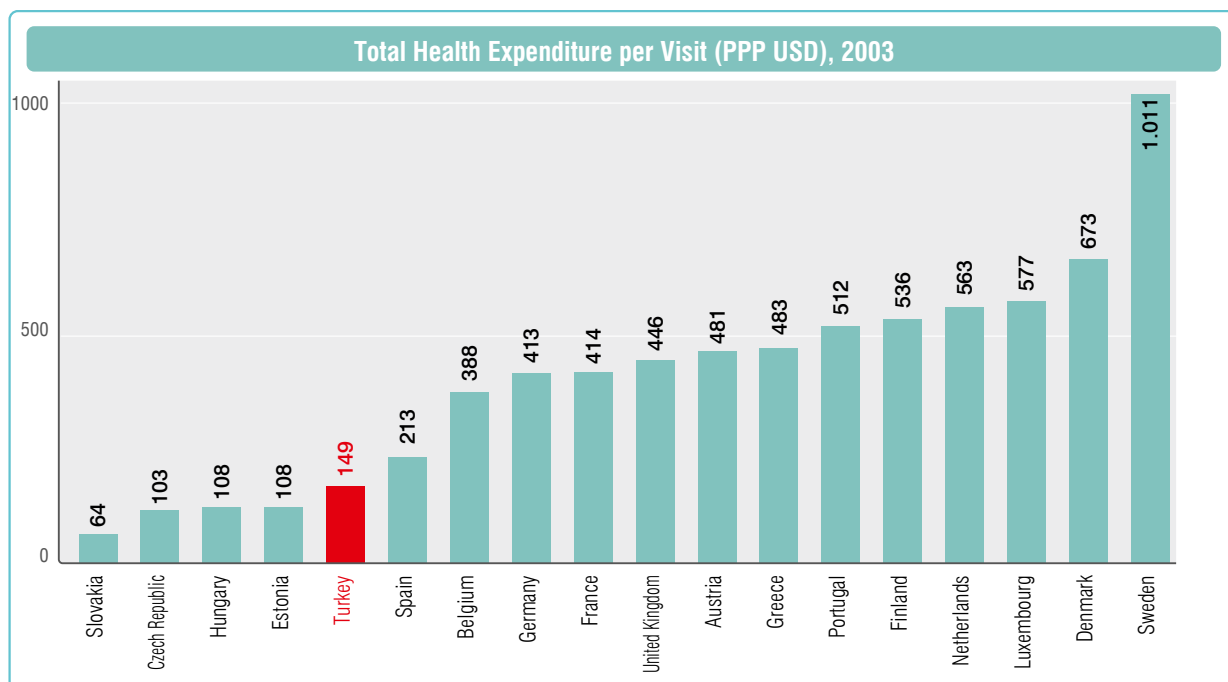
“Public spending on health as a percentage of general government expenditure has been increasing steadily – from 8% in 2000 to almost 13% in 2008. This is comparable to the spending levels of other OECD countries and of countries in the European Union (EU). This trend indicates the increasing prioritization of health in government policies.”



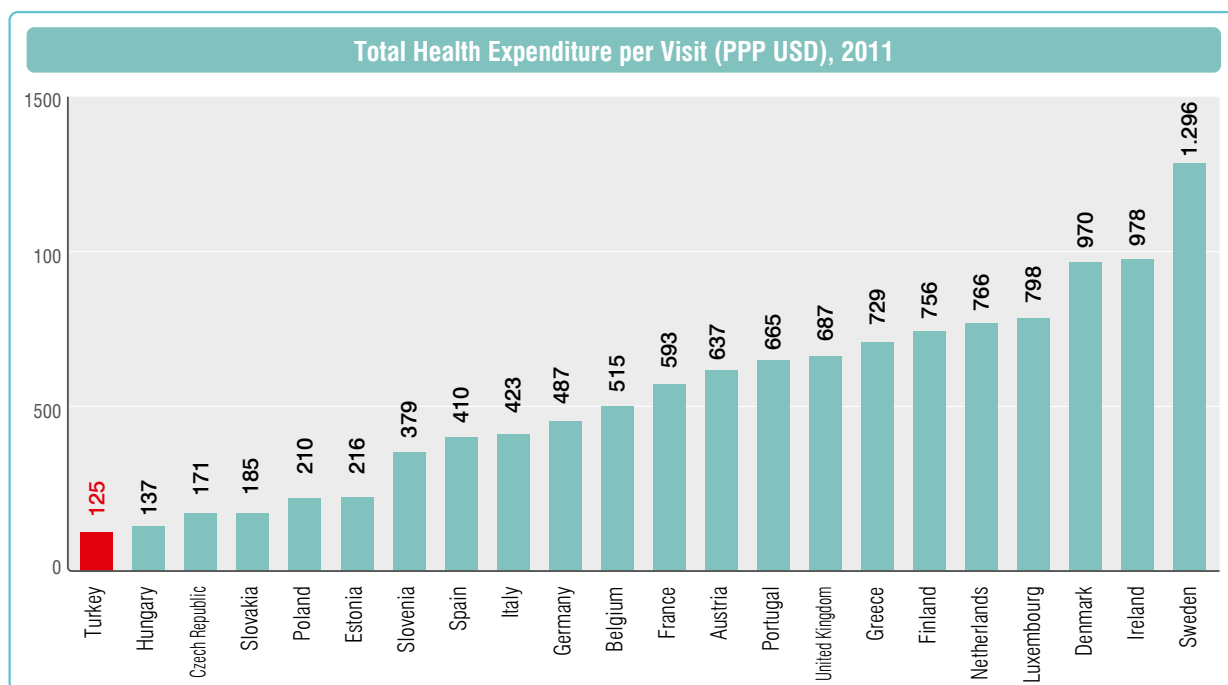
Share of Health Expenditures in the GDP (%)



Graphic131
Source: TURKSTAT



Graphic 132
Source: OECD Health Data



Graphic 133
Source: OECD Health Data

TURKEY HEALTH TRANSFORMATION PROGRAM



INTERNATIONAL REFLECTIONS OF THE HEALTH TRANSFORMATION PROGRAM



1. Reports



A. OECD Reviews of Health Systems, Turkey

Year of Publishing: 2008

Published By: OECD, World Bank

Authors: Jeremy Hurst, Peter Scherer, Sarbani Chakraborty, George Schieber

This analysis applied for the Turkish Health System was conducted jointly by OECD/World Bank. At the end of the 5th year of the Health Transformation Program, it was carried out on demand of the MoH of Turkey in order to review the reform process by international institutions.

Analysis of Turkish Health System starts mentioning about the main features of the system before the implementation of the Health Transformation Program

(HTP) in 2003. Then it tells about the main reforms implemented under the scope of HTP. This is followed the assessment of basic health policy in terms of its targets such as the performance of the system, access and equality, improvement of health, responsiveness to users, money's worth and financial sustainability.

The analysis evaluates the recent reforms implemented along with the transition to Universal Health Insurance (UHI) and possible effects of such transition. The report finally refers to the points where additional policies might be needed in order to strengthen the system. The determinations included in the report on the assessment of Health Transition Program in 2008 with regard to how HTP will be concluded between 2009 and 2013 are as follows:

Up-to Date Assessments of the HTP

The assessments of the HTP which follow, are made against the background of the three main goals of health policy:

- maximising health outcomes and responsiveness to consumers,
- minimising costs, subject to attainment of these outcomes,
- pursuing equity both in terms of financial protection against unpredictable catastrophic medical care costs, and in terms of access to health services.



In many ways, the content of the HTP appears to represent a “textbook” set of reforms for a health system of the type found in Turkey prior to 2003, building on the strengths of the system, yet targeting the weaknesses. That system (like those in many other middleincome and some OECD countries) displayed excessive fragmentation and incomplete health insurance coverage; focused on costly curative hospital-based care; had limited availability of new technologies; encouraged dual physician practice arrangements resulting in significant informal payments and out-of-pocket costs; had limited incentives for efficiency; contained serious inequities in access to care for the poor, near poor, and those in rural areas; and often provided poor-quality care. The HTP/UHI reforms represent a comprehensive blueprint to tackle the main weaknesses of the system.

They also seem to have been designed to build on the strengths of the system, such as the institution of a Green Card scheme for the poor in the previous decade, public services of a reasonable underlying quality in many parts of Turkey, a vibrant private sector, upward momentum in levels of health status in the population and a government and a Ministry of Health committed to providing access to quality services to the entire population, but especially to the poor and other underserved groups.

The steps taken to implement the HTP appear to have made significant improvements to the performance of the system. On the health insurance side, Green Card coverage was extended to include outpatient services and outpatient prescription drugs in 2005, and SSK enrollees were given access to all hospitals and to private pharmacies in 2004. These changes were associated with a 7.5% increase in Green Card enrollees and a nearly 33% increase in SSK enrollees between 2003 and 2007. They were also associated with sharp increases in both access to hospitals and per capita spending on pharmaceuticals for these groups. The latter was offset to some extent by reductions in pharmaceutical prices. As discussed in the previous chapter, the level of health spending overall, but particularly the public share, increased significantly over much of this period, while out-of-pocket payments for consumers fell. Fortunately, the Government of Turkey was able to accommodate these increases due to Turkey’s strong economic growth over this period.

Indeed, both the SSI and the MoH have taken the view that by 2008, most Turkish citizens with significant needs for health care are enjoying reasonable access to services. That is because there are no eligibility barriers to primary care and to emergency hospital care. Moreover, partly because there has been adverse selection in enrolment into Bağ-Kur and the Green Card schemes, in addition to some casual or fraudulent use of insurance cards by non-eligibles, most of the population with significant needs has been accessing government-financed health services, even though “formal” enrolment information suggests uncovered groups to be between 10 to 15% of the population.



Meanwhile, the introduction of the performance management system in MoH facilities – which from February 2005 included the former SSK hospitals – together with improvements in consulting facilities, appear to have been associated with a rise in full-time working of specialists in the public sector and a significant rise in hospital activity. The most recent Ministry of Health information suggests that the number of full-time physicians in MoH facilities has increased from 11% in 2003 to 73% in 2008. Considerable outsourcing of support services has been developed in MoH hospitals, and many staff, especially nurses, are now on short-term contracts rather than on civil service appointments.

The new family practice system has been implemented in 23 provinces as of August 2008 and will cover 59 provinces by late 2009. Some 20% of the population had been assigned to family practitioners as their source for basic primary care, a level of coverage that MOH plans to increase to 50% by the first quarter of 2009. Several evaluations of pilot projects are underway, with some preliminary results available on certain outcomes. For example, patient satisfaction has increased in provinces that have implemented the family practice system. Visits to primary health-care facilities have increased by 27% in provinces with the new system compared with 23% in provinces without it. Hospitals accounted for 58% of all visits before implementation of the family practice system compared with 41% after. Despite suspension of the referral system penalties, provinces which are implementing family medicine had 51% of their visits in primary care and 49% in secondary care in 2008, and the Ministry of Health expects the primary care percentage to increase to 60% when the new copayment rules are put into effect. Based on these preliminary evaluations, it appears that the system has shifted utilisation toward primary care and away from secondary care and increased patient satisfaction (Department of Family Medicine; Akdağ, 2008). The effects of the new system on outcomes await the results of the full scale evaluations now in progress. These changes were backed up on the supply side with improvements in the distribution of doctors across geographical areas in Turkey.

On the supply side, the changes outlined above appear to have represented improvements in capacity and productivity – although it is arguable that too much of the expansion of ambulatory services was in the “wrong” place – i.e. in hospital outpatient departments. In particular, consultations per physician rose steeply following the introduction of the performance management system and the shift towards full-time working. Thus, improvements in coverage were matched both by rising activity and by the equity-enhancing redistribution of capacity in primary and secondary care. Given that there was almost certainly unmet need in Turkey prior to the reforms, their effect is likely to have been improved access and equity, at least for the groups which had formerly faced barriers to access. Had the improvements in capacity and productivity not taken place, the rising demand for care might have been left unsatisfied because of constraints on human resources and on facilities.



In its early years, the HTP appears to have remained affordable; the increase in health expenditure has been in line with GDP growth. The costs of improvements in Access and staff remuneration appear to have been offset, at least partially, by improvements in productivity and reductions in pharmaceutical prices. Public spending on health care rose on average by about 7% per annum between 2003 and 2006 having risen at 10% per annum between 1999 and 2004. The share of total health spending in GDP remained virtually constant between 2003 and 2006 due to strong economic growth whereas it had risen by nearly a percentage point between 1999 and 2003.

Completing HTP, 2009-2013

The Health Transformation Programme is far from complete in 2008 due to: controversy over the reforms in Parliament and the courts, leading to legislative delays; difficult policy choices, such as on extra billing by private providers and setting budget caps; and the inevitable lags involved in setting up incentive-payment schemes such as DRGs, increasing the capacity of SSI to pay the large numbers of new claims, and training new staff and retraining existing staff.

On the funding side, the parts of the Social Security Bill which dealt with UHI passed Parliament only in April 2008. The Green Card scheme has not yet been fully integrated into the SSI – although plans are in place to integrate it by 2009. Many Turkish citizens, above the level of income defined for Green Card eligibility, work in the informal sector and many do not appear to be registered for or contributing to health insurance. New procedures for means-testing by SSI for both Green Card eligibles and those formerly uninsured are not yet in place. Decisions about co-payment rates await secondary legislation following passage of the UHI bill, although it is envisaged that there will be higher co-payment rates for inappropriate self-referral behaviour including hospital outpatient consultations which are initiated without a referral from a family practitioner. Critical issues concerning the referral system are otherwise still in abeyance – awaiting completion of the Family Practitioner system (i.e., according to the MoH this means 30 000 new family practice physicians trained and in practice). Similarly, decisions about extra billing ceilings in private hospitals await implementation of new draft rules limiting extra-billing to 30%. In addition, while the UHI Law states that SSI will implement the Global Budgets with state health-care institutions (MoH and university), it is unclear how SSI will deal with private health-care facilities. This is critical since spending on private health-care facilities is the fastest-growing component of SSI expenditures, and is likely to generate a deficit for SSI in 2008.



On the delivery side, as discussed above, the family practitioner services have been rolled out in only 23 of Turkey's 81 provinces. Public hospitals have not yet achieved significant autonomy and the purchaser-provider split is not yet fully operational for MoH hospitals. Also, capacity constraints have increased among doctors and nurses, exacerbated by the increased demand from enhanced coverage and a buoyant private, health-care sector in some parts of Turkey. The government has announced that it is planning to increase medical school intake from about 4500 students per annum to about 6000 per annum. It has also published new planning regulations, early in 2008, setting standards for new private hospitals and outpatient diagnosis and treatment centres in order to rationalise joint public and private sector capacity.

The new payment system envisaged in the HTP - to have money follow patients according to DRGs - is not yet operational. The Ministry of Health is still deciding the budgets and monthly payments for MoH hospitals, including the revolving-fund revenues which flow from SSI to MoH hospitals. SSI funds are disbursed to MoH hospitals monthly, based on MoH decisions, rather than in accordance with bills submitted for services rendered. In addition, the Ministry is still paying part of the salaries of hospital staff in public hospitals and the funds required for primary care and public health services, including the new family practitioner projects. The introduction of DRGs for hospital care is still at a design stage, albeit ready to be tested - with exploratory projects in 47 hospitals. Hospital performance standards have increased hospital activity; yet, the incentives in the Performance-based Supplementary Payment System need to be implemented in line with those in the proposed DRG system, and complement those implicit in the budget caps for public hospitals in order to improve, simultaneously, physician and institutional productivity, enhance allocative and technical efficiency, and assure macro efficiency by controlling overall costs by discouraging the provision of unnecessary services.

Finally, the changes in governance envisaged by the HTP are far from complete. The SSI has not yet acquired the capacity to process all claims adequately or to design and implement innovative incentive-based payment systems. The Ministry of Health is still deeply involved in budgeting for and providing primary and secondary services rather than assuming a steering/stewardship role.

Thus, there are still a large number of key policy decisions awaiting final specification and some of these will take many years (e.g. increasing the supply of physicians). These ultimately will determine the effectiveness, affordability and sustainability of UHI in improving health outcomes, financial protection, and consumer responsiveness for the Turkish population. The key implementation decision areas for completion of the HTP are discussed in what follows."

Exerts from the report:

"While many factors are responsible for these improvements in health status in Turkey, it seems to be plausible to argue that a significant part has been due to higher and more effective spending on health care in recent decades." Page 13.



“The Health Transformation Programme in many ways reflects “good practice” in the development and implementation of a major health sector reform including the introduction of UHI. Strong government commitment and leadership along with major financing reforms have been complemented by carefully planned service delivery reforms. While it is too early to evaluate the impacts of the HTP on all aspects of health status, financial protection, and consumer satisfaction, the preliminary indications from the available data suggest important progress in all three areas. Turkey is closing the performance gap with other OECD countries and, on a number of measures including overall costs, performs well relative to other comparable upper middle-income countries. Indeed, there may be much that other countries can learn from the recent health reforms in Turkey, especially in the use of performance-related pay to raise staff productivity.” Page 14

Nevertheless, based on the overall information available from the latest “National Health Accounts and Household Budget Surveys”, it appears that the Turkish health system performs quite well in terms of equity and financial protection, both in absolute terms and relative to other countries. The OOP share is relatively low and the incidence of OOP is progressive, falling disproportionately on the rich. The level of impoverishment due to catastrophic medical expenses is also low. Page 65

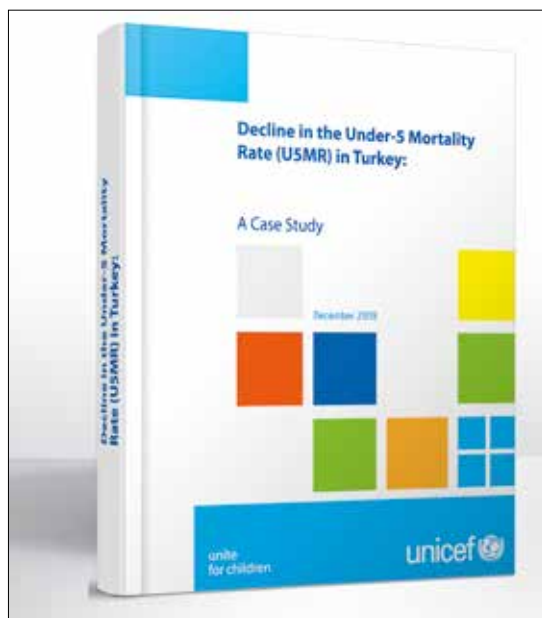
“Since the introduction of performance-related pay, there seem to have been large increases both in the volume of activity and in physician productivity in Turkey, judging by reported consultations per physician (headcount). By 2006, reported consultations per physician had reached levels which exceeded the average level in the OECD by over 25%. There may be lessons for other OECD countries to learn from Turkey’s apparent success with using performance-related pay to raise doctor’s productivity – although the effect on health outcomes is not yet clear and more rigorous evaluations are still in progress..” Page 84

“Health system reform is a perpetual process. At this early stage in its implementation, Turkey appears to be one of the few middle-income countries to be implementing a “big bang” reform effectively. The HTP represents both an important improvement in Turkey’s social welfare system and a “good practice” example for other countries struggling with the same issues. Yet the ultimate success of the program, including its sustainability, will very much depend on the difficult policy and implementation decisions that the Turkish authorities are still in the process of addressing. International experience suggests that the right choice of policies and their effective implementation will be required to ensure the financial sustainability of the health system in the long-term and continuing improvement in the health status and well-being of the Turkish people.” Page 124



Summary of key suggestions:

- Maintain a hard cap on total public spending on health care by the SSI
- Implement co-payments for visits to hospital outpatient departments without a Referral Pursue
- Further reductions in pharmaceutical prices and implement rational drug prescribing
- Control entry to the medical profession in the medium to long term after the expansion in physician supply, needed currently
- Continue with implementation of the HTP in the next five years
 - Continue to roll out family practitioner services
 - Continue to develop and co-ordinate community public health services alongside the family medicine service
 - Complete transfer of purchasing of hospital and primary health-care services to the SSI when management capacity is appropriate
 - Complete the DRG and bundled outpatient payment systems and develop new systems to transfer risk to providers based on managed care principles
 - Reform the performance management system to support DRG payment and to put more emphasis on efficiency and cost effectiveness
 - Continue with granting more autonomy to hospitals with appropriate management capacity
 - Invest in stronger IT systems and data for decision making
 - Develop capacity to undertake health technology assessment and to evaluate and monitor health reforms
 - Enhance the number and role of nurses in Turkey
- Take action on the supply side to support the new health system in improving geographical equity in access (possibly informed by weighted capitation targets for regions)
- Increase registration with, and payment of, contributions to UHI and carefully monitor solvency
- Address wider public health issues across Ministries
- Continue to develop the stewardship capacity of the Ministry of Health



B. Decline in the Under-5 Mortality Rate (U5MR) in Turkey : A Case Study

Year of Publishing : 2010

Published by : UNICEF

Authors : Dr Lilia Jelamschi, Prof. Dr. Timothy DeVer Dye,

The purpose of this report is to present a description and analysis of U5MR mortality decline in Turkey, with a particular focus on policy, programmatic, and epidemiological changes observed since 1990 that may help explain Turkey's rapid progress toward reducing U5MR, and indeed underscoring Turkey's experience in achieving the Millennium Development Goal 4. Further, this report provides interpretation of trends in Turkey

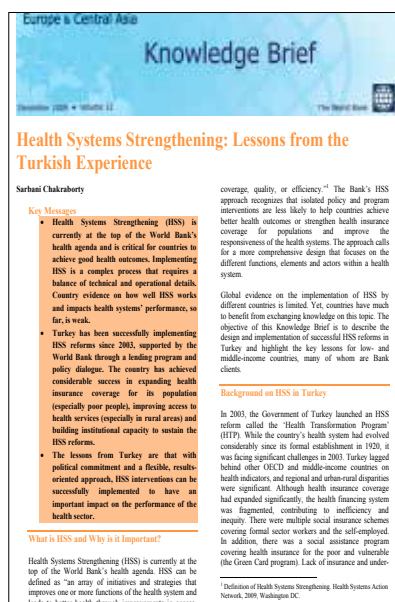
and summarizes the Turkish experience in improving maternal and child health status.

Several notable points from this assessment include:

- Turkey has observed a rapid decline in the Under-5 Mortality Rate (U5MR) since 1990, largely due to the rapid decline in both components (neonatal and postneonatal) of the infant mortality rate. Since both components of the infant mortality rate declined significantly, these declines were likely systemically-induced, the result of broad comprehensive improvements in the public health and health services systems in Turkey.
- This decline occurred in the context of a similarly rapid population shift from rural to urban areas, a corresponding large increase in GDP/capita, decreased family size, and increased education achievement for women.
- Sustained focus on health strategy and planning, and implementation of widespread, effective public health campaigns namely focused around family planning, vaccination, child survival, and neonatal resuscitation have contributed significantly to the decline in the IMR and subsequently in the U5MR.
- The resulting strengthening of components of maternal and child health systems in Turkey – namely, a rapid increase in antenatal care attendance, large increases in the proportion of women delivering in health institutions and in the proportion of women whose deliveries were attended by health providers, and the rapid development of neonatal intensive care, all directly contributed to increased survival of newborns and children.



- Despite these achievements, some populations remain at elevated risk for infant and under-5 mortality, namely: residents of the Eastern region, in rural areas, with no/ incomplete primary education, in the lowest quintile of wealth, and for infants born to women who already have several other children (higher birth order). There has been an impressive expansion of public health programs and strengthened health systems in Turkey; though a gap remains in health disparities between high- and low-risk groups, this gap is narrowing.
- While exhibiting a precipitous decline, the infant mortality rate in Turkey could decrease further with attention to the major causes of infant death, which are largely preventable with scale-up of and access to existing technology and intervention: low birthweight/ prematurity, congenital anomalies, and sepsis, among others.
- As a result of Turkey's investments in public health programs and health systems, in the context of a generally stronger socioeconomic status of its population, the U5MR decline since 1990 is one of the highest in the world, likely a decline of more than 70 percent from 1990 to 2007. The Turkey Demographic and Health Survey (TDHS) is an invaluable resource in assessing risk, progress, and opportunities; a population-based perinatal data system would enhance the utility of TDHS and provide more real-time monitoring, evaluation, and research opportunities for targeting further declines in U5MR.



C. Health Systems Strengthening: Lessons from the Turkish Experience, 2009

Year of Publishing : 2009

Published by : World Bank

Authors : Sarbani Chakraborty

“Health Systems Strengthening: Lessons from the Turkish Experience” is included on the 12th issue of the document named “Knowledge Brief” of the World Bank.

Health Systems Strengthening (HSS) is currently at the top of the World Bank's health agenda and is critical for countries to achieve good health outcomes. Implementing HSS is a complex process that requires a balance of technical and operational details. Country evidence on how well HSS Works and impacts health systems' performance, so far, is weak.

- Turkey has been successfully implementing HSS reforms since 2003, supported by the World Bank through a lending program and policy dialogue. The country has achieved considerable success in expanding health insurance coverage for its population (especially poor people), improving access to health services (especially in rural areas) and building institutional capacity to sustain the HSS reforms.
- The lessons from Turkey are that with political commitment and a flexible, results oriented approach, HSS interventions can be successfully implemented to have an important impact on the performance of the health sector.

Key Lessons Learned:

- By defining a comprehensive HSS reform program and getting the buy-in of key stakeholders early on, the GoT was able to set the stage for major reforms in Turkey. Nevertheless, comprehensive HSS reforms take time and the Turkey experience shows that in operationalizing such a strategy, a flexible and results-oriented approach works best.
- While pushing for fundamental legal and institutional changes in how health services are financed, delivered and regulated in Turkey, the GoT identified a few critical incremental reforms that could be implemented without major legal changes. Nevertheless, these changes were extremely effective for delivering better health services to the population, especially to poor people. This helped build support for the reforms and credibility for the Government. Balancing the need for ‘big bang’ HSS reforms with an incremental approach is the reality in most countries, and much can be learned from Turkey on how to balance the two approaches.



- Hospital autonomy or privatization of public hospitals is one of the most politically contentious reforms in many countries. Therefore, it is no surprise that countries make little progress on this important HSS reform. Yet, without public hospital reform, a major element of HSS remains unfinished - this impacts the achievement of quality, efficiency and equity goals. The Turkey experience shows that it is possible to implement incremental changes that have a major and immediate impact on service delivery (especially for the poor), while keeping a longer-term horizon on public hospital reform.



D. Making Reform Happen Lessons from OECD Countries

Year of Publishing : 2010

Published by : OECD

Authors : Jeremy Hurst (Chapter 7)

This report mentions the reform studies, which have been or is being conducted by OECD member countries on financial consolidation, taxing, environment, employment, health, training, public administration, competition in 9 chapters. The main purpose of the report is to share the experiences of the countries, transfer opinions and compare implementations. Therefore, the opinions of the experienced countries are expected to

light the way for countries which embark upon such large-scale structural reforms.

The 7th chapter of the report refers to the health reforms under the title “Effective ways to realise policy reforms in health systems”. The factors that help, facilitate or hinder health system reforms in OECD countries are described. In this respect, health reform experiences of 5 countries including Turkey are mentioned.

This chapter consists of two parts. The first part focuses on the reform requirement of the health system. Here, a general framework is introduced including the factors that determine the success and failure of reform implementations. The factors of the health system reforms that are under the control of the administration and the governments and that will be activated or deactivated during the reform studies are defined.

The reform studies from five different OECD countries are evaluated in the second chapter as examples of reform studies. This evaluation is made based on OECD Health System Assessment Reports (Finland, Korea, Mexico, Sweden and Turkey).



The chapter including health reforms in Turkey is as follows :

Turkey: Increasing Quality and Efficiency

The Turkish health system has been undergoing a profound structural transformation since 2003. Prior to 2003, the system was a combination of a number of social health insurance schemes for different segments of the employed population and their dependents: different insurance programmes providing health service under different coverages. Social assistance programme for the poor (the Green Card) has been in practice. There were both overlaps and gaps in these arrangements. Moreover, there were serious problems on the delivery side, which meant that even insured people did not always get access to appropriate services. For example, primary care was generally weak, leading to over-utilisation of crowded hospital outpatient departments. There was also considerable geographical inequity in access to health services. Although health status had been improving in Turkey prior to 2003, life expectancy remained below and infant mortality above the levels found, on average, in countries with a comparable standard of living. Only limited data on outcomes are available but comparisons of patient satisfaction with primary health-care services across countries, suggest that satisfaction in Turkey was well below the average in a group of ten European countries.

The “Health Transformation Programme” sought to address both efficiency and quality of care

A major set of reforms, the “Health Transformation Programme” (HTP) was introduced by the newly-elected Justice and Development government in 2003. The main aims were to unify the existing social insurance schemes and administration of the Green Card under a single insurer, which would provide universal health insurance. A purchaser/ provider split would be established and autonomy would be granted to public hospitals. A family practitioner service with capitation payments and gate-keeping would be set up throughout Turkey. There would be investment in staff and in information systems. It was planned that the HTP would be implemented during the decade 2003-2013. Although Turkey has a relatively centralised administration, this reform required cooperation across several different ministries with responsibilities in the health sector including the ministries of health, labour and social security, and finance, together with the State Planning Organisation. Many of these measures were under consideration well before 2003, but a major economic crisis in 2000-2001 helped to delay action. It required the election of the Justice and Development Party in 2002 with a strong electoral mandate and the renewal of that mandate in 2007, to kick start and sustain the political momentum for reform.

When an OECD/World Bank team reviewed the Turkish health care system and its reforms in 2008, the HTP was half completed. Universal Health Insurance was achieved in 2008 with the unification of the social security programmes with the Green Card scheme under the Social Security Institute. The new family practitioner services had been rolled out to about 20% of the population. Public hospitals had been unified under the Ministry of Health and a performance-management scheme had been introduced to incentivise staff.



The beginnings of a purchaser/provider split had been put in place although public hospitals had not yet gained significant autonomy. As a result of these and other related changes, there has been a large increase in activity, both in primary care and in hospitals. Satisfaction with primary care has risen sharply in provinces which have introduced family practitioners. Also, there was a general rise in satisfaction with the health system as a whole in the population. Although health expenditure has risen sharply, it has risen no faster than GDP. The OECD/World Bank Review concluded that, although it was too early to make a final assessment, the HTP seemed to represent “good practice” in the development and implementation of major health system reforms and preliminary indications were that it had been successful.

The Turkish experience exemplifies many of the political economy lessons identified in this Chapter.

Many of the conditions for successful health system reform, which were outlined in the first part of this chapter, seem to have been present in Turkey at the launch of the HTP and during the first stage of its implementation.

- Turkey had informed itself about weaknesses in the performance of the Turkish health system by international comparisons provided (for example, by OECD and WHO data).
- Reforms of the kind adopted under the HTP, had been put forward under the National Health Policy in 1990, following health-reform studies by the Ministry of Health and the State Planning Organisation, and these had been articulated further in the 7th Development Plan, 1996-2000. In particular, studies had been carried out of family practitioner services in a number of European countries.
- Strong leadership was shown by the new health minister.
- Because of the controversial nature, complexity and likely cost of the proposed reforms, a long period - ten years - was set for steering the reforms through the legislative process and for implementing the results.

The reform plans also took due account of the need to motivate public sector providers to support reform.

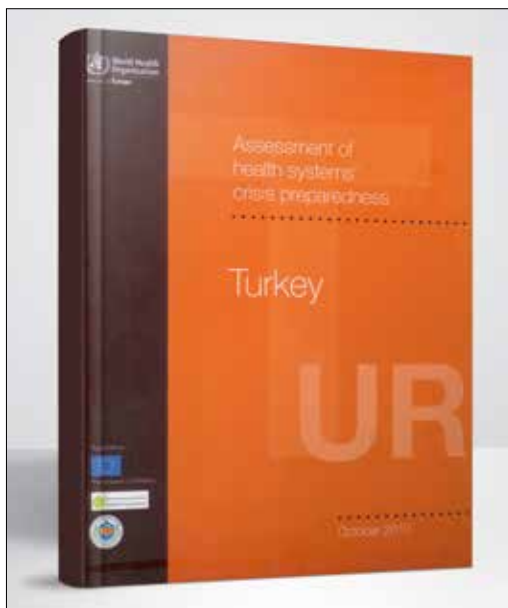
- Under the HTP, there were major reforms to the incentives facing medical specialists and other hospital staff in public hospitals with the introduction of bonus payments under the “performance-based, supplementary payment system”. This linked pay to improved performance by staff. As a result, there were sharp increases in pay rates for doctors between 2003 and 2005; an increase in full-time working by previously part-time specialists in public hospitals; increases in hospital activity rates; apparent increases in productivity per physician; and large improvements in the satisfaction reported by patients with hospital services.



- The introduction of family-practitioner services gave primary care doctors greater pay and autonomy, and was associated with a relative shift in consultations away from hospital outpatient departments towards family practitioners and a sharp increase in patient satisfaction with primary care. Meanwhile, strong economic growth in Turkey between 2002 and 2006 helped to fund the extensions to health insurance coverage, the improvements to incentives and the increases in services.

In the following parts of the report, under the title **“What do the case studies tell us?”** a synthesis has been made. Here, the following evaluations are included in brief:

- Several of the case studies - especially those for Korea, Mexico and Turkey - appear to illustrate occasions when newly elected administrations with strong leadership and strong popular mandates seized political “windows of opportunity” to make structural reforms to health systems.
- In Turkey, significant prospective increases in doctors’ pay, combined with new performance incentives, helped to ensure that many individual doctors co-operated enthusiastically with the reforms, despite vociferous opposition from the Turkish Medical Association.



E. Assessment of Health Systems' Crisis Preparedness, Turkey

Year of Publishing : 2011

Published by : WHO

Authors : WHO European Region, European Commission Directorate-General for Health and Consumers, Related Experts from the MoH of Turkey.

This report evaluates the level of preparedness of the Turkish health system to deal with crises and the current regulations for dealing with crises, regardless of cause. The report also examines the risk prevention and mitigation initiatives in the country. While the main focus is on the national level, some attention has been paid to crisis management capacity at the regional level and to the links between the various levels of government.

The evaluations included in the conclusion part of the report are as follows:

Turkey has based its disaster and emergency management system on lessons learnt, especially from the devastating earthquakes, which occurred in 1999 and has made quite a dramatic improvement in its management and coordination structure though the country is still in the transition period of institutionalizing the most recent changes. The “new system” has, fortunately, not yet been tested at the national level.

Turkey has a high level of political commitment to crisis preparedness and the proven capacity to respond to national and international disasters. The emergency response system has a strong legal framework; it is adequately staffed and well equipped. Regulations and detailed instructions at the national and regional levels define the coordination bodies, the designation of authority and the contingency requirements. Dedicated emergency and contingency funds are available at each administrative level. Resources for response and the surge capacity of the health facilities and the EMS system are available at all levels (national, provincial and local).

Hospital capacity is huge in terms of number of beds, availability of trained staff, and accessibility to equipment, contingency supplies and modern medical technology. The EMS is well resourced with staff, ambulances (many with full resuscitation capacity), contingency, dispatch centres, etc. Preparedness activities are ongoing; these include community and staff training, as well as exercises and drills carried out jointly by different institutions. Every hospital is required to have a dedicated focal point for emergency preparedness, as well as an emergency response plan.



Health promotion activities at the community level include emergency response and awareness-raising. A strategy for risk communication and public information during emergency situations exists.

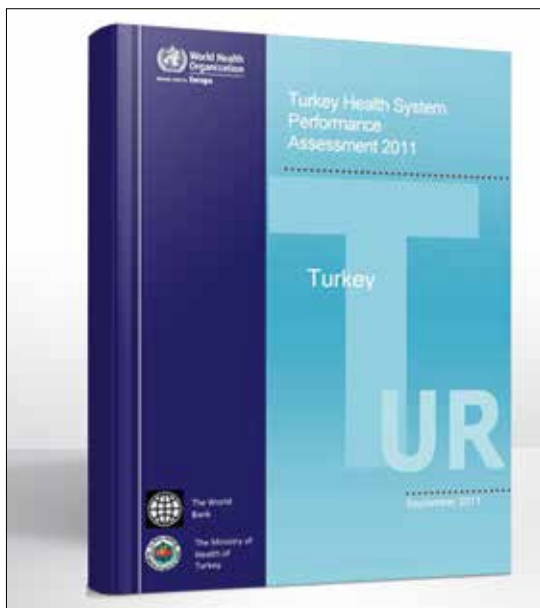
The Ministry of Health could address a few issues, such as strengthening the capacity to assess the non-structural and functional vulnerability of critical health facilities and to introduce rapid health needs' assessments as a key management issue for relevant decision-making in the first 24 hours of an event. This would be part of a full-scale emergency preparedness programme.

Within the context of the global economic slowdown, it might be expected that the Ministry of Health of Turkey could face challenges in securing the necessary funds to sustain its highly sophisticated disaster and emergency management system. However, the economic indicators for Turkey show that, although health expenditure has risen rapidly since 2003, increases in both total and public health expenditure have remained affordable, attributable seemingly to an equally rapid economic growth in the country. (24) In addition, these increases in expenditure have been parallel since 2003 (25).

Because of Turkey's unique position, with its broad experience in disaster situations and its advanced disaster and emergency management system, the country could play a leading role in training and research related to disaster risk reduction at global level.

The findings and recommendations outlined in this report could be used to identify priority areas for further joint Ministry of Health–WHO projects and activities. In this context, the Ministry of Health may wish WHO to facilitate the implementation of the IHR core capacities by introducing the Hospital safety index: guide for evaluators (24) for use in assessing the non-structural and functional safety of hospitals. As the given scenarios of a major earthquake include mass fatality situations, WHO could also assist by organizing a national workshop on the key issues related to the management of the dead and missing in disaster situations.

From their numerous international and national operations, Turkey has amassed vast experience in delivering medical aid in disaster situations. This experience should be shared and used for joint capacity-building activities in the WHO European Region. In this connection, WHO could also contribute by sharing with the Ministry of Health its experience in developing public health and emergency management courses for national and international managers.



F. Health System Performance Assessment, 2011 Turkey

Year of Publishing : 2012

Published by : WHO, World Bank

Authors : WHO European Region, World Bank, Related Experts from the MoH of Turkey

In general, the primary goal of the HSPA study is to raise the current performance of the national health care system and to use limited resources to maximum effectiveness and efficiency for good health targets.

Findings:

There is a strong rationale for the Ministry of Health of Turkey to adopt a systematic approach towards HSPA. This ministry has been implementing the Health Transformation Program (HTP) aimed at improving the governance, efficiency and quality of the Turkish health sector and continued successful implementation of this major reform programme is dependent on tracking its impact on health outcomes, outputs and structures. The Ministry of Health has identified further monitoring and evaluation (M&E) capacity building as a critical issue for phase II implementation of the HTP (2009). This has become even more important following the development of the Ministry of Health Strategic Plan for 2010–2014 and the likelihood that this ministry may be required to move to performance based budgeting within the next two years. This effort is part of ongoing reform of the public sector in Turkey that requires all sectors (particularly health) to establish five-year and annual strategic plans and budgets.

The Ministry of Health of Turkey, WHO Regional Office for Europe and the World Bank consider HSPA to be an effective tool for steering Turkey's ongoing health reforms by helping to monitor achievements and further improvements in the health system and to address prevailing challenges; ensuring effective utilization and exploitation of health data produced/collected within the system; enhancing knowledge and building capacity among all actors in the health system; and supporting and encouraging intersectoral cooperation to achieve higher level goals.



HSPA Report - Main results and policy recommendations

This section develops the “storyline”, bringing together the main findings on both the HSPA indicators and the policies implemented and across the performance dimensions.

Good health; healthy lifestyle and environment; utilization effectiveness

The Ministry of Health Strategic Plan 2010–2014 states that Turkey is “a country where all citizens enjoy a healthy and wealthy life.” There have been significant improvements in population health over the last twenty years, in particular during the eight-year period following the initiation of the HTP in 2002. However, it is unlikely that better health care alone will enable Turkey to reach its full health potential. There is strong evidence that other non-medical determinants (such as educational attainment) are major influences on health status.

Life expectancy at birth and life expectancy at age 65 are two major indicators for population health as they reveal the overall effect of risk factors, incidence and disease severity as well as the effectiveness of interventions at different levels of care. Both indicators show steady improvement since 1990 while an accelerated improvement was observed after the initiation of HTP; the former is particularly notable as health gains have been achieved mostly through decreased mortality at earlier ages, particularly under the age of five.

The National Strategic Plan for Strengthening Surveillance and Control System of Communicable Disease in Turkey (2009–2013) is now published. The available data in this report suggest very good results on the control of communicable diseases. There has been great progress towards the elimination of malaria, with no case fatalities in the last five years. The treatment success rate among newly detected laboratory-confirmed cases of tuberculosis (TB) increased from 73% in 2000 to 92% in 2008. An impressive pace of DOTS since 2006 resulted in universal coverage in 2008 (100%). Currently, innovative modalities of DOTS are being piloted - a combination of health services and social services in which nongovernmental organizations (NGOs) and municipalities play a significant role. The success of these provides a good illustration of how intersectoral action and collaboration between local authorities, NGOs and the Ministry of Health have contributed to better health outcomes.

Within the national immunization programme there is high coverage (both at national and provincial levels) of infants and children with vaccines including 11 antigens. This has enabled Turkey to have surpassed the average performance in the European region. There has been significant success in expanding the programme by adding four new antigens since 2006 and in decreasing inequalities by increasing the proportion of provinces having 90% coverage with third dose DTP vaccines to 98% in 2009. The combined effect of the extensive measles immunization campaigns in 2003 and 2005 and routine immunization and strengthened surveillance for measles and rubella have brought the country to incidence levels close to elimination in 2009; observed cases are of foreign origin. Access to safe drinking water has been generalized in both urban and rural areas. Also, access to sewage connections in rural areas increased very substantially between 2003-2004 and 2007-2008.



Results vary depending on the sources (Household Budget Survey or Demographic Health Survey) but all suggest that about a quarter of the population in rural areas gained connection to a sewage system during this period.

However, the picture for noncommunicable diseases (NCDs) is worrying. NCDs were the main causes of mortality for around 70% of all cases in 2000. More recent studies on limited samples point to a troubling trend. Confirmation of its scope and a good understanding of the risk factors will be necessary in order to tackling this emerging problem. This will require a comprehensive approach that includes health promotion, prevention, early diagnosis and access to treatment and calls for multisectoral action.

Air pollution is one of the most severe environmental problems caused by rapid population growth and industrialization. The presence of small particles in the atmosphere continues to represent a public health threat although the trend shows a slight improvement. The decrease in the number of cities with very high measurements has resulted in less variability across the cities of Turkey but results for individual cities continue to vary over a wide range. The Ministry of Health's role in leading Health for All policies to tackle this problem through both short- and long-term actions will be strengthened by documenting pollution's impact on population health.

Recent data also demonstrate that obesity (BMI >30) among adults has increased sharply from 1/5 in 2000 to 1/3 in 2010. This is a generalized problem that represents a major public health issue in Europe and worldwide. The rate of obesity among women (4/10) is particularly alarming.

The impact of anti-tobacco measures is very well illustrated in Turkey. Indeed, the percentage of the Turkish population aged 15 years or above who smoke daily (current daily smokers) has reduced from 47% in the mid 1980s to 27.4% in 2008 and 25.7% in 2010. This represents a significant decrease, the largest in all Organisation for Economic Co-operation and Development (OECD) countries. However, Turkey continued to have the second highest smoking rate in the OECD in 2007 (and the second highest among males). Turkey became a 100% smoke-free country on 19 July 2009 – smoking is no longer permitted in indoor public places including all social dining and drinking places and public transportation. Exposure to second-hand tobacco smoke has also decreased substantially since 2008. (Turkey Global Adult Tobacco Survey-2010). The gap between men and women decreased but remains significant in 2010.

Turkey which signed the WHO Framework Agreement on Tobacco Control in 2004 became one of the leading countries in that it put all components of MPOWER - "MPOWER: A Policy Package to Reverse the Tobacco Epidemic" was prepared by the WHO in the light of international experience with the aim of functioning as a guideline for countries in their efforts to lead the way for tobacco control - strategy into practice.

The striking parallel between high rates of smoking in Turkey and high mortality from coronary heart disease (CHD) reinforces the importance of aggressive campaigns against tobacco consumption. CHD prevalence in Turkey is still higher than in European countries and monitoring of risk factors and implementation of multisectoral programmes is required. Easy access to health-care services and the improving quality of health services have contributed to the decline in CHD mortality despite increasing CHD prevalence.



Data on the prevalence, incidence and risk factors of NCDs in Turkey remain incomplete, building on studies limited in time and scope. It is necessary to develop an information system which will help to monitor those important trends. Reliable vital registration and injury health data are not yet routinely available from official statistical sources.

Mother and child health has become a public health priority in the 21st century. As the core of the Millennium Development Goals (MDGs), this is a major focus for the reduction of poverty and enhancement of equity. Interagency estimates show that remarkable improvements have been observed on all indicators in Turkey, most significantly for infant mortality (from 69/1000 in 1990 to 36/1000 in 2000, 18/1000 in 2009). Maternal mortality has dropped. The MDG for under-five mortality has been reached and surpassed. Those positive results are associated with both the general improvement of the socioeconomic situation over the last 20 years and the most recent policy initiatives to address these issues within the health system. The observed decline is sharper than for comparator countries within the same range of results five years ago. Unfortunately, the methods used by international agencies to estimate infant and child mortality do not allow capture of the immediate impact of intensive interventions such as those within the HTP. Conversely, smoothing avoids ad-hoc and sometimes unexplained fluctuations which can be observed. Reported rates from the Turkish Statistical Institute (from TURKSTAT) and the Ministry of Health for 2009 and 2010 need to be seen in this light (13.1 and 14 infant deaths per 1000 live deliveries in 2009 and 10.9 infant deaths per 1000 live deliveries in 2010).

Coverage of preventive, diagnostic and primary care services has improved greatly; immunization rate, cancer screening, antenatal care and newborn screening are among the examples. In addition, prompt response time to emergency call (within 15 minutes) for acute care has also been generalized. These positive results are in parallel with improved financial access (increased coverage of vulnerable population through extension of the noncontributory Green Card Scheme), improved responsiveness (patient satisfaction) and increased supply of services (HRH service quality and productivity and health infrastructures). We continue to observe some regional disparities and disparities in coverage rate by socioeconomic level but these have been reducing over time. Dedicated incentives targeting vulnerable populations were implemented, including conditional cash transfers to motivate mothers to have regular health check-ups for their children or social services support for TB patients.

Further improvements in population health status will require reduction of the health gap between men and women. Life expectancy at birth is lower than the European region average for females and in line with the regional figure for males. There is a worrying gap between men and women with regards to cardiovascular diseases and obesity. The latter requires interventions. There is a disturbing recognition that malnutrition and stunting in children and obesity show a parallel pattern within the same socioeconomic categories. This pattern points to the risk of double epidemic (obesity combined with malnutrition) which calls for the rapid implementation of interventions within those vulnerable populations. Mother and child health indicators highlight an important gradient according to education level and between rural and urban areas. There is an inverse relation between smoking and education among males. However, smoking frequency increases with education level among women (smokers comprise only 4% of women with no formal education but almost 20% of high school and university graduates) which points out to the fact that the economic status of women are indicative especially in developing countries.



Service delivery; productivity; resource generation

The increase in NCDs, especially cardiovascular diseases, has been targeted as a priority by the Ministry of Health. Health promotion and disease prevention feature prominently in the HTP-II. This is reflected to some degree in the budget allocation of the Ministry of Health: the budget for these activities has increased very significantly in absolute terms and per capita but has remained stable or even slightly decreased as a proportion of the ministry's overall budget. A more comprehensive analysis of all spending, including that of the Social Security Institute (SSI), would be necessary to draw any firm conclusion. The emphasis on disease prevention is illustrated by the recently published Turkish Control Program for Prevention of Cardiovascular Diseases which focuses on the reduction of tobacco consumption and passive smoking; prevention of obesity and unhealthy dietary habits; and raising awareness of the benefits of physical activity.

Strengthening of primary health care (PHC) and coordination with higher levels of care through the implementation of family medicine is a key priority for the reform programme in Turkey. Family medicine implementation has started in 2005 and overspread countrywide by the end of 2010. Studies are currently under way to assess the impact of this development but preliminary results are positive as they indicate a more human-centred and holistic approach and greater professionalism. In support of those studies, the two related indicators in this report indicate that PHC has been strengthened with relatively more examination at PHC level and fewer referrals to higher levels of care.

As health care has become accessible so the population's confidence in the use of public services has improved. Mechanisms such as ombudspersons and patient satisfaction surveys have been established to give a voice to citizens and patients. One key feature of family medicine in Turkey is the assignment of individuals to a named family doctor.

This is instrumental in establishing a personal relationship between the doctor and the patient and concomitant trust, continuity of care and patient satisfaction. It should become a policy priority to strengthen quality monitoring and adverse event reporting mechanisms.

Very rapid rises in capacity and productivity were required to meet the increased pressure on the health system caused by the expanded demand for care. It is well-reflected in the greatly improved coverage for preventive, diagnostic and PHC services. On the supply side, there has been substantial investment in the health system infrastructure and the health workforce. Before the HTP-1, Turkey's health-care resources (facilities, beds, equipment, health professionals) lagged well behind those of other middle-income countries but since its introduction there have been rapid quantitative and qualitative improvements.

Turkey still has very low numbers of health workers and therefore synergies to maximize capacity were created by combining substantial investment with financial and nonfinancial incentives to increase the satisfaction and productivity of health workers. The Performance Based Supplementary Payment System for health workers in public hospitals is at the heart of such schemes. This complex system was crafted to provide incentives to both individuals and organizations; to combine financial components with prestige; to foster simultaneous improvements in productivity, quality (norms) and working conditions (individual examination rooms); and to include the patients' perspective. This system has brought a major reduction in part-time private practice and a substantial increase in the income of specialists. It is currently being evaluated by the WHO Regional Office for Europe.



Health financing; financial protection

Prior to the implementation of HTP in 2003, Turkey faced four key challenges in health financing: (i) low public spending on health in comparison to other countries with similar incomes and to OECD averages; (ii) health insurance coverage had grown but gaps in coverage remained, especially among poor households; (iii) fragmented risk pools were generating inefficiencies; and (iv) substantial out-of-pocket payments constituted a barrier to access, particularly for poor households. (OECD Health System Review - Turkey, 2008)

HTP has focused on all dimensions of health financing policy. Overall, substantial progress has been made and is summarized below.

- Public spending on health has increased in line with GDP growth (within financial sustainability limits). Public spending on health as a percentage of general government revenues has been increasing steadily - from 8% in 2000 to almost 13% of general government expenditures in 2008 (50% increase over almost a decade). This is comparable to the spending levels of other OECD countries and of countries in the European Union (EU). This trend indicates the increasing prioritization of health in government policies.
- Consolidation of previously fragmented health financing pools has begun. Various social health insurance schemes were consolidated into a single scheme managed by the SSI. The final version of the law requires all beneficiaries to receive the same benefits package (access to public and private sector doctors, outpatient benefits and drugs).
- The SSI has been working on various strategies to ensure collection of premiums, especially from informal sector workers. All Turkish citizens have a mandatory requirement to enroll and contribute to the social insurance system, unless contributions are paid by the State (as in the case of the Green Card).
- Progress has been made on purchasing arrangements. It was expected that the consolidation of risk pools would make the SSI the key purchaser of health services through contracts with the Ministry of Health, university and private hospitals and with other health-care facilities. However, this consolidation has taken longer than anticipated and is still ongoing. In this context, transformed and transitional purchasing arrangements have emerged. Currently all Ministry of Health hospitals have performance based payment arrangements in place. The Ministry of Health is beginning to implement case-based payments based on diagnosis-related groups (DRGs). The introduction of DRGs will standardize prices for medical procedures and encourage greater efficiency in hospitals.

Government efforts to provide universal coverage to Turkish citizens have rendered concrete results. Fewer families now face catastrophic health outlays and the subsequent risk of impoverishment. The population covered under social protection has increased from 70% in 2000 to 85% in 2004 before rising sharply to achieve close to full coverage (98%) in 2010.



In fact there have been significant improvements not only in the scope but also in the depth of coverage - especially for poor households. For instance, outpatient benefits and outpatient drugs were included under the Green Card (non-contributory scheme for vulnerable population) in 2004. Countries seeking to expand universal coverage through a health insurance system may draw important lessons from the Turkish experience. A narrow, hospital-based package does not provide adequate coverage and pharmaceuticals often constitute a large percentage of households expenditures. Therefore, it is critical to improve the depth of coverage. The HTP's next challenge is to advance these health financing transformations by: (i) completing the consolidation of risk pools under the SSI; and (ii) encouraging the SSI to take on all purchasing functions.

Leadership and governance

“One of the success factors for the implementation of the HTP program is the importance of the vision and leadership to set values and guiding principles, and the determination to follow through policy implementation” (Baris et al. 2011).

“Governments face a key challenge in leading their health systems in a manner that ensures that all constituents fully understand the vision and priorities for change; supports them in embracing their roles and responsibilities in contributing to the desired changes; and encourages mutual accountability to enable movement towards better, higher-performing health systems. As recognized by the Ministry of Health, the interdependence of health system functions calls for a coherent approach and coordinated action. Strong and stable leadership has enabled the implementation of considerable reforms that have yielded significant improvements in utilization, effectiveness and health outcomes in the Turkish national health system.”

These results have been achieved by a combination of measures to:

- i. invest in the health system (generate resources to create capacity);
- ii. create incentives for health professionals (for more productive use of the infrastructure);
- iii. encourage demand for essential health services (through increased confidence and trust in the health system and targeted interventions aimed at most vulnerable population); while recognizing the importance of prevention and health promotion and fostering intersectoral action.
- iv. Each policy measure is important but, within the Turkish setting, the key characteristics are that these were all addressed in a coherent and coordinated way and that the reform programme was implemented in a remarkably short period.



The guiding principles for the HTP are a people-focused approach, pluralism, separation of power, incremental shift towards health provider autonomy and competitiveness. These goals entail radical restructuring of the governance mechanisms by: redefining the roles and responsibilities of the Ministry of Health towards “more steering and less rowing”; separating the provision and financing of health care in order to achieve more efficient allocation and use of resources; and by increasing financial and administrative autonomy for public hospitals in order to improve technical efficiency and strengthen management.

There is a crucial link between a core message of The Tallinn Charter: Health Systems for Health and Wealth and the ability to sustain public commitment to health spending – health systems need to demonstrate good performance. This is very clearly illustrated in Turkey where there have been major investments during the two phases of the HTP and the Ministry of Health is a pilot institution for implementation of performance based budgeting. Restructuring of public financial management should help to establish accountability, financial transparency and discipline and cost effectiveness in the public sector. The Ministry of Health is one of the pilot institutions that have initiated performance based budgeting and strategic planning activities.

The process of developing an HSPA report for Turkey has highlighted the fragmentation and gaps in information systems that make it very difficult to gather some indicators. In particular, it was not possible to disaggregate results for sex, income quintile or education (except for the few indicators based on household survey data). Most of the distribution analysis for this HSPA is reliant on observation of regional or provincial differences. It is advised that the establishment of a comprehensive health and gender equity surveillance system is required in order to tackle the possible health and gender gaps identified in the limited but important observations above (CSDH, 2008).

The Ministry of Health recognizes the importance of increasing the awareness of health responsibility within all sectors and leading intersectoral action towards improved health. For instance, major steps in tobacco control have already been implemented including a total ban on smoking in closed spaces and increased taxation of tobacco products. Such advances have been achieved due to strong commitment at the highest level – in 2010 His Excellency the Prime Minister Recep Tayyip Erdoğan received the WHO Director General’s Special Recognition Award for Contribution to Global Tobacco Control. The Ministry of Health recognizes the need to provide leadership within Turkey and also internationally by developing international cooperation, supporting international development and building on quality improvement achieved within the Turkish sector in order to gain international recognition that will attract international health tourism.



G. Health Systems in Transition, Turkey Health System Review

Year of Publishing : 2011

Published by : European Observatory on Health Systems and Policies

Authors : Mehmet Tatar, Salih Mollahaliloğlu, Bayram Şahin, Sabahattin Aydın, Anna Maresso, Cristina Hernandez-Quevedo

Health Systems in Transition reports are the country-based reports which are developed by the European Observatory on Health Systems and Policies of the World Health Organization Regional Office for Europe. They present analytical descriptions about health care

systems and reform initiatives under implementation or development.

Following are some of the key findings in the report:

- 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.
- 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.
- 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;
 - introducing a performance-based payment system in Ministry of Health hospitals;
 - transferring ownership of the majority of public hospitals to the Ministry of Health; and
 - enhancing the accessibility of health care services of acceptable quality for the whole population.



H. Tobacco Control in Turkey, Story of Commitment and Leadership

Year of Publishing : 2012

Published by : World Health Organization Regional Office for Europe

Authors : Nazmi Bilir, Hilal Özcebe, Toker Ergüder and Kristina Maurer-Stender

The report developed by the World Health Organization Regional Office for Europe discusses what needs to be done in order to reach success in tobacco control. In this context, the report discusses the anti-tobacco actions in Turkey and emphasizes Turkey's commitment and leadership in this field, as a good example to other countries.

Zsuzsanna Jakab, the Director of the World Health Organization Regional Office for Europe, states in the foreword that : “ Turkey faces a serious tobacco epidemic. Nearly 16 million of the nation’s adults are smokers. Smoking is the most important public health challenge and preventable cause of mortality in the country. Beyond health hazards, the economic burden of tobacco use is equally enormous. Smokers spend nearly US\$ 20 billion annually on tobacco products – four times the annual budget of the Ministry of Health. Turkey, a country with a high prevalence of smoking and important tobacco production, has taken bold and courageous steps in tobacco control in recent years. Driven largely by Government leadership and policy initiatives, Turkey is now considered a model country in tobacco control at both regional and global level, emerging as a leader in Europe in terms of policy measures such as taxation and the introduction of smoke-free indoor public places. The implementation of a comprehensive tobacco control law in Turkey has already saved thousands of lives and encouraged countries around the world to follow the Turkish example.”

Following are the key findings in the report:

- Smoking has a long history in Turkey and smoking prevalence is quite high. Yet, a major progress has been made in the fight against tobacco.
- With the Bill No. 5727 Amending the Law on Prevention of Hazards of Tobacco Control Products, Turkey became one of the first completely smoke-free countries in the world.



Turkey owes its success to these three factors:

- I. The commitment and dedication to tobacco control and public health of all authorities
 - II. Powerfull media campaigns
 - III. Powerfull non-gpvernmantel organizations
- In spite of the achievements, the following still needs further consideration:
 - I. Smoking in private premises and vehicles
 - II. Smoking during pregnancy and breastfeeding
 - III. Regulations and inspection to be made by the TAPDK in points of sale
 - IV. Inspections and preventing violations
 - V. Monitoring the effectiveness of tobacco control measures

The report ends in the following statement: “In conclusion, Turkey is well on the way to becoming a tobacco-free country”.



I. Successful Health System Reforms: The Case of Turkey

Year of Publishing : 2012

Published by : World Health Organization, Regional Office for Europe

Authors : Dr. Anne Johansen, Dr. Ann-Lise Guisset

This paper is intended to serve as a background paper for a technical briefing - Equitable Access to Health: Snapshots from Health Reform Country Experiences - at the 65th session of the World Health Assembly. It is also prepared as a case study for the World Health Organization (WHO) Global Learning Program on National Health Policies, Strategies, and Plans. The objective of this paper is to analyse the reforms and

health system strengthening efforts that led to these improvements in order to share lessons learned with other countries seeking to transform their health sectors.

Following are the key findings in the report:

- At the turn of the millennium the performance of Turkey's health sector in terms of health outcomes, financial protection, and patient satisfaction put it at the bottom of the OECD countries and in the European Region of WHO.
- Dissatisfaction with the health system was so widespread that government made health sector reform a key priority when it came into power in late 2002. By 2010, however, the situation had changed dramatically.
- It is particularly noteworthy that life expectancy (at birth) increased from 71 in 2000 to 75 in 2009, according to WHO estimates (World Health Report 2011), a significant improvement in a relatively short period of time.
- In part, this was brought about by a major reduction in infant and under five mortality rates. Increasing immunization rates and expansion of the immunization programs helped contribute to this decline.
- Maternal mortality also declined significantly in part due to an increase in the percentage of deliveries taking place in hospital.
- Equally impressive is the increase in general satisfaction with the health sector, which grew from 39.5% in 2003 to 75.9% in 2011.



- Not only did the total resources increase, but, remarkably, the geographic distribution of health care providers also improved, with the ratio of best-to-least endowed provinces in terms of human resources for health (HRH) declining significantly.
- Access to sophisticated equipment, such as CT and MRI scanners also grew significantly, as did the supply of ambulances and the number of intensive care beds for both adults and infants. The expansion in the health care delivery system helped contribute to noteworthy improvements in utilization of health care services, increases in immunization rates, as well as to an increase in productivity of doctors.
- These achievements did not come for free; according to HFADB public health expenditures grew from 9.74% of all public expenditures in 2003 to 12.8% in 2008, reflecting the greater priority placed on health relative to other sectors, only increased from 5.3% to 6.1% of GDP due to rapid economic expansion during this period.
- More recent data indicate that the pace has been decreasing or is even reversing. Indeed, public health expenditure ratio within non-interest overall public expenditures has been reported to change from 14.7 in 2003 to 15.2 in 2008 and 13.1 in 2011.
- Why has Turkey succeeded and what lessons can be learned from these reforms? The answer is not simple. It lies partly in the systematic and analytical way in which the MoH approached the reforms, partly in the strategic ways in which they sequenced the reforms; but other factors also played a critical role.
- The Turkish reforms provide a number of lessons for reformers in other countries, most importantly, perhaps, that is possible to achieve major improvements in health system performance in a relatively short period of time under the right conditions.
- Some might argue that the situation in Turkey was unique either because of the favourable political situation or because the economic environment made it possible to sustain large increases in health expenditure over a fairly long period of time. While this may be the case, the lessons above from Turkey would seem useful for other countries even in the absence of those two key factors for success: Sequencing of reforms, focus on outcomes, clear statement of objectives, and monitoring of the progress toward the objectives with both formal and informal monitoring and review mechanisms to identify new and emerging problems, and to ensure that they are (re)solved.
- Other countries have much to learn from Turkey's experience, not only from the particular reforms, such as P4P, autonomization, and family medicine, but also from the way in which virtuous cycles have contributed to sustaining the momentum of the reforms.
- Also, financial risk protection improved impressively.



Articles

A. Journal of Healthcare Finance, Outsourcing Profile in the Turkish Health Care System 2009

This article on the Outsourcing Profile in the Turkish Health Care System has been published in the Journal of Healthcare Finance in 2009. The authors are Salih Mollahaliloglu, Sahin Kavuncubasi, Hakkı Gursoz, Ismail Agirbas, Hakan Oguz Ari, Hasan Gokhun Oncul, Recep Akdağ and Mustafa Z. Younis. The main objective of this study is to determine the outsourcing practices in MoH hospitals.

Conclusions and Policy Implications

The primary purpose of this study is to describe the profile of outsourcing practices in MoH hospitals in Turkey. Frequency, types, and content of services outsourced by MoH hospitals have grown and changed considerably over the past decade and are estimated to continue growing. Consistent with the findings of the other studies, this study shows that outsourcing practices are constantly spreading from support functions to administrative and clinical functions of hospitals. In summary, outsourcing has become an attractive option for hospital managers.

Outsourcing core hospital functions in MoH hospitals appears to be less common than outsourcing noncore services; however, it can be expected that outsourcing clinical services will grow rapidly because the “service continuity” policy approved by MoH directs managers to meet whole needs of patients within hospitals. According to the service continuity policy, a separate principle of the Health Transformation Project, instead of directing patients to the referral hospitals (secondary and tertiary hospitals), which are usually located in urban areas of Turkey, hospitals should provide specialized services their patients through outsourcing.

On the other hand, MoH is planning to implement a Public Private Partnership (PPP) strategy in Turkey. This strategy can be expected to create cooperation between public and private hospitals to deliver higher quality services with a minimum cost level. PPP will be able to facilitate and to accelerate outsourcing practices especially in the provision of high-cost, low-volume services to patients. Recent trends in outsourcing has revealed that outsourcing of diagnostic and treatment services is widening; therefore, new market opportunities will undoubtedly be appeared for national and international organizations (vendors). As Augurzky and Scheuer (2007) note, analogical to a case in Germany, we propose that, “nobody should be surprised if service firms from other countries enter the Turkish health market if Turkish service firms do not rapidly make themselves more attractive to hospitals.”



B. The Turkish Journal of Pediatrics, Recent Improvements in the Turkish Childhood National Immunization Program, 2010

The article has been published in Turkish Journal of Pediatrics in 2010. The Author is Prof.Dr. Mehmet Ceyhan.

The findings and evaluations regarding the Turkish Childhood National Immunization Program are included.

Abstract:

The Childhood National Immunization Program (NIP) is a key element of the primary healthcare and plays a major role in the national health status. The Turkish NIP, which is run by the Ministry of Health, included mainly the basic vaccines (Bacillus Calmette-Guerin [BCG], diphtheria-pertussis-tetanus [DPT], polio, measles) until 2005. However, a change in the governmental policies in 2002 and a close collaboration with the Advisory Board of Immunization have improved the Turkish NIP not only in terms of the quality of the vaccines and vaccination rates but also the number of pathogens covered. Currently, Turkey has a NIP

that is equivalent to or better than that of the other European countries. However, making vaccination a constant part and priority of the state health policies is necessary for sustainability. Political commitment and efficient multi-sectoral collaboration and awareness are crucial.



C. BMJ, Healthcare in Turkey: from laggard to leader, 2011

The authors of this analysis are Enis Barış, Salih Mollahaliloğlu and Sabahattin Aydın, and it was published in British Medical Journal in 2011.

Abstract:

“Less than a decade ago, the health system in Turkey was considered a laggard, not only relative to the rest of the Organisation for Economic Cooperation and Development (OECD) but to other high middle income countries. A major discrepancy existed between constitutional aspirations of equitable access to healthcare for all citizens and the reality on the ground. Health mattered, yet was seldom addressed on the political agenda. Today, the health system in Turkey is transformed, not quite to the point of favourable comparison with the rest of the OECD and most of the European Union, but fast closing the gap in health outcomes, responsiveness, and fair financing. We describe the Health Transformation Programme (HTP) launched in 2003, analyse the reasons behind its achievements, and share the lessons learnt.”

Achievements and Lessons:

Health for all in Turkey is no longer merely an aspiration. Universal health coverage is ensured as a result of a high level of political commitment. Today, catastrophic health expenditure impoverishes only 0.4% of the Turkish population.

Equally important is the growing international recognition that it is indeed possible to improve health outcomes in such a short span by investing in health systems. Turkey is now frequently cited as a success story, rather than as an underperformer, having improved its health outcomes at a pace and to a level almost unheard of in middle income countries, and in the case of health related millennium development goals, well before the 2015 deadline.

The recent Turkish experience provides at least three key lessons for other high middle income countries. One obvious lesson is the need to invest in health systems. Among the OECD countries, Turkey allocates the largest proportion of its public health budget, about 7.7%, to investment, compared with the OECD average of 4.2%. The budget allocated to expanding prevention and primary healthcare to underserved areas has also increased 58% in real terms. The 112 emergency telephone line now serves rural areas as well as cities. 17 air ambulances routinely serve geographically remote areas, transporting high risk pregnant women and sick children to better equipped urban facilities. An additional 111.000 health workers have been recruited.



The health workforce is now distributed more equitably in geographical terms resulting in reduced inequalities in access to care among the poorest. The urban/rural and rich/ poor ratios are now 1:1 for both birth attendances by skilled health staff and measles immunisation coverage.

A second and less obvious lesson is the importance of encouraging demand for essential health services by reducing sociocultural barriers and offering financial incentives. Pregnant women who live in remote areas are provided with free accommodation in cities for up to one month before delivery. Since the programme began in October 2008, close to 7000 pregnant women have used free predelivery care. In 2004, Turkey introduced a conditional cash transfer scheme, about 17 ₺ per month payable to mothers, to encourage pregnant women, mothers, and their children to visit health facilities regularly, with an additional payment of about 55 ₺ if women delivered their babies in public hospitals. As a result, the proportion of women who have attended at least four prenatal visits rose from 53.9% in 2003 to 73.7% in 2008 and the proportion of births attended by skilled health staff rose from 83% to 91.3% over the same period. Also in 2008, measles immunisation coverage reached 96%, from 82% in 2002. As a result, there were only 4 measles cases in 2008, down from 30.509 in 2001.

The third lesson is the importance of vision and leadership to set values and guiding principles, and the determination to follow through policy implementation. A shift of perspective has placed the patient or citizen as the basis of all policy goals and performance evaluation. Reference to, and continuous monitoring and evaluation of, responsiveness to patients' needs and preferences and patient satisfaction figure prominently in policy papers, reports, and public speeches, and have been introduced as benchmarks into various supplementary payment schemes that are performance based and measured regularly through patient satisfaction surveys. The population's satisfaction is now, at the highest level since regular polling of patients began and service utilisation is at an all time high.

Finally, considerable investment has been made to improve data availability, quality, and timeliness, complemented by household and user surveys. A nationwide survey on maternal mortality in 2006 put an end to the large disparity that had existed between national and international estimates and set the benchmark against which future progress will be assessed. All maternal deaths are now investigated, at times by the health minister himself, to identify the cause of death and take corrective action. Onsite oversight is routine, with the minister and his field coordinators reportedly having travelled 600.000 km and visited all 81 provinces, often more than once a year.



Unfinished Agenda

Health systems alone can only do so much to improve health without concurrent improvement in human development and increase in equality of opportunity. This is particularly true in Turkey, where income inequality is rising and literacy is yet to be universal (Table 2). A large gender gap persists as a result of lower enrolment and participation of girls and women in education and labour. Regardless of the socioeconomic differences, non-communicable diseases are rising because of unhealthy lifestyles: Turks still smoke a lot, and as they rapidly urbanise, they also become less physically active and more obese. A rapidly ageing population, especially in the west of the country, is already using health services more often as a result of improved access, demanding higher quality and more user friendly care.

All these factors mean that the much improved health system needs constantly to adapt to changing health and healthcare needs. The emerging challenges are now more programmatic and less structural, such as further embedding health in all policies, especially in relation to environmental and behavioural determinants of health; establishing disease prevention and health promotion services in all family based and community based primary care services; and improving public knowledge about healthy behaviour and healthier living and ageing.

Conclusion:

In just seven years, Turkey's Health Transformation Programme has been able to ensure universal health coverage for essential care and significantly improve health outcomes. The major challenge now is how to steer a much more complex health system in the right direction and adapt it to the changing needs and preferences of an increasingly assertive citizenry and a democratic and pluralistic governance structure, while improving efficiency and financial sustainability. These are the same challenges that the rest of OECD and EU member states face today.



D. Journal of Methods of Information in Medicine, Electronic Health Record Interoperability as Realized in the Turkish Health Information System, 2011

The authors of this paper are A. Dogaç, M. Yüksel, A. Avcı, B. Ceyhan, Ü. Hülür, Z. Eryılmaz, S. Mollahaliloğlu, E. Atbakan and R. Akdağ, and it was published in Journal Methods of Information in Medicine in 2011.

The subject of the paper is the development of the National Health Information System of Turkey (NHIS-T).

Abstract:

Objectives: The objective of this paper is to describe the techniques used in developing the National Health Information System of Turkey (NHIS-T), a nation-wide infrastructure for sharing electronic health records (EHRs). Methods: The UN/CEFACT Core Components Technical Specification (CCTS) methodology was applied to design the logical EHR structure and to increase the reuse of common information blocks in EHRs. Results: The NHIS-T became operational on January 15, 2009. By June 2010, 99% of the public hospitals and 71% of the private and university hospitals were connected to NHIS-T with daily feeds of their patients' EHRs. Out of the 72 million citizens of Turkey, electronic healthcare records of 43 million citizens have already been created in NHIS-T. Currently, only the general practitioners can access the EHRs of their patients. In the second phase of the implementation and once the legal framework is completed, the proper patient consent mechanisms will be available through the personal health record system that is under development. At this time authorized healthcare professionals in secondary and tertiary healthcare systems can access the patients' EHRs."

Conclusions

A number of factors affected the successful implementation of NHIS-T. First, all stakeholders have to adopt the specified standards. Second, the UN/CEFACT CCTS approach was applied which facilitated the development and understanding of rather complex EHR schemas. Finally, the comprehensive testing of vendor-based hospital information systems for their conformance to and interoperability with NHIS-T through an automated testing platform enhanced substantially the fast integration of vendor-based solutions with the NHIS-T.



E. Turkey Wins Plaudits for Tobacco Control

The author of this paper is Sharmila Devi and it was published in the Lancet in May 2012.

The subject of the paper is Turkey'S fight against tobacco, which is also respected worldwide, and the major progress that has been made so far.

Abstract:

“Smoking like a Turk” was a common expression in several European languages during the past century but now Turkey is receiving international plaudits for its efforts to stamp out the country’s traditional and deeply rooted consumption of tobacco.

Turkish tobacco control measures include a ban on smoking in all indoor areas, raising cigarette prices, a full advertising ban, antismoking media campaigns, warnings on tobacco packaging, and increased access to cessation products and treatments.

One in three Turks, or about 31% of the population, smoked in 2008, when Turkey became the third country to introduce a widespread smoking ban after Ireland and the UK, Nazmi Bilir, a professor of public health at Ankara’s Hacettepe University, told The Lancet. “Smoking has been a traditional, male behaviour in Turkey so it’s not been easy”, Bilir said. “But my feeling is that Turkey will become truly smoke-free.”

“We’ve had the same prime minister and health minister for the last 9 years so political stability and having the same key people in government and parliament has worked in our favour”, said Bilir.

4 years have passed since the [antismoking law] came into effect and it has yielded positive results during this time”, Elif Dagli, chairwoman of the SSUK, said earlier this year. “The smoking rate has decreased by 15% and the number of people being admitted to hospitals for treatment for smoking-related diseases has decreased by roughly 20% in Turkey.”



F. Malaria in Turkey: Successful control and strategies for achieving elimination

The authors of this analysis are Ahmet Özbilgin, Seher Topluoğlu, Saffet Es, Elif İşlek, Salih Mollahaliloğlu and Yasin Erkoç. The article was published in the Journal of Acta Tropica in July 2011.

The article discusses Turkey's fight against malaria, which is also respected worldwide, and the major progress that has been made so far.

Abstract:

Turkey is located in the middle of Asia, Africa and Europe, close to Caucasia, Balkans and Middle East in subtropical climate zone. Malaria has been known since the early ages of human history and it was one of the leading diseases in Anatolian history, as well. Today, chloroquine-sensitive Plasmodium vivax is the only agent of autochthonous malaria cases in Turkey. The other Plasmodium species identified are isolated from imported cases of malaria. The most common vector of malaria in Turkey is Anopheles sacharovi followed by An. superpictus, An. maculipennis and An. subalpinus. In 2009, pre-elimination stage of Malaria Program was started due to dramatic decline in the number of malaria cases in Turkey (Total,

84; 38 autochthonous cases only in 26 foci in south-eastern Anatolia, and 46 imported cases; incidence: 0.1/100,000). As there were no detected cases of new autochthonous malaria in the first 8 months of 2010, elimination stage was started. The role of the persistent policies and successful applications of the Ministry of Health, such as the strict control of the patients using anti-malarial drugs especially chloroquine, avoidance of resistant insecticides, facilitation of access to patients via Health Transformation Program (HTP), establishment of close contact with the patients' families, and improvement of reporting and surveillance system, was essential. In addition, improvement maintained in the motivations and professional rights of malaria workers, as well in the coordination of field studies and maintenance of a decline or termination in vector-to-person transmission were all achieved with the insistent policies of the Ministry of Health. Other factors that probably contributed to elimination studies include lessening of military operations in south-eastern Anatolia and the lowering of malaria cases in neighbouring countries in recent years. Free access to health services concerning malaria is still successfully conducted throughout the country.



3. Letters

A. Letter from Sir Andrew Dillon, the Director of NICE

In his letter dated 20 December 2010, Sir Andrew Dillon, the Director of NICE, invited Prof. Dr. Recep Akdağ, Minister of Health of Turkey to be the keynote presenter at the international conference on “Global Health 2011 - Policy for Sustainable and Effective Healthcare”.

It is stated in the letter that NICE and the MoH of Turkey has been working together since 2008 and that the said conference may be a way to show the progress made in the collaboration so far and raise awareness amongst the global community of Turkey’s commitment to universal coverage and evidence-based policy making. It is mentioned that the Turkish model would be of relevance to many countries faced with similar challenges in their attempt to improve the quality and efficiency of care offered to their citizens.

NICE and BMJ invited our Minister for sharing experiences at the conference, which was organized with the aim of supporting leaders and decision makers that want to improve health outcomes and generate cost-effective and evidence-based health policies.



NICE International



BMJ Group

National Institute for Health and Clinical Excellence
71 High Holborn,
London,
WC1V 6NA

20 December 2010

Invitation to keynote: Global Health 2011 – Policy for sustainable and effective healthcare

On behalf of NICE International and the British Medical Journal, we would like to extend a warm invitation for you to be our keynote presenter at a new international conference on global health policy. The conference will be held over two days, on 29/30 September 2011 at the British Medical Association, BMA House, Tavistock Square, London. The conference mission is to support healthcare leaders and decision makers operating in resource-constrained settings to improve health outcomes, by promoting cost-effective, evidence-informed healthcare policy-making.

Given your country's groundbreaking reforms likely to serve as a model for poorer countries around the world and to have a global impact on rich and emerging markets, it would be a real privilege to have you open our global conference. We have preliminary agreement from Ministers and senior officials from Latin America and China, industry CEOs and from the Head of the World Bank for Health, Population and Nutrition. Leaders from the global health world, the CEO of Astra Zeneca and also DFID and USAID officials are also going to be joining us.

During the conference we would like to:

- explore the most cost-effective ways for sharing and for adapting evidence and decision-making processes across both rich and poor countries
- discuss the challenges in institutionalising evidence-informed policy and practice in healthcare and ways of addressing these in poorer systems
- highlight experiences and identify ways in which rich and poorer governments and their institutions, as well as healthcare professionals, academics and multi and bi-lateral agencies can work together to support accountable and legitimate decision-making processes locally
- describe the pre-requisites for local institutions to be effective, such as local epidemiological, clinical and economic data; local technical and decision-making capacity; and local institutions; and collectively identify practical ways for meeting these



NICE International



BMJ^{Group}

We are hoping that this conference will serve to unite stakeholders who usually operate in separate spheres including those involved in applying tools and methods such as health technology assessment, evidence based medicine and comparative effectiveness research, and global development donors and poorer country governments wishing to explore these approaches. The audience will be international policy makers, government representatives, international aid givers, non-government organisations, academia and the commercial sector.

If you remember you kindly hosted me at the Ministry in 2008. Since then, NICE International and the Turkish MOH have been working together. We could, subject to your agreement, showcase progress made in our collaboration so far between the Ministry of Health and NICE International in order to raise awareness amongst the global community of Turkey's commitment to universal coverage and to evidence-based policy making. The Turkish model will be of relevance to many countries faced with similar challenges in their attempts to improve the quality and efficiency of care offered to their citizens.

I appreciate that there are many calls on your time and I would be delighted if you were able to accept my invitation. I would be happy to speak to a member of your staff to provide further information about the conference, if it would help you to decide whether to accept this invitation. My direct line number is +44 20 7045 2047 and my email address is andrew.dillon@nice.org.uk. My assistant is Frances Abebreseh. Her number is +44 20 7045 2048 and her email address is frances.abebreseh@nice.org.uk.

Yours sincerely,

Sir Andrew Dillon



B. Letter from Dr. Chan Director General to the WHO

In her letter dated 4 May 2011 to our Minister, Dr. Margaret Chan, the Director General to WHO says:

“Dear Minister,

I have had the opportunity to visit your country on several occasions and during these visits I have been very impressed with the extraordinary progress in health that has been achieved in Turkey during the last 8-10 years. The “Health Transformation Programme” introduced in 2003 to address the key public health issues is producing impressive improvements in areas such as infant and maternal mortality rates, smoking rate and immunisation coverage.

...

I appreciate the excellent relations that WHO currently has with the Government of Turkey and, in particular, for your personal investment on global health issues, and I look forward to our continuing collaboration.”



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In reply please
refer to:

Your reference:

Professor Dr Recep Akdag
Minister of Health
Ministry of Health
Mithatpasa Caddesi no. 3
Sihhiye Ankara
Turquie

4 May 2011

Dear Minister,

I have had the opportunity to visit your country on several occasions and during these visits I have been very impressed with the extraordinary progress in health that has been achieved in Turkey during the last 8-10 years. This is a testimony to the Government's strong commitment to the health of the country's population. The "Health Transformation Program" introduced in 2003 to address the key public health issues is producing impressive improvements in areas such as infant and maternal mortality rates, smoking rate and the immunization coverage.

On the subject of health statistics, and in particular WHO estimates for infant mortality data, as highlighted in your letter of 21 March 2011, I suggest that the technical staff from the European Region and Headquarters meet as soon as possible with Turkish experts to discuss and agree on the best methodology for presenting estimates which could reflect more accurately the recent progress made in your country.

I appreciate the excellent relations that WHO currently has with the Government of Turkey and, in particular, for your personal investment on global health issues, and I look forward to our continuing collaboration.

Yours faithfully,

Dr Margaret Chan
Director-General

cc: The Permanent Representative of Turkey to the United Nations Office at Geneva and other
International Organizations in Switzerland
The WHO Representative and Head of Country Office, Ankara Cankaya

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C. Letter from Zsuzsanna Jakap, Regional Director of WHO Regional Office for Europe

In her letter dated 29 April 2011 to our Minister, Zsuzsanna Jakap, the Regional Director of WHO Regional Office for Europe says:

“Dear Minister,

...I was recently introduced to the executive report of your Health System Performance Assessment, where it is evident that Turkey has translated into action the values and principles of the Tallinn Charter. We would be grateful if you could confirm those achievements (as summarized at appendix 1) in order for the WHO Regional office for Europe to include Turkey experience in the reporting back on the Talinn Charter.

Let me use this opportunity to express my respect and gratitude on having undertaken major reforms of the national health system, yielding significant improvements in utilization, effectiveness and health outcomes. This success story was achieved thanks to a combination of measures to invest in the health system, provide incentives to health professionals, and encourage the demand for essential health services, while recognizing the importance of prevention and health promotion and fostering intersectoral action.



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Ihr Zeichen:
На Ваш номер:

Date: 29 April 2011

Professor Recep Akdag
Minister of Health
Ministry of Health Sağlık Bakanlığı, Mithatpaşa
Caddesi 1
Sıhhiye - Ankara
Turkey

Dear Sir,

The World Health Organization Regional Office for Europe committed to report back to the Regional Committee in 2011 on the achievement in implementing the Tallinn Charter on Health and Wealth (2008). Those achievements were discussed at the recent meeting in Andorra of the European Health Policy Forum for High-Level Government Officials. It was with regret that we were unable to benefit from the presence of a representative from Turkey at this meeting. However, I was recently introduced to the executive report of your Health System Performance Assessment, where it is evident that Turkey has translated into action the values and principles of the Tallinn Charter. We would be grateful if you could confirm those achievements (as summarized at appendix 1) in order for the WHO Regional Office for Europe to include Turkey experience in the reporting back on the Tallinn Charter.

Let me use this opportunity to express my respect and gratitude on having undertaken major reforms of the national health system, yielding significant improvements in utilization, effectiveness and health outcomes. This success story was achieved thanks to a combination of measures to invest in the health system, provide incentives to health professionals, and encourage the demand for essential health services, while recognizing the importance of prevention and health promotion and fostering intersectorial action. Taken in isolation each policy measure is important, but the key characteristics within the Turkish setting are that all of these were addressed in a coherent and coordinated way, and that the health reform program was implemented in a remarkably short period.

This major reform process was only achievable thanks to political commitment at the highest level. It not only brings the Tallinn Charter for Health and Wealth (2008) into action, but also goes one step further and reflects the key values and principles of Health2020, the new European Health Policy currently being developed by WHO Regional Office for Europe. Indeed, thanks to the commitment and strong vision of the Minister of Health, wellbeing and health for all has been brought to the forefront of the government's policy agenda.

Turkey understood that substantial health gains and reduction of the health and gender gap – which is still significant in Turkey – cannot be achieved through the health care sector alone but needs a concerted and comprehensive approach. The importance of tackling the growing epidemics of non-communicable diseases observed throughout the Region is also recognized. In addition, further steps towards strengthening the health system can be achieved through, among others, increasing

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the use of primary health care as first contact point and balancing the proportion of outpatient visits at the primary care level with regards to other levels.

The transformation of the health system in Turkey is exemplary. To document the outcomes of these reforms and experience gained, WHO will look forward to working with the Ministry of Health and the wider government of Turkey to improve information systems and build a strong evidence base for ongoing monitoring, in-depth evaluations and continual development. In this way, the unique and valuable experience of Turkey may be shared with other WHO Member States.

Yours very truly,

Zsuzsanna Jakab
Regional Director

Copy for information to:

Prof Ahmet Davutoglu, Minister for Foreign Affairs, Ministry for Foreign Affairs, Dr Sadik Ahmet Cad. No. 8, Balgat, 06100 Ankara, Turkey

Dr Bekir Keskinilic, Head of Foreign Relations Department, Turkish Ministry of Health, Mithatpasa Cad. No:3, Sıhhiye, Ankara, Turkey

H. E. Mr. Mustafa Oguz Demiralp, Ambassador, Permanent Mission of Turkey to the United Nations Office in Geneva and other International Organizations in Switzerland, Chemin du Petit-Saconnex 28b, CH-1209 Geneva

Switzerland H. E. Mr Berki Dibek, Ambassador, Embassy of the Republic of Turkey, Roshæksvej 15, 2100 Copenhagen Ø, Denmark

Dr Maria Cristina Profili, WHO Rep/Head of Country Office in Turkey, WHO Country Office, Turkey, UN House - Birlik Mahallesi 2 - Cadde 11, TR-06610 Cankaya, Ankara, Turkey

Mr Shahid Najam, UN Resident Coordinator - UNDP Res. Rep., United Nations Development Programme UN House, Birlik Mahallesi 2-Cadde 11, Cankaya-Ankara 06610, Turkey



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CHRONOLOGY OF THE HEALTH TRANSFORMATION PROGRAM



2003

- We put an end to being held in pledge.
- We made 112 Emergency Health Care Services entirely free-of-charge.
- We started the scaling-up of free mobile health care services in rural areas.
- We enabled the citizens to access the services provided by private hospitals and medical centers using their health insurance.
- We initiated Total Quality Management (TQM) implementation in the MoH.
- We started performance-based supplementary payment system. Therefore, we ensured full-time practice for physicians in hospitals and we substantially reduced patients' need to apply to private practice.
- We started "one examination room for each physician" practice in health facilities affiliated with the MoH.
- We launched the transition from ward system to room (including bed and bathroom) system.



2004

- We started the free-of-charge distribution of iron supplement and vitamin-D to babies and pregnant women.
- We started to establish free-of-charge Cancer Screening and Training Centers (KETEM).
- We started to implement personal performance-based payment system in MoH institutions.
- We included outpatient services in the benefits package of Green Card holders.
- We started the implementation of “right to choose physician” in MoH hospitals.
- We started the conditional cash transfer implementation.
- We compensated retroactive health care payments of the citizens who had been entitled to hold Green Card but had not been able to get it before getting sick.
- Establishment phase of the NMRTs for which training and establishment procedures started in 2003 was concluded.
- We started Reference Price System implementation for medicine.
- We put Health Information Communication Centre (SABİM) into service.
- We launched contract-based employment of health care personnel in deprived areas.



2005

- We enabled 37 million SSK enrollees to benefit from public hospitals by uniting public hospitals under a single roof.
- We enabled the Green Card holders to benefit from public health care services like other insured citizens and we enabled them to take their medicine from any pharmacy.
- We included institutional criteria and quality criteria in performance-based payment system in MoH institutions.
- We started Family Medicine pilot implementation in Düzce province.
- We established Patient Rights unit in every MoH hospital.
- We introduced compulsory public service for physicians.



2006

- We started global budget implementation for MoH hospitals.
- We initiated the enforcement of the Law no. 5502 (Integration of social security institutions).
- The Law on Public Private Partnership (PPP) was adopted by the National Assembly.
- We included measles, mumps and rubella vaccines in routine vaccination program.
- We scaled-up Directly Observed Treatment (DOT) implementation for tuberculosis patients countrywide.
- We started a screening program for Hypothyroid.



2007

- We enabled all citizens to access primary care services free-of-charge.
- We terminated the referral obligation from MoH hospitals to university hospitals for SSK and Bağ-kur enrollees.
- We initiated bundle (fixed) payment based on and ICD – 10 for outpatient and inpatient procedures in all SSI-contracted MoH hospitals, university hospitals and private hospitals.
- We started an implementation for SSI-contracted hospitals including the free supply of medicine and medical equipment (under insurance coverage) and the sanctioning of hospitals receiving payment from patients.
- We took Green Card holders' outpatient expenses for medical examination, test- analysis, medicine, dental extraction, dental prosthesis, eyeglasses and emergency care under the coverage.
- We procured ambulances with snow pallet to provide accessibility in areas with hard winter conditions.
- We started an implementation for SSI-contracted hospitals including the free supply of medicine and medical equipment for hospitalized patients.



2008

- We started providing emergency and intensive care treatments free-of-charge in all public and private hospitals.
- We ensured that no additional payment is taken for the procurement of the following services in private hospitals: Burns, cancer, newborn, tissue transplantation, congenital anomalies, dialysis and CVS procedures.
- We included all population below 18 and students in UHI coverage without seeking social security.
- We enabled every citizen (insured or non-insured) to benefit from free health care services in case of emergencies, epidemics, occupational accidents and occupational diseases.
- We launched air ambulance system.
- We reduced premium payment period to 30 days for SSK and Bağ-Kur enrollees with a view to enabling them to get health service.
- In case of diseases which cannot be treated in Turkey, we provided all insured citizens with the possibility of receiving treatment in foreign countries.
- As MoH, we started planning private health facilities in terms of physicians and certain medical devices.
- We included pentavalent vaccines into routine immunization program.
- The Law on the Prevention and Control of Harmful Effects of Tobacco Products, which prohibits smoking in indoor public places, was adopted by the National Assembly.
- We launched Guest Mother Project in order to welcome future mothers and provide them with healthy delivery conditions in places with transportation problems.
- We launched biotinidase scanning program.
- We started community-based mental health services.
- We launched Health Promotion Program.



2009

- We started PTS pilot implementation.
- We started Central Patient Appointment System (CPAS) pilot implementation.
- We introduced “when the generic of an original product is placed on the market, the price of the product should not exceed 66% of existing product’s price” (for both original and generic products)” rule.
- We started mobile pharmacy implementation to ease the access of people living in rural areas to medicine.
- We added conjugated pneumococcal vaccine to the vaccination program.



2010

- We enabled Green Card holders to benefit from emergency and intensive care services from private hospitals free-of-charge.
- We enabled Green Card holders to benefit from root canal therapy and dental filling free-of-charge.
- We prepared Full-Day Law regarding full-time working of University and healthcare personnel.
- We started to provide home-care.
- We scaled-up PTS implementation countrywide.
- We scaled-up Family Medicine implementation countrywide.
- We started studies on reducing bureaucracy and administrative simplification.
- We included ambulance planes in air ambulance group.



2011

- We have restructured the Ministry of Health. In this scope, we have issued the decree on Organisations and Duties of the Ministry of Health and the Associated Institutions.
- We made the prospectuses simpler and more comprehensible for the citizens to understand all types of information about all drugs.
- We rolled out the Central Hospital Appointment System (CHAS) across the country. Moreover, we made it possible to get an online appointment from CHAS via internet.
- We initiated the “White Code System” to prevent violence against health professionals.
- We made regulations on promotion and information activities to be carried out by the private health institutions.
- We specified the conformity criteria for composite tissue transplantation.
- We started to implement the “Cardiovascular Diseases Prevention and Control Programme of Turkey.”
- We published the “Mental Health National Action Plan” covering the period between 2011-2023.
- We provided smoking cessation medications free-of-charge to our citizens in Smoking Cessation Centres.



HEALTH TRANSFORMATION CONTINUES



1. Towards New Horizons

- We are establishing **gigantic provincial hospitals**. We will roll out the provincial hospitals with the aim of improving service quality and establish health service balance in a cost-effective way.
- We have established the Public **Hospital Unions**. Thanks to them, our hospitals will be managed with further effectiveness, quality and efficiency. We are based on decentralized management model. We have introduced contracting and performance criteria for managers. We have preserved the existing rights of employees.
- We have introduced incentives for the production of medical products and services. So, we aim to strengthen R & D and cooperation in technology. We will develop **off-set practices** in this context.
- We are establishing **Free Health Zones**. Turkey will become an attractive center for health. We will accelerate the inflow of foreign capital and high-tech medical technology into the country.
- We will empower **health tourism** in Turkey. Turkey will become a center for health across Europe, Middle East, Africa, Central Asia and Russia. The revenues to be collected from health tourism are exempted from taxation. We have established an international hot line for patient counseling and our operators can speak four languages. We have established health units in accommodation facilities.
- We will increase **health human resources**. In cooperation with the HEC, we have doubled the student quota in medical schools and have tripled the student quota in nursing schools.
- We will improve **clinical quality**. We are improving the clinical quality standards. In June 2013, we will have started to make clinical quality at all hospitals pertaining to diabetes, knee prosthesis and pregnancy/delivery. We will disseminate clinical guidelines.
- We will strengthen **the role of individuals so that they actively participate in decisions related to their own health**.
- Our fight against **obesity and physical inactivity** will continue.
- We do not and will not tolerate **violence in health care services**. We have taken a number of measures for this purpose. We will not ignore or tolerate any negative attitudes towards our devoted health care personnel.



2. Ministry of Health Strategic Plan (2013-2017)

Our Vision

A TURKEY where healthy lifestyles are embraced and everyone can easily exercise their right to health.

Our Mission

To maximise the protection of individual and community health with a human-centered approach and to offer timely, appropriate and effective solutions to health problems.

Fundamental Principles and Values

- Human - centred
- Universality
- Equity
- Participation
- Solidarity
- Reputability
- Work Ethics
- Transparency
- Accountability
- Sustainability
- Evidence-based
- Quality and Efficiency
- Innovation in Health

ULTIMATE GOAL

To protect and improve the health of our people in an equitable manner



Strategic Goal 1

To protect the individual and the community from health risks and foster healthy life styles.

Objectives

- S.O. 1 To develop healthy dietary habits, increase the level of physical activity and to reduce obesity
- S.O. 2 To sustain the fight against tobacco and to reduce the exposure to tobacco and the use of addictive substances
- S.O. 3 To develop health literacy to increase individuals' responsibility for their health
- S.O. 4 To raise awareness of reproductive health and encourage healthy behaviors
- S.O. 5 To reduce the impact on health of public health emergencies and disasters
- S.O. 6 To protect and promote the health and well-being of employees by improving occupational health
- S.O. 7 To mitigate the negative impact on health of environmental hazards
- S.O. 8 To carry out effective actions on social determinants of health by mainstreaming health in all policies
- S.O. 9 To combat and monitor communicable diseases and risk factors
- S.O. 10 To reduce and monitor the incidence of non-communicable disease and risk factors



Strategic Goal 2

To provide accessible, appropriate, effective, and efficient health services to individuals and the community.

Objectives

- S.O. 1** To improve the quality and safety of health services
- S.O.2** To protect and improve maternal, child, and adolescent health
- S.O.3** To ensure the effective utilization of preventive and essential health services
- S.O.4** To sustain appropriate and timely access to emergency care services
- S.O.5** To improve the integration and continuity of care by strengthening the role of primary healthcare
- S.O.6** To control and reduce complications of non-communicable diseases
- S.O.7** To strengthen the regulations of traditional, complementary and alternative medical practices to ensure their effectiveness and safety
- S.O.8** To continue to improve the distribution, competences, and motivation of human resources for health, and to ensure the sustainability of human resources for health
- S.O.9** To improve the capacity, quality and distribution of the health infrastructure and technologies and to ensure their sustainability
- S.O.10** To ensure accessibility, safety, efficacy and rational use of drugs, biological products, and medical devices, and the safety of cosmetic products
- S.O.11** To enhance the health information systems for monitoring and evaluation of, and evidence-based decision-making for the health service delivery system



Strategic Goal 3

To respond to the health needs and expectations of individuals based on a human centred and holistic approach.

Objectives

- S.O. 1** To strengthen the role of individuals in order to ensure their active participation in decisions regarding their healthcare
- S.O.2** To better meet the needs of individuals with special needs due to their physical, mental, social, or economic conditions by ensuring easier access to appropriate health services
- S.O.3** To contribute to ensuring equity in the financing of health services and protection of individuals from financial risks
- S.O.4** To increase the satisfaction of individuals with their health services and that of health workers with their working conditions

Strategic Goal 4

To continue to develop the health sector as a means to contributing to the economic and social development of Turkey and to global health.

Objectives

- S.O. 1** To maintain the financial sustainability of the health system without compromising service quality through the implementation of evidence-based policies
- S.O.2** To monitor health system performance and to document its contribution to health and the national economy
- S.O.3** To promote research, development and innovation in priority fields of the health sector
- S.O.4** To foster the contribution of the health sector to the economy
- S.O.5** To strengthen health tourism in Turkey
- S.O.6** To be among the leaders in the development and implementation of global and regional health policies
- S.O.7** To contribute to global health through cooperation and development aid



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