Health Transformation Program in Turkey

and

Primary Health Care Services

November 2002-2008

(In Celebration of the 30th year of the Declaration of Alma-Ata)

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THE MINISTRY OF HEALTH OF TURKEY

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Foreword

Recep Tayyip Erdoğan
Prime Minister

When we came to office as the government, we clearly stated the special importance we attach to healthcare services in the Urgent Action Plan, in which we announced our priority objectives. We have put forward our sincerity in our actions so far, and we have executed our services with this consciousness.

In the last 6 years, we have proudly implemented many actions under the name of Health Transformation Program, and while implementing those actions, we have always indicated that we care about our citizens, their health and welfare. We have aimed at solving the problems of our citizens who are seeking cure for themselves or for their relatives, in terms of access to healthcare services one by one but in full.

Our first priority was the citizens who had difficulties in using healthcare services because of financial problems or who had difficulties in paying for the services they received.

We eliminated the shameful incidents of becoming hostages at the hospitals which upset us all and offended many citizens. The news stories covering this topic are now in the archives as historical documents of lesson.

We opened the doors of all public healthcare institutions to our citizens who could not benefit enough from all healthcare institutions or services because of

health insurance differences without making any discrimination. We eliminated the queues for medicine supply by putting the private pharmacies into the service to all citizens. Thus, queues waiting for medicine have become history.

We increased the facilities of public hospitals and paved the way for providing faster and more qualified healthcare services for our citizens. We cleansed the health institutions from the scenes not consistent with.

We provided free iron and vitamin D supplements so that our children can start a healthy life for a better future. We added the vaccines which are offered for a fee even in the developed countries into our routine free vaccination table.

We developed follow-up programs so that our mothers-to-be can have a healthy pregnancy period and give birth to healthy babies.

We united the health insurances through the Social Security Reform. Thus, by eliminating the classification practice in the healthcare service delivery to our citizens, we made sure that all citizens received first class service.

We took all our children below the age of 18 under the coverage of universal health insurance and considered it a social state duty to tackle with their health problems irrespective of whether their families have health insurance.

We have launched the Family Medicine implementation, which are already included in the programs of many governments for years and we have ensured that the citizens have their own physicians that they entrusted them with their health.

We have expanded the 112 Emergency Ambulance Services to the villages and thus supplied even the remotest places with emergency service network. We eliminated the climatic and geographical barriers with the helicopters and snow ambulances with pallets.

Knowing that our citizens deserve the best, we never think the current situation is sufficient. We will always continue to see it as a duty to deliver all the modern healthcare services to our citizens.

As the heirs of a past with the understanding of dignifying the state by dignifying the citizens, we will keep our promise for continuing service.

On this opportunity I would like to express my gratitude on behalf of my people to everyone who has contributed to the delivery of qualified, effective and easily accessible health services that our people deserve, and I wish a healthier and happier future for all my citizens.

Introduction

Prof. Dr. Recep Akdağ
Minister of Health

According to World Health Organization (WHO), the health system of a country should be designed in a way to ensure the delivery of high quality health 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 system taking those factors into consideration.

However this uniqueness does not necessarily mean making concession from the universal principles. Since health is an inherent right, the health services should be organized to ensure equal access for all. In line with the principles of justice and equity, health insurance should be provided for all; distinctions such as gender, social status or social class should not hinder benefiting from health services; health services should be easily accessible; and the health services provided should be modern and effective.

The problems encountered in the health system inevitably have negative impacts on the whole health sector and on the health status and happiness of the society. The current situation of the Turkish health system makes it necessary to make fundamental changes in many areas including service delivery, financing, human resources and information system. However it should be noted that this requirement is not solely for our country. We can easily say that many countries are working on reforms regarding health service delivery. Efforts for improving health services and health infrastructure and structuring the organization bring together significant changes in health policies.

Thus, we initiated the transformation movement in a decisive manner both in terms of preventive services and curative services in health. The people, who talk about those two concepts, sometimes state that we might neglect one of them and focus on the other. We know that they are inseparable; we have to succeed in both areas. On the one hand, we will give the most modern vaccines of our times to our children and protect them from all preventable diseases and accidents, and on the other hand we will admit the people who come to the hospital with health problems and embrace them with great compassion, meet their needs, and if necessary, we will try to meet their needs at home. Therefore we have to carry out all those services within an integrated logic.

If your aim is to improve the health systems in a country, first of all you need to get the support of that country's political authority, i.e. the president, prime minister and the government. You will have to take into account the financial and social dimensions of the action; and you might even be in a position where you have to oppose many interest groups. In such times you need to have a prime minister, a president, a cabinet and an assembly who stands by you, supports you and encourages you. Otherwise you cannot succeed. As the Minister of Health I have always had this support by me in these 6 years.

There is also another aspect to this which is quite important: We would not have succeeded if the health professionals hadn't believed in the spirit and necessity of this transformation or if they hadn't taken risks or worked with love and extraordinary zeal in this path or hadn't given their support,.

Now we read more, we write more and we have more modern medicines. Although we reach the cases in the shortest time possible, provide service to people without making them wait, give service in the most modern hospitals with the most modern devices, we never forget that the most important thing that we can give to our patients is love. For this reason, we endeavor that our efforts for health under the slogan of "Love is the best medicine" have a place in the hearts of all our citizens. We will show love to our people and they will show love to the health professionals. We will continue this path by looking at each other with compassion and kindness and, respecting the each other's honor.

In 2003, Ministry of Health (MOH) has started to implement the Health Transformation Program, which was prepared based on these fundamental realities. We have prepared this program by getting inspiration from our 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 Republic, we have reviewed the project activities implemented within the Ministry and embraced the positive inheritance of the past.

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. My Ministry has shown its decisiveness for the implementation of this program and reaching the desired point in the field of health, and has put many implementations into practice.

The recent years are full of examples of political, bureaucratic and social decisiveness for turning many policies which have been discussed for years for solving country issues into actions rather than just talking. The period 2003 - 2008 is a very important one in which many significant changes took place in health. In this period our country has witnessed a process in which health policy changes are frequently discussed in public, and the actions taken are explicitly felt by both the service providers and the service receivers.

In this period, the steps easing the lives of our citizens are taken with courage and determination. In this understanding, the hospitals of other public institutions, including the SSK ones, were transferred to the Ministry of Health.

Healthcare services have been provided for all our citizens in the best way possible without making any discriminations or making different implementations. Our citizens have had the chance to go to any hospital they want, including the university hospitals and the private hospitals.

The coverage of green card have been widened for low-income groups; the health services and the pharmaceutical expenses of the green card holders within the scope of “outpatient services” are also now covered by the state.

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

The coverage of social security has increased, and the ratio of out-of-pocket health expenditure to total expenditure has fallen from 30% to 16%.

Now “112 Emergency Health” 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 technologies. Sea and air transportation vehicles are added to snow vehicles. For the “112 Emergency Health”, our target is to reach more than 95% of all calls in 10 minutes in the cities and in 30 minutes in the rural areas. The medical rescue team for disasters, which is the biggest one in Europe, has been established with 2500 specifically-trained health professionals in 81 provinces.

The regions lacking building, equipment or health personnel are accepted as priority areas and the imbalances of this sort have largely been eliminated.

In this period, we focused on completing the health investments rapidly; a total of 1249 health facilities are opened for service including 211 hospitals, 191 hospital outbuildings, 752 health centers. A hundred and eleven thousand new health professionals have been recruited in public sector. In order to make up for the human resources shortage in health sector, collaboration is made with all relevant parties, particularly the universities and thus maximum effort is shown for solving the problems.

Primary healthcare services, including preventive healthcare and mother-child healthcare services, are strengthened and expanded. Family medicine implementation, which is an element of modern health understanding, has been launched. Being a big step for the future, this implementation is successfully carried out within the framework of the project and gradually more and more citizens are benefiting from it.

We have already reached our targets for 2010 in terms of decreasing infant mortality below twenty per mille and maternal mortality below twenty per hundred thousand. Infant mortality dropped from 29 to 17 per mille and maternal mortality dropped from around 70 to 19 per hundred thousand.

Preventing ill-health and premature deaths related to non-communicable diseases has constituted the core of important health programs of our term. In this context, national programs are planned and put into implementation for certain diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory tract diseases, stroke, and kidney failures.

Among our priority targets are eliminating measles; minimizing the hepatitis B carriage; keeping mumps, whooping cough and malaria below 2 per hundred thousand; and reducing the negative results and mortality caused by TB, child pneumonia and diarrhea in order to further advance the success made in terms of protection from communicable diseases.

In 1985, Republic of Turkey has made a big vaccination campaign under the Prime Ministry of late Turgut Özal. I was a general practitioner at the time and became a part of that vaccination campaign with great excitement. For the first time in Turkish history the success rate of a vaccination was over 80%. This meant saving the lives of thousands of children and preventing thousands of children from disability.

Later on, the vaccination ratios continued at those levels. New vaccines could not be added to our vaccination calendar. There were two other important achievements for the vaccination history within the period from the 1980s till the launch of the Health Transformation Program. One of them was the introduction of the Hepatitis B vaccinations and the other was eliminating polio in Turkey.

Today we have got ahead of the European average in all vaccines in terms of ratios. That is, we not only caught up with them but also have surpassed them in terms of increasing vaccine diversity and the vaccine-preventable diseases. While we were vaccinating our dear children with 7 types of vaccines, we have added 4 more vaccines to that in the last 4 years. I would like to explicitly state that all health professionals who are knowledgeable about the subject such as the pediatricians, public health specialists, social pediatricians, infectious diseases specialists, childhood infections specialists, senior Ministry of Health managers, have long desired for Turkey to reach the current point that it attained today in terms of vaccines.

Of course Ministries of Health, before us wanted to perform those vaccinations, but they did not have the chance. Almost 15 million liras was spent for vaccines every year. For 2009 we intend to spend 300 million liras for vaccines. I would like to extend my gratitude to our esteemed Prime Minister, our government and the Ministry of Finance for their support on this. Without their support, we would not have been able to immunize our children with those vaccines. However my highest gratitude is to the health professionals who carry out this program with success and who vaccinate our children at the field. I would like to express my appreciation for the health professionals who reach out even to the remotest places all around Turkey, from Hakkâri to Ardahan, Mardin, Konya, Sinop, Hatay, Denizli, and Edirne, who give vaccination with great enthusiasm, without considering the climatic conditions, by risking themselves, and by fully grasping the vision we set forward. In a country like Turkey, you can show political determination, you can allocate enough resources for the vaccines, and your vision might embrace the matter. However, unless the health professionals working in such geography have full faith in the matter, you cannot achieve the 96% vaccination rates.

After those big steps taken in the combat against communicable diseases we have added the programs for preventing undernourishment and malnutrition in infants and children into our agenda. Today Vitamin D deficiency in children is a very rare case. Likewise iron deficiency has decreased a lot. We have made progress in terms of malnutrition in children. Under those circumstances, our burden of disease (BOD) is gathered in two main groups similar to the developed countries. One of them is the cardiovascular diseases and the other one is the cancers.

It seems that we need to focus especially on those two issues in the next 15 or maybe 30 years. Our emphasis should be not only on the curative services but also on the preventive healthcare services with respect to those two areas.

We have made significant progress in cancer screening in Turkey. We have opened Cancer Screening Early Diagnosis and Training Centers, which are known as KETEM, in all provinces. We will spread out those screenings in the upcoming years especially in the fields of breast cancer, colon cancer and cervical cancer.

We have included the cancer screenings in the reimbursement program. We have taken decisions that will ensure the free treatment of citizens who are diagnosed with cancer, even in private hospitals.

World Cancer Report 2008, published by the World Health Organization, defines Turkey as an "exemplary country" in terms of cancer control strategy. The reason for all those successes is that with the Health Transformation Program, cancer control has become a state policy in terms of raising awareness, screenings and treatments.

We have started to work in order to develop proper strategies for the health of our youth, for ensuring their participation in the society and for protecting them from violence, accidents, and hazardous behaviors such as drugs, tobacco and alcohol consumption. In our country, we carry out tobacco control within the framework of a program which can set a real example for the world. The patron of this Tobacco Control Program is our Prime Minister himself and this has eased our work in terms of action. Of course the Turkish Grand National Assembly's support is of great importance as well. It is very interesting that there is no regular smoker in the cabinet which has 25 members including Mr. Prime Minister. This is very important for giving a clear message to the society.

We have supported this action with the slogans of "Smoke-free Air Zone Project" and "Let's Protect Our Air", which has achieved a great deal of success; and reaching such a big success in such a short period of time was greatly helped by the support our people have provided in this matter. Turkish people has perceived this matter in a perfect way, and contrary to some expectations, they are backing the law and the implementations rather than reacting against it. The implementation is accepted and supported by the majority of the people; even the smokers support it a lot.

Many things have changed in health in the last 6 years with the Health Transformation Program. Turkey's burden of disease does not mainly consist of infectious diseases any longer. Our country is not struggling against malaria, typhoid, measles in children and similar diseases. While there were 28 thousand recorded typhoid cases in 2002, it was only 218 in 2008. Likewise while there were 20-30 thousand measles cases in children in every 2-3 years in Turkey, there was "0" measles case in children last year. The number of malaria cases dropped from 10 thousands to around 100 last year. Along with the health system, Turkey's health profile and burden of diseases are really changing a great deal now.

There are different dimensions to the protection of public health. The first one can be addressed within the scope of the tasks directly under the responsibility of the Ministry of Health, the health professionals, i.e. the health sector. You can even broaden this area and you can invite all sectors that affect the social determinants related to health into the responsibility area. The other important

dimension is individuals' awareness and protection of their own health. Unless the individual changes his lifestyle, it is not possible to protect him from the important public health threats. Of course Ministry of Health and the health sector again have significant tasks to undertake in this matter. Within the framework of the western concept of health promotion, which is translated into Turkish as "sağlığın geliştirilmesi", it is necessary to inform the society, educate people, and make them health-literate. It is compulsory to raise awareness in each individual so that he/she changes his/her lifestyle to become healthy.

The actions are widespread and very effective, and this is an indication of what will and can be done from now on. Therefore people who demand better healthcare services now have trust in and expectations from us. It is necessary to meet those expectations by completing the services that we have initiated and by making new advances. In this way, the aims of Health Transformation Program will come closer.

First Part

Our Health Policies from Past to the Present

First
Part

Our Health Policies from Past to the Present

Besides the continuity of the Seljuk – Ottoman medical tradition, a cultural unity stands out in the organization of the health services. While that structure was developed with the foundation of our Republic, a western-oriented path was mostly followed for the organization of the state including all its institutions and the formation of service policies. Within this process, health policies demonstrated basic preference changes related with the trends in the world.

Health Policies between 1920-1923

The Ministry of Health (MOH) was established by the Law No: 3 and dated 3 May 1920. 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 recovering from the damages of the war and on developing legislation.

Health Policies between 1923-1946

During his ministry beginning from the foundation of the Republic until the year 1937, Dr. Refik Saydam made great contributions in the establishment and development of the health services in Turkey. In 1923, health 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 our country.

In this period,

the following Laws, inter alia, which are still in effect, have been adopted:

- Law No: 1219 on the Practice of Medicine and its Branches (1928)
- Law No: 1593 on General Hygiene (1930)

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

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

Under the light of these principles;

- The health services have been conducted with "single purpose service in a wide area/ vertical organization" model
- "Preventive medicine" concept has been developed through legal regulations, the local administrations were promoted to open hospitals, offices of government doctor
- Diagnosis and treatment centers have been established in district centers beginning with the places with high population (150 district centers in 1924 and 20 district centers in 1936), the salaries of the physicians working in preventive healthcare services were increased but they were banned from working in private practice.
- As a guide for the cities, Ankara, Diyarbakır, Erzurum, Sivas Numune Hospitals were opened in 1924; Haydarpaşa Numune Hospital was opened in 1936. In the following years the number of Numune Hospitals was increased to 7 with the Trabzon and Adana Numune Hospitals.

Health Policies between the Years 1946 - 1960

"First Ten-Year National Health Plan" which we will call the first health plan of the Republic 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 December 12, 1946. However, before this work became a law, Behçet Uz had to quit his office as the Minister of Health.

When Dr. Behçet Uz became the Minister of Health 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 Grand National Assembly, however it could not become a law due to the change in the government.

Although National Health Plan and the National Health Program could not be turned into a legal text or implemented as a whole, majority of their notions 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 the villagers, envisaged to establish a ten-bed health center for each 40 villages and to provide the curative medicine and the preventive healthcare services together. Efforts were made to assign 2 physicians, a health official, a midwife and a visiting nurse to those centers along with a village midwife and village health officers who would work with the groups of ten villages. In 1945, there were 8 health centers, this increased to 22 in 1950 and to 181 in 1955 and to 283 in 1960.

Under the Ministry of Health, the Division Directorate of Mother and Child Health was established in 1952. A Mother and Child Health Development Center was established in Ankara in 1953 by providing collaboration and assistance from international organizations such as UNICEF and World Health Organization.

In that period, there was high mortality in terms of children and due to infections and 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 announced by Dr. Behçet Uz in December 8, 1954 and 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 the organization for our country.

National Health Plan categorized the country into seven health regions, and considered establishing a faculty 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 (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's Faculty of Medicine was opened for student admissions in 1955 after Istanbul and Ankara Universities Faculties 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 1.658, midwives from 1.285 to 3.219. More than a 100% increase was ensured for all 3 occupations.

The number of hospitals and health centers was also increased as well as the number of beds. Among the special service delivery fields, the increase in the numbers of paediatric hospitals, maternal hospitals 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. There were 9 beds per a hundred thousand people in 1950 whereas this ratio became 16.6 in 1960,

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

Tuberculosis related mortality had a significant decrease in this period. While the morality rate caused by tuberculosis in city and district centers in Turkey in 1946 was 150 per a hundred thousand, this was down to 52 per a hundred thousand in 1960.

There was also a similar positive change in infant mortality rate. Infant mortality rate was 233 per mille in 1950 and this came down to 176 per mille in 1960.

Both the National Health Plan and the 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 this bank, 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, Biological Control Laboratory was established in 1947 under the Refik Saydam Hygiene Center Presidency and a vaccine station entered into service. From that year onwards, intra-dermal BCG vaccine has been produced. Pertussis vaccine was started to be produced in our country in 1948.

Again in the same framework, Workers' Insurances Administration (SSK Social Insurances Agency) was established (1946). Starting from 1952, health institutions and hospitals were opened for the insured workers.

In this period, the legislation was also formed which carry the legal infrastructures of the non-governmental organizations and some medical occupations to present day:

Law on the Turkish Medical Association (1953/6023)

Law on Pharmacists and Pharmacies (1953/6197)

Law on Nursing (1954/6283)

Law on Turkish Association of Pharmacists (1956/6643)

Health Policies between the Years 1960-1980

The Law No.224 on the Socialization of the Health Services was adopted in 1961. The socialization in health actually began in 1963 and became widespread in the country in 1983. A structure was established as health posts, health centers, and province and district hospitals through a widespread, continuous, integrated, and gradual approach.

Law No: 554 on Population Planning was adopted in 1965 and thereby, anti-natalist policy (population control) was adopted instead of pro-natalist (population rising) policy.

"Multi dimensional service in narrow area" approach was adopted as an alternative to the "single dimensional service in wide area".

Although a draft law on general health insurance was prepared in 1967, it could not be forwarded to the Council of Ministers. In the 2nd Five Year Development Plan in 1969, the initiation of the General Health Insurance was anticipated again. Draft Law on General Health Insurance was forwarded to the Parliament in 1971 but it did not become a law. In 1974, the draft which was presented to the Parliament was not discussed.

In 1978, the Law on the Principles of Health Personnel's Full Time Working was adopted and the doctors in public sector were prohibited from establishing private practices. Then, this Law was repealed with the Law on the Amends and Working Principles of the Health Personnel in 1980 and public doctors were permitted to open private practices again.

Health Policies between the Years 1980 – 2002

The 1982 Constitution ensures citizens to have social security rights and the State to assume the implementation of this right. According to the 60th Article of the Constitution, everyone has the right to social security and the State shall take the necessary actions 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 productivity, the State shall regulate central planning and functioning of the health services. The State shall fulfill this task by utilizing and supervising the healthcare and social institutions, in both the public and private sectors". Besides, the article includes the provision "General Health Insurance may be introduced by law."

In our Constitution, the third section titled as Social and Economic Rights and Duties has a subtitle as the Protection of Family, and its 41st article says that "Family is the foundation of the Turkish society. The State takes the necessary actions and builds the organization in order to ensure the protection of the peace and welfare of the family and especially of the mother and the children, and the teaching and implementation of family planning".

The second law regarding the family planning services is Law No:2827, which has been put into implementation in 1983, has expanded the scope and limitation of the family planning services in line with the said article of the Constitution. The Law No.2827 defines family planning (under the name of population planning as per the name of the Law) as "free decision of the number and time of having children".

The third article of the Law says "…For this purpose, Ministry of Health and Social Assistance is authorized to establish a special organization, to supply or manufacture contraceptive pharmaceuticals and devices or have them supplied, to provide those pharmaceuticals and devices for the poor for free or with a below cost price to have them given or sold". In addition, the 4th and the 5th articles of the Law permit the voluntary surgical sterilization in men and women and optional abortion will within the first 10 weeks of the pregnancy.

"Basic Law on Health 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 could not have been put into effect in full.

In 1990 the State Planning Organization (SPO) prepared a basic plan on the health sector. This "Master Plan Study on Health Sector" which was conducted by the Ministry of Health and SPO is the beginning of the health reforms in a way.

The first and the second National Conference on Health were held and the theoretical studies on health reform gained acceleration. Green card implementation has been introduced in 1992 with the Law no. 3816 for the low income citizens who are not covered by social security scheme. The effort was aiming at including the needy part of the society in the health insurance even limitedly.

"The National Health Policy" which was prepared by MOH in 1993 included 5 main chapters as the support, environmental health, lifestyle, provision of health services and the goals for a healthy Turkey.

Universal health insurance was presented to the Parliament by the Council of Ministers under the name "the Law on Personal Health Insurance System and the Establishment and Operation of the Health Insurance Institution" in 1998 but it did not become a law. A Draft Law on the "Health Fund" was presented for the opinion of the ministries however it was not concluded either.

The main components of the Health Reform which was conducted in 1990's were:

1. Establishment of a universal health insurance by gathering the social security institutions under one umbrella,
2. Development of the primary health care services in the framework of family medicine,
3. Transformation of the hospitals into autonomous health facilities,
4. Providing a structure to the Ministry of Health which plans and supervises the health services prioritizing preventive health services.

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

Health Policies after 2003: Turkey's Health Transformation Program

Right after the elections on 3 November 2002, the basic objectives to be conducted under the title of "Health for All" were determined in the Urgent Action Plan of the 58th Government, which was declared on 16 November 2002.

The key objectives are:

1. Administrative and functional restructuring of the Ministry of Health,
2. Covering all the citizens by the universal health insurance,
3. Gathering the health institutions under one umbrella,
4. Providing the hospitals with an autonomous structure administratively and financially, 5. Introduction of the implementation of family medicine,
6. Giving special importance to mother and child healthcare,
7. Generalizing the preventive medicine,
8. Promoting the private sector to make investment in the field of health,
9. Devolution of the authorities to the lower echelons in all public institutions,
10. Eliminating the lack of health personnel in the areas which have priority in development,
11. Implementing the e-transformation in the field of health.

Right after the determination of the Urgent Action Plan, the Health Transformation Program was prepared and announced to the public by the Ministry of Health. The Health Transformation Program aims transformation in the framework of 8 themes:

1. Ministry of Health as the planner and supervisor,
2. Universal health insurance gathering everyone under single umbrella,
3. Widespread, easily accessible and friendly health service system,
    a. Strengthened primary health care services and family medicine,
    b. Efficient and gradual referral chain,
    c. Health facilities having administrative and financial autonomy,
4. Health manpower equipped with knowledge and skills and, working with high motivation,
5. Education and science institutions to support the system,
6. Quality and accreditation for qualified and efficient health services,
7. Institutional structuring in the rational management of medicine and supplies,
8. Access to effective information at decision making process: health information system.

The period between the years 2003-2008 has witnessed important changes. The program which was prepared and announced at the beginning of 2003 was inspired by our former experiences, health reform studies of the recent years and the successful examples in the world.

Each step taken in the field of health from the foundation of our Republic until today has been evaluated. The project studies conducted under the Ministry of Health has been examined and the positive heritage of the past has been embraced.

Within the last few years in which the Health Transformation has been implemented, Turkey has witnessed a period wherein the health policy changes was discussed by the public opinion and the progress of implementations is noticed by the service users as well as the service providers.

The matters subject to public displeasure have changed. Now, the patient safety or patient satisfaction is being discussed rather than queues or access to health services.

The scoop of social security and Universal Health Insurance are the main issues today, not the unreleased patients who could not afford to pay. Likewise, as there is no more a problem in the emergency patients' transportation, we are no able to discuss what will be the adequate number and how to further develop the quality of the intensive care beds.

Instead of low numbers in vaccination rates, addition of new vaccines in the calendar has come up in the agenda.

While health personnel used to suffer because of their low income, now they are in a position following up their continuous income.

From the private sector to the public sector, from the poorest to the richest, the determined steps taken in the field of health have taken their places in the lives of our citizens.

After the establishment of the 60th Government in 2007, 3 new topics have been added into the Health Transformation Program in the light of the experiences within the 5 years and the successful steps we have taken:

1. Health promotion for a better future and healthy life programs,
2. Multi-dimensional health accountability for mobilizing the parties and inter-sectoral collaboration,
3. Cross-border health services which will increase the country's power in the international arena.

Second Part

Primary Health Care Movement from Alma-Ata to the Present Day

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Introduction

World Health Report 2008 focuses on primary health care services. On the occasion of the 30th anniversary of the Alma-Ata Conference, the World Health Organization (WHO) held a conference again and introduced the report on 15-16 October 2008 in the same city, which is called Almaty today. The Ministry of Health was represented in the meeting by three high-ranking managers, whom were assigned by the Ministry. During the meeting, I had the opportunity to learn about very interesting experiences of Professor Torageldy Sharmanov and Professor Venediktov – Assistant Deputy Minister of Health of Russia, both of whom played active roles in the Alma-Ata conference and whom I shared the floor with as a panelist. Being the Minister of Health of Kazakhstan in 1978, Sharmanov was among the key players of the meeting organization. Sharmanov is also the author of the book "Almaty, Turning Point of the World Health System", which the WHO published and disseminated to participants in this conference. Together with the introduction of the World Health Report, the conference focused on the rise and development of primary care understanding, which was also the core of the report, as well as how it is interpreted or how it should be interpreted today.

In her addresses for the introduction of the WHO Health Report 2008, Director General Dr. Margaret Chan gives a brief summary of the picture of health in today's world: "This year (2008) marks both the 60th birthday of the WHO and the 30th anniversary of the Declaration of Alma-Ata on Primary Health Care in

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1978. While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remained true. Yet, despite enormous progress in health globally, our collective failures to deliver in line with these values are painfully obvious and deserve our greatest attention. We see a mother suffering complications of labor without access to qualified support, a child missing out on essential vaccinations, an inner-city slum dweller living in squalor. We see the absence of protection for pedestrians alongside traffic-laden roads and highways, and the impoverishment arising from direct payment for care because of a lack of health insurance. Those realities and many other everyday facts of life personify the unacceptable and avoidable shortfalls in the performance of our health systems" [1].

On this occasion, I would like to talk about the rise of primary care services, historical development, the Alma-Ata process and changes that have occurred in health understanding in the light of the experience that has been gained so far. Putting primary health care in the hard core of the World Health Report 2008 on the occasion of the 30th anniversary of the Alma-Ata Conference, the WHO pointed out the significance of primary health care. In addition to this, health systems strengthening to guarantee health promotion has been brought to the higher ranks of the WHO Regional Office for Europe agenda in recent years. Not only the Tallinn Conference that I attended but also the Regional Conference in Tbilisi and many other references all aimed to draw attention to the issue by emphasizing the concepts of "re-visiting to primary health care services" or "re-vitalising" [2, 3, 4].

In this point, it could be helpful to touch on the expression of "primary health care" in terms of semantics. "Primary health care", which is an expression in English, has been translated into our language as "temel sağlık hizmetleri". Considering the meaning of words, the expression of "temel sağlık hizmetleri", which refers to "primary, basic or fundamental health care services", also substitutes the expression of "birinci basamak sağlık hizmetleri", which are "primary care services" in English. Again, some resources make a distinction between primary care and primary health care. As obvious, we have not managed to do away with confusion in a concept, which lays the foundation for such a significant policy. The need for discussing about nuances and using different expressions, in fact, originate from the concern to separate the model of limited service delivery from the understanding of an overall system that focuses on reaching the objective of health for all. The objective of health for all could be achieved by providing everybody with access to health care services. The most important instrument, in this sense, is widespread and integrated primary care services that could come closer to individuals. However, considering primary care services as a model isolated from the system would not help to meet the primary health care objective. From time to time, such misinterpretation may also degrade primary health care services. Therefore, distinction between the expressions of "primary health care services" and "primary care services" in Turkish language further clarifies the issue than it is interpreted in English language. However, one cannot claim that such verbal distinction also applies to conceptualization, which facilitates better analysis of the issue.

Global Movements towards Primary Health Care Services

Although the past century staged more than one world war, it also staged the efforts of countries to come together under a single roof and take joint actions in some basic issues perhaps due to the terrific results of these wars. Although the WHO, being an organ of the United Nations Organization, took a significant initiative, the efforts made for health did not manage to roll out to national levels first and to individual levels then. Considering the process, one can not claim that health of individuals was protected and countries were satisfied with health care services. Economic bottlenecks, wars, pandemics and non-transparent governance – perhaps the most important factor- put big obstacles on the path towards improving health status of countries. It cannot be considered that the problem is solved in the former colonies, either. When the countries in Asia, Africa and Latin America declared independence in 19502s and 1960's, a new era in health care services emerged there in line with the WHO understanding. Although no universal description has been made yet, the understanding of Primary Health Care Services, which could be summarized by the slogan of "health for all", has been respected in a number countries.

Despite the fact that different various perceptions and various opportunities and understanding of countries lead to variations in implementation, which is very natural, this issue has a significant place in the agenda of countries regardless of they are wealthy or poor. Although it might have been controversial and hesitant at the beginning, the countries with better economic status started to review the attitudes towards general practitioners as the understanding was improved. New residency fields were created for primary health care services (such as family medicine, community medicine, general practice) and professional organizations were built for general practitioners [5].

Although many countries in the Western world tried to organize health care services in a generalized and integrated way, the United Kingdom proved to be the only country, which managed to facilitate the access to primary health care services in large extent. In 1946, the National Health System (NHS) law was adopted in the United Kingdom. The system is still running with some amendments and updates. Although one could allege a great many strengths and weaknesses in the United Kingdom's National Health System, the system is regarded important in that it has not fully managed to fill the gap between treatment and prevention yet [5]

Differently from the United Kingdom, some other countries such as Sweden, France and Germany started to develop health insurance principle-based primary health care services organizations (1959- 1981). In Canada, free access was provided to public services through public health insurance (1962-1970).

In the former USSR, a system was developed, which was based on outpatient and dispensary services. Mr. N. Semashko, Public Commissary of Health Care Services, and Mr. Z. Soloviev, Chairman of the Health Committee of the Red Army, made a visit to the European countries in 1920 and transferred into their country the knowledge and experience that they obtained from the experts in the UK and Germany. Subsequently, a kind of structuring was launched in primary health care services, which targeted general access [5].

In Turkey, on the other hand, the Law on the Socialization of Health Care Services Numbered 224 was enacted on 12.01.1961. The rationale of this law points out to the successive effect in that process: "Socialized medicine, in full terms, is applicable in the United Kingdom and the Soviet Russia, where a general practitioner is allocated per a few thousands population. The cases, which cannot be cured by these general practitioners, are referred to hospitals. Physicians are obliged to examine and treat the patients in their registries with any charges" [6].

Indeed, we know that efforts were launched in Turkey for integrating and rolling out health care services in the same year, when the UN General Assembly declared the WHO Constitution. The National Health Plan, which was prepared by Dr. Behçet Uz, the Minister of Health at that time, was a major step taken to this end. Although the plan was not implemented in legal terms, mobilization was launched to roll out health centers and their services. The plan, for the purpose of ensuring fairness, targeted to develop adequate number of health zones in the country. Therefore, it would not be so pretentious to underline that the actions take in that period laid the basis for socialization [7].

Development of the World Health Organization and the Understanding of Primary Health Care Services

After the World War II, an idea emerged to build a new structure in health under the shelter of the United Nations. In an international conference, which was held by 51 countries in New York in 1946, the WHO constitution was declared. The constitution, for the first time in the world history, respected health as a fundamental human right regardless of race, religion, and political view, economic and social status. The WHO constitution held governments responsible for the health of their citizens and such responsibility required regulations in social and health sectors. After 2 year's time, the constitution was approved by 26 countries and put into implementation on 07 April 1948. The date, which is the birth date of the World Health Organization, is celebrated as the "World Health Day" every year.

In the same year, the United Nations General Assembly adopted the Universal Declaration of Human Rights, which aimed to protect citizens from ruling powers, dictators and governments. It was just like a memorandum, which instructed ruling powers what to do or not to do to protect the rights of their citizens. In fact,

the primary difference between the fundamental human right described in the Universal Declaration of Human Rights and the understanding of primary health care right laid out in the Alma-Ata Declaration is that the latter does not only make a warning to the states but also enforces them to guarantee this right. So, putting health in the hard core of the issue, the idea and concept of "right" was unified with the understanding of liability and was assigned as a primary task of governments by the Alma-Ata Declaration.

Studies conducted by a specific study group, which was established by the Executive Board, were the turning point of primary health care services in the WHO history. The report produced by the group, which conducted studies in 1971-1973, presented a methodological description of primary health care services for the first time. According to the description in the report, primary health care services were the general health care services, which a society came across when it demanded health aid for the first time. Also, they refer to the first contact point within a health care system, which the individuals asking for health care services come across first. Primary health care services address not only patients but also a society in good health [5].

Following these actions, the WHO started to develop primary health care service programs in 1974. However, these programs, details of which could be found in the report submitted to the LV. Executive Board, were about supporting the poor countries that were developing. The program did not offer anything remarkable about the roles of physicians and nurses, and the place of hospitals and health personnel training. The program rather focused on providing the community with primary health care services by means of local healers.

Under the description of "primary health care service employees" in the book titled People for Health published by WHO, the local healers, who took courses for 3 to 4 months, and voluntary health officers were regarded as if they were physicians, and traditional midwives, healers and traditional medicine were overdrawn.

Representatives of developed countries claimed that such kind of services were necessary for developing countries. However, it was found out that the efforts for formulating the concept of primary health care services and even developed countries did not manage to solve the problems during preparations for the Alma-Ata conference.

In the LV. Meeting of the WHO Executive Board in 1975, participants voiced the opinion that primary health care services, in close relation with social and economic development, had to be accepted as a part of the national health care system. Primary health care services could be successful only when they were given by teams, which consisted of a physician, a nurse and other health personnel trained in various fields. So, the Executive Board adopted the historical draft resolution: "Primary health care services at national level should be prioritized as a part of the comprehensive medical service system. The system is comprised of

preventive, curative and rehabilitative services covering entire population in all countries."

In the XXVIIIth session of the World Health Assembly in May 1975, the understanding of primary health care services was supported. The draft resolution adopted pointed out to the fact that primary health care services were a complementary part of the national health care systems in countries and they had to be fully integrated with other sectors in a society. It was decided to hold an international conference under the WHO leadership in the soonest time possible. The conference aimed to facilitate countries to share their experience in primary health care services, which were a part of their national health care systems. Also, in the XXIXth and XXXth sessions, it was proposed to hold various meetings and conferences in various regions of the world.

WHO Eastern Mediterranean Regional meeting was held in November 1976 in Tehran. In October 1977, the WHO, UNICEF, UNDP and the World Federation of Public Health held a joint meeting. In January 1978, a regional seminar was organized, too. WHO Regional Office for Africa organized a series of seminars and conferences in the member states. In May 1977, draft papers of the Alma-Ata Conference were reviewed in the European Region Program Committee meeting. In September 1977, African Conference of Ministers of Health was held upon the proposal of the Pan American Health Organization and the continent's approach towards the Alma-Ata Conference was discussed. Following a series of workshops held in the member states of the WHO Regional Office for Southern Asia, a joint meeting was conducted with the UNICEF in November 1977 and the member states exchanged views on primary health care services.

1977 was marked as a year, in which a number of countries held a great many national meetings on the issue. Some countries started to implement primary health care service programs, which focused on personnel training, particularly.

In December 1977, an international conference was held in New York to discuss the problems of primary health care services in developed countries. In the meeting, it was articulated that such problems were not only peculiar to developing countries but also to the industrialized ones. The World Public Health Association, together with the Canadian Public Health Association, held a congress in May 1978. Documents were produced in the congress on the role and participation of non-governmental organizations in the implementation of primary health care service programs.

In the XXXIst session of the World Health Assembly, the WHO and UNICEF authenticated the joint report on primary health care services. The report served as a preparation for the Alma-Ata conference for the understanding of primary health care services and practice.

Alma-Ata Conference and the Understanding of Primary Health Care Services

Alma-Ata Conference was held on 10 -12 September 1978 in Alma-Ata province, which was the capital city of Kazakhstan at that time. Of all participants, 70 countries were represented in the conference by their health ministers, while the other 40 were represented by either education or agriculture ministers [8]. Turkey was represented in the conference by a committee headed by the Minister of Health and Social Aid at that time. The main theme of the conference was "Health for all in 2000". At the end of the conference, a declaration was issued, which put a light on handling national health organizations as integrated systems within national borders and regarded primary health care services as a part of the national health care systems. According to the description made in the Alma-Ata declaration, "primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation; it forms an integral part both of the country's health system and social and economic development of the country"[8].

Yet, one should not assume that it was easy to reach consensus on the Alma-Ata message. In addition to some European journals such as Lancet, Nature, Observer and Le, also a great many American journals published articles for atrocious propaganda. For example, an article by R. Passimore, which was

published in the Lancet in 1979, claimed that the concept of primary health care services, which was expected to raise health status of individuals to an acceptable level by the year 2000, was nothing but a utopia. According to Passimore, such acknowledgement was controversial with human nature and his biologic role, which we knew really well. Therefore, some considered that the Alma-Ata Conference produced just doubtful and illusory expectations. It was regrettable that the WHO was perceived as an instrument to all these. On the other hand, A. Argaval from the Nature claimed that the international resolution put the WHO in a bottleneck. A commentary in the Lancet, very similarly, stated that declaring health as a major human right was irrational. Humanity was not powerful enough to provide health for all. Why would the number of desperate people be raised by unrealistic expectations when there were already many desperate people? It was a final objective to ensure optimal health status for all individuals but it was not a right, which the government had to warranty [5].

Under the shadow of such debates in the academic arena, the final report, which was submitted by H. Mahler, the WHO Director General, in the XXXIInd World Health Assembly, had quite ambitious statements: "The Alma-Ata Declaration is called the Major Health Charter of the twentieth century. The charter is the starting point of an international action, which will guarantee the objective of health for all by the year 2000. The Alma-Ata Declaration does not only draw up a Jesus dream but also lays out very clear terms to make this dream come true" [5].

In fact, the objective of "health for all", similarly to the concept of "primary health care", needs to be further clarified because unclear understanding leads to debates and cliques, which might even result in the opposition to the idea itself. As expressed by Sharmanov, if the word "primary" refers to the expectation that all people in the world will have reached the same health status, no more births with congenital anomalies occur, no one will remain ill, and no traumas and injuries will be noted in the next 20 years, such expectation is certainly a true fantasy because it does not comply with human nature. For this reason, discussions on the original expression could be regarded reasonable. We do know that the goal is to bring individuals up to an acceptable health level by ensuring equal distribution of services by the year 2000. Perhaps, the goal might have been identified as at least providing health and care services on minimum level, which was to be acceptable to service providers and users (5). Yet, generalizing services would not mean sharing opportunities and risks equally. Therefore, all countries are recommended to tailor this approach for their own needs and circumstances.

The Alma-Ata Conference launched "Primary Health Care Movement" by various professional groups, organizations, governments, non-governmental

organizations and researchers to fight with health inequities in all countries, which are acceptable by no means, in political, social and economic aspects. The action was based on the principle of "health for all". The values proposed by the Alma-Ata Declaration were quite clear: the right to reach a better health status for everybody, social justice, participation and solidarity. Radical changes were required to alter the way that health systems were running and other factors' probability to create adverse effects on health. It was not easy to transform the demand for radical change into reforms. With the primary health care movement, ministers of health, political leaders, local administrations, professional organizations and non-governmental organizations adopted an attitude, which put further emphasis on equality in health. However, it did not always pave the way for the goal-oriented concrete actions. This expression of mine should not be commented as if no actions have been taken in primary health care; what I am trying to point out is that a universal reform and a transformation model, which reflected an organizational change upon consensus, could not be achieved. In my opinion, primary health care was not addressed as "service integrity" and as a "system" but it was maintained just as a "movement". I believe that it would be more appropriate to talk about primary health care movement instead of primary health care services. Perhaps, it might be possible to explain why primary health care services are generally confused with primary care services.

I think the problem is about how the primary health care movement is/should be understood while it is being transformed into a concrete action that changes the health system. These remarkable statements made by Dr. Margaret Chan, WHO Director within her article published by The Lancet: "The primary health care system approach was almost immediately misunderstood. It was a radical attack on the medical establishment. It was utopian. It was confused with an exclusive focus on first-level care. For some proponents of development, it appeared cheap: poor care for poor people, a second-rate solution for developing countries [9]. Chan has also expressed her opinion in the Tallinn Ministerial Conference held by WHO Regional Office for Europe on the "Strengthening of the Health Systems". I was a panelist for the Conference too. I had the opportunity to discuss her opinions regarding this issue. I congratulated her especially for her courageous approach and attitude.

I had the chance to discuss in detail this issue with WHO Expert Joe Kutzin and Professor Rıfat Atun while we were conducting the theoretical studies on the strengthening of primary care around family medicine within the scope of Turkey's Health Transformation Program. When I stated that there were no clear system reforms aiming at primary healthcare service and that there were no clear definitions of primary health care service and WHO resources were unclear, they

both agreed on the Alma-Ata Declaration made a "policy based" definition; an "evidence based" definition was needed and it was what WHO had been working on. Indeed, most of the WHO-supported resources are making effort to determine reasonable, evidence based and visionary actions for the primary health care movement, aimed at meeting health needs and anticipations of communities [10,11,12,13]. Richard Saltman who was aware of my concern and my questions to the WHO, was very kind to sign and gave me the book he also edited: "Primary Care in the Driver's Seat? Organizational Reform in European Primary Care" [11].

Lately, some approaches focused on primary health, determine this movement as "the right to access the best accessible health level" under the light of "meeting people's needs" [10]. Unfortunately, this approach cannot go any further policy based approach. However it refers to principles that empower the implementers, it is far away from referring the systems transformation tool. I think Sharmanov has a more concrete approach. He thinks that the current primary healthcare service shall be defined as providing the necessary support for the health system through ensuring complex contribution that surrounds the health system entirely but not a simple contribution at a priority level [5].

Basic health values that will realize the "health for all" principle need health systems that "considers human as the center of health service" [14]. What people want as a lifestyle and what they what for their community are important parameters for reshaping the health system and steering the health sector. In order to meet the citizens' anticipations regarding the health condition and health service, while studying on system design and service organization proper measures must be taken to make effective their preferences over the design and presentation of health service [15]. Thus, we can have a health movement with the participation of everybody. If we recall the main philosophy of the primary healthcare service is "health for all" we can be successful in transforming this into "health for all from all". As a matter of fact, the headline of the 1998 dated press release of WHO for the 20th anniversary of Alma-Ata was "Primary Health Care in the 21st Century is Everybody's Business" [16].

Traditional Health Care Services Style

The values introduced in Alma-Ata, understanding of "health for all", directing all sectors to the priority of health and primary health care movement to direct this were not sufficient in directing the health systems efficiently. The increasing expectancy levels of societies could not make the expected contribution to this either, even sometimes the incorrect management of these expectancies resulted in undesired changes. The health systems developed out of these, led to the rise

of a traditional service delivery model, or rather they ensured the continuity of this model. Due to different mechanisms and reasons, the traditional health care services are less efficient than expected in comparison to spent energy and resources; in addition to this, it is already known that they bring along a lot of common defects, reverses and contradictions. This situation was handled in the report of the World Health Organization in details [17].

5 main defects are discussed in the delivery of traditional heath care services:

1- Inverse care:

The people who probably have the least need of health care services are the ones who mostly benefit from this service network. On the other hand, the people who have the least facilities and many health problems are the ones who can benefit from the health care services at the least [18]. It is seen that the public expenditures in health care services in total are spent for the services delivered to the rich people rather than to the poor. This case is the same in high and low income countries, too [19, 20, 21].

2- Impoverishing care:

Wherever the lack of social security and the expenses of health care services are substantially covered out of pocket, then it becomes inevitable for the patients to be overwhelmed by the excess amount of financial burden and become poor. Annually, more than 100 million people in the world become poor in order to meet the health expenses.

3- Fragmented and fragmenting care:

Excessive branching out in health care services and the limited scope view of the many disease control programs make it difficult to approach to individuals and families in a holistic manner and to ensure the sustainability in health care. In general, the health care services delivered to the poor and marginal groups are substantially fragmented and performed with very limited resources. Assistance provided for this sort of services further increases the fragmentation [22, 23, 24].

4- Unsafe care:

The systems that cannot secure the safety and hygiene standards, which are also badly designed and badly implemented, cause to hospital infections in high proportions and medical implementation defects and introduce preventable adverse effects, and even they are among the ignored causes of many diseases and deaths [25].

5- *Misdirected care:*

When they are left alone, the systems are in tendency to turn to the result that they can get in the fastest manner. Resource transfers in great amounts are shifted to the curative service areas. Primary prevention and health promotion have a potential to decrease the burden of disease by 70 %, however this is unfortunately neglected (26, 27). The stewardship and specialty of health sector is insufficient to mitigate the adverse effects of other sectors on health and to direct the activities of those sectors in a way to make a contribution to health [(28)].

Opportunities and Threats of the Changing World

Today the world is quite different from what it was 30 years ago. At the present time, life expectancy is longer than what it was 30 years ago. If we had lost our children at the ratio of 1978, 16.2 million children would have died in 2006 in the world. However there were only 9.5 million deaths [(29)]. The difference of 6.7 million here means that 18.329 children are saved every day.

The understanding of basic pharmaceuticals list, which was like a revolution in the past, is now lost and forgotten in the possibility of common access to pharmaceuticals. There are great progresses in access to water, sanitation, and prenatal care. Never before such a big resource was allocated to health as today. During the 5 years in the period of 2000-2005, the health expenditures (excluded from inflation) in the world increased by 35%. Great changes have occurred in health information and health understanding. Rapid technological developments have given great momentum to health promotion and increase of health literacy in a well-trained and modernized global society. There is a general tendency to move from an intense experience sharing amongst the countries based on the sharing of dangers, threats and opportunities to an understanding of increasing solidarity; and with the influence of the determined attitude towards eliminating poverty, which is one of the Millennium Development Goals, a global stewardship is emerging. [(17)]

If we can see both the full and empty parts of the glass our judgments will be healthier. The responsibility of reaching the designated targets leaves the health systems face to face not only with the task of dominating the existing situation but also resisting the threats of the changing world and meeting the increased expectations that require better performance. Most of the failures derive from not being able to foresee this or establish renewable systems that can show flexibility according to those situations. While trying to state the reason why the primary health care movement that started in Alma-Ata could not get us the results of expected level today Dr. Chan says “the thinkers of 1978 could not have foreseen

the events in today's world". In this process, she points at the results of the oil crises, global economic crises and the structural change programs that are proposed to the countries by the development banks and that move the resources away from social services and health [9].

We have to recognize the important developments that threaten the population health and that should not be ignored by the health policy makers. World Health Report unfolds them as follows:

1- The developments in health in the last 20-30 years have further increased inequalities; while the health facilities in the majority of the world have gone up to very good levels many countries have lost their position. This situation has derived from the inequalities in access to resources and developments and it has also become more evident with better documentation. Existence of various documentation and communication facilities that were not there 30 years ago makes the inequalities in and amongst the countries more visible.

2- The nature of the health problems goes through an important change in time. Aging of the population, unhealthy urbanization and globalization accelerate the spread of communicable diseases around the world and increase the burden of the chronic (non-communicable) diseases. The patients apply with more than one disease and complex symptoms, and this threatens the delivery of the integrated and inclusive health service. As a result of this the health personnel

that are trained in line with certain disciplines can become insufficient against the problem. Changes in work conditions, changes in income and population increases, climate changes, changes in food safety, and social tensions are the determinants that will face health in the upcoming years.

3- Health systems cannot be independent from the process of rapid transformation and change, which is an important feature of the current globalizing world. Economic and politic crises risk the states and the institutional roles of the states that will guarantee access, service delivery and financing. Uncontrolled commercialization blurs the boundaries between the public and private actors; the delivery authorities and rights are increasingly associated with politics. The age of information has changed the style of relationship between the citizens, professional and politicians. The scope and framework of the health sector has gone beyond the usual, limited definition of sector; it has become extremely complex particularly in terms of human resources and relation between professions. The problems regarding population health, health service delivery, financing, infrastructure or human resources for information systems have gone beyond the limits of the health sector and have started to be discussed as international problems.

Today when health systems are left in the hands of the economic and social dynamics or left to the tools valid in the market, obviously they do not go in the direction of the goal of health for all (over the primary health care movement as stated in the Alma-Ata declaration) in its natural course. When the health systems are left to follow their own courses, they can rarely protect equity and social justice and they fail at getting the best result in comparison with the money spent [17].

Because of this, controlled or audited competition and planning are discussed instead of leaving the field of health to the market dynamics [30].

Awareness in Health and Increasing Social Support

The economic significance and the social and political importance of the health sector are increasingly realized. We know that health reform promises have occupied big places in the election statements of Blair in England and Clinton in the USA. As a matter of fact, in the recent election in the USA, Obama's health policy priorities were among the important discussion topics. In brief, health currently has become an area which draws more attention amongst the politicians. It is calculated that health issues have been uttered more than 28 times in average in each election campaign recently in the USA [31]. Common belief

has also occurred in public in our country that the health policy implemented under Health Transformation Program had a significant impact on the election of 22 July 2007 [32]. Actually this is a pleasing situation, which is in favor of health, health sector, health system and finally the citizens benefiting from this service, in short, in favor of the society as a whole. The rising expectation of the society pushes the society leaders to give priority to this expectation. In fact, this is what it expected. It is clear that one-dimensional health programs, which only health professionals try to carry out, with the services gathered at a single level of care, cannot serve the primary health care services adequately. If we remember that Sharmanov defines the understanding of today's primary health care services in a nutshell as giving basic support to the whole health system, we better realize how encouraging the newly emerging situation is [5].

As societies become modernized, people demand more from the health systems for themselves, for their families and even for the society they are living in. Thus more societal support occurs for a health service that is more equitable and indiscriminative. More interest and support occur for the health services that are focused on the needs and expectations of the people, the health safety of the society they are living in, and the internal and external factors that can affect the health of their communities and themselves [33].

Changes in the Understanding of Primary Health Care Services

Actually, I think I have expressed the changes in the understanding of primary health care services while unfolding the understanding that began before Alma-Ata and telling the international adventure. I have highlighted especially the different perceptions of the poor and developed countries regarding primary health care services. When we assess many positive and negative developments all together, it is not easy to say that the impact of primary health care movement is enough considering the backgrounds of the health systems structuring today. We can say that the handling of primary health care movement with different understandings, along with the problem of adaptation to changing conditions, play a role in this. The message of primary health care movement was simplified with the claims that a single measure or a single program can meet all demands, and problems can be addressed by focusing on the services at one level of care. Thus adaptation to different problems and different understandings has become difficult [34]. World Health Report points out this situation and voices this judgment. According to the report, in the end, national and global health authorities are occasionally inclined to see primary health care services not as a reforms package but rather as a single health service delivery program which provides poor service to the poor people among many of its alternatives [17].

Initially dominant understanding of primary health care	Current understanding of primary health care
Easier access of the poor living in the rural areas to the primary health care service packages and basic pharmaceuticals	*Reorganization and transformation of current health system for universal access and access to social health insurance*
Special care to mother and child health	*Interest in the health of all in the society*
Focus on a few selected diseases, particularly on acute and communicable ones	*Meeting the needs and expectations of the people extensively by taking the diseases and risks into consideration*
Ensuring village-level health education, sanitation, water and hygiene improvement	*Encouraging healthy lifestyles, decreasing the health impacts of the social and environmental hazards*
Simple technology for the volunteering, non-professional community health workers	*Health professionals team that ease access to technology and pharmaceuticals and ensure correct use*
Mobilization of the local resources via local health committees and participation in the management of health centers	*Organized participation of the civil society into the policy discussion and accountability mechanisms*
Centralized, top-to-bottom health services financed and delivered by the state	*Pluralistic health systems functioning on a global context*
Management of the increasing disabilities and downsizing	*Managing the increase of the health resources and directing them to universal coverage*
Mutual assistance and technical support	*Global collaboration and joint learning*
Primary Health Care as the antithesis of the hospital	*Primary health care as the coordinator of getting comprehensive results at all levels*
Primary Health Care Services are cheap and require humble investment	*Primary Health Care Services are not cheap; require reasonable investment; but generates better value of money compared to the alternatives*

The report puts forward the change in the understanding of primary health care movement in a detailed fashion, and this was the issue particularly emphasized in 2008 Alma-Ata Conference. While primary health care evokes a primary health care service package for the poor in the rural areas according to the previous understanding, the new approach to primary health care reforms accepts universal access to comprehensive health services. Again, while the previous approach focuses on the mother and child, now the target is all disadvantages groups. In the past acute infection diseases were targeted but today health risks and the diseases encountered throughout a lifetime are addressed. The understanding of a healthy local environment has evolved into an understanding of healthy local and global environment. Economizing and small-scale structuring now turned into the management of growth in a complete manner that enables universal access to service. Transition from state-centered and top-to-down organizations to health systems in public and private sector collaborations has taken place. Mutual assistance and technical support are beginning to be replaced by global collaboration and joint learning. Primary care services distant to hospitals become prioritized, and coordinated referral system for proper service stands out. Primary health care was cheap but now it is not, however good value is obtained for the money spent.

The table below indicates the differences between the initially dominant understanding of primary health care and the present understanding of primary health care [17].

Need for Primary Health Care Service Reform

2008 World Health Report states that health systems are largely moving from one short-term priority to another one in a fragmented manner and without any clear objectives instead of developing their capacities to meets the society's needs and fighting the new threats that are emerging. Although numerous accomplishments have been made in health and significant progress has been made in the combat against diseases, in quality of life and life expectancy, even in the most developed countries the health systems cannot fully reach the desired targets and people are dissatisfied with the system. Health systems and health promotion agenda include changes like a rag bag. Excessive branching in developed countries, programs focusing on a single disease and executed with the support of donors in poor countries play the most important role in preventing the integrity of the systems. Again as the report states it, this situation makes it necessary to reform the operating styles of the health systems in present societies and to do reorientation. Those reforms form the renewal agenda of the primary health care services [17].

The aim of the said primary health care reforms is not limited to the delivery of the known "basic" health services. It goes beyond service delivery and intersects

with the main elements forming the national health systems and goes beyond the defined limits of them [35]. That means, it has a potential that can affect the whole health system. For example, if we aim at organizing the health systems according to the values directed by the primary health care services, then we will needs very extensive human resources policies. In addition, it is not possible to think that all these can be realized separately from a series of arrangements including economy, financing, service delivery policies, public personnel reform and transnational migration of health personnel.

In addition, it is also known that, with the development and modernization, primary health care reforms should respond to the gradually changing societal expectations. This situation makes it necessary to stay away from some habits, to meet with different stakeholders of the health sector and to move away from the top-to-bottom vertical models of the past [17].

Suggested Reform Headings

2008 World Health Report presents the actions to be taken for eliminating the unacceptable gaps in health systems and securing the primary health care services under 4 reform headings. Those reforms are asserted with the claim of being effective tools in addressing the health threats emerging in the world today, and being in intersection in the equity values that give life to primary health care movement, solidarity and social justice that empower societal unity, and the increasing expectations of modernizing societies [17].

1- Coverage of the health insurances /universal coverage reforms:

This particularly means the objective of an insurance that covers the whole society and social health protection. When this objective is approached, a health system will be produced in which equity and social justice is ensured, social differences are eliminated and there is no discrimination [17].

Most of the social determinants of health have a share on inequalities. Therefore the solution of this problem covers many sectors. At the same time health inequalities are shaped by the availability and accessibility of service, the differences in its quality, the financial burden it imposes on people and even by language, culture and gender-related obstacles [36]. A health system in line with the primary health care movement that claims health for all has to decrease the inequalities and ensure the delivery of services to all. Today health services are more common than the past however this situation cannot still prevent big populations to lag behind the services. As a matter of fact uncontrolled commercialization makes service more possible for certain groups and increases

inequalities. In many places around the world the developing health services cannot go in parallel with the principle of equity. More particularly when the individuals have to purchase the health services developing with technology with their own money, most of them inevitably get poor. Therefore the developments in health and the spread of services should be in parallel with social protection. This king of protection is essential for equity in health; in addition to that the realization of coverage depends on the existence of widespread service networks. And this shows that we need reforms in health service delivery for realizing social protection.

2-Service delivery reforms:

The important role of health system is to ensure that people adapt more into the changing world and that they are more at peace socially and to get better results in terms of their health. Service reform is the reorganization of health service delivery to achieve these in line with the needs and expectations of the people [17].

The main theme of the service delivery reforms is to transform the traditional health service into primary health care services; it is to optimize the health service delivery through organizations such as local health systems, health service networks, and comprehensive health regions in line with equity. It is to meet the increasing expectations and "to place people at the center of health service and to harmonize mind and body, and human and system" [14].

While the service delivery reforms are one of the subheadings of the reforms set, sometimes it can mask the agenda of the whole primary health care services since it has a generally high profile. As a matter of fact, the complexities born by the efforts in that direction sometimes expose the primary health care services and its features that separate it from traditional service delivery style to the risk of over-simplification [24]. Especially in the countries where resources are limited those reforms are simplified and the spirit of primary health care is lost.

3-Public policy reforms:

Population health is a capacity and responsibility area in addition to being a collaboration area for the stakeholder in the health sector. Therefore arrangements should be done to ensure multiple sector cooperation with the leadership of the senior authorities. It is necessary to implement the policies trying to protect population's interests via collaboration amongst different sectors and to strengthen both the national and transnational population health interventions. In this way population health actions will be integrated with primary health care and healthy societies will be formed [17].

Despite all the conceptual discussions I mentioned above and the uncertainties in the evidence based definition of primary health care services, the characteristics of the primary health care services such as being human-centered, comprehensive and extensive inclusive, integration, continuity of services and the participation of patient family and community are obvious [22, 37]. It is clear that those characteristics are important and effective to increase the health levels of the communities in a conceptual sense. However forming the life conditions that will ensure and protect high health levels for people, providing equity, and at the same time ensuring that communities continue their lives in line with their values are closely related to the public order. In addition to that it is among the responsibilities of the governments to combat against health threats such as urbanization, climate changes and social class differences. There is need for arrangements that cover different sectors to stop the actions that can form a threat against health and to direct the responsibility areas into health promotion. Therefore, the success of the primary health care movement can only be possible by forming a series of public policies in that direction. That is, there is need for technical policies and programs that handle priority health problems. In fact, in the globalizing world those societal policies should be addressed not only within the country borders but also at an international relations level.

4-Leadership reforms:

NThe modern health systems have become very complicated under the pressure of human resources that experience quality and quantity problems, diagnosis and treatment devices, all kinds of developments, the risk areas that differ with changes and social events, and the scientific developments showing high momentum for their solution. It is necessary to ensure a steady balance between the two extremes of solid central management and control understanding on the one hand and the recklessness of the state saying “let them do it” on the other hand. In this complexity a discussion-based and participatory leadership that balances the imbalance of powers is very beneficial and essential for the integrity of the system [17].

The range of the factors influencing the population health is quite wide. Many issues such as school curriculums, industry policies, safety of food and consumption products or transportation and disposal of toxic wastes have significant impacts on population health and even define the population health. It is essential to make the aims and objectives of non-health sectors parallel to health; thus health would have a significant place within the framework of public policies addressed above. Purposeful and conscious efforts are required for ensuring collaboration amongst the sectors in order to attain the goal of “health for

all" [37]. In this extremely complex environment, the essence of the work is a strong societal leadership that can drive multiple sectors into collaboration on health. So it is necessary to have restructurings that will form a societal acceptance and public order which will allow for this leadership and form policy dialogue models based on collaboration with numerous sectors. This leadership should go beyond the limits of the public sector and have close relations with various stakeholders including clinicians, civil society, communities, researchers and academicians [17]. In general one of the most important tools of this leadership undertaken by the Ministries of Health is collecting adequate and realizable data, turning this into information and using it in decision-making. Therefore health information systems are indispensable elements of the reforms in this field.

Despite all developments and many discussions, the topic of leadership is still an important problem for the health system. This issue of leadership is mostly addressed within the scope of "stewardship", a term used frequently in management science. Stewardship, which translates as `önderlik` or `vekilharçlık` into Turkish, can be defined as the careful and responsible management of everything related to health care. It covers managing the policies and actions in all sectors that can affect population health. It stands for the ability to develop strategic policies for accurate planning and development of tools that will ensure the implementation of those plans. It means the supply of intellectual accumulation that will create health system performance that will ensure sustainability and transparency [38]

Without a strong stewardship function, a harmonious order cannot be established between the other inputs of the health system such as resource development, service delivery and financing. Overlapping of the tasks will lead to the domination of the powerful institutional structures in time although not recognized at first. And this would lead to a dominant institution with a high performance rather than a human-centered, high performing health system. There is always the risk that institution-centered approaches undermine system outputs and the happiness of humans. Therefore, if we want to attain the goals in line with the primary health care movement and have high performing health system, we have to keep the main functions –inputs- of the system alive, pin them down and ensure a harmonious integrity amongst them [38]. And this indicates the importance of the leadership reforms.

....and Transformation in Health

If we look away from the global primary health care policies and look at our own experiences we might encounter a striking result. I can further elaborate that by addressing a couple of the main headings of the Health Transformation Program,

which we have been implementing for 5 years now. The first three headings of the Program are 1-Ministry of Health as a planner and auditor, 2- Universal health insurance to bring all together within one body and 3-widespread and good humored health service that is easy to access. It is not difficult to realize that those correspond to leadership, universal coverage and service delivery reforms. Along with the inclusiveness of many sections of the program, the component of "mobilizing the parties and multi-faceted health responsibility for intersectoral collaboration", which was added to the program in the second phase, can be evaluated with respect to the public policy reforms. Societal perception and time will show to how close those components have brought us to the intended targets in implementation.

The comment in OECD Review of Health Sector-Turkey on the Health Transformation Program can help us nurture our hopes for the future:

"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... The steps taken to implement the HTP appear to have made significant improvements to the performance of the system [39]."

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Third Part

A New Era in Health

Third
Part

A New Era in Health

1. Mentality Change towards a Human-Centered Service Understanding

Our needs in the field of health cannot be delayed. Unfortunately this fact has been neglected for years. We set off with an approach focused on an understanding of human centered service, putting aside the institutional concerns and priorities and started to respond to health needs on time.

We placed "human centered" approach at the top of the Health Transformation Program. We are aware that the health services are not the mercy of the State but delivery of people's rights.

We left the days behind that the patients were pledged and price demanded for ambulance services. We are experiencing a period in which we can provide "112 Emergency" service not only in cities but also in the villages; a period that we can provide service to our citizens without any access to services in their homes by the mobile services, in which we have introduced the "Air Ambulance System" and a period that we can provide service for the patients who need dialysis through driving them from home.

We eradicated all of the difficulties obstructing our citizens from accessing health services. Now, our people can consult to any hospital they wish; they can take their medicine from the pharmacies without being returned empty handed because of the lack of medicine and they do not wait for their queues for hours.

Currently, family medicine practice that we initiated in Düzce three years ago is being executed in 30 provinces. Eighteen million citizens are benefiting from this practice and can choose their doctors.

We follow the pregnant women and the infants delicately. We have significant accomplishments in terms of health personnel attendance in deliveries, starting to use the most developed vaccines and having vaccinations completed.

We have established one of the greatest medical rescue teams in Europe with 2526 specially trained health personnel ready to act in emergencies in 81 provinces.

A significant decrease in the number of the communicable diseases such as malaria, typhoid fever and measles is recorded.

Today, every hospital in our country includes a “Patient Rights” unit. We can choose our own doctors in the majority of our hospitals. Our hospitals are well equipped in terms of medical devices and equipments. We provided 20.000 new hospital beds. In the new hospital projects, we place bathrooms and toilets in the patient rooms and we place one or two beds in the rooms. We have increased the bed capacity of intensive care with 7.5 times.

We took very important steps regarding the improvement of our altruistic health personnel's income level and working environment. However we do not consider these accomplishments sufficient; we will increasingly continue our efforts.

We eradicated the imbalance in Health, through giving priority to places with inadequate equipment and health personnel country-wide. We employed more than 110.000 new health personnel in public sector.

On the basis of the principle of human oriented and decentralization, some of the authorizations of the central Ministry have been given to provincial organizations: several authorizations such as opening and closing primary health care institutions, determination and operation of 24-hour service provision procedures, follow-up of the sale and consumption of pharmaceutical preparations, opening and closing pharmacies and their authorization procedures, personnel rights were given to provinces.

Chiefs of disbursement have been authorized within certain limits in order to lessen bureaucratic procedures and to provide medical devices and maintenances from revolving fund on time.

2. Widespread and Equal Health Insurance: Universal Health Insurance

Health Transformation Program aimed at developing a social insurance model which will enable the citizens to contribute in proportional with their abilities to pay and take health services they need in the framework of equity principle.

Efforts were made in order to provide the harmonization between the existing social security institutions until the legal and institutional infrastructure of the general health insurance is formed. Reimbursement commission was established including the representatives from the Social Security Institution, Occupational Pension Fund, Ministry of Finance, State Planning Organization and the Treasury. Thus, different reimbursement mechanisms conducted by different social security institutions were eradicated and a joint model and strategy were built.

Regulations covering the presentation form and pricing of the health services being provided by university hospitals and state hospitals for the public servants with the participation of the Ministry of Health and the Ministry of Finance was handled. Service denominations determining medical services were reviewed and new and detailed lists were prepared by the help of international service names code systems. Consequently, important steps were taken in the registration of health services, establishment of a joint database for all of the institutions and standardization of the service invoices.

Radical changes were completed for providing unity between service provision and target groups of healthcare service providers. The citizens under the public insurance were provided the opportunity to access service from the private health institutions also. Thus, the service presentation forms of the private hospitals were harmonized. On the other side, the discrimination between state hospitals and Social Security Institution hospitals was eradicated and thus unity was provided between public hospitals' operation models.

An infrastructure providing the usage of a joint medicine database by all the social security institutions was developed. This infrastructure enabled the central audit of medicine. Similarly, joint databases were developed for the controlling of progress and services based on a single system. The coverage of the green card implementation widened and provided to be more realistic and effective. Thus, the citizens with low income were covered by a health insurance which is not different from the Social Security Institution, Social Security Institution for Artisans and Self-employed, and the Government Employees' Retirement Fund.

The harmonization works, carried out by the health service providers and the social security agencies that will pay for this service, are important steps which prepared the environment for the universal health insurance.

The first step of the social security reform was taken with the Law No: 5502 and all the security institutions were restructured and gathered under the Social Security Institution. With the Law No: 5510, it was aimed to eradicate the inequalities in the accession to health services through defining the rights and responsibilities, besides covering all the population by the social security.

Public insurance which consisted of SSI, Social Security Organization for Artisans and Self-employed, Government Retirement Fund, civil servants and green card owners has been unified and turned into a structure in which all citizens are treated equally.

The main objective of the social security reform is to form a financially sustainable system which is fair, easily accessible and supporting the poor.

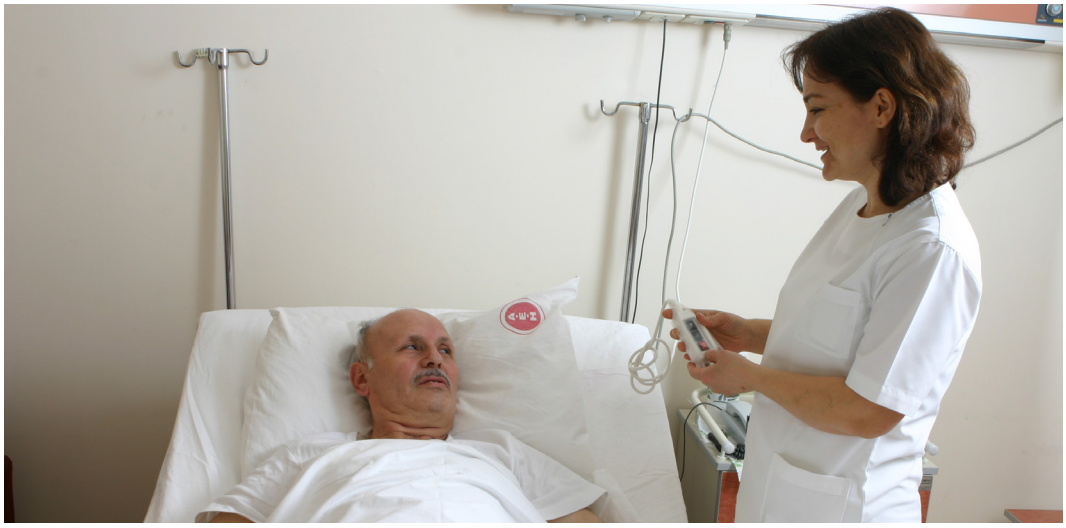
Access to health services is one of the most important components of the social security system. Bad health increases poverty and poverty prevents people from accessing to health services. Health insurance affects the usage of health services in a positive way. Easy access to health care services prevents diseases and improves the general health indicators of public.

The health system of Turkey was a mixed model institutionally and financially. This system was inefficient and complicated. For example, SSI and Social Security Organization for Artisans and Self-employed used to be premium based funded and the civil servants and the retired and the green card owners used to be financed through taxes.

Centralization of the programs carried out through different finance methods by SSI, Social Security Organization for Artisans and Self-employed, Government Retirement Fund and the Ministry of Finance and procurement of health services via efficient control mechanisms have played important roles in accomplishing the objectives of the Health Transition Program.

Instead of the subvention of services via resource allocation to health institutions and service providers, a social insurance program in which people who can not pay for the premiums are subsidized has been initiated.

All the population were taken into scope and the ones without a health insurance were provided with health insurance. Now people insured with different instructions with different practices are equal. Children under the age of 18 benefit from health services without any specific conditions.



Again with the same law, the authority to define the additional fee which the service providers can get from the patients was given to the Cabinet. Previously there was no limitation to the difference and it was totally under the initiative of the health service provider and not the Cabinet decided this difference to be 30 %. From now on the citizens will know what will be demanded from them as an additional fee when they apply to a private health service provider within the scope of the universal health insurance while they are getting any service. In addition, another novelty introduced by this law is that during serious health threats and in sudden disease conditions the private healthcare providers shall not demand any additional cost from the patients. In this way the concern for payment is eliminated in the relation between the patients and the health institutions. The law also defined a ceiling for the fees to be received by the academicians for the healthcare services they provide.

Thanks to the same law, retirement insurance has been altered significantly. Now there is a single retirement regime that will provide equal and fair services to the people within this system.

The age, premium payment and insurance duration of the actively insured people have been maintained in the same way.

Based on the retirement pensions will be estimated in accordance with the duration in the previous and the new system and the weighed mean of the pensions to be obtained in both of the systems. Thus transition into the new system will be carried out gradually and unity of norms will be provided in times without causing problems for the currently insured.

In the new retirement system, the age of retirement will not be changed until the year 2035.

By 2035, in parallel with the life expectation, there will be a gradual increase. The disabled insured will retire sooner depending on their disability degrees.

In case of deaths of the insured for a period of 5 years (1800 days), the beneficiaries will be able receive monthly-payments. For the ones who die before completing 9000 days will be treated as if they completed 9000 days.

Single daughters, without age limits, will receive survivors' pensions on condition that they do not have any incomes.

Sons, will receive survivors' pension until the age of 18, if they are enrolling higher education until the age of 20 and if they are enrolling universities until the age of 25.

When the treatment is not possible within the country, all the insured will be sent abroad for accurate treatment with the approval of the Ministry of Health. Additionally, travel expenses, compulsory expenditures and the expenses of the companions will be paid as well.

Meanwhile, the Communiqué on Social Security Institution published by the Social Security Institution started a new era that enabled citizens to access health services equally and easily. This equalized the citizens, who were under the coverage of different social securities, in front of healthcare services.

Additionally, beginning from January 2007, no payment is required from the citizens for primary healthcare even though they do not have social security.

A SUCCESS STORY

PRIMARY HEALTH CARE SERVICES ARE
NOW FREE OF CHARGE

One of the main principles of the Health Transition Program was to create "a common, easy-access and friendly service provision system". The number of the primary health care institutions had to be increased in order to increase the rate of extensity. Application family medicine would erase this problem. Another point which was of high importance was that people should not pay for the services concerned. The family medicine service was going to be provided free of charge for everybody. On the other hand family physicians was going to be paid well so that they would provide friendly health care services.

However, we needed time in order to apply family medicine across the country. There had to be something to do during the transition period as well.

The capacity of health centers was strengthened through increasing the number of examination rooms. New additional units were rented. Building of new health centers were encouraged by the local authorities. Meanwhile health personnel were supported as well through additional performance based payment system against the increasing patient load. The scope of the social security was increased. However we had to meet the needs of the people who are not included in this scope and we had to do that without disturbing the sustainability of the services and the motivation of the personnel.

The law No: 4736 stated the scope of the public services that could be provided free of charge through the Cabinet Decision. The cabinet approved our demand and the decision was published in the Official Gazette dated 20 July 2007. We made a protocol with the Social Security Institution and the Ministry of Finance and this was a very significant event. Thus, by July 1, 2007 primary health care service have been provided free of charge. Since that date, people consult to any primary health care institution and obtain services free of charge.

Additionally with the Prime Ministry's circular dated June 26, 2008, it is ensured that the all patients requiring emergency medical intervention are brought to a proper health institution and the required emergency intervention is performed with priority and without any preliminary condition in that health institution. It became obligatory that transfer and referral procedures of all patients are done under the coordination of the 112 command and control center regardless of private and public difference, and thus the harms which are caused by the transfer of a patient from one institution to another is prevented. In the cases requiring emergent medical intervention; the patients who do not have social security or who cannot pay are not asked for a payment; the service costs are demanded from the social assistance and solidarity foundations/municipalities where the health institution is; for the patient who have social security, the private hospitals cannot ask for a difference fee and with all these the citizens are protected from injury. The last part of the steps taken in this field was completed when the law no.5510 was enacted in October 1, 2008.

3. Campaign for Primary Healthcare Services

Health Transformation Program aims at providing a structure for the primary healthcare services' institutional position so as to have the authority and control over other service levels. The main focus of this transformation is to improve the conditions of the individuals in general and patients and health staff in particular. The program is based on the primary healthcare services in relation with the service presentation. A large number of activities and projects have been handled with this approach; this was almost a multi dimensional campaign. The current operations were not neglected because of the new regulations and widespread improvement studies were carried out. The most outstanding feature of the Health Transformation Program is that it keeps the existing heritage and improves it as significantly as it can during the transformation.

We are planning to establish an extended area of responsibility interesting all the actors in health sector apart from the issues of Health Promotion and Healthy Life Programs, one of the components of the Health Transition Program. Within this scope, we will increase the efforts that will create awareness in all the relevant fields.

To ensure access to healthy life programs will be our primary objective. Issues such as long life expectancy, combating against communicable diseases and decreasing the patient load due to the successes for mother and child care will be

privileged in order to prevent chronic diseases. The ratio of the chronic diseases might increase and as a result treatment expenses might increase as well. For this reason, we have to give privilege to prevention of chronic diseases risk factors, improving people's ability to control their own health conditions and preventive medicine.

a) A New Face and New Tasks for Health Centers

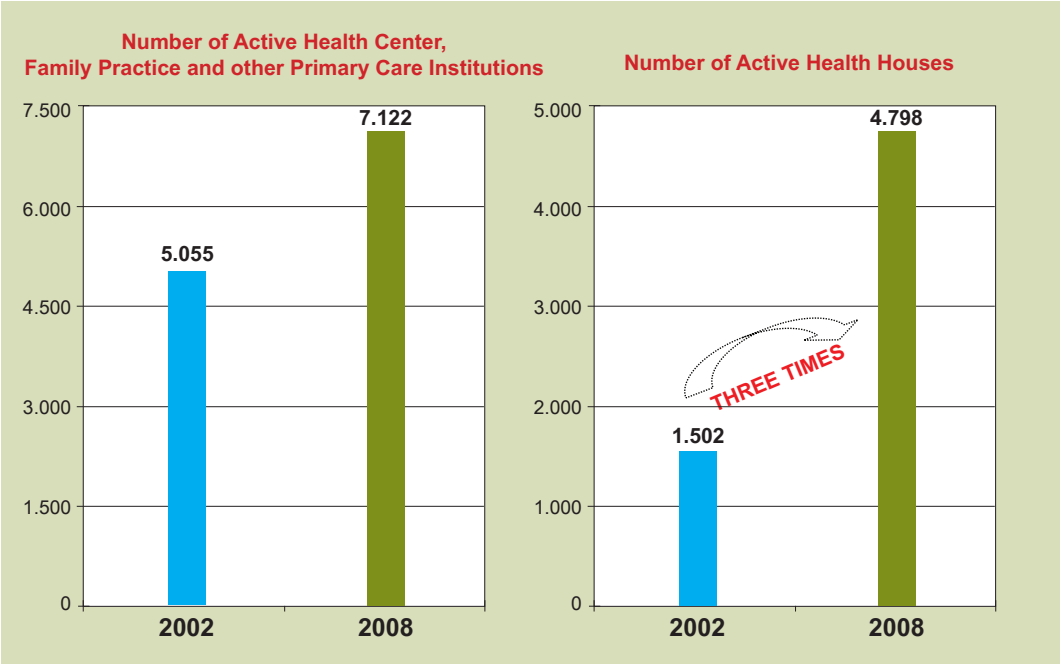
Health Transformation Program strengthened the health centre network which was provided by the socialization policy it also put the local administrations in action as well as the Ministry resources. "A room for each physician" principle was turned into a campaign. The one-to-one communication between the public and physicians was promoted and simplified. Additionally, primary healthcare institutions strengthened with circulating capital and the diagnosis equipments were generalized. The personnel have been provided additional payment based on performance which became an economic and personal motivation source.

The primary healthcare services have been restructured with the entry of the Family Health Centers and the Community Health Centers into the system.

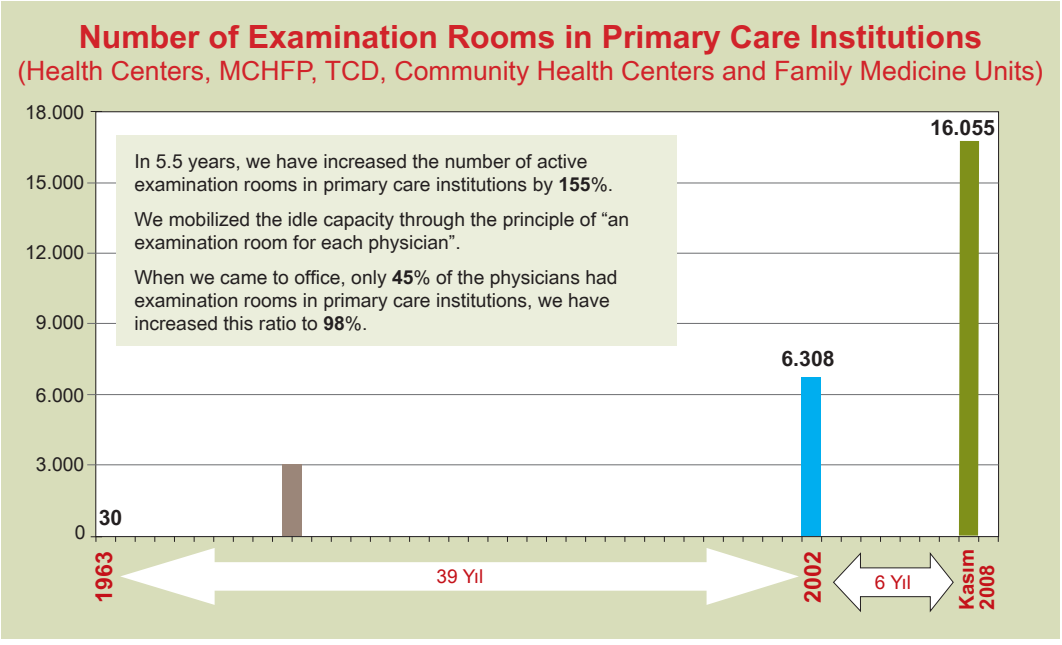
As of November 2008, 7.122 primary health care institutions continue to function actively. In 2002 there were 1572 active health house, as of November 2008, there are 4798 health houses. This increase also affected the quantity and the quality of the health services we delivered to rural areas. Our final objective for the active health houses (with midwives included) is 5950. In 2002 the rate of the active health house was 22%, in 2008 this rate was 81%.

At the moment, the ratio of the Primary Healthcare Institutions which has a building but not a physician is only 2%, and the premises serving as Family Medicine (FM) centers now in the provinces where FM is introduced will be continued to be utilized as Family Health Centers.

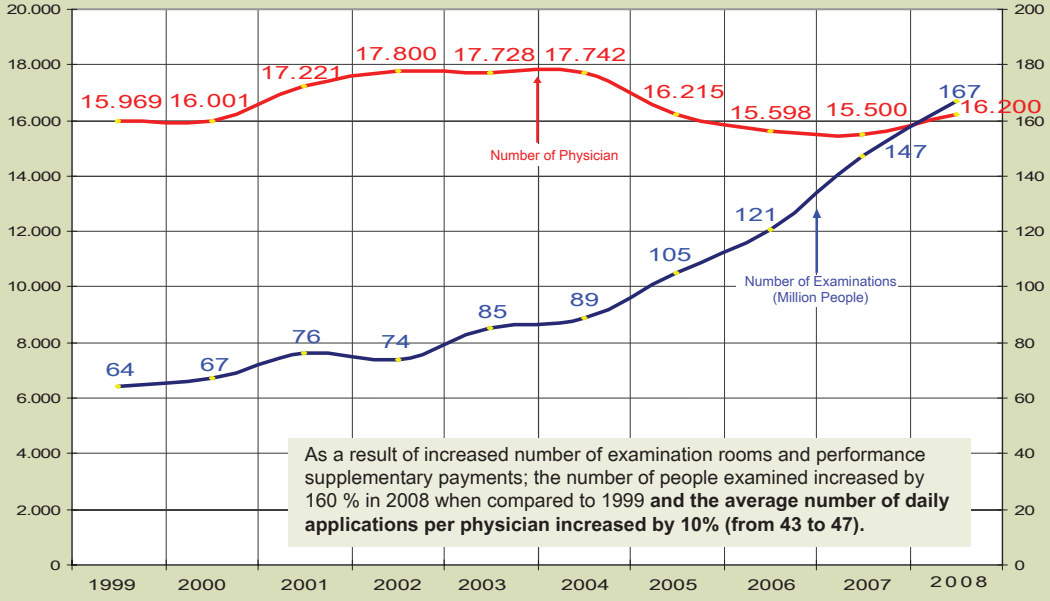
The examination rooms in the primary health care service institutions were increased by 155% in 6 years. A private examination room was assigned for each physician and the inactive capacity was activated. In the beginning of the Health Transition Program, only 45 % of the physicians had their own examination room. Now this rate is 98%. The obstacles people come across in accessing health care services were removed after these innovations.



In 2008, even though the number of the physicians was the same as in the year 2002, the number of the patients examined increased by 125 %. The patient rate per physician only increased 10%. The rate of consulting to a physician was 3 times annually in 2002; in 2008 this rate was 6.3. as a result of the studies we carried out we provided both accessible and effective health services.



Number of Physicians and Examinations in the Primary Care

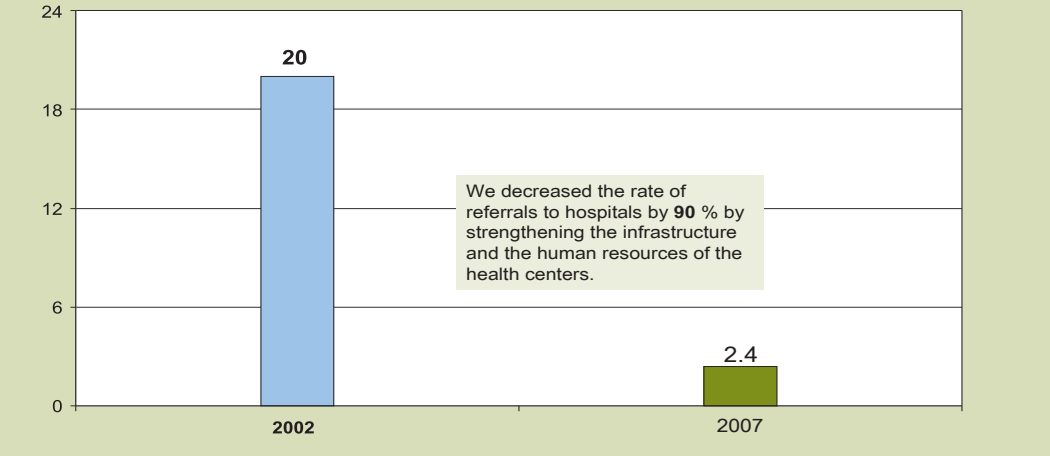


Note: The calculations use the data from health centers, MCHFP, Community Health Centers, TCD, SSK dispensaries, SSK health stations and FM

The problems of the primary healthcare are started to be solved in a great deal with increasing interest and hardware. Also resource savings are achieved since the senior levels are not occupied in vain.

The health service delivery rate was regulated and increased to 99% from 10%.

Rate of Referrals from Healthcare Institutions to Hospitals (%)



b) Emergency Healthcare Services Gained Speed

Emergency healthcare service is an important public health matter. It is very important to reach the place of incident, to carry out the first intervention and to provide the transportation to a health institution as soon as possible in cases of urgent disease and injuries. The digital infrastructure of the 112 Emergency Health Service Control Centers has been completed in all provinces. Thanks to the digital infrastructure in all provinces the followings can be accomplished:

- Calls can be received through the Operation Management Software by the users and delivering the calls to receivers automatically,
- Displaying the calling number,
- Voice recording from the beginning of the calls or the signals,
- Recording the information obtained into the database and sharing such information simultaneously with the consultant physicians and the other units,
- Searching for the addresses on the numerical maps of the city,
- On-line follow-up of the ambulances through GPS,
- Follow-up of the spare beds in hospitals,
- Provision incoming call regimes, daily case numbers, operator situations, team situations, access time, working forms and of the immediate and past statistics.

Land, Sea and Air Ambulances

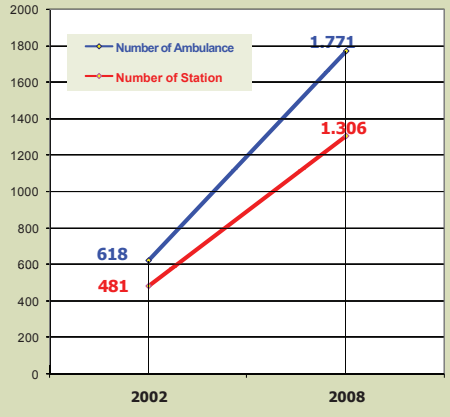
In the last 5 years our capacity with regard to transportation of emergency patients improved 3 times. Now it takes 10 minutes to get to the case place. The number of the well-equipped ambulances was 618 in 2003; today it has reached to 1771. The number of the stations which was 481 in the beginning of 2003 is now 1306 and the number aimed was accomplished.

The European Standard was established for the 112 ambulances. Suspended stretcher systems, ventilator devices and defibrillator devices were provided as well as the hardware ensuring security and comfort both for patients and personnel. Ambulances have been insured, thus the personnel and the patients were taken under guarantee.

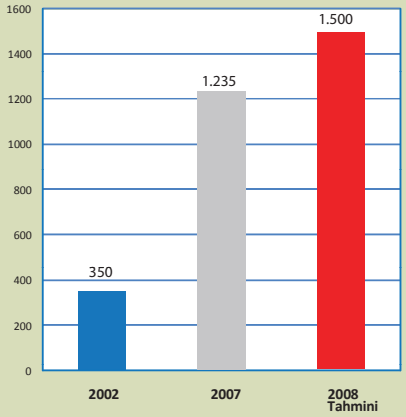
Special snow adjusted ambulances and patient snow-tracks were provided for the regions with transportation difficulties due to geographical and seasonal conditions. Thus, patients are not transported on coasters to hospitals anymore.

In 2002, the number of people benefiting from health care services was 350 thousand, in 2007 it was 1 million 235 thousand people. In 2008, the figure is estimated to be 1 million 500 thousand people, 4 times more. In 2002, only 20% of the people living in rural areas used to benefit from 112 emergency health care services, today all the regions benefit from these services.

Number of 112 stations and ambulances



Number of 112 cases (thousand)



We put 63 **"snow track ambulances"**, 12 **"snow vehicles with patient cabin"** and 4 **"sea ambulances"** into service for the first time in our country.

For emergent consultations, people are taken care of before carrying out the insurance and payment procedures. People without a social insurance are not charged for ambulance services.

Now 112 is flying...

We initiated the air ambulance system in the provinces of Ankara, İstanbul and Erzurum in 2008 October. Until the end of 2009, the number of the helicopter ambulances will be increased to 17 and 3 plane ambulance will be provided.

Air ambulance can be used for patient transportation, medical support during the transportation, emergent transportation for organ transplantation, first aid and transportation during mass injuries, medicine provision in emergencies and transportation of sample, blood derivatives, health equipment and materials.

A SUCCESS STORY

112 EMERGENCY HEALTH SERVICES

In 1994, 112 emergency health services was established in order to take patients to an appropriate health center having applied the first aid on site as a service which patients can consult in case of emergencies.

The importance of emergency health services has been recognized better recently and there have been significant changes in the last 6 years. The steps carried out thanks to intensive studies and efforts of the health personnel within this scope are as follows:

- *At the end of 2002 the number of the stations was 481; in November 2008 it was 1306.*
- *At the end of 2002 the number of the emergency ambulances was 618, now it is 1771.*
- *At the end of 2002, there was only one station per 140 000 people to provide services, now there is a station per 50 000 people.*
- *At the end of 2002 380 000 people were provided with emergency health care services, in 2008 1 million 350 thousand people received emergency health care services. In the last 5 years the number of the people benefiting from 112 emergency health care services increased by 180%.*
- *In 2002, only 20% of the people living in the rural areas could receive 112 emergency health care services. Today all the regions benefit from these services.*
- *In 2003, we issued a Cabinet Decision to prevent ambulances from paying for the ticket highways and bridges in order to deliver patients in a faster way without losing time.*
- *In 2004 we issued a Cabinet Decision not charge people for ambulance services.*
- *As in the developed countries, we have authorized the paramedics and Emergency Medical Personnel in order to treat patients and we started to employ such personnel in the Ministry of Health in 2004.*
- *We insured the 112 ambulances so that we guaranteed the life and goods of people and health personnel.*
- *We bought special snow adjusted ambulances and patient snow-tracks to be provided for the regions with transportation difficulties due to geographical and seasonal conditions. Thus, we removed the obstacles encountered due to winter conditions while rescuing people.*
- *In 2007, the average time to reach patients in need of emergency health care in the first 10 minutes was 92%. This rate is the same as the developed countries.*
- *We ensured European standards in ambulance equipment and we started to use suspended stretchers and equipment providing security and comfort for patients and personnel. We equipped the ambulances with intensive care devices.*

- *We turned 4 speed boats into ambulances and started to use them by 2007 July in İstanbul Sarıyer, Balıkesir Marmara Island, Çanakkale and Gökçeada*
- *We completed the digital infrastructure of Command Control Center of the 81 provinces in the beginning of 2008. Thus we could follow all the ambulances and the spare beds in hospitals immediately.*
- *We started to use helicopter ambulances in 2008 in Ankara, Erzurum and İstanbul.*
- *We completed all the preparation in order to start plane ambulances and motorbike emergency health care personnel in 2009.*
- *We are happy to provide land, sea and air health care services with our well equipped and trained personnel.*

Tele-Health Emergency Health Call-Center

Tele Health Emergency Call Center provide services Turkish, foreign air and sea vehicles about any kind health and/or diseases since 20 December 2006.

Fully-equipped sea ambulances transport patients in İstanbul Büyükdere, Gökçeada, Marmara Island and Çanakkale regions .

Healthcare Organization in Disasters

We one more understood from the disasters we experienced that we should be stronger and prepared for the disasters. Especially after the 1999 Marmara Earthquake, there was a lack of medical rescue teams. Under the scope of the Primary Health Care DG, the Department of Health Management during Disasters was established. The National Medical Rescue Teams (UMKEs) were established in order to carry out medical services during disasters in the 81 provinces.

In 2008, Departments of Emergency and Disasters were united in order to manage emergency health care services and health organization during disasters centrally and were turned into the Department of Emergency Health Services during Disasters.

Today there are 2526 UMKE professional personnel available to carry out medical and treatment services.

UMKE teams are equipped with the knowledge and the material to rescue people who are stuck in the wrecks after disasters like earthquakes and to treat people on site. Thus, disabilities and deaths occurring due to inappropriate or late treatment are reduced to the minimum rate.

UMKE teams are the biggest medical rescue teams of the world in terms of their training and special equipment and organizational structure and number.

UMKE teams receive basic and complementary training. The scope of the training are as follows:

Basic training subjects

- General approach training for disasters and extraordinary situations
- Turkey disaster and crises management system
- Health services during disasters
- Health risk management during disasters and extraordinary situations
- Working principles during disasters and extraordinary situations
- Emergency medical treatment training
- First aid training
- Basic and future life support training (theory)
- Basic and future life support training (practical)
- Stabilizing patients/ the injured with alternative plasters
- Carrying with Stretchers techniques

Improvement training

- Health disaster management
- Water rescue team
- Air rescuing training
- KBRN training
- Snow, mountain rescue training
- Mobile and field hospital training

- Treatment of multiple injuries training
- Triage training
- Crush syndrome training
- Disaster logistics training
- Disaster psychology training
- Basic camping and survival and physical condition training during disasters and extraordinary situations
- Communication and international signs training
- Exercise training for disasters and extraordinary situations
- National and international institutions on disasters and cooperation training
- Taking the disaster risk characteristics of the country into consideration, we are continuing the training and implementation studies in order to establish UMKE teams especially in risky regions.

"Mobile emergency health treatment units" have been established in order to be utilized during disasters. The distribution of these units to the coordinator provinces established in accordance with the risk analysis will be completed in

2009. Thus the disabilities and deaths will be avoided occurring due late treatment as these units will provide immediate health services. At the same time patient load of the hospitals will be decreased and causalities will be treated as soon as possible.

A SUCCESS STORY

THE BIGGEST MEDICAL RESCUE TEAM IN EUROPE

We established the "Department of Healthcare Organization in Disasters" in 2004 with the aim of keeping the mortality and the number of the injuries at the lowest level possible by providing medical rescue services in the shortest time by adequately equipped and trained voluntary teams during possible disasters (earthquakes first of all) that may happen, as well as providing the safest and fastest patient transportation and the emergency treatment units and services and the required professional administration organization.

We provided basic training for 2.526 personnel performing duty on a voluntary basis in the National Medical Rescue Teams that are established in 81 provinces in four years.

Medical rescue teams continue their field exercise and always ready for duty, besides their basic, theoretical and station training programs.

Some of the studies that the National Medical Rescue Teams participated in since its establishment are:

Abroad

Earthquake in Iran, Bam

Earthquake in Pakistan

Sudan Humanitarian Aid Organization

Flood and Landslide in Afghanistan

Earthquake in Indonesia

Tsunami in Indonesia

Domestic

Konya Zumrut Apartment Building Collapse

Explosion in Diyarbakır Military Housing

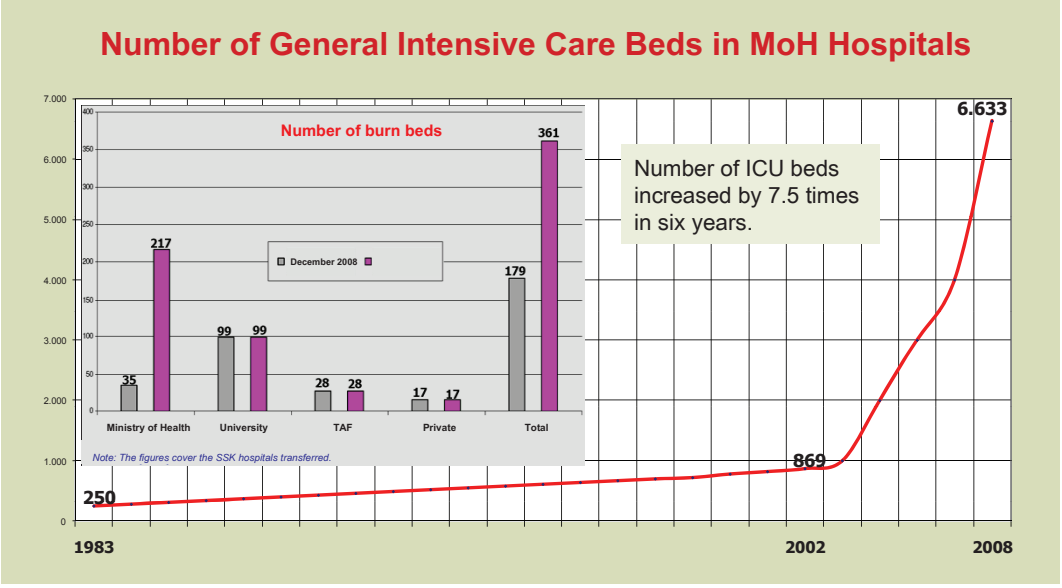
Bursa Intam Building Collapse

Two Building Collapses in Istanbul

Konya Taşkent Balcılar Building Collapse

General Intensive Care and the Number of the Beds for the Burnt

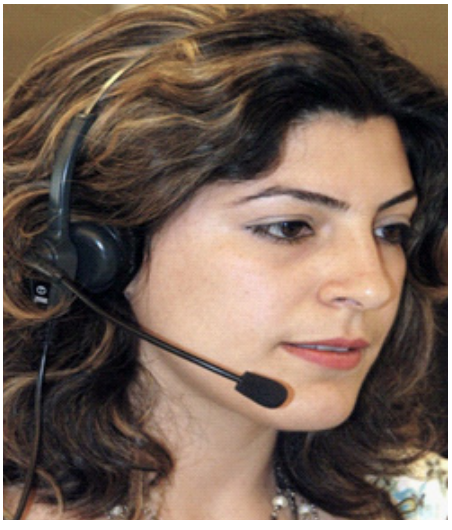
There are bed needs in emergency and burned people's departments due to the significant improvements in emergency and first-aid heath services and fast transportation facilities. Within this scope, the number of the beds in these departments has been tried to be increased and there were significant improvements. The general intensive care number was increased by 7, 5 times in 2008 November compared to 2002 November.



Note: The figures cover the SSK hospitals transferred.

Poison Consultancy Services

The only unit providing consultancy service both for physicians and people for 24 hours is the Poison Consultancy Service (UZEM) under the scope of Refik Saydam Hygiene Center Presidency. UZEM, having received 497.027 calls in 2007, provided consultancy for 76.508 poisoning cases.

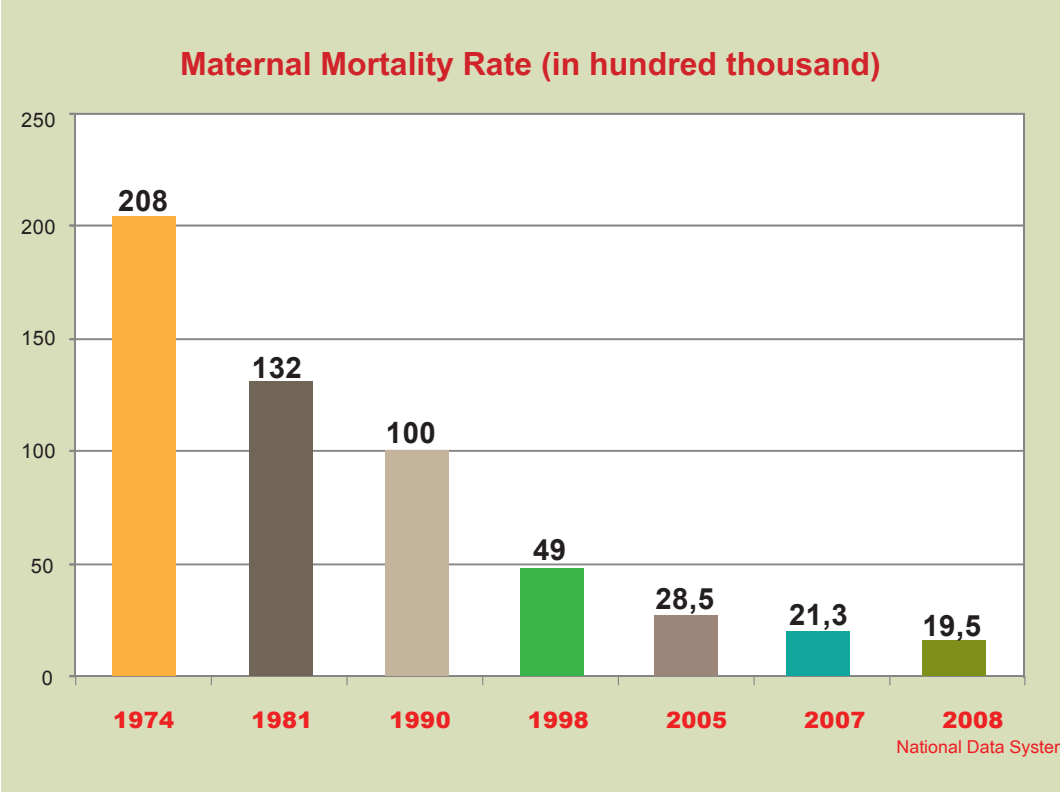


Additionally, this unit also carries out the delivery of the antidotes needed for the poisoning cases in the country (mushroom poisoning, botulism, pesticide poisoning, therapeutic drug poisoning, etc).

c) For the Future: Mother and Child Health

Mother mortality rate, an important development indicator, is closely related with the execution of reproductive health and its quality. For this reason, the international institutions in the field of heath seriously track the rate of mother mortality.

According to the "National Mother Mortality Study 2005", the mother mortality rate in the country is 28,5 %. Under the light of the experiences derived from this study, a Mother Mortality Data System was established and the data with regard mother mortality were collected with their causes. In 2007, there were 285 mother deaths and the mother mortality rate was 21.3 per a hundred thousand. In 2008, this rate was 19.5 per a hundred thousand according the national data system.



MOTHERS WILL BE ABLE TO ENJOY MOTHERHOOD…
STEP BY STEP TO THE TARGET IN THE PREVENTION OF MATERNAL MORTALITY

Access to health care services during pregnancy, in delivery and post-delivery period, benefiting from health care services, training of women, gender equality and social conditions are related with maternal mortality. With this feature, the rate of maternal mortality is used as a multi dimensional indicator of development. Maternal mortality includes women's deaths which occur in pregnancy and delivery, and in 42 days following the delivery, as well.

According to calculations made by the WHO, 529.000 mothers die in every year. 99% of the maternal mortality is reported in developing countries. World average for maternal mortality is 400/100,000. African average is 870/100,000, Asian (excluding Japan) is 380/100,000, WHO upper medium income level group countries' average is 1/100.000 and European is 24/100,000.

Data and information on maternity mortality was lacking in Turkey until recently. The data as the rates which reflected the existing situation were provided by the population censuses. In 1997 – 1998, maternal mortality was found to be 49/100,000 at 615 delivery hospitals located in 53 provinces in Turkey. This rate is calculated as 70/100.000 considering the mortality outside the hospital

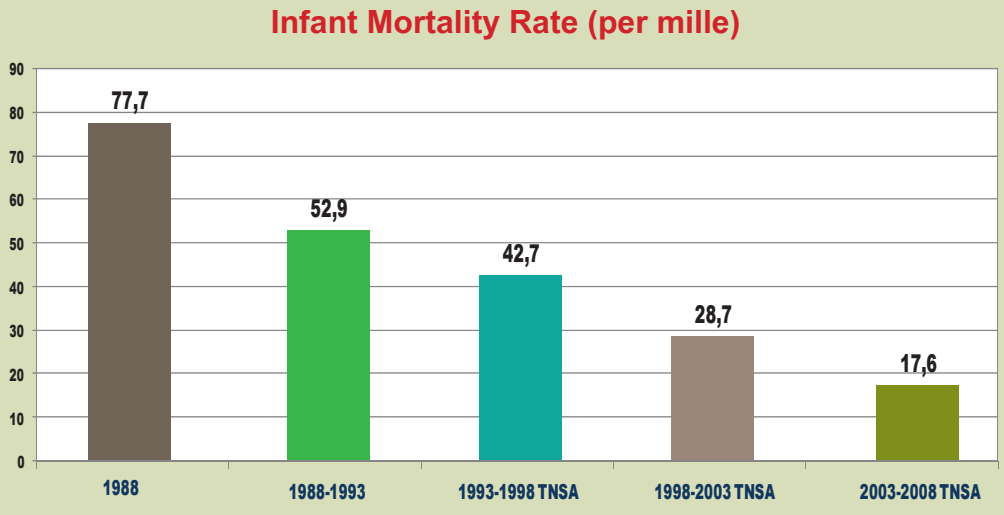
Survey on Maternal Mortality in Turkey was conducted between the dates 1 June 2005 – 31 May 2006 in order to find out the maternal mortality rate in Turkey. Results were publicized at a meeting held on 8 December 2006.

The afore-mentioned survey is the single study of scientific competence in the Republic's history. The survey pointed out that the morbidity rate for 2005-2006 was 28.5/100,000. Turkey accessed to the real and actual numbers in this issue for the first time and introduced its achievement in maternal morbidity rate which is very close to Europe's.

The data about mother mortality between the age of 12-50 in the 81 provinces are collected with the Mother Mortality Data System, revised on the basis of the system in the 2005 Turkey Mother Mortality Research. Under this scope, in 2008, mother mortality rate was 19,5 per a hundred thousand. Our aim is to decrease mother mortality rate under the rate of 15 per a hundred thousand.

Baby mortality follow-up used to be carried out through the Turkey Population and Health Researches applied in every 5 years and the other studies. Today it is included in periodical follow-up research programs. Reasons of death are examined for every case of mother and baby mortality in order to prevent other mother and baby mortality cases.

Baby mortality follow-up used to be carried out through the Turkey Population and Health Researches applied in every 5 years and the other studies. Today it is included in periodical follow-up research programs. Reasons of death are examined for every case of mother and baby mortality in order to prevent other mother and baby mortality cases.



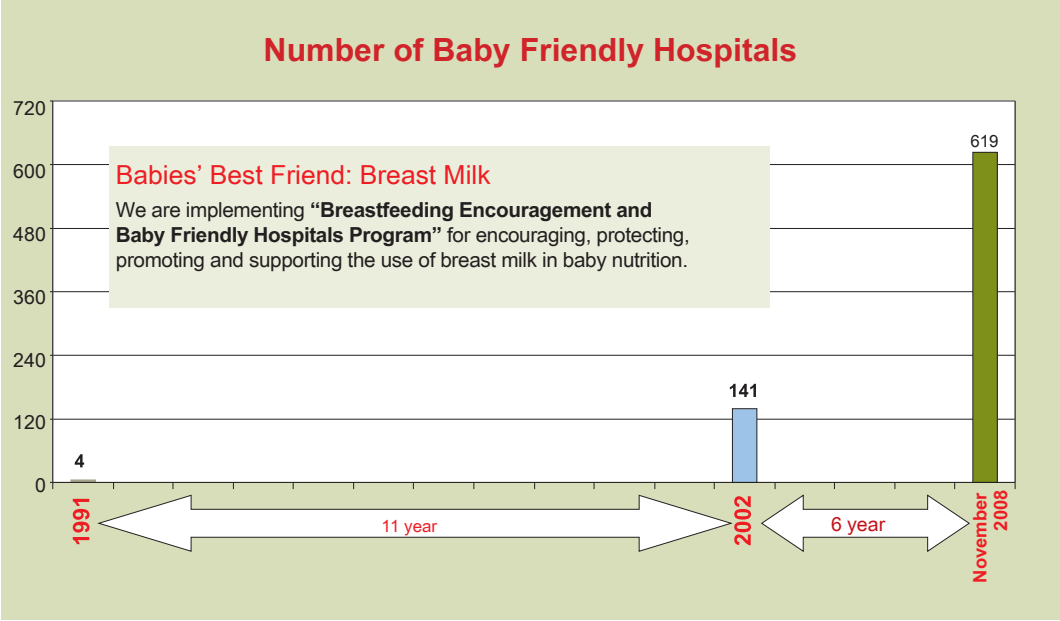
Our place among the world countries in terms of infant mortality in 2007

TURKEY (per mille)	22
WORLD AVERAGE(per mille)	49
INCOME STATUS (per mille)	
Low income group	73
Low-middle income group	27
High-middle income group	**22**
High income group	6
WHO REGIONS GROUP (per mille)	
Africa region	94
America region	18
Southeast Asia region	52
European region	**14**
East Mediterranean region	62
West Pacific region	20

According to the Current Situation of Children in the World Report of UNICEF in 2009, Turkey is the 6th country among the most successful countries reducing child mortality under the age of 5.

Ranking of countries according to annual rates of decrease in child mortality under the age of 5

COUNTRIES	CHILD MORTALITY UNDER 5 1990	CHILD MORTALITY UNDER 5 2007	AVERAGE ANNUAL RATE OF DECREASE 1990-2007	DEVELOPMENT COMPARED TO 19990
Thailand	31	7	8,8	77
Peru	78	20	8,0	74
Maldives	111	30	7,7	73
Portugal	15	4	7,8	73
Vietnam	56	15	7,7	73
TURKEY	**82**	**23**	**7,5**	**72**



More than half of the child mortalities in the world results from mal-nutrition. Today it is the right of every person to receive safe and healthy nutrition. The Ministry gives special importance to this subject. Babies should be given only breast-feeding in the first 6 months. After the first 6 months, appropriate supplementary food should be given and vitamin and mineral deficiencies should be well taken care of. Within this scope, some certain programs are being carried out such as "Promotion of Beast-feeding and Baby-friendly Hospitals", "Iron-like Turkey", "the Program on Prevention of Vitamin D Deficiency and Promotion of Bone Health", "the Program on Iodine Deficiency Diseases and Iodization of Salt".

Promotion of Beast-feeding and Baby-friendly Hospitals

Human milk is indispensable as it strengthens the relation between the baby and the mother as well as its being the most beneficial nutrition for babies. The Ministry renews and updates the activities carried out within the scope of breast-feeding program taking the importance of the issue into consideration and continues the studies in order to ensure that more babies receive breast-feeding.

As a result of these studies, the rates of breast-feeding in the first 6 months were increased from 20.8% (in 2003) to 40.4% (in 2008).

Within the scope of "Promotion of Beast-feeding and Baby-friendly Hospitals", it is aimed to accelerate "Baby-friendly Health Institutions Program" in 2004 and to reach to delivery hospitals.

In accordance with this aim, cooperation has been maintained with universities, other health institutions, private sector and the voluntary institutions. The results of this cooperation have been incredible positive. The number of baby-friendly hospitals was 141 in 2002; in 2008 November this rate was 619. The number of the baby-friendly provinces is 76.

Iron-like Turkey

Iron deficiency is one of the factors effecting children's healthy growing in a negative way. We initiated the Iron-like Turkey Program in 2004 April in order to eliminate these deficiencies, to scan all the babies in terms iron deficiency, to provide babies without anemia between the months of 4-12 with iron supplement and to treat babies with anemia between the months of 4-12 with iron treatment. Since this date, we have been delivering iron drops free of charge. We can provide this facility for 91% of target group. Our aim is to keep this rate above 95%.

We knew that iron deficiency rate among babies was above 30%. According to the results of iron researches carried out in 2006 and the data analyses carried out in 2007, the iron deficiency rate decreased to 7%.

IRON-LIKE TURKEY

According to the data from the WHO, 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 anemia was very common in Turkey and, according to the researches, approximately 50% of the 0-5 age group children, 30% of the school age children and 30% of the nursing women had anemia.

Children have iron deficiency anemia between the 6-24 months most. In this period the growth of children is in its fastest process. Nutritional problems and iron deficiency occurring in this period have negative impacts on the

mental, physical and social development of children in the future. The easiest way to prevent this negative impacts from occurring is to protect children from iron deficiency anemia.

We started the "Iron-Like Turkey Program" in order to provide consciousness for the society on anemia, ensure the nursery of the babies for the first six months with breast milk, continuation of the nursery until the age 2 together with the proper additional food, ensuring iron support between 4-12 moths for all the babies ad iron treatment for the 13-24 months babies with anemia. We provided iron support for 4.225.000 babies from the beginning of the program to the end of 2006.

We enlarged the scope with the Iron Support for the Pregnant Program. We provided 2.853.850 boxes of iron preparation in since the beginning of the program.

"Research on iron deficiency" was conducted by the participation of our Ministry and Hacettepe University Medical School Social Pediatrics Department in March-April 2007. According to the unpublished preliminary results, anemia prevalence for children of 12-23 months drops from 30 % 3 to 7.8 %. The progress we have made for healthier and cognitively developed babies is clearer with these results.

Program on Prevention of Vitamin D Deficiency and Promotion of Bone Health

In order to ensure that bones of babies improve as well as their brains, along with breast-feeding and iron support, the Vitamin D support program has also been implemented.

Vitamin D is good for calcium balance of the body and bone muscle health as well as auto-immune diseases and prevention of malign cell reproduction. Vitamin D sub-clinical deficiency is estimated to be common and result of this deficiency affect baby and child health negatively.

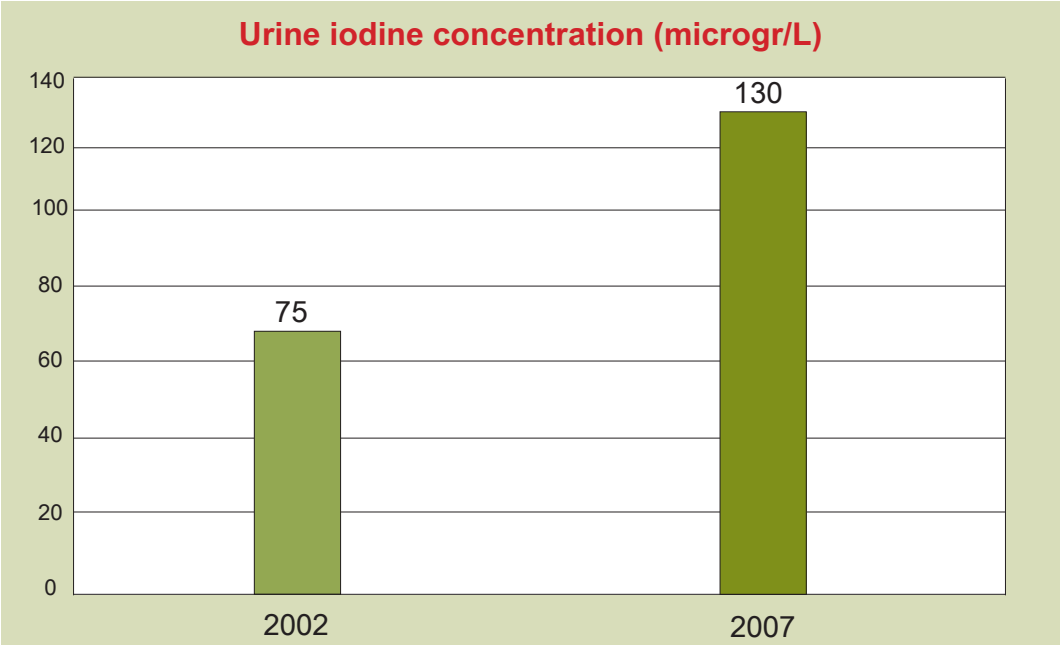
As for the solution of this problem the Program on Iodine Deficiency Diseases and Iodization of Salt has been initiated. Now Vitamin D is delivered free of charge and this service has been given 91% of the target group. Our aim is to keep this rate above 95%.

According to a study carried out in Atatürk University Medical Faculty, the rachitism incidence due to Vitamin D deficiency was 61 per a thousand between the ages of 0-3. This rate was 1 per thousand in February 2008.

Program on Iodine Deficiency Diseases and Iodization of Salt

Iodine deficiency is the cause of preventable mental disorders and is available in a small portion in human body. It is an efficient element for normal growing-up process.

The goiter disease due to iodine deficiency is a significant public health problem in the country. When the disease is at certain level, it causes serious problems like growing disorders for babies and children, mental disorders, being unsuccessful for school kids, dwarfism, miscarriage and death delivery and incidence of goiter in different age groups. As a result of the studies carried out under the scope of the "Program on Iodine Deficiency Diseases and Iodization of Salt", usage of iodine salt was 18.2 in 1995, 64% in 2002 and 70% at the end of 2003 and 85.4 in 2008 according to Turkey Population Health Research.

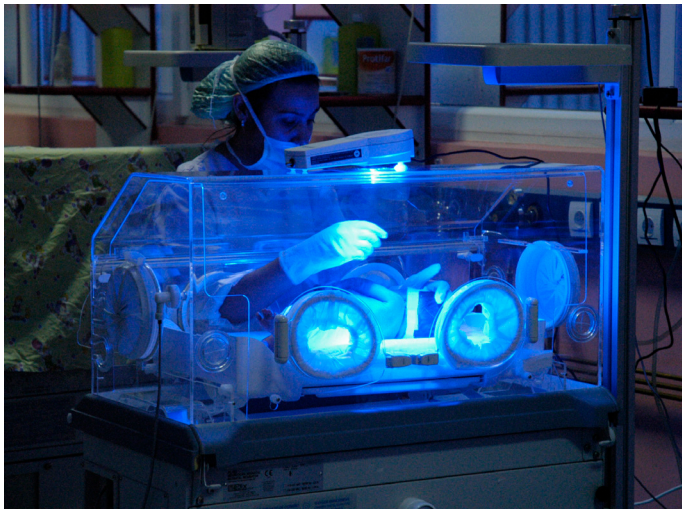


Additionally in 2002, in 30 provinces school children were examined in terms of their iodine levels in their urines and the average iodine level was found to be 75 micro/L. In 2007, the same study was carried out once more in the same provinces and the average iodine level was increased to 130 micro gr/L.

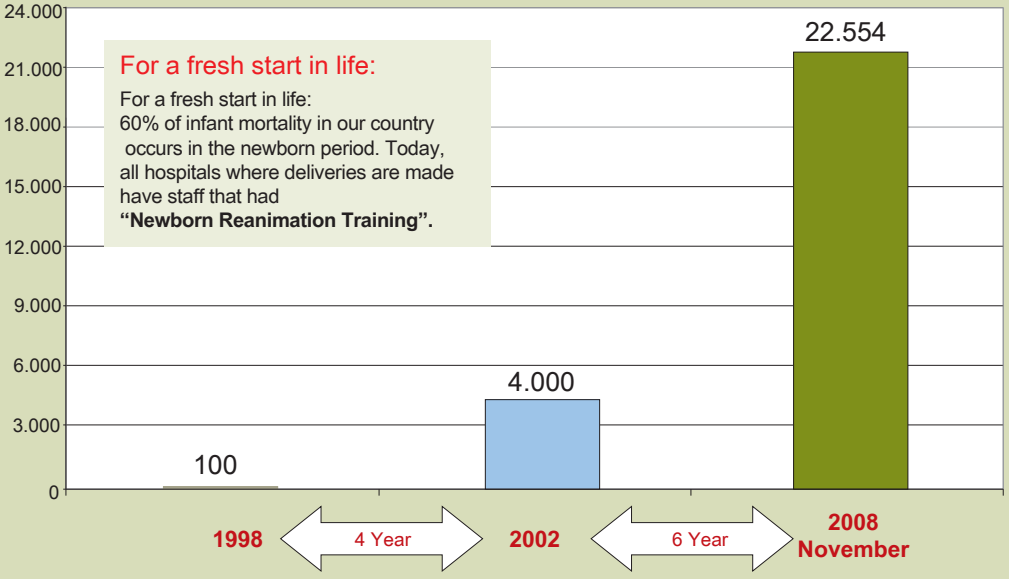
Neonatal Resuscitation Program

60 % of baby mortality happens in the first days after the delivery. The Neonatal Resuscitation Program has been accelerated in the period of Health Transition Program in order to provide the assistance and the care babies need in the first moments at the end of a difficult process, to decrease newborn mortality and to provide effective resuscitation.

22.554 health personnel have been trained since the beginning of the newborn reanimation program until November 2008. Today, trained personnel are available in all delivery units. Now the personnel to be employed in the delivery department is required to have NRP certificate.

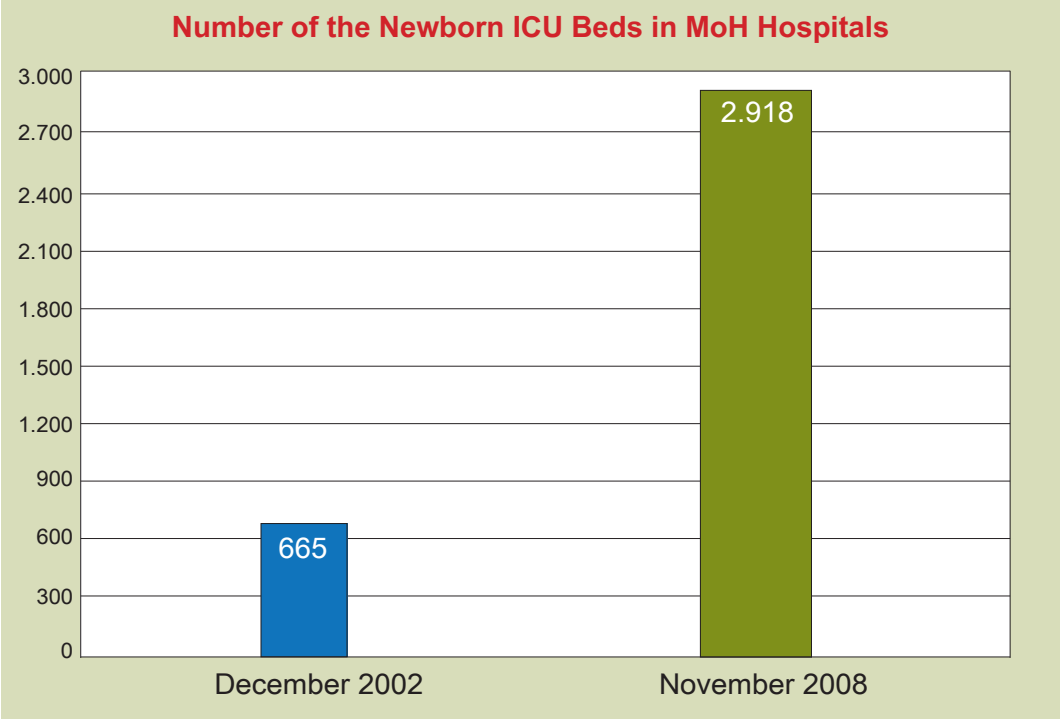


Number of Personnel who had "Newborn Reanimation Training"



Number of Intensive Care Bed for Newborns

The number of beds which was 665 in 2002 in the hospitals of Ministry of Health was increased to 2.918 in November 2008. The increase rate between the years 2002-2008 was 359%. In the same years, the number of the transport incubators was increased to 440 from 158 and the number of ventilators was increased to 491 from 252. The increase rates respectively were 170% and 105%. The increase rate of the nurses assigned for the newborn department was 155%.



Newborn Screening Programs

Phenilketonuria, Congenital Hypo-thyroid and Biotinidasis

In order to ensure that newborn babies start a healthy life, newborn screening programs were accelerated and communized throughout the country and it was improved. The phenilketonuria scanning was communized. Thus newborn babies were protected from phenilketonuria and congenital hypo-thyroid which can cause mental and bodily disorders if they are not prevented at an early stage. For phenilketonuria and congenital hypo-thyroid scanning, 89% of the target group was reached in 2007. In 2008 another metabolic disease biotinidasis was included into the scanning program.

A SUCCESS STORY

NEONATAL RESUSCITATION PROGRAM

The improvements in the socio-economical conditions among the society and strengthening the health infra structure helps to reduce baby and child mortality. Neonatal and prenatal mortality is less related with socio-economic improvements. These cases are more related with health precautions such as early diagnosis and treatment as well as the care provided during pregnancy and delivery.

The first moments after the delivery are the most important moments during which babies should receive assistance in order to adapt to an environment other than mother' womb. The treatments to be applied to a baby crying in order to breathe affect the whole life directly and cause life-long results.

To provide assistance and care for the newborn can only be achieved by professional personnel trained in this field. Under this scope, with the aim of preventing mortality and disabilities due to lack of oxygen, we started Neonatal Resuscitation Program in which we assign at least one trained health personnel and communized the implementer and trainers training all across the country.

In 1998, we started with 103 people in 4 implementation school. Today we have 23.028 health personnel in 1.154 implementation school (Gynecologists, pediatricians, anesthetists, practitioners, midwives, nurses, anesthetics technicians, etc). Among the people trained there are also participants from universities, military hospitals and private hospitals. Today there are trained personnel available in delivery hospitals and in private hospitals the personnel to be assigned for the delivery departments are required to have an NRP certificate.

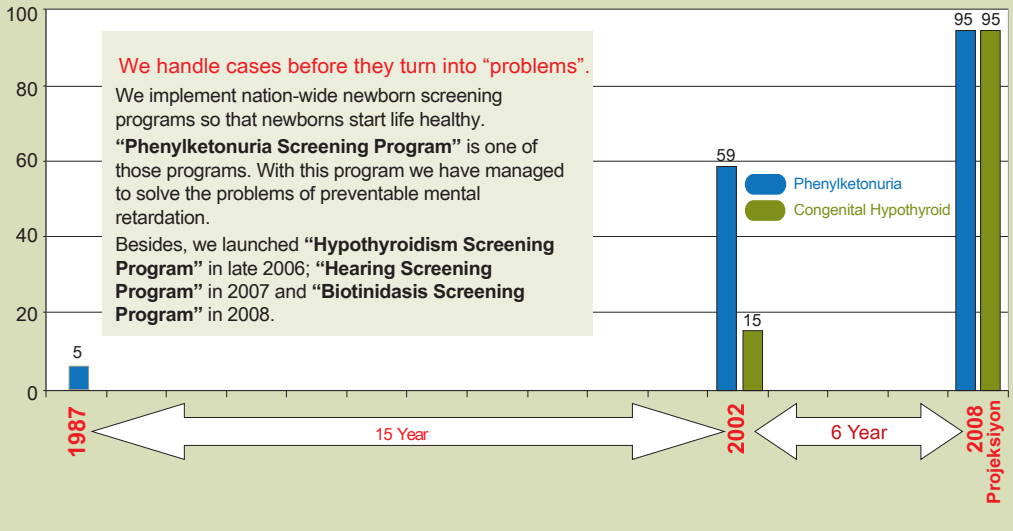
In order to prevent mortality in the entire world we carried out training programs in Cyprus, Afghanistan and Sudan. Additionally we provided NRP implementer training for the physicians and supplementary health personnel employed in Azerbaijan, Uzbekistan, Tajikistan, Kyrgyzstan, Georgia and Iraq.

We provided updating training for more than 700 personnel who received training 3 years before.

It is for sure that this program, aiming at everybody assigned in the delivery room, has been significant in reducing the mortality and disabilities due to lack of oxygen. As a result of the studies carried out for NRP and other studies (TNSA 1998-2003), baby mortality rate decreased from 43 per thousand to 29, post neonatal mortality rate decreased from 17 per thousand to 12 and neonatal mortality rate decreased from 26 per thousand to 17. When we have a look at the newborn period mortality in the past, we see that neonatal mortality rate was reduced to 26 per thousand in 1998 from 29 per thousand in 1993. However between the periods of 1998-2003 this rate was reduced from 26 per thousand to 17. This decrease is significant but still not enough.

We will continue our efforts until we stop loosing our babies due to preventable reasons.

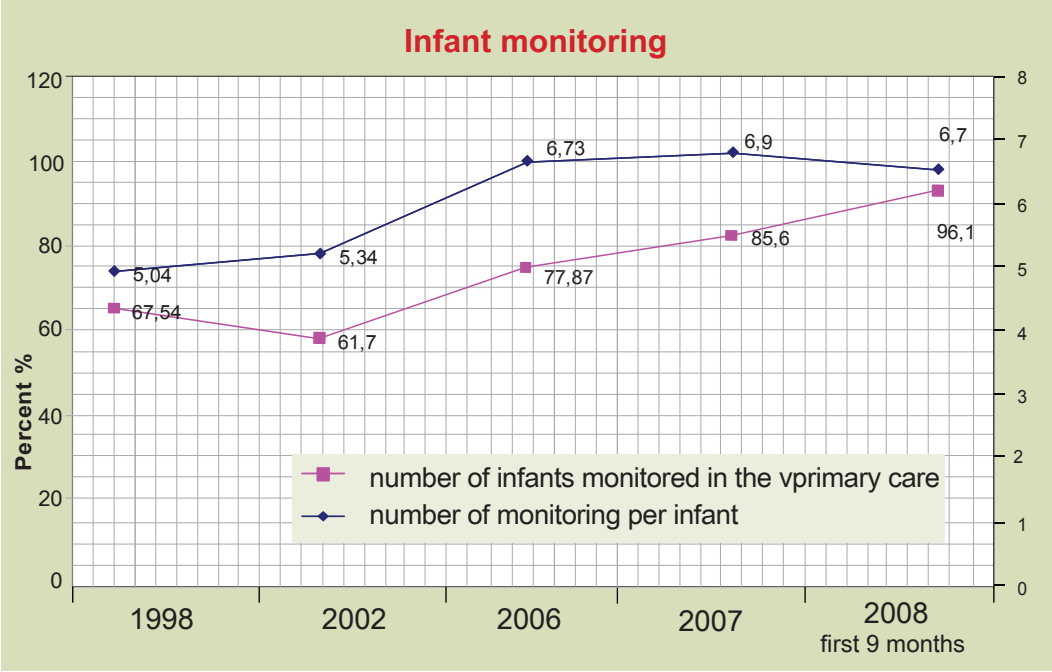
Rate of Newborns screened for Phenylketonuria and Congenital Hypothyroid (%)



Baby monitoring

Monitoring babies not only when they are sick but also when they are healthy will provide the necessary equipment in order to ensure that they lead a healthy life. The Ministry also monitors the quality of the monitoring processes as well as the quantity.

In order to improve quality child monitoring protocols were prepared and delivered to provinces. The aim of the Ministry is to monitor every baby and child in the same quality and quantity.



Hearing Screening

1-3 per mille of newborn babies are born with advanced hearing loss. This ratio sometimes rises to 6% as a result of diseases in the childhood, ear infections, accidents and some used drugs. “Newborn Hearing Screening Program” was initiated to perform hearing screenings to ascertain the babies born with a hearing disability in the early period and to ensure final diagnosis, hearing aid implementation and to perform the required rehabilitation works. Within the scope of this work, establishment of Newborn Hearing Screening Units was completed and hearing screenings were started in 75 provinces, in 143 institutions under our Ministry. Since the beginning of the program, 730 thousand babies were performed hearing screening procedure until the end of November 2008.

Conditional Cash Transfer

Until recently, our citizens might have been refused by the health institutions, but today the families in the poorest part (6%) of the entire population are given cash financial aid at a value of 20 TL per month for each pregnancy and for each child on condition that they continue their health controls in the health institutions and they are additionally given 60 TL financial aid on condition that they give birth to their child in the health institutions. Since March 2004, 1 million 600 thousand citizens have benefited from this initiative.

Conscious Mother Healthy Baby Program

"Conscious Mother Healthy Baby Program" was initiated in 2004 in order to reach all mothers giving birth at inpatient health institutions. With this program, it is aimed to inform the mothers on the basic issues related to themselves and their baby's health before they leave the hospital. Right after the birth of the baby, the families are informed about the basic care and health information for healthy growing of the babies, and the "Conscious Mother Healthy Baby Guideline" is distributed to mothers. Since the beginning, the Guideline has been distributed to almost 4 million mothers, up to the present.

Toy and Additional Food Safety

One of the leading important issues in terms of children's health is the introduction of healthy formulas consumed by children into the market and ensuring the safety of toys the important contribution of which to their mental development is already known.

In this context, in addition to the studies related to the quality of formulas consumed by babies and children, laboratory substructure was established in order to allow the analyses of toxicological materials that might pose a risk to children's health.

Within the scope of the protection of children's health, considering the European Union norms related to toys, legal arrangements were performed. Supervision personnel to be serving in provinces were trained by the specialists of our Ministry in order to increase the effectiveness of the market surveillance and supervision of uncontrolled toys which might pose a risk for health. The standards suited for European Union norms were put into effect for feeding bottle teats and nipples which are used in daily lives of our babies.

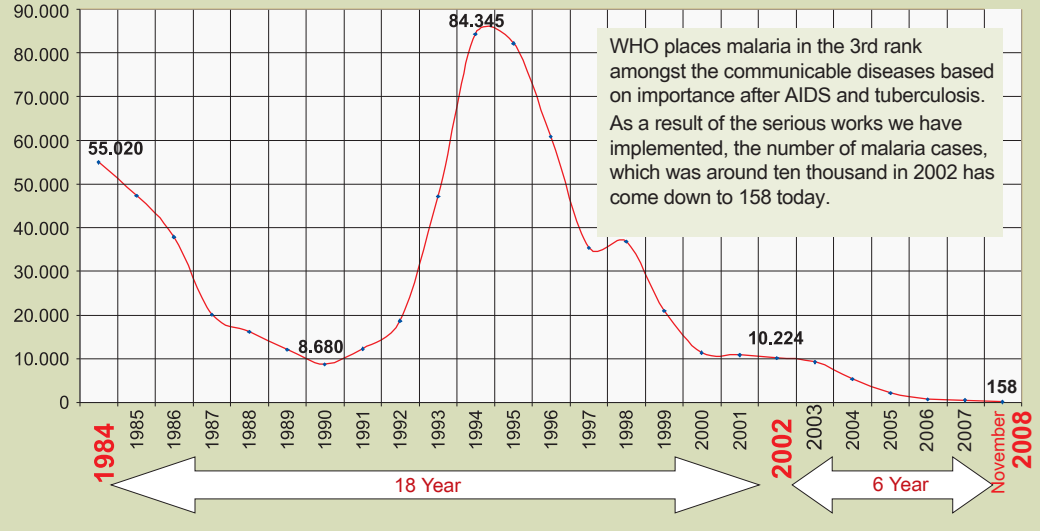
d) Effective Combat against Communicable Diseases

Malaria

The World Health Organization considers Malaria as the third important communicable disease after AIDS and tuberculosis. We have taken brave and rational steps to eradicate malaria disease within the framework of the WHO strategies and the policies of the Ministry.

Victory in Combat Against Malaria: Determination and Stability

Insecticide groups which have been used for years for the purpose of vector control were changed and more effective drugs were provided. Intensive working programs were prepared for vector control and the control of these programs conducted regularly. Coordination was provided in malaria-intensive provinces. Joint studies and information share were developed. Surveillance studies were carried out in order to find malaria cases. Establishment of the mobile teams was considered important with the aim of strengthening surveillance treatment services. One-to-one treatment of the patients with malaria diagnosis was performed. Temporary workers were assigned during the malaria season from the areas with no malaria or a low level of the disease. The number of malaria



Note: Malaria Control Department was established in 1983.

cases was 10.224 in 2002. With our effective fight with the disease, the number of malaria cases fell to 313 by the end of 2007. The number of cases was reduced to 158 by November 2008.

We prepared a country strategy to eliminate malaria in our country. The final aim of the Malaria Elimination Program, which is planned to be initiated in 2009, is to eliminate local malaria transmission in our country by 2012.

TO FORGET ABOUT MALARIA FOR GOOD

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The number of malaria cases was 10.224 in 2002. With our effective fight against the disease, the number of malaria cases fell to 313 by the end of 2007. As of the end of November 2008, the number of malaria cases was reduced to 158 cases and now we're at the stage of elimination for malaria.

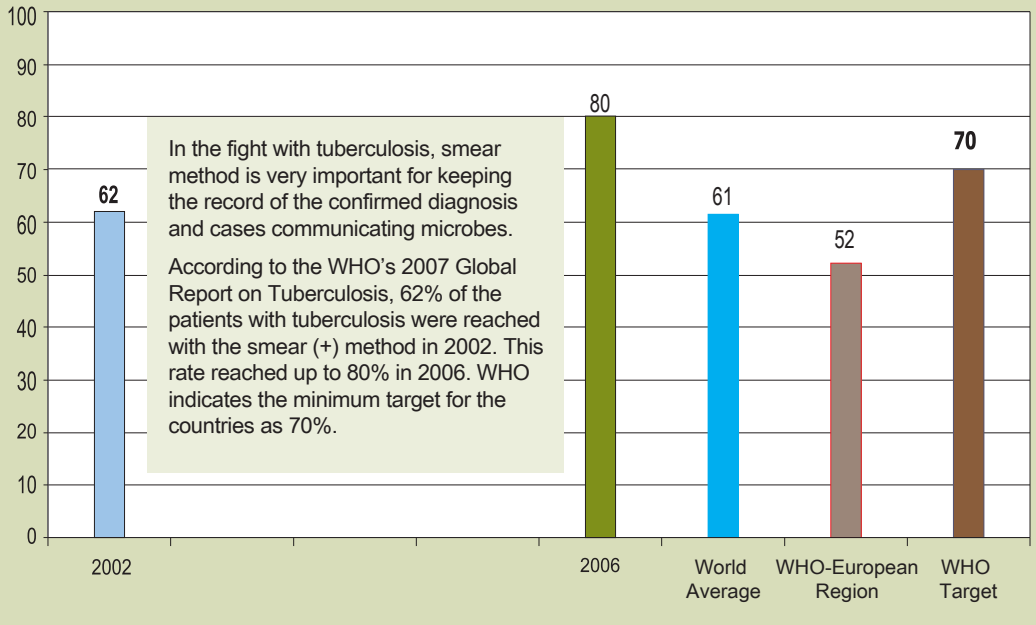
Tuberculosis

Although tuberculosis is a disease as old as human history, it still protects its importance as a public health problem in all over the world. According to the WHO reports, one third of the world population has already had tuberculosis microbe without being a tuberculosis patient.

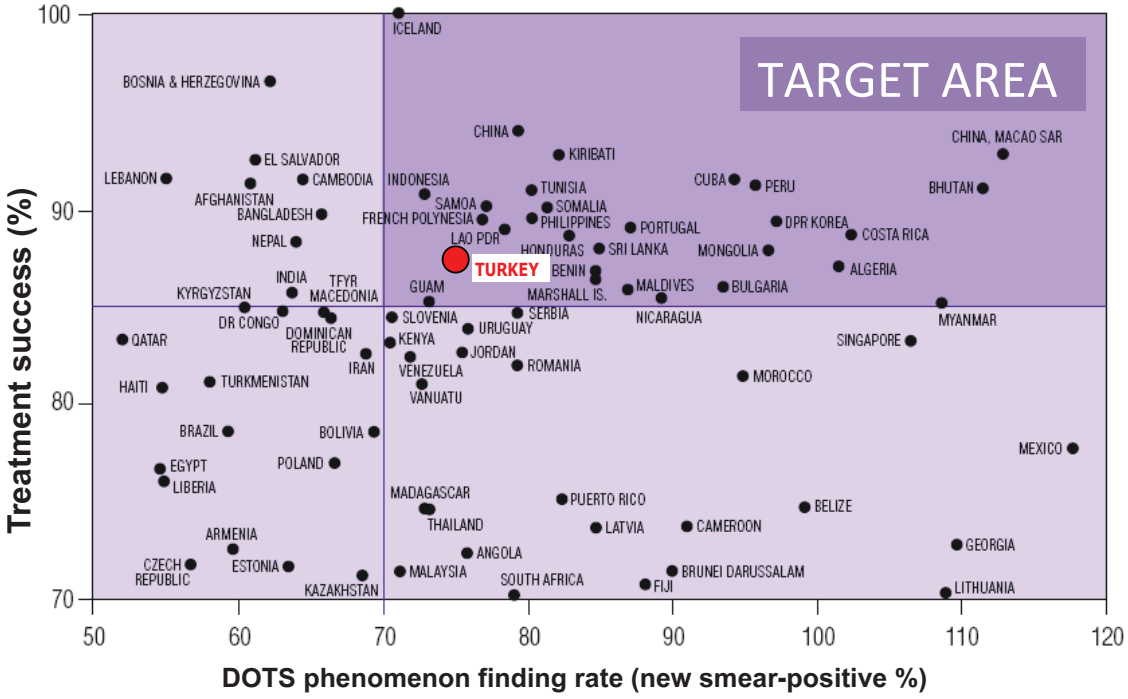
In our country, tuberculosis control are executed within the framework of National Tuberculosis Control Program including all primary and secondary health care institutions in addition to 243 TB Control Dispensaries, 22 Regional TB Laboratories, 4 Multidrug Resistant Tuberculosis (MDR TB) Reference Centers, 22 Chest Diseases Hospitals.

In TB Control Dispensaries, almost 3 million policlinic examinations and almost 2 million radiological tests and more than 100 thousand bacteriological examinations are conducted per year. According to the WHO Global Report, TB incidence of our country is 29 per hundred thousand and TB prevalence is 32 per hundred thousand. In counteracting TB, detecting with smear method is very important for definitive diagnosis and also for keeping the record of contagious cases. According to WHO 2004 Global Tuberculosis Report; in 2002, 62% of the projected TB patient number of Turkey was reached by using smear (+) method. According to 2008 Global Tuberculosis Report; in 2006, this ratio increased to 80%. Thus, we reached a ratio above the level of 70% set by WHO as the minimum target for countries. The target of Turkey in this issue is to reach a ratio above 90%.

Smear (+) Tuberculosis Patient Detection Percentage per Year



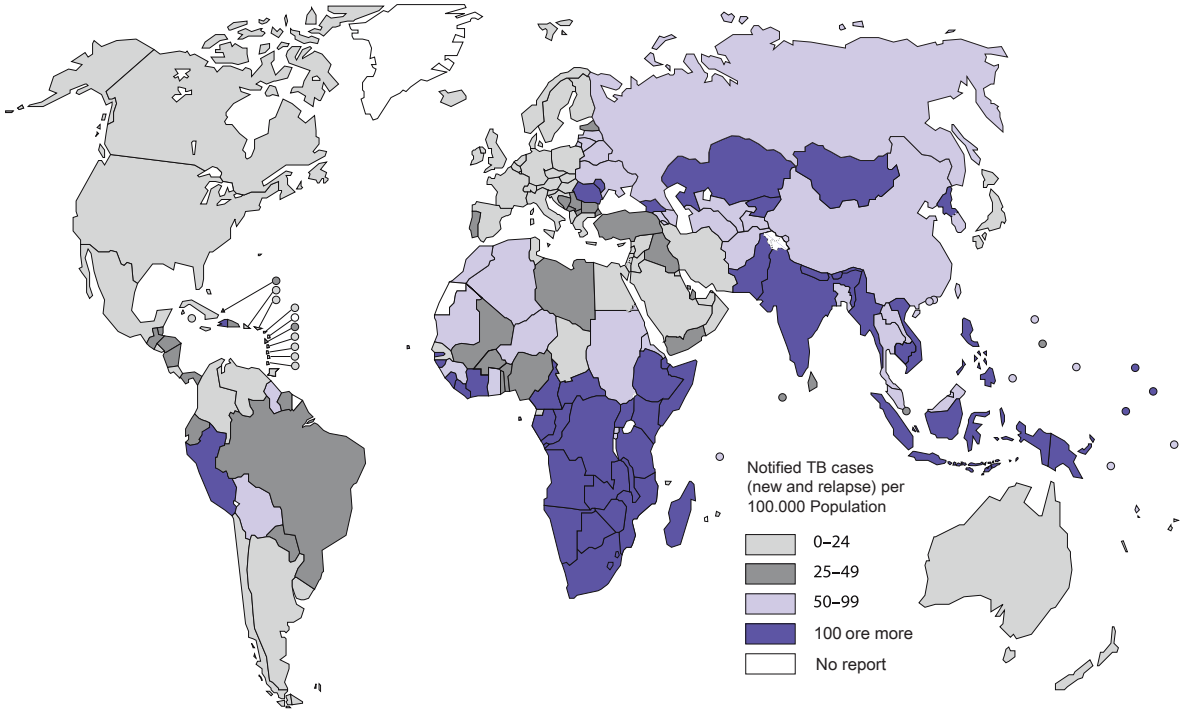
Situation of Access to Target Region in terms of Case Detection and Treatment Success Percentages of the Countries



Since tuberculosis requires long term treatment, cooperation and control of the patient is important. The practice of "Direct Observed Therapy-DOTS" started in 2003 for the fight with tuberculosis. Now, the treatment of the patients with tuberculosis is being conducted with this practice. DOTS is the medicament of the tuberculosis patients directly by the physician until the treatment is concluded. We provided nationwide generalization of this practice in 2006. In 2007 DOT strategy was implemented by 100% throughout the country, and 90,5% of the patients were treated under DOT.

Refik Saydam Hygiene Center Presidency (RSHCP) central laboratory is serving as the National TB Reference and Research Laboratory and it executes the technical consultancy and trainings works without stopping in order to improve the infrastructure of TB Control Dispensaries and Regional Reference Laboratories. External quality control system was established for microscopy and drug sensitivity tests in order to ensure the technical standardization of TB laboratories, and pilots, which were conducted in 7 centers in 2005-2007, were completed.

Tuberculosis Notification Rates by Countries 2006



Source: WHO Global TB Report, 2007

COUNTERACTING TB

In counteracting TB programs, "surveillance system" is very important for the follow up of the program. The data of TB patients, which were collected as aggregate data by 2005, began to be recorded on case-basis as of 2005 and the patients began to be followed up one by one. By this means, in addition to increasing the data quality, it became possible to sort out duplicated records and the results of treatments were made possible to be followed up separately for each patient. Another main component of the program is the uninterruptedly continuation of the treatment requiring long time and completion of it successfully. In our country, all TB drugs are supplied by our Ministry and delivered to TB patients free-of-charge in the form of Direct Observed Therapy-DOTS.

The treatment results are notified on case-basis and the treatment success is so high in the past few years; as a result of these, TB prevalence, which was 44 per hundred thousand in 2006, showed a significant decrease and reduced to 32 per hundred thousand in 2007.

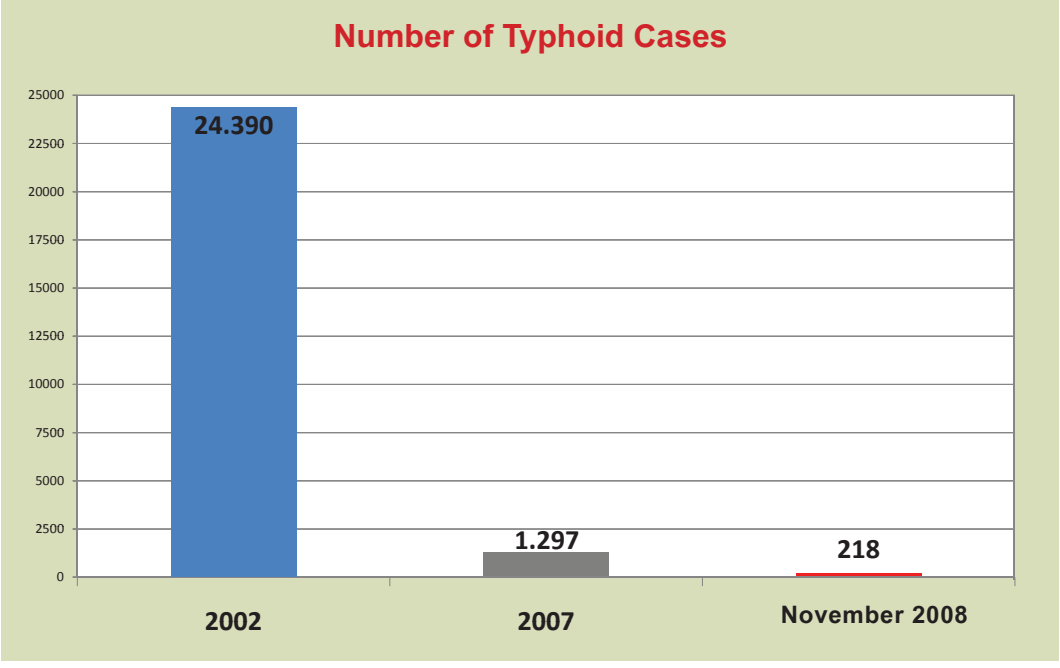
Waterborne and Food-Borne Diseases

Projects related to communicable diseases control were initiated as of 2005. Within the scope of these projects, 46 member staff (physicians) working in the central and provincial health organization were given advanced level epidemiology training and the trainings are continued to be given. Within the scope of the same projects, 240 physicians working in the Communicable Disease Branch of Provincial Health Directorates were given middle level epidemiology training. 7000 physicians working in the field were given basic level epidemiology training. With this enhancement in the personnel capacity, the outbreaks were begun to be responded earlier and more scientifically. The number of the waterborne and food-borne diseases is decreasing as a result of the training programs performed in the field and the surveillance differences brought by the notification system renewed in 2005.

The number of dysentery/acute bloody diarrhea cases was 27.550 in 2002 and there were 4 deaths connected with these, this number reduced to 6.670 in 2008 and in the past two years no death case was detected.

Typhoid fever

Across the country, the number of typhoid cases was 24.390 in 2002, and this number reduced to 1.297 in 2007. At the end of November 2008, the number of cases reduced to 218. To reach this success, collaborations with municipalities were developed and microbiological safety of drinking water was significantly improved.



Other Communicable Diseases

Concerning Avian Influenza, which was seen in our country in 2006, our preparations, initiated 2 years ago, made it possible for us to control this disease in a short time with an appropriate intervention. Our activities are going on in line with the "National Preparation Plan on Pandemic Influenza" which was prepared by a total of 60 specialists including scientists from training and research hospitals, representatives of related public agencies and institutions, and from private sector.

Very important studies were conducted within the scope of the project entitled Strengthening of the Epidemiological Surveillance and Control of Communicable Diseases System in Turkey (ESCCDS), performed with the contributions of European Union and World Health Organization.

Communicable diseases strategic plan was prepared and published.

Crimean-Congo Hemorrhagic Fever

Following the detection of the disease in 2003, heavy studies were initiated related to the issue. The Zoonotic Diseases (CCHF-Crimean Congo Hemorrhagic Fever) Advisory Board was formed from academicians who are specialists on this issue and from the officials of related institutions. In line with the recommendations of this Board; clinical identification, case identifications, case approach recommendations, surveillance system, referral criteria and case management and isolation measures were identified.

An info note on CCHF disease and a Circular pertaining to "clinical identification, case definitions, case management of disease and isolation measures" were published.

Within the scope of public awareness raising and information activities; a booklet, a film about tick removal, information documents were prepared for health professionals, and posters, brochures and a short TV film were prepared for public. Within this scope a total of 400.000 brochures and 200.000 posters were distributed to Provincial Health Directorates.

Since minimizing the tick-human relation is of great importance for protection from Crimean Congo Hemorrhagic Fever, our Ministry has completed the registration of tick-repellents/miticides containing 0.5% permethrin as the active ingredient which can be used through applying it to clothes in special conditions, and these medicines were made to be easily available by the public in the market. Our Ministry has procured some certain amount of these medicines and distributed to people in regions where the disease is frequently seen. The houses in the region were visited and face to face trainings were given to people about the disease.

In addition to these, frequent visits to the region were performed by officials of our Ministry and they conducted trainings, evaluations and reviews on the field.

Besides, in service trainings were performed in order to inform the health professionals, to share the scientific data produced by the scientists of our country and also to conduct the surveillance in the correct way.

Norovirus

Surveillance follow-up for waterborne and food borne diseases is performed in 81 provinces. As a result of this surveillance, it became possible to early respond to outbreaks.

A case management guideline was distributed to all field workers through a Circular including what to do during the outbreaks of chlorine resistant Norovirus and the measures for preventing these outbreaks.

Within the scope of counteracting communicable diseases, bio-safety cabins were procured to improve the existing laboratories, thus the contamination risk of the performed tests was minimalized and their reliability was increased. Developments in molecular tests enabled the quick diagnosis and epidemiological typing of microorganisms, in this way they provided a chance to serve the whole country.

With the coordination of RSHCP, National Enteric Pathogens Laboratory Surveillance Network was established in 2007, it was composed of laboratories in different regions in Turkey. Participating laboratories send their isolated strains of Salmonella spp. (including Salmonella typhi and S. paratyphi A, B, C), Shigella spp., Enterohemorrhagic Escherichia coli (O157 and E. coli apart from O157), and Campylobacter spp. to Refik Saydam Hygiene Center Presidency (RSHCP) for verification. Data sharing is carried out in electronic environment. Up to the present time, approximately 600 strains have been sent to enteric pathogens laboratory. The number of the microorganisms, which will be included into the network in the future, is planned to be increased.

Various studies have been conducted in relation to the establishment of diagnosis of the new diseases that came into the agenda in recent years and pose a serious threat to public health.

Crimean Congo Hemorrhagic Fever: The serum samples collected from

suspected cases and sent to our laboratory are studied with advance methods (PCR and ELISA). In addition, advance tests (sequencing) might also be carried out in the positive samples.

Norovirus: Norovirus antigen is searched in feces samples with ELISA method.

Arbovirus: Tests might be carried out with PCR method for West Nile virus, TBE virus, chikugunya , Sand Fly Fever; and for WNV and TBE virus with ELISA method.

Within the scope of the Project for Strengthening the Surveillance of Communicable Diseases, we might handle the performed training activities under two titles:

Basic Laboratory Management Training: Approximately 500 people who work in MoH hospitals, University hospitals, Regional Hygiene Center Directorates and Public Heath Laboratories as "microbiology and clinical microbiology" and "infectious diseases and clinical microbiology" specialists were given trainings.

Specific Laboratory Trainings: 2 Trainings have been conducted under 6 headings beginning from 2 June 2008 to 31 January 2009, the headings are Parasitological, Enteric Bacteriology, Diphtheria-Pertussis, Zoonotic Agents, Sexually Transmitted Infections and Antibiotics Resistance Surveillance. 186 people who work in MoH hospitals, University hospitals, Regional Hygiene Center Directorates and Public Heath Laboratories as "microbiology and clinical microbiology" and "infectious diseases and clinical microbiology" specialists were given trainings.

A mobile laboratory was procured in order to respond to the outbreaks in place. This laboratory has all the infrastructure and satellite communication systems to review the waterborne and food borne outbreaks and, if required, it can work in BSL-3 the conditions. Appropriate vehicles were procured for transferring the outbreak investigation teams into the locale.

Prevention of Hospital-acquired Infections

Despite the developments in medicine, hospital infections are a great health problem all over the world. Hospital infections might cause to deaths if they are severe, and they pose a great threat especially for patient safety and to health professionals, visitors, non-health professionals and public health. By taking measures, it is possible to reduce the frequency of hospital infections which bring a financial burden to the country's economy by extending the patients' duration of hospital stay.

Just as in the whole world, the hospital infections are also an important problem for our country. Despite the fact that serious studies have been undertaken in the developed countries on hospital infections for 40-50 years; except for the studies of relevant specialty fields on the issue, the studies and administrative support in our country were insufficient. Under our Ministry, the studies on this field were initiated in September 2004.

Legislative studies in the field of hospital infections were completed in the years of 2005-2007. The implementations have been executed within the scope of "Inpatient Health Institutions Infection Control Regulation" (dated 11.08.2005, Official Gazette No. 25903).

The studies, pioneered by our Ministry, have been performed in line with the opinions and decisions of the "Hospital Infections Scientific Advisory Board" which is composed of experts of the field from various schools of medicine and training and research hospitals.

One of the important tools in the improvement of the delivery of qualified health care services is to train manpower appropriate for the features required by the service delivery. In accordance with the relevant Regulation, all inpatient health institutions are obliged to assign an "infectious diseases and clinical microbiology" specialist per thousand beds as the infection control (IC) physician, preferably having a national/international certificate. They are also obliged to assign one of their nurses who has infection control nursing certificate, issued by the Ministry, as the infection control nurse per two hundred and fifty beds.

Thanks to the infection control trainings, conducted since 2007, up to the present, 145 infection control physicians and 365 infection control nurses have been given National Certificates.

National standards of "Ventilation in Hospitals and Its Control" were prepared with the works of Scientific Advisory Board.

In consequence of our serious studies in the field of hospital infections, we have been able to reach national data and develop national policies since 2006.

In accordance with the relevant Regulation, the hospital administrations are obliged to submit their annual activity reports, including hospital infection rates and surveillance results, to the Ministry no later than the end of February of each year. With the support of Scientific Advisory Board, "National Hospital Infections Surveillance System" was developed in order to collect and analyze the hospital infections data in a single center, to give feedbacks by evaluating the analyses, to develop policies for the prevention and control of hospital infections.

The data with regard to hospital infections have been collected by forms via internet and mail between the years of 2005-2007.

In 2006 the number of the notifying institutions was 937. In 2007 this figure was increased to 1113. In 2006 there was an infection control committee in 91.0% of the inpatient treatment institutions, an infection control physician in 89.1%, an infection control nurse in 92.8% and an infection control program in 74.9%. These figures were 91.7%, 92.8%, 94.6% and 80.6% respectively in 2007.

Similarly in 2006, the infection surveillance used to be carried out in 18.4% of the intensive care departments of institutions. In 2007 this rate was increased to 26.2%. In 2007 surgical infection surveillance was applied in 37.7% of the institutions.

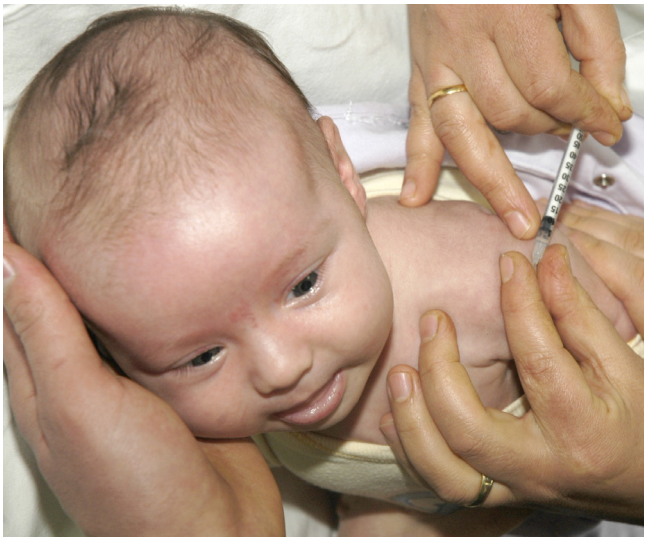
Today hospital infection rates are categorized and their percentages are documented. Now hospitals can compare their infection rates in the surgical field, invasive device and services. Additionally their anti-microbial resistance rates are also evaluated.

The National Hospital Infections Surveillance Web (UHESA) initiated in August 2007 under the scope of the Ministry collects and analyzes updated hospital infection data in accordance with the international standards. Hospital accesses to UHESA through the passwords provided by the Ministry and reach their own hospital infection data. Participation of inpatient hospitals linked to the Ministry into UHESA was made compulsory in May 2008. The data on hospital infections of inpatient hospitals not included in the web will be collected as an integrated part to UHESA at the end of the year.

In a well-functioning surveillance system, there should be standardized data collection forms and standardized diagnosis criteria. The “Pocket Book”, “National Hospital Infections Surveillance Guide” including national hospital infections surveillance forms and the standard diagnosis criteria were prepared and delivered to inpatient treatment institutions and they were published on the web page of the Ministry.

The Ministry supports this service via Infection Control Consultancy Line forum established on the web page and via phone and e-mails in order maintain access to surveillance data on time and accurately. Thanks to efficient control of hospital infections, the quality of patient care will be improved and there will decreases in health expenses.

e) Immunization Programs: Vaccines



In year 2002, nation-wide target for the vaccination of the children was 78%; for some provinces in the south-east it was even below 50%. A 96% rate was reached in year 2007. There were no provinces with a vaccination rate below 90% in 2008.

While the budget allocated for vaccine in 2002 was YTL14 million, it reached up to YTL 205 million in 2008. Vaccination was administered for 7 diseases (diphtheria, pertussis, tetanus, polio, measles, hepatitis-B, tuberculosis) up to the end of 2005. Along with the HİB, rubella, mumps vaccines which were started to be administered in all health institutions, the number of the prevented diseases decreased to 10 from. The number was 11 with the conjugate pneumococcus vaccine, which was started to be administered

The Assurance of our future, our children are assured

When we came to office, the countrywide vaccination rate was 78 % for targeted children group. This ratio was even below 50% in provinces like Şırnak, Hakkari, Diyarbakır. Today the ratio of 96% that we reached is achieved only by the developed countries in the world.

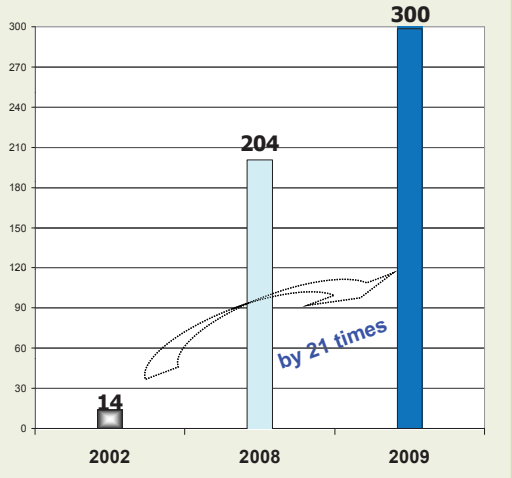
With the innovations we made in 2006 in the vaccination schedule, we included rubella, mumps and meningitis in our vaccination program.

In 2008, we started to use the DaBT-İPA-Hib (diphtheria, acellular pertussis, tetanus, inactive polio, hemophilus influenza type b) vaccine and the conjugated pneumococcus vaccine which are in the cavvine schedules of the developed countries.

Vaccination Rates of Countries in WHO 2008 Report(%)	
Low income group	68
Low-middle income group	89
High-middle income group	94
High income group	96
Turkey*	**96**

Source: WHO - World Health Statistics 2008 ;
* Ministry of Health

Resources Allocated to Vaccination (million YTL)



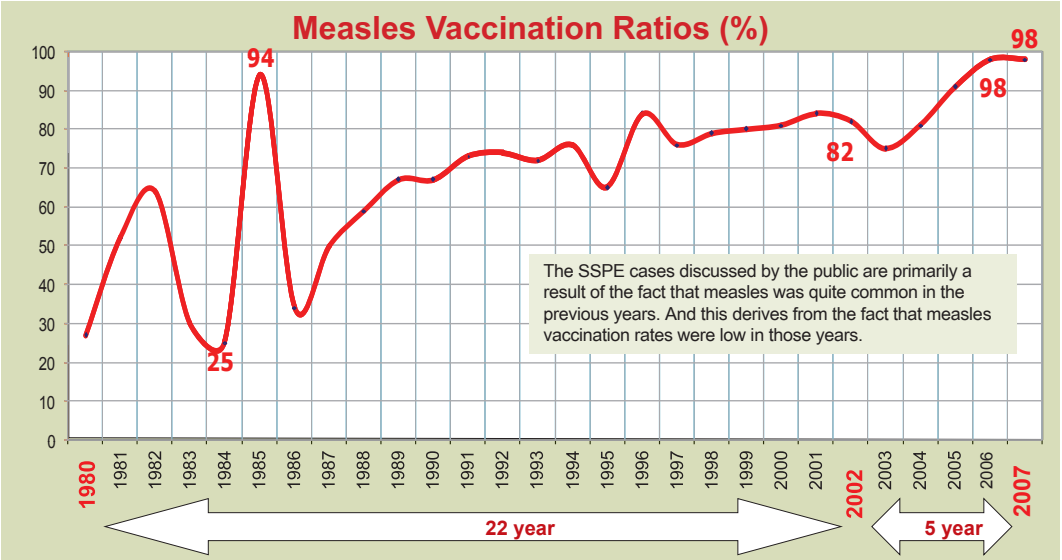
in November 2008. Starting from the year 2008, DaBT-İPA-Hib (diphtheria, acellular pertussis, tetanus, inactive polio, hemophilus influenza type b) vaccines were started to be administered within a single injector (5 in one, mixed vaccine) and thus vaccination against 5 different diseases was done, all at once. So, the total number of injections up to the completion of the first age, decreased to 8 from 11. The number of vaccination visits decreased to 6 from 7.

RIn addition to the routine school vaccination program, under the current Hepatitis B Control Program, Hepatitis vaccine was administered to the 8th grades in 2005-2006 term, to the 7th and 8th grades in 2006-2007 term and to the 3, 4, 5, 6th grades. Approximately 8 million children were vaccinated. Additionally, hepatitis B disease protection has been ensured for the community through administering the hepatitis B vaccine to adults.

Within the scope of Rubella and Congenital Rubella Syndrome Control Program, 8th grades were vaccinated in 2006-2007 term and all the students older than the 2nd grades were vaccinated and thus, approximately 7 million 200 thousand children was administered rubella vaccination.

Within the scope of Maternal Neonatal Tetanus (MNT) Elimination Program which had been started in 1994 and reviewed in 2005, the 1st and 2nd Tetanus Vaccination Days were held in 2006 and the 3rd Tetanus Vaccination Days were held in 2007 May-June. 68% vaccination rate was accomplished in the 3rd Vaccination Days. Newborn tetanus number was 44 in 2003 and it fell down to 3 in 2007. Currently the newborn tetanus is at elimination stage. No diphtheria case was reported since 2004. We started conjugated pneumococcus vaccination in October 2008. YTL84 million (YTL59 million general budget, YTL25 million central circulating capital) budget was allocated for this implementation. With this resource, the budget allocated to the vaccination will reach up to YTL205 million.

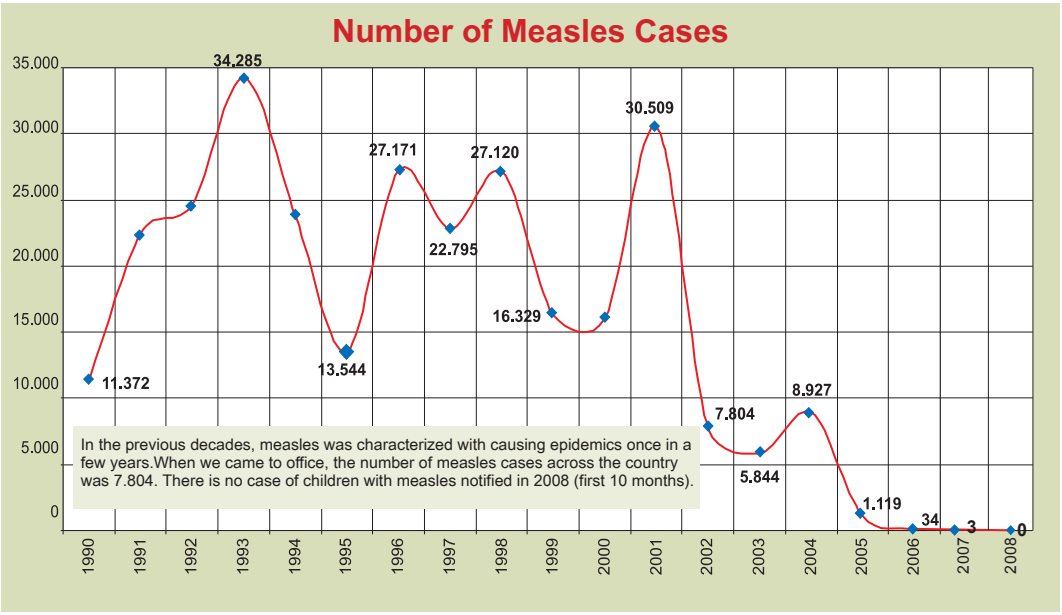
A major vaccination campaign was conducted between the years 2003-2005 in order to eliminate measles and 18 million 217 thousand children were vaccinated. Vaccination rate was 97% for this campaign. The campaign was aiming at the largest target group of the Republic history and in Europe. In addition, support is being given to the elimination target by vaccinating all the enlisted young men by 2009. These studies gave result in the shortest time. In 2002, 7.804 measles cases were reported but in 2007 only 3 cases were reported. No children cases were reported for 2008 by December.



When we came to office the measles vaccination ratio was below 50 % in some provinces and 82% across the country. We vaccinated 18 million 217 children in order to eradicate measles. We achieved the most comprehensive vaccination campaign of Europe. We reached the highest ratio in the Republican period.

In 4 years, we raised measles vaccination ratios to 98%. According to WHO Report 2008 vaccination ratio is 94 % in the European Region.

SSub-acute Sclerosing Panencephalitis (SSPE) cases were begun to be recorded annually starting from 2005. 1.131 cases were reported between 1995-2005. 115 cases were reported in 2006, 58 in 2007 and 29 cases were reported by the end of 2008 November. SSPE disease onsets 6 years after measles.



A DREAM IS COMING TRUE:

FAREWELL TO MEASLES…

Within the scope of fighting against measles, WHO's "Elimination of Measles" target is about to be accomplished in Turkey. We are decisive for our aim to stop the domestic virus circulation in Turkey by the end of 2010.

Within this framework, we conducted a major vaccination campaign for 2003-2005. The target groups were all the students in primary education in 2003, all pre-school children, 1st grades and the children aged 6-14 who do not attend to school in 2005.

18.217.000 children were vaccinated during this campaign. The vaccination rate was 97%. The campaign was aiming at the largest target group of the Republic history and in Europe.

As a result of the vaccination during and after the campaign, only 3 cases were reported in 2007 while this figure had been 30.509 in 2001. No cases were reported in 2008. No we are working to prevent the importation of measles from other countries. Dreams come true: Farewell to measles…

Vaccine Symposium

The first of the National Symposium on Vaccine was held in 2005 with international participation. The latest information on vaccination in the world was shared and Turkey's vaccination program was considered again under the light of the scientific information. 3 new vaccines (rubella, mumps and Hib) were added into the program in 2006. 600 local and foreign individuals participated in the symposium. It is aimed at conducting the symposium biannually with the contribution and participation of the Ministry of Health.

The 2nd National Symposium on Vaccine was held in Ankara between 31 October-3 November 2007 with international participation. Nearly 750 local and foreign experts participated in the symposium and the latest scientific information on vaccine and vaccination were discussed. The participants appreciated the positive development of Turkey's vaccination program, the high vaccination rates, the Measles Elimination Program and the major decrease in the prevalence of the vaccine protectable diseases. The inclusion of new vaccines in the program was discussed and the inclusion of five-set (DaBT-IPV-Hib) vaccines (with easy application and less side effects) was supported following the necessary logistic preparations. These preparations were accomplished in 2008 January and five-set vaccination was initiated. Also, conjugate pneumococcus vaccine was added considering the high level accomplished for the vaccination program in Turkey.

Having regard to the benefits provided by both symposiums and its contribution to our vaccine program, it is considered very important to make the vaccination symposium traditional. We initiated the preparations in order to realize the 3rd National Symposium on Vaccine in Fall 2009.

A SUCCESS STORY:

WE ARE IN THE FIRST LEAGUE OF VACCINATION SCHEDULE

The first obligatory vaccine –small pox vaccine- came into our lives in 1930. In 1963 systematic vaccination was initiated in our country. Our children were getting closer to a more healthy future step by step.

A great success was reached with regard to diphtheria, pertussis, tetanus, polio and measles for 0-5 aged children in 1985. 92% of the non-vaccinated or deficiently vaccinated children were vaccinated. However the inequality between the vaccination rates in the provinces could not be eliminated.

Hepatitis B vaccine was added into the National Vaccine Calendar in 1998. We began protecting our children against this disease beginning from their birth. It was after 8 years that a new antigen was added. In 2006, meningitis (hemophilus influenza type b), rubella and mumps vaccines were added. Starting from the year 2008, (diphtheria, acellular pertussis, tetanus, inactive polio, hemophilus influenza type b) vaccines were started to be administered within a single injector (5 in one, mixed vaccine) and thus vaccination against 5 different diseases was done, all at once.

Turkey is celebrating the 10th year of the elimination of polio in 2008. The children born in the last 10 years never faced or even heard of polio disease.

Now it is time to eliminate measles

Turkey conducted a successful fight against 10 children's diseases up to 2008. The fight against pneumonia began with the conjugate pneumococcus vaccine in 2008. Now our children are protected against 11 diseases. They have healthier lives ahead.

During the implementation of the Program for Transformation in Health, the budget share allocated for vaccination grew enormously. It was YTL14 million in 2002; YTL205 million in 2008 and is planned to be YTL300 million for 2009.

We have a 95% vaccination rate and there are no provinces or areas under 90%. This rate can only be reached by the developed countries. Following the inclusion of the pneumonia vaccine in the national vaccine calendar, the number of the vaccines reached up to 11.

Our "National Vaccine Calendar" is between the first 17 countries in the world now and it joint to the first league.

f) Sexual Health and Reproductive Health Program

Turkey's Program on Reproductive Health

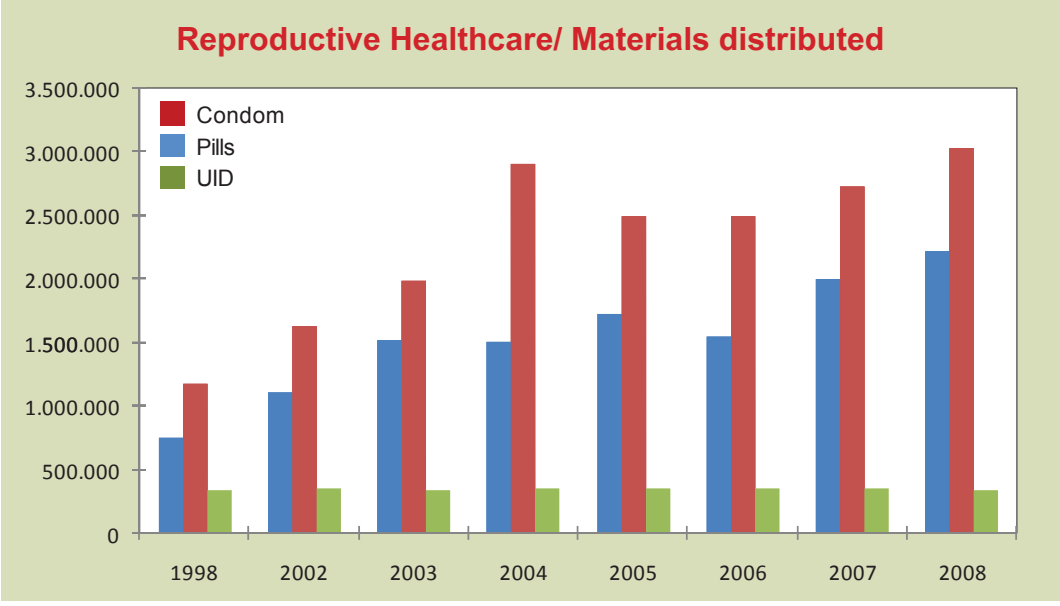
Within the scope of Turkey's Program on Reproductive Health (TPRH) between 2003-2007, programs were established for internationally important issues which were also among the priorities of our country. These issues were determined such as Safe Motherhood and Emergency Obstetric Care, Family Planning, Sexually Transmitted Diseases, Youth-friendly Reproductive Health.

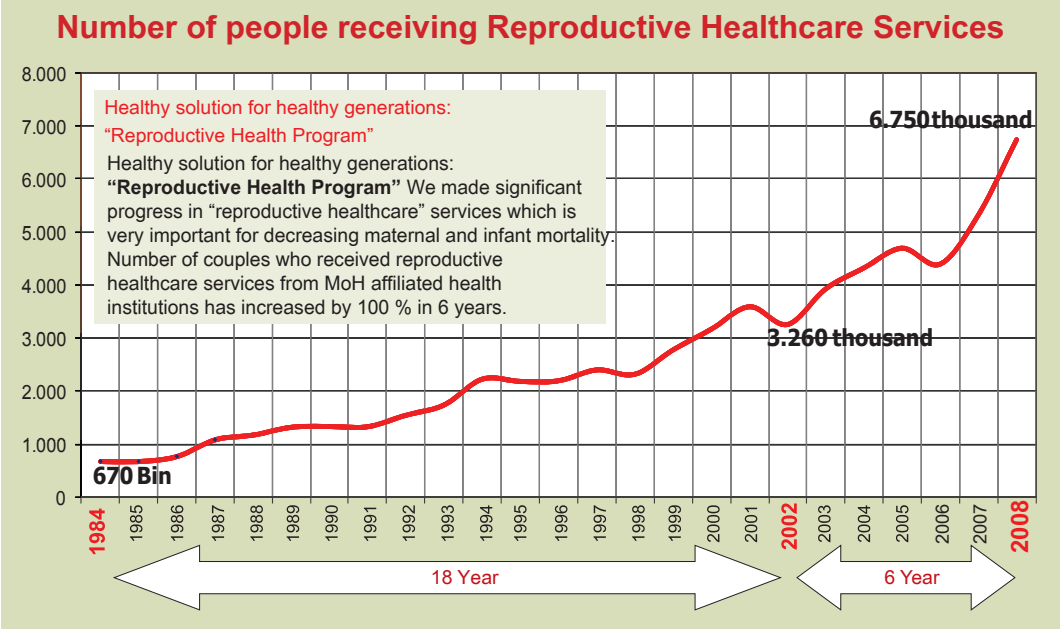
The quinquennial Demography and Health Survey in Turkey (DHST) which is an important source of data that shows us where we are in reproductive health was lastly conducted in 2003. The 2008 survey has just accomplished and the statistical evaluation is within the final phase. National Survey on Maternal Mortality and the Study on Health Behavior were conducted in 2005.

88 projects were conducted with 108 non-governmental organizations on all reproductive health related areas. Direct training was provided for 5 million individuals within the scope of these projects.

The births with intervals shorter than two years and a large number of births (4 and more), births at early (below 18) and old ages (35+) increase mother and infant mortality rates.

Number of the persons benefitted form the reproductive health services provided by our Ministry is also astonishing. A total of 5 million 600 thousand citizens benefitted from our free reproductive health services on in 2007. This figure reached up to 6 million 750 thousand in 2008.





Pre-marriage and pre-pregnancy consultation program

A happy start and continuation for the marriage is possible with the knowledge of the issues such as sexual health/reproductive health and inter-family communication besides loving and caring for each other. This can be achieved through the positive attitude of the health personnel. Thus, we initiated the pre-marriage and pre-pregnancy consultation program.

Within the scope of this program, for a happy and health start, consultancy service on reproductive health and support is given to the couples who come in for health report for marriage.

Hemoglobinopathy Control Program

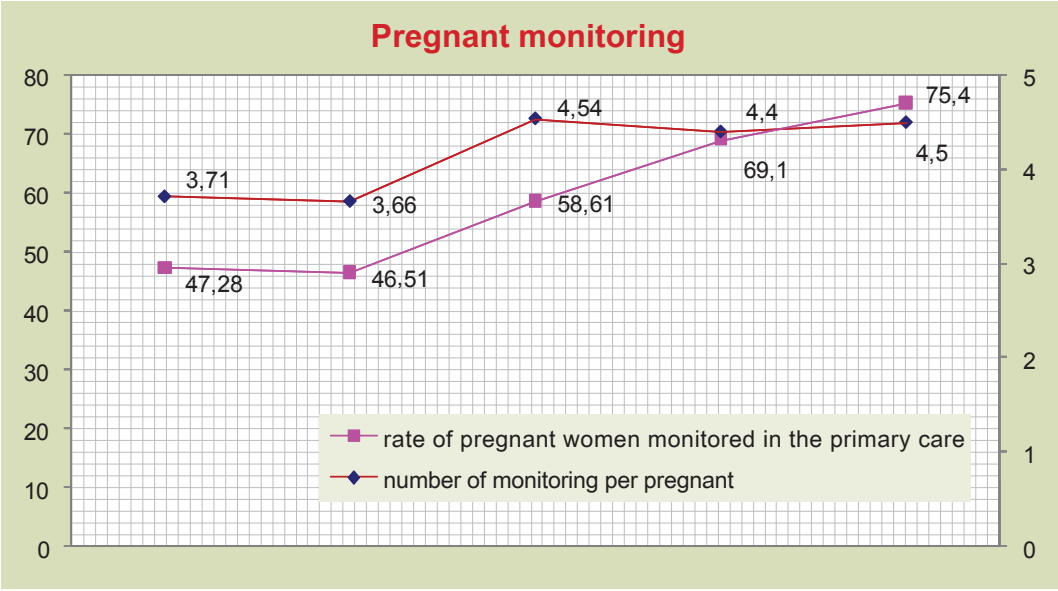
Genetic blood diseases -especially thalassemia and sickle cell anemia- are very important in Turkey. The rate of healthy carrier of beta-thalassemia disease is 2,1% in Turkey. There are 1 million 300 thousand carriers and 4.500 patients.

Therefore, the Hemoglobinopathy Control Program was initiated in 2003 in order to conduct the organization and scale-up of the current services within the 33 provinces in which the genetic blood diseases are mostly intense.

Through this program, screening tests are administered to the couples to be married and measures are tried to be taken.

Pregnancy Monitoring

Especially the proper follow-up of the risky pregnancies and emergency interventions save the lives of lots of mothers and babies.



The importance given on this issue by our Ministry positively reflects on the surveys. In 1998 DHST the rate for taking pre-birth care once was 68%. This rate was 81% in 2007. At least 4 follow-ups are considered necessary for a health pregnant woman by international institutions. According to the DHST 2003 results, the rate for the pregnant women attending at least 4 follow-ups was 54%. This rate is 75% according to the records of our Ministry.

Iron Support for the Pregnant

Health problems related with iron deficiency are seen in Turkey; therefore it is essential to provide additional iron support to the mothers in order to meet the increasing iron need during pregnancy. Our aim is to provide iron preparation for each pregnant woman for 9 months (beginning from the third month of the pregnancy until the end of three months following the delivery). 5 million boxes of iron have been distributed to pregnant women to date.

The Number of Hospital Deliveries is increasing

Having the deliveries in health institutions prevent mother and infant mortalities. We attached great importance to this issue within the training studies we provide for our citizens. Moreover through "Conditional Cash Transfer Project" we provide monetary aid for poor pregnant women having their deliveries in hospitals.

These implementations also reflect to the number of hospital deliveries. Thus, there is a great deal of increase in the number of deliveries in health institutions.

Year	Deliveries Made at the Hospital
2002	806.367
2003	788.206
2004	824.443
2005	857.156
2006	988.168
2007	1.127.092
2008*	838.553

*2008 first 9 months

In order to increase the service demand through improving the quality of service provision we continue to successfully provide reproductive health training for the health personnel. 3665 personnel were trained through Introduction to Reproductive Health module, 2740 personnel were trained through Safe Motherhood module, 3073 personnel were trained through Family Planning Consultation module, 3073 personnel were trained through Sexually Transmitted Diseases module, 2624 personnel were trained through Youth module.

Additionally, clinical protocols for pre-delivery care, management of delivery, post-delivery care and emergency obstetric care were established and were put into effect by a circular notice in 81 provinces.

Cooperation with the Turkish Armed Forces

Ministry of Health and Turkish Armed Forces initiated collaborative work in educating men on sexual health and family planning. In this respect, trainer's training was given to 4.000 military health care personnel so that they give Reproductive Health and Family Planning Counseling Services and Trainings to military men and noncommissioned officers under Turkish Armed Forces. So, these personnel started to give reproductive health trainings in all platoons and troops. So, every year 500,000 young men will be trained on reproductive health when released from military service and set off to go back home. Since April 2004, more than 2 million military men and noncommissioned officers have received training.

g) Healthy Environment Healthy Humans

Prevention of the negative effects of environmental pollution on human health, determination and monitoring of the environmental risk factors are constitutional duties. The related units of the WHO and EU attach a great importance to environmental health. Our Ministry is maintaining its studies within the scope of these sensitivities.

Studies on drinking and potable water, bathing water, labeled water, non-healthy establishments (determination of class and health protection band), housing health, workers' health, noise, indoor and outdoor air pollution, non-ionizing radiation, pesticides, detergents, pool chemicals, water and surface disinfectants, toys and health effects of climate change, etc.

We initiated Healthy Villages Project in order to provide the establishment of the necessary conditions for environmental and social health (which are the basic principles of preventive health services) in villages just as in the urban areas.

In accordance with the decisions made in the 4th Ministerial Conference on Environment and Health (2004) the National Action Plan on Children Environmental Health was prepared and published.

Control of Biocidal Products

The Ministry of Health is managing the required authorization process for the use of the pesticides against flies, insects, rats, etc. Laboratory services are also provided for the determination of the biological effectiveness of these pesticides.

Market control analyses for the pesticides and authorization analyses for the disinfectants are conducted by the RSHCP laboratories.

Under public health and within the scope of the fight against vectors 321 production and 139 importation permits were given to pesticide products. Responsible manager training were provided for the users in order to ensure the accurate usage of these permitted products. To date, more than 2000 persons were trained within this scope.

Food Toxicology

Food poisoning is an important health problem in Turkey. The socio-cultural structure and nutrition habits are the basis for the food poisoning problems. We can also see deliberate poisoning from time to time. The necessary laboratory has been established in order to determine the problem and give support for the solution of the problem and also to help the Justice for judicial issues.

Water Safety

Water is one of the substances with a vital importance to people. However if water is not clean and not safe it endangers human health and may cause major health problems.

For this purpose, the By-law on Water for Human Consumption was prepared in harmonization with the EU legislation and put into effect with its publication in the Official Gazette dated 17 February 2005 and numbered 25730.

Continual micro-biological, physical and chemical analyses and remaining chlorine measurements are being conducted for the drinking waters country-wide. Upon the detection of any inconveniency immediate action is taken and the inconveniency is removed.

We amended our legislation on spring water, drinking water and mineral water having regard to the European Union norms. We gave authorization to 119 spring water establishments, 11 drinking water establishments, 36 natural mineral water establishments, 137 spa establishments, 10 thalassotheraphy establishments and 4 pleoid production and packing establishments which were compatible with the legislation. We continue to monitor these establishments in terms of physical, chemical, micro-biological and radioactive parameters.

In order to protect the community health, we evaluate the production and importation authorization process regarding surface water, drinking water and pool water chemicals and disinfectants by means of our scientific commissions. 176 pool water chemicals and disinfectants were granted production and importation authorization. The Ministry's authorization on these products makes it possible for our citizens to use them safely.

Air Quality Control

Within the scope of environmental health services, it is very important to measure and monitor the air pollution in the cities. We run the related activities in coordination with the Ministry of Environment and Forestry. Measurement network including 8 stations have been established in Ankara for the measurement of sulfur dioxide, particle substances, nitrogen oxides, ozone, heavy metals, volatile organic compounds and meteorological parameters which are very important for public health. The measurements are made in every 10 minutes 24-hour based. Public information is provided regarding the results of the measurements and evaluations by information screens (electronic network) and by other means.

The measurements from other provinces are made by the Ministry of Environment and Forestry's stations and are shared with the Ministry of Health.

Control of Cleaning Substances

Our Ministry is conducting the production and importation authorizations and authorization analyses for the detergents, bleachers, soaps and air aromatizers. These products are controlled through market surveillance where they are placed on the market.

Control of Products for Medical Purpose and Internal Nutrition Products

The analyses for the authorization of the dietary foods for special medical purposes and internal nutrition products are conducted by our laboratories of which infrastructures renewed for this purpose. These products are controlled through market surveillance where they are placed on the market.

Chemical Biological Radioactive and Nuclear Hazardous Substances (CBRN)

Certainly, one of the important threats against public health is CBRN

A unit was established in order to provide the coordination of the studies of related agencies and organizations and a laboratory was established in order to run the analyses within the scope of CBRN.

CBRN trainings were initiated for the physicians. It is planned to have at least one physician with CBRN training in each province. Also, CBRN exercises are conducted in the provinces. The Ministry of Health is providing planning and technical support for these trainings. Distant training on CBRN is also planned.

h) Healthy Nutrition for a Healthy Future

All countries desire to increase the health level of the society and all people desire to live in a more efficient, productive and prospering world where healthy generations are raised. However today people lead a riskier lifestyle in terms of their health, move less because of the facilities provided by the modern life and the eating habits can also be affected negatively. However adopting a balanced and proper diet and an active lifestyle is very important for health protection and promotion.

Department of Food Safety within the General Directorate of Primacy Health Care carried out services related to food audit, working permits and nutrition until 2004. With the "Law on Amending and Accepting the Decree Law on the Production, Consumption and Audit of Foods" numbered 5179, published in the Official Gazette dated 5.6.2004 and numbered 25483, the food-related services carried out by our Ministry have been transferred to the Ministry of Agriculture and Rural Affairs as of this date. After this, the Department of Food Safety has been restructured as the "Department of Nutrition and Physical Activities" in line with the new needs.

The duties of the Department of Nutrition and Physical Activities include raising awareness in the society on nutrition, preventing obesity and nutrition problems with high prevalence in society and executing works for promoting a

more active lifestyle. The works carried out in collaboration with the universities and the relevant institutions in line with this are summarized below.

Program for Raising Awareness on Nutrition in Society

Trainings are implemented in 81 provinces to train the health personnel and the public with the training materials prepared specifically for this matter. In order to raise awareness on nutrition in society trainings were given to 4 million people in 2005, 5.5 million people in 2006, and 6.6 million people in 2007 on various subjects such as healthy nutrition, overweight, breastfeeding. Within the scope of those trainings various training materials, (15 spot films, Nutrition Guide Specific to Turkey, Nutrition Information Series, and Healthy Nutrition CD set etc.), press releases and information noted that are published on our website have been prepared.

"Let's Eat Healthily and Protect our Heart" Project (2004)

A research was carried out within the scope of "Let's Eat Healthily and Protect our Heart" project in 14 health centers in 7 provinces selected from 7 geographical regions. The study covered 15.468 people that are 35+ years old and indicated that obesity rate was 21.2 % in men and 41.5% in women and %35.0 for the whole society, and it was seen that 96.5% of the society does not carry out regular physical activities. The research report was published in 2004.

Nutrition Guide Specific to Turkey (2004)

Nutrition Guide Specific to Turkey was prepared in order to prevent message pollution in nutrition and to ensure that right messages are given to the public and its first edition was made in 2004. This Guide gives information on proper and balanced nutrition, foods and nutritional elements, the impacts of the nutritional elements on body functions, food groups, food diversity, food safety, meals and the importance of meal patterns, importance of breakfast, body weight control, physical activity and health, sugar consumption and health, salt consumption and health, diet fats fatty acids, importance of breastfeeding, alcohol consumption and health, fluid consumption and it gives health nutrition recommendations.

White Flag Project (2006)

M"White Flag" project was started with the purpose of promoting sanitation and hygiene in all public and private schools under a program executed in collaboration with Ministry of Education. Volunteering schools are audited and rated by using the forms by the Provincial Education Directorate and Provincial Health Directorate teams, and the schools which get a score higher than 90 points are given a "White Flag certificate" by out Ministry and a "White Flag" is flied at the school. Up until now, more than 2400 schools have been given "White Flags" and the works are continuing.

With the aim of evaluating and improving the school health, students' health and school staff's health, ensuring and sustaining healthy school life, giving health education to the students and thus to the public, the health works continued and planned by our Ministry are also continuing in collaboration with the other units of our Ministry and the Ministry of Education. In this scope our country also carries out the project of "The Network of Health Promoting Schools in Europe", which is supported financially and technically by WHO, Europan Council and European Commission, and which is implemented in more than 40 schools in Europe with

the aim of improving the health information of the students in elementary schools and to teach a healthy lifestyle in a healthy environment.

WHO "European Ministerial Conference on Counteracting Obesity" (2006)

WHO "European Ministerial Conference on Counteracting Obesity" was held in November 15-17, 2006 with the hosting of our country and with the chairmanship of our Minister of Health in Istanbul.

The conference was conducted with the participation of the health ministers of the countries affiliated to WHO European Region Office and the Ministers responsible for issues such as Agriculture, Sports, Youth, Education etc and their delegates. The conference took three days and at the end "European Charter on Counteracting Obesity" was adopted and signed by WHO European Region Director Marc DANZON and our Minister of Health Prof. Dr. Recep AKDAĞ.

Turkey's Program for Counteracting Obesity

In our country, various public institutions and agencies, universities, NGOs, etc. carry out several programs, projects and training efforts for preventing obesity. However, implementing those efforts in coordination and executing them within a road map obezite are very important elements that affect the success level of the fight. In order to be able to execute, to measure and to monitor all the continuing and planned actions within a certain program in our country "Turkey's Program for Counteracting Obesity" was prepared. The formed draft text was sent to 165 institutions including public institutions and agencies, Provincial Health Directorates of 81 provinces, the relevant units and academicians of the universities and NGOs for getting their opinions and it was also opened for public view on the web site of our Ministry. During the "Workshop on Turkey's Program for Counteracting Obesity", which was held in Ankara in July 2008 the draft text was evaluated with the participation of the relevant institutions and agencies, academicians, NGOs and the representatives of the private sector.

The scope of this program covers the issues of providing the political will and determination at the national and local level, raising awareness in society on the topics of obesity, balanced diet and physical activity within the scope of preventive health care services, getting the precautions for diagnosis and treatment of obesity and the monitoring and evaluation works.

i) *Decreasing the Harms of Alcohol, Drug and Tobacco*

Alcohol Control Program

According to BOD (burden of disease) assessments of the WHO, alcohol was the third most important of 26 risk factors after hypertension and tobacco. As known, alcohol consumption is among the causes of 60 different diseases such as lung diseases, breast cancer, mental illnesses, gastrointestinal diseases, cardiovascular disorders. In addition to that it is known that alcohol consumption might cause many social problems such as violence, crime, suicide, domestic problems, social problems, drink-driving accidents, mortality and injuries and workplace problems.

In our country, per capita consumption of pure alcohol in the age group of 15+ is between 1,0–1,29 liters, and according to the studies the ratio of elementary school students who consumed alcohol at least once was 15,4%, the same ratio amongst high school students was 45%-50%. The ratio of people who consumed alcohol at least for once in the last month was 16,5% (31,5% in men and 10,6% in women); the ratio of university students who consumed alcohol at least for once was 43,0- 53,9% and the ratio of the ones who consume alcohol frequently was 22,9%.

Actions are taken in many countries in the world in order to decrease alcohol consumption and to prevent its harms. In its meeting in January 2008, WHO Executive Board took the decision of developing a global strategy on alcohol and as of 1 January 2008 a project was initiated with the support of the European Commission in order to implement the framework alcohol policy in the European Region and to decrease the alcohol-related harms in Member States.

In our country, since the age of first alcohol consumption is in decline and alcohol consumption among the youth is in increase, works have been launched for National Alcohol Control Program for decreasing alcohol consumption and preventing the harms of alcohol with the participation of all relevant institutions and agencies under the coordination of our Ministry. While preparing the program, the alcohol policies implemented in Europe with the same purpose were also utilized. National Alcohol Control Program aims at informing, training and raising awareness in the society on the health, economic and social harms of alcohol; and decreasing the alcohol-related harms such as domestic violence. Program also covers strategies such as facilitating the detection and treatment of the alcohol addicts in the primary care institutions, protecting the vulnerable groups with arrangements related to the sales and advertisements of alcoholic beverages and collaborating with NGOs.

Moreover, in order to ensure traffic safety, Driver Behavior Development Trainings are organized for the drivers whose licensed are confiscated temporarily because of drink-driving for the second time. Driver Behavior Development Trainings are prepared in line with the Traffic Law and at the first stage Driver Behavior Development Training units are established in the Health Directorates of 30 provinces for healthy continuation of those trainings. The purpose of the trainings conducted in those units is to raise awareness in the drivers on the fact that drink-driving is a risky behavior and to change the knowledge, attitude and behavior of the drivers regarding drink-driving.

The personnel working in the Driver Behavior Development Training units consist of psychiatrists, psychologists and practitioners that are trained and licensed by our Ministry and also traffic trainers working in the Traffic Audit Branch of the Provincial Security Directorate. In order to roll out this service of traffic safety in the country, 8 provinces (Ankara, Istanbul, Izmir, Kayseri, Gaziantep, Trabzon, Mersin, Samsun) were authorized as Regional Training Centers to give those trainings on behalf of the Ministry. Trainings are conducted in the Regional Training Centers in line with the needs with the participation of the provinces that lack trainers and after that the Driver Behavior Development Training units are activated. At the moment, Driver Behavior Development Training units are activated in 58 provinces. We also continue our works to increase the number of units at the provinces and to revise the trainings.

Tobacco Control Program

Framework Convention on Tobacco Control, which was prepared because tobacco consumption gradually increases and threatens the human health in the world and which is the first international agreement on this subject, was adopted in the 56th World Health Assembly of WHO in May 21st, 2003. Framework Convention on Tobacco Control was adopted by our country when it was published in the Official Gazette date 30 November 2004 and numbered 25656. According to the Family Structure Study made in our country in 2006, 33.4% of the people aged 18+ consume tobacco. Tobacco consumption rate in men is 50,6% and 16,6% in women.

After the convention was signed, “National Tobacco Control Program” was prepared in order to plan the works to be done in this scope with the participation of the relevant Ministries, universities and NGOs. National Tobacco Control Program was published in the Official Gazette dated 7 October 2006 and numbered 26312 with the Prime Ministry’s Circular numbered 2006/29. “National Tobacco Control Program 2008–2012 Action Plan” was prepared to define the activities to be organized within the scope of the National Tobacco Control Program and the bodies responsible for implementing them. The Action Plan was introduced to the public in 12.12.2007. The Action Plan consists of 10 headings:

COUNTERACTING TOBACCO

Smoking is an important and preventable public health problem that causes the death of 5 million people in the world and more than 100 thousand people in our country every year. In terms of tobacco consumption our country ranks in the 3rd place amongst the European countries and 10th place in the world.

Throughout Turkey 33,4% of our citizens above the age of 18 consume smoke cigarettes. This ratios is 50.6% in men and 16.6% in women.

"Law on Preventing the Harms of Tobacco Products" was enacted in 1996. However there are not effective tobacco control strategies followed until 2003. With the Health Transformation Program started in 2003 and in the framework of the importance attached to the issue by the Ministry, "Framework Convention on Tobacco Control", adopted by the WHO, was signed by our Minister of Health Prof. Dr. Recep AKDAĞ in 28 April 2004 and it was published in the Official Gazette dated 30 November 2004 after its approval by the Turkish Grand National Assembly.

After the convention was signed our Ministry prepared the "National Tobacco Control Program" with the participation of the relevant Ministries, universities and NGOs within the scope of , "Framework Convention on Tobacco Control".

In this scope, Law on Amending the Law on Preventing the Harms of Tobacco Products", which is one of the most important steps in counteracting tobacco, was adopted by the Turkish Grand National Assembly on 03.01.2008 with great support with the purpose of taking the necessary actions to protect people and the future generations from the harms of the tobacco products and the adds and promotion campaign that encourage those habits and ensuring that everybody breathes clean air. With this Law a big step was taken to take tobacco consumption in Turkey under control and Turkey has become one of the few countries in the world that has legal arrangements on this matter.

As of 19 May 2008 tobacco consumption is forbidden in all closed areas and public transportation vehicles, and most places of our country are declared smoke-free air zone. When our law is compared to the laws of other countries it is seen that it provides an extensive protection for the people. This Law was prepared based on the basic human right of breathing clean air and the biggest supporters of this Law are our citizens who have the right to live and work in a healthy environment.

WHO European region gave one of the 6 awards given to the figures who set examples in counteracting tobacco to our Minister of Health Prof Dr Recep AKDAĞ.

Our country makes an exemplary effort in counteracting tobacco and tobacco products among the world countries and therefore our children are walking towards a healthier future. Now our citizens have a cleaner air and they are impatiently waiting for 19 July 2009 when the second part of the Law will become effective.

1. Public Information, Raising Awareness and Training Activities
2. Promoting and Facilitating of Smoking Cessation
3. Price and Taxation Policies
4. Prevention of Exposure to Circumferential Tobacco Smoke
5. Organizing Advertisement, Promotion and Sponsorship Activities
6. Activities for Product Control and Consumer Information
7. Preventing Illegal Trade
8. Preventing Youth's Access to Tobacco Products
9. Tobacco Production and Alternative Policies
10. Monitoring and Evaluation of Tobacco Use

The Department of Counteracting Tobacco and Addictive Materials has been established in 2007 under the General Directorate of Primary Health Care of our Ministry. In addition, Provincial Tobacco Control Councils are established in the provinces to carry out the implementation of the National Tobacco Control Program, the coordination and follow-up of the tasks and the activities of tobacco control.

The WHO gave awards to 6 figures and institution in the European Region where there are 53 countries for their effective efforts in the field of tobacco control. One of those figures was our Minister of Health and his award was presented by Marc Danzon, WHO European Region Director in 8 July 2008 in an organization held in Ankara.

4A new period has started as of 19 May 2008 in line with the amendments made in the Law on Preventing the Harms of the Tobacco Products numbered 4207 with the purpose of preventing the negative impacts of exposure to smoking on our citizens' health. In the process of implementing the law that aims at protecting primarily the non-smokers, youth and the children works were also initiated to facilitate smoking cessation for the smokers who are willing to do so. At the moment we carry out a Media Campaign with the slogans "Protect your air" and "Smoke-free air zone" in order to inform our citizens, raise awareness and cause behavioral change.

Counteracting Material Addiction

In 2003 ESPAD (European School Survey Project on Alcohol and Other Drugs) work was done in Adana, Ankara, Diyarbakır, Izmir, Istanbul and Samsun with WHO support and with this work important data was gathered on the situation of alcohol and material addiction in our country. In line with this, in the same year, a circular was issued for ensuring that paints and glues that do not contain volatile materials are used at schools.

Trainings are conducted by the provincial health directorates in order to inform the public about material addiction.

Works are continuing to prepare guidelines for the parents, teachers, young people and the patients.

"European School Survey Project on Alcohol and Other Drugs", which was pioneered by the Swedish Council of Alcohol and Other Materials Information and which has started to be implemented in Sweden in 1971 and then spread to other European countries, is carried out in our country with the collaboration of the Ministry of Health, Ministry of Education and the Ministry of the Interior.

The main aim of this project is to carry out simultaneous surveys in the European countries on tobacco, alcohol and other materials. The purpose is to

gather comparable data from as many European countries as possible on the consumption of alcohol, tobacco and other addictive materials among the students of 15-16 age group, and in the long term to monitor the trend of consuming alcohol and materials among the European students and to make comparisons between the countries.

A commission was set with the participation of Ministry of Health, Ministry of Education, the Ministry of the Interior and the specialists of the topics in order to prepare a "Training Manual for Preventing Material Consumption", which would cover basic trainings topics; to share this manual with the Provincial Health Directorates, relevant institutions and agencies and the NGOs; to forma common language on the area through the trainings conducted by different institutions, agencies and NGOs; and to prevent the use of expression that might be harmful in the trainings.

j) Mental and Psychological Health (Happy Individuals)

Due to the fact that the mental health forms used in mental health services do not meet the need, especially –diagnosis classification- updating studies were initiated and completed in October 2003.

Hospital	Maintained For More Than a Year
Bakırköy	235
Elazığ	120
Adana	14
Manisa	70
Samsun	41
Total	**480**

1With the Circular (dated 13.10.2005 and No. 14160) pertaining to "Referral and Follow-up of Mentally-ill Patients", the referral and follow-up of the mentally-ill patients were regulated in accordance with the modern law. In the Circular, the actions related to the appointment of guardianship for mentally-ill patients were specified in details in accordance with the Civil Code.

Works are carried on to form units (judicial psychiatry beds) having middle and high security systems, also implemented in EU countries, for the people who subject to the Article 46 of the Turkish Penal Code and do not have criminal liability. In this sense, the number of patients who have been contained for more than one year time in the past five years among the patients needed to be contained and treated in our currently working regional hospitals due to judicial reasons subjected to the Article 46 of the Turkish Penal Code is indicated in the table below.

In 2005, through the collaboration between Ermelo Meerkanten Psychiatric Institute in the Netherlands and Turkey Elazığ Mental Health and Diseases Hospital, a project entitled "Enhancing the Community based Mental Health Services for Chronic Schizophrenia Patients" was put into practice for the patients who have chronic mental disorders. This project was supported by MATRA project and started to be implemented for a period of three years; it will be closing at the end of 2008. Works are going on to sustain the project. The aim of the project is to increase the community-based mental health service capacity for the treatment of schizophrenic and mentally retarded patients.

With this project, it is targeted to deliver community-based service for the schizophrenic and/or mentally retarded patients who departed from the inpatient health institutions. The main targets of the project are to establish 15-20 protected houses for these patients and to provide vocational rehabilitation for approximately 100 patients and these were put into effect within the project.

The project entitled "Improving the Services for the Disabled", which was proposed by the General Directorate of SHÇEK (Social Services and Child Protection Agency) to the EU IPA 2008 program, was started to be discussed in the commission. The Ministry of Health is the main beneficiary of the project to be implemented between 2009 and 2012. For the said project, General Directorate of Primary Health Care and General Directorate of Curative Services will work coordinately under our ministry. In the first phase of the joint project, the practices in the other European countries related to the care and service models to be delivered for the disabled people especially the psychologically disabled ones will be reviewed. In the second phase, it is planned to review the current practices in Turkey and to develop the service model appropriate for our country. The technical support of WHO will be ensured in the project, through direct contracting.

The rest of the project will be provided to the IPA 2008 program and it is planned to initiate pilot of community-based mental health service. In line with this project, 2 pilot provinces (Ankara and Bolu) will be selected in the first phase, and it is planned to establish community mental health centers in both provinces. In the "Community Mental Health Center", some services such as psycho-social support programs, individual and group works, work and occupation therapy will be provided for the disabled people, psychologically-ill people and their care-provider family members.

Works on Fighting the Domestic Violence against Women were initiated in line with the protocol pertaining to "Training on Health Personnel's Role in Fighting the Domestic Violence Against Women and the Procedures to be Followed" signed between our ministry and the Ministry of State for Women on the date of 3 January 2008. The General Directorate on the Status of Women and the General Directorate of Primary Health Care in our ministry was assigned as the coordinator units. Within this protocol, trainer trainings of approximately 500 people from 81 provinces for five days were initiated in June 2008, and it will be ensured that these people will train the related personnel (physician, nurse, midwife, health official, psychologist, social worker, etc.) in their provinces.

As of November 2008, the trainer trainings were completed, and field trainings are to be started in 81 provinces in 2009.

Mental Health Control Program

The text of the National Mental Health Policy was made public in 2006. When forming the text, WHO's seven modules related to mental health policies were taken into consideration as the basis. In this respect, the text itself in general and the modules in themselves are structured properly. The text, in this state, has the WHO's modern emphases related to mental health field. The main suggestions in the policy text are as follows:

- Mental health system should be community-based, should be integrated with the general health system and primary care,
- Community-based rehabilitation works should be carried out,
- The money allocated for the mental health field should be increased,
- The quality of mental health services should be increased,
- Laws should be enacted related to mental health field,
- Patient rights should be defended against stamping,
- Trainings, Researches and Human Resources should be increased in mental health field.

Following this policy text, a draft text was prepared within the scope of National Mental Health Action Plan preparatory works, and it was opened to discussion in a meeting held in Ankara with the participation of the representatives of our ministry, NGOs, Head Doctors of Mental Health ad Diseases Hospitals and academicians.

The activities in the Draft Action Plan are listed in the following subtitles:

1. Ensuring that mentally-ill patients receive the services appropriate to the nature of their illness in the natural habitat, providing community-based mental health service,
2. Increasing the number of beds allocated for psychiatry patients,
3. Increasing the number of people working in the field of mental health,
4. Caring patients who have heavy mental illness and employment of mental health patients,
5. Performing legal arrangements in the field of mental health and opening high-security judicial psychiatry hospitals,
6. Advocacy activities in the field of mental health,
7. Training and research in the field of mental health,
8. Increasing the budget allocated to the field of mental health,

9. Integrating the mental health services into primary care,
10. Developing policies for rational drug use in the field of mental health,
11. Supporting the psychosocial development of children and mental health services for children,
12. Preventing suicides,

Supporting Program for the Psychosocial Development of Children Age 0–6

The works were started in June 2005 to roll-out the "Supporting Program for the Psychosocial Development of Children Age 0–6" nationwide.

Program aims to follow-up and support the development and growing of the children of age 0-6 beginning from the pregnancy and their health from mental and social point of view as a whole with a bio-psychosocial point of view within the primary health care, and it also aims to ensure early intervention by early determining the risk factors and pathologies.

The awareness of the midwives, nurses and physicians working in the primary care health institutions, the implementers of the program, are increased through the provided trainings on risk factors affecting the negligence-exploitation, domestic violence. They are informed about the negative impacts of these factors on family integrity and the development of children, and they are provided information about the processes influencing the development and follow-up of the development and growing.

In case of any kind of negligence and exploitation (domestic violence, etc.) against women-babies and children, program implementers are informed about the following issues:

- How to treat the case,
- Issues needs to be paid attention during physical examination in negligence and exploitation cases,
- In exploitation cases, the responsibilities of health personnel, notification and initiating the required legal procedures.

During the training, the existence of mental disorders in mother-father such as depression, anxiety disorder and schizophrenia, whether the child is an unplanned or unwanted one, disorder story related to alcohol and drug use in the family, baby-child who is hard to be cared (premature, disabled, development deficiency, etc), existing problems in the social-economic conditions of the family (crowded family, literacy status, unemployment, migration, etc.), ages of mother-father (their early marriage or having child at late ages), the traumas the family encountered are emphasized as the risk factors to trigger the negligence and exploitation against child and baby and also for domestic violence, and the sensitivity of the health personnel on this issue was tried to be increased. At the same time, the pregnant and the children of 0-6 age that applied to health centers or detected during the house visits are monitored through follow-up charts questioning the above mentioned subtitles by the trained health personnel; and the problem detected families are tried to be provided with required support and information. In order to remove the problems out of the service scope of the health centre, the families are directed to related institutions where they can get the required support.

With the above mentioned program, the father interviews began to be followed-up by using charts for the first time in our country. The fathers are given information on the support to be provided to the pregnant/mother, alcohol and cigarette consumption, healthy nutrition and family planning issues and the facts seen as risk factors for violence are questioned.

"Supporting Program for the Psychosocial Development of Children Age 0–6" is currently implemented in 41 provinces and it is targeted to be rolled out to 81 provinces by the end of 2009.

Suicide Phenomenon and Its Prevention

Suicides emerging in connection with mental disorders are increasing both in the world and in our country; and at the present time, an average of one million people per year in the world put an end to their lives by a suicide. When the epidemiology of suicides are taken into consideration, though some cultural differences are seen, it attracts attention as one of the leading causes of deaths especially among the young right after the traffic accidents in many countries.

Suicide rate in our country is 3.30 per hundred thousand, according to TurkStat's 2002 data. Suicides are gradually increasing and this makes it mandatory to develop effective policies in the field and first of all to adopt the training of health personnel as the sine qua non of suicide prevention works as the guiding principle.

Suicide prevention works were started in our country by our ministry as of 2004, and in this sense a provincial trainer training was organized in Yalova province, on 21-24 September 2004, for psychiatrists and deputy directors of provincial health directorates.

Provincial trainings were given to physicians, psychologists and social service specialists by the trained psychiatrists; in line with this the training of 16.056 health personnel was completed.

A booklet entitled “Suicide Phenomenon and Its Prevention” was prepared and published in 2004.

In addition to these, a series of 6 books from WHO publications was published in 2004 and 2006 (120 thousand in total) and distributed to the health personnel and other occupation groups to be used as a source.

Psychosocial Support for Suicide Attempts and Crisis Intervention Program in Emergency Services

It is aimed to provide the required psychosocial support to the people who encountered suicide attempts and other crisis situations and to their families in proper time.

To this end, staff of the emergency services, the person in charge of crisis room, 112 emergency staff and primary care health personnel are informed about the suicide phenomenon and its prevention and they are trained on the appropriate ways of approaching to such patients in crisis.

The required psychosocial support is provided to the people who attempted suicide and to people who encountered other crisis situations and also to their families by the trained professionals in an appropriate time after the urgent medical treatment.

Apart from the patients who have any kind of suicide risk and have attempted suicide, the main service areas are defined as domestic violence, exploitation phenomena, losses (loss of a beloved, loss of status, loss of health – get a fatal disease, loss of an organ- divorce, bankruptcy), harsh living conditions occurring in natural or artificial ways (migration, traffic accidents, exam anxiety, fire, earthquake, flood).

On the other hand, provincial trainings given to other occupation groups (guidance counselors, policemen, gendarme officials, prison workers, religious officials, local media staff, and fire-fighters) in a multidisciplinary structure were completed

Within this scope, the training of 17.667 health professionals and 4.926 staff from other occupations were completed.

The program is currently implemented in 49 provinces and in 97 hospitals and it is planned to be rolled out across the country by the end of 2010.

k) Health Promotion, Social Movement and Awareness for Chronic Diseases

The combination of supports provided on especially health education, and also organizational, economical and environmental basis with the purpose of forming behavioral change directed towards health protection and promotion, and ensuring that citizens would become claimants and decision makers on the issues regarding their own health is called health promotion or health development. This field is a field of art and science which helps people to change their lifestyle to be able to move in the direction of ensuring their most appropriate health status. The health education conducted for this purpose aims to turn the health into a social value, to furnish the public with the information and skills that they can use to solve their health problems, and to form health-related changes in thoughts, beliefs, attitudes, behaviors and lifestyles of individuals.

Health promotion activities:

- Helps to reduce the mortality,
- Addresses the leading risk factors and underlying determinants of health,
- Helps to strengthen the sustainable health systems,
- Puts the health at the center of agenda of the large-scale development. (Source: WHO)

Historical process: Lalonde Report (A new perspective on the health of Canadians) (1974) is the first report where the health promotion was mentioned as a concept. In Alma-Ata Conference in 1978, WHO accepted that primary health care, as a part of social justice and development, plays a key role in the attainment of the desired level of health in the world. A great many health-related developments have been taken place since Alma-Ata. Discovering the fact that many diseases are related to individuals' lifestyles; and comprehending the fact that social, cultural, economical, environmental, behavioral and biological factors might affect the health either in positive or negative way; some scientific evidence identifying risk factors related to some diseases; in addition to the reduction in mortality and in morbidity, upsurge of interest in the quality of life; and the limited effectiveness of the traditional strategies related to health education, as an integrated approach led the concept of "health promotion" to come into the agenda in 1980. Health promotion was defined in Ottawa Charter in 1986 as "the process of enabling people to increase control over, and to improve their health." This definition requires the efforts to be performed for the implementation of health promotion approach are to be strengthening, community involving, intersectoral, equal and just, accessible and with multi-strategies.

In Jakarta Conference, in 1997, the importance of developing international strategies for health; health is a basic human right and is essential for social and economical development; health promotion is a process of enabling people to increase control over, and to improve, their health; and the importance of determinants of health for health promotion have been emphasized. In 2005, The Bangkok Charter for Health Promotion in a Globalized World, identified actions and recommendations required to address the determinants of health.

WHO identified the five priorities for health promotion in the 21st century:

1. Promote social responsibility for health
2. Increase investments for health development
3. Expand intersectoral partnerships for health promotion
4. Increase community capacity and empower the individual
5. Secure an infrastructure for health promotion

The aim in the health promotion is to ensure the right health behaviors are to be implemented into people in mass. Within this scope, health promotion practices represent the process through which individuals improve their health by improving their personal choice and social responsibilities. Health promotion practices also include building healthy public policies, creating supportive environments for health, the reorganization of health services beyond clinical and curative services.

Health is important for individuals and the community. People expect to be protected against diseases, foster their children in a healthier environment and expect their workplaces become safe and hygienic. They feel the need for accessing to reliable and high-quality health services. At this point a new restructuring requirement came into being for Ministries of Health for the purposes of enabling people make healthier choices; supporting healthy people and patients by providing people with accurate and reliable information; promoting health and helping in controlling the health-influencing elements such as nutrition, physical activity, alcohol consumption and smoking; dealing with important problems such as mental health; and turning the citizens into not only service receivers but also service requesters.

In line with this understanding, within our ministry, “Department of Health Promotion” and “Department of Chronic Cases and Diseases” were established to ensure the search for the diseases existing in our country; to raise the awareness level of people regarding these diseases and to increase the health level of public by combating against the risk factors constituting these diseases and giving priority

to preventive healthcare; to increase the awareness of people on health, to take necessary precautions before the diseases arise by predetermining the risks for health and in this way to reduce the permanent disabilities, workforce loses and health expenses connected to diseases; to reorganize the healthcare services in accordance with the health needs of the community. These departments were organized so as to determine the privileged problems and privileged groups in terms of health; to plan and conduct the necessary screening programs on diseases and risk factors; to execute the national health promotion programs in cooperation with public agencies and institutions, local administrations, universities and other formal education institutions, NGOs, working places, etc. and to plan, conduct and analyze the results of "impact assessment" works of these; to coordinate the research and development works on problems encountered in service delivery fields; to coordinate and cooperate with international institutions (WHO, EU, OECD, CDC, ECDC, etc); to regularly follow-up and assess how much the national plans and programs are adopted and put into practice, as well as the efforts regarding the execution of common health promotion programs.

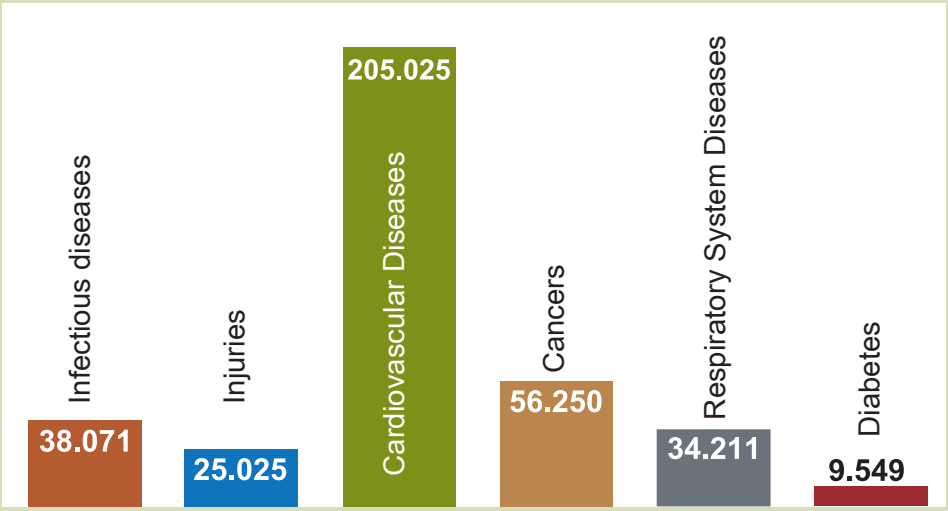
Within the field of duties of Department of Health Promotion, the following activities are included: activities to train the citizens together with media, national and/or international institutions, NGOs, through using the social marketing techniques and to ensure they make their decisions on their own health; execution of information campaigns directed towards health professionals and public; activities providing health consultancy hotlines and accurate health information resources; production and distribution of any kind of material (posters, brochures, guidebooks, books, mass media spots, etc.) within the scope of health promotion; meetings, organizations and introduction activities. Within the scope of health promotion, a campaign called "Love is the Best Medicine" expressing the relations between the health professionals and citizens in a lovely approach has been completed and a new campaign called "smoke-free air zone" has been launched and ongoing. A large-scale hygiene campaign and promotional works for preventing obesity and increasing physical activity are to be put into effect in 2009.

Chronic Diseases and Combat Against Risk Factors

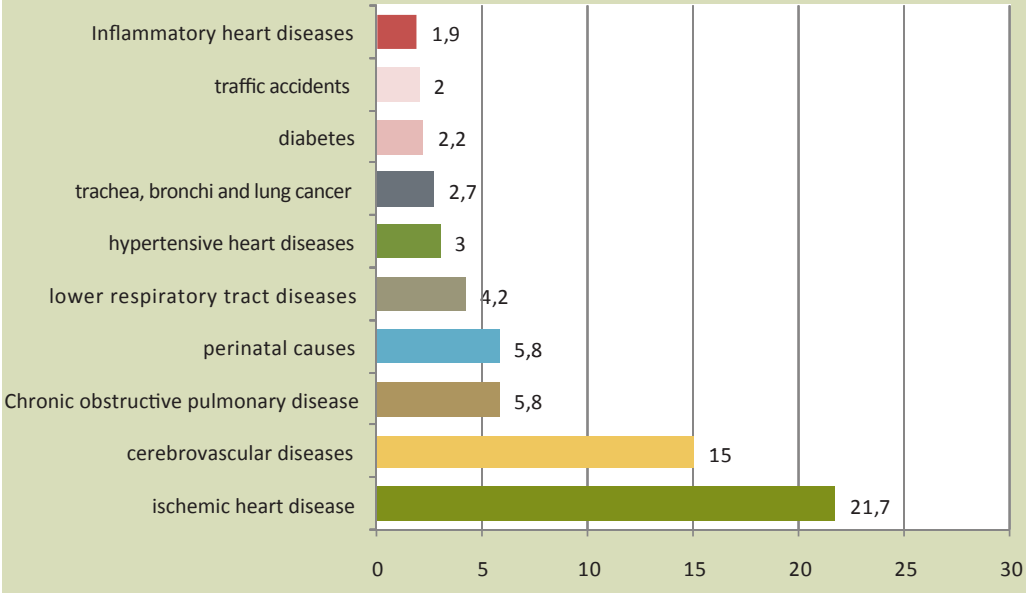
HChronic diseases have been increasing in parallel with the currently increase in the expected life span and unhealthy life habits both in the world and in our country. In 2005, 35 million people in the world lost their lives due to chronic diseases and 60% of the deaths are caused by chronic diseases.

According to the data of Turkey National Burden of Disease Study; 71% of deaths in our country are due to chronic diseases and non-communicable chronic diseases (e.g. Ischemic Heart Diseases, Cerebrovascular Diseases, COPD, Trachea Bronchus and Pulmonary Cancers, Antihypertensive Heart Diseases, Diabetes Mellitus, etc.) are in the first ranks among the first 20 diseases that cause to deaths in national level and they constitute an important burden of disease (BOH).

Distribution Of The Numbers Of Deaths In 2000 According To Disease Causes



Distribution of first 10 diseases that cause death at national level in Turkey



Considering the negative impact of chronic diseases on life span and life quality, and the height of its physical and moral costs as well, the importance of preventive programs directed towards changing lifestyles will be better understood. Through getting the risk factors under control and other basic measures; diseases requiring hospitalization, expensive curative and surgical operations; and workforce loses and deaths related to these diseases; and also the economic burden related to these will be decreased.

From this point of view, the Department of Non-Communicable Diseases and Chronic Cases, the Department of Combat Against Tobacco and Addictive Drugs and the Department of Nutrition and Physical Activity were established under our ministry's General Directorate of Primary Health Care.

Prevention and Control Program for Cardiovascular Diseases

Cardiovascular diseases are the most frequent cause of death in the world and they are estimated to continue to be the first leading cause of death for a long time. In 2005, approximately 17.5 million people died because of cardiovascular diseases and this number represents the 30% of global deaths.

Cardiovascular diseases are in the first rank in our country too, among the causes of death and represent the 47.73 % of the all causes of deaths. Among the first ten diseases causing deaths, Ischemic Heart Diseases (21.7%) and Cerebrovascular Diseases (15%) are in the first ranks. The frequency of Hypertension disease in our country has been found 18.2-49.1% in females and 7.5-39% in males in various researches.

For a healthier Turkey, together with the cooperation of our ministry and NGOs, "Turkey Prevention and Control Program for Cardiovascular Diseases, Strategic Plan and Action Plan for Risk Factors" was prepared in order to prevent the cardiovascular diseases and take control in this filed through decreasing the main risk factors.

The objectives of the plan: to inform the public on cardiovascular diseases, to increase public awareness, to ensure that people live on a high-quality life in terms of health by creating positive and permanent behavioral changes on main risk factors.

The draft program was prepared related to other approaches (including manpower, technology, medicine and finance) for secondary and tertiary prevention in cardiovascular diseases and it will be included into the national program in the first half of 2009.

GARD: The Global Alliance Against Chronic Respiratory Diseases

World Health Organization's project called "GARD- the Global Alliance against Chronic Respiratory Diseases", aiming to prevent and control the Chronic Respiratory Diseases was put into effect with the participation of 79 member states including Turkey.

To prevent the Chronic Respiratory Diseases (Asthma-COPD), Turkey General Assembly of GARD- the Global Alliance against Chronic Respiratory Diseases which is established under the leadership of WHO was convened on 26 October 2007, with the participation of all relevant agencies and institutions in our country. The 3rd Plenary Council of the GARD and GARD Country Launch were conducted in Istanbul on 30-31 May 2008. In this meeting, the draft of "Turkey Chronic Respiratory Diseases National Action Plan" was presented, and through the completion and implementation of this action plan, it is aimed to decrease the diseases and deaths related to asthma and COPD and the economic burden which took along with. "GARD Turkey Action Plan" is the first action plan prepared in the world on this issue.

Diabetes Control Program

World Health Organization estimates that there are more than 180 million people in the world who are suffering from diabetes. In 2005, it is estimated that more than 1.1 million people died because of diabetes. 80% of the diabetes-related deaths take place in low or middle income countries. WHO points out that deaths due to diabetes will increase more than 50% in the forthcoming ten years unless immediate actions are taken.

Diabetes prevalence in our country, according to the study of TURDEP-Turkish Diabetes Epidemiological Study, was found out 7.2% (8.0% in females and 6.2% in males). However, in SINGLE-LETTER study it was found out 8.1% in males and 8.9% in females. When the percentage distribution of the first ten diseases causing deaths in national level is reviewed, it could be seen that the rates of Ischemic Heart Diseases (21.7%) and Cerebrovascular Diseases (15.0%) are in the first two ranks, whereas Diabetes (2.2%) is in the 8th rank.

Efforts for the development of "National Diabetes Control Program" and relevant action plans have been in progress. The control program is aimed to be completed in 2009.

Diabetes Mellitus In Turkey And The Incidence And Prevalence Rates Of Its Complications

	incidence (100.000)			prevaillance (1000)		
Disease Categories	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
Diabetes Mellitus	3210,200	4280,100	3820,000	46,500	62,800	55,800
Diabetic Foot	386,600	411,500	398,900	2,000	2,100	2,000
Neuropathy	92,600	110,200	101,300	8,600	9,300	8,900
Retinopathy- Blindness	2,400	2,200	2,300	0,200	0,200	0,200
Amputation	6,800	5,000	5,900	0,100	0,100	0,100

Source: National Burden of Disease and Cost Effectiveness Study Burden of Disease final Report, Ankara 2005

The Disabled

"The Regulation on Disability Criteria, Its Classification and Health Board Reports to be Given to the Disabled" was issued in the Official Gazette dated 16/07/2006 No. 26230 and came into effect under the coordination of Prime Ministry's Administration for Disabled People, in accordance with the provision of "the determination and implementation principles of disability criteria are set by the regulation jointly issued by Ministry of Finance, Ministry of Health, Ministry of Labor and Social Security, Ministry of National Education and the Administration of Disabled People"

To ensure that the disabled people easily access to health institutions and to lessen the density in our hospitals, as a result of the efforts to raise the number of health institutions authorized to give health council report for the disabled people, the number was 261 in 2006 and it was raised to 377 in 2007.

Within the scope of the said Regulation, taking the international standards into account, all body function loss rates have been re-defined in relation to disease and disability situation and a system-based tabulated list has been prepared by means of scientific boards.

In addition, our Circular on "Delivery of Healthcare Services for Disabled People" dated 05/06/2008 and No.17999 (2008/43) was issued for the purpose of meeting the needs of health care demanding disabled people in environments appropriate for their situations, in an efficient way and without aggrieving them

WHO Europe Region CINDI (Countrywide Integrated Noncommunicable Diseases Intervention) Program

World Health Organization collaborates with the member countries by developing integrated approaches together with them in order to develop more effective national and local strategies against common determinants and risk factors of chronic diseases. Within the scope of this collaboration, CINDI (Countrywide Integrated Noncommunicable Diseases Intervention) Program was developed in the WHO Europe Region. CINDI Program provides the necessary integrated approaches to participating countries to prevent and control the risk factors such as smoking, high blood pressure, high blood cholesterol, obesity and excessive alcohol consumption, etc.

At present, 29 countries participate in the CINDI Program and there are 3 candidate countries. Required actions have been started for our country's joining the WHO Europe Region CINDI Program.

Chronic Diseases Risk Factors and Health Promotion Symposium

With the collaboration of International Union of Health Promotion and Education (IUHPE), "Chronic Diseases Risk Factors and Health Promotion Training" was held in Ankara on 01-05 September 2008. Participants from Ministry of Health's central organization and from other institutions such as Refik Saydam Hygiene Center Presidency, Turkish Statistical Institution, State Planning Organization and Social Security Institution attended the said training.

In addition, "Chronic Diseases Risk Factors and Health Promotion Symposium" was organized in Ankara, on 13-14 November 2008, with the participation of invited international speakers

Studies on Chronic Diseases Control and Surveillance Jointly Conducted with NGOs.

Some of the projects conducted by NGOs and supported by our Ministry of Health for chronic diseases control are as follows:

- Turkey Diabetes Control Project (TDC) - "Turkey Diabetes Control Project" was actually launched on 21/06/2008, with the approval and support of our Ministry of Health. This project was developed by The Society of Endocrinology and Metabolism of Turkey, Turkish Diabetes Foundation, Turkish Diabetes Society, Turkish Diabetes and Obesity Foundation, Diabetes Obesity and Nutrition Association, Diabetes Nursing Association and also supported by 15 universities. Within the scope of the project, 18 regional meetings were planned to be conducted in 17 city centers to cover 81 provinces. Under the works completed in Ankara, Istanbul and Konya provinces, trainings were

conducted for physicians and other relevant health professionals involved in the diagnosis, follow-up and treatment of diabetes, public information meetings were organized, and screening works for diabetes were conducted through measuring the blood sugar of the voluntary citizens and also implementing a questionnaire.

- Diabetes and Obesity Training Course – It is regularly conducted by Turkish Association for the Study of Obesity (TASO)
- "Measuring blood pressure… of Turkey" – the campaign was conducted together with the Turkish Society of Hypertension and Renal Diseases (TSHRD), on 2-16 May 2006; approximately 20.000 people's blood pressures were measured and nearly 40.000 leaflets were distributed. The campaign started in Istanbul's European Side on 2nd May 2008 and conducted in 9 provinces. Physicians and nurses appointed by the Provincial Health Directorates measured the blood pressures of people all day long both in the hypertension truck which stayed in the major plazas of the provinces all day long and in the various blood pressure stations established in the frequently visited places, hospitals and health centers of provinces. In this campaign;
- Almost half of those whose blood pressures were measured were in the 40-60 age group.
- Approximately 60% of those whose blood pressures were measured had hypertension diagnosis.
- Approximately 12% (n=1829) of those whose blood pressures were measured had never had their blood pressure measured before.
- Among those people who had their first blood pressure measurement during the campaign, 31% in men and 23% in women had blood pressure readings at the hypertension limits.
- Among those people who had never had their blood pressure measured before, approximately 10% of them had blood pressure readings at Phase 2 (>160/100 mmHg) and above.
- "Protect Your Heart. It Holds Your Beloved Ones" Project: Under the support of our Ministry of Health, with the collaboration of Turkish Society of Cardiology, Turkish Society of Internal Medicine Specialty, Turkish Neurological Society, The Society of Endocrinology and Metabolism of Turkey and Turkish Society of Hypertension and Renal Diseases (TSHRD) the project was launched in order to ensure public awareness rising, to encourage behavioral change and to increase awareness of physicians on early diagnosis and prevention.

Within the scope of the "Protect Your Heart. It Holds Your Beloved Ones" Project, a non-formal training work was started to conduct in 81 provinces through the organization of Provincial Health Directorates and approximately 3.000 general practitioners participated in these trainings which was transmitted into city

centers via satellite broadcasting. In addition, a training program was developed for physicians who deliver primary health care services, a joint notice was formed and total cardiovascular risk calculation table and calculator was prepared. This notice and training materials were mailed to approximately 23.000 general practitioners, besides, the related materials were allowed to access through the link of www.kalbinizikoruyun.org website.

Under the project, training works were conducted for the public in order to increase awareness on modifiable cardiovascular risk factors and precautions that might be taken. Awareness rising works were performed in the visual media about the cardiovascular risks and the diseases caused by those risks. Information is being delivered to the public on cardiovascular diseases through the website and the free hotline for consultation (0800 211 78 78).

Healthy Ageing

In-service trainings have been conducted in provinces since 2003, throughout Turkey and provincial activity plans were prepared for the improvement of elderly people's nourishment status and nourishment trainings were ensured to be conducted. Mobile healthcare delivery in our provinces include various programs such as regular examination by mobile teams, patient transportation service, pneumococcal vaccination - adult vaccination, diabetes patient follow-up, home care training, supply of medicine. Geriatrics polyclinics were opened in Antalya and Aydın Public Hospitals and Geriatrics Centers were opened in Kayseri and Kırıkkale, and Community Health Center Geriatrics Units were opened in Aydın, Denizli and Sivas.

Cancer

Cancer is an important public health problem in our country as it is in the world.

Our Ministry collaborates with a lot of national and international agencies and institutions. The international institutions which our ministry collaborates with are as follows:

1. WHO(DSÖ),
2. IARC (International Agency for Research on Cancer),
3. IACR (International Association for Cancer Registry),
4. UICC (International Union Against Cancer),
5. NCI (National Cancer Institute),
6. APOCP (Asian Pacific Organization for Cancer Prevention),
7. MECC (Middle East Cancer Consortium),
8. NHS (National Health Service)

Inside Turkey, our ministry cooperates with specialty societies, various public agencies, NGOs and universities.

Cancer Registration:

Cancer registration is the starting point of "Cancer Control" works. Once the database is established, it is possible to search for etiological or causal agents and to take appropriate steps to prevent cancers.

The objective of the population-based cancer registry system is to collect information on each of the cancer cases occurred in a certain community. In order to be successful on this issue, it is necessary to decide on a clearly limited geographic region and to get accurate data out of the community living in this region. In order to get information such as the frequency of cancer in the community, risk levels of special groups, incidence and mortality of cancer types, it is necessary to perform a scientific and systematic cancer registry activity.

In Turkey, two systems are used in Cancer Registration to collect data.

Passive System: Cancer registry form filled by physicians or other health staff is sent to Provincial Health Directorate and entered into the computer program. Provincial Health Directorate Cancer Registry Centers electronically send these data, entered into computer environment, to our ministry quarterly.

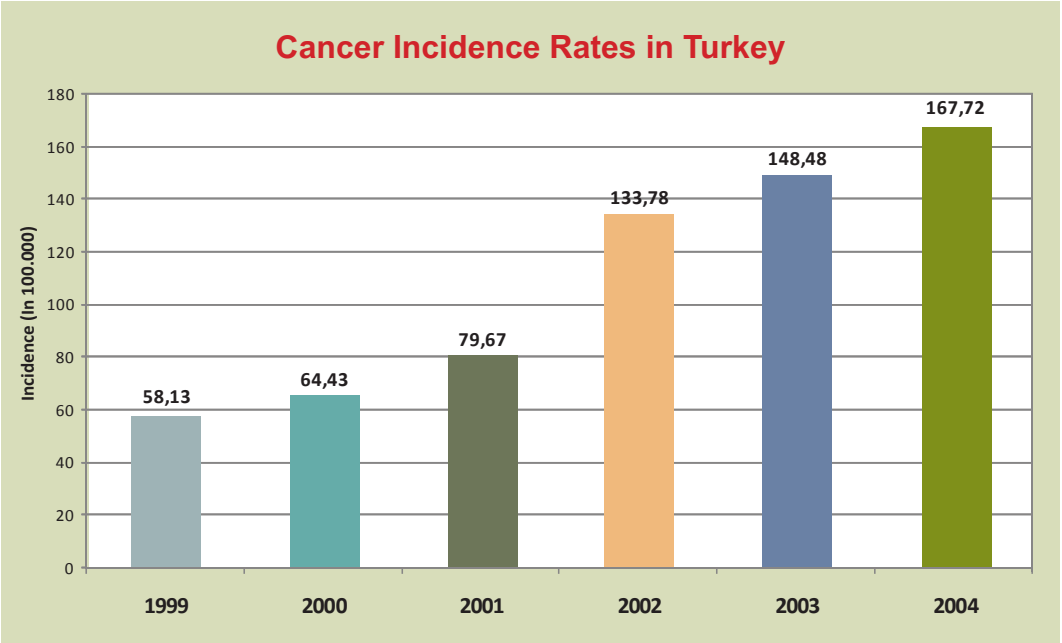
Active System: The pillar of the active system is cancer registry staff. Cancer registry staff examines the patient files one by one and transfer the information into cancer registry forms. These forms are entered into Canreg-4 computer program in

Provincial Health Directorate Cancer Registry Centers; and afterwards, dual recording check and other quality control works are performed and data are sent to our ministry electronically.

As is the case all around the world, it is the same in our country that cancer registration is performed in regions (provinces) reflecting at least 20% of the country population. There are 14 Active Cancer Registration Centers in our country collecting data in this system. These provinces are Ankara, Izmir, Antalya, Samsun, Adana, Eskişehir, Erzurum, Edirne, Trabzon, Bursa, Şanlıurfa, Kayseri, Van and Kocaeli.

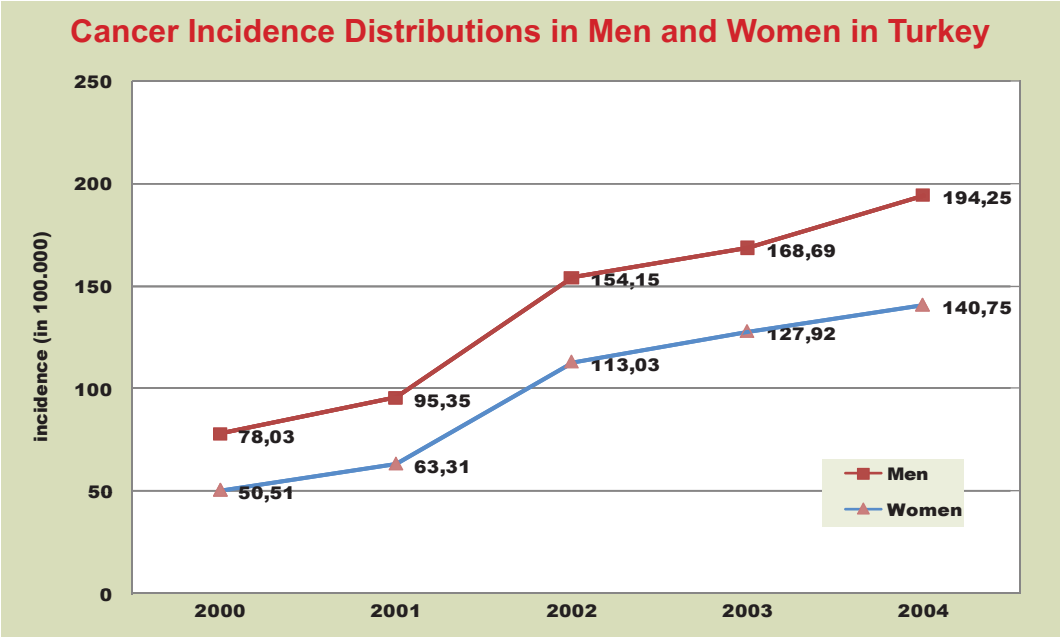
To this end, 12 different trainings were conducted from 2005 to 2008 for Cancer Registration Centers' Personnel who work in provinces which collect cancer data in the Active System and 550 staff members were trained in these trainings.

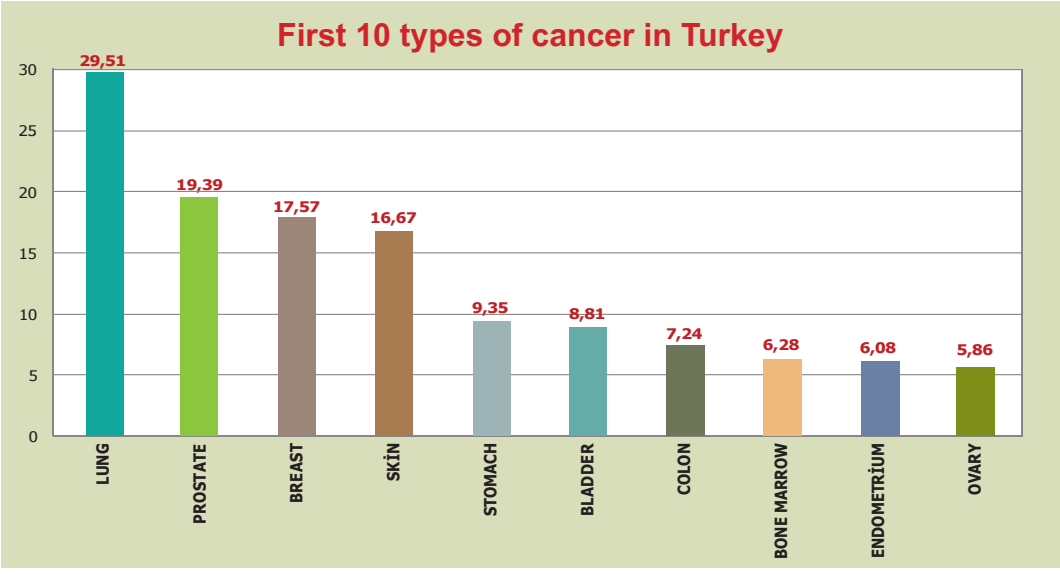
Of Active Cancer Registration Centers, Izmir Cancer Registration Center became the member of WHO/ IARC/IACR (World Health Organization/ The International Agency for Research on Cancer/ International Association of Cancer Registries) in 1995 through its publications and became the member of ENCR (European Network of Cancer Registries) in 1997. After the officially membership of Turkey in 2004, it joined the Joint Cancer Registry Project which is conducted within the framework of MECC (Middle East Cancer Consortium). In 2007, Antalya Cancer Registration Center was took part among the internationally recognized centers and its data were published in "Cancer in Five Continents" book. Bringing Erzurum and Samsun provinces to the internationally recognized level is among our privileged objectives for 2009.

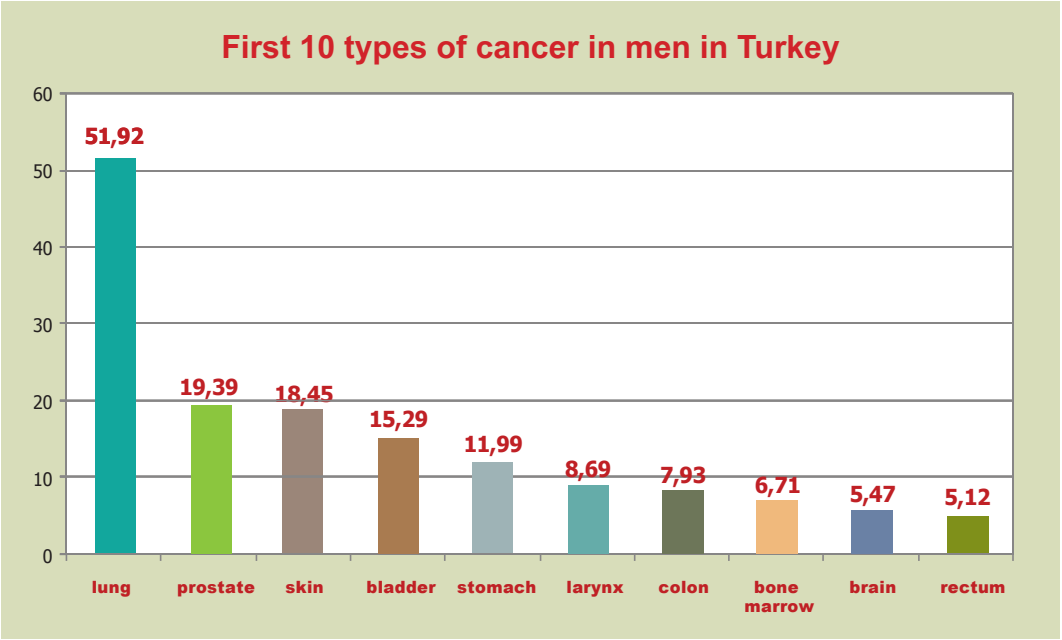


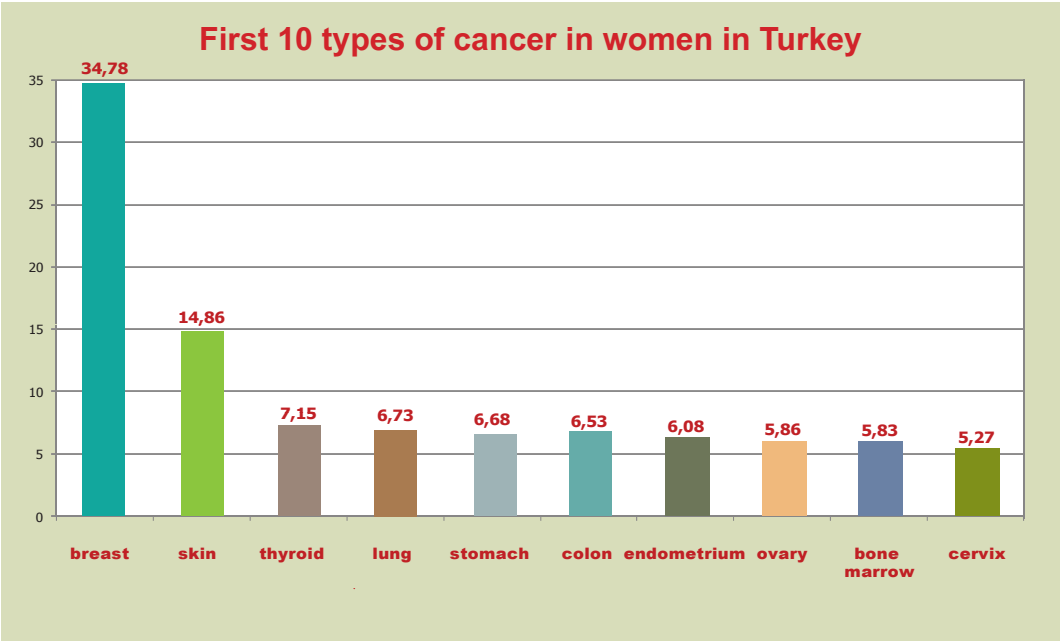
For this reason, in collaboration with "New Hope in Health" Foundation, the "Forward in Fight Against Cancer" project was started in 2008 and through this project, strengthening the cancer registration is aimed in Samsun, Erzurum, Izmir and Antalya provinces.

The best indicator for the current situation in cancer registration is that our cancer data has reached the level of cancer data expected for Turkey. The following graphs clearly indicate the present situation. Because of the data quality and duplication controls, the publication of cancer statistics in the whole world comes from behind and reflects the data of 3-4 years ago. For this reason, our latest cancer statistics belong to the year of 2004.









Cancer Control Program:

Considering the developed and less developed countries, cancer incidence rates and profiles in these countries are observed to be different. Lung and prostate cancer in males and breast cancer and colorectal cancers in females are more frequently seen in developed countries; whereas, lung, stomach and liver cancers in males and breast and cervical cancers in females are more frequently seen in less developed countries.

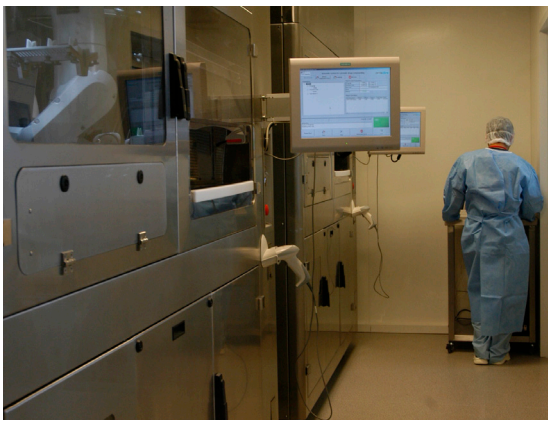
Lung, bladder and stomach cancers in male population; breast and colorectal cancers in female population are more frequently screened in Turkey. The most important difference of our country with respect to the developed countries is that the tobacco-related cancers are more frequently seen in our country. Lung cancer incidence in Turkey is 0.00063% and larynx cancer incidence rate is 0.00010%, whereas in European Union countries, the same incidences are 55 and 8.

It is known that, because of the tobacco problem, cancer incidence increases 6% every year. The cancer incidence rate in males between 1993 and 1998 was 0.001658%, whereas this rate became 0.002163% in 2003. As for the females, cancer incidence rate increased from 97.3 to 152.2 in this 10-year period.

Our Ministry primarily focused on preventing cancer and cancer screening programs. To this end, a "National Cancer Control Program" was organized in coordination with NGOS and universities. Breast and cervical cancer screening programs have been carried on throughout the country and colorectal cancers will be included into the scope of cancer screening programs as of 2009.

One of the most important factors in cancer formation is environmental factors (particularly, mesothelioma is the most important environmental factor and our country has an existing "National Mesothelioma Control Program"). In Turkey, careful studies were conducted in recent years in the regions where risk increase is possible in terms of cancer.

In our Black Sea region, a study with four components was conducted in order to search the impacts of radiation arising out of the Chernobyl Nuclear Accident taking place in 1986. According to these studies;



1. In terms of cancer incidence rate, no difference was detected between the Black Sea region and Isparta region which was the control group (1.85% in both regions). In addition, no difference was put forth in the results of the survey conducted in the households migrating from Trabzon.
2. In Black Sea region, cancer doesn't reflect an increase and distribution different from the other regions.
3. Blood samples were taken from the Black Sea region cancer patients and also from three relatives of these through cytogenetical techniques and ionized radiation effect were searched on chromosomes. At the end of this study, no radiation-specific special findings were discovered.
4. Thyroid cancers which could be developed in connection with the radiation and where effects of radiation could be indicated through tests were searched. At the end of this study, no difference was discovered between the Black Sea region and control regions.

The results of these searches set forth the fact that there is no Chernobyl-related cancer increase in the region.

Mesothelioma is a cancer of mesothelial tissue, especially that of pleura or peritoneum, rarely seen in the world, however it is seen 4000 fold more in Nevşehir Province, Gülşehir District, Tuzköy Town than it is in the world. For that reason, for the solution of the problem which was set forth as a result of the scientific studies carried out in this region since 1970, it was decided to move the town into another place within the scope of a project prepared after 2000.

In the first months of 2008, the building construction works of the houses in the region was completed, the old houses were evacuated and the movement to the new settlement area was started and completed. The old settlement area was started to be improved.

Studies on thermal power plants' negative effects to the environment are going on.

Regarding the electromagnetic fields, the relevant regulation required to be issued in the EU harmonization process is planned to be issued in 2009.

Cancer Early Diagnosis, Screening and Training Centers (KETEM) Project:

It is a practice aiming to organize trainings for health personnel and the public intended for giving information and consciousness raising on cancer (increasing awareness), to diagnose identified risk groups in early period through community-based screening programs (breast, cervical, colorectal cancers, etc.) to be conducted in line with the formed screening standards, and to refer cancer-diagnosed patients to treatment centers by giving necessary medical advice, to perform patient follow-ups and assessments, to provide social, psychological and medical support as far as possible,.

- It is a project jointly implemented by Ministry of Health and MEDA (Mediterranean Development and Aid Program) and within this framework 54 KETEMs were established until now in 52 provinces and 83 centers will have been established in all 81 provinces by the end of 2008.
- In these centers, screening services are freely delivered to our citizens who cannot afford.
- Colorectal Cancers will be included into the National Screening program in the beginning of 2009.
- Pilot screenings for skin cancer have been conducted in Adana and Antalya KETEMs.

Early Warning, Registration, Follow-up, Analysis and Training System Project in Determining the Incidence of Subgroups of Human Papilloma Virus (HPV), an agent of Cervical Cancer, in Turkish Society:

There is no adequate data about the HPV level and types in the women in our country. For this reason, within the scope of the project which aims to set forth the frequency and genotype variation of Human Papilloma Virus (HPV) in women population in our country in order to support cervical cancer screening programs for women in all age groups, the detection of HPV DNA and HPV DNA type determination in the positive results were planned to be performed in 3500 liquid based cervical smear samples to be taken from the women applying to Cancer Early Diagnosis, Screening and Training Centers and also in paraffin blocks and/or sections obtained from the pathology materials belonging to 1500 patients, who were diagnosed with invasive cervical cancer as of the year 2000, to be supplied from the Pathology Laboratories of MoH's Training and Research Hospitals, the transactions regarding these were started in September 2008. This project was planned to be completed in July 2009.

National Cancer Institute:

Regulatory Impact Analysis for the establishment of National Cancer Institute has been carried out by Economic Policy Research Foundation of Turkey (TEPAV). The law for the establishment of National Cancer Institute is aimed to become effective not later than 2010. The reorganization works of our cancer control program which could be considered under this title have been conducted together with the technical support of WHO.

Various Project Activities:

Various projects were started and have been carried out such as "Nutrition and Cancer" Project together with Başkent University in Districts of Eskişehir and Ankara, "Pharmocogenomic Research on Stomach Cancer Genetics in Turkish Society" Project together with TUBITAK Marmara Research Center Molecular Biology Unit officials, a project regarding the relationships between the carcinogens in the springs of drinking waters in Turkey and the regional cancers together with TUBITAK Marmara Research Center and a project called "Hand by Hand Against Cancer" and "Improvement of Cancer Registration and Patient Advocacy" expected to last 3 years together with 18 different NGOs founded by the cancer patients and patient relatives along with New Hope in Health Foundation.

Trainings

The standards of in-service trainings were determined in order to provide cancer control services at the highest quality and in a humanely understanding. In the last 6 years, 84 health personnel participated in the Breast Self Examination (KKMM) Training, 85 health personnel participated in the KETEM Training, 800 health personnel participated in the Cancer Registration Training, 50 health personnel participated in the Tobacco Control Training, 268 health personnel participated in the Cytology and Colposcopy Training, 235 health personnel participated in the Reproductive Health and Cervical Cancer Screening Training, and National Cancer Control Program Workshop was organized with the participation of 176 scientists who are experts on their fields.

4. Transformation in the Primary Healthcare Services: Family Medicine (FM)

Health Transformation Program is human-centered. This principle reflects the individual who will make use of the service in the planning and delivery of the system, and indicates to be based on individual's needs and expectations. In the delivery of the healthcare services, primary healthcare services is the element which is the nearest to the individual, the most easily accessible in health problems by the individual, and the entrance door to the system. While the Health Transformation Program is planning the delivery of the healthcare service as human-centered, it sets forth the introduction to family medicine implementation (FMI) in primary healthcare services. Health is improved in the family environment; from this point of view, family medicine handles the individual's health as a whole from the birth to the death in biological, psychological and social environment within the framework of "family health" concept. It is known that, undertaking the responsibility of the individual's health and approaching the individual in "single window" will increase the success. Considering these principles, preventive healthcare services and primary diagnostic and curative services for the individual were started to be executed by physicians selected by the individuals themselves. It becomes possible through FMI that physicians-family health staff and the family members will establish closer relations, the role of the physicians and their teams who serve in primary healthcare services such as health education, preventing diseases, health consultancy and health promotion will become clearer and the adoption of these roles by both service providers and service receivers will be possible.

In the program, the terms of general practitioner, family doctor or family physician are used in the same meaning and represent the physicians who had special training to serve in the primary healthcare. A family physician is responsible for the health and all kinds of health problems of all family members beginning from the fetus to the oldest member of the family. The family physician takes due precautions to protect the person whose responsibility he/she undertook against diseases; when the person becomes ill, the family physician does his/her best to solve all kinds

of health problems of that person; the family physician undertakes a coordinator's role through his/her providing consultancy services in health problems the solution of which requires specialty and special equipment by directing the person to other specialist physicians, dentists or secondary or tertiary health institutions. Therefore, the family physician is also the health consultant, and like a lawyer, a guide and a defender in health issues for the people registered under his/her name.

A family physician is generally located in a place which is close and easy of access to the residences of the family members. He/she knows the society which he/she serves at all points, evaluates their family, environment and business relations. He/she is the one who knows the health status of all family members, their living conditions, and how to apply the preventive health services and health education to those individuals in the best way. A family physician evaluates the individuals under his/her responsibility not only within the framework of a disease but also with a holistic approach together with the health-related possible risks, current health conditions, psychosocial environment and, if there is any, other acute and chronic health problems as a whole.

According to Prof. Dr. Nusret Fişek, "Personal preventive medicine services and outpatient and home care services should be executed all together (integrated). (…) The simplest of the integrated organization model is the contemporary family medicine. Contemporary family physicians examine children in the family periodically and vaccinate them. They teach the mothers how to perform child care. They also examine elder people and if any pregnant women and give due advice. They train family members on health, domestic hygiene and personal hygiene. If there are family members at home who get ill, they treat them and refer them to a specialist or to a hospital, if necessary."

An effective and graded chain of referral needs to be established to enable the

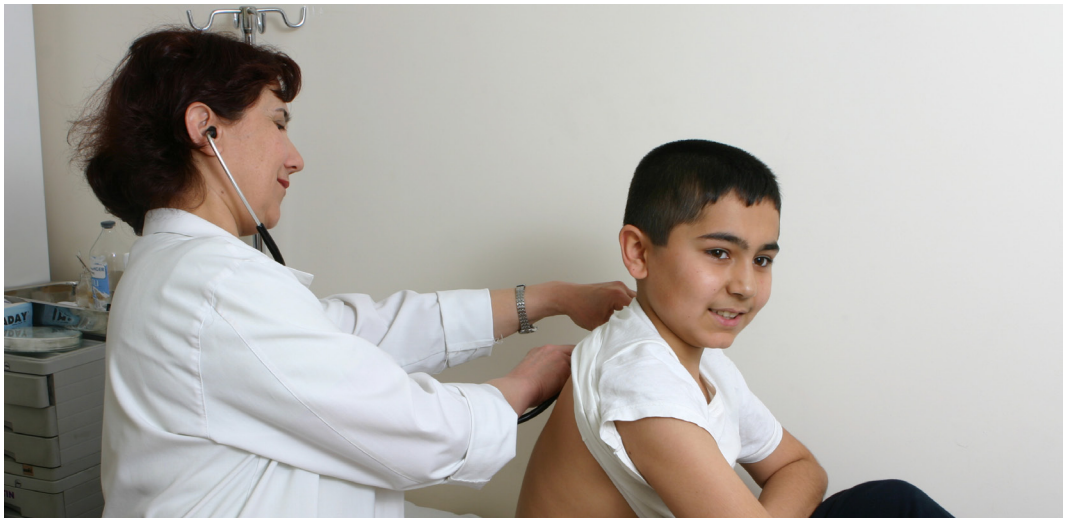
health systems to provide more qualified and economical healthcare services. The prerequisite of establishing an effective and graded chain of referral is that the patients receive primary healthcare services from a physician whom they select and trust.

Emerging of this demand for service is directly related with the strengthening primary health care services and the quality of services provided by family physicians to the individuals under his/her own responsibility. In this respect, family physicians, as coordinators of the healthcare system, have an effect to prevent false referrals, disorders and unnecessary health expenditures that might cause individuals and service providers to lose time. Family physicians prevent the waste in healthcare expenditures; hinder the unnecessary long waiting lists and patient's suffering in secondary healthcare services.

As is the case in the world, family medicine has been structured as a primary healthcare specialty in our country. Family medicine specialists are naturally the most appropriate people to provide the family medicine service. However, at this point, the insufficient number of the family medicine specialists makes the general practitioners working in the field to be included in the implementation absolutely necessary. When building the family medicine model within the scope of Health Transformation Program, it was possible to authorize some general practitioners to perform family medicine services just like in some EU countries. However, a more difficult way was preferred to be able to keep up the quality of the healthcare services to be delivered to our citizens. It was decided to provide a standardized training to the general practitioners who will perform family medicine.

A very heavy study was carried out in order to achieve this important goal of the Health Transformation Program. Family Physicians Counseling Committee was formed with the participation of professional organizations and academicians. The committee prepared the training curriculum for general practitioners who will take part in the family medicine implementation. The training was planned to be conducted in two phases. In the first phase, the general practitioners who will take part in the family medicine implementation (except for the family medicine specialists) were subjected to orientation training for 10 days long and the auxiliary health personnel were subjected to orientation training for 3 days long. The trainings have been conducted continuously under the supervision of academicians who are the experts on the issue. As of November 2008, 22,407 physicians and 17,720 auxiliary health personnel in total successfully completed their trainings and received their certificates. In 2008, additional 4,200 physicians are envisaged to complete the trainings. By the end of 2010, approximately 40,000 physicians from different duty and service fields will have been trained in the first phase orientation training.

The second phase training was planned as a long-term training targeting the update and improvement of professional knowledge and skills. Within this plan, the physicians who completed their first phase orientation trainings will be subjected



to second phase modular training for one year long. The second phase training was planned in the form of 37 knowledge modules having clinical content and 3 skills development modules. The second phase training will be conducted with a mixed education method consisting of distant learning via internet and face to face training.

Through the second phase trainings, the clinical knowledge levels of all physicians who had the first phase training and currently working as family physicians were planned to be elevated to the competence level by the year of 2013. It is also planned to ensure the physicians who had the second phase training will be motivated to get the family medicine specialty education.

For the Community Health Centers (CHC), a Scientific Advisory Board was formed predominantly from the academicians of public health departments and improvement of CHC personnel's knowledge peculiar to their field and its certification is aimed. As a result of the intensive works carried out with the Scientific Advisory Board, it was decided that the CHC personnel are to be trained in a two or three-phased training including the selected public health topics. In the first phase, a CHC 1st Phase trainer training was carried out for 6 days in December 2008.

Community Health Centers were founded in order to provide more effective and productive services by gathering primary healthcare services under a single roof except for personal preventive healthcare, diagnostic, curative and rehabilitation services. These centers give free-of-charge logistic support to family physicians in privileged service fields such as vaccination campaigns, mother and child care and family planning services in accordance with the program identified by the Ministry of Health. Thus, in a sense, both family health and community health care services were unified and primary health care structure was integrated. As the process moves forward, family medicine specialists are planned to be employed in family health centers and public health specialists in community health centers.

The Law on Pilot Implementation for Family Medicine was enacted by the Turkish Grand National Assembly in November 2004. Pilot implementation was first initiated in Düzce in October 2005. Then, implementation was launched in 2006 in Eskişehir, Bolu, Edirne, Adıyaman, Denizli, Gümüşhane, and in 2007 in Elazığ, Isparta, Samsun, İzmir, Bartın, Sinop, Amasya, and in 2008 in Bayburt, Çorum, Manisa, Osmaniye, Karaman, Karabük, Adana, Burdur, Kırıkkale, Yalova, Çankırı, Tunceli, Kastamonu, Kırşehir, Bilecik and Erzurum . So, our approximately 18 million citizens were brought under the coverage of family medicine in 30 provinces. At present, 5,032 family physicians have been serving in 1,687 family health centers. By the end of 2010, the implementation will have been introduced all over the country.

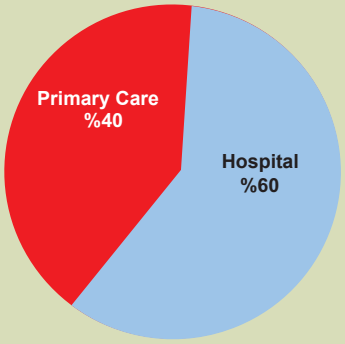
Family medicine implementation, preliminary results of which are so encouraging and successful, put primary healthcare services at the top of the public agenda, and makes primary healthcare attractive. In the starting provinces where the system has been executed successfully, the number of patients visiting hospitals is reduced (although there is no obligatory referral implementation) and the excessive workload at hospitals is alleviated. At the same time, physicians who are employed in primary care will re-gain the professional respect that they already deserve. For now, the implementation is supported by in-service training programs. However, the system encourages training family medicine specialists in long-run for well functioning of the system. This will increase people's trust in the reliability of primary care services and enhance the quality of services.

All health data, together with the family medicine implementation in the primary healthcare, will only be kept in electronic environment as of 01 May 2009. By this way, primary healthcare works will be able to be evaluated and reported in the light of healthier, more up to date, and more reliable data.

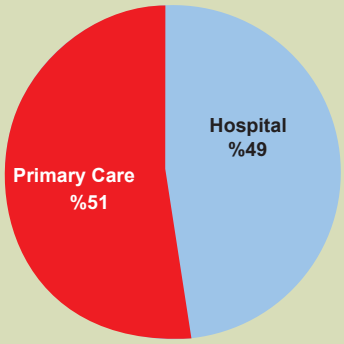
Family medicine implementation which has been currently carried on all over the country is evaluated by the implementers themselves, academicians, local administrators, NGOs and the authorities of the Ministry in quarterly periods; in addition, possible suggestions for improving the implementation are discussed in details. At the same time, various researches have been conducted to compare the FM provinces and non-FM provinces, to collect the opinions and suggestions of our citizens about family medicine implementation, and to follow the implementation costs dynamically. The results of these researches have been used for the improvement of the implementation.

When our citizens were asked to what extent they were satisfied with the services provided by the Primary Healthcare Institutions in 81 provinces, the results figured out rather high level of satisfaction. It is seen that our citizens are highly contended with the primary healthcare services developed within the framework of Health Transformation Program, and this satisfaction figures are much higher in those places where family medicine implementation is performed.

Pro rata Distribution of the Examinations made in the Primary Care and in Hospitals in Family Medicine Provinces



Before FM implementation



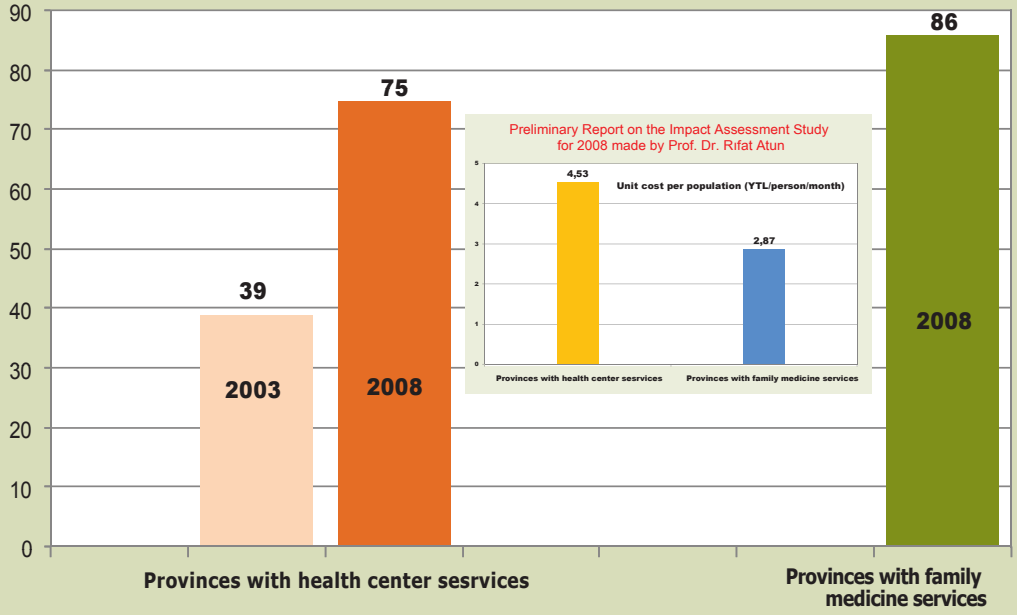
After FM implementation

In the provinces where FM implementation was launched examination services increased at the Primary Level. While 40 % of all examination services were made in primary level, in the FM provinces this ratio became 51 %.

Due to significant lack of number of physicians and practitioners in our country, referral chain obligation is not yet introduced, yet those ratios are significant and promising.

EUROPEP Scale 81 provinces' satisfaction survey (October 2008)

Average satisfaction with the service delivered by the primary care institutions



Note: 2003 data is taken from TURKSTAT

5. Performance-Based Supplementary Payment, Quality and Accreditation

Primary Healthcare Services and Performance-Based Supplementary Payment

Health transformation Program aims a human-centered change with regard to both the service providers and service receivers. For that reason, with regard to service provider, performance-based additional payment implementation which has been developed up to the present since 2004 as a model peculiar to our country was introduced; in this way, it was ensured that current human resources were used more effectively and in addition, the personnel was financially supported in line with the difficulty and risk of healthcare services.

Performance-based additional payment is an implementation which includes various dynamics inside and enhances the efficiency and motivation of the personnel as well as the payment to the personnel in proportion to his/her contribution to the service. Through this implementation, it was aimed at improving the working conditions of the personnel who works in the public and provides healthcare service and it was also aimed at providing productive and effective service by payment in return for personnel's performance in the delivery of healthcare service.

Performance-based additional payment implementation which was put into practice across the country in 2004 was launched in all institutions providing healthcare services under the Ministry. Within this scope, distinctive criteria of each step were set forth. The issues included in the program related to primary healthcare services appear in different forms in all steps.

The criteria set forth in the field of preventive and primary healthcare services in primary healthcare institutions are as follows:

- Interregional development,
- Distance to the center,
- Vaccination,
- Infant follow-up,
- Pregnant follow-up,
- Newborn screenings,
- Family planning method utilization rate, etc.
- Diagnosis and follow-up works for tuberculosis control.

The indicators related to preventive healthcare services include the following components:

a) Average number of follow-up per infant,
b) Average number of follow-up per pregnant,
c) HepB1 vaccination percentage,
d) DBT1 vaccination percentage,
e) KKK vaccination percentage,
f) Screening tests (Neonatal hypothyroidis, phenylketonuria, thalassemia, etc.) sampling percentage,
g) Modern family planning method utilization percentage.

Performance-based additional payment implementation and the above mentioned criteria are strengthening primary healthcare services; however, they are reflected into the additional payment of the service providing personnel through monthly evaluations.

- Support for scientific studies,
- Support for educational studies,
- Support for participation in congress, seminar, etc. activities,
- Infection control,
- Laboratory Safety

In these issues, supportive and performance-based remuneration is utilized in a positive way.

All health personnel working in primary, secondary and tertiary healthcare institutions are provided support in terms of performance-based additional payment when they take part in training works, congress, seminar, and similar activities. In this way, personnel's knowledge related to his/her profession is enhanced and necessary personnel substructure is formed in order to provide more qualified healthcare services through more qualified health personnel. Health education, in one sense, is extremely important for the citizens to get information and become conscious.

Similarly, the scientific studies conducted by all health personnel working in primary, secondary and tertiary healthcare institutions are supported at the same rate, too. The personnel who publish scientific studies and papers inside and outside the country are made an additional payment at a higher rate. The scientific study support provided to the personnel also means providing support for the quality and nature of health.

Primary Healthcare Services and Institutional Performance and Quality

By our ministry, a new implementation was also initiated to evaluate the institutional performance and quality studies of the institutions, which was integrated into the performance-based additional payment implementation in all our institutions since 2005. This initiated implementation differentiated the healthcare services in accordance with the content of the primary, secondary and tertiary health institutions and it put forth a new evaluation set envisaging the delivery of healthcare services in the right, sufficient, qualified and efficient way.

Institutional-level performance measurement is the complement of the healthcare performance measurement delivered by the personnel and it evaluates the primary healthcare services in a broader universe. Institutional-level performance measurement aims to increase the quality, efficiency and patient satisfaction in healthcare services and ensures the participation of all personnel in the qualified service due to its impact on individual performance.

Institutional performance and quality implementation in primary health institutions

The criteria which were established in primary health institutions regarding the primary healthcare services are as follows:

- Access to medical examination,
- 112 service quality indicator,
- Preventive service indicator,
- 112 efficiency indicators.

'These components which were evaluated in 4-month-periods have influence on the amount of additional payment to be paid to personnel when evaluating the service quality and efficiency of primary health institutions.

Preventive services indicators are the most important indicators to reflect the development of a country. For that reason, in addition to the indicators of services for infant and mother health; preventive health indicators such as tuberculosis, environmental health, vaccination, mobile health services, etc are the main indicators to evaluate the institutional performance in terms of health institutions.

The criteria set forth for the evaluation of the units which deliver 112 Emergency Healthcare Services increase the service quality and accessibility to these units.

In line with the criteria used in institutional performance measurement, an examination room is given to each physician, the communication between the physician and the public is facilitated and the access of the public to the healthcare services is increased.

Primary healthcare services in secondary and tertiary health institutions;

The service quality standards of the criteria set forth to evaluate the institutional performance and quality of inpatient health institutions are as follows:

Training of personnel,

Training of patients,

Prevention and control of infections,

Laboratory safety,

Standards for improving the processes of hospital services.

Institutional performance and quality studies are performed in four-month-periods. Within the scope of the criteria specified by the ministry; infection control studies conducted in hospitals, training processes for personnel and patients, scientific studies and laboratory safety are directly associated with individual performance.

On the other hand, evaluation criteria for infection control are involved in institutional performance measurement as well, and all personnel are participated in these studies.

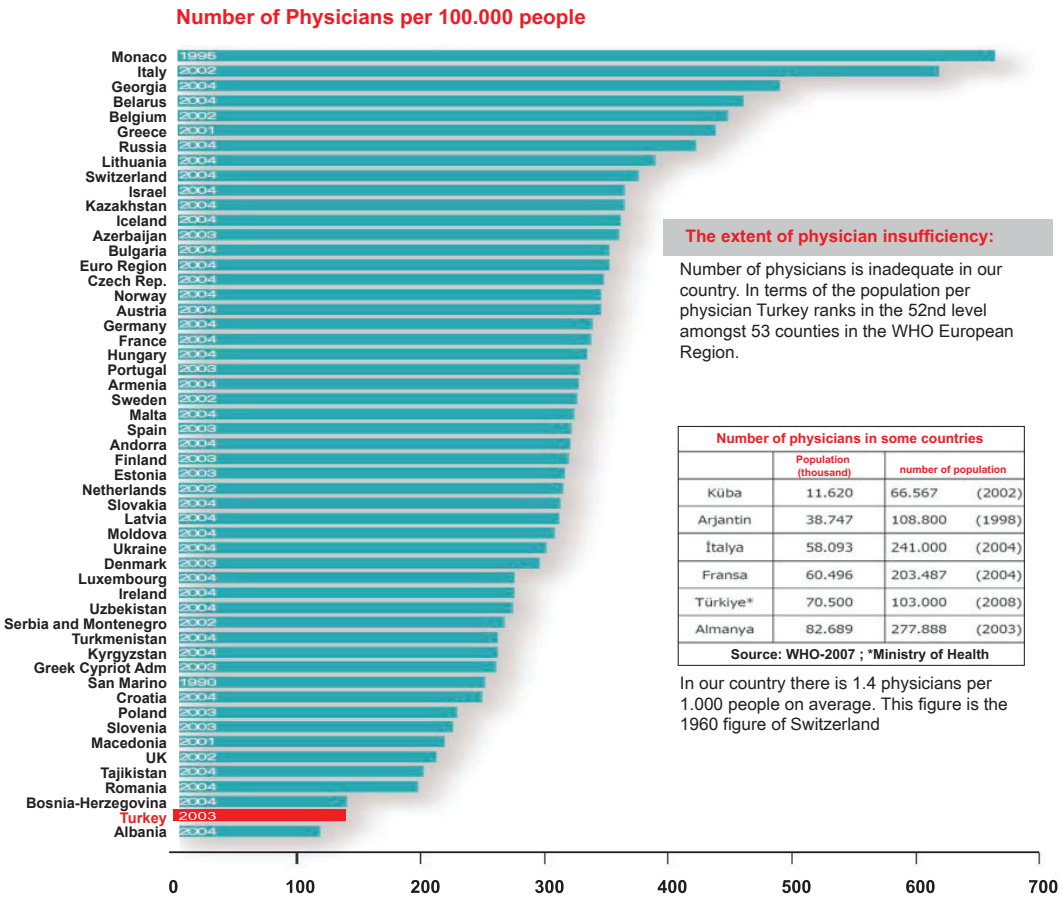
Evaluation of the institutions regularly in every four months both ensures the continuity of these studies and contributes to the implementation of these standards through increasing their efficiency.

6. Human Resources Management in Health

a) Determining the Human Resources Situation and Solution Planning

Before the Health Transformation Program, there were distinctly striking wrong approaches to health human resources 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. Unfortunately, the truth is that the important principle of "quality in education" was used as an excuse in order to shadow the need to increase numbers.

It is important to raise the numbers particularly of the physicians and the nurses without compromising education quality in health human resources. In terms of the number of physicians per hundred thousand, Turkey ranks at the bottom of the WHO European Region. The situation is not different in terms of the nurses, physiotherapist, and other health professionals.



The extent of physician insufficiency:

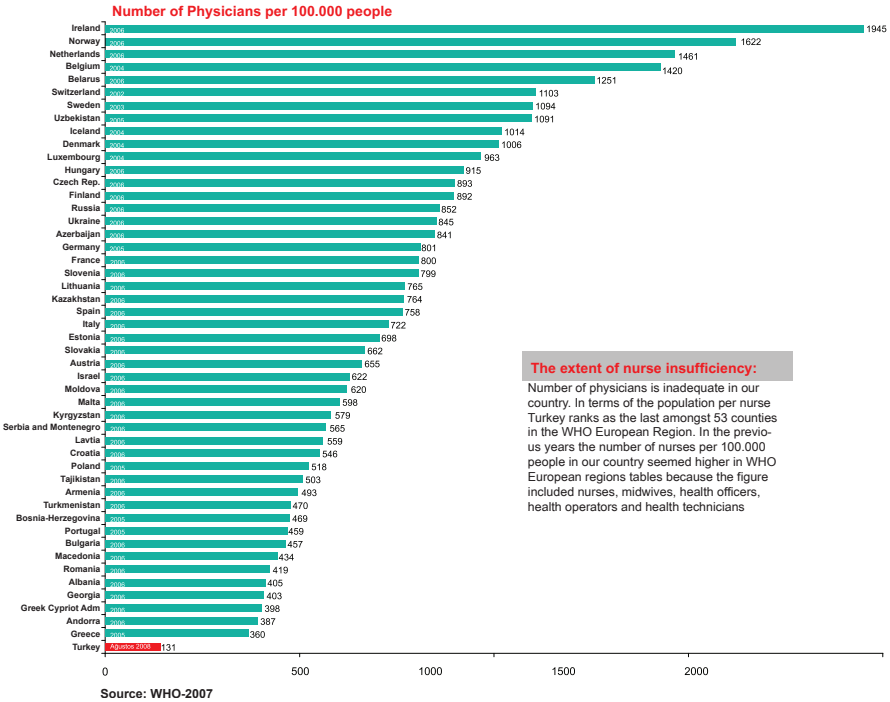
Number of physicians is inadequate in our country. In terms of the population per physician Turkey ranks in the 52nd level amongst 53 counties in the WHO European Region.

Number of physicians in some countries

	Population (thousand)	number of population	
Küba	11.620	66.567	(2002)
Arjantin	38.747	108.800	(1998)
İtalya	58.093	241.000	(2004)
Fransa	60.496	203.487	(2004)
Türkiye*	70.500	103.000	(2008)
Almanya	82.689	277.888	(2003)

Source: WHO-2007 ; *Ministry of Health

In our country there is 1.4 physicians per 1.000 people on average. This figure is the 1960 figure of Switzerland



Source: WHO-2007

The needs of the population and the increasing demand for the healthcare services makes it inevitable to increase the number of the physicians and the nurses. At the same time, the education quality must be preserved certainly and even improved. The number and competency of academicians in the schools of medicine in Turkey are sufficient for this purpose.

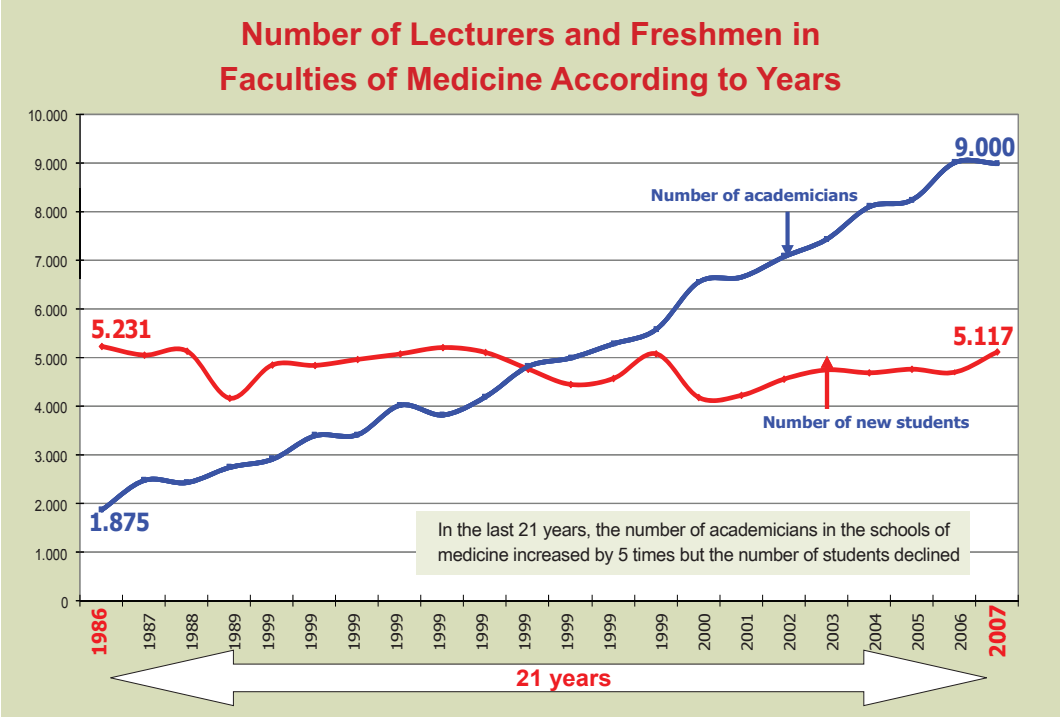
Number of students per academicians in schools of medicine in some countries

Country	Population (million)	Number of schools of medicine	Number of academicians	Number of students	Number of students per academician
Germany	82,6	36	3.550	79.866	22,5
Spain	41,9	28	2.500	36.049	14,4
İtaly	58	39	12.583	148.157	11,8
France	60	44	5.849	62.921	10,8
Slovakia	5,4	3	893	6.561	7,3
Slovenia	2	1	285	1.717	6
Finland	5,2	5	698	3.583	5,1
Denmark	5,4	5	1.570	6.598	4,2
Turkey*	70,5	52	9.020	32.985	3,6

Our country is in WHO European Region. When the average of this region is taken as the basis, there should be 14.000 graduates from the schools of medicine every year according to the population we have

However, the annual number of graduates is the 1/3 of the European average (around 4.500).

Source: Ministry of Foreign Affairs, Ministry of Health



In the light of these facts, School of Public Health initiated a study with the participation of the relevant sectors in May 2006. An assessment analysis was done with WHO and Harvard School of Public Health and "Health Human Resources Current Situation Analysis" was published a book. A workshop was held on April 22-24, 2007 in order to evaluate its findings and analyze the policies and the results of this workshop were published under the name of "Health Human Resources and Policy Making Workshop". MoH, with the collaboration of Higher Education Council (YÖK) and SPO published the Turkey Health Workforce Situation Report in March 2008. Health human resources planning and training is the constitutional roles of those institutions and it is very hopeful that those institutions meet at a common ground. The collaboration which continued during this work and afterwards gave its first fruit and YÖK increased the student quota for the Schools of Medicine by 30 % and for the Nurse Vocational Schools by 15 % in 2008. The quotas were increased to 6 thousand for the Schools of Medicine and 14 thousand for the Nurse Schools (Health College and Nurse Vocational Schools) in 2008.

Assuming that our population will become 83 million in 2023 with the expected increase rate, we think that it is necessary to increase the quotas gradually in the coming years and to have 13 thousand new students to the Schools of Medicine and 23 thousand new students to the Nurse Schools every year.

In this way, we will be able to get close to the European average with 200 thousand physician and 400 thousand nurses in 2023. With those figures, we will have 250

physicians and 500 nurses for every hundred thousand people. The same approach is of great importance for physiotherapists and in many other health disciplines.

The following estimation of requirements is within reason for 2023:

- In 2008, the number of physician application per capita will be around 6,3. We expect that this number will reach 7-8 per year in the following 15 years. As stated above, Turkish population is expected to reach 83 million in 2023. Thus, we estimate the total number of applications will reach 664.000.000 in 2023. (83.000.000 x 8 = 664.000.000)
- For a qualified and reliable health service delivery, a physician should spare in average 15-20 minutes for a patient. Assuming that the family physicians and the specialists of the outpatient institutions spare 17 minutes for each patient, it would be reasonable to aim at meeting the requests of 25 patients a day. (in outpatient admission, a physician works for 7 hours a day; 420 min/17 =~25).
- There are approximately 220 workdays a year, 664.000.000 / 220 days = 3.018.181 application/day needs to be done.
- 3.018.181 / 25 = 120.727 physician / day rate is found. (i.e. in 2023 we will need 120 thousand physicians who will be examining patients at the same time).

The figure of 120 thousand is only the required number of the family physicians and the specialists examining patient in outpatient institutions at the same time. When the other services such as community health services, training services (including trainers and trainees), inpatient services, surgery and intensive care services, laboratory services, researches, etc. are considered, it is seen that the number which will really meet the needs is 200 thousand physicians.

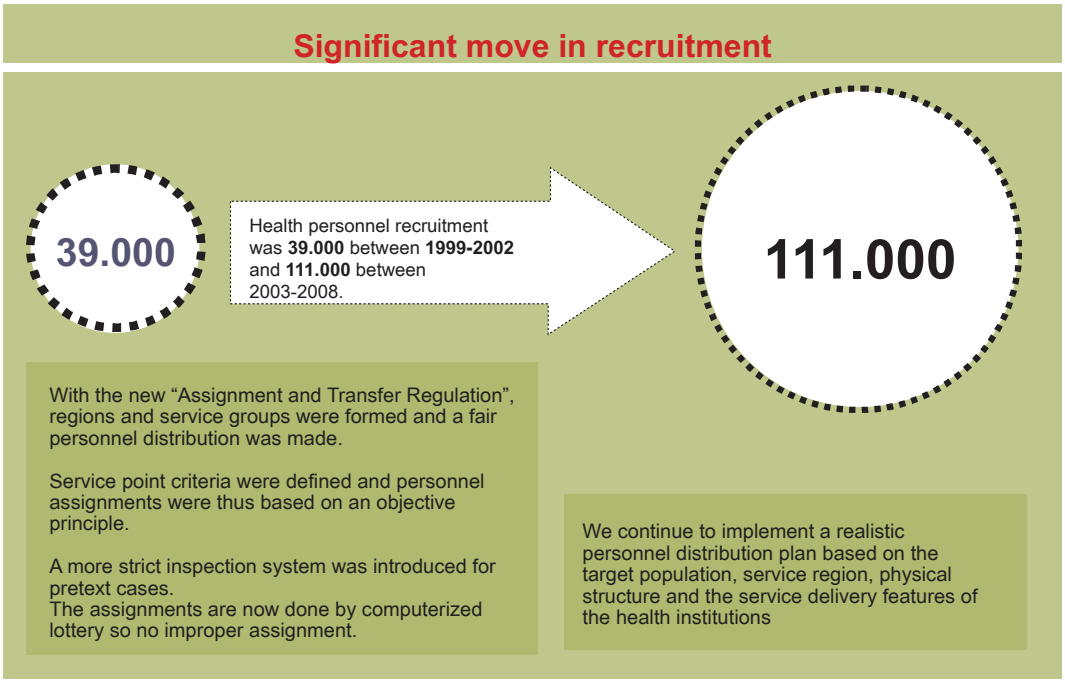
It is also necessary to add that the insufficient number of physicians is unable to optimally meet the service demand and this hardens the distribution of the physicians geographically, increases the cost of the physician supply, results in unnecessary test and poly-pharmacy practices, and as a result increases the costs.

b) Break-through in Health Human Resources

111 thousand new health personnel were appointed during the last 5 years in public health institutions. 16,000 contracted health personnel have been assigned in deprived health facilities which had no personnel for years in the past. In this way, the gap between the best and worst rates of provinces were diminished (for specialists: from 1/14 to 1/3,5; for practitioners: from 1/9 to 1/2,7; and for nurses and midwives: from 1/8 to 1/3,8). In the next few years, distribution of

health care personnel will be more equal and fair through the balancing studies regarding some provinces placed in extreme top and bottom of the rank. Another recruitment model is the recruitment of the staff working in outsourced services such as housekeeping, information processing, security, and catering. The number of these personnel was 25 thousand in 2002 and it reached 95 thousand in 2008.

In 2002, the number of personnel working in the health institutions of MoH and SSK was 272 thousand and it reached 414 thousand as of November 2008. (This figure includes the ones recruited directly by the public and also the ones recruited through outsourcing.)



c) Transparency in Personnel Appointment

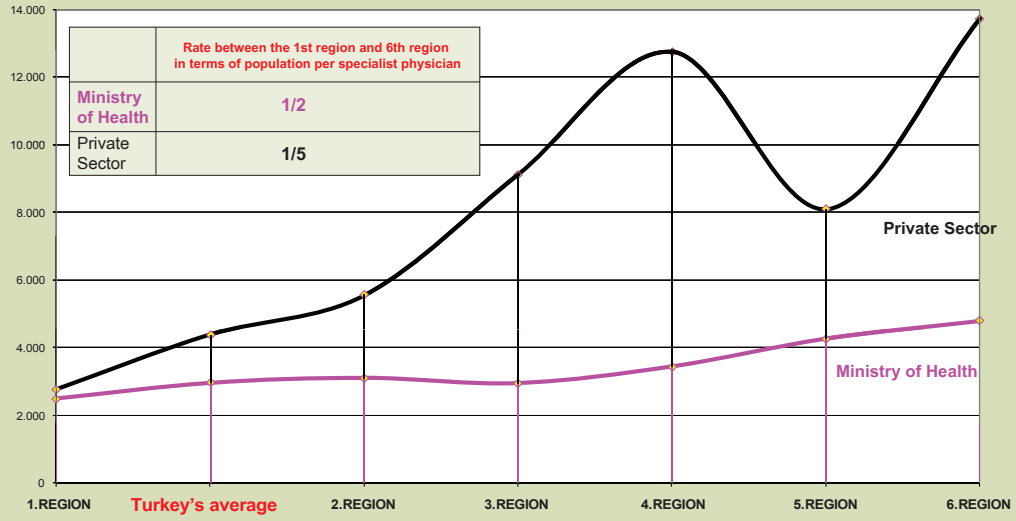
It is known that unbalanced health personnel distribution was one of the most important problems in our country in the previous period. Among the priorities of the Health Transformation Program are to reduce the regional differences in personnel distribution into the acceptable levels, to determine realistic standards in accordance with the titles in personnel employment and to plan human resources in line with this and to establish an objective and equitable system to be used in the appointments and assignments.

In order to encourage personnel to work in priority regions for development, the law no: 4924 was adopted; this law allows the recruitment of contracted personnel. Thus, it was encouraged to work in the places where difficulties were encountered in the recruitment of health personnel. Thanks to this policy, more than 7 thousand new health personnel were assigned in the East and Southeast Anatolia Regions.

Physicians are already inadequate in number and it is getting difficult to employ them in the less developed regions since most of them would like to work in metropolitan cities. Within the framework of the understanding that everybody should get access to healthcare services, the compulsory service with incentives was put into effect for physicians.

Considering the incomplete and defective aspects of compulsory service implementations in the past, a more acceptable and sustainable arrangement was made to allow identifying different work periods and higher payment policies in accordance with deprivation areas.

Average population per specialist physician according to development regions



Note: Regions are ranked by SPO

Within this framework, in accordance with SPO Regions for Development, the rate of population per specialist between the 1st region and 6th region was 1/5 in private sector and this rate was reduced to 1/2 in public sector.

In order to prevent nepotism in personnel appointments, The Regulation on Appointment and Assignment was prepared with a different understanding so that health care personnel are distributed to all the MoH-affiliated health care facilities in a balanced way. In first appointments, specialists, general practitioners, dentists and pharmacists are appointed by a computer-based lottery and other health personnel is appointed by a central examination conducted in accordance with general provisions. In the new implementation, personnel appointment and assignment proceedings are based on the "service points" that depend on the features of work places and term of employment. A more strict supervision system was set up for excuses. Service points-based and computerized lottery prevented favoritism and nepotism pressures on politicians and bureaucrats as well as some unjust interventions. Thus, a marked success is achieved in the equitable and balanced distribution of health personnel all over the country.

d) Health Personnel Training

Orientation trainings are given to family physicians and nurses to be assigned in primary healthcare services. The curriculum of the in-house training for the longer second period is already prepared and the preparation of the training materials is almost completed.

Primarily, a kind of mobilization process has been initiated in order to train current directors. On one hand, regional training meetings are held on technical issues. On the other hand, School of Public Health provides systematic health management trainings on the web.

Within the scope of those trainings, 6.500 students (500 of them were managers) benefited from the system. The distant learning system is a modern technology product providing information on internet and it is used for the first time in the Republican Period and it aims at training the managers, manager candidates and the specialists in the health institutions. The training web address is www.hm-uses.gov.tr.

In 2008, all provincial health directors were provided one-week orientation training and the training of the heads of health groups were initiated.

The nursing-training program has been leveled up to international standards by grounding it in university-basis. The law on nursery was enacted and this law is thought to help nursing services turn into a scientific discipline for patient care. However nurse education in colleges in the transition period will continue due to the big need. Relevant arrangement is made in the law for this.

7. National Medicine Policy

On behalf of the public, the Ministry of Health is responsible to determine the relevant norms and standards about medicine and pharmaceutical services. It is also authorized and obliged to carry out inspections in this field and to encourage rational drug use in cooperation with other relevant institutions and organizations. The duty of the Ministry of Health is to ensure our citizens to get the drugs in an efficient and reliable way with high quality and reasonable prices. The aim of the Health Transformation Program is to ensure that our citizens can reach the drugs without any discrimination and also to ensure this accession is to be sustained. To realize that purpose, the followings have been performed.

a) Reduction in Medicine Prices

One of the leading findings of the Health Transformation Program is that increases in medicine prices were not evidence-based in the past.

As for medicine pricing, the program clearly emphasized the need for developing a method which all parties would agree on. "The Decision on Pricing of Medicinal Products for Human Use" of 2004 removed the confusion and negative aspects and rendered the issue of pricing medicine transparent through the reference-based system. Thus the prices have been cheapened significantly and now the prices of medicine are at the lowest level in Europe. Discounts ranging from 1 % to 80 % have been done in approximately a thousand products just after the implementation was initiated.

Thanks to the reference system, the reduction in prices still goes on in many products. In addition to that, The VAT rates for medicine have been reduced to 8 % from % 18 leading to another decline in medicine prices. The negotiation of medicine prices by the public insurance institutions as the sole buyer and the resulting reduction further decreased the cost of the medicine prices to the public.

In order to relief the burden of Public Finance, a Reimbursement Commission has been established under the directorate of the Ministry of Health. This commission has enabled "The Single Reimbursement System". With the consensus of the reimbursement institutions, a rule was established that the prescribed medicines will be reimbursed on condition that their prices are up to the 22 % over the cheapest bioequivalent medicines. With this practice, some medical firms that are out of this circle have diminished their prices voluntarily in order to benefit from the reimbursement system. Eventually, a significant saving has been achieved for public finance.

"Price Decree" dated 1984:

Prices were based on the firms' cost statements, it was not practically possible to investigate the cost of imported pharmaceuticals, and market prices were determined by adding the costs and the profit rates.

The new decree dated February 6, 2004 by our government:

We established the Reference Price System and introduced transparent, measurable, objective criteria and gradual profits which will decrease the burden on the public.

We established the structure which includes the reimbursement institutions to the decision making process.

We disposed the "Technical Obstacles in Trade" investigation" opened against our country by the EU Commission.

Regulating the Pharmaceuticals' prices with the Reference Price System

*We take 5 EU member countries which have with cheapest pharmaceutical prices and are followed, as the reference. With the revision on the decree, number of the reference countries was turned into "between 5 and 10", and in this way taking more countries as the reference was made possible.

*We identify the maximum price of any pharmaceutical in our country by taking the cheapest price within those 5 countries as the basis. (Reference price)

*The prices of almost a thousand medicines decreased by 1 to 80 % with this implementation.

Annual Public Savings made by reference price system:

1 Billion YTL

Public Pharmaceutical Expenditures in 2002 prices (million YTL) and Amount of Consumed Pharmaceuticals (million boxes)

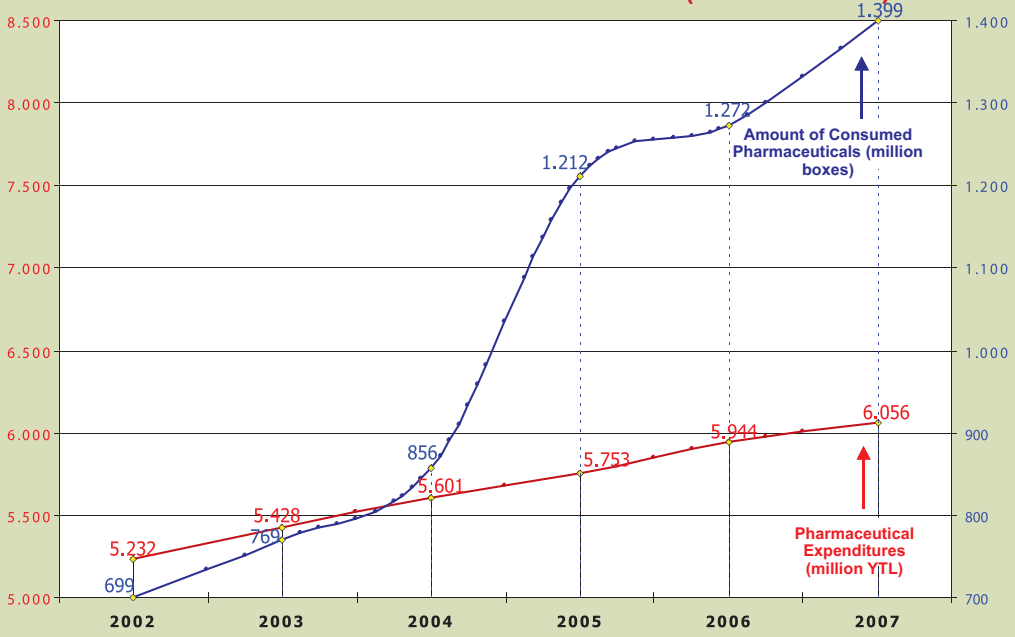
	2002	2003	2004	2005	2006	2007	% five year increase
Public Pharmaceutical Expenditures (million YTL)	5.232	5.428	5.601	5.753	5.944	6.056	16%
Consumed Pharmaceuticals (million boxes)	699	769	856	1.212	1.272	1.399	100%

Thanks to our pharmaceutical policies, the amount of medicines consumed in 5 years increased 100 % and the public pharmaceutical expenditure increased only by 16 % in reality.
We used the savings achieved by our pharmaceutical policies for ensuring public's easy access to medicine.
SSK enrollees and green card holders can now get their medicines from all pharmacies.

b) Opening Pharmacies to Everybody

The advantages provided in the medicine prices were directly reflected into our citizens and the obstacles in front of our citizens (especially SSK enrollees and the Green Card holders) for accessing to medicine were removed. In the Health Transformation process, decisive steps were taken to ensure easy and economic access to medicines and the result of those steps are observed by the public closely.

Public Pharmaceutical Expenditures in 2002 prices (million YTL) and Amount of Consumed Pharmaceuticals (million boxes)



People insured by the SSK had to obtain their medicine from a limited number of hospitals and some of them could not obtain their medicine for this reason and some had to pay the medicines from their pockets. Now they are also free to obtain their medicine from any pharmacy like the other Turkish citizens. With the changes in the Green Card legislation, Green Card holders are also in the out-patient treatment system; hence they are free to obtain their medicine from any pharmacy.

All these practices have eliminated the discrimination dividing people into categories.

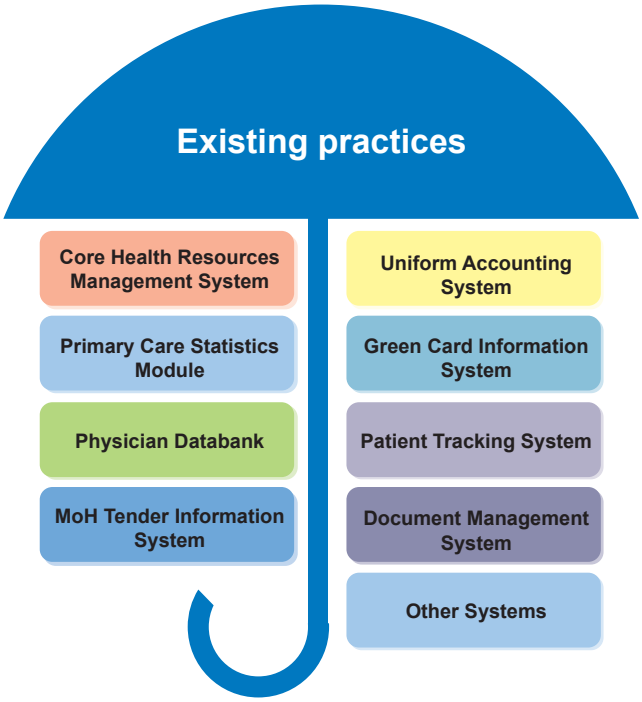
c) Rational Drug and Material Management

Within the framework of rational drug use, we published diagnosis and treatment guidelines especially for primary family practitioners. Our preparations for institutional structuring on this issue are continuing.

We initiated the preparations of television programs to raise the awareness of our public about rational drug use. We are developing collaboration with Ministry of National Education to give informing seminars to students in schools and to include these issues in the curriculum of health lessons in schools.

8. Health Information System

It has been emphasized in the program that an integrated information system is needed in order to establish harmonization of all the components in the system. It is known for sure that health system policies and administrative decisions should be based on information. Health information system cannot be built solely by making investments in technologies, the establishment of the system depends on national and international health informatics standards, coding, classification and terminology identification, integration of the data collected from different institutional levels, and making this information usable in the decision making processes.



Primarily the standard coding systems such as the standard definitions of institutions contacted in providing health services, the data banks of physicians, international disease classification, medicine and medical product codes have been identified, harmonized and began to be used in the sector.

Family Medicine Information System, which is a pioneer of the electronic patient records and a limited scale example of the health information system, was put into practice. In this way we started to keep the Electronic Health Records of 17 million citizens until now in the FM provinces.

The Uniform Accounting System was put into use. Through the Core Health

Resources Management System we ensured that all managers were provided accurate and up-to-date information support for monitoring and directing human, material and financial resources.

Through the MoH Tender Information System, it is possible to see the tender results for the procurement of medicines, medical devices, materials and services in all MoH Provincial Health Directorates, all hospitals, and Hygiene Regional Directorates.

Through the Green Card Information System, the green card holders are included in the Retirement Fund prescription control system. Pharmaceuticals and International Disease Classification codes were put into practice. National Health Data Dictionary and Minimum Health Data Sets were prepared for the first time in health informatics and Health Coding Reference Server was put into service.

Again for the first time, Organ Transplantation and Tissue Data Bank was established in order to find the most suitable organ for the citizens waiting for organ transplantation and to prevent illicit organ transplantation.

Through the Physician Data Bank, the diploma and the specialty information of all physicians during the republican Period are fettered into records.

Through the Tele-medicine Project, distant reporting service was provided in the field of screening with the use of information and communication technologies and a total of 18 hospitals are put into service consisting of 11 sender and 7 receiver hospitals in the field of tele-radiology, tele-pathology and the roll-out works are continuing.

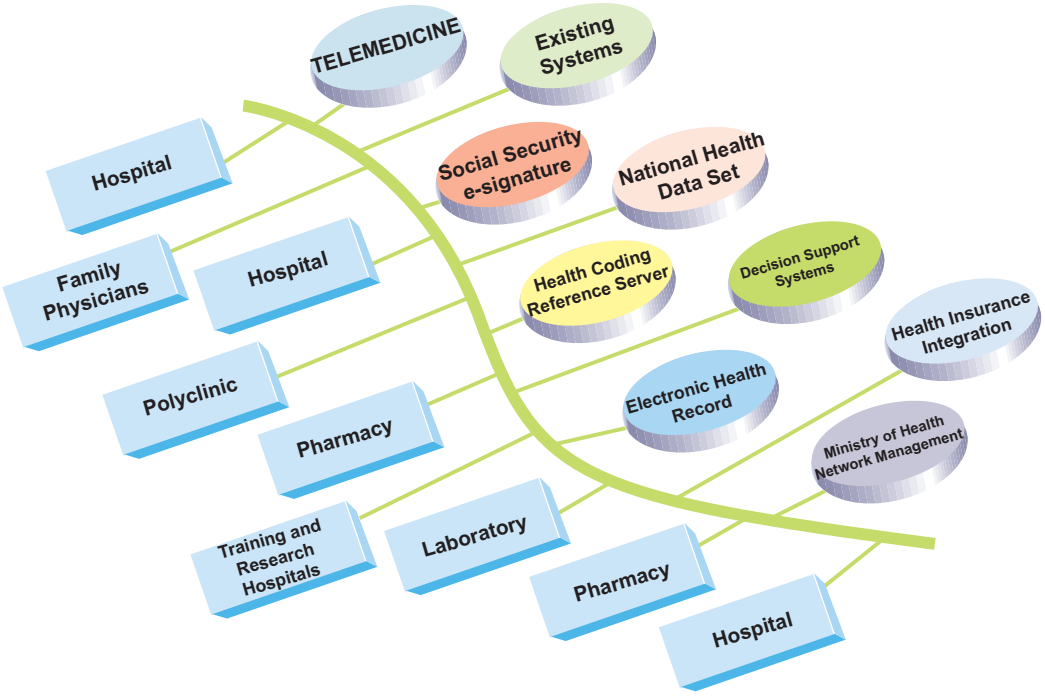
National Health Information System /e-Health Project completed the infrastructure works for the establishment of a health information system covering all health services and all actors of the health system. According to the Minimum Health Data Sets included in the National Health Data Dictionary, the project aiming at gathering electronic health records from all hospitals was put into service and in the near future health data will be collected in this way.

Decision Support System which provides analysis, reporting and statistic support for the Health Policy makers, planners and decision makers was put into service. In this way, it will become possible to do epidemiologic and demographic analysis for the burden of disease. Saglik-NET portal was put into service for the citizens, information officers and health workers.

Under the coordination of SPO; Ministry of the Interior, our Ministry, SSI and TUBİTAK-UEKEA execute works all together;

a) With the e-identity (smart card) project, both the citizens and the physicians will access the health records safely and violation of confidentiality will be prevented

Health portal is functional



b) With the e-prescription project, paper prescription will disappear and the prescriptions will be processed in the electronic environment.

The pilots of those projects were initiated in Bolu province in October 2008.

9. Rationalism in Investments

A detailed health inventory has been created with the Health Transformation Program and all the health investments so far have been reviewed. Public health investments have been re-planned. The financial, medical and technical analyses of investments have been re-evaluated. These planning procedures have been carried out on-site at the level of district, province and region together with the local administrators. The projects have been re-arranged in accordance with the priority and importance level and investment budgets began to be utilized more logically.

We conducted "Turkish Health Inventory" study.
We assessed the financial, medical and technical analysis of investments.
We made planning through on-site inspections and in collaboration with local administrators on district, provincial and regional level.
We classified projects with regards to priority and significance.
We made rational use of investment budgets based on above principles.

Health Investments Concluded in November 2002-November 2008

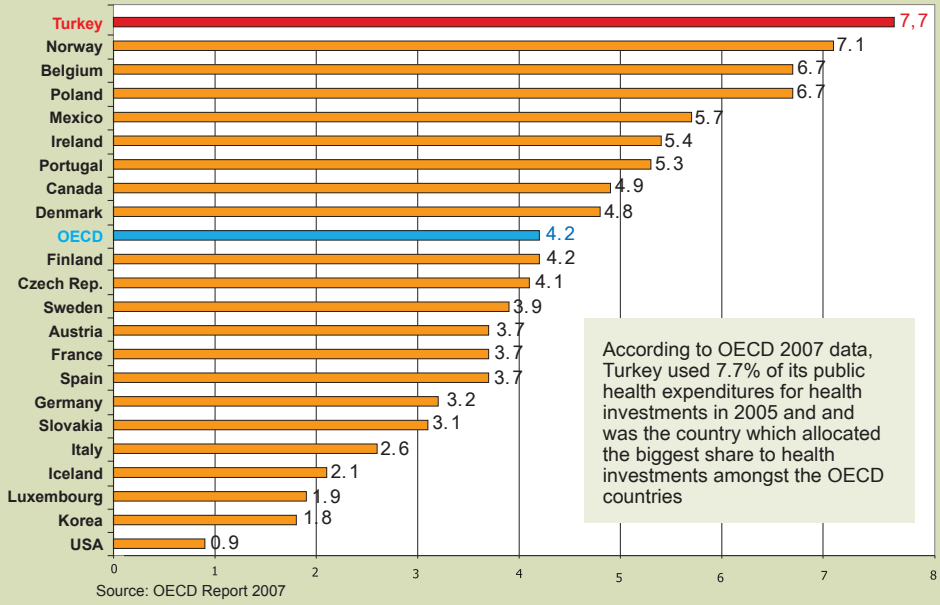
Hospital	Hospital side buildings	Health centers	Other	Total
211	191	752	95	1.249

The Amount Spent For Health Investment, Maintenance And Medical Hardware Between The Years 2003-2008 (Million YTL)

General Budget	Revolving Fund	Province Special Admin.	TOKI	TOTAL
3.274	3.260	753	207	7.594

We spent 7 billion 594 million YTL under Health Transformation Program for investment, maintenance and medical devices. We opened 1.249 health facilities, of which 752 are health centers.

The ratio of the health investment expenditure within the public health expenditure

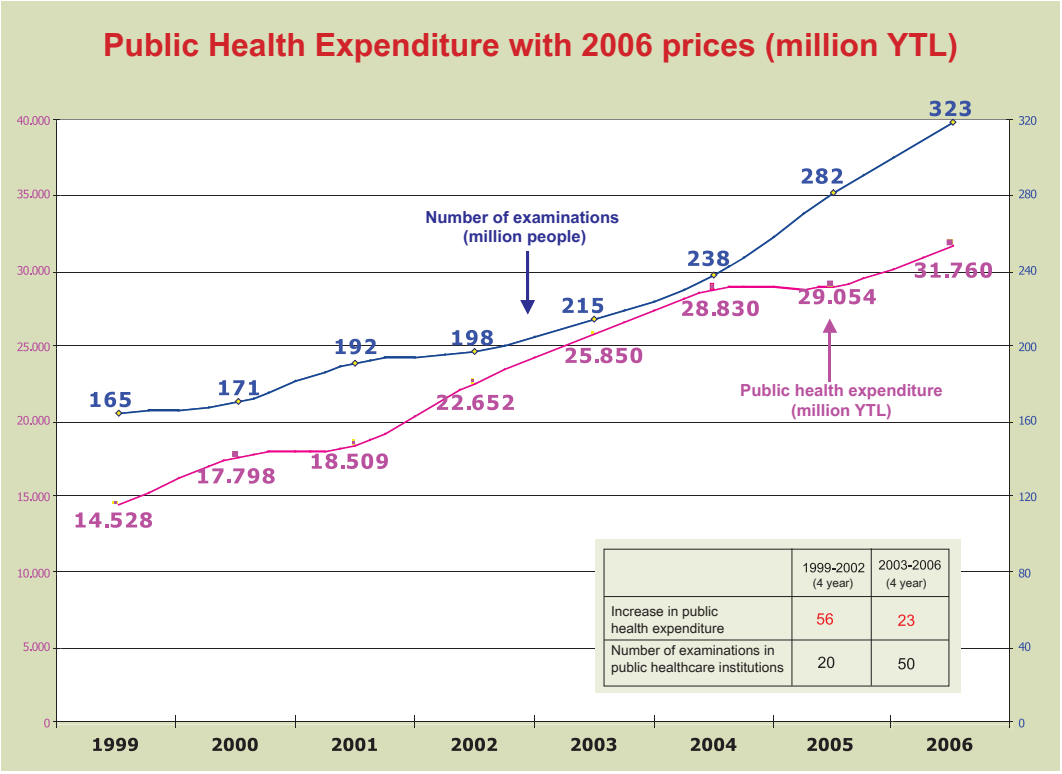


According to OECD 2007 data, Turkey used 7.7% of its public health expenditures for health investments in 2005 and and was the country which allocated the biggest share to health investments amongst the OECD countries

Source: OECD Report 2007

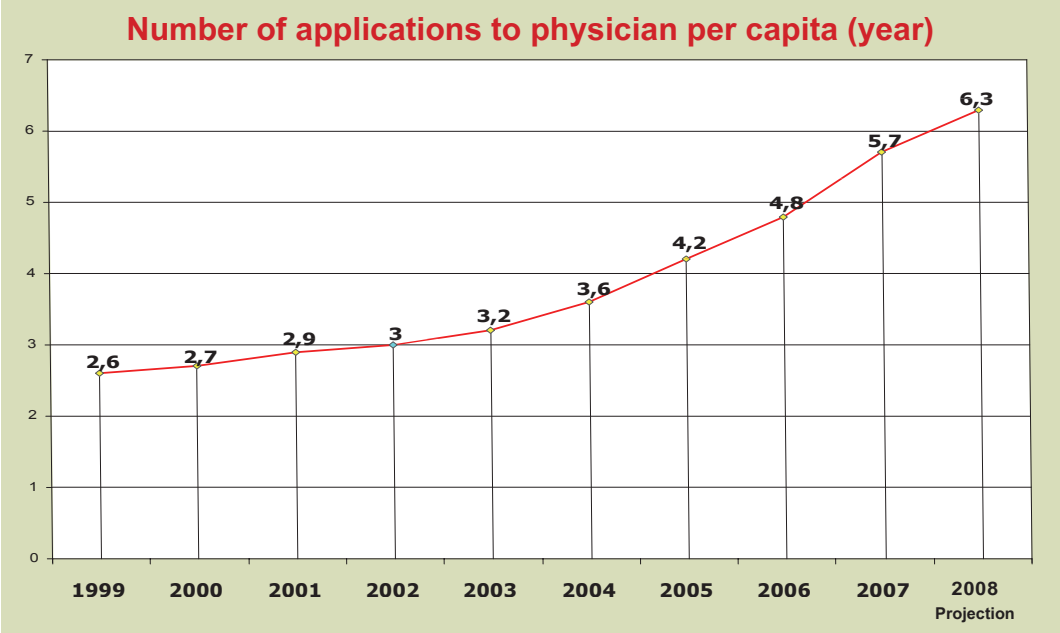
10. Health Expenditures

When we assess health service delivery in terms of figures and quality, it is possible to say that the resources were not used effectively, efficiently and rationally before the Health Transformation Program.

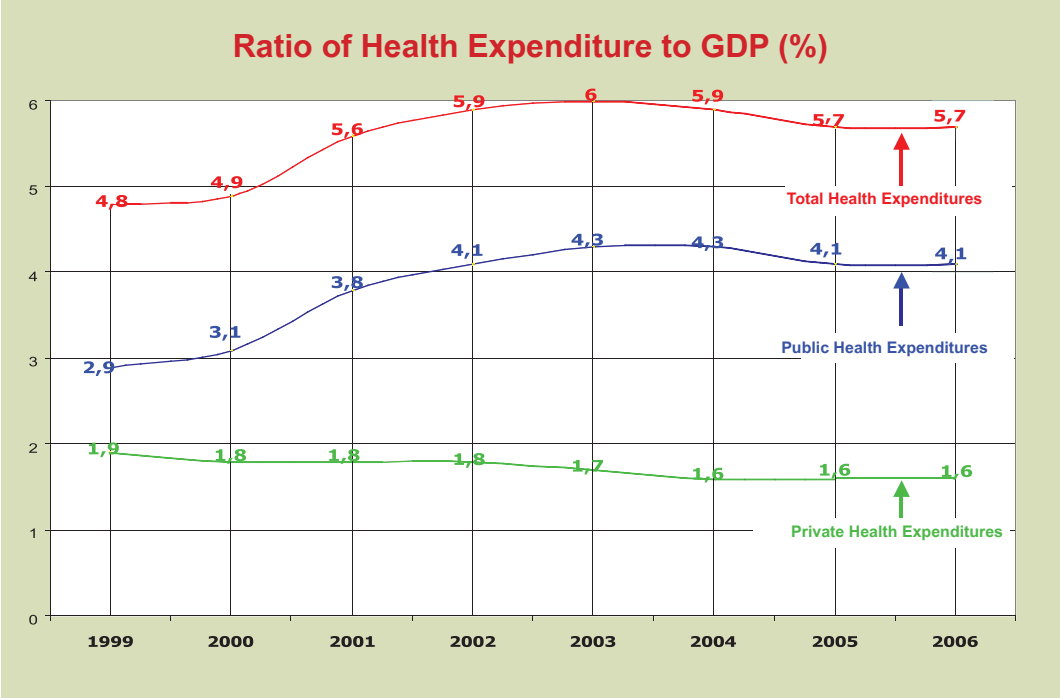


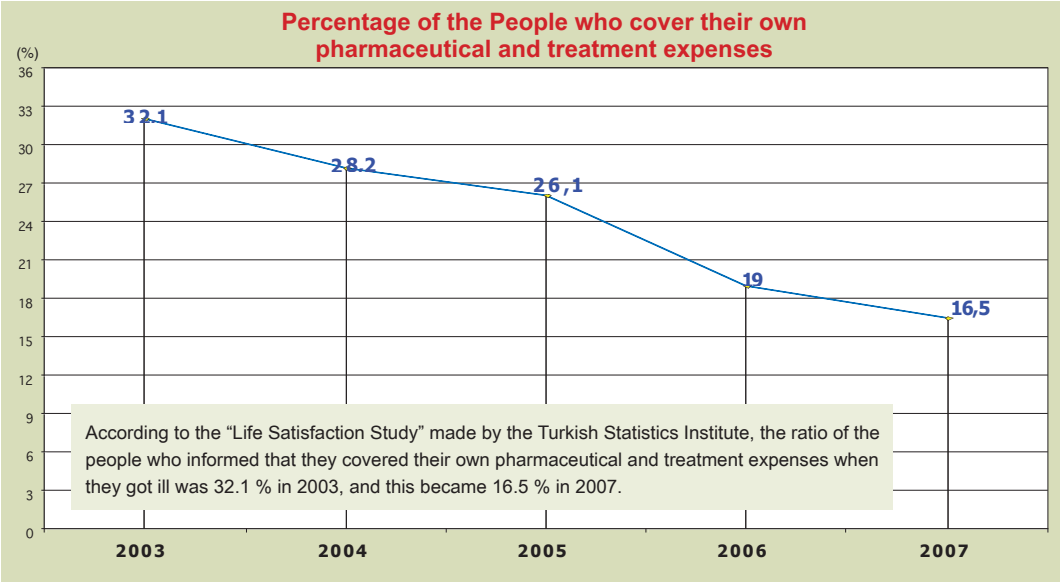
Health Transformation Program ensured the optimum use of the resources and established an effective, efficient and just health system.

In our country, the number of applications to physicians per capita doubled in 6 years. This is effected in a great deal from the elimination of the obstacles in front of the citizens in accessing pharmaceuticals and health within the framework of Health Transformation Program. It should be noted that the figures reached in 2008 are still below the European averages.



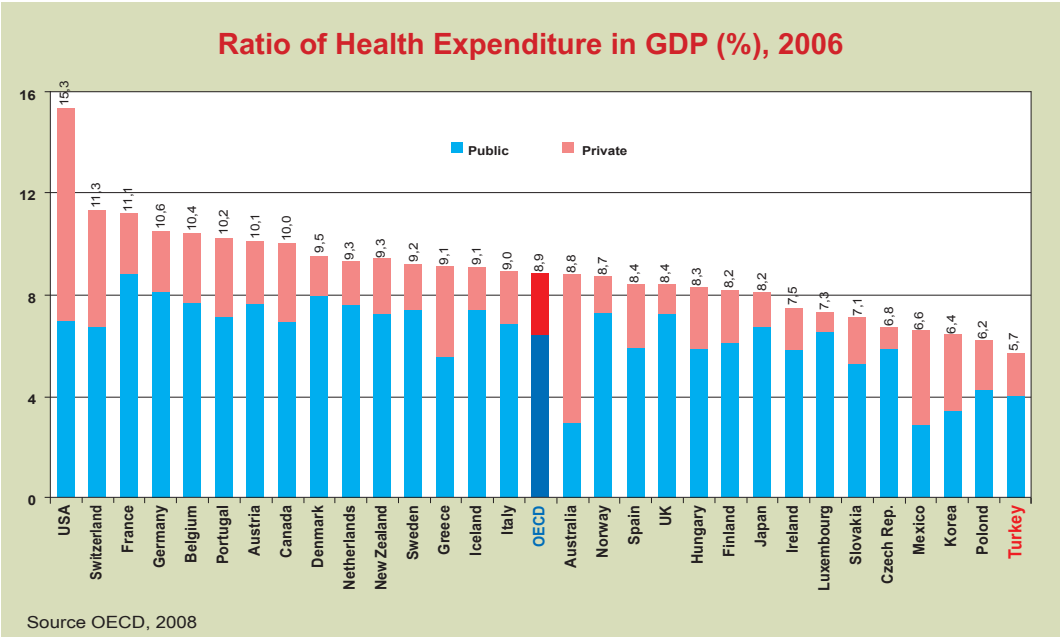
Further improvement of the quality and the quantity of the health services is possible by continuing the optimum use of the resources and increasing the resources allocated for health services (within the framework of the financial facilities of our country).





The share of or health expenditures in our GDP is the lowest amongst the OECD countries, and our country ranks as the third from the last in terms of public expenditures, but despite those ratios we have reached a position where we are able to deliver effective, qualified and sustainable health service.

It is widely known that the use of high technology increases health service costs. However, we prevented the high costs that might occur due to the use of high technology in Turkey with the help of our cost effective policies.



Source OECD, 2008

With the Health Transformation Program, a mobilization was initiated in preventive and primary healthcare services, the budget of primary healthcare services was 876 million YTL in 202, and it reached 2 billion 973 million YTL in 2008. The budget that we allocated into preventive and primary healthcare services is 3 billion 979 million YTL in 2009. The amount of the budget figure is composed of the total of budgets of General Directorate of Primary Healthcare Services, General Directorate of Mother and Child Health and Family Planning, Department of TB Control, Department of Malaria Control and Department of Cancer Control.

Provincial health Directorates were authorized for the expenditures of the procurement of medical devices and machine and equipment and repair of these, for the procurement of fixed assets, for the repair and maintenance of immovable from the Revolving Fund resources in order to ensure the operation of services at the desired level in Primary Healthcare Institutions under our Ministry and to lessen the bureaucratic procedures.

Budget allocated for preventive and primary health care services in 2008 prices (million YTL)

In six years we have increased the budget allocated for preventive and primary health care services by 58% in real terms. In 2009 the budget allocated for preventive and primary health care services is 3 billion 979 million YTL.

**Some data in our previous publications are revised and updated with this publication.*

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