Health Policies from the Past to the Present


Kazakistan
Kırgızistan
Özbekistan
Tacikistan
Türkmenistan
Afganistan
Pakistan
İran
Türkiye
Suriye
Irak
Ermenistan
Gürcistan
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- Along with the continuity of the Seljuk-Ottoman medical tradition, a cultural unity stands out in the organization of the health services. While this structure was being developed since the foundation of our young Republic, a western-oriented path was mostly followed for organizing the state and its institutions and establishing service policies. Within this process, health policies could not remain independent of global trends, and demonstrated basic preference changes.

Health Policies between the Years 1920-1923

- The Ministry of Health (MOH) was established by the Law no: 3 and dated 3 May 1920 following the opening of the Turkish Grand National Assembly. The first Minister of Health was Dr. Adnan Adıvar. An opportunity of regular recording did not exist in this period. The focus was mostly on healing the damages of the war and developing the legislation. The important point here is that Ministry of Health was one of the first ministries to be established within the young state that was organized before the foundation of the Republic and during the most difficult days of the struggle for existence. The Government of the Turkish Grand National Assembly continued to work for the institutional arrangements of the health services even during the difficult years of warfare.
- In this period, Law no. 38 on Forensic Medicine (1920) was passed.

Health Policies between the Years 1923-1946

- During his office starting from the foundation of the Republic until the year 1937, Dr. Refik Saydam made great contributions to the establishment and development of the health services in Turkey. According to the records, 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 196 midwives in Turkey in 1923.

- Health policies of the Refik Saydam era were centered on the following four principles:
- 1- Central execution of the planning, programming and administration of the health services by sole authority,
- 2- Separation of preventive medicine and curative services by deploying their implementation to respectively central administration and local administration,
- 3- In order to meet health manpower demand, improving the attraction to Medical Schools, opening dormitories for medical school students, establishing compulsory duty for medical school graduates,
- 4- Introduction of control programs for communicable diseases such as malaria, syphilis, trachoma, tuberculosis and leprosy.

- In the light of these principles;
- - The health services were conducted with the “single-purpose service in a wide area/ vertical organization” model,
- - “Preventive medicine” concept was developed through legal regulations; the local administrations were encouraged to open hospitals; and government’s local public doctors were assigned in every district.
- - Diagnosis and treatment centers have been established in district centers beginning from the places with high population (150 district centers in 1924 and in 20 district centers in 1936); physicians were prohibited to work independently.
- - As a guide for the cities, Ankara, Diyarbakır, Erzurum, Sivas Numune Hospitals were opened in 1924; Haydarpaşa Hospital was opened in 1936; Trabzon Hospital was opened in 1946 and Adana Numune Hospital was opened in 1970.

Health Policies between the Years 1946 - 1960

- The “First Ten-Year National Health Plan”, which can be called the first health plan in the history of the Republic, was approved by the Higher Council of Health in 1946. This plan was announced by the Minister of Health, Behçet Uz, in 12 December 1946. However, before the adoption of this plan, which had been prepared through a hard-working process, Behçet Uz had to quit his office as the Minister of Health.
- When Dr. Behçet Uz was re-appointed as the Minister of Health in the government of Hasan Saka (10 August 1947/10 August 1948), the National Health Plan, which became a draft law in one and a half year, was negotiated and approved by the Cabinet and the four commissions of the Turkish Grand National Assembly. However it could not be adopted as a law due to the change in the government. The predecessor Minister of Health, Dr. Kemal Bayazit, withdrew the plan.
- Although National Health Plan and the National Health Program could have been turned into a legal document or implemented entirely, 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 the establishment of a ten-bed health center serving 40 villages each and to provide curative medicine and preventive health services together. Efforts were made to assign two physicians, a health official, a midwife and a visiting nurse to those centers along with village midwives and village health officers, who would be assigned to serve for a group of ten villages.
- In 1945, there were 8 health centers; which were increased to 22 in 1950, to 181 in 1955 and to 283 in 1960.

Health Policies between the Years 1960-1980

- The Law no. 224 on the Socialization of the Health Services was adopted in 1961. The socialization actually had begun 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. Thereby, anti-natalist policy (population control) was adopted instead of pro-natalist (rising population) policy.
- "Multi-dimensional service in narrow area" approach was adopted as an alternative to the "single dimensional service in a wide area".

- Although a draft law on Universal 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 foreseen again. Draft Law on Universal Health Insurance was conveyed to the Turkish Grand National Assembly in 1971 but it was not adopted. In 1974, the draft which was presented to the National Assembly was not negotiated.
- In 1978, "Law on the Principles of Health Personnel's Full Time Working" was adopted. Physicians working for the public sector were prohibited to open private practices Then this Law was repealed with the Law on 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 includes provisions both regarding the citizens having social security right and the State's responsibility towards realizing this right. According to the 60th Article of the Constitution, "Everyone has a right to social security, and the State shall take the necessary measures and establish the necessary organization to provide this security". Additionally according to the 56th Article of the Constitution, "To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased 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 both in the public and private sectors". This article also includes a provision stating "Universal Health Insurance may be introduced by law."

- “National Health Policy”, which was prepared by the Ministry of Health in 1993, included 5 main chapters, which were assistance, environmental health, lifestyle, delivery of health services and goals for healthy Turkey.
- In 1998, Universal Health Insurance was presented to the Parliament by the Cabinet under the name “Law on Personal Health Insurance System and the Establishment and Operation of the Health Insurance Institution” but it was not adopted a law. In 2000, 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 activities conducted in 1990s were:
- 1- Establishment of a Universal Health Insurance by gathering the social security institutions under one umbrella,
- 2- Development of the primary care services in the framework of family medicine,
- 3- Transformation of the hospitals into autonomous health facilities,
- 4- Providing Ministry of Health with a structure that plans and supervises the health services and prioritizes preventive healthcare services.
- Consequently, this was a period in which theoretical studies were conducted but not put into practice sufficiently.

Health Policies after 2003: Health Transformation Program in Turkey

- At the end of 2002, the status of the Turkish health system made it necessary to undertake radical changes in many areas from service delivery to financing and from human power to information system.
- If a country aims at improving its health systems, the first thing to do is to sustain the support of the political authority in that country. The financial and social aspects should also be taken into account. It should also be known that many interest groups will stand in the way of reform. It is essential to have a prime minister, a president, a cabinet, an assembly that stands by you, supports you and encourages you. Otherwise success cannot be achieved. Health Transformation Program in Turkey is formulated based on this fact.
- Another aspect of the issue, which is as important as this, is that the health professionals believe in the spirit and necessity of this transition and work with humanitarianism.

- 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. Ministry of Health 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.

- In this period, the steps easing the lives of our citizens are taken with courage and determination. With this understanding, the hospitals of other public institutions, including the SSK ones, were transferred to the Ministry of Health.
- 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 both on the public and on the citizens has lightened a lot. Those arrangements have played an important role in expanding the access to pharmaceuticals.

- “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 technology. Sea and air transportation vehicles are integrated into the system.
- Primary healthcare services, including preventive healthcare and mother-child healthcare services, are strengthened; Family medicine implementation, which is an element of modern health understanding, has been launched and spread out.

- In terms of infant mortality rate; our country has managed to achieve the progress made in 30 years by the developed countries within the last eight years. The same success was also achieved in maternal mortality rate, and again the progress made in 20 years by the OECD countries in terms of maternal mortality was achieved with the last eight years by our country.

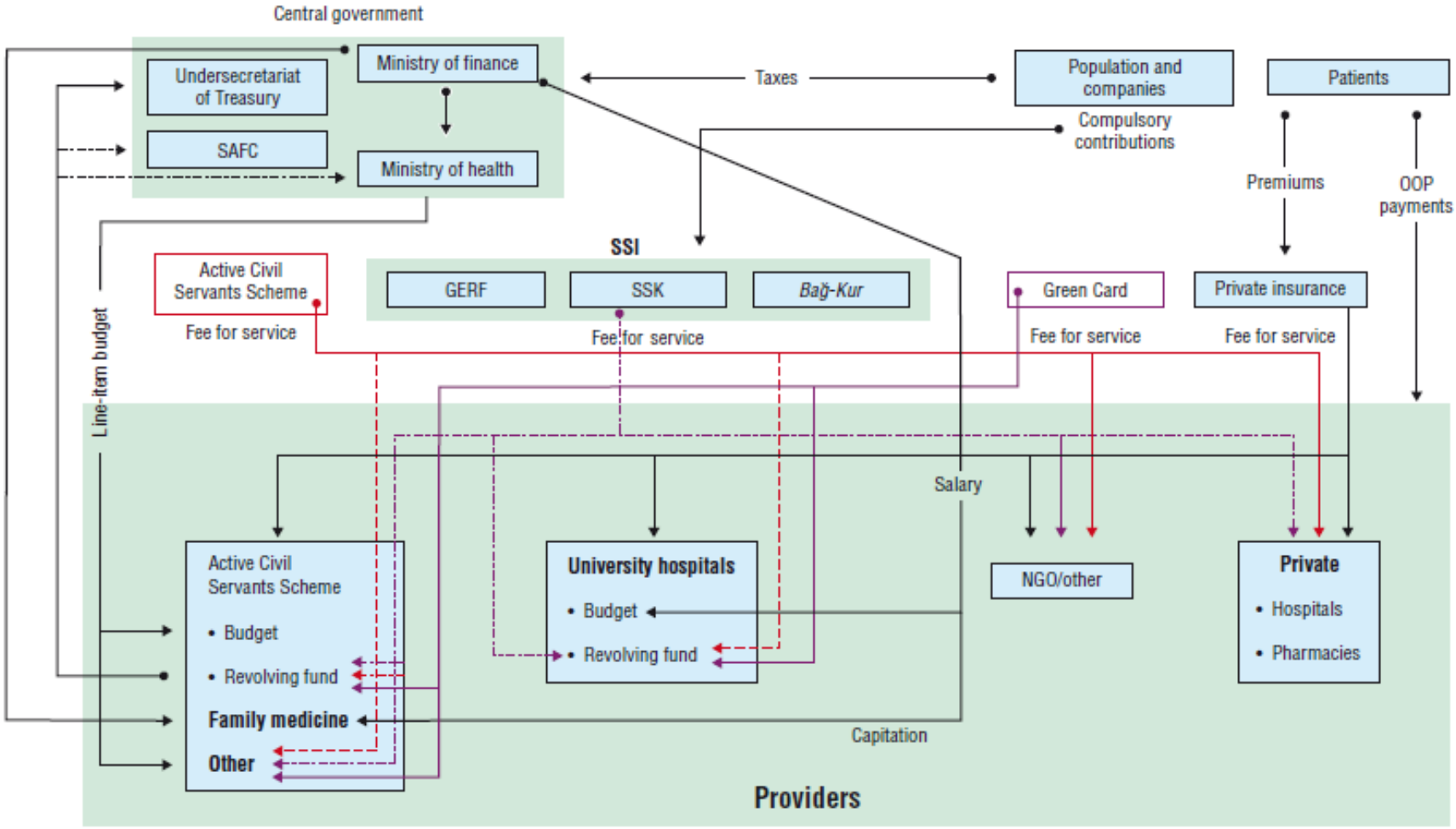
- Preventing ill-health and premature deaths related to non-communicable diseases has constituted the core of important health programs of our term. In this scope, national programs are planned and implemented for certain diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory tract diseases, stroke, and kidney failures.
- Our indicators for communicable diseases have reached the level of the developed countries after the implementation of Health Transformation Program has started.

- The regions lacking building, equipment or health personnel are accepted as priority areas and the imbalances of this sort have largely been eliminated. In the last eight years, a total of 1.771 new health facilities including 476 independent hospitals and new hospital buildings were opened for service. In the same period, the number of personnel working in the public health institutions has increased by 183 thousand people with service procurements.

- Although a large-scale transformation program appreciated by the world has been implemented for the last eight years, it is seen that the increase trends in the primary overall public expenditures and in the public health expenditures are parallel. Public resources have started to be used efficiently with the Health Transformation Program. Eventually, financial sustainability has been taken assured with the medium term financial plan covering the years 2010, 2011 and 2012.

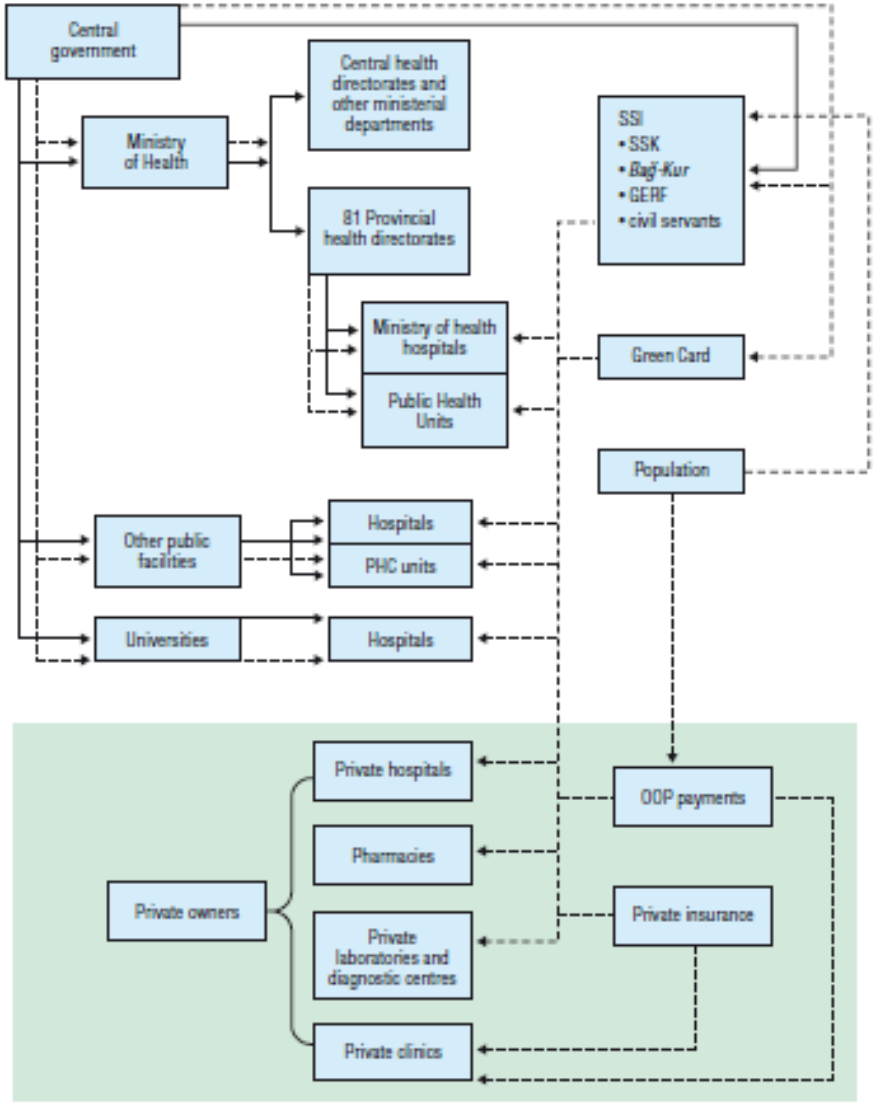
- The actions are so widespread and effective that they foretell what will and can be done from now on. In 2003, the level of satisfaction with health services was 39,5% and in 2009 this figures reached 65,1%. As a result of this satisfaction our people have started to demand better service and their trust and expectations have risen. It is necessary to complete the ongoing services and to undertake new enterprises in order to meet these expectations.

Fig. 2.1
Overview of the health system



Source: Based on Mollahililoğlu et al., 2007a.
Notes: Solid lines represent managerial links; dotted lines represent financial relationships.

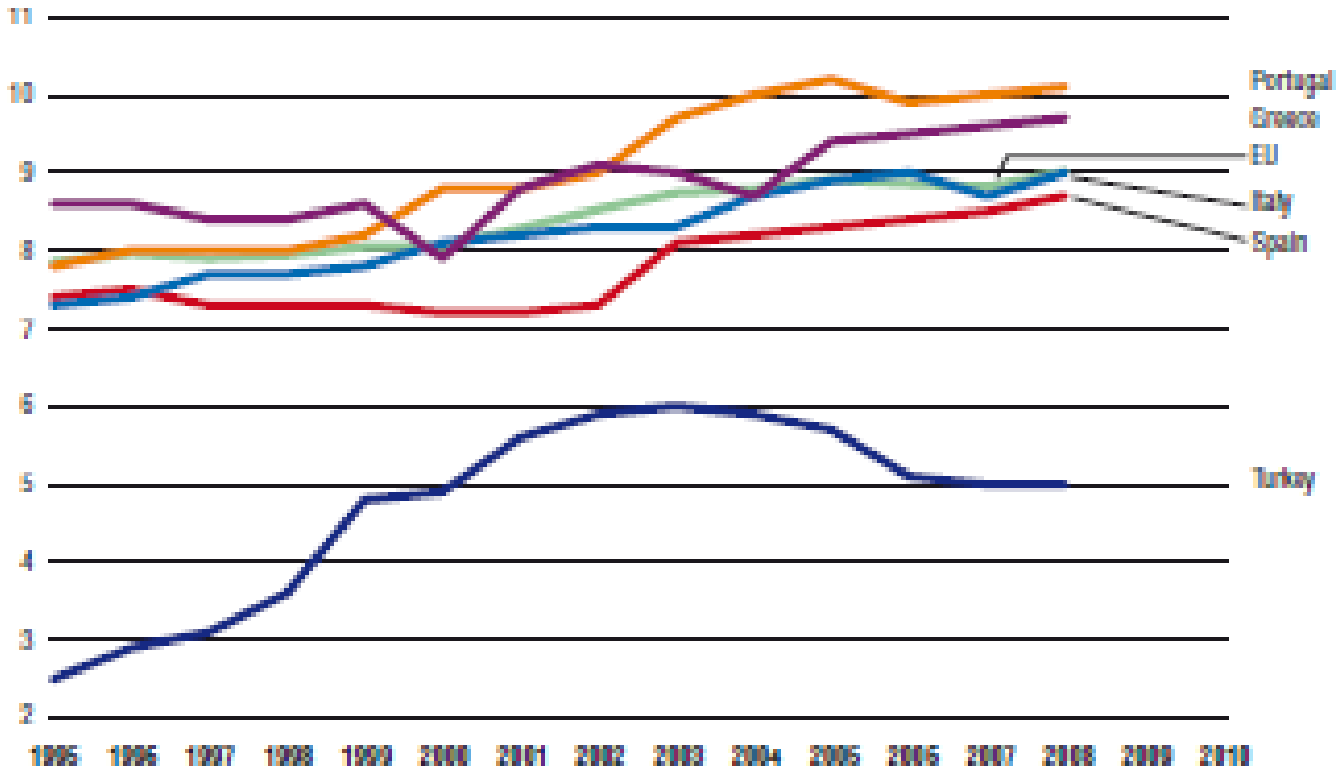
Fig. 3.1
Financial flows in the Turkish health system



Notes: Solid lines represent administrative relationships; dotted lines represent financial relationships.

Fig. 3.2

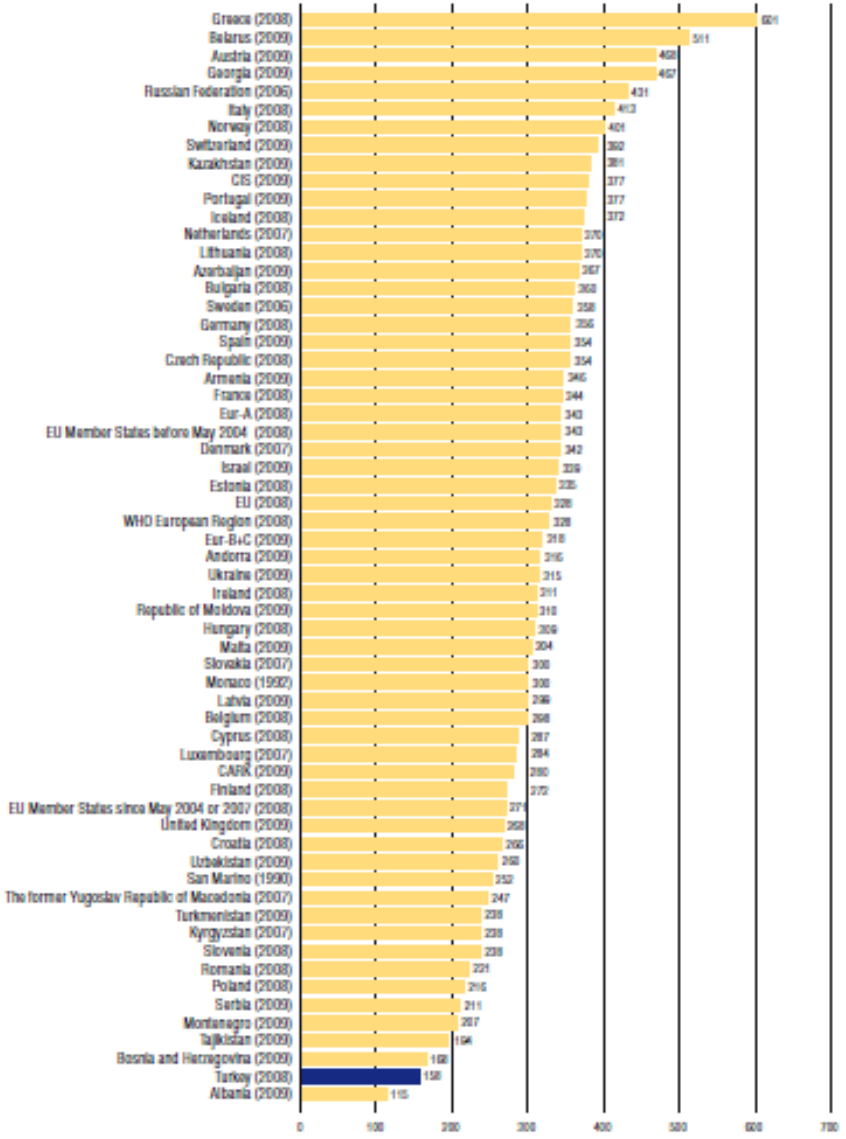
Trends in health expenditure as a share (%) of GDP in Turkey and selected other countries WHO estimates,1995–2008



Source: WHO Regional Office for Europe, 2011.

Fig. 5.4

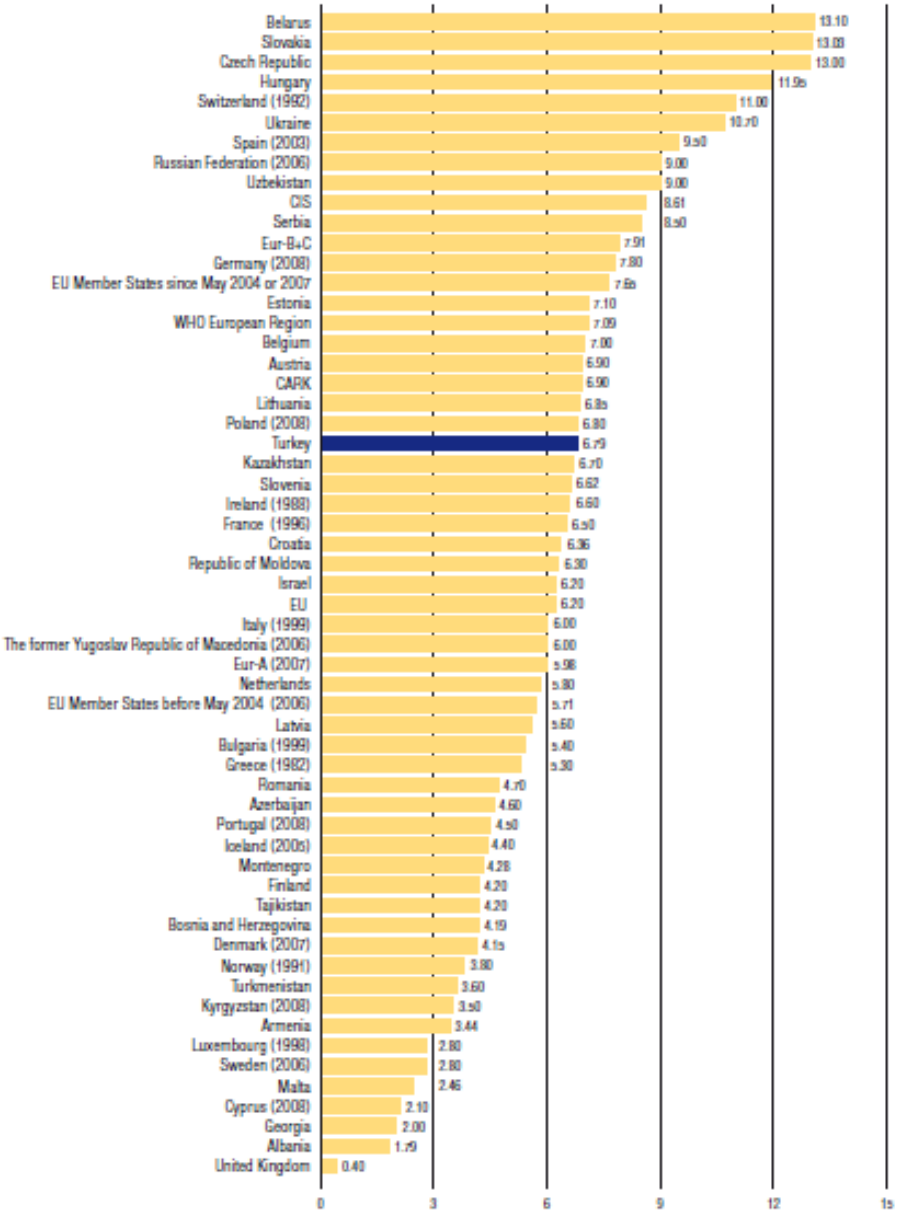
Number of physicians per 100 000 population in the WHO European Region, latest available year



Source: WHO Regional Office for Europa, 2011.

Fig. 6.1

Outpatient contacts per person per year in the WHO European Region, 2009 or latest available year



Source: WHO Regional Office for Europe, 2011.

THANKS

- ***1. Problem Identification and Diagnosis***
- The concept of health is interconnected with every moment of an individual's life. It is one of the major factors that affect the social welfare. Considered in this framework, existence of health problems is inevitable in any country and at any time. Therefore it is more productive to act with an understanding that prioritizes the problems that are not expected to exist in the current level of development. Identifying the current status of the health system, determining the performance objectives and defining problems in this respect is a realistic way of developing sustainable and strong policies.
- Some specific criteria are applied in order to objectively reflect the current situation. The first of those criteria is the primary care indicators. In addition, financial risk protection and citizen satisfaction are important in terms of the comprehensiveness of the health system.

- ***a) Primary indicators***
- Major primary care indicators that can reflect the status of the health system are as follows:
- • Infant mortality rate,
- • Maternal mortality
- • Average life expectancy,
- • Incidence of infectious diseases,
- • Incidence of vaccine preventable diseases,
- • Incidence of waterborne and food borne diseases,
- • Prevalence of chronic diseases and some risk factors,
- • Routine vaccination rates (BCG, Tdap-IPV-HiB3, Hep-B3, MMR, Td+2)
- • Full immunization ratio,
- • Ratio of health expenditures within GDP.

- ***b) Protecting citizens against financial risks***
- This is the primary aim of the health sector policies and the most important focal point of the health reform policies. It means an assurance through which an individual receives his or her medical treatments without facing financial difficulties. There should be assurance that no disease would create a financial burden for the patients or their families that would affect their daily lives or impoverish them. These assurances may be constructed under different models. Such protection is largely affected by how the sector is financed.
- The scope of the protection against risks may be defined by taking objectives, such as providing adequate services regardless of financial constraints of individuals and compensating financial losses due to malpractices, into consideration.

- ***c) Citizen satisfaction***
- This is the satisfaction level of citizens from the services provided by the health sector. It is common perception that it cannot demonstrate the efficiency or the quality of health services on its own. However, it is not possible for a system, which is not citizen-oriented and cannot meet people's expectations, to obtain good results. Adoption of services by citizens will enable participation in the process and help obtain results much faster. Therefore, satisfaction is considered to be one of the main criteria and policy is developed by taking into account how people assess the health services they receive.
- The waiting periods in the health institutions, the complexity level of hospital procedures and processes, the time saved for each patient, and information mechanisms are all taken into consideration during these evaluations.

- ***2. Policy development***
- It follows the identification of health problems and the development of policies to overcome such problems under the program. While the problems studied on might vary, it is universal because it aims at overcoming the problems and reaching the established targets. Within this framework of universality, each society develops its own policies in accordance with its conditions. Within the framework of the Health Transformation Program, policy development takes into account the prioritized criteria particularly access, quality, equality and efficiency.

The scope of responsibility while developing reform plans is both analytic and politic. The process of policy making should be designed to be technically strong and politically adoptable. Hence, the principles provided below should be taken into consideration while developing policies under the Health Transformation Program:

- • The principle of “health for all” should always be given priority.
- • International experiences are reviewed, and successful examples are tailored according to our own conditions.
- • Cautions should be taken against ideological approaches, and practices that would emphasize individual or group interests.
- • The political, economic and cultural realities of our country should always be taken into account.
- • Possible implementation problems (sources, potentials and administrative law, etc.) should be regarded.

- ***3. Political Decisions***
- Accepting transformation in the health sector is not only related with the political will. It is a problem of formatting an effective policy strategy as well. Whether a reform proposal will be adopted is dependent on the willingness, interest and capability of the parties and the political strategies they use. The political stand of the authority behind the implementation facilitates the adoption of the transformation by the implementing bodies and the ones affected by the transformation. Particularly the support of the government authorities along with the commitment of the ministers is of great significance. The contribution of Mr. Prime Minister has played a significant role in implementing many radical changes and accomplishing them under the Health Transformation Program.

- ***4. Implementation***
- As in all the reform processes, it is necessary to monitor and observe the transformation in the health sector for an effective implementation. Thus the problems likely to emerge during the process may be identified and corrective measures can be taken. In this respect, the key to a successful implementation is an appropriate supervision and reporting system.
- The major inputs of the system are the provision of effective, high-quality and accessible health care services. The aim of those inputs is to reach the outcomes indicating to the success of the system. These outcomes, in other words the performance indicators, are the targeted health indicators, a comprehensive financial protection and citizen satisfaction.

- In order to direct the outcomes of the health system, some important tools which can be regarded as “control mechanisms” may be used. It is possible to affect the performance of the system and the expenditures through such mechanisms. There are some other factors that may alter the system standards involuntarily except for the control mechanisms (for example, wars, natural disasters, epidemics, etc), and we can change their inevitable results in a positive way by making a few alterations. Nevertheless, sometimes it is necessary to address a couple of control mechanisms together. The control mechanisms in question are the health service financing, the method of payment for services, the organizational structure of the health sector, arrangements and the behaviors of the actors playing a role in the sector.

a) Finance

It is the way to provide financial sources for the system. Here the idea is to distribute the burden in a fair and equal way, to make it politically and socially acceptable, and to adjust it to the economic conditions of the country.

b) Payment

It refers to paying for the services provided and ensuring the sustainability of the services.

Every payment system has its own logic, a scale and a rate. The payment method we may use is related with the service delivery system. Payment methods are almost always conflicting; the payers want to pay less and the service providers want to get more. There is no perfect payment system; every payment system provides certain negative and positive incentives. The important thing is to know which problems we will encounter when we choose a specific payment model.

- Payment can be made to the health institutions per service, per hospitalization day, per patient admission or per capitation through allocation from the general budget.
- Payment can be made to the health personnel per service, as salary, as salary + incentives, per capitation + incentives.

- ***c) Organization***
- Organization means organizing the service-provider institutions and their functions at the macro level. At the micro level, it means the internal structuring of the organizations. The legislative arrangements, audits, incentives and employment policies within the system directly affect this type of organization.
- ***d) Regulation***
- Regulation is established through the exercise of power by the competent health authority, i.e. the government in order to form the behaviors of the actors in the health sector. The purpose of regulation is to construct the health sector, to protect service receivers and to correct the problems in the health sector. What is needed most for regulation is the reception of timely, accurate and

- ***e) Behavior***
- The behavior of the service receivers is as important as and maybe even more important than the behavior of the service providers. The behaviors and attitudes of citizens are of great importance in preventing the communicable diseases and counteracting chronic diseases. Provision of services (access, quality, prices) is dependant on the functioning of the system. However, demand on the services (senses, attitudes, expectations and beliefs) is directly dependant on individuals and patients. All these shape the patient behavior.
- Changing people's behaviors is a challenging process. People believe that the things they are asked to do should comply with their beliefs and values. Persuasion does not happen only through knowledge; it is necessary to use additional communication tools to affect behaviors.

- ***5. Evaluation***
- Evaluation of a new program cannot be postponed until this program is completely implemented. Before implementation basic data should be collected and administrative systems to carry out evaluation should be created.
- The easiest evaluation approach is the before and after comparison. Evaluations should be evidence-based, and data should be collected in accordance with this. The data should be standardized beforehand and should be sufficient. Irrelevant and unnecessary data results in information pollution. Data collection method and the data diversity should be simple enough not to disturb sustainability. The data acquired should definitely be evaluated and used in the continuity of the policy.