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EVALUATION OF THE HEALTHCARE TRANSFORMATION PROGRAMME IN TURKEY AS A STRATEGY FOR BETTER HEALTH

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ABSTRACT

In November 2002 elections, when Justice and Development Party (AKP) came into power as a single party government, after several coalition governments in the country, it was the beginning of a new term for Turkey. In 2002, health indicators of Turkey was far behind of the OECD countries, patient satisfaction was 39.5%, often news about holding patients hostage by hospital administrations because of unpaid healthcare service bills was taking place on the media. Thus, there were several problems in terms of accessibility and efficiency of health services in Turkey (TURSTAT, 2003; OECD, 2003; WHO, 2012). Under this circumstance, AKP declared its agenda and urgent action plan for healthcare in 2002, and the reform programme in 2003, naming Healthcare Transformation Programme (HTP). And the programme has been implementing by the Ministry of Health since 2003. The programme aims revolutionary changes in Turkish healthcare system and most of these changes have been successfully implemented.

In this study, it is aimed to evaluate the HTP regarding components of the programme based on the reports of Turkish Ministry of Health and international institutions, mainly OECD. Firstly, objectives of the HTP will be explained with the comparison of healthcare system before 2003 and today, and then selected health indicators of the country in 2003 and 2013 will be handled for assessing the success of the programme.

1. WHAT WAS THE AIM OF THE HTP AND WHAT IS THE SITUATION NOW?

based on the World Health Organisation's mission of *"health for all in 20th century"* (MoH, 2003, p.24, 26). Key principles of the HTP were designated as sustainability, continious quality improvement, participation, reconcilement, volunteerism, division of power, decentralisation, and competition in service (MoH, 2003). The HTP is formed with 8 main components which clearly explain the objectives of the programme in detail. Hence, the first part of the evaluation will be based on these eight components.

1.1. The Ministry of Health as the Planner and Controller

Before 2003, healthcare services were multi-headed, fragmented, and lacking of integration in Turkey. Hence, inefficiency was a big problem caused by the vertical organisation of Turkish Ministry of Health (MoH, 2003; OECD, 2008; World Bank, 2003). There were different healthcare institutions which were working with separate bodies (purchasers). Therefore, redesign and decentralisation of all institutions of the Ministry was aimed and the mission of the Ministry was designated as planner and controller of health services at the beginning of the programme (MoH, 2003).

In 2005, all public healthcare providers, except for university hospitals, gathered under the umbrella of the Ministry in order to have a harmonised provision system (MoH, 2011). Nowadays, there are three different healthcare providers in the country, which are

Objectives of the programme were defined as "*to organise, provide financing, and deliver the health services in an effective, productive, and equal way*",

ministry hospitals, university hospitals, and private institutions. This component was stated as the one that "the slowest" progress have been made in a stakeholder analysis by Akinci, Mollahaliloglu, Gursoz, and Ogucu (2012) especially because of the delay in the legislations about Public Administration Main Law and Public Personnel Reform Law. Public Personnel Reform law is still yet to be established. However, all changes in the organisation of the Ministry can be stated as appropriate steps towards New Public Management Approach, increasing efficiency and competition (Lamba, Altan, Aktel, & Kerman, 2014).

1.2. General Health Insurance: Gathering Everybody under a Single Umbrella

In 2002, there were three different insurance schemes in addition to Green Card scheme for low income people, which were gathered under one body which is named Social Security Institution in 2006 (MoH, 2009). Thus, a single purchaser system was built in Turkey. Previous fragmented structure was causing several problems, including applying different prices for the same services. In 2007 with Health Burden Law, a change in payment system and a standard payment system for all type of healthcare providers (ministry, university, and private) based on ICD 10 coding system was established. With this law, Diagnosis-related Groups were

defined, and an integrated e-billing system called MEDULA was created (MoH, 2009). All public and also private providers that are in contract with the security institution are required to use this system.

Currently, there is a single compulsory national health insurance system in Turkey as well as supplementary private insurance schemes. Public health insurance coverage was 64% in 2002 and this figure increased to 98.5 % in 2013 (WHO, 2012; OECD, 2005 and 2015). As a result, accessibility of healthcare services improved dramatically in the country in ten years (Chakraborty, 2009; OECD, 2014).

1.3. Widespread, Easily Accessible, and Friendly Health Service System

This component was explained with three headings, which are strengthened primary care, effective referral chain, and health enterprises having financial and administrative autonomy (MoH, 2003).

Prior to the programme, primary care service in Turkey was lack of a well-designed and performance-based system (World Bank, 2003, WHO, 2012). Family medicine implementation was stated as an important part of a strong primary care at the beginning of the programme and establishment of a more effective system in Turkey was planned (MoH, 2003). Currently, all citizens are registered with a family physician who works for the public sector (MoH, 2011). Improvement in primary care and accessibility of primary health services concluded with high level patient satisfaction according to approximately 80% of family physicians (MoH, 2010). In 2008, number of patients for each general practitioner was 3.400, and in 2013 this figure was 3.621 (OECD, 2008; MoH, 2013). Therefore, in spite of significant improvements in primary care, the ratio of family doctors is still low in Turkey due to the shortage in number of physicians.

As well as having a strong primary care, effective referral chain is showed as a requirement for efficiency by allowing people to jump the first step with a small amount of contribution fee (MoH, 2003). Currently, there is no compulsory referral chain in the country. This was criticised because of causing inefficiency (Yildirim, 2013) and having a weak gatekeeping system (OECD, 2014). And as the contribution fee is small, it questionable as to whether this disincentive prevents people who can be treated at the first step from going to the second or third step. On the other hand, compulsory referral change was not stated as an aim of the programme. Thus, the aim of improved primary care have been achieved, especially services for maternal and child care.

As there is one unified social security institution at present, patients have the right to choose the public hospital where they want to be treated. Additionally, patients are able to go to private hospitals that the security institution has a contract with; and several proportions of the expenses, depending on the terms of the contract, are paid by the institution as well as some services that all expenses are paid by the institution like cancer treatment (Adaptation of Social Security and Universal Health Insurance Law, 2006). Hence, patient satisfaction with healthcare system increased to 71.2% in 2014 from 39.5% in 2002 (TURKSTAT, 2014).

Decentralised public hospitals with financial and administrative autonomy were another aim of the programme. Union of Public Hospitals was established firstly in 2011 to be piloted with a new structure towards encouraging performance management (Official Gazette of Turkey, 2011). Currently, every city has at least one union, being more than one for big cities like Istanbul, and all ministry hospitals are formed to provide service under this union. Each union has one council and a president to organise these establishments, and these unions are under Institution of Public Hospitals of Turkey which is subject to Ministry of Health. Additionally, state hospitals (or integrated health campuses) are to be built under the programme with public-private partnership, and the process is continuing (MoH, 2009). Private sector also developed rapidly in ten years, representing 36% of hospitals and 18% of hospital beds. Thus, important investments have been made in terms of hospital capacity in the country.

1.4. Health Manpower Equipped with Knowledge and Competence and Working with High Motivation

Number of physicians for per 1000 population was 1.4 and for nurses the figure was 1.7 in 2003. These numbers has changed to 1.8 for both in 2013 (OECD, 2005 and 2015). While assessing this, change in Turkish population should be considered and number of people who live in Turkey increased approximately 6 million in 10 years, increasing to around 76 million from 70 million (TURKSTAT, 2013). Therefore, there is a relatively good progress in terms of health manpower in the country despite still staying behind of the OECD countries.

In terms of motivation of the personnel and increasing productivity, in 2004, performance based supplementary payment system was established for ministry hospitals and piloted firstly in 10 hospitals, before extending to all ministry hospitals (MoH, 2011). This was criticised by some authors because of giving more attention on quantitative indicators of the performance (Yildirim, 2013). However, there are some studies show that with the implementation of pay for performance system productivity of public hospitals enhanced (Sahin, Ozcan, & Ozgen, 2009; Sulku, 2011).

1.5. Education and Science Institutions Supporting the System

Need for a national public health institution which would supply necessary education to healthcare professionals, in terms of healthcare management and healthcare economics and planning, during the implementation of the HTP was defined as another component of the programme (MoH, 2003). In this context, Public Health Institution of Turkey, and Council of Health Occupations established in 2011 (Official Gazette, 2011).

Cooperation with universities was also aimed at the beginning of the programme. In 2002 registered student number in faculties of medicine was 31.719 and this figure went up to 55.879 in 2015 as a result of increasing number of universities in the country (Council of Higher Education, 2015). Therefore, it is clear that in terms of education and science institutions there is a good progress.

1.6. Quality and Accreditation for Qualified and Effective Health Services

Prior to the HTP, quality of care was varying across insurance scheme and healthcare provider and this was one of the biggest motivators for the programme (MoH, 2003; WHO, 2012). Establishment of National Health Quality and Accreditation Institution was planned at the beginning of the programme (MoH, 2003). According to Ministry of Health (2009), implementation of supplementary payment for performance improved efficiency in health institutions. In addition, technical quality, patient centeredness, and working conditions improved in the country (WHO, 2012). Since 2010 physicians are required to work just for public or just for private institutions with full-time legislation (Offical Gazette, 2010) in order to enhance quality of service delivery in public hospitals. In 2007 National Health Quality and Accreditation Institution was founded (MoH, 2009). And Service Quality Standards which are applied to all public hospitals were announced by Ministry of Health. Therefore, considerable steps are taken in terms of quality an accreditation.

1.7. Institutional Structure in the Management of Rational Medicine and Equipment

As expenses for medicine was one of the most important proportion of healthcare spending, a national body was needed for standardisation (MoH, 2003). National Institution of Medicine and Medical Devices were established in 2011 with a special budget.

Before the HTP, there were several important problems in access to medicine in the country (WHO, 2012). There is a remarkable reduction in drug prices, more than 200 times, in Turkey due to reference payment system since 2004; and VAT rate also decreased to 8% from 18% for drugs (MoH, 2011). With the Decree on Pricing of Medicinal Products for Human Use (Official Gazette, 2009), another important decision was made: “When a generic of an original product has been marketed, the price of the product may not exceed 66% of the current market price (both for the original and the generic product)” (MoH, 2011, p. 97). Although accessibility and efficiency enhanced, still there is a need for putting more effort on rational medicine use.

1.8. Access to Effective Information at Decision Making Process: Health Information System

This component was explained mainly with the aim of building a national health information system and a national social security information system in order to provide necessary data for planning and provision of healthcare services (MoH, 2003). Currently, National Health Data Information System has been using by all citizens to see their own health records which are retrieved from all health institutions. A national social security information system (MEDULA) has been using by the Social Security Institution and healthcare providers. Additionally, an online portal (HEALTH-NET) which is for communication with health professionals and also citizens is another important step of this programme.

Increased use of health technology tools at every stage of healthcare services was aimed with the HTP (MoH, 2003),

currently an online appointment system is in use for ministry hospitals, e-prescribing, clinic decision support systems are used by physicians, and other e-health applications are in service. So that, with the implementation of the HTP, Turkey made a significant progress regarding health information systems and technologies despite of some technical problems and concerns about sustainability of these expensive services (Akinci et al., 2011).

2. COMPARISON OF TURKISH POPULATION'S HEALTH STATUS IN 2003 AND 2013

Looking at selected heath indicators that are presented in OECD Health at a Glance Reports (2005 and 2015) is chosen as a reliable way in order to understand the impact of the programme on Turkish people's health.

Life expectancy at birth was 68.7 in 2003 and increased to 76.6 in 2013 (OECD, 2005 & 2015). Though this figure is still behind of the OECD average (80.5), in one decade longevity went up approximately 8 years among Turkish people (OECD, 2015). In terms of infant mortality, the figure was 29 per 1000 birth in 2003 and ten years later declined dramatically to approximately 10 (OECD, 2005 & 2015). As the average is 3.8, the number is comparatively higher. Nevertheless, 19 year reduction is not a number that can be underestimated. Similarly, there is a good progress in childhood immunisation from 2003 to 2013, rising to 98% from 68% (OECD, 2005 & 2015). In 2013, Turkey was ahead of several OECD countries and the average, while it was far behind of all OECD countries in 2003 (OECD, 2005 & 2015). These figures can be explained with the great emphasis of the reform programme on strengthening primary care services and improving accessibility.

With regarding economic figures, health expenditure as a share of GDP was 7.4% in 2003 and decreased to 5.1% in 2013 (OECD, 2005 & 2015). This change can be explained with the high investments at the beginning of the programme and the effects of global economic conjuncture. Additionally, change in GDP of the country should be considered, increasing significantly from approximately 300 billion USD to 822 billion USD in ten years according to World Bank. Thus, the amount which was spent for healthcare services did not reduce and, indeed, increased. Despite the decline in the percentage of GDP which was spent on healthcare, public health expenditure per capita soared from 364 USD to 941 USD. However, this figure still far behind of the OECD average, which was 3.453 USD in 2013 (OECD, 2005 & 2015).

In spite of these encouraging numbers, obesity rate among Turkish people almost doubled from 12% in 2003 to 22% in 2013 (OECD, 2005 & 2015). Fight with obesity was one of the initiatives of the programme, and despite of all public campaigns and increased number of sport facilities all around the country, there is an increase in this determinant of health. Although alcohol consumption is far behind of OECD countries because of religious and cultural factors, this figure increased to about 1.8 litres in 2013 from 1.4 litres in 2003 (OECD, 2005 & 2015). Negative change in these two determinants is needed to be investigated further. Daily smoking, on the

other hand, declined considerably from 32% in 2003 to 24% in 2013 (OECD, 2005 & 2015). This change can be explained with increasing effort of the Ministry and the President Erdogan, who was the head of AKP until 2014, for fighting against smoking, and Tobacco Control Law established banning smoking in closed and open public places in 2008.

Though still there are considerable differences between rural and urban areas with respect to health status (Tatar et al., 2011), the comparison of Turkish people's health status in 2003 and 2013 shows that the programme has a remarkable affect on the country's health indicators.

3. CONCLUSION

As it can be seen, outcomes of the HTP are beyond being encouraging. Admittedly, most of these positive changes in health and healthcare can be attributes to the HTP. However, it is difficult to distinguish results of healthcare policies and other socioeconomic improvements in a country. There is a broad consensus among the citizens of the country and healthcare professionals about the positive impacts of the programme on health system and health status of the country (Akinci et al., 2012, Eracar, 2013, Jadoo, Aljunid, Sulku & Nur, 2014).

In the study, it was aimed to evaluate the success of the Healthcare Transformation Programme based on its main aims and comparison of OECD health indicators in 2003 and 2013. Regarding the aims of the programme, components that were defined at the beginning of the HTP journey have been mostly achieved, providing better health outcomes and better services to the citizens of Turkey.

Compared with the OECD countries, there is no doubt that, Turkey still has a long way to go, but the progress have been made is a remarkable example for middle income countries. And while making comparisons with the OECD countries and Turkey, population and GDP of the country should also be considered. For example, comparing the United Kingdom with Turkey might be appropriate in terms of population, but not in terms of GDP.

Reasons behind the successful implementation of the HTP can be summarised under six main points as following: clear vision and strong leadership, political and economic stability, the European Union dynamic (efforts have been made in the context of being a member of the union), reforms dynamic itself, impact of international institutions, political demand, support and persistence (OECD, 2014; Yildirim & Yildirim, 2010). As in 2015 November elections Justice and Development Party (AKP) elected as single party for third times, political feasibility was ensured for the future of the programme, with economic growth and consistency in the country.

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