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The Historical Background of Transition from Socialization in Health Policy to Family Medicine Practices: Organizational Network of Primary Care in Turkey

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ABSTRACT

Organization of primary health care services is the backbone of a health system. The aim of this study is to scrutinize the policy trends regarding primary healthcare services and try to understand the transitions among them.

The health policy changes and the related legislative documents were investigated throughout Turkish Republic period. The data were collected through document review method, and content analysis was made.

Apart from political controversies and utterances, it is seen that in various time frames of the Turkish Republic, health policy has depicted the same issues as its objective. These issues have taken place not only in the country's political agenda, but also in lots of others in the new global view as well.

Keywords: Family Practice, Health Policy, National Health Plan, Primary Care, Socialization in Health.

INTRODUCTION

The effects of the health care reforms implemented in the last 15 years in Turkey are well known (Atun et al., 2013; Bariş, Mollahaliloğlu, & Aydin, 2011; Tatar et al., 2011). The primary healthcare services based on family medicine

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practice, constitute a significant component in this reform process.

Healthcare policies during the early years of Turkish Republic, which go back to almost hundred years, were mainly focused on public health issues "hıfzıssıhha" under the leadership of the first Health Minister Dr. Refik Saydam. The other well-known Minister of Health who tried to put concrete plans and programs about primary health care into action during 40's and 50's was Dr. Behcet Uz. Along with these policies, reorganization of primary health care services became more remarkable in healthcare system after 1960, with the concept of "socialization of healthcare services".

The aim of our study is to scrutinize the policy trends regarding primary healthcare services and try to understand the transitions among them without tending to a positive or negative point of view. Some conflicting issues within these policies can be seen as expected, since they emerged in different times with different point of views. We believe that political preferences and polarization prevented them to be evaluated independently enough in an objective comparable manner. It should be evenly normal that they influenced each other, and they passed favorable knowledge on each other during the time sequence. We believe that this approach, the driving force of this study, will have a positive effect on the development of future healthcare policies.

MATERIAL AND METHOD

Qualitative research methods were used in this study. National Health Plan, National Health Program, the Law on Socialization of Healthcare Services together with Social Security and General Health Insurance Law, and Family Medicine Law which were mainstreams of Health Transformation Program were reviewed in details. The data were collected through document review method and content analysis was made.

The "First Ten-Year National Health Plan", which we can call the first health plan in the history of the Turkish Republic, was approved by the Higher Council of Health in 1946. This plan was announced by the Minister of Health Behçet Uz in 1946. As a continuation of the first Ten Year National Health Plan, "National Health Program and Studies on Health Bank" was also announced by Dr. Behçet Uz during his second term in the ministry in 1954, which was one of the cornerstones for the planning and organization of the Turkish national

health system. (Akdağ, Demirel, & Aydın, 2009)

The Law no.224 on the Socialization of the Healthcare Services was adopted in 1961. The socialization began in 1963 and became widespread in the country in 1983. The Law on the Socialization of Health promoted the establishment of an integrated health service scheme with a three-tiered health system managed by the Ministry of Health and Social Affairs (Atun et al., 2013)

The Health Transformation Program was prepared and announced to the public opinion by the Ministry of Health in 2003. The Health Transformation Program aimed reforms in the framework of 8 themes including universal coverage and family medicine practice (Akdağ, 2012). Turkish Grand National Assembly enacted the Law on Pilot Implementation for Family Medicine in 2004. Pilot implementation was first initiated in Düzce and the implementation was expanded to other provinces during the following years. In 2006, the Grand Assembly ratified the Social Insurance and the General Health Insurance Law to bring together the five health insurance schemes within a unified General Health Insurance scheme integrated within the Social Insurance Organization with synchronized benefits. (Akdağ, Aydın, & Demirel, 2007; Atun et al., 2013)

DISCUSSION

National Health Plan and National Health Program, the Socialization in Health and Health Transformation Program are the corner stones of health policy actions which focus on primary health care. Evaluating them in a time sequence revealed that in a way they are the successive policy chain rings. We observed that they have common goals such as providing an integrated healthcare organization throughout the whole country starting from small settlement sites, modernizing the city and district hospitals compatible to the current expectations and to providing adequate and competent human resources in the field of healthcare services.

The socialization and transformation programs both essentially gave importance to patient choice to select physicians. Health Transformation Program aimed to establish the health regions similar to the National Health Plan and Program. These regions were planned to have their own performance goals with adequate supplies. On the other hand, consistent with these programs, socialization in health care policy aimed to establish somewhat a

similar approach within the hierarchy of district, city and region hospitals (Akdağ, 2012; Demirel, 2008; Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun, 1961; Uz, 1946, 1954).

It is a surprising issue that, along with the socialization in health, the hospitals of Social Insurance Institution were legally transferred to the Ministry of Health (Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun, 1961). Unfortunately, for the implementation of this reform, we had to wait for 45 years for Health Transformation Program, in which the same issue was raised again. The plan prepared in 1961 within socialization policy was realized in 2005 during the implementation of Health Transformation Program. According to the law numbered 5283, all healthcare units belonging to state institutions and organizations, all kinds of duties, rights and obligations, portables, premises, vehicles related to these healthcare units along with the belongings of Social Insurance Institution were transferred to Ministry of Health in exchange for current market value (Bazı Kamu Kurum Ve Kuruluşlarına Ait Sağlık Birimlerinin Sağlık Bakanlığına Devredilmesine Dair Kanun, 2005).

National Health Program sought means for health financing and addressed "social healthcare bank", as a social security fund (Uz, 1954). On the other hand, Socialization Policy principally required the allocation of financial resource by the state (Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun, 1961). However, for financial sustainability, the proposed law included items related to "social security contributions" and "direct and indirect taxes". Nevertheless, the articles including these decrees were not passed in the General Assembly. It is obvious that not realizing these articles badly affected the sustainable integrity of the system and its applicability. Thus, the foreseen additional taxes were not materialized, the compulsory insurance previously foreseen in the National Health Plan within the scope of socialization was not put on the agenda. In short, the cited reform policies were tried to be materialized within the shoestring budget of that period.

With the implementation of Health Transformation Program, a mixed model mainly based on premiums was put into practice under the name of General Health Insurance. However, it also comprised general budget contributions as non-contributory payments and direct contributions undertaken by the state. Article 60 of law 5510 encompasses those considered as insured by the

General Health Insurance and henceforth lists two types of citizens covered by this law: first, those based on the designated test methods and data used by Social Security Institution and taking into account the expenditures, considering premises and movables and benefits stemming from these as such; and second, those citizens whose monthly revenue within the family per person is less than one third of minimum wage or those younger than 18 years of age -without applying an income test- who are not covered by a health insurance or dependency (Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu, 2006). Assessing the Law in its entirety; it is duly presumed that a social health insurance has been designated pooling not solely by income basis premium covering a certain number of population with a limited benefit package, instead of a health insurance based on actuarial balances. Article 62 of the same law states that provision of health services and other rights provided within the boundaries of the general health insurance is a basic right for those and their dependents, and financing these services and rights is in fact a commitment for the Social Security Institution (Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu, 2006).

Usually, the health financing models are categorized on the way their resources are built either as tax or premium based. Reviewing the background of today's models, it is not easy to classify them as the historical known Beveridge, Bismarck or Semashko models. Having experienced a series of reforms based on their own needs and perspectives, most countries formulated a distinguished financial model of their own by time.

Issues such as the organization and financing aspects of the health systems, distribution mechanisms of resources, quality and volume of healthcare services, range of benefit package and coverage of the population are becoming main topics of health care reforms. Recently, hybrid systems have become more viable by mobilizing resources both through taxes and compulsory or optional premiums with different ratios. In this respect, even though basic differences like the tax based national health systems or social health insurance systems may theoretically ease comprehension, it will not be clear enough to capture the core of financial aspects of the system properly and compare it with those of other country models. As a matter of fact, this categorical approach in the health financing system, instead of concentrating on the society and system

thereof as a whole, limits the success and failures of critical applications within the system and complicates the developments of probable policy alternatives (Kutzin, 2010).

Both socialization of health services and family medicine legislation documents declared that services are free of charge. Overall, there is a current misleading perception on the political front that health services are free. The consequence of this perception leads to imaginary implications and dynamics of transition and complicates the comparative analysis of health policies in our country. Neither socialization nor the current health policies do have claims that provide complete free health service for everyone at every step.

Article 2 of Law titled 224 refers to premium and partial contribution to expenditures. Article 5 describes personal fee payment for those living in areas where health services are socialized, if they apt to choose health personnel or institution. In addition; article 14 of the law specifies conditions in which payment is required (Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun, 1961) . Law 5258, organizing family medicine practice refers to partial payments for those individuals who directly attend to hospitals without having been referred by a family physician except emergency and force major situations (Aile Hekimliği Kanunu, 2004). The main aim of both legislations is to promote primary health care, instead of imposing financial burden to the patients. The logic behind these documents is to provide strategic directions for health care delivery and use copayments as control mechanisms leading the patient accordingly.

Once we analyze the socialization policy deductively, we reach the conclusion that the objectives are to organize and plan centrally, to distribute health personnel evenly throughout the country, to increase the effect of local share within the health management system, to set up the health care service network reaching as far as distant locations such as villages, to encourage patient visits at home, to focus on preventive health services, and to enforce civil servant physicians work full time allowing a space for private organizations. It is also possible to repeat almost all of these issues for family physician scheme, which has been implemented through Health Transformation Program (Aydın, 2010). It is known that in various time frames of the Turkish Republic, health policy has depicted the same issues as its objective. These issues have taken

place not only in our political agenda, but also lots in that of other countries' agenda as well in the new global restructuring following World War 2.

Even though many European countries tried to organize health services in a widespread and integrated manner after World War 2, UK case was the one which made primary care reaching every corner of the country in an efficient manner. In 1946, the National Health System (NHS) has been adopted and is still in use today with several changes and updates. Even though several pros and cons of UK NHS may be put forth, one of its significant shortfalls is that it could not achieve filling the gap fully between treatment and protective support services (Sharmanov, 2008). Apart from UK, primary care services based on health insurance principles have been experienced in countries like Sweden, France and Germany.

Another system based on outpatient clinic and dispensary services was developed within the former Union of Soviet Socialist Republic. Health Services Community Commissioner N Semashko and Red Army Health Commission Chief Z Soloviev, having visited European Countries, have carried over the organizational aspects of UK and Germany into their country. As a result, a new reorganization has been initiated targeting the widespread access to primary care services (Aydın, 2010; Sharmanov, 2008).

The important thing is to set up a structural organization which will pave the targeted outcome of the health system in the end. Ignoring the primary objectives of the health system and evaluating the organization or corporate structure as indispensable elements would no doubt prevent it from adapting and upgrading itself in accordance with the changing environment.

As a result, presenting the organizational structure of primary care aimed by socialization in health care and the family medicine scheme within Health Transformation Program as if they are opposing elements, prevents us from reaching the details of both systems, analyzing their successful and unsuccessful aspects, and thus, finally prevents us from designing the right reforms.

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