Turkey occupies 789,452 km² at the cross-roads between Europe, Asia and the Middle East. Since the establishment of the Turkish Republic in 1923, the country has strived to develop a secular democracy. It is the third most populous country in the EU Region. In the last decade, stability characterized Turkey's political life with a majority government since 2002. Political stability has ensured the implementation of long-term strategies and policies across strategic sectors and health reform. Since 1999, Turkey has been a candidate for membership in the European Union (EU); this is a major objective of the government, with important influence on the direction of economic and political policy. To this end, Turkey is in the process of further strengthening democracy and consultation with civil society.

HEALTH & DEVELOPMENT

Health Care Reform in Turkey (Health Transformation Programme) - The health status of people in Turkey has significantly improved in recent years. Improvements in the health status are mostly attributable to the successes of health reform, the so-called Health Transformation Program (HTP) with the tag line “People First”. The Government of Turkey is implementing measures to improve the accessibility, efficiency, and quality of the health sector. A serial legal change was enacted within the frame of health reform with the new legislation re-structuring the Ministry of Health (MoH). Re-structuring guarantees functions of its sub and regional units of the Ministry and enhancing its role in health sector policy development, planning, supervision of implementation, monitoring and evaluation. A new Public Health Institution has been established to support the implementation of the MoH's preventive health care services. HTP aims at strengthening primary health care services through the use of a family medicine system. At the end of 2010, the Family Medicine Programme (FMP), assigning each patient to a specific doctor, was established throughout the country. Community Health Centers (CHC), providing free-of-charge logistical support to family physicians for primary services such as vaccination campaigns, maternal and child health and family planning services, were established. Both Family Health Centers and CHC are under the supervision of Provincial Health Directors (8 provinces) which are responsible for planning and provision of health services at provincial level and accountable to the MoH. The fragmementary financing and service delivery system was replaced with strengthened financial and organizational structure. The Ministry of Health is the main provider of health services. The Social Security Institution (SSI) has become a monopoly on the purchasing side of healthcare services, financed through payments by employers and employees and government contributions in cash of districts.

The health services delivery system was dramatically expanded and improved through investments in infrastructure, equipment, and supplies as well as through training of staff. The number of public health professionals increased from 0.6% to 6.1% in 2002. This slight shift is expected to improve the health status of people. In 2011, the government took significant steps towards improving people’s health status depends on effective use of the funds rather than magnitude of it. The proportion of public health expenditure to GDP increased to 4.4% in 2008 from 3.8% in 2002. On the other hand, public health expenditures per capita and the figure increased to 152.3% in 2008. A system called performance-based supplementary payment for family physicians and key hospital personnel was implemented in order to improve productivity, and the proportion of high impact health services at primary level is ensured for family physicians.

As Turkey has a long list of tobacco-related deaths, the number of smokers per population provided a favorable context for tobacco control and health reform. Since 2002, health services and insurance systems in the health sector have also played in improvements in health status. Turkey has a large proportion of health and mortality burden have been improved considerably. The IMR decreased, at 47 per 1000 live births in 2011 from 51.5 per 1000 live births in 2002. The MMR decreased to 21.5 per 100000 for deaths in 2011, from 64.1 in 2002. Increasing immunization rates and expansion of immunization programmes contributed to this decline. Average life expectancy reached 72.0 for men and 77.0 for women in 2009. In recent years, higher emphasis was given prevention of important diseases by public health centers and primary health care institutions. Incidence of malta cases was 0.1 per 100.000 populations in 2009 and only agent for autochthonous malaria cases was Plasmodium vivax. However, there is no reported autochthonous malaria case since 2010. Incidence of some communicable diseases for the year 2011 are: tuberculosis 21; AIDS: 0.01; and measles 0.09 per 100000 population.

Diseases of circulatory system (9.8%), malignant neoplasms (20.7%) and diseases of respiratory system (8.9%) are the three most common causes of deaths (Turkish Statistical Institute, Cause of Death, 2009). New policies and programs to address important public health challenges, including but not limited to, mental health and non-communicable diseases, were developed and introduced. A community-based mental health model was implemented, necessary adjustments were made for patients to be served under the SSI coverage and 50 community mental health centers were introduced in 44 provinces. To prevent chronic diseases, Turkey has started programs including the Cardiovascular Diseases Prevention and Control Programme and the Diabetes Prevention and Control Programme. The government also has the highest implementation grade, according to international evaluation criteria of WHO. The government is highly ambitious to replace its in tobacco control that bans smoking in public places into other public health areas such as prevention of chronic diseases and injuries, countering obesity, early diagnosis of cancers, diabetes prevention, road traffic safety, etc.

Access to health care services in all regions - The health insurance coverage increased from 76.8% in 2002 to 95.0% in 2011. The number of people covered to health facilities was 3.2 in 2002, it was raised to 8.2 in 2011. Similarly, per capita hospital visits increased from 2.0 in 2002 to 4.9 in 2011. The number of acute care hospital beds held per 100000 increased from 256 in 2002 to 283 in 2011. During the same period, the number of doctors per 100000 population increased from 1.2 (2002) to 1.4 (2011). The number of premiums paid in 2011 was increased about a half to a million, ranging from 47 per 100000 to 53 per 100000 in 2011. Additionally, the geographic distribution of health care providers also improved with the ratio of tests to cancer patients in their homes has been recently started. Similar to EU member countries, emergency health care services are being coordinated by 112 Emergency Call Centers. The MoH has started to “112 Emergency Health” only not in city centers, but also in villages in recent years. Financial risk protection was improved significantly. The share of households with catastrophic expenditures declined from 0.81% to 0.37% between 2000 and 2008, in part due to a rapid expansion of health insurance coverage, which grew from 65.7% in 2002 to 95.5% in 2011. The proportion of out-of-pocket health expenses in total health expenditure has decreased from 19.8% in 2002 to 17.4% in 2008. Similarly, the percentage of people paying for medicine and therapy costs themselves decreased to 11.1% in 2011 from 32.1% in 2003. Major discounts in medicine costs lead the way to lighten the burden of both government and people. There is a significant increase in the general satisfaction with the health sector, which grew from 39.5% in 2003 to 75.9% in 2011. (TURKSTAT – Life Satisfaction Survey, 2011).

Patients were empowered, in part by the improvements to, and effective implementation of, the Patients’ Rights Charter, established in 1998, and through the establishment of hotlines (SABRM 184) exclusively for patient complaints. Alongside the public support, major initiatives were launched to fight unhealthy lifestyles, in particular tobacco use and obesity.

Autonomy of hospitals is to increase – After the establishment of Public Hospital Unions which is a part of HTP process, legislative changes were made to ensure autonomy of the public hospitals for outsourcing some medical and non-medical services, and other diagnostic and imaging services, cleaning, laundry, and food services. The new system allows hiring hospital managers on a contractual basis; as doctors and nurses remain civil servants.

Data sources:
1. MoH, Health Statistics Yearbook, 2011
2. HFA Database, 2010
PARTNERS

The World Bank is the main international agency contributing to health system reform; the EU also supports health systems development, and population and family planning activities as well as major projects aiming establishment of early warning system for communicable diseases, developing community based mental health services, improving blood safety, etc.; UNICEF plays an important role in supporting child health services particularly in the areas of nutrition and immunization. Other United Nations agencies also provide technical assistance, including FAO, ILO, UNDCP, UNDP, UNFPA, UNHCR and UNIDO. As an upper middle income country, Turkey is not entitled for financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

OPPORTUNITIES

- The Health Transformation Programme (2003-2013) has been strongly support by the World Bank-funded Health loan (US$60 million) with important policy conditionalities.
- Political stability and the current government majority allow major policy change and implementation of the reforms including the health sector reform.
- The ongoing economic development in Turkey enabled the implementation of HTP and allocation of funds for health sector. Thus, controlled health expenditures made contributions to sustainability of the system.

CHALLENGES

- Resistance to implementing the most politically challenging aspects of Health Transformation Programme (HTP) which are also conditions for the World Bank loan (e.g. extent of increased managerial autonomy for public hospitals, full time work of staff in MoH hospitals).

WHO STRATEGIC AGENDA (2008-2013)

The Country Health Need Assessment (CHNA) outlines changes within WHO to better meet the health needs of Turkey; identifies strategic directions, operational principles and functions of WHO in the country based on the MOH priorities, the HTP and the Millennium Development Goals (MDGs).

The strategic agenda focuses on:

- MOH Stewardship - Capacity development to enhance stewardship role of the MOH with strengthened leadership functions in health sector for improved governance, efficiency, and quality; supporting and guiding the MOH and its affiliated institutions in development of institutional capacity for monitoring and evaluation strategy with tools for performance assessment.
- Policy Development – Technical assistance for development of policies and public health programmes designed with focus on social determinants of health in various areas of public health including maternal and child health, reproductive health, health programmes, blood-safety, health promotion and advocacy.
- Primary Health Care/Family Medicine – Advocating and promoting an integrated approach to and developing family medicine model as the core of the health care delivery system; technical assistance for the development of health care service delivery at primary level with particular focus on preventive health interventions by immunization programmes aiming to improve coverage and reduce inequalities.
- Public Health Security – Technical support and guidance to the MOH in its leading role to prepare and respond to emergency situations such as disasters, new and emerging diseases, humanitarian emergencies, mitigate health effects of climate change or environmental degradation, bioterrorism and other public health emergency of international concern; ensuring donor coordination and partnerships for emergency responses.
- Communicable Diseases – Maintain and strengthen surveillance system and response capacity for communicable diseases and ensure its consistence with the requirements of IHR; technical assistance for eliminating malaria, reducing burden of other communicable diseases such as measles, rubella, tuberculosis by strengthened immunization programmes; preventing spread of HIV/AIDS.
- Non-Communicable Diseases - Technical assistance for strengthening MOH institutional capacity in developing NCDs prevention measures by screening programmes for early detection and health promotion activities; guidance for developing technical guidelines for prevention and treatment; addressing injury prevention, particularly with regard to road traffic accidents and violence.
- Health Information System – Technical guidance for development of a reliable health information system compatible with international standards; assistance to develop national institutional capacity to lead development of evidence-based policies and programmes better addressing public health problems.

ADDITIONAL INFORMATION

WHO country page http://www.who.int/countries/tur/en/
EURO country page http://www.euro.who.int/en/where-we-work/member-states/turkey

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The brief is available online at http://www.who.int/countryfocus
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