

## *Chapter 2*

# **Recent Health Reforms in Turkey**

This chapter focuses on recent reforms to the health system in Turkey: the Health Transformation Programme (HTP) of the Ministry of Health, which includes the implementation of Universal Health Insurance (UHI). The HTP was conceived as a ten-year reform programme covering the period 2003-13. The reforms described here cover the period 2003-08.

## 2.1. The Health Transformation Programme

The HTP was designed to address long-standing problems in the Turkish health sector (as described in Chapters 1 and 3 namely: i) lagging health outcomes as compared to other OECD and middle-income countries; ii) inequities in access to health care; iii) fragmentation in financing and delivery of health services, which contributes to inefficiency and undermines financial sustainability; and iv) poor quality of care and limited patient responsiveness.

The HTP's objective is to make the health system more effective by improving governance, efficiency, user and provider satisfaction, and long-term fiscal sustainability. Key institutional and organisational changes envisioned under the HTP include:

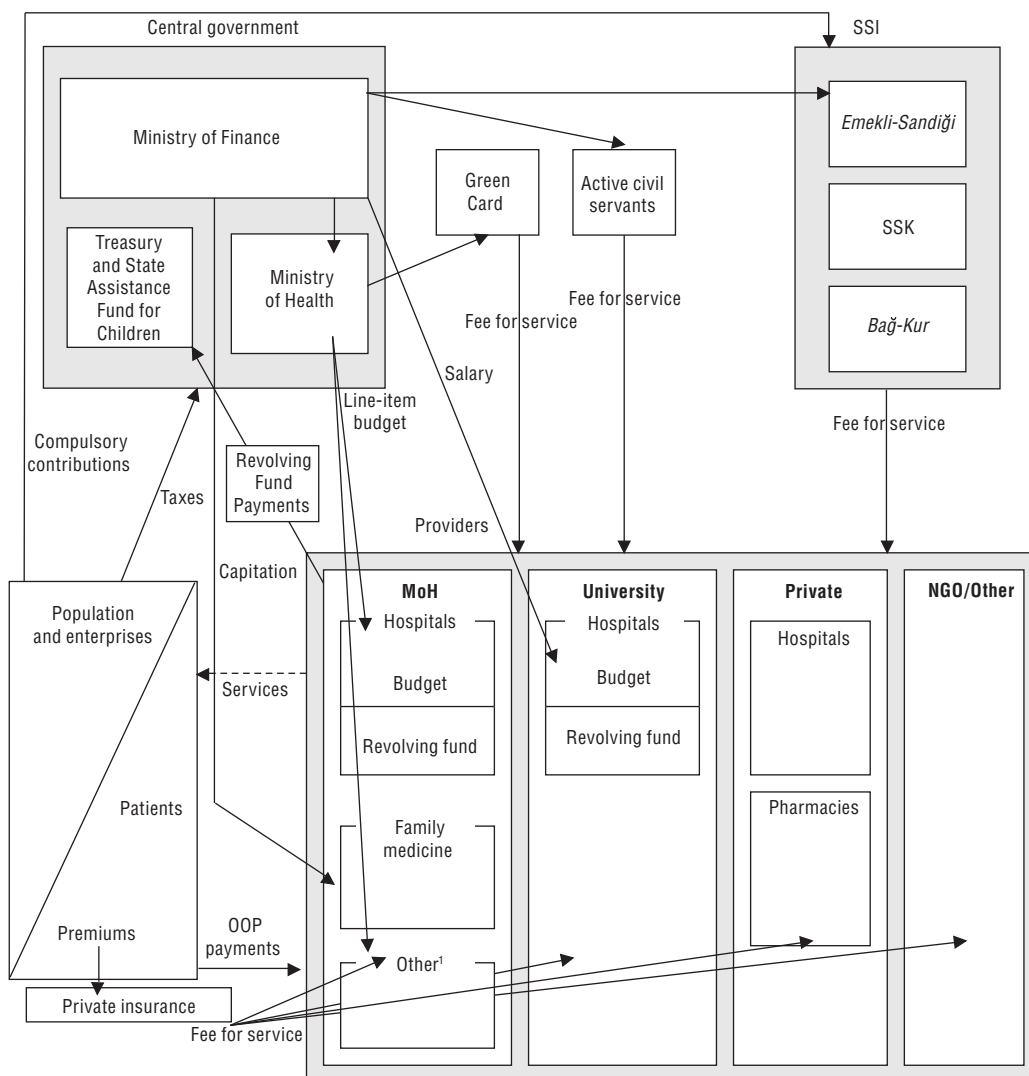
- Restructuring the MoH with the objective of strengthening its *stewardship function*. This entails ridding the MoH of its provider functions and instead strengthening and expanding functions such as: health surveillance/disease control, health regulation, planning and management capacity, monitoring and evaluation, health promotion, social participation in health, promotion of equitable access, quality assurance, human resources training, research in public health and control and disaster prevention.
- Establishing a *Universal Health Insurance (UHI)* system (also referred to as the General Health Insurance system) which would combine SSK, *Bağ-Kur*, *Emekli-Sandığı* and the Green Card programme under one umbrella, the Social Security Institute (SSI). Enrolment in UHI is to be mandatory, with contribution rates proportional to ability to pay and all beneficiaries entitled to the same benefits package. Contributions for those deemed unable to pay premiums would be paid from public funds on the basis of a means-tested system. The SSI, as the single purchaser in the health sector, is to contract with public and private providers to deliver the benefits package.
- *Reforming the health services delivery systems* by granting autonomy to public hospitals, creating a strong preventive and primary health-care system based on a model of family medicine, establishing an efficient referral system, and improving the quality of care in health facilities.
- *Addressing important cross-cutting issues* relevant for achieving the health-reform goals of the HTP, namely, ensuring the availability of motivated health personnel with adequate information and skills, strengthening education and science institutions to support the health system, and improving access to effective information in health-sector decision-making processes (Ministry of Health, 2007b).
- A timeline for the health sector reforms which have been implemented so far under the HTP is set out in Table 2.1, below. Figures 2.1 and Figure 2.3 depict financial flows in the Turkish health system prior to and after the implementation of UHI in 2008.

Table 2.1. **Timeline for health sector reforms in Turkey, 2003-08**

2003	2004	2005	2006	2007	2008
Ambulance services were made free-of-charge	Individual performance-based payment system implemented in MoH institutions	Green Card holders covered for outpatient prescription drugs	Global budget implemented for MoH hospitals	No payment required from citizens for primary care, even if not covered under social security.	New MoH Regulation on Private Outpatient Diagnosis and Treatment centres adopted that includes "Certificate of Need" requirement and new licensing procedures to be adopted by MoH
Mechanisms introduced so that the system of patients being held in hospitals as pawns due to non-payment of fees was abrogated	Green Card holders covered for outpatient services	Institutional and quality criteria added to performance-based supplementary payment system in MoH institutions	Implementation of Law 5502 (integration of social security institutions) begins.		Amendments to Social Security and UHI Law adopted by the Grand National Assembly and signed by the President of the Republic
Total quality management (TQM) put in place in MoH	Reimbursement Commission responsible for reimbursement decisions established according to Ministry of Finance decree	SSK pharmacies closed and members allowed to access private facilities	Family medicine implemented in Eskişehir province	New Health Budget Law adopted (SUT) according to which: <i>i</i> ) referral requirement from MoH hospital to university hospitals removed for SSK and <i>Bağ-Kur</i> ; <i>ii</i> ) patients with chronic condition can refill prescription at pharmacy without authorisation from physician first; <i>iii</i> ) bundled (fixed-price) payment for outpatient and inpatient procedures based on CPT and ICD-10 introduced in all MoH and university hospitals and private hospitals under contract with the SSI; <i>iv</i> ) hospitals under contract with the SSI required to provide in-patient pharmaceuticals and medical devices (covered by insurance) for free, and would be fined if they charged patients; <i>v</i> ) all MoH, university and private hospitals under contract with the SSI required to report claims through MEDULA	Implementation of UHI begins. Green Card programme brought under SSI. Green Card holders to receive same benefits as enrollees in other health insurance schemes under UHI
Performance-based payments piloted in ten MoH hospitals	Right to choose a physician system implemented in MoH hospitals	SSK hospitals transferred to the MoH	Family medicine implemented in Edirne, Denizli, Adiyama and Gumushane provinces	Ambulance services made more accessible in hard-to-reach areas in winter	Pentavalent vaccine introduced in routine immunisation programme
Vaccination days organised in the context of the national campaign of vaccination against measles	Iron supplements distributed free of charge to pregnant women nationally	Co-payment required for Green Card for pharmaceuticals	Pharmaceutical expenditure tracking system established in SSI and work on an integrated claims and utilisation management system for SSI (MEDULA) initiated	Family medicine implemented in Elazığ, Isparta, samson and Izmir provinces.	Tobacco Control Law passed banning smoking in closed and open public places.
	Family medicine first implemented in Duzce		Public-private Partnerships (PPP) for Health Law adopted by the Grand National Assembly		
	Licensing regulation for pharmaceuticals passed		Measles, mumps and rubella (MMR) vaccinations included in the routine vaccination programme		

Source: World Bank compilation based on Ministry of Health and SSI data.

Figure 2.1. Main financial flows in Turkey's health system, December 2007



1. Lower-level MoH institutions, such as health centres, dispensaries, village posts, or other primary health institutions do not have a budget or revolving funds that are individually managed; instead, the provincial health directorates manage the institution's finances and are in control of the unit's operations (Mollahaliloğlu et al., 2006, pp. 146-147). A nearby hospital may also manage the revolving fund of some lower-level institutions.

## 2.2. Health coverage and health financing reforms in Turkey under the HTP (2003-08)

### **Synchronisation of health benefits and coverage**

Several reforms have been implemented to harmonise health benefits across the different health insurance schemes, as well as Green Card holders. In 2005, Green Card holders were given access to outpatient care and pharmaceuticals. With this change, Green Card holders were given access to the same benefits as SSK, Bağ-Kur and Emekli-Sandiği enrollees. The objective of this reform was to enhance financial protection and access to care for Green Card holders.

In 2005, SSK beneficiaries were given access to all public hospitals and pharmacies. In 2006, the pharmaceutical positive list across all the health insurance schemes, including (in effect) Green Card holders, was integrated.<sup>1</sup> In 2007, legal measures mandated that all

citizens of Turkey would have access to free primary care, even if they are not covered under the social security system. Under the 2007 Health Budget Law (*Saglik Uygulama Tebligi* or SUT), benefits across the formal health insurance schemes of SSK, *Bağ-Kur*, and *Emekli-Sandigi* were further harmonised.

Prior to the SUT, there was no referral requirement for SSK and *Bağ-Kur* enrollees for visits to MoH hospitals, but there was a referral requirement for accessing university hospitals. This referral requirement was removed. Access to private health facilities remained the same as before, i.e., SSK and *Bağ-Kur* enrollees were allowed to access outpatient and inpatient services in private hospitals with which the health insurance scheme had a contract. A referral was required for accessing outpatient and diagnostic services in a non-contracted private facility. With these changes, the benefits of SSK and *Bağ-Kur* beneficiaries were improved to the level of *Emekli-Sandigi*.

The operationalisation of the Social Security and UHI Law (in October 2008) has completed the harmonisation of the benefits package; Green Card holders have now formally joined UHI and will receive the same benefits package that other beneficiaries have been receiving since the July 2007 Health Budget Law. Under the recently approved Social Security and UHI Law, changes are also envisioned in the contributory and non-contributory elements of UHI. Under the contributory scheme, 12.5% of pensionable salaries of blue-collar employees in the public and private sectors, active civil servants, white-collar employees and the self-employed will be collected. Of this amount, the employer's contribution is 7.5%. For the non-contributory system, the law alters both eligibility and financing of the current Green Card system, and a new means-tested system will be introduced. The new means-tested mechanism is expected to have several impacts. First, some portion of the population that is currently under the Green Card is not expected to qualify for non-contributory health insurance. For this group, the Social Security and UHI Law defines a reduced premium rate which is supposed to create incentives for this group to join. The non-contributory arm (for which the government will make the premium contribution) and the reduced premium rate are the main mechanisms for enrolling informal-sector workers in UHI.

### ***Administrative harmonisation of separate health insurance schemes and the creation of a single-payer system***

In 2006, Law 5502 was adopted by the Turkish Grand National Assembly. This law, which was meant to accompany Law 5510 (Law on Social Security and Universal Health Insurance), aimed at unifying the three different social security and health insurance schemes (SSK, *Bağ-Kur* and *Emekli-Sandigi*) into one unified social security institute. Implementation of this law has been underway since 2006. As a result, there currently exists within the SSI, a Universal Health Insurance Fund (UHI Fund).

A claims and utilisation management system called MEDULA has been established to process claims for all the health insurance funds including the Green Card. Under the 2007 Health Budget Law (SUT), all public and private health facilities under contract with SSI are required to submit claims through the MEDULA system. The establishment of a unified claims management system has standardised the submission of claims across all the health insurance funds and contributed to the establishment of a virtual single-payer system, even in the absence of the UHI Law.

### 2.3. Relationship between purchaser and provider

An important objective of the HTP, is to get rid of the previous fragmentation and duplication in purchasing and provision functions and to create uniform institutional and accountability relationships between purchasers and providers. The first change in this direction was taken in 2005, when SSK gave up its provision function to the Ministry of Health. Transfer of the Green Card programme to the SSI was planned under the Social Security and UHI Law. However, since the Social Security Law was subject to a constitutional court challenge and therefore not implemented as planned on 1 January 2007, the MoH remained in charge of the Green Card programme. Under this programme, the MoH receives an annual allocation from the Treasury as part of its line-item budget and uses these funds to finance expenditures at the hospital level for Green Card beneficiaries.

As of September 2007, however, in preparation for unification of the Green Card programme under SSI, MoH hospitals are required to submit information on utilisation of health services by Green Card beneficiaries to SSI. In 2006, in response to rapidly growing MoH expenditures, the SSI negotiated with MoH a capped annual budget for all 850 MoH hospitals (global budget for MoH hospitals). With this arrangement, and with the fact that the MoH has retained the function of managing the Green Card programme, the MoH has continued to function as a very dominant purchaser and provider, funding and managing a large network of primary care providers and hospitals.

In order to improve performance of MoH hospitals, the MoH has also introduced some elements of “internal markets”, whereby the MoH Performance Management and Quality Improvement Unit implements a pay-for-performance scheme in MoH hospitals, linked to institutional performance criteria (see Box 2.1 for details on the performance management system). Essentially, this means that purchaser-provider relationships in Turkey are under transition. The relationship between SSI and university hospitals and private facilities operates under a more traditional purchaser-provider model, whereby the SSI contracts with individual university and private hospitals to deliver services included in the benefits package.

At the beginning of the HTP, there were few changes to payment mechanisms. Payment by health insurance funds was on a retrospective basis (fee-for-service) and fee schedules and payment mechanisms across the different health insurance funds and types of hospital (i.e. university, public and private) were not co-ordinated. In 2007, under the Health Budget Law (SUT), the SSI developed a bundled price for outpatient and inpatient health services, based on procedural and ICD-10 coding systems. The introduction of the same price across all health insurance funds and public and private hospitals was the first step in moving towards a prospective-payment system in which money would follow the patient (as in a fee-for-service system).<sup>2</sup>

As has been mentioned above, a global budget for MoH hospitals was first introduced in 2006. This is a capped budget amount, annually negotiated with the MoH, reflecting historical expenditure levels and medium-term budget forecasts by the Treasury. MoH hospitals are paid a monthly amount determined by the MoH based on the global budget. These payments are adjusted to meet the global budget cap, and end-year claims may not be paid if spending exceeds the cap.

The amended Social Security and Universal Health Insurance Law adopted in April 2008, specifies payment mechanisms for state hospitals. For state hospitals, it is expected that the SSI will adopt global budgets with DRGs. For private hospitals, the payment mechanism is

### Box 2.1. Performance management in health: the performance-based supplementary payment system (PBSP)

A performance-based supplementary payment system (henceforth referred to as the PBSP system) was introduced in MoH hospitals in 2004. It was initially piloted in ten hospitals and subsequently expanded to all MoH health facilities. When SSK hospitals were devolved to the MoH in 2005, the PBSP system was extended to these hospitals. Currently all 850 MoH hospitals and primary health-care facilities have in place the PBSP system. This system does not exist in other public institutions providing health care (e.g. university hospitals).

The main objective of the PBSP system is to encourage job motivation and productivity among public sector health personnel. When the HTP was launched, it was recognised that the human resources crisis in the public sector would be a major impediment to achieving HTP goals. At the time of launch of the HTP, the ratio of health personnel to population was lower than in other middle-income countries and OECD countries (as described earlier in this chapter and in Chapter 3), the majority of public doctors worked part time, and doctors preferred to work in the private sector. As a result, there was overcrowding in public hospitals, long waiting times to see a doctor and low patient and provider satisfaction with the health system. The PBSP system was considered a key intervention to address these problems. The PBSP is a critical component of the HTP aimed at enhancing performance management in MoH hospitals, and focusing on quality of care, efficiency and patient satisfaction.

What is the PBSP system and how does it work? Essentially PBSP is an additional payment health personnel receive each month in addition to their regular salaries. The base salary is paid from the MoH line item budget (under health personnel salaries). The performance-based payments are paid from the revolving funds that are financed mainly from the general insurance system.

The following factors determine how much health personnel will receive as performance-based payments. First, the total amount that health facilities can allocate to performance-based payments to health personnel is capped at 40% of revenues. Some hospitals may choose to allocate less than the 40% depending on other needs in the hospital (for example, if laboratory equipment needs to be upgraded or the hospital needs to hire more auxiliary health personnel). The hospital management is responsible for deciding how much will be allocated for performance based payments within the limits defined by the Ministry of Health. Moreover, individual bonuses for staff are capped at a certain multiple of basic salary. This means, for example, that a specialist earning TRL 1 000 per month in basic salary can receive a maximum bonus of TRL 7 000.

Second, this total (capped) amount is subsequently adjusted based on the institutional performance of the health centre or hospital. Every health centre and hospital is given a score from 0-1 based on institutional performance indicators and the performance-based bonuses are multiplied by this factor. For example, if a hospital wishes to devote 40% (the capped limit) to staff bonuses, and its institutional performance score is 0.8, then in reality only 32% can be devoted to staff bonuses. This places a high premium on good institutional performance and balances the individual incentives for high service volume with group incentives for overall institutional quality. The MoH has established five categories of indicator to measure the institutional performance of hospitals, each of which carry equal weight. These indicators largely target the structural quality of care and patient and provider satisfaction. The five categories include: i) access to examination rooms; ii) hospital infrastructure and process; iii) patient and caregiver satisfaction; iv) institutional productivity (bed occupancy, average length of stay); and v) institutional service targets (caesarian-section rate, share of doctors working full time, surgery points per surgeon and per operating room, and the reporting of scores for the performance monitoring system to the MoH).

**Box 2.1. Performance management in health: the performance-based supplementary payment system (PBSP) (cont.)**

Third, an individual-level performance score is calculated for each staff member. This score is used to determine how the aggregate amounts of bonus payments for a hospital are distributed across individual health workers.

For physicians the individual performance score depends first on the number of procedures performed by that staff member. Each clinical procedure carries a particular point level that is determined by the Ministry of Health.

The total points score for a physician is then adjusted by a job-title coefficient that is meant to measure workload aside from providing clinical care for different types of doctors (i.e. administrative duties, teaching, etc.) This adjustment varies only by job title not by individual. The score is also adjusted by the number of days the person has worked in the year. The score is adjusted depending on whether the person is employed full-time or part-time in the hospital. The current coefficient for full-time status is 1 but for part-time status is 0.4. This adjustment was put in to encourage full-time practice in public hospitals and discourage “moonlighting” in the private sector.

not defined but the SSI is mandated to establish appropriate payment mechanisms based on the scope of services provided. This provision gives the SSI the legal backing to implement payment mechanisms such as global budgets, or case-mix based payment systems, based, for example, on Diagnosis-related Groups or DRGs. Moreover, the UHI Law allows “extra billing” by private providers, whereby, based on detailed criteria adopted by the Council of Ministers, private providers will be allowed to charge up to 100% above the price paid by the SSI. The extra charges are to be paid by patients on an out-of-pocket basis. Secondary legislation recently adopted by the SSI, limits the amount that private hospitals can charge to up to 30% above the price paid by SSI.

A pilot project on paying hospitals, based on Diagnosis-related Groups (DRGs), has been ongoing since 2006. Under this project, the Australian DRG system is being adapted to Turkey. Hospital cost data have been collected and analysed from almost 50 hospitals and base costs and relative weights have been developed. The next step is to start implementing DRGs in selected public and private hospitals under contract with the SSI.

## 2.4. Service delivery reforms

### **Strengthening primary care including family medicine implementation**

A pilot family-medicine implementation law was adopted by the Turkish Grand National Assembly in 2004, thereby creating the necessary legal framework for piloting family medicine with capitation payment. Under the model of family medicine currently under implementation in Turkey, salaried general practitioners working at the primary-care level (e.g. in MoH primary health-care centres) or at the secondary-care level (e.g. in outpatient departments of MoH hospitals) are given an option to take a leave of absence from their public sector jobs and take up a position as an independent, capitated, family doctor. These doctors have a right to return to their original public sector jobs at any time.

In order to qualify, these doctors must complete a ten-day, first-phase orientation training course on family medicine. This course covers the principles of family medicine practice, communication, clinical methods and epidemiology. The trainers are generally professors of family medicine from accredited universities in Turkey. Since there are

not enough graduates of family medicine from existing programmes, a recertification programme is necessary.

Once the orientation training is complete, family doctors are given a monthly capitation payment based on the number of persons enrolled with them. In urban areas, it is an open-enrolment system and individual members of the population can choose their family doctor, but in peri-urban areas, where there is not enough choice of family doctors, the population is assigned to specific doctors based on catchment areas. There are both group practices and solo practitioners. The family doctors are allowed to operate out of primary health-care centres owned by the MoH and have to pay a monthly rent for this amenity. The capitation payments cover salaries and all other expenditures by the family doctors, including the purchase of necessary diagnostic equipment for the practice.

A portion of the capitation payment is paid on the basis of achieving performance benchmarks which include achieving specified levels of vaccination rates, ante-natal visits and referrals. For example, the greater is the number of referrals, the lesser the points assigned to the family doctor. Continued training in family medicine is also a requirement and all family doctors will have to complete the second-level training, which is more intensive, focusing on the promotion of professional knowledge and skills. Until July 2006, a mandatory referral requirement was in place: family medicine clients were required to obtain a referral before they could receive secondary care from a hospital. However, this requirement was suspended due to the high work burden on family doctors.

The implementation of family medicine began with a pilot in Duzce and is currently operational in 23 out of 81 provinces in Turkey. Approximately 20% of Turkish citizens are enrolled with family doctors. The ratio of family doctors to population is low (1:3 400). In most countries that have implemented family medicine, the ratio of family doctor to population is on average 1:1 200. It was the low family physician ratio that forced the suspension/abandonment of the referral system, referred to above. Moreover, since the law only allows piloting of the model, a framework law on family medicine will eventually have to be adopted if there is to be institutional sustainability. It is unclear when the government plans to submit such a framework law to the Grand National Assembly.

While the family medicine model is being implemented incrementally, efforts are also being directed under the HTP to strengthen the existing preventive and primary health-care network in Turkey, so that eventually family doctors and preventive health centres can work in a synchronised manner to achieve better population health. In provinces where family medicine is under implementation, community health centres are being established. These centres provide integrated preventive, diagnostic, curative and rehabilitation services and are responsible for overseeing preventive health services such as vaccination campaigns, and reproductive and child health services. In provinces where family medicine is not under implementation, the old system of health centres remains operational.

One of the biggest barriers to effective implementation of the family medicine system, to date, is the shortage of doctors in the country (especially general practitioners). Unless this shortage is addressed, it will be difficult to implement the full “gatekeeper” model in family medicine where family doctors control referrals to higher levels.

### **Reforming Ministry of Health (public) hospitals in Turkey**

One of the key reforms implemented under Phase I of the HTP, is the integration of all public facilities (with the exception of university hospitals and health facilities belonging to the Ministry of Defense) under the Ministry of Health. This integration, which took place

in 2005, helped SSK rid itself of the provision function and only focus on purchasing, since SSK hospitals were integrated under the MoH. The objective behind this reform was to harmonise management and payment mechanisms across all public hospitals and to pave the way towards autonomy for these hospitals. The integration was expected to increase access to hospitals substantially and to improve their allocative and technical efficiency through the adoption of the same performance management model that MoH hospitals had successfully adopted earlier on, which had resulted in higher productivity and efficiency (see Box 2.1 and Chapter 3).

It was recognised early on in the implementation of the HTP, that country-wide implementation of a hospital autonomy model by 2008 was far too ambitious. Therefore, mid-way through the HTP, the government instead decided to pilot hospital-autonomy reforms. A pilot, hospital-autonomy law (Draft Law on Pilot Implementation of State-Owned Hospital Unions) was drafted in 2007 and submitted to the Grand National Assembly for consideration. It was still under discussion when this report was prepared in 2008. The law sets out the principles of hospital governance based on a public-enterprise model whereby hospitals joining the pilot project would be managed by boards, but remain affiliated to the MoH. The law offers the possibility for the creation of a joint hospital union at the regional level, consisting of a network of hospitals that would jointly undertake programme planning, budgeting and implementation. Pilot hospital unions would have greater autonomy and flexibility over hiring health personnel and making resource allocation decisions. Hospital employees would no longer be classified as public employees and would no longer have the right to life-long employment in the health sector. The MoH would be responsible for guaranteeing quality of care and adherence to MoH standards in hospital unions.

Since the plans for the implementation of hospital autonomy changed during Phase I implementation of the HTP, selective hospital reforms were implemented with the objective of making public hospitals more client-responsive and productive and improving the quality of care provided. The reforms gave hospitals more autonomy and flexibility to carry out the service delivery function within an accountability framework which emphasised quality, efficiency and effectiveness of care. The reforms carried out to date include: i) granting hospital managers more autonomy and flexibility over the management of revolving funds, as well as procurement and investment decisions; ii) implementing a performance-based supplementary payment system (see Box 2.1); iii) outsourcing of hospital clinical services (diagnostics) to the private sector (public-private partnerships); iv) upgrading health information systems, and v) implementing hospital quality and efficiency audits.

The reforms are underpinned by training programmes for hospital managers.

### ***Private sector provision of health services and public-private partnerships***

Under UHI, the Social Security Institute is contracting with private facilities for the delivery of outpatient and inpatient health services. Approximately 1 000 private facilities currently have contracts with the SSI of which 350 are private hospitals. Provider payment methods, such as allowing private hospitals to implement “extra billing” were adopted by the SSI to stimulate private sector interest in contracting with the SSI. These mechanisms are counterbalanced by increased strengthening of the regulation of private provision by the MoH. In February 2008, a new regulation was adopted by the MoH which will implement a “certificate of need” requirement for new private-sector hospitals, outpatient clinics and diagnostic centres. The regulation is expected to have a significant positive

effect on ensuring an effective, better-qualified and needs-responsive operation of public and private establishments throughout the country. In 2006, a Public-Private Partnership (PPP) Law for the health sector was adopted and a new PPP unit was set-up under the MoH, mandated to pilot PPPs in the health sector. Several PPP initiatives that would involve the private sector in building new MoH research and training hospitals are planned for implementation in 2008.

## 2.5. Governance reforms under the HTP

In 2005-06, a broader Public Administration Framework Law, which would create an enabling legal environment for restructuring the MoH was submitted to the Grand National assembly. This law, if passed, would have allowed governance arrangements in the health sector to change significantly, and would have helped to establish quasi-independent units responsible for health sector regulation and public health.

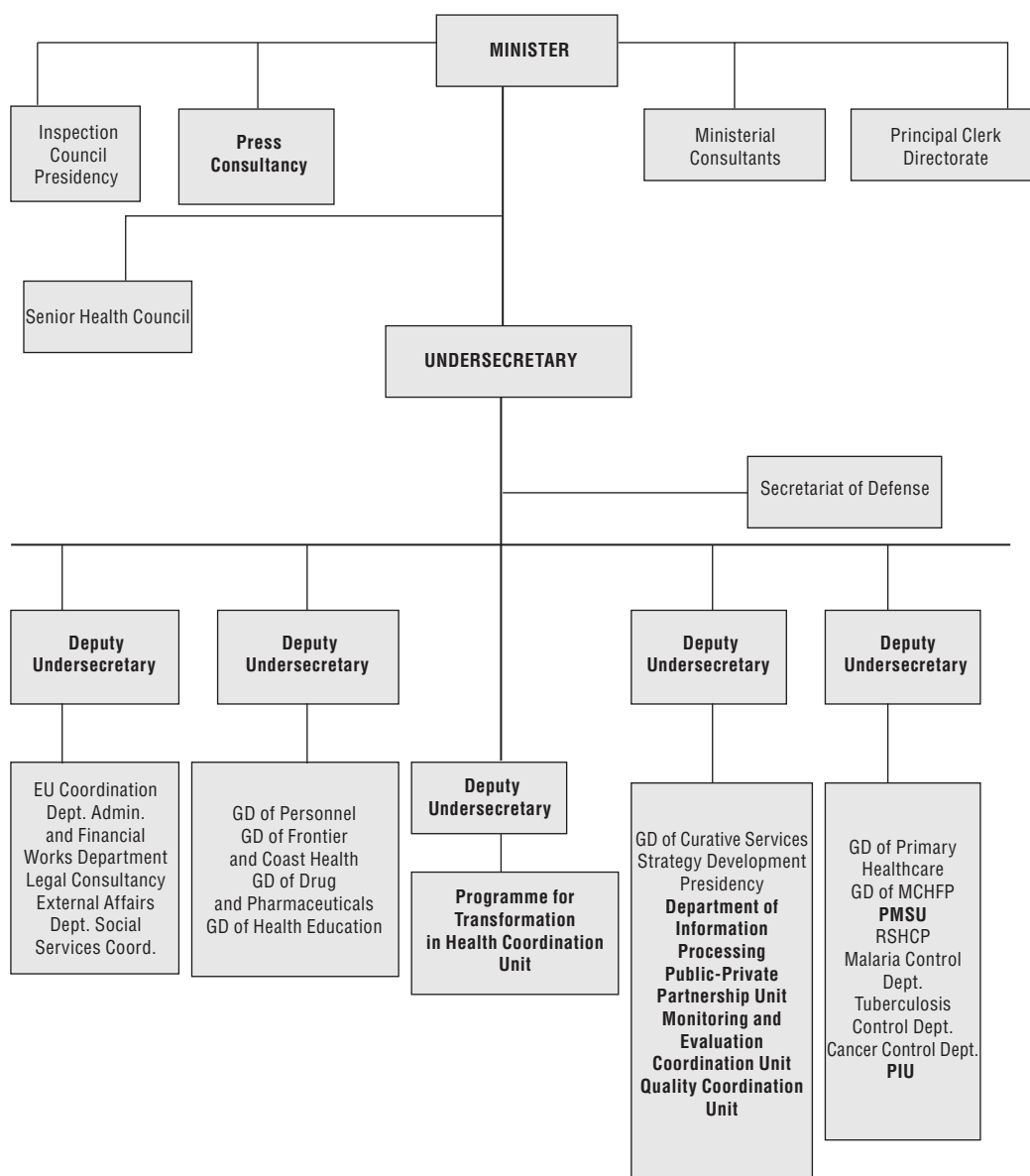
The framework law was vetoed by the then President of Turkey and as a result, MoH restructuring was delayed. The MoH has during Phase I implementation of the HTP, established several new departments (through ministerial decrees) responsible for functions such as monitoring and evaluation, performance management and quality improvement (see bolded sections in Figure 2.2). However, major restructuring of the MoH and establishment of quasi-public institutions responsible for regulation in the health sector as well as restructuring of the public health system remain unfinished tasks under Phase I of the HTP.

New governance arrangements for the system of Universal Health Insurance have emerged as a result of the establishment of the SSI. A Reimbursement Commission was established in 2004 consisting of representatives from the SSI, the Employment and Pension Fund, the MoH, the Ministry of Finance, the State Planning Organisation and the Treasury. This commission is responsible for setting prices for health services and pharmaceuticals reimbursed by the SSI, as well as for making changes to the SSI benefits package. A Medical and Economic Appraisal Commission operates under this commission and is responsible for the necessary technical work to facilitate decision making by the Reimbursement Commission. With the establishment of one Reimbursement Commission for all the health insurance funds, a mechanism has been put in place for addressing payment strategies that affect all the funds, replacing the previous fragmented system.

## 2.6. Important cross-cutting issues: human resources and health information systems

Early in the implementation of the HTP, it was recognised that information and appropriate human resources capacity would be critical for implementation of the HTP. Therefore, major efforts have been made to put in place the conditions for a motivated and well-performing workforce and for establishing information systems. In the past few years, the Ministry of Health Information System has expanded and substantially increased its collection of data. The Ministry of Health information system, known as Health-NET, contains a number of different information systems and datasets, such as the Family Medicine Information System, the Green Card Information System, the Doctor Data Bank, the Patient Rights Information System, the National Data Dictionary, and the Minimum Data Sets. The Minimum Data Sets focus on a number of health topics, including: follow-up of reproductive health-care services provided to women from 15-49 years with a special

Figure 2.2. Ministry of Health central organisation



Note: GD: General Directorate; MCHFP: Mother and Child Health and Family Planning; PIU: Project Implementation Unit; PMSU: Project Management Support Unit; RSHCP: Refik Saydam Hygiene Center Presidency, The School of Public Health.

focus on the provision of antenatal services; drug addiction; psycho-social follow-up; contagious diseases; causes of infections and malaria; HIV registration; newborn registration; non-national registration; test results; outpatient services; inpatient services; and organ transplantation, among others. Expenditure data are not currently collected but there are plans to integrate them with the SSI claims and utilisation management system (MEDULA). Health-NET has been piloted among select health-care institutions and is planned for roll-out in the near future. A telemedicine pilot was launched by the Department of Data Processing of the MoH and is currently covering 18 hospitals. The MoH health systems are harmonised with MEDULA to prevent duplication and minimise the administrative burden on MoH hospitals.

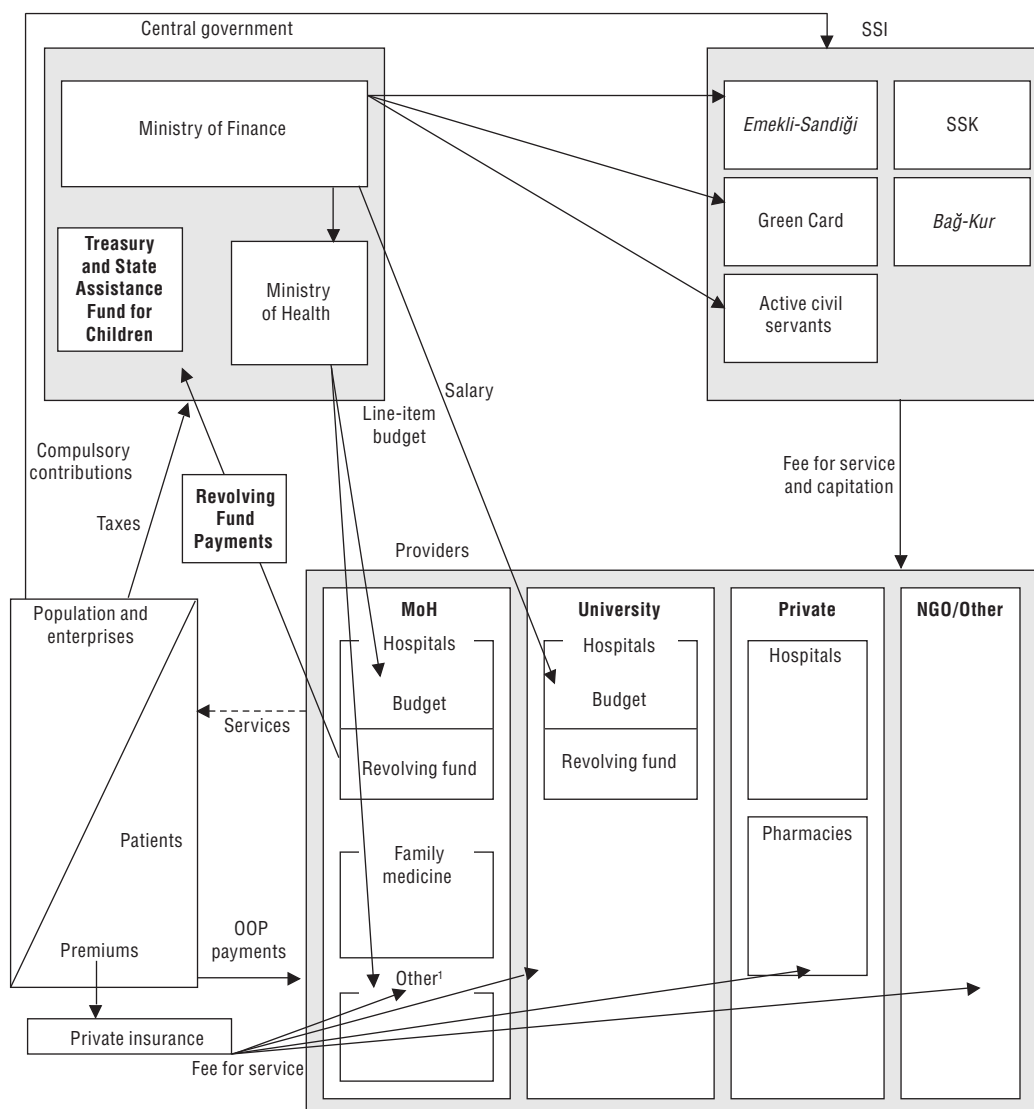
Systematic coding of diseases using ICD-10 codes has been implemented in all MoH hospitals, and the infrastructure for hospital management and family doctor information systems, respectively, has been established. The information system for family doctors is operational and every month family doctors report on a “minimum data set” which includes information on disease patterns and referrals. The information system is required for successful implementation of the pay-for-performance scheme for family doctors.

A key step in creating a motivated and well-performing workforce under the HTP, was the implementation of the performance-based supplementary payment system (described in Box 2.1). As mentioned in Chapter 1, although hospitals and health facilities were allowed to use revolving funds for bonus payments to health personnel prior to the HTP, the levels of payments were rather low, there was variation in payment levels across health facilities, there was limited transparency in how these payments were made and there were no performance criteria against which these payments were benchmarked. A major initiative under the HTP was the formulation of a framework for making these bonus payments linked to the performance of health personnel. The framework was applied to all MoH hospitals, thereby making the process standardised and transparent. The main objective was to encourage productivity among health personnel. This was consistent with human resources policy under the HTP which, recognising shortfalls in supply of health personnel in the public sector, aimed at increasing on-the-job productivity. In addition to boosting the payment systems, management training programmes for doctors and hospital managers were initiated using distance education methodologies, and MoH personnel in hospitals as well as in administrative positions were trained in subjects such as health-systems performance improvement, health reform implementation and other relevant topics. The number of health personnel working under the MoH was increased by 100 000 and the requirement for newly graduated doctors to serve in rural areas was enforced.

## 2.7. Public health

In recognition of the growing burden of chronic diseases, national programmes targeting diseases such as cardiac health, mental health and diabetes were implemented under the HTP. Free cancer screening services and accompanying training centres for practitioners were opened in 49 provinces. In January 2008, the MoH published its Action Plan for the Control of Cardiovascular Diseases. This plan focuses on the risks associated with non-communicable diseases and tackles tobacco consumption, passive smoking, obesity and lack of physical exercise. Efforts to control communicable diseases such as malaria, leishmaniasis, typhoid and tuberculosis were scaled-up. The practice of “Directly Observed Therapy” for tackling tuberculosis was introduced in 2003 and a cross-sectoral National Plan on combating avian influenza was developed. The number of “Baby Friendly Hospitals” was increased over fourfold (from 141 in 2002 to 619 in 2007), and the immunisation programme for children under five was expanded to include rubella, mumps and meningitis. Pregnant women have been provided with free iron supplements with the objective of addressing anaemia and protecting mother and child during delivery and in the antenatal period. To address possible Vitamin D deficiency, free Vitamin D supplements were disseminated to up to 4 million infants between May 2005 and August 2008. Efforts under the neonatal screening programme were accelerated and scaled-up nationally. Screening for phenylketonuria was also rolled out throughout the country.

Figure 2.3. **Main financial flows in Turkey's health system, 2008**  
(after adoption of the UHI Law)



1. Lower level MoH institutions, such as health centres, dispensaries, village posts, or other primary health institutions do not have a budget or revolving funds that are individually managed; instead, the provincial health directorates manage the institution's finances and are in control of the unit's operations (Mollahaliloğlu et al., 2006, pp. 146-147). A nearby hospital may also manage the revolving fund of some lower-level institutions.

## Notes

1. The positive list of drugs for Green Card contains the same drugs as the combined list for the other health insurance schemes but will be kept separate until Green Card holders are formally integrated into UHI, which is planned for October 2008.
2. In March-April 2008, the high court of Turkey issued an injunction against the implementation of bundled pricing as provided for in the SUT. According to the High Court, bundled prices were unconstitutional and could compromise access to health services. The High Court also ruled that the analytical basis for the bundled pricing system was inadequate.