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Universal Health Coverage for Inclusive and Sustainable Development

Country Summary Report for Turkey

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Acronyms

GDP	Gross Domestic Product
GNI	Gross National Income
HEU	Health Economics Unit, Ministry of Health and Family Welfare
HIG	Health Implementation Guide
HRH	Human Resources for Health
HTP	Health Transformation Program
MCH	Maternal and Child Health
MDG	Millennium Development Goals
NGO	Non-governmental organization
OOP	Out of pocket health spending
PPP	Purchasing power parity
SSI	Social Security Insurance
SSK Kurumu)	Social Security Insurance for formal sector employees (Sosyal Sigortalar
THE	Total Health Expenditure
UHC	Universal Health Coverage
UHI	Universal Health Insurance

Preface

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on Turkey is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, and Vietnam. A synthesis of these country reports is in the publication "Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies," available at:

http://www.worldbank.org/en/topic/health/brief/uhc-japan.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

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The Program was led by a team comprising Akiko Maeda, Lead Health Specialist and Task Team Leader for the World Bank, and co-Team Leaders, Professor Naoki Ikegami, Department of Health Policy and Management, Keio University School of Medicine and Professor Michael Reich, Taro Takemi Professor of International Health Policy, Harvard School of Public Health.

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Country Summary Report for Turkey

Overview

Turkey is an upper middle-income country that has seen rapid economic growth and development over the last decade. In a relatively short period, it has essentially achieved universal health insurance (UHI) coverage of the population, high levels of financial protection and equity, and high and rising levels of consumer satisfaction, while significantly improving health outcomes. The universal health coverage (UHC) strategy, embedded in its Health Transformation Program (HTP), was initiated in 2003 to improve the effectiveness of the health system through improved governance, efficiency, and user and provider satisfaction.

Table 1. Turkey at a glance

Population	74,724,269* (2011)
Gross domestic product (GDP; current US$)	$775.0 billion** (2011)
Gross national income per capita in purchasing power parity (current international $)	16,940 ** (2011)
Total health expenditures (THE) as % of GDP	6.74** (2010)
THE per capita (current US$)	678** (2010)
Public health spending as share of total health spending (%)	75.2** (2010)
Life expectancy at birth, total (years)	73.94*** (2010)
Hospital beds (per 1,000 population)	2.6**** (2011)

Sources: * TurkStat, ** World Bank, ***OECD Health Data 2012,**** *Health Statistics Yearbook 2011*.

PART I. UNIVERSAL COVERAGE—STATUS AND SEQUENCING

A. Overview of current status

1. Legal and statutory basis

The 60th article of the 1982 Constitution states that “everyone has a right to social security, and the state shall take the necessary measures and establish the necessary measures and organization to provide this security”(MOH 2011a). Social Security Institution Law No. 5502 dated May 16, 2006 guarantees that all Turkish citizens receive primary health care services free of charge irrespective of insurance status. The Social Insurance and Universal Health Insurance Law No. 5510 of May 31, 2006 (Law No. 5510) defines population groups to be covered by the UHI program.

2. Current status of coverage along the key dimensions of UHC

a. Population

Enrollment to the UHI program under the control of the Social Security Institution (SSI) is mandatory for all Turkish citizens. According to the SSI, 97 percent of the population was covered by the UHI program in 2011, while household level data coming from the Household Budget Survey 2011 suggests that coverage of health insurance is 90 percent.

b. Services

According to the Law No. 5502, under the UHI program, individuals are classified into one of four income groups (G0-G3) (Table 2). The premium for each group is calculated annually. For those in formal employment, employers cover 7.5 percent of the premium, employees the rest (5 percent).

Table 2. Four income groups

Income group	Definition: Average monthly income per household	Premium calculation	Contributors
G0	Under 1/3 of gross minimum wage (GMW)	1/3 GMW X 12.5%	Paid by the government
G1	Between 1/3 of GMW and GMW	1/3 GMW x 12.5%	Paid by beneficiary or if formally employed share is employees 5%, employers 7.5%
G2	Between GMW and 2 times GMW	GMW x 12.5%	Ditto
G3	Over 2 times GMW	2 GMW x 12.5%	Ditto

Source: Law No. 5502 on Social Security.

According to Law No. 5502 all population groups except the following are covered by the UHI program: conscripts undertaking military service, foreigners with their own social insurance coverage in their home country, people working in country representative offices abroad with social security coverage in the host country, tourists or short-term visitors, illegal immigrants, and prisoners.

All beneficiaries of the UHI are entitled a fairly comprehensive benefit package (Table 3) listed in the Health Implementation Guide.[1] This list is updated yearly.

[1] The Health Implementation Guide (HIG (Sağ lık Uygulama Tebliğ i)), published annually, covers the rules and regulations for the benefits package and there is a unified guide that covers all existing schemes. For more details, see Tatar et al., 2011.

Table 3. Benefit package for all income groups

Benefit package for all income groups	➢ Personal preventive health care including preventive care for addictive substances harmful to health ➢ Outpatient and inpatient services, medical consultation, diagnostic tests, treatment, dressing, tooth extraction, dental prosthesis and eyeglasses ➢ Outpatient and inpatient maternal health care, medical examinations, diagnostic tests and procedures, delivery, treatment and emergency care costs of newborns after delivery, follow up services ➢ Hospitalization for emergency cases and treatment ➢ In-vitro fertilization, up to two attempts ➢ Blood and blood products, vaccines, medicines, prosthesis, medical goods and equipment ➢ Pharmaceuticals and medical devices ➢ Free health care provision for children under 18 regardless of their insurance status

Source: Law No. 5502 on Social Security.

c. Financial protection

Out-of-pocket payments are low and progressive. Households in the top quintile in 2008 paid 1.97 percent and 2.44 percent of their total and nonfood expenditures for health care, compared with 1.43 percent and 2.37 percent in the lowest quintile, indicating a progressive system (Aran and Hentschel 2012). The same study also shows that impoverishment as a result of catastrophic medical expenses fell from 0.8 percent of all households in 2003 to 0.3 percent in 2008.

Copayments are waived for visits to family medicine providers. They apply to outpatient visits and are TL 8 per visit to university and Ministry of Health (MOH) hospitals, and TL 15 for visits to private hospitals. Copayment for pharmaceuticals is 20 percent, except for retirees who pay 10 percent.

Extra billing, up to an additional 70 percent of the SSI tariff, is allowed for private hospitals to compensate for supply-side government subsidies (personnel salaries, capital investment, etc.) to public hospitals. Beginning in January 2010, a new classification system for private hospitals was implemented, which classified private hospitals into five categories (from A to E) based on the numbers of beds, patient operations, and the like. Private facilities can request extra billing according to their classification. For example, Category A facilities can charge up to an additional 70 percent of the SSI tariff, while Category E facilities can bill up to 30 percent more.

3. How is governance structured?

a. Goal setting

The MOH is steward of the system and is responsible for policy making, regulation, and monitoring and evaluation. The Public Health Institution is responsible for the provision of primary and preventive care services while the Public Hospital Institution is in charge of

secondary and tertiary care services (see below). The SSI is the single purchaser of services in the public health system, which now includes all five of the previously fragmented health insurance programs.

b. Financing

Total health spending as a share of GDP was 6.74 percent in 2010. In 2008, 43.9 percent of funds for health spending came from the SSI, 27.6 percent from other government sources, 17.4 percent from out-of-pocket payments, and 9.6 percent from other private sources (Menon et al. 2013). There is no earmarking of general revenues for the UHI program. Initiated in 1992, the Green Card (Yesil Kart) Program—a noncontributory health insurance program—is the main flagship social protection program funded through the national budget. Based on survey data, the number of beneficiaries more than tripled, from 2.5 million in 2003 to 9.1 million in 2011, due to expansion of the Program's benefits (Menon et al. 2013).

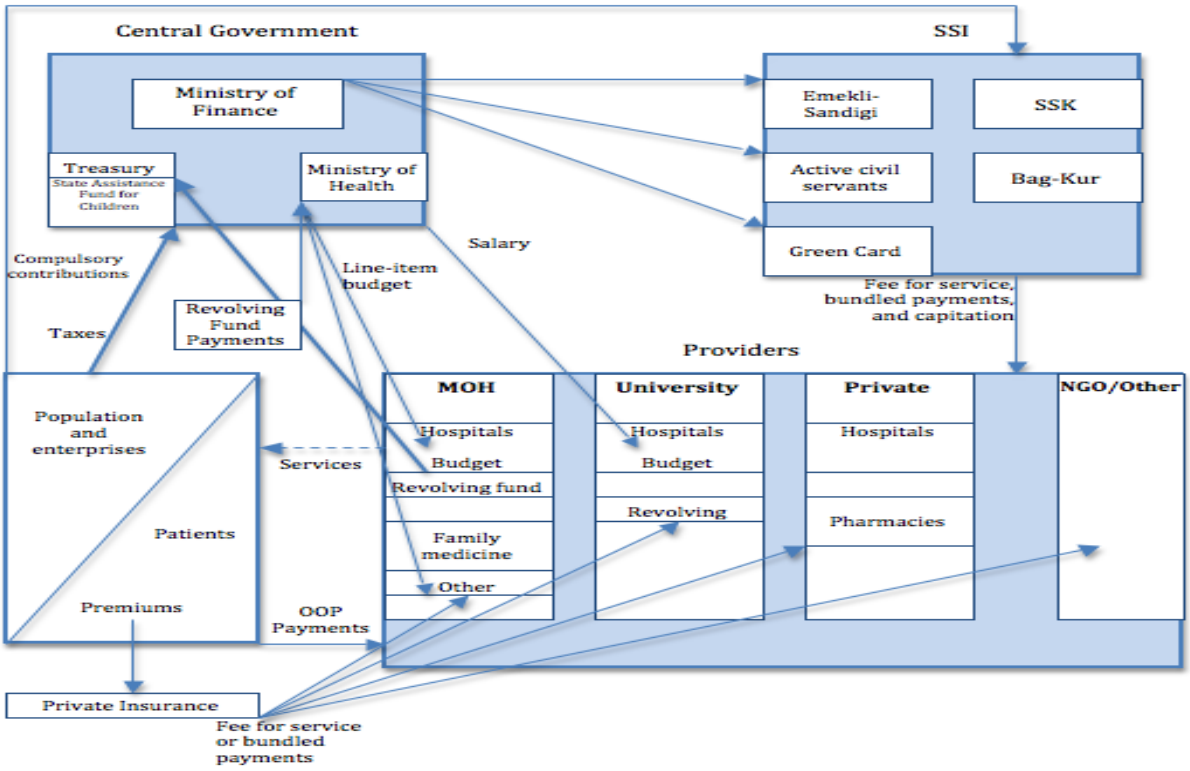
Until 2012, a hybrid-targeting program was used to identify individuals eligible for the Green Card. Centrally appointed *kaymakam*s (district officers) were given discretion for distributing the cards following eligibility rules determined by the central government. Enrollment was voluntary and applications were collected at district-level Green Card offices, which usually reported directly to centrally appointed district or provincial officers (*kaymakam*s or *vali*s). The ultimate decisions on the distribution of the cards were made by local committees chaired by the *kaymakam* (in districts) and the deputy governor in charge of the Green Card in the provincial center.

In January 2012, the Green Card Program was merged into the UHI, leading to changes in the flow of funds (funds for Green Card holders have been transferred from the Ministry of Finance to the SSI), while the identification, certification, and monitoring of Green Card holders are now regulated by the Regulation on the Rules and Principles of Identifying, Certifying, and Monitoring Income Under the Universal Health Insurance. The identification of the poor to be covered by the state budget is now based on the national Integrated Social Aid Services System, managed by the Ministry of Family Affairs and Social Policies. The system also determines beneficiaries of scholarships, home care for the elderly, and conditional cash transfers and benefits for disabled people.

c. Payment

Primary care and preventive services are financed mainly through the state budget. For MOH hospitals, salaries and investment costs are covered by the general budget. The SSI transfers a global amount for services provided to its beneficiaries. These funds go into the revolving fund of each hospital and cover all other expenses, including performance-based bonuses for providers. University hospitals have a structure similar to MOH hospitals and receive funds from the state to cover salaries and other investments, and have revolving funds from which they generate income from the SSI and patients. For private sector hospitals, the SSI negotiates and concludes annual contracts (allowing extra billing based on hospital category). Figure 1 presents a flow of funds chart.

Figure 1. Flow of funds



Source: Menon et al. 2013.

d. Service delivery

Secondary and tertiary health care services are provided by MOH-affiliated public hospitals, university hospitals, and private hospitals, although the MOH predominantly controls these services. In 2011, there were 1,453 hospitals in Turkey, of which 840 were owned by MOH, 65 were university hospitals, 503 were private facilities, and 45 were owned by other public establishments and local administrations (MOH 2011b). A total of 20,243 family practice doctors and family health personnel (mainly nurses and midwifes) worked in primary and preventive care services in 6,463 family health centers at December 31, 2011 (World Bank 2013).

B. Current status of health financing

1. How sustainable is current coverage?

a. Fiscal space

The last decade has been a period of rapid economic growth and development for Turkey, largely thanks to sound macroeconomic management and structural reforms since a banking crisis in 2001. The economy grew by an average of almost 5.5 percent in 2002–11, compared with the pre-2001 average of around 4 percent. Per capita income tripled over the period to reach $10,444 in 2011. The government prioritized the health sector, enabling expansion of breadth and depth of coverage. Through improved efficiency in health spending, the introduction of fixed global budgets for MOH hospitals in 2007, and expenditure caps for university and

private hospitals and for pharmaceuticals in 2010, fiscal sustainability of the UHI is ensured. SSI deficits have narrowed and are covered by the government budget.

b. Cost management and value for money

For its spending and income levels, Turkey appears to get reasonable value for money in terms of health outcomes. The relative generosity of the comprehensive benefit package and spending on pharmaceuticals are key cost drivers. Changes to the system are made regularly to ensure continuing efficiency gains on both demand and supply sides.

Under the Family Medicine Program, funded through general revenues within the budget of the MOH, family medicine physicians and other family medicine staff are contracted individually. They are expected to function as a unit under the overall guidance and management of the family physician. The payment for family medicine staff has five components (Table 4).

Table 4. Five components of payments for family medicine staff

A. Capitation-based payment	• The monthly base payment for family physicians is defined with a capitation-linked formula, i.e. in proportion to the number of people registered to the family physician. • Pregnant women have the highest payment coefficient (adjustment factor of 3), followed by prisoners (adjustment factor of 2.25), children under 4 years and the elderly over 65 years (adjustment factor of 1.6), and the general population that does not fall into any of these categories (adjustment factor of 0.79).
B. Capitation adjusted for socioeconomic level of area	• The monthly base payment is adjusted for the socioeconomic development of the area in which the family physician practices. Family physicians serving in less developed districts with a shortage of medical personnel receive an additional payment “service credit” on a sliding scale that is linked to the socioeconomic development index of the district.

C. Operational costs and other reimbursements	• Family physicians are paid a lump sum each month to cover equipment and operational expenses including rent (where needed), electricity, fuel, water, telephone, Internet, data processing, cleaning, office supplies, small repairs, secretarial and medical consumables. This lump sum payment is calculated as 50 percent of the maximum monthly base payment. • Depending on the category of the family medicine unit, family physicians are paid an additional lump sum payment that ranges from 10 percent of the maximum monthly base capitation payment for category D family medicine units to 50 percent of the maximum monthly base capitation payment for category A family medicine units. The purpose of this monthly lump sum payment is to ensure that family physicians have the additional resources needed to meet the mandated service delivery conditions.
D. Reimbursements for expenditures on laboratory tests and consumables	• The Core Resource Management System of the Ministry of Health is used to track budgets and expenditures of these items. • Family Medicine Information System includes an electronic health record for each person registered to the family physician, including diagnostic test results from laboratories to which patients are referred, and is used as an oversight for reimbursement of expenses to family medicine units.
E. Ambulatory health care service fees	• To meet mobile health care service expenditures, family physicians receive an additional lump sum payment of 1.6 percent of the maximum base capitation payment for every 100 persons who receive mobile services.

Source: World Bank 2013.

In public hospitals doctors are paid both by salary and through revolving funds based on their performance in the previous month based on specified individual and institutional criteria. There is no differentiation between medical specialties as performance is graded by medical procedures. A different coefficient based on the difficulty and time demand is assigned to medical procedures ranging from medical examination to operation and invasive diagnostic techniques. The coefficients differ for part-time practitioners, specialists and for some departments such as intensive care, dialysis, operating rooms, and emergency.

The range of provider payment types under the current health system are described in Table 5, below. They include: Case-based payments such as diagnostic related groups - CP; preference price system to subsidize medical goods and pharmaceuticals purchased by patients (RP); capitation for all services for an individual for a fixed period of time (CP); Performance-related pay (P4P); and fee for service (FFS). For public hospitals there is a performance based payment system for the personnel, which covers all categories workers including administrative personnel.

Table 5. Payment systems

Service type	Payment system	Utilization controls
Inpatient services[a]		
Birth delivery	CP	
Emergency services	CP	
Other Inpatient hospital services		
Hospital component (hotel services, nursing care, disposables, tests)	CP	
Physician service components	CP	
Pharmaceuticals	RP	
Diagnostic imaging	CP	
Adjustments (e.g. teaching, disp. share of poor, capital)		
Outpatient Services		
Public health services, such as immunizations	CAP, P4P	
Outpatient primary care contacts	CAP, P4P	
Outpatient specialist contacts	FFS	Copayment
Pharmaceuticals for outpatient services	RP	Copayment
Clinical laboratory tests for outpatient services	FFS	
Diagnostic imaging for outpatient services– basic (X rays and ultrasound)	FFS	
Diagnostic imaging for outpatient services—beyond X-rays and ultrasound (e.g. MRI, Cat Scan)	FFS	
Other services		
Eyeglasses	CP	Copayment
Dental care	CP	Copayment
Prosthetics and orthotics	CP	Copayment
Dialysis or Transplants	CP	
Home-care services	CP	

Source: Menon et al. 2013.
a. For public hospitals there is a performance based payment system, which covers all workers including administrative personnel.

CP: Case payment (e.g. DRG); RP: Preference price system to subsidize medical goods and pharmaceuticals purchased by patients; CAP: Capitation (all services for an individual for a fixed period of time); P4P: Performance-related pay; FFS: fee for service.

2. How equitable is coverage?

a. Solidarity and redistribution

Financial protection in Turkey is high, equitable, and continues to improve under the HTP. All population groups are covered under a single universal health insurance program and premium contributions differ based on income (see Table 2).

b. Targeting for priority population groups

Incentives to focus on maternal and child health (MCH) including immunizations, a key health sector priority under Millennium Development Goals (MDGs) 4 and 5, are introduced under the Family Medicine Program to service providers through the following performance levers:

- Up to 20 percent of base salary payments are "at risk" conditional on meeting MCH coverage targets.
- Provider contracts could potentially be terminated for repeated failure to meet MCH performance targets.
- The base capitation payment assigns higher weights to enrolling pregnant women and children to motivate providers to improve access to care among these categories of the population. Pregnant women have a payment coefficient of 3 while under-fives have a payment coefficient of 1.6. Both these payment coefficients are considerably higher than the coefficient of 0.79 for the general (non-prison) population. In effect this means that family medicine providers are paid more per pregnant woman and child under five, which incentivizes family medicine personnel to seek out pregnancies and register children under five, thus improving their access to care.

C. Human resources for health (HRH) policies

1. Current status of HRH

Inequitable geographic distribution of HRH in Turkey has been a longstanding issue, one recognized and addressed by the MOH through the HTP. As a result of various policy changes introduced by MOH (see below under "Labor market dynamics"), the personnel gap between the highest and lowest provinces fell between 2001 and 2011 as follows: for specialists from 1:14 to 1:2.7; for general practitioners from 1:9 to 1:2.3; and for nurses and midwives from 1:8 to 1:4.

But disparities remain: in 2011, Western Anatolia had 2.6 physicians per 1,000 population, against Southeastern Anatolia's 1.16 physicians (the lowest). The highest-ranking region for nurse and midwife density was the Eastern Black Sea, which had 1.84 times as high density as Southeastern Anatolia, the lowest ranking.

Table 6: Current status of HRH

		Entry	Exit

	Current number per 1,000 population	Qualifications	Government determines the number of new entrants	Number of entrants per year	Number of years of education	Number of newly licensed per year
Physicians	1.69 (2011)	Undergraduate Degree + Compulsory Medical Service	NO[a]	8,438 (2010-2011)	6 years	5,138 (2010-2011)
		Specialized Physicians: Successful in "Central Medical Specialization Examination" +Specialization Training		4,295 (in 2010-2011)	3-5 years	4,980 (in 2010-2011)
Nurses	1.67 (2011)	Undergraduate degree	NO[a]	7,734 (2010-2011)	4 years	4,358 (2010-2011)
		Vocational high school degree	YES[b]	10,296 (2011-2012)	4 years	8,874 (2010-2011)
Midwives	0.70 (2011)	Undergraduate degree	NO[b]	1,889	4 years	1,307 (2010-2011)
Community health workers[c]	N/A	N/A	N/A	N/A	N/A	N/A

Source: Ministry of Health 2011a.
a. Physician education and higher education of health professionals is regulated by the Higher Education Council, a fully autonomous supreme corporate public body responsible for the planning, coordination, governance, and supervision of higher education.
b. Vocational high school entrants are determined by the Ministry of National Education.
c. Community health worker is not an applicable category in Turkey.

In 2011, 58.2 percent of all physicians and 77 percent of all nurses and midwives worked in MOH facilities; 20.9 percent of all physicians and 10.3 percent of all nurses and midwives worked in universities; and 10.3 percent of all physicians and 12.7 percent of all nurses and midwives worked in the private sector (MOH 2011b). In 2011, there were 0.65 physicians per 1,000 population specialized in gynecology and obstetrics, 0.64 in internal diseases, 0.53 in anesthesiology, while only 0.03 physicians per 1,000 population specialized in medical oncology and 0.07 in thoracic surgery (MOH 2011b).

The number of faculties of medicine increased from 56 in 2008/09 to 69 in 2010/11, and the number of students who recently enrolled in faculties of medicine increased from 6,655 to 8,438

over the same period, which should greatly improve the density of physicians and nurses after 2015 (MOH 2011b).

The State Planning Organization, the Higher Education Council, the State Department of Personnel, and the MOH are responsible for HRH policies. Workforce planning is mainly the responsibility of the General Directorate of Health Services on behalf of the MOH.[2] The MOH is responsible for coordinating health care personnel education and employment in the public sector.

Medical specialization requires further education after the completion of the undergraduate degree and the central medical specialization examination.[3] Medical residency training is provided in MOH teaching hospitals. There is no health education accreditation institution. The Higher Education Council approves all new programs.

2. Labor market dynamics

The Family Medicine Program explicitly encourages doctors and health workers to serve in rural populations. When a family practitioner has registered patients in rural areas, he or she is also assigned health house midwives. In addition, periodic mobile outreach services are provided to those who live in rural areas. The monthly base payment of family medicine physicians is adjusted for the socioeconomic development of the area in which they practice (see Table 4). Family physicians working in underserved areas receive a "service credit" on a sliding scale, linked to the socioeconomic development index of the district (World Bank 2013). In the least advantaged areas, the service credit can be as high as 40 percent of the maximum base payment. Since the introduction of the Family Medicine Program, disparities in the distribution of health personnel across the country have declined.

Compulsory service for all public and private medical school graduates has also helped improve geographic distribution. Further, a Regulation on Appointment and Transfer has been introduced to ensure a more balanced distribution of health care personnel to all MOH health care facilities. According to this regulation, specialists, general practitioners, dentists, and pharmacists are appointed through a computer-based lottery, and other personnel are appointed based on the results of a national examination system.

Although there were variable practices for certified trainings conducted in professional fields of health by many other public and private institutions, primarily the MOH and universities, there was no regulatory framework before 2010. In 2010, the MOH introduced its Implementing Regulation on Certified Trainings in order to regulate the policies and procedures on certified training to be delivered by the MOH, the Turkish Armed Forces, universities, public agencies and organizations, private entities, and individuals. The MOH introduced the Distance Health Education System in 2006 to provide education to all health care personnel particularly managers, management trainees, and specialists and to ensure orientation training to family physicians to be assigned in primary health care and other health care personnel to be assigned in family medicine.

There are signs of improvement in workforce productivity over recent years. Consultations per physician per year—a crude measure of physicians' productivity—increased from 2,272 in 2002 to 3,176 in 2006 and to 4,850 in 2011. Several complementary reforms contributed to the increase in productivity including the introduction of performance-based payment, the activation

[2] Turkish Public Hospitals Institution and the General Directorate of Health Research also have responsibilities in this area.
[3] The duration of specialization training depends on the requirements of the specialty.

of dormant health centers, and the increase in the availability of examination rooms for each physician in health centers.

In 2004, a performance-based supplementary payment system was introduced in MOH hospitals to encourage job motivation and productivity among public sector health personnel. Health personnel receive a payment each month in addition to their regular salaries. The base salary is paid from the MOH line item budget under health personnel salaries. Bonus payment for a health worker is determined through a combination of individual and institutional performance criteria. Performance-based payments are paid from hospital earnings. Under this payment system, 93 percent of all specialist physicians preferred to work full time in the public sector in 2010, up from 11 percent in 2003 (MOH 2011b).

C. Sequencing of reforms

1. How and why were the relevant UHC reforms put into effect?

a. Historical sequence

In 2005, fragmentation in service delivery was reduced with hospitals under the Sosyal Sigortalar Kurumu for formal sector employees being transferred to the MOH hospital system. In the same year, the family medicine program was piloted in Duzce province. In 2006, fragmentation in financing was reduced with the three social insurance programs—Sosyal Sigortalar Kurumu, Bag Kur (social insurance for the self-employed), and the social insurance for retired civil servants (Emekli Sandigi)—integrated into the SSI (Law No. 5502). In 2008, the Social Security and Universal Health Insurance Law was adopted (Law No. 5510), which provided the legal basis for fully synchronized UHI.[4] In 2010, the Active Civil Servants program was transferred to the SSI and by 2010 the Family Medicine Program was rolled out nationwide. In 2012, the Green Card Program became a part of the SSI system. During the same period, significant efforts were made to harmonize the benefits packages of the various programs. (The Annex at the end of the document presents a timeline of health sector reform from 2003–12.)

b. Actors

The Justice and Development Party (AKP) came to power after national elections in 2002. The primary objectives of the health care sector were outlined in the AKP's Urgent Action Plan, announced in November 2002. The HTP was launched in 2003 and had support from the highest levels of government.

c. Economic context

Various governments in the past had made considerable efforts to restructure health service delivery and financing with limited success. In 2003, there was a unique opportunity when the new AKP government outlined its reform objectives under the HTP, which highlighted the need for a broad "transformation" in health care. This decade was also a period of high economic growth. This and priority to health in government policies helped support the move toward universal coverage.

[4] Law No. 5510 was accepted in 2006, though it took some time to be phased in.

PART II. Policy Priorities and Lessons

A. Current policy priorities, challenges, and opportunities

The HTP has achieved many of the goals of UHC. Several challenges remain, though, where the focus in the near future needs to be in the following four areas.

1. Sustainably cultivating the health workforce

The HTP achieved rapid expansion of the health workforce, with the introduction of contracting, new employment conditions, and outsourcing. The full-time work regulation gradually eliminated dual practice and expanded public sector capacity to benefit patients, but also increased the workload for health staff. There is a common perception of negligence and disregard among the health staff, who believe that they have been insufficiently included in the decision-making mechanisms during this restructuring process (Bump and Sparks 2013). Physicians working in training and research hospitals and family health centers underline the fact that they lack the required time and resources for improving themselves professionally within the existing system. As the pay-for-performance system does not include allowances for teaching or research, those interested in these activities felt personally punished (Bump and Sparks 2013).

Specialist physicians interviewed explained that due to MOH cost controls, they are not always able to procure the supplies they need to serve patients. Because the MOH scheduling system makes appointments that are 15 minutes in length, there is too little time to adequately diagnose problems or provide lifestyle guidance. The capacity to perform complex procedures at leading medical centers has been severely reduced and concerns were expressed with regards to the quality of care under the HTP because quality assurance rests on patient satisfaction, but patients are not well informed about what care is appropriate (Bump and Sparks 2013).

These concerns by health workers may have negative implications on the quality and availability medical staff (and thus the sustainability of reform) in the medium and long term. Investments and efforts are now needed to expand opportunities for professional development and research, so as to create a committed and well-trained health workforce.

2. Quality and safety

The next phase of UHC needs to focus on quality and safety in health care. While the performance-based supplementary payment system incentivizes health staff for competition, health staff report that it reduces quality and safety of health services as physicians focus on number of patients treated rather than quality of care. There is a common belief among health staff that significant revisions are needed in various components of that payment system. Health staff believes that this system, which could potentially contribute to their motivation and income if executed properly, has functioned in the opposite direction. It is key for this quality management process that the MOH uses its regulatory powers while the SSI uses its strategic purchasing power. Both organizations should establish clear quality parameters and undertake transparent benchmarking of health care providers across the country, whereby performance pay is not only linked to the number of patients cared for but other measures more appropriate for reflecting quality of care.

3. Adapting to the changing burden of disease

The Global Burden of Disease 2010 analysis suggests that the country faces an emerging burden of chronic illnesses, which in disability-adjusted life-year terms increased by more than

50 percent in 1990–2010 (Atun et al. 2013). An efficient health system is crucial to sustain UHC as Turkey goes through this epidemiological transition with a rising burden of chronic illnesses, disability, and risks of illnesses.

To manage future health risks, Turkey needs to strengthen its primary health care system further. Additional investments are needed to increase the number of family physicians and nurses, develop the skill set of staff, and improve the physical and technical resources within primary health care to establish a comprehensive system that provides high-quality services with well-functioning referral and counter-referral systems. In particular, it needs to expand access to community-based prevention and screening programs for cancer; chronic illnesses; and for physical, nutritional, and metabolic risk factors. To monitor emerging risks for noncommunicable diseases, it could also consider investment in population data systems.

4. Ensuring financial sustainability and containing costs

As a natural consequence of improved utilization of health care services, health care expenditures have also increased. Turkey spent an additional 1.4 percent of its GDP on health between 2003 and 2011, and the share of health care in GDP increased to 6.7 percent by the end of this period (Tatar et al. 2013). Turkey's per capita health care expenditures are still relatively low and its share of health expenditures in GDP is the lowest among OECD countries. This also indicates that the progress made above has been achieved with reasonable resources (Tatar et al. 2013).

Fiscal space is the main determinant of sustainability. Increasing THE may be tolerated as long as it can be sustained and supported by increasing government revenue and GDP.

5. Ensuring rational allocation of HRH

Challenges remain in transitioning from a focus on expanding the hospital sector in terms of capacity and production, to one focused on ensuring rational use of services and countering pressure to increase spending on hospital services (Docteur 2013). These reforms will entail:

- Establishing an effective referral system that reduces demand for services that can be met more efficiently in the primary care setting. This is dependent on growing the primary care service capacity and may also require changes in public understanding regarding appropriate site for provision primary care.
- Making needed further investment in primary care/prevention so as to improve public health while helping take pressure off of hospital sector, especially in the light of projections for large, looming increase in chronic diseases such as diabetes.
- Establishing measures to combat the problem of supplier-induced demand, to the extent there is evidence of this problem emerging.
- Conducting the necessary studies to ensure that the bundled payment levels are consistent with absolute and relative costs of providing the care for which payments are bundled and helping hospitals employ effective procurement models and rational decision making via central assessments.

Meeting these challenges will require development within the SSI to become an increasingly sophisticated purchaser of hospital services and increasing capacity within the MOH to adopt a public-health orientation in management of hospital service supply, planning and coordination. Furthermore, the SSI and MOH will need to develop improved coherence and competence in their respective roles. Finally, the MOH will need to prioritize the timely production of reliable

data on hospital (and health) expenditure and financing. Such data are essential for both retrospective assessment and prospective planning (Docteur 2013).

B. Lessons to be shared

Several lessons emerge from Turkey's experience of UHC. Though contextual and related to the political economy of reform, they may be useful for other middle-income countries that have embarked on steps to UHC.

1. Political stability and speed of reform

The AKP acted quickly on health reform to capitalize on the popular support it enjoyed following the 2002 elections. The political stability achieved by the government, which benefited from a majority in the Grand National Assembly, was an important factor that enabled the transformation (Atun et al. 2013). The MOH reduced the time needed to develop its policies by drawing largely from health reform plans that had been devised throughout the 1990s. Previously, various coalition governments had developed reform plans, but had been unable to gain the broad support required to adopt and implement them (Tatar et al. 2011).

2. Committed health transformation team

On taking office in 2003, Minister Akdağ and his reform team embraced them for their own use. This reform team was in place from 2003 to 2013, when he stepped down as minister of health (Atun et al. 2013). This team of trusted colleagues worked closely with the minister on all aspects of the design, adoption, and implementation of the reform. According to interviews with current and former senior officials involved with the process, the reform team drew on the technical expertise of those who had devised these reforms and in parallel developed a politically viable communications strategy to present and promote the HTP. A committed transformation team at the MOH, strong prime ministerial support for change, and the leadership and continuity of the minister of health and senior management provided the opportunity to execute laws that had been legislated by the Grand National Assembly (Bump and Sparks 2013).

3. Use of citizen satisfaction surveys

A key feature of the HTP was the emphasis placed on systematically gathering information about population perceptions of general living conditions and public services. Regular focus groups and annual household surveys undertaken by the Turkish Statistical Institute (Life Satisfaction Surveys) provided comprehensive intelligence to the government on citizen satisfaction with public services so that it could fine-tune its policies. Health services, the worst performing in 2003 of all public services surveyed regularly, were to improve substantially with the introduction of the HTP and UHC (Atun et al. 2013). Improved satisfaction levels increased the legitimacy of the HTP, providing a receptive context for change, and increased the standing of the MOH and its minister within the Cabinet of Ministers. In 2003–12, health transitioned from being a marginal ministry (as in the 1980s and 1990s, with ministerial changes almost annually) to a strong and assertive ministry, with annual budget increases (Atun et al. 2013).

4. Clear and well-communicated vision

The last decade's reforms in the hospital sector appear positive for increasing equitable access to higher-quality services. Keys to success included a clear and well-communicated vision for

the model pursued, a plan for strategically implementing the reforms in an appropriate sequence, and backup plans to surmount legal and administrative barriers (Docteur 2013).

5. Combination of comprehensive demand-side changes with supply-side transformation

Comprehensive health system changes on the demand side (expansion of health insurance for the poor and conditional cash transfers) and the supply side (human resources and service delivery) were instrumental in expanding insurance coverage and translating UHC to greater service access, especially for the most disadvantaged population groups. Although improved insurance coverage enhances access, benefits were more likely to be realized and were stronger in the presence of supply-side interventions (Atun et al. 2013).

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Annex: Timelines of Health Reform in Turkey, 2003-2012