

PROGRESS REPORT

Health Transformation Program in Turkey

January 2009



Prof. Dr. Recep AKDAĞ



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Foreword

We have put into effect one by one what we promised in our Government Program and Urgent Action Plan so far in order to provide effective, equitable, accessible and quality health services for our citizens. We have been implementing the Health Transformation Program and we continue our services in this field all along the line.

Keeping in mind that health services is one of the most important criteria making a country liveable, we have mobilized all of our sources to provide high quality, easily accessible and patient-friendly services for our people.

We, as the Government, have always cared about and given priority to the trust that our citizens have towards the State in this most vulnerable field for them, the health services, and to deliver the health services without making our citizens bothered and troubled. Thus we have wanted all our citizens to have a State which they are proud of when their children, spouses and parents are being treated, and a State where they experience its endless compassion.

As a result of the successful implementation of the Health Transformation Program in a serious, determined and careful manner, all our citizens are able to receive their medication and have access to health services without any discrimination, as equal and honourable citizens, from all the health institutions they wish. Our hospitals are more modernized and this modernization process is rapidly continuing.



While accomplishing all these, we have conceived the delivery of modern and qualified health services not as a grace but as our responsibility and our main duty. Because, we think that the basis of both politics and action is human. The “Let the man live so the state lives” philosophy is our maxim.

While working to ensure mothers to give birth to healthy babies and individuals to be assure of their parents’ health, we have bravely conducted new regulations which will please every member of the health staff in accordance with our existing means.

It is our most important objective to enhance our efforts in the field of health as well as other fields when building a healthy society. Because we know that our nation deserves the best of all services and we continue on our way by saying “human first”.

I would like to congratulate everyone involved in the efforts for the implementation of Health Transformation Program and present my gratitude on behalf of my nation.

Recep Tayyip ERDOĞAN
Prime Minister

Preface

As you know, we have accomplished a significant transformation within five and a half years through the Health Transformation Program. The main goal of this transformation is to make the Turkish health system compatible with the vision of 21st century and to provide our people with a high quality health service which they deserve.

As the 58th, 59th and the 60th Governments of the Republic, we set out our way believing that we have had the power to deliver the citizens a humanistic, equal and modern healthcare service.

We have strengthened this belief by elaborating all the efforts displayed in the field of health since the foundation of our Republic.

We have developed our unique Health Transformation Program, which is a Turkey Model particularly focusing on human, by analyzing and evaluating the health systems of several developed countries' health systems on site; and then combining them with our own inheritance. We have implemented all the components of this model with the power we gain from our nation, the instructions of our Prime Minister, the determination of our Governments and the support of Turkish Grand National Assembly.

Today we experience the contributions and the most important outcomes of this program to healthy life. We strongly believe that we will also accomplish better results in the future.

At the end of this productive process, when we take a look at the past, the accomplishments of our government can be perceived clearly. We, of course, do not find it enough but we believe we have further work to do and services to offer.



As the Ministry of Health of the 60th government, which has been established after 22 July Election, we have expanded the Health Transformation Program and included 3 new topics in the light of the experiences within these five years and the successful steps we have taken so far:

1. Health promotion for a better future and healthy life programs,
2. Multi-dimensional health accountability for mobilizing the parties and inter-sectoral collaboration,
3. Cross-border health services which will increase the country's power in the international arena.

We have completed the strategic plan covering the period of 2009-2012 for the Ministry of Health.

In the framework of these developments, the responsibility for identifying current status and conveying our vision to all stakeholders have enabled us to share this book with you.

On this occasion, we would like to thank everyone, -physicians, nurses, midwives, technicians, officers, drivers, etc. the entire health community- for their devoted efforts, during night and day, for the noble goal of health for our people who all have embraced the essence of the Health Transformation Program.

Yesterday was not like this, tomorrow will be better...

Prof. Dr. Recep Akdağ
Minister of Health

Introduction

Improvement in health services, studies addressing the regulation of the health infrastructure and organization bring forth important changes in health policies.

It will not be realistic to allege that health policies are not influenced by the global trends. Though the World Health Organization introduces a number of priorities in the field of health systems, the Organization also suggests that each country should establish a system in accordance with its own conditions.

During the history of the Republic, the health policies experienced some fundamental changes. Some of the important milestones are Refik Saydam era (1923), Behçet Uz era (1946) and the introduction of socialization in health services practice (1963). Health Transformation Program constitutes the last ring of these milestones.

The 9th Development Plan, which was prepared in accordance with the aims of Health Transformation Program in 2006, anticipates facilitating access to health services, improving the service quality, strengthening the planning and supervising role of the Ministry of Health, developing health information systems, providing the rational use of drugs and supplies and, establishing a universal health insurance system.

Being implemented in this scope, Health Transformation Program is the supplementary part of the national policy. By realization of this programme, health services are gaining a dynamic base which will meet the rapidly changing and transforming health priorities.

With this study, we present the examples of the progress achieved so far through the implementation of the Health Transformation Program, which is a unique model to Turkey, by taking into consideration the contemporary health policies. You can also find in this book, “The Progress So Far: Turkey Health Transformation Program”, the success stories in an updated form and with new additions. Our aim is to continue our process with the feedback we will get from all the related parties and stakeholders in Health.

CHAPTER 1



Our Health Policies

from the Past to the Present

Our Health Policies from the Past to the Present

Along with the continuity of the Seljuk – Ottoman medical tradition, a cultural unity stands out when the organization of the health services are considered. While this structure was being developed since the foundation of our young Republic, a western oriented path was mostly followed for the organization of the state including all of its institutions and the establishment of service policies. Within this process, health policies could not remain independent of global trends, and demonstrated basic preference changes.

Health Policies between the Years 1920-1923

The Ministry of Health of Turkey was established by the Law No: 3 and dated 3 May 1920. The first Minister of Health was Dr. Adnan Adıvar. During this period the focus was mostly on recovering the damages of the war and developing legislations but could not allow a regular health recording system.

Health Policies between the Years 1923-1946

During his office, starting from the foundation of the Republic to the year 1937, Dr. Refik Saydam made significant contributions to the establishment and development of the health services in Turkey. According to the records, health services were provided by the government, municipality and quarantine centres, small sanitary stations, 86 inpatient treatment institutions, 6.437 hospital beds, 554 physicians, 69 pharmacists, 4 nurses, 560 health officers and 196 midwives in Turkey in 1923.

In this period the following Laws, which are still in effect, were adopted:

- Law No: 1219 on the Practice of Medicine and its Branches (1928)
- Law No: 1593 on General Hygiene (1930)

Health policies of the Refik Saydam Era can be defined with these four principles:

1. Central execution of the planning, programming and administration of the health services by sole authority,
2. Separation of preventive medicine and curative services by deploying their implementation to respectively central administration and local administration.
3. In order to meet health manpower demand, improving the attraction of Medical Schools, establishing dormitories for medical school students, establishing compulsory duty for graduates,
4. Introduction of control programs for communicable diseases such as malaria, syphilis, trachoma, tuberculosis and leprosy.

In the light of these principles;

- The health services were conducted with “single purpose service in a wide area/vertical organization” model
- “Preventive medicine” concept was developed through legal regulations, the local administrations were promoted to open hospitals, and Government’s local public doctors were assigned in every districts.
- Diagnosis and treatment centres have been established in district centres beginning from the places with high population (150 district centres in 1924 and in 20 district centres in 1936), physicians were prohibited to work independently.
- As a guide for the cities, Ankara, Diyarbakır, Erzurum, Sivas Numune Hospitals were opened in 1924; Haydarpaşa Hospital was opened in 1936; Trabzon Hospital was opened in 1946 and Adana Numune Hospital was opened in 1970.

Health Policies between the Years 1946 - 1960

The “First Ten-Year National Health Plan”, which we can call the first health plan in the history of the Republic, was approved by the Higher Council of Health in 1946. This plan was announced by the Minister of Health Behçet Uz on 12 December 1946. However, before the adoption of this Plan, which had been prepared through a hard-working process, Behçet Uz had to quit his office as the Minister of Health.

When Dr. Behçet Uz was re-appointed as the Minister of Health in the Government of Hasan Saka (10 August 1947-10 June 1948), the National Health

Plan, which had become a draft law in one and a half years, was negotiated and approved by the Council of Ministers and the four commissions of the Grand National Assembly, however it could not be adopted as a law due to the change in the government. The predecessor Minister of Health Dr. Kemali Bayazit withdrew the plan.

Although National Health Plan and the National Health Program could not have been turned into a legal text or implemented entirely, majority of their notions deeply influenced the health structuring of our country.

The inpatient treatment institutions, which were basically under the supervision of the local governments until that day, were started to be managed from the centre.

National Health Plan, in the framework of the principle of bringing health organization to villages and villagers, envisaged the establishment of a ten-bed health centre serving for each 40 villages and, to provide the curative medicine and the preventive healthcare services together. Efforts were made to assign two physicians, one health officer, one midwife and one visiting nurse to those centres along with village midwives and village health officers who would be assigned to serve for a group of ten villages.

In 1945, there were 8 health centres, which were increased to 22 in 1950 and to 181 in 1955 and to 283 in 1960.

Under the Ministry of Health, the Division Directorate of Mother and Child Health was established in 1952. A Mother and Child Health Development Centre was established in Ankara in 1953 by providing cooperation and assistance from international organizations such as UNICEF and World Health Organization.

High infant mortality incidence and mortality due to infections in that period led to elaborate the implementation of policies addressing the promotion of population growth. In this framework, significant progress was achieved in terms of health facilities and human health resources aiming health centres, maternal hospitals and infectious diseases.

Average life expectancy at birth was 43.6 years in 1950-1955, 52.1 years in 1960-1965, 57.9 years in 1970-1975.

As a continuation of the first Ten Year National Health Plan, “National Health Program and Studies on Health Bank” was announced by Dr. Behçet Uz on 8 December 1954 and, it has become one of the foundation stones for the health

planning and the organization for our country.

The National Health Plan categorized the country into seven health regions, and hence envisaged establishing a faculty of medicine in each region and increasing the number of physicians and other health staff (Ankara, Balıkesir, Erzurum, Diyarbakır, İzmir, Samsun, Seyhan). The National Health Program foresaw a structure composing of 16 health regions and the planning was completed accordingly (Ankara, Antalya, Bursa, Diyarbakır, Elazığ, Erzurum, Eskişehir, İstanbul, İzmir, Konya, Sakarya, Samsun, Seyhan, Sivas, Trabzon, Van).

In order to establish human resources infrastructure, Ege University Faculty of Medicine was opened for student admissions in 1955 after İstanbul and Ankara Universities Faculties of Medicine. When the years 1950 and 1960 are compared, it can be seen that the number of physicians increased from 3.020 to 8.214, nurses from 721 to 1658, midwives from 1.285 to 3.219. More than a 100 % increase was ensured for all 3 occupations.

The numbers of hospitals and health centres were increased and within the same framework the increase in the number of beds was also ensured. Among the special service fields, the increase in the numbers of paediatric hospitals, maternal hospitals and tuberculosis services was quite promising.

Even though these numbers are affected by the devolution of management power from the local administration to the central administration, when we take into consideration the number of hospital beds per a hundred thousand people, its rate increased to 16,6 in 1960 from 9 in 1950.

Along with these positive developments in health institutions and hospital beds, there were very promising improvements in the health indicators.

Tuberculosis related mortality had a significant decrease in this period. There were also similar promising outcomes in infant mortality rate.

While the tuberculosis-related mortality rate in city and districts in Turkey in 1946 was 150 per a hundred thousand, it decreased to 52 per a hundred thousand in 1960.

Infant mortality rate was 233 per thousand in 1950 and then decreased to 176 per thousand, in 1960.

Both the National Health Plan and the National Health Program had aims such as

insuring the citizens in return for a fee, meeting the costs of the uninsured people and the people who could not afford for treatment from a special administrative budget, establishing a health bank and financing the health expenditure from this bank, auditing the production of medical materials including medicine, serum and vaccine and establishing industrial institutions which would provide child food like milk or infant formula.

In this framework, Biological Control Laboratory was established in 1947 under the Refik Saydam Hygiene Centre Presidency and a vaccine station entered into service. From that year onwards, intradermal BCG vaccine has been produced. The production of pertussis vaccine was started in 1948.

Again in the same framework, Workers' Insurances Administration (then SSK Social Insurance Institution) was established (1946). Starting from 1952, health institutions and hospitals were opened for the insured workers.

In this period, the legislation was also formed which carry the legal infrastructures of the non-governmental organizations and some medical occupations to present day:

Law on the Turkish Medical Association (1953/6023)

Law on Pharmacists and Pharmacies (1953/6197)

Law on Nursing (1954/6283)

Law on Turkish Association of Pharmacists (1956/6643)

Health Policies between the Years 1960-1980

The Law No 224 on the Socialization of the Health Services was adopted in 1961. The socialization actually had begun in 1963 and became widespread in the country in 1983. A structure was established as health posts, health centres, and province and district hospitals through a widespread, continuous, integrated, and gradual approach.

Law No: 554 on Population Planning was adopted in 1965. Thereby, anti-natalist policy (population control) was adopted instead of pro-natalist (population rising) policy.

“Multi dimensional service in narrow area” approach was adopted as an alternative to the “single dimensional service in wide area”.

Although a draft law on General Health Insurance had been prepared in 1967,

it could not be forwarded to the Council of Ministers. In the 2nd Five Year Development Plan in 1969, the initiation of the General Health Insurance was foreseen again. Draft Law on General Health Insurance had been conveyed to the Turkish Grand National Assembly in 1971 but it was not adopted. In 1974, the draft which was presented to the Turkish Grand National Assembly was not negotiated.

In 1978, the Law on the Principles of Health Personnel's Full Time Working was adopted. Physicians working for public sector were prohibited to open private practices. Then this Law was repealed with the Law on Amends and Working Principles of the Health Personnel in 1980 and public doctors were permitted to open private practices again.

Health Policies between the Years 1980 – 2002

The 1982 Constitution ensures citizens to have social security rights and the State to assume the implementation of this right. According to the 60th Article of the Constitution, everyone has the right to social security and the State shall take the necessary actions and establish the necessary organization to provide this security. Additionally according to the 56th Article of the Constitution “To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the State shall regulate central planning and functioning of the health services. The State shall fulfil this task by utilizing from and supervising the healthcare and social institutions, in both the public and private sectors”. Besides, the article includes the provision “General Health Insurance may be introduced by law.”

“Basic Law on Health Services” was adopted in 1987. However because the necessary regulation for the execution of this Law was not concluded and some of its articles were repealed by the Constitutional Court, the Law was not put into effect in full.

In 1990 the State Planning Organization (SPO) prepared a basic plan on the health sector. This “Master Plan Study on Health Sector” which was conducted by the Ministry of Health and the State Planning Organization is the beginning of the health reforms in a way.

The first and the second National Conferences on Health were held and the theoretical studies on health reform gained acceleration. Green card

implementation has been introduced in 1992 with the Law No. 3816 for the low income citizens who are not covered by social security scheme. Thus people with low income who do not have adequate economic means to access to health services were ensured to be covered by the health insurance scheme even limitedly.

“The National Health Policy” which was prepared by the Ministry of Health in 1993 included 5 main chapters such as support, environmental health, lifestyle, delivery of health services, and goals for a healthy Turkey.

Universal Health Insurance was presented to the Turkish Grand National Assembly by the Council of Ministers under the name “the Law on Personal Health Insurance System and the Establishment and Operation of the Health Insurance Institution” in 1998 but it was not adopted as a law. A Draft Law on the “Health Fund” was presented for the opinion of the ministries however it was not concluded either.

The main components of the Health Reform activities which were conducted in 1990's were:

1. Establishment of a Universal Health Insurance by gathering the social security institutions under one umbrella,
2. Development of the primary health services in the framework of family medicine,
3. Transformation of the hospitals into autonomous health facilities,
4. Providing a structure to the Ministry of Health which plans and supervises the health services prioritizing preventive health services.

Consequently, this was a period in which important theoretical studies were conducted but not implemented sufficiently.

Health Policies after 2003: Health Transformation Program in Turkey

Right after the elections on 3 November 2002, the basic objectives to be conducted under “Health for All” title were determined in the Urgent Action Plan which was declared on 16 November 2002. The key objectives are:

1. Administrative and functional restructuring of the Ministry of Health,
2. Covering all the citizens by the universal health insurance,
3. Gathering the health institutions under one umbrella,
4. Providing the hospitals with an autonomous structure administratively and financially,
5. Introduction of the family medicine implementation,
6. Giving special importance to mother and child healthcare,
7. Generalizing the preventive medicine,
8. Promoting the private sector to make investment in the field of health,
9. Devolution of authority to lower administrative levels in all public institutions.
10. Eliminating the lack of health personnel in the areas which have priority in development,
11. Implementation of the e-transformation in the field of health.

As soon as the determination of the Urgent Action Plan, the Health Transformation Program was prepared and announced to the public opinion by the Ministry of Health. The Health Transformation Program aims transformation in the framework of 8 themes:

1. Ministry of Health as the planner and supervisor,
2. Universal health insurance gathering everyone under single umbrella,
3. Widespread, easily accessible and friendly health service system,
 - a. Strengthened primary healthcare services and family medicine,
 - b. Effective and staged referral chain,
 - c. Health facilities having administrative and financial autonomy,
4. Health manpower equipped with knowledge and skills, and working with high motivation,
5. Education and science institutions to support the system,
6. Quality and accreditation for qualified and effective health services,
7. Institutional structuring in the rational management of medicine and supplies,
8. Access to effective information at decision making process: Health information system.

The period between the years 2003-2007 has witnessed significant changes. The program which was prepared and announced in the early 2003 was inspired by our former experiences particularly in socialization period, the health reform studies of the recent years and the successful examples in the world.

Each step taken in the field of health from the foundation of our Republic until today has been evaluated. The project studies conducted under the Ministry of Health has been examined and the positive legacy of the past has been embraced.

Within the last few years in which the Health Transformation Program has been implemented, health policy changes were frequently discussed by the public, and the process of the implementations is noticed clearly by not only the service providers but also service users.

The scope of social security and Universal Health Insurance are the main issues today, not the unreleased patients who could not afford to pay, just like the demand for adequate number and quality of intensive care beds rather than emergency patient's transportation problem.

Instead of low numbers in vaccination rates, addition of new vaccines in the calendar has come up in the agenda.

While health personnel used to suffer because of their low income, now they are in a position following up their continuous income.

From the private sector to the public sector, from the poorest to the richest, the determined steps taken in the field of health have taken their places in the lives of our citizens. Shortly, the Health Transformation Program is beyond being a program; it is the name of action.

After the establishment of the 60th Government, 3 new topics are added into the Health Transformation Program in the light of our experiences within the 5 years and the successful steps we have taken:

1. Health promotion for a better future and healthy life programs,
2. Multi-dimensional health responsibility for mobilizing the parties and inter-sectoral collaboration,
3. Cross-border health services which will increase the country's power in the international arena.

Program continues with the objectives of the second five-year period.

CHAPTER 2



Ethical, Political and Methodological

Principles of the Health Transformation Program

Ethical, Political and Methodological Principles of the Health Transformation Program

Health Transformation Program has been prepared as an improvable and sustainable program which confronts to the socio-economic realities of our country and follows global improvements. The Program is built up on ethical concept aiming equal access to health services for the citizens as individuals with equal rights. During the political methodological preparations of the program, a gradual and sustainable policy cycle enabling well-functioning of health policies was envisaged. Accordingly, first the problems are identified and the conditions leading to these are analyzed. Then policies are developed in order to solve the problems, political decisions are taken with the aim of implementing this policy and these decisions are implemented. Finally, the outcomes of this policy executed within the established ethical framework are evaluated. The transformation process can be described through the cycle below.

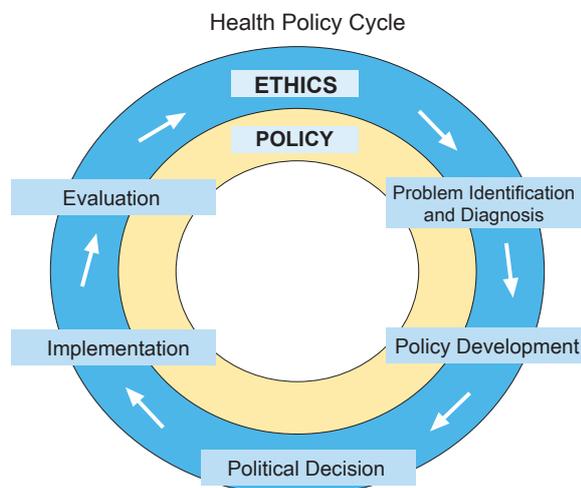


Table: 1 - Modified from the study by M. Roberts et al (2008)

The process is continued by solving the existing, looming or emerging problems through the same methodology by remaining within the framework of the program. The decisions are taken within the framework of the fundamental ethical approaches all through the process.

1. Problem Identification and diagnosis

The concept of health is related with almost every moment of individuals' lives. It heads the list of the factors which affect the social welfare. Within this framework, existence of health problems is inevitable in any country and at any time.

Therefore, embracing an approach which prioritizes the problems which should not exist at the present development level can be a more beneficiary and efficient approach. Identification of problems within this scope defining the performance objectives and identifying the current situation of the health system is a realistic and sustainable ways in order to improve strong policies.

In order to draw the picture of the current situation objectively, some specific criteria are applied. Primary healthcare indicators are the leading of the aforementioned criteria. Additionally, financial risk protection and citizen satisfaction are important in terms of the comprehensiveness of the health system.

a) Basic indicators

Major basic healthcare indicators to reflect the current health care system are as follows:

- Infant mortality rate,
- Maternal mortality rate,
- Average life expectancy,
- Prevalence of infectious diseases,
- Prevalence of vaccine preventable diseases.
- Prevalence of chronic diseases,
- The amount of the out of pocket expenditures for health care,
- Utilization rate of the primary health care services.

b) Protecting Citizens against Financial Risks

This issue is the primary target of the policies of the health sector and the most important focus point of the health reform policies. Through such a protection,

which ensures citizens to receive treatment without any financial constraints is meant. There should be security systems in place which will not make people poorer or affect their daily lives by putting financial burdens on them and their relatives. These security systems may be constructed under different models. Such protection is largely affected by the financing method of the sector.

The scope of the protection against risks may be defined taking into consideration the objectives such as provision of services regardless of financial means of individuals and compensation of faulty practices against financial losses.

c) Citizen Satisfaction

This issue is related with the satisfaction level of citizens from the services provided by the health sector. It is a common perception that the effectiveness or the quality of health care services can not be demonstrated solely. However, it is not possible for a system which is not citizen-oriented and can not meet the needs of people to achieve successful results. Adoption of services by citizens will enable their participation in the process and help obtain results much faster. Therefore, policies are developed by adopting satisfaction among main criteria and by taking into account how citizens evaluate the health systems offered to them.

The waiting periods, the complexity level of hospital operations and procedures, the time period allocated per patient and information mechanisms in the health institutions are taken into consideration during these evaluations.

2. Policy Development

It follows identification of problems in health and development of policies to overcome these problems within the content of the program. Though policies may vary, they are also universal as it aims to overcome the problems and to reach to the targets identified. Within this universality framework, each society improves its own policies in accordance with its own conditions. During policy development processes within the Health Transformation Program, accessibility, quality and efficiency are taken into account as priority criteria.

The scope of the responsibility while improving reform plans is both analytic and politic. The process of policy making should be designed as technically strong and politically adoptable. Hence, the principles provided below should be taken into consideration while improving policies under the Health Transformation Program:

- The principle of “Health for All” should always be prioritized.
- International experiences are elaborated and successful examples are harmonized with our own conditions.
- Ideological approaches or practices which can reflect individuals’ or groups’ interests should be handled prudently.
- The political, economic and cultural realities of our country are always taken into account.
- Possible implementation problems (sources, potentials and administrative law, etc) are elaborated.

3. Political Decisions

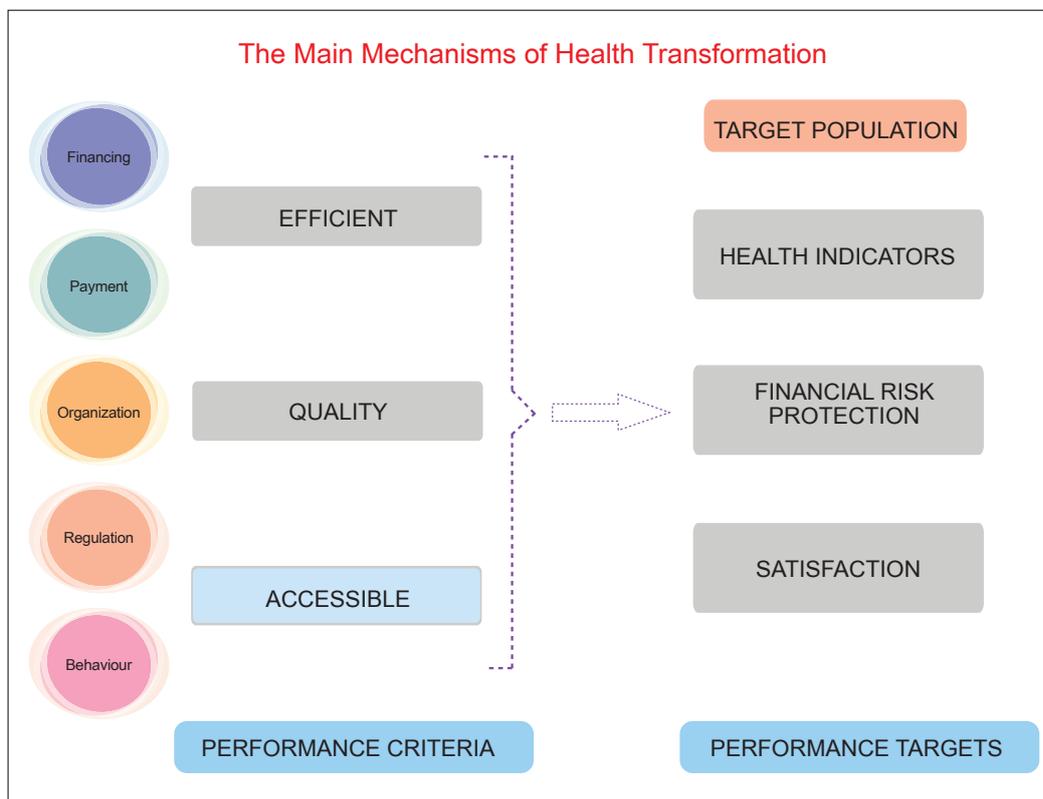
Acceptance of transformation in the health sector is not only related with the political will but also is a problem of establishment of an effective policy strategy. Whether a reform will be adopted or not is related with the willingness, interest and capability of the parties and the political strategy used. The political stand of the authority behind the implementation facilitates the adoption of the transformation by the implementing bodies and the ones affected by the transformation. Especially the support of the government heads along with the determination of the ministers are of great significance. Under the Health Transformation Program, the contribution of the Mr Prime Minister has played a significant role in implementing many radical changes and accomplishing them.

4. Implementation

As in all reform processes, effective monitoring and observation of transformation are required, too. Thus the problems likely to emerge during process may be identified and corrective measures can be taken. In this respect, the key to a successful implementation is an appropriate supervision and reporting system.

Provision of effective and accessible health care services which are in good quality are among the major inputs of the system. The aim is to reach the outputs indicating to the success of the system. These outputs, in other words the performance indicators, are primarily targeted health indicators, a comprehensive financial protection and citizen satisfaction.

In order to direct the outputs of the health system, some mediums, which can be regarded as “control mechanisms,” may be used. Through such mechanisms, it is possible to affect the performance of the system and the expenditures. There are such other factors which may alter the standards of the system non-voluntarily except for the control mechanisms (for example, wars, natural disasters, epidemics, etc) whose inevitable results can be changed through realizing a few modifications in a positive way. Nevertheless, sometimes two or more control mechanisms should be handled at the same time. The aforementioned control mechanisms include health services financing, the method of payment for services, the organizational structure of the health sector, regulations and the behaviours of the actors involved in the sector.



Source: M. Robert et al, 2008.

Table:2

a) Financing

It is the way to provide financial sources for the system. The main principles are to distribute the burden in a fair and equitable way, to render that it is politically and socially acceptable and, it compromises to the economical conditions of the country.

FINANCING

- Financing consists of general incomes (taxes), social insurance, private insurance, out of pocket payment and public financing.
- In many countries there is a mixed system.
- The amount of the money which a country can allocate is related with its economical conditions.

If adequate sources can not be provided services should be limited.

b) Payment

It is the issue of paying for the services provided and ensuring the sustainability of the services.

Every payment system has its logic, scale and rate. The payment method we may use is related with the service provision system. Payment methods are mostly conflicting, the payers want to pay less and the service providers want to receive more. There is no perfect payment system and, every payment system has negative and positive incentives. The important issue is to know what kinds of problems are likely to cope with when a specific payment model is chosen.

- Payments can done for health institutions per service, per hospitalization day, per patient admission and per capita through allocation from the general budget.
- Health personnel may receive payments in various methods like salary, salary + incentive premium, payment per capita + incentive premium for each service they provide.

c) Organization

Organization means the regulation of the organizations providing services and their functions at the macro level. At the micro level, it means the internal construction of the organizations. The legislative regulations, inspections, incentives and employment policies directly affect this organization method.

EVERY PAYMENT METHOD HAS SPECIFIC HANDICAPS:

- In Austria, where payments were made per hospitalization day, patients were hospitalized for longer periods than they should have been.
- When the payments are made per patient admission, patients are hospitalized for shorter periods and more patients are admitted.
- When physicians are paid fee for service, the amount of service they provide increases. They have been observed to be working inefficiently when they receive mere salaries.

d) Regulation

Regulation is established through the exercise of power by the competent health authority, i.e. the government in order to form the behaviours of the actors in the health sector. The purpose of the regulation is to construct the health sector, to secure service receivers and to correct the defects in the health sector. The most important requirement in regulation is timely-arrived, accurate and sufficient data. Therefore, regulating bodies require well-designed information systems.

REGULATION PROCESS

- As actors of the sector tend not to change, they will try to resist, put back-door constraints and handle the process.
- The best way is to reach an understanding on objectives and rules.
- If the harmonization level is high, negligence and violation will be low. If persons are not persuaded, forcing may not result in the desired change.
- Technical competency, sufficient sources and political support are vital factors

e) Behaviour

The behaviour of the service users are also of great significance – even more- as well as of the service providers. In preventing the communicable diseases and combating with chronic diseases, the behaviours and attitudes of citizens are essential elements. Provision of services (access, quality, prices) is dependant on the functioning of the system. However, demand for the services (senses, attitudes,

expectations and beliefs) is directly dependant on individuals and patients. All of these together direct the behaviour of the patient.

Changing people's behaviours is a challenging process. They believe that what is asked from them to be done should comply with their own beliefs and values. Persuasion is not only a matter of knowledge. Additionally communication instruments should be used to affect behaviour.

5. Evaluation

Evaluation of a new program can not be postponed until the program concerned is completely implemented. Before implementation, baseline data should be collected and administrative systems to carry out evaluation should be established.

The easiest evaluation approach is the "before and after" comparison. Evaluations should be evidence based and data should be collected accordingly. The data collected should be standardized beforehand and should be sufficient. Unnecessary and irregular data result in information pollution. Data collection method and the variety of the data should be plain so as not to disturb sustainability. The data acquired should be certainly evaluated and used in the rest of the policy.

CHAPTER 3



A New Era in Health



A New Era in Health

1. Mentality Change towards a Human-Centred Service Understanding

Our needs in the field of health cannot be delayed. In our country unfortunately this fact was neglected for years. We set our way leaving institutional concerns and priorities with placing human at the core of the services.

We placed “human first” approach at the centre of the Health Transformation Program. We are aware that the health services are not the mercy of the State but the delivery of people’s rights.

We left the days behind that the patients were pledged or refused by the emergency services and the times when fees were charged for ambulance services. We are experiencing a period in which we can provide “112 Emergency” service not only in the cities but also in the villages; a period that we can provide service to our citizens in their own homes by the ambulatory services in rural areas and a period that we can provide service for the patients who need dialysis through driving them from home.

We eliminated all of the difficulties preventing our citizens from accessing health services. Now, our people can consult to any health facility whichever they wish; they can get their medicine from any pharmacies whichever they prefer without being returned empty handed because of the lack of medicine and they do not wait for hours in the queues.

We have set our way with the conception that places human in the centre of service, leaving aside all institutional concerns and priorities.

Currently, family medicine practice that we initiated in Düzce three years ago is being executed in 31 provinces. Nineteen million citizens are benefiting from this implementation and are able to choose their own doctors.

We follow the pregnant women and the infants delicately. We have significant accomplishments in terms of health personnel attendance in deliveries, starting to use the most developed vaccines and full and complete vaccination programs.

We have established one of the greatest medical rescue teams in Europe with 2.526 specially trained health personnel ready to act in emergencies in 81 provinces.

When compared to past days, a significant decrease in the number of the communicable diseases such as malaria, typhoid fever and measles is recorded.

Today, every hospital in our country includes a “Patient Rights” unit. We can choose our own doctors in the majority of our hospitals. Our hospitals are well equipped in terms of medical devices and equipments. We have provided 20.000 new hospital beds. In the new hospital projects, we place bathrooms and toilets in the patient rooms and we place one or two beds in each room. We have increased the bed capacity of intensive care by 7.5 times.

We have taken very important steps regarding the improvement of our altruistic health personnel’s income level and working environment. However we do not consider these accomplishments sufficient; we will increasingly continue our efforts.

We have the consciousness that the health service is a right for the citizens, not a grace of the government.

We have eliminated imbalances vastly by giving priority to regions lacking building, equipment and health personnel althrough the country, from the north to the south, from the east to the west. We have employed more than 110.000 new health personnel in public sector.

A New Era in Health

2. Widespread and Equal Health Insurance: Universal Health Insurance

Health Transformation Program aims at developing a social insurance model which will enable the citizens to contribute in proportion with their abilities to pay and receive health services they need in the framework of equity principle.

Efforts were made in order to provide the harmonization between the existing social security institutions until the legal and institutional infrastructure of the universal health insurance is formed. Reimbursement commission was established by the 2004 Drug Price Decree including the representatives from the Social Insurance Institution, Social Security Fund for the Self-Employed (BAĞ-KUR), Pension's Fund, Ministry of Finance, Ministry of Health, State Planning Organization and the Treasury. Thus, different reimbursement mechanisms conducted by different social security institutions were abolished and a joint model and strategy is ensured.

Regulations covering the delivery form and pricing of the health services being provided by university hospitals and state hospitals for the citizens with the participation of the Ministry of Health, the Ministry of Finance and Ministry of Labour and Social Security were completed. Service denominations determining medical services were reviewed and, new and detailed lists were prepared by the help of international service names code systems. Consequently, important steps were taken in the registration of health services, establishment of a joint database for all of the institutions and standardization of the service invoices.

Radical changes have been completed for providing unity between service provision models and target groups of healthcare service providers. The citizens covered under the public insurance are provided with the opportunity to access service from the private health institutions, too. Thus, the service presentation forms of the public and private hospitals have been harmonized. On the other side, the discrimination between state hospitals and Social Insurance Institution hospitals has been eradicated and thus unity is provided between public hospitals' operation models.

By using a joint drug data base by all security institutions, an infrastructure ensuring central drug follow-up and control based on same standards is enabled.

Similarly, based on a single system, joint databases were developed for the controlling of progress and services. The coverage of the green card implementation available for citizens with low income widened and ensured to be more realistic and effective. Thus, the citizens with low income are assured under a health insurance scheme which is not different from the Social Insurance Institution, Social Security Fund for the Self-Employed and the Pension's Fund.

The harmonization activities carried out by the health service providers and the social security agencies that will pay for this service, have set the important steps which prepared the environment for the universal health insurance.

The first step of the social security reform was taken with the Law No: 5502 and all the security institutions were restructured and gathered under one umbrella by the Social Security Institution. With the Law No: 5510, it was aimed to eradicate the inequalities in access to and financing of health services through defining the rights and responsibilities, besides covering all the population by the social security. Again with the same law, the authority to define the additional fee which the service providers can get from the patients was given to the Council of Ministers. This difference, which used to have no limitations and was determined completely by the health service provider, was decided by the Council of Ministers to be 30%. From now on the citizens will know how much will be demanded from them as an additional fee when they admit to a private health service provider within the scope of the universal health insurance while they are getting any service. In addition, another novelty introduced by this law is that during serious health threats and in sudden emerging disease conditions, the private healthcare providers shall not demand any additional fee from the patients. In this way the

concern for payment is eliminated in the relation between the patients and the health institutions. The law also defines a ceiling for fees for health services to be delivered by the academicians.

Meanwhile, the Communiqué on Health Implementation issued by the Social Security Institution has started a new era that enables citizens to access health services equally and easily. This has equalized the citizens, who were under the coverage of different social security schemes in the healthcare delivery process.

Additionally, beginning from January 2007, no payment has been required from the citizens for primary healthcare services even though they do not have social security.

In addition with the Prime Ministry's Circular dated 26 June 2008; it is ensured that the all patients requiring emergency medical intervention are brought to a proper health institution and the required emergency intervention is performed with priority and without any preliminary condition in that health institution. It has become obligatory that transfer and referral procedures of all patients are done under the coordination of the 112 command and control centre regardless of private and public difference, and thus the harms which are caused by the transfer of a patient from one institution to another is prevented. In the cases requiring emergency medical intervention; the patients who do not have social security or who cannot afford to pay are not asked for a payment; the service costs are demanded from the social assistance and solidarity foundations/municipalities where the health institution is; for the patient who have social security, the private hospitals cannot ask for a difference fee and thus, the citizens are protected from being aggrieved within the system. Through enactment of Law No: 5510 on 1 October 2008, the final ring of the activities in this field is completed.

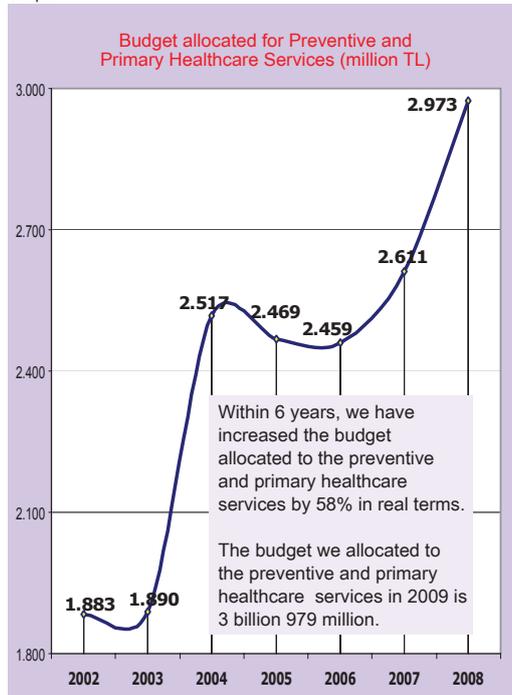
A New Era in Health

3. Mobilization for Preventive and Primary Healthcare Services

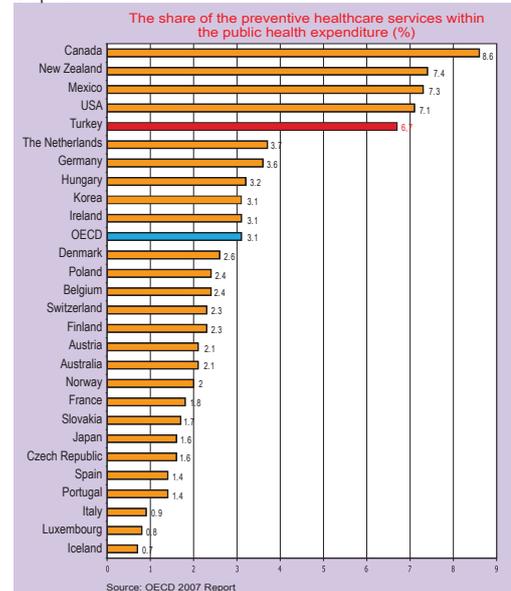
Health Transformation Program aims at providing a structure for the primary healthcare services' institutional position so as to have the authority and control over other service levels. The main focus of this transformation is to improve the conditions of the individuals in general and patients and health staff in particular. The program is based on the primary healthcare services in relation with the service delivery. A large number of activities and projects have been handled with this approach; a multi dimensional campaign was conducted. The current operations were not neglected because widespread improvement studies were carried out. The most outstanding feature of the Health Transformation Program is that it keeps the existing heritage and improves it as significantly as it can during the transformation.

This period witnessed a mobilization in preventive and primary healthcare services. To this end, the budget of the aforementioned services reached to 3 billion 979 million TL in 2009 from 1 billion 883 million TL in 2002.

Graph: 1



Graph: 2



According to OECD 2007 data, Turkey used 6,7% of the public health expenditure in 2005 for preventive healthcare services and ranked in the 5th place among the OECD countries which allocated the biggest share for the preventive healthcare services.

a) A New Approach and New Tasks for Health Centres

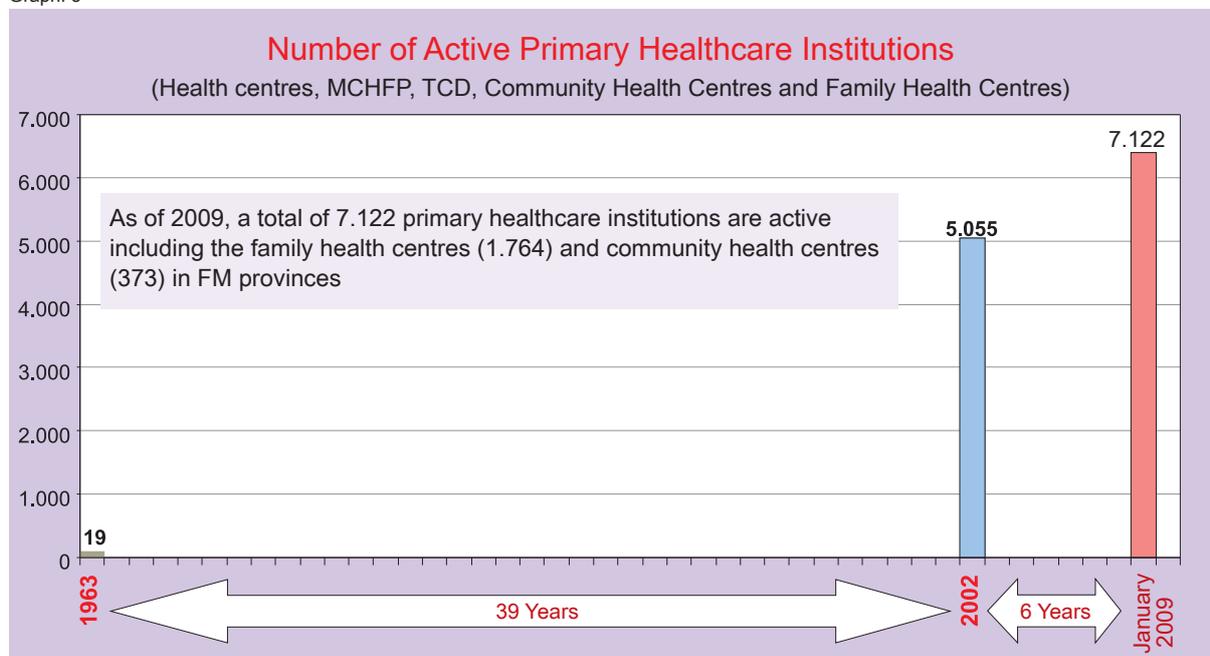
Health Transformation Program strengthened the health centre network which was provided by the socialization policy, and mobilized the local administrations’ as well as the Ministry’s resources for physical renovation of health centres. “An examination room for each physician” principle was turned into a campaign. The one-to-one communication between the public and physicians has been promoted and simplified. Furthermore, primary healthcare institutions strengthened with revolving fund and the diagnosis equipments have been expanded. The personnel have been provided with supplementary payment based on performance which has become an economic and personal motivation source.

The primary healthcare services have been restructured with the integration of Family Health Centres and the Community Health Centres into the system.

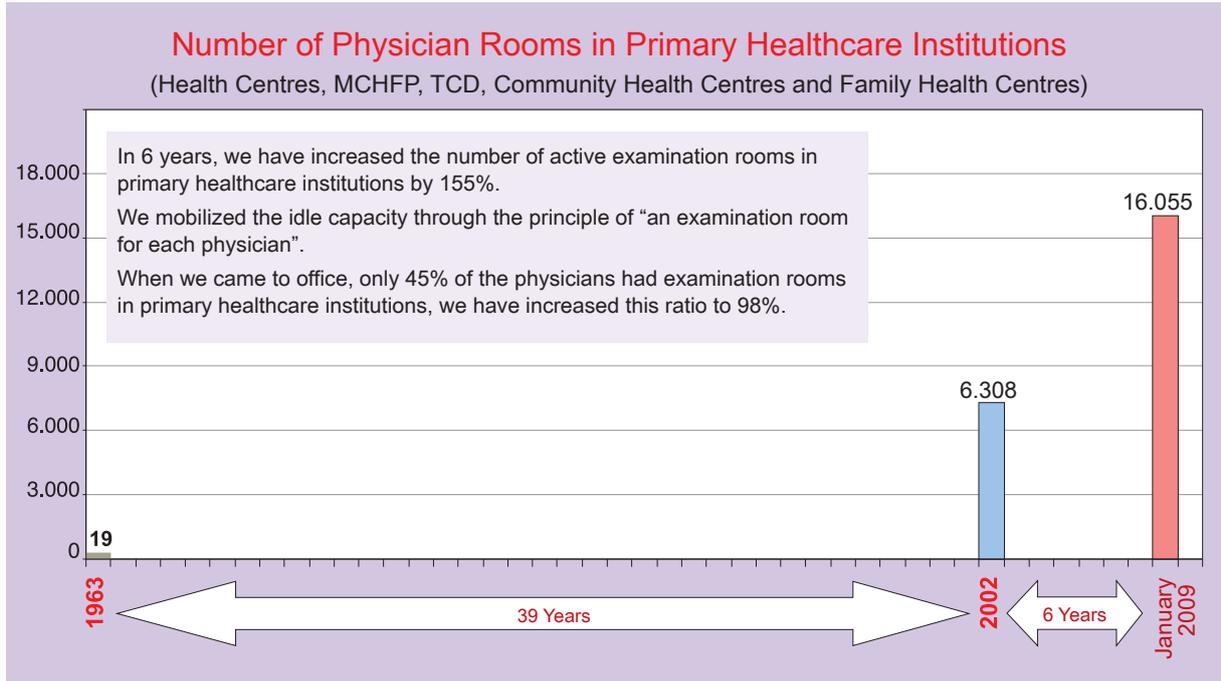
As of January 2009, 7.122 primary healthcare services are actively continuing service provision (with physicians).

At the moment, the ratio of the Primary Healthcare Institutions which has a building but not a physician is only 2%, and the premises serving as Family Medicine (FM) centres now in the provinces where FM is introduced will be assessed as Family Health Centres.

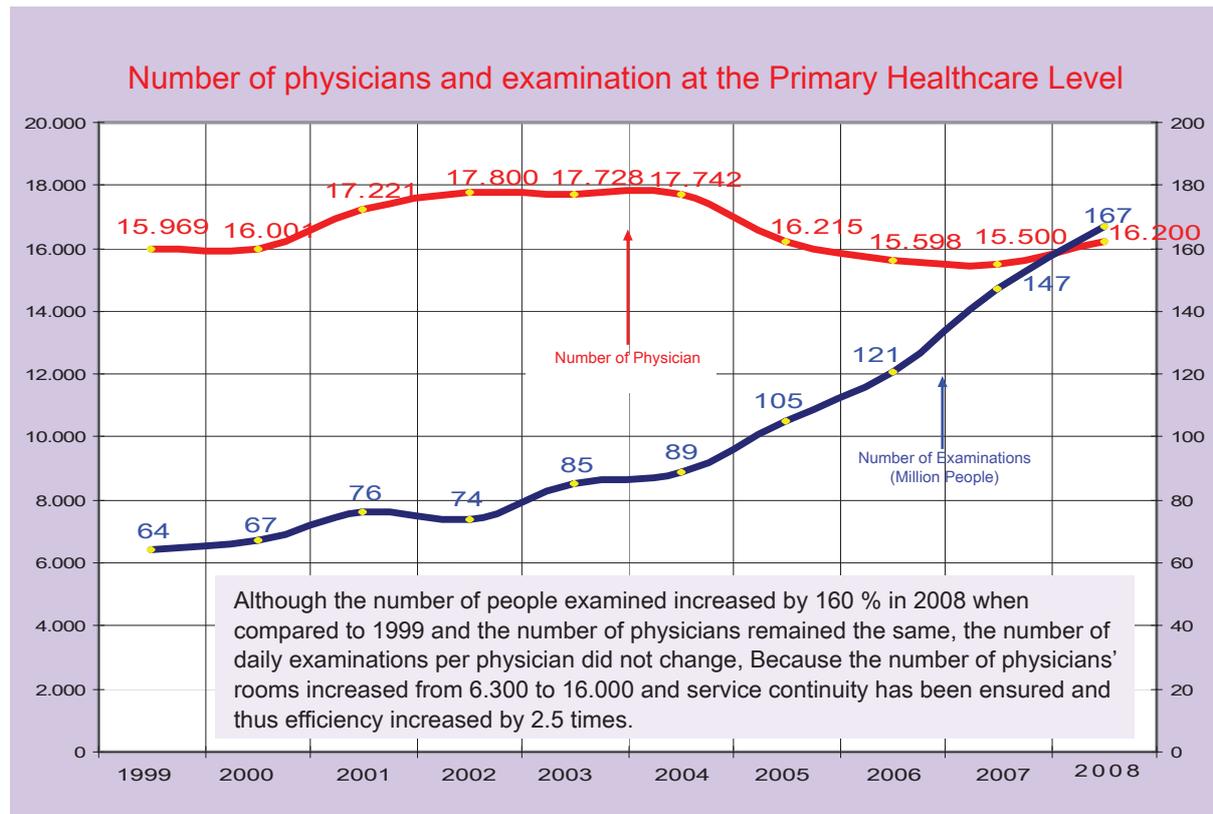
Graph: 3



Graph: 4



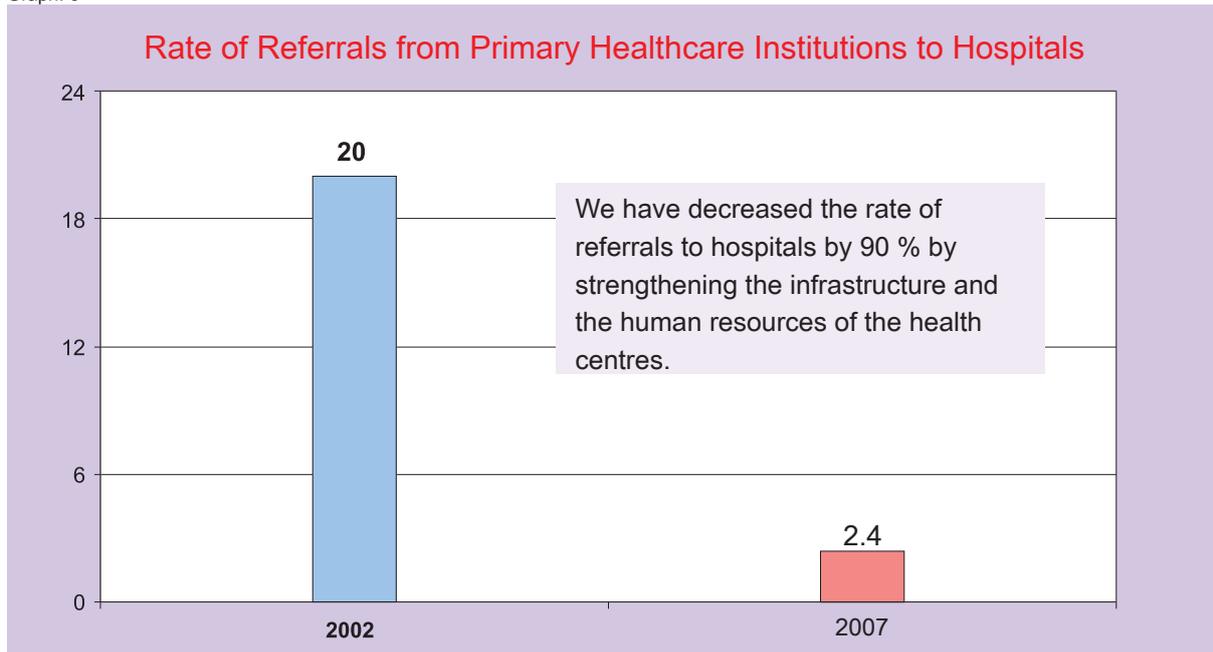
Graph: 5



Note: The calculations use the aggregate data from health centre, MCHFP, Community Health Centres, TCD, SII dispensaries, SII health stations and Family Medicine.

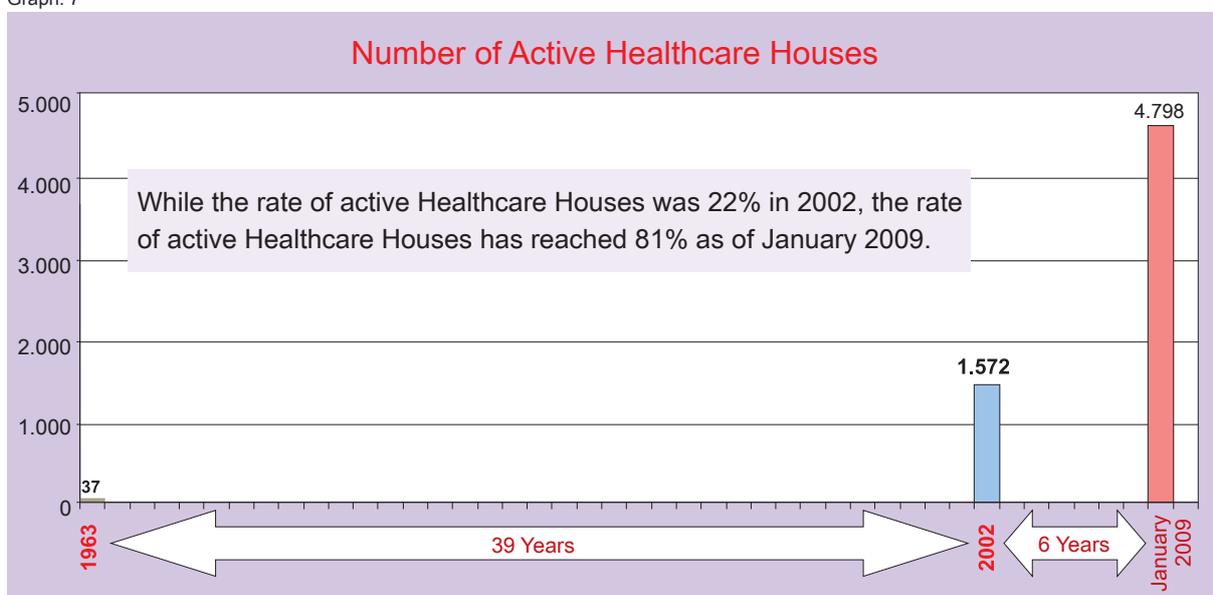
The majority of problems in primary healthcare have been solved by increasing interest and equipped attention. Also resource savings are achieved since the upper levels are not occupied unnecessarily.

Graph: 6

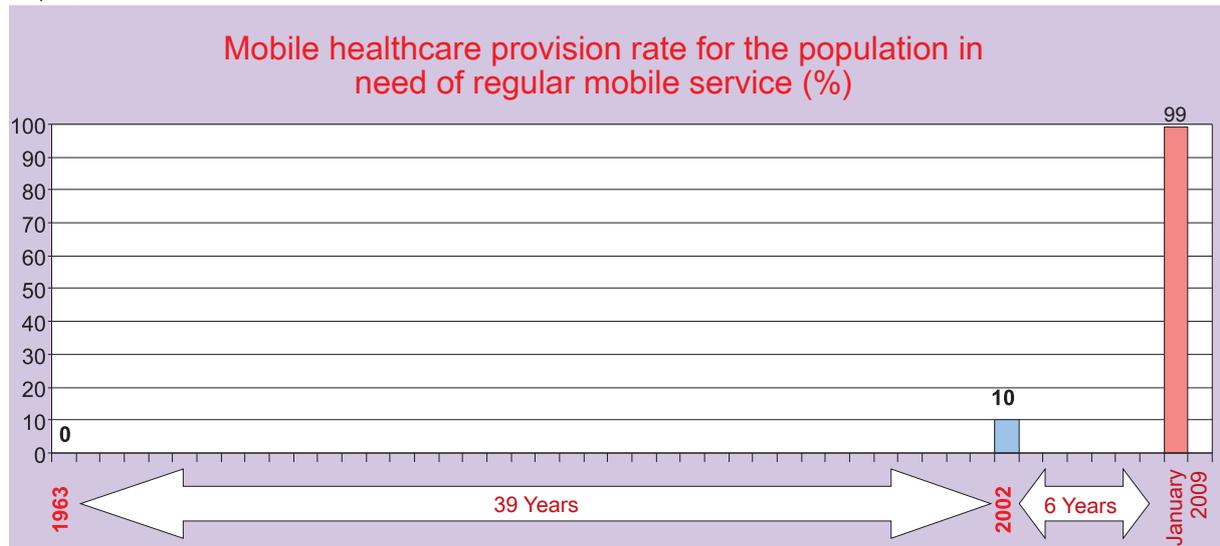


While there were 1.572 active healthcare houses in 2002, this number reached to 4.798 as of January 2009. This increase has enhanced the quality and quantity of the healthcare services in the rural areas in a great deal. Our final target in terms of active healthcare houses is (with midwives) 5.950.

Graph: 7



Graph: 8



We developed the implementation of mobile healthcare services in order to reach the remotest places in the rural areas.

Health personnel we employ in certain centres provide periodic village visits on pre-announced dates, primarily for the follow-ups of infants, pregnant and chronic disease patients.

The rate of bringing healthcare service to the population in need of regular mobile healthcare services increased from 10% to 99%.

b) Emergency Healthcare Services Accelerated

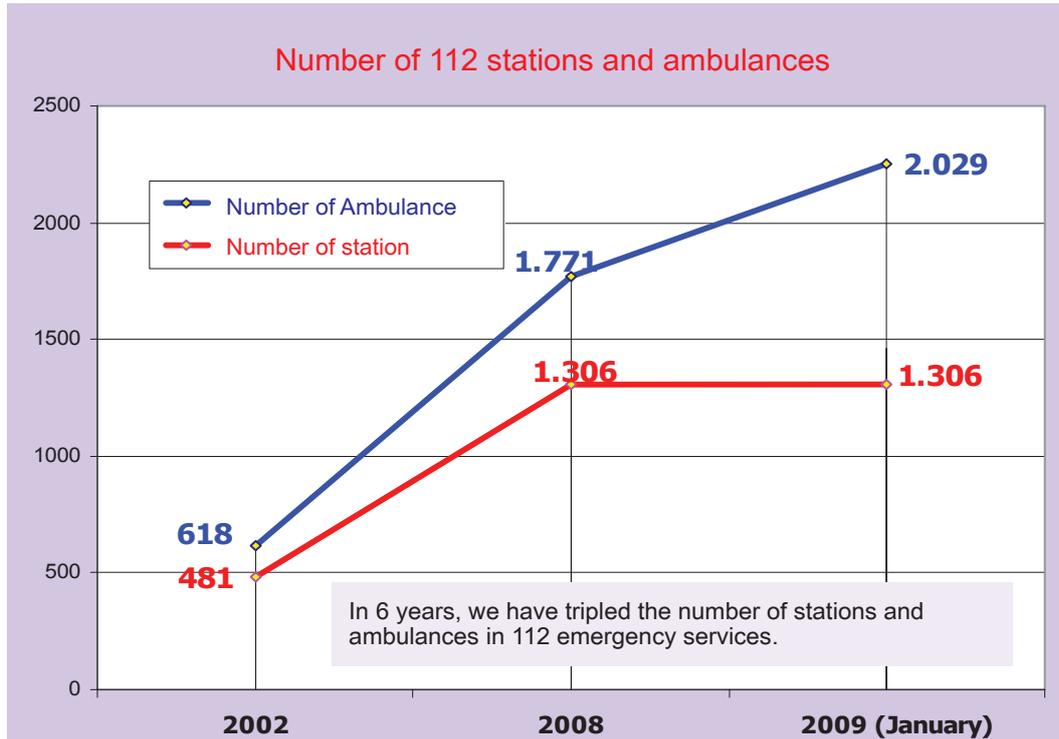
Emergency healthcare service is an important public health matter. In cases of emergency diseases and injuries, it is very important to reach the place of incident, to perform the first intervention there and to provide the transportation to a health institution when necessary. In the 10th anniversary of the establishment of 112 Emergency Services, we have established Command Control Centres in all the provinces all over the country.

In the last 5 years, our capacity to transport emergency patients has been

improved three times. 90% of the cases are reached in the first ten minutes now. The number of the fully equipped ambulances was 618 in 2003. This number is 2.029 today. The number of health stations has been increased to 1.306 today while it used to be 481 in 2003. The target is achieved on this matter.

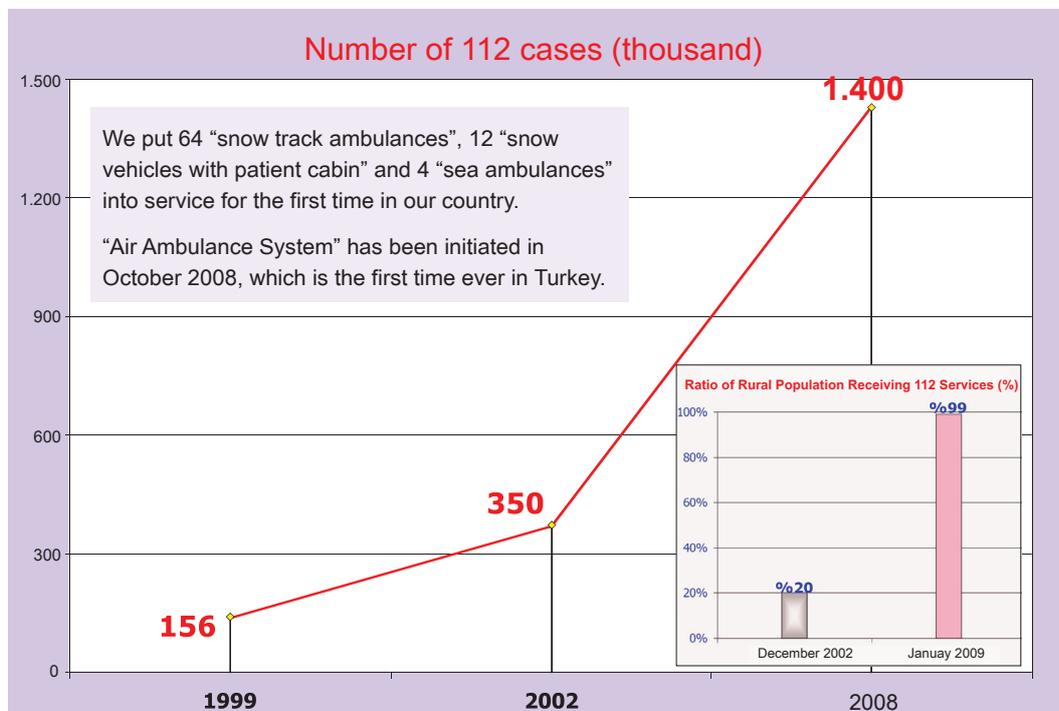
First stop on the road to health: 112 Health Station

Graph: 9



In 2002, the number of people benefited from the 112 emergency services was 350 thousand. This number reached to 1 million 235 thousand in 2007. It is estimated to reach 1 million 400 thousand as of 2008 which is 4 times higher than in 2002. The rate of benefiting from emergency services was 20% for the citizens in rural areas. This rate has been raised to 99% today.

Graph: 10



Long waiting durations and rejection due to insurance or payment process ended in terms of emergency applications in all the health institutions. Payment for ambulance services is not required from citizens without social security.

c) Healthcare Organization in Disasters and National Medical Rescue Teams (UMKE)

The implementation of the Healthcare Organization in Disasters Project was launched for possible disasters, primarily for earthquakes. Adequately trained and equipped personnel have been deployed in order to ensure medical services within the possible shortest time and by the safest patient transportation at the time of disasters. The fact that 95% of Turkey is located on the earthquake line shows the importance of specializing and being well prepared.

Basic and complementary training was provided for 2.526 health personnel from the National Medical Rescue Teams (UMKE) within the scope of the project under the control of the Ministry. The scope of the training program is given below:

- * Triage,
- * Stress Management,
- * Alternative Splints,
- * Overview of Disasters,
- * Stretcher Placement and Transportation,
- * Contact and Communication
- * Basic and Advanced Life Support,
- * Prevention from the NBC Attacks,
- * Strategic Team and Conflict Management,
- * Psychological Support and Intervention to Shock,
- * International Signs and Signalling system,
- * Fixation, Identification, Packaging of the Patient/Injured,
- * Terms of Reference of the Medical Team and Legal Dimensions,
- * Disaster Psychology,
- * Wreckage Study,
- * Crush Syndrome,
- * Disaster Epidemiology

Being well qualified to attend operations abroad, these teams showed extraordinary performances during rescue operations in Iran and Pakistan earthquakes and tsunami disaster in Indonesia.

THE BIGGEST MEDICAL RESCUE TEAM IN EUROPE

We have established the “Department of Healthcare Organization in Disasters” in 2004 with a view to keeping the mortality and the number of the injuries at the possible lowest level by providing medical rescue services in the shortest time by adequately equipped and trained voluntary teams during possible disasters (primarily earthquakes), as well as providing the safest and fastest patient transportation and the emergency treatment units, services and the required professional administration organization.

Withine 4 years, we provided basic training for 2.526 personnel performing duty on a voluntary basis in the National Medical Rescue Teams that are established in 81 provinces.

Medical rescue teams continue their field exercises are always ready for duty, besides their basic, theoretical and station training programs.

Deserving rightously all the pride of our country, here below are the examples of various national and international activities in which the National Medical Rescue Teams participated.

International

Earthquake in Iran, Bam
 Earthquake in Pakistan
 Sudan Humanitarian Aid Organization
 Flood and Landslide in Afghanistan
 Earthquake in Indonesia
 Tsunami in Indonesia

National

Konya Zumrut Apartment Building Collapse
 Explosion in Diyarbakır Military Housing
 Bursa Intam Building Collapse
 Two Building Collapses in Istanbul
 Konya Taşkent Balcılar Building Collapse

d) Social Movement and Creating Awareness for Chronic Diseases

“Turkish Cardiovascular Diseases Prevention and Control Program” was initiated with the aim of improving the cooperation between primary and secondary health institutions, providing strengthening of the system on disease prevention, early diagnosis, proper treatment and regular follow-up of the patients as well as improving life quality by reducing mortality and morbidity.

In line with WHO's warning regarding the rapid increase in the chronic diseases and that it will be the main work load on the health systems in the future, our Ministry revised the institutional structure of its units for chronic diseases. Two new departments have been established related to work on the chronic diseases and health promotion.

All relevant agencies and institutions in our country participated in the GARD- The Global Alliance against Chronic Respiratory Diseases-which is established under the leadership of WHO for combat against chronic respiratory diseases. The 3rd Plenary Council of the GARD was held in Istanbul on 30-31 May, 2008. "GARD Turkey Action Plan ", which was presented in this meeting as a draft, is the first action plan prepared in the world on this issue.

Obesity, with an increasing prevalence throughout the world, is a clinical disease. If the obesity epidemic continues with this rate, it is expected to become an obstacle in front of the health, economic and social development of the countries in the near future. WHO European Ministerial Conference on Counteracting Obesity was held on 15-17 November 2006 in order to draw attention to this situation, to give the necessary priority to the issue and to develop international and inter-sectoral collaboration, with our country as the host and "European Charter on Counteracting Obesity" was adopted during this meeting. This document was signed by Prof. Dr. Recep Akdağ, Minister of Health, on behalf of the European Ministers. "Turkey's Obesity Action Plan" was prepared in line with the European Charter on Counteracting Obesity.

Smoking is an important public health problem in our country. Our country ranks in the 3rd place in Europe and in the 7th place in the world in terms of tobacco consumption, and the addiction rate is calculated to be around 50 % among adult males. Tobacco consumption is the major reason for many diseases particularly the cancer. Our country signed the "Tobacco Control Framework Agreement" prepared by WHO in 2004, and the "National Tobacco Control Program", which was prepared in line with this program, was declared by our Prime Minister in December 2007. In accordance with the program, new regulations were introduced for the use of cigarette and tobacco products with the amendments made in the Law no.4207 Regarding the Prevention and Control of Tobacco Product's Harms. There has been a great support to the measures which implementation started in May 19, 2008 and includes the prevention of passive smoking.

There are two other important programs: Turkey's programme for Health Health and Turkey's Program for Mental Health. Mental Health Program was completed in 2008 while Health Health Program is continuing at the moment. Significant steps have been taken in setting the Turkish Diabetes Policy, progress has been achieved with the participation of the scientists and NGOs working in this field.

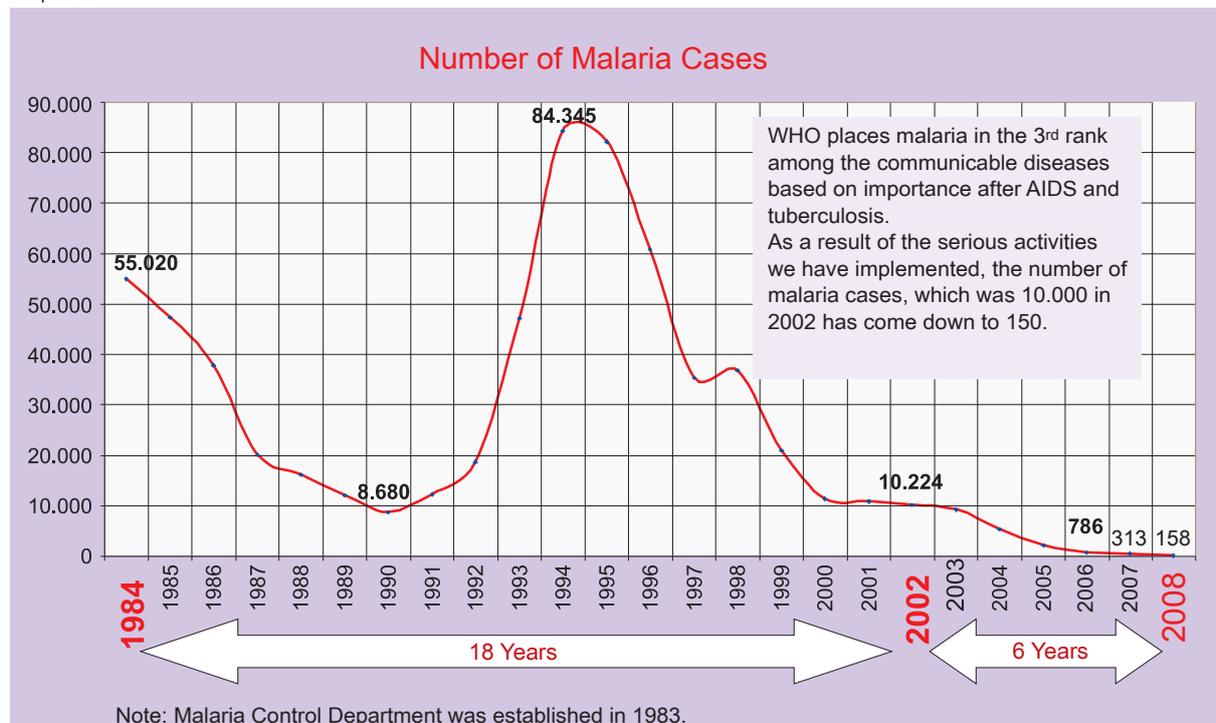
National Advisory Board on Cancer was established with the aim of policy and strategy development in the planning of Turkey's cancer control program. Turkey's Program for Cancer is in developing process. "Cancer Screening and Training Centres" were opened in 55 provinces in the last five years. Citizens with no ability to pay can benefit from services at these centres free of charge.

e) Effective Combat against Communicable Diseases

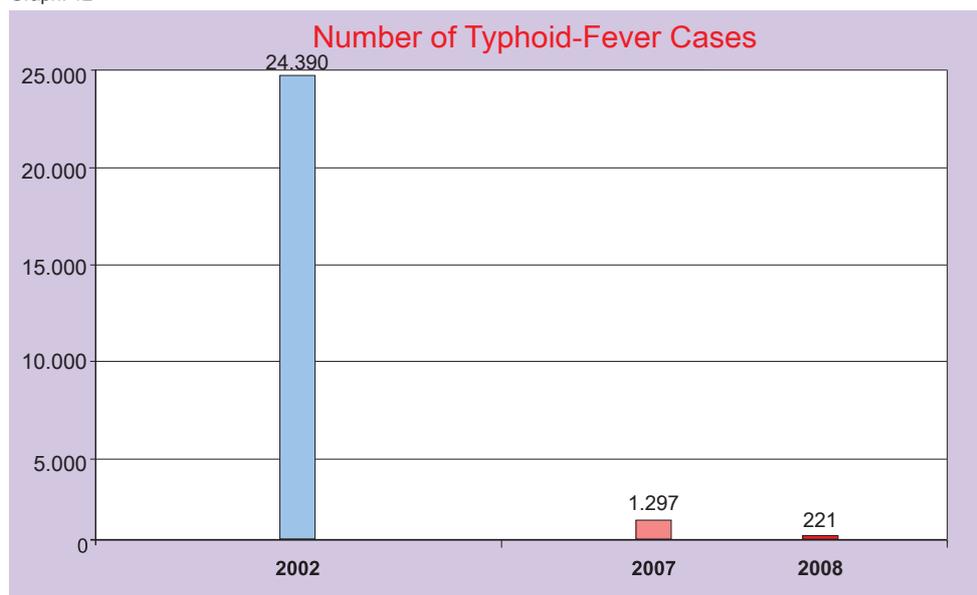
The intensive studies that the Ministry has been conducting regarding the communicable diseases have given significant outcomes. A great achievement has been obtained in the field of malaria control. The number of malaria cases was over 10.000 in 2002. In 2008, number of malaria cases was dropped to 158.

The number of typhoid-fever cases which was 24.390 in 2002 in the country, decreased to 221 in 2008.

Graph : 11



Graph: 12



We have started to take typhoid-fever, which is an important public health issue in our country, under control by closely collaborating with the municipalities. As a result of the serious activities we have implemented, the number typhoid cases has decreased by 1/100 when compared to 2002 figures.

New Solutions for the Old Problem:

TO FORGET ABOUT MALARIA SO AS NOT TO REMEMBER

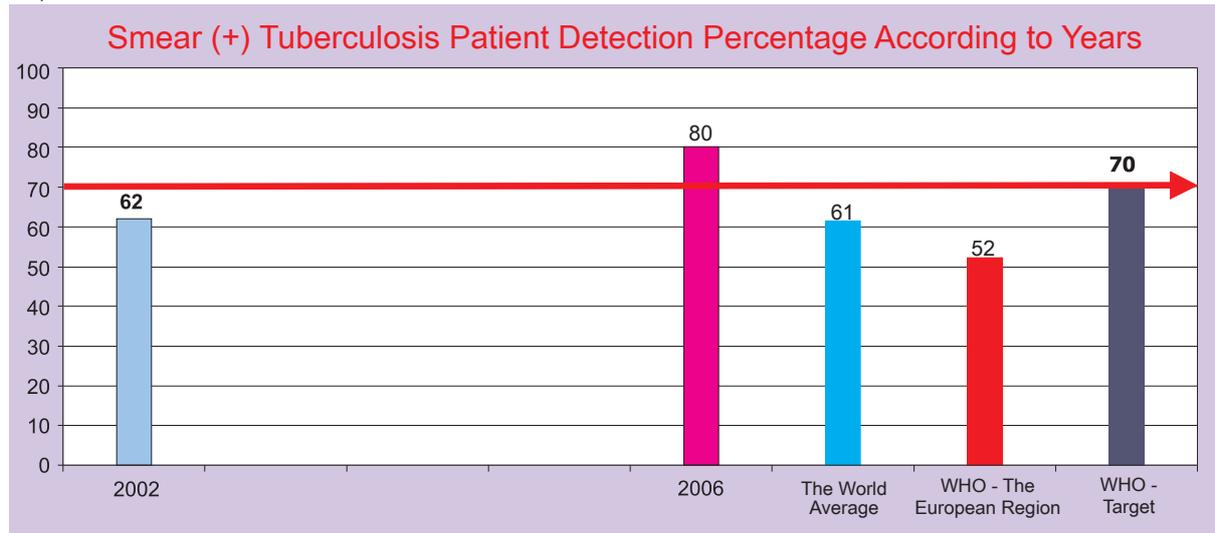
The World Health Organization considers Malaria as the third important communicable disease after AIDS and tuberculosis. We have taken brave and rational steps to eradicate malaria disease within the framework of the WHO strategies and the policies of the Ministry.

SUCCESS STORY

Insecticide groups, which were used for years for the purpose of vector control, have been changed and more effective drugs have been provided. In malaria intensive regions, working programs were prepared for vector control and the control of these programs was conducted regularly. Coordination is provided in malaria-intensive provinces. Joint studies and information exchange have been developed. Surveillance studies were carried out in order to detect malaria cases. Establishment of the mobile teams was considered important with the aim of strengthening surveillance and treatment services. One-to-one treatment of the patients with malaria diagnosis was performed. Temporary workers were assigned during the malaria season from the areas with no malaria or a low disease prevalence. Collaborative work has been realized with municipalities and related public institutions.

The number of malaria cases was 10.224 in 2002. With our effective fight against the disease, the number of malaria cases decreased to 158 by the end of 2008.

Graph: 13



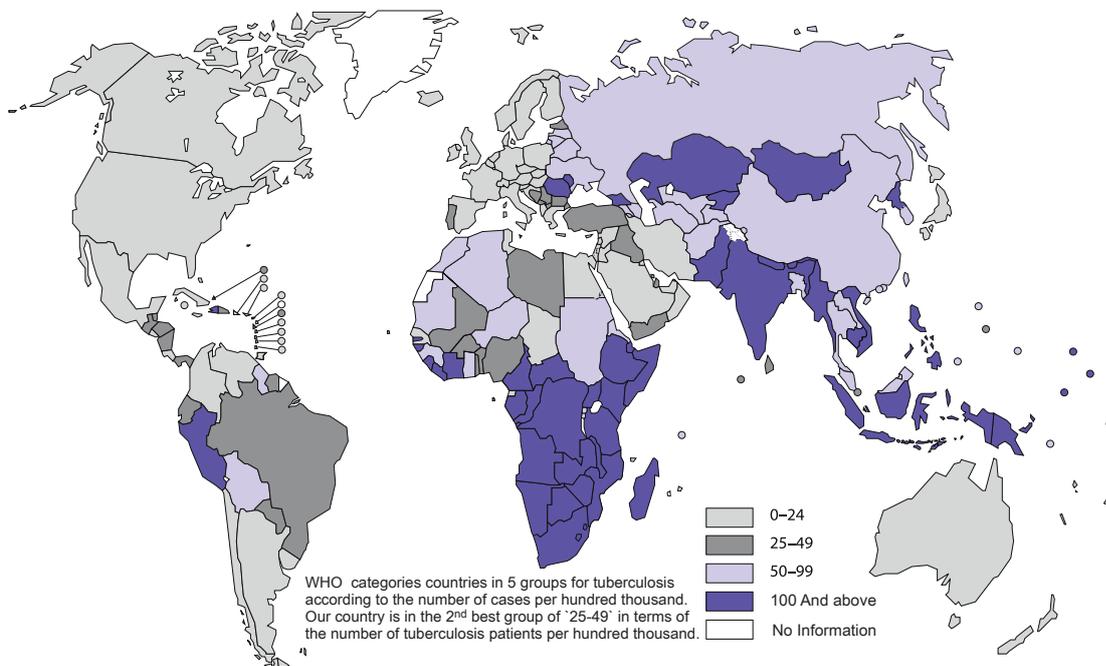
In the fight against tuberculosis, smear method is very important for keeping the record of the confirmed diagnosis and cases communicating microbes.

According to the WHO's 2008 Global Report on Tuberculosis, 62% of the patients with tuberculosis were reached with the smear (+) method in 2002. This rate increased to 80% in 2006. WHO sets the minimum target for the countries as 70%.

In the fight against tuberculosis, smear method is very important for keeping the record of the confirmed diagnosis and cases communicating microbes.

Tuberculosis Notification Rates by Countries, 2006

Table: 3



Source: WHO Global TB Control Report. 2007

According to the WHO 2007 Global Tuberculosis Control Report, 62% of the patients with tuberculosis were reached with the smear (+) method in 2002. This rate increased 80% in 2006. Thus 70% rate, which is the target rate set by WHO for countries has been exceeded. As Turkey, our target field is to reach over 90 %.

Since tuberculosis requires long term treatment, cooperation and control of the patients are important. The implementation of “Directly Observed Therapy-DOTS” started in 2003 for Tuberculosis Control. Now, the treatment of the patients with tuberculosis is being conducted with this practice. DOTS is the medication of the tuberculosis patients directly by the health personnel or a competent person until the full treatment is concluded. We provided nationwide generalization of DOTS implementation in 2006. In 2007 DOT strategy was implemented by 100% throughout the country, and 90,5% of the patients were treated under DOTS.

SUCCESS STORY

A dream coming true:

MEASLES IS ALMOST ERADICATED

The WHO’s target “Measles Eradication” within the scope of measles control is nearly being accomplished in Turkey. We are still dedicated to the aim of stopping the domestic virus circulation in Turkey by the end of 2010.

Within this scope, we conducted a wide vaccination campaign covering the years 2003-2005. The target groups were all the primary school students in 2003 and; all the pre-school age children, 1st grade primary school children and children aged between 6 -14 not attending school in 2005.

18.217.000 children were vaccinated within the framework of the campaign. The vaccination rate was 97%. The vaccination campaign has the widest target population when the Republic history and Europe are concerned.

The number of the measles cases was 30.509 in 2001. In 2008 this number descended to 4. A dream coming true: close to zero...

The number of the notified measles cases was 7.804 in 2002. This number decreased to 4 in 2008 as a result of the measles elimination program. (The said 4 cases were imported cases no local cases were seen)

Concerning Avian Influenza, which was seen in Turkey in 2006, our preparations had started 2 years ago and made it possible for us to control this disease with an appropriate intervention and in a short time. Our activities continue within the scope of “National Preparation Plan on Pandemic Influenza” which is prepared by scientists from training and research hospitals, representatives of the related public bodies, and from private sector with a total of 60 experts.

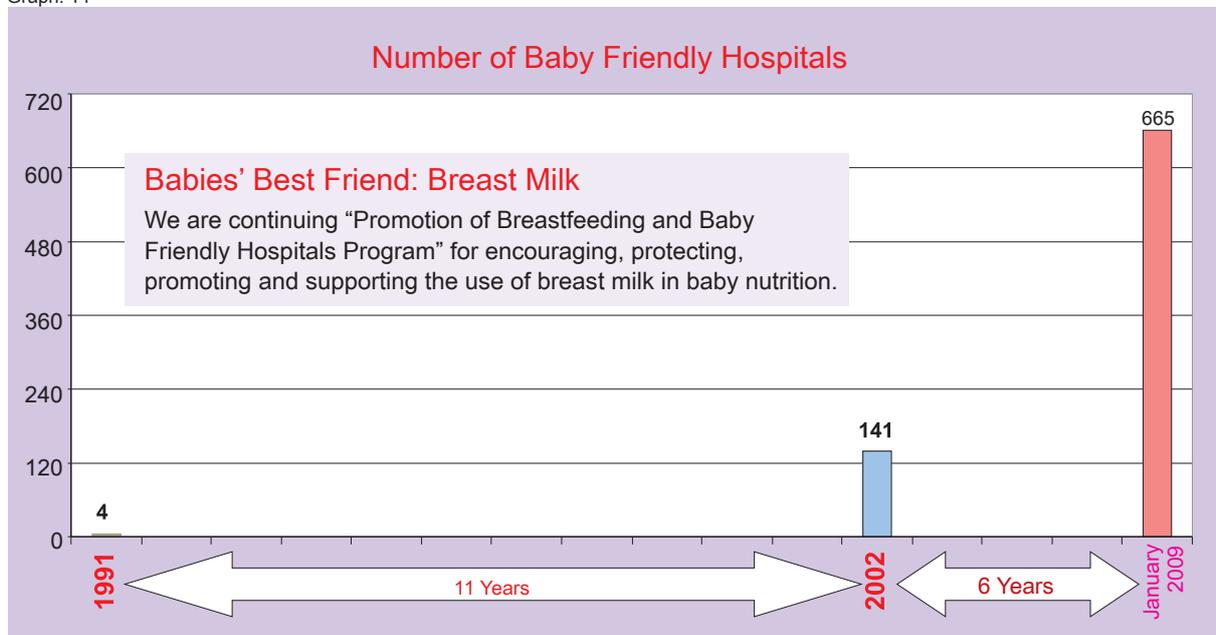
f) The Assurance of Our Future: Mother and Child Health

The number of the “Baby Friendly Hospitals”, aiming at the improvement of baby health, reached 665 in 2009 while it was 141 in 2002.

We are continuing “Promotion of Breastfeeding and Baby Friendly Hospitals Program” for encouraging, protecting, promoting and supporting the use of breast milk in baby nutrition.

As a result of this program, “the percentage of babies between 0-6 months fed only with breastmilk” increased to 40.4 in 2008 while it was 20.8 in 2003.

Graph: 14



We have started to provide free of charge iron support to the pregnant woman to protect the babies and the pregnant women from anaemia.

Each year, approximately 1 million pregnant women benefit from this service. The number of infants provided with iron support between May 2005 and January 2009 is 5 million 270 thousand.

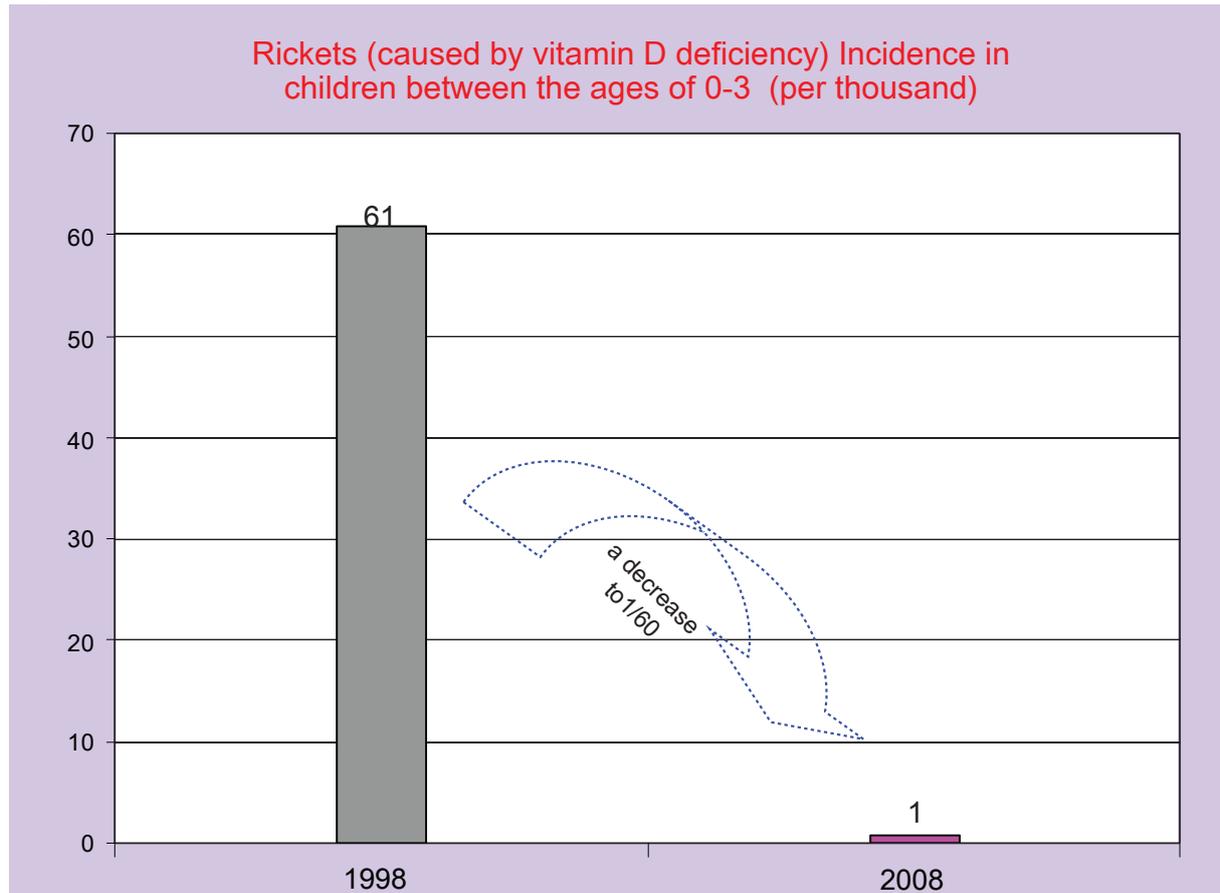
Low cost, high efficiency:
Iron-like Turkey

Vitamin D is being provided free of charge to support bone development of the babies. The number of infants provided with Vitamin D between May 2005 and January 2009 is 4 million 820 thousand.

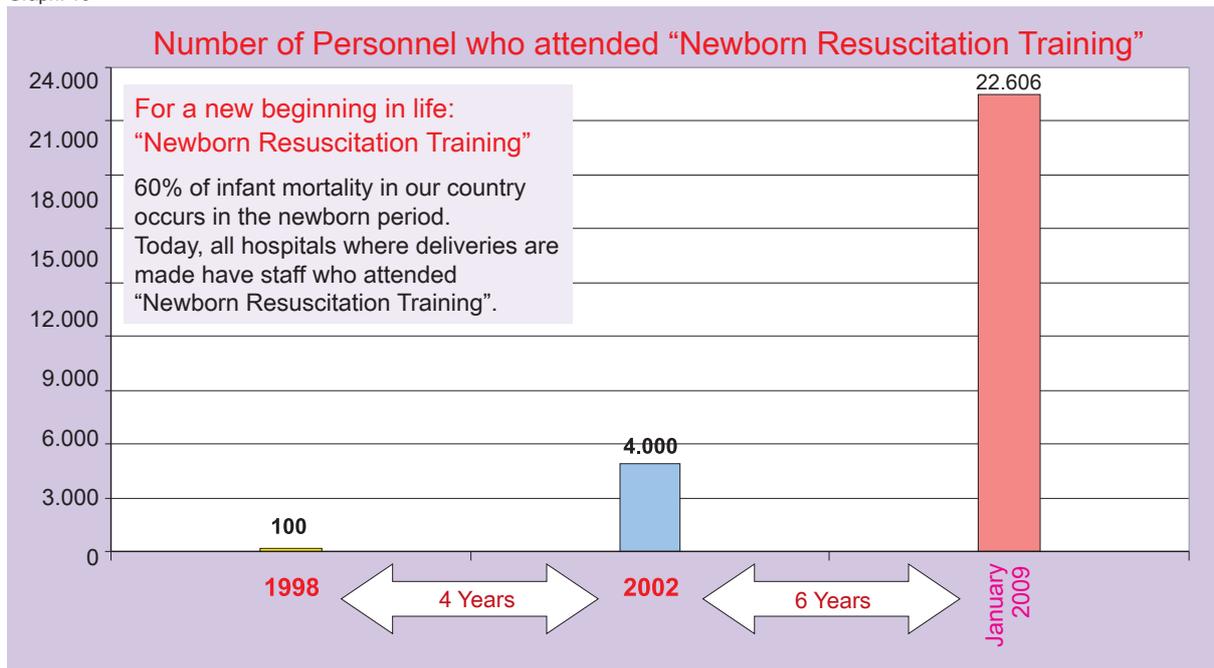
Two Free-of-charge
Vitamin D Sources for
Babies: the Sun and the
Ministry of Health

The studies carried out in Atatürk University Faculty of Medicine indicated that in 1998 the incidence of rickets (vitamin D dependant deficiency) in children between the ages of 0-3 was 61 per thousand and this ratio is 1 per thousand in February 2008.

Graph: 15

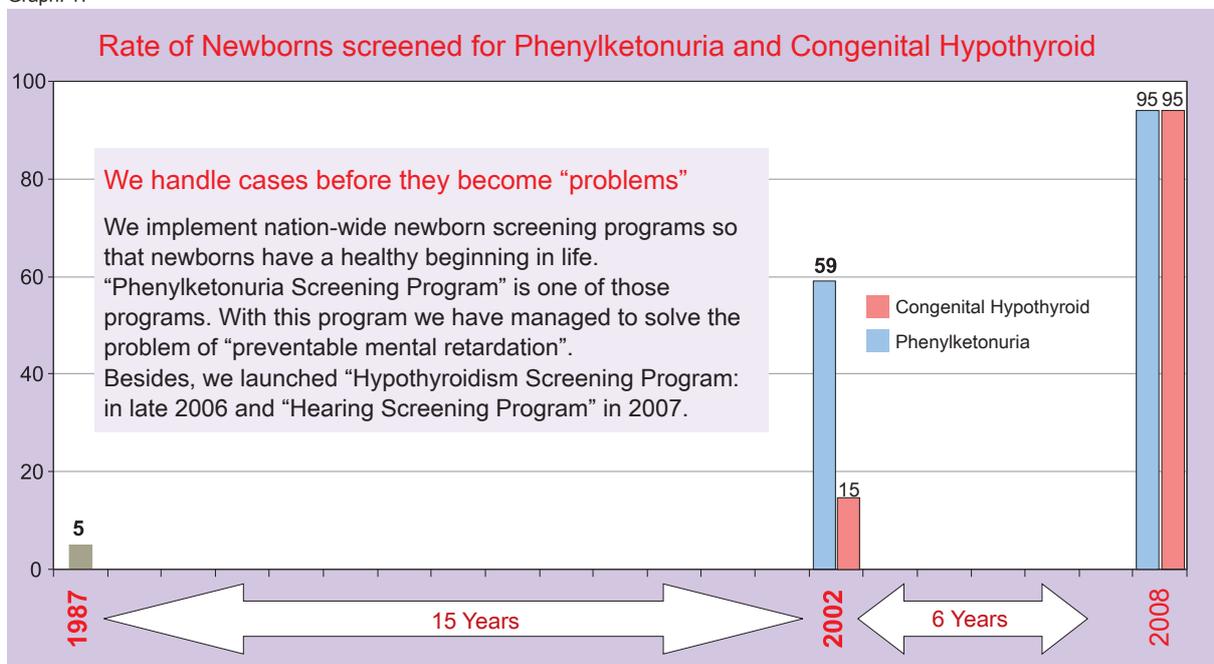


Graph: 16



22,606 health personnel have been trained since the beginning of the newborn resuscitation program until January 2009. Today, trained personnel are available in all delivery units.

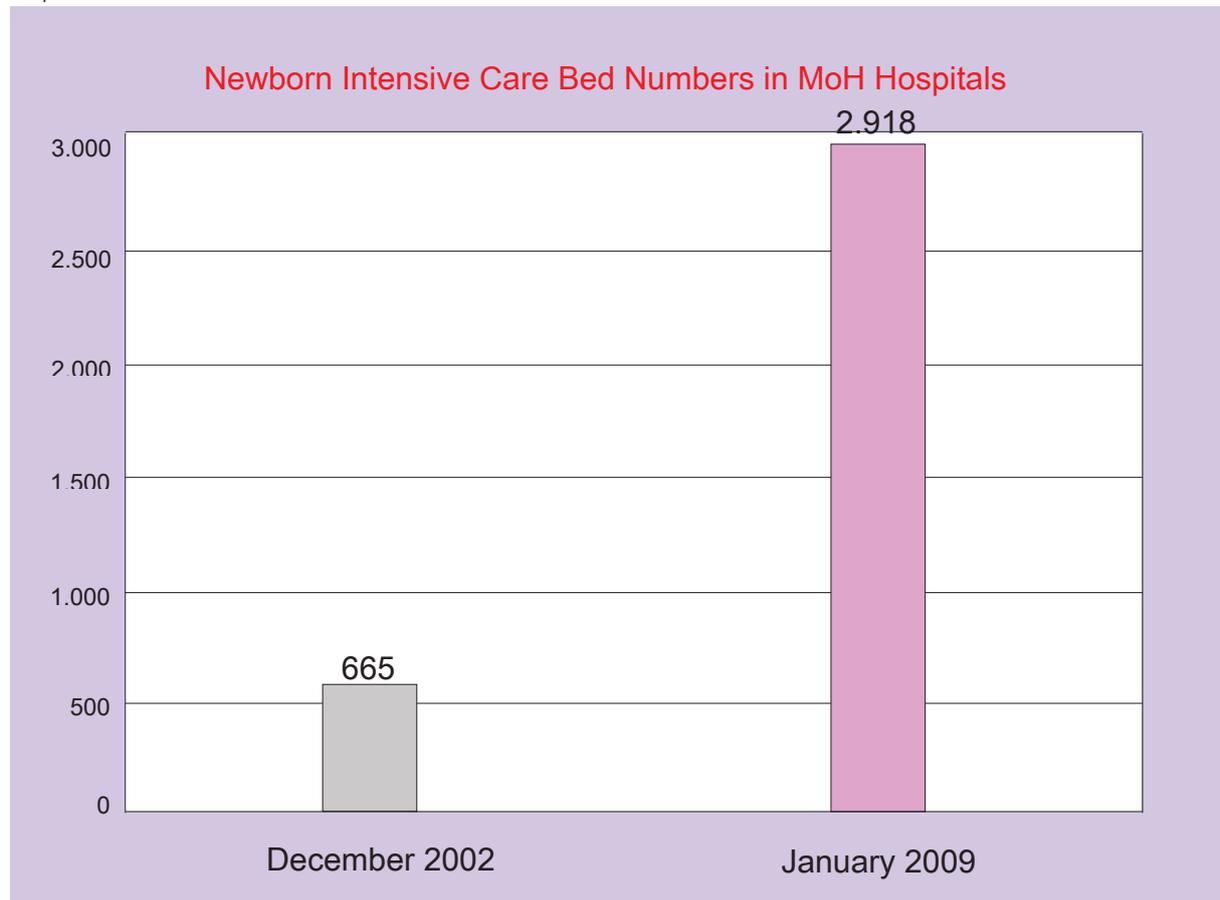
Graph: 17



Newborn screening program has been expanded and accelerated countrywide to ensure a healthy beginning in life by the newborns. Phenylketonuria Screening, which was launched previously, has been expanded, too. Another vital programme, Congenital Hypothyroidism Screening, has been launched in a rapid and widespread manner. In this way, our babies are widely protected from Phenylketonuria and Congenital Hypothyroidism, which can be prevented easily when detected, however cause irreparable damages such as mental and physical development retardations when missed. During Phenylketonuria and Congenital Hypothyroidism Screenings, 95% of the target population was covered.

Newborn Hearing Screening Units are completed in 176 institutions under the Ministry as well as in 76 provinces and, screenings have been initiated. Approximately 750.000 infants underwent hearing screenings until January 2009.

Graph: 18



The number of newborn intensive care beds was 665 in 2002 in MoH hospitals, in 2008 it has increased to 2.918. The increase ratio between 2002 and 2009 is 350%.

IRON-LIKE TURKEY

According to WHO data, it is predicted that approximately 30% of the world's population and more than half of the pregnant women have anemia.

Before the Health Transformation Program anemia was very common in Turkey and, according to the researches, approximately 50% of the 0-5 age group children, 30% of the school age children and 30% of the nursing women had anemia.

Children have iron deficiency anemia most frequently between the 6-24 months. In this period the growth of children is in its fastest process. Nutritional problems and iron deficiency occurring in this period have negative impacts on the mental, physical and social development of children in the future. The easiest way to prevent these negative impacts from occurring is to protect children against iron deficiency anemia.

We started the "Iron-Like Turkey Program" in order to provide consciousness among the society on anemia, ensure breastfeeding for the first six months, continuation of breastfeeding until the age 2 together with the convenient supplementary food, ensuring iron support between 4-12 months for all the babies and iron treatment for the 13-24 months babies with anemia. We have provided iron support for 5.080.000 babies from the beginning of the program until today.

We enlarged coverage with the Iron Support for the Pregnant Program. We distributed 5.211.000 boxes of iron prepartate since the beginning of the program.

"Research on Iron Deficiency" was conducted by the participation of our Ministry and Hacettepe University Faculty of Medicine, Social Pediatrics Department in March-April 2007. According to the unpublished preliminary results, anemia prevalence for children of 12-23 months decreased from 30 % to 7.8 %. The progress we have made for healthier and cognitively developed babies is much more obvious with these results.

When the same years are taken into account, it is seen that the number of transport incubators rose from 158 to 440, the number of ventilators rose from 252 to 491. The increase ratios are 170% and 105% respectively. The increase ratio in the number of nurses working in the newborn intensive care is 155%.

While the ratio of deliveries performed in the hospitals was 78% in 2002, it has increased to 92 % in 2008.

Until recently the citizens were refused by hospitals but today people with lowest income, who constitute the poorest 6 % of entire population are granted monthly allowance amounting to 17 YTL for each pregnancy and child on condition that

they continue their health controls in health institutions.

Also, pregnant are granted monetary aid of 55 YTL when they give birth at public hospitals. 1 million 600 thousand citizens have benefited from this incentive since March 2004.

Healthy Mothers, Healthy Generations

SUCCESS STORY

ALMOST...

Mothers will enjoy motherhood...

Step by step to the target in the prevention of maternal mortality.

Access to health care services during pregnancy, delivery and post-partum periods, benefiting from health care services and the quality of these services and, from a broader perspective training of women, social gender equality and social conditions are related with maternal mortality. With this feature, the rate of maternal mortality is used as a multi dimensional indicator of development.

Maternal mortality includes women's deaths which occur during pregnancy and delivery, and within 42 days following the delivery, as well.

According to WHO projections, 529.000 mothers die in the world every year. 99% of the maternal mortality is reported in developing countries. World average for maternal mortality is 400/100,000. African average is 870/100,000, Asian (excluding Japan) is 380/100,000, WHO upper medium income level group countries' average is 91/100.000 and European is 24/100,000.

Data on maternity mortality was lacking in Turkey until recently. Data was obtained from population surveys as rates which reflect current national situation. In 1997 – 1998, maternal mortality was recorded as 49/100,000 in 615 maternal hospitals located in 53 provinces in Turkey. This rate is calculated as 70/100.000 considering the mortality outside the hospitals.

Survey on Maternal Mortality in Turkey was conducted between 1 June 2005 – 31 May 2006 in order to determine the maternal mortality rate in Turkey. Results were publicized at a meeting held on December, 8, 2006.

The above mentioned survey is the single study of scientific competence in the Republic's history. The survey pointed out that the maternal mortality rate for 2005-2006 was 28.5/100,000. Turkey, for the first time, collected accurate and updated numbers for maternal mortality through a very comprehensive field survey. Moreover, the outcomes indicated the success achieved in maternal mortality rate showing that the numbers are very close to European average.

After the Maternal Mortality Study In Turkey in 2005, through Maternal Mortality Data System, based on the system of the survey and then revised, data is collected pertaining to maternal mortality among women between the ages of 12 and 50 in 81 provinces. In this scope, maternal mortality rate for 2008 is 19.5 per 100 thousand. Our target is to reduce the maternal morbidity rate below 15 per 100.000 by 2010.

The assurance of our future our children are assured

“Conscious Mother, Healthy Baby Program” was initiated with the aim of reaching all the mothers who give birth at in-patient health facilities. By this program it is aimed to provide information for mothers on the basic issues related with themselves and their babies’ health before they leave the hospitals. Mothers are given basic information on baby care for healthy growing and health after delivery, and

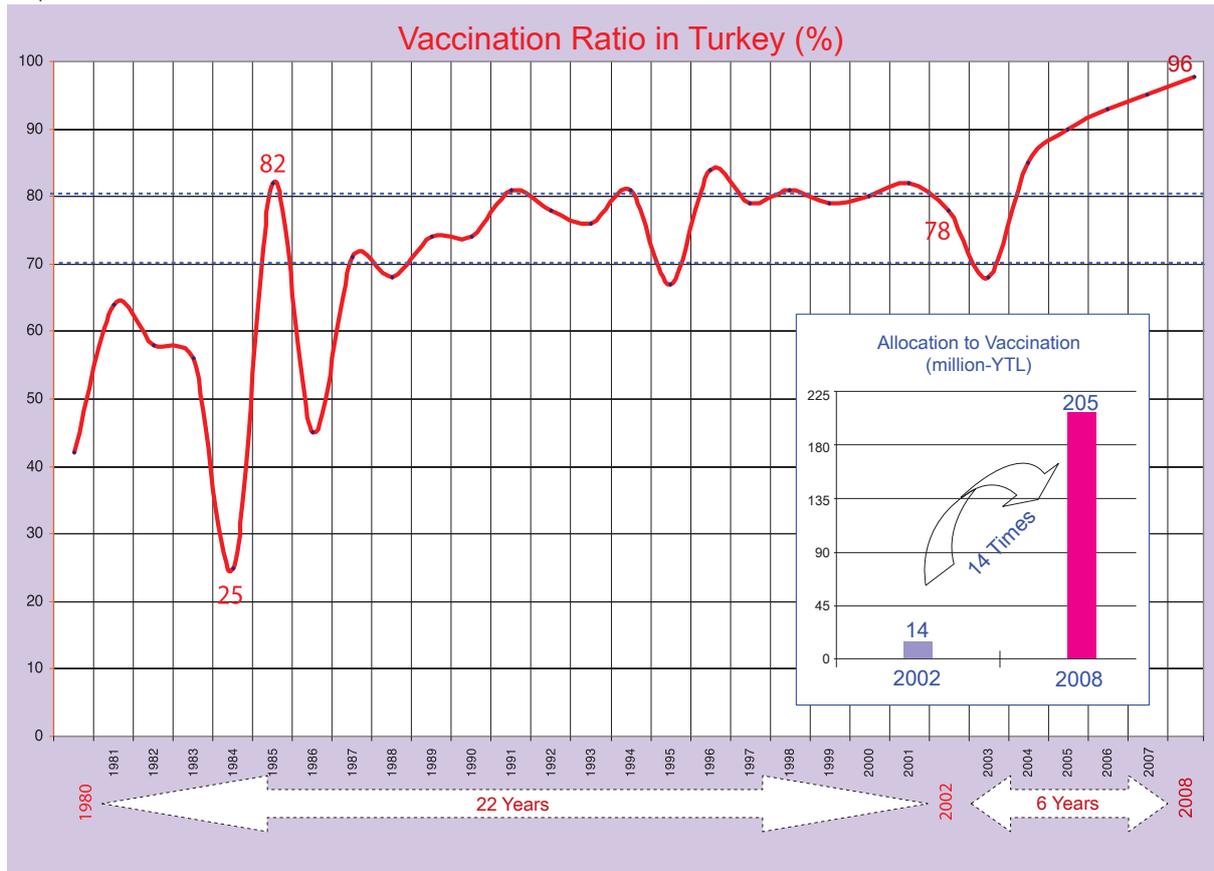
“Guidelines for Conscious Mothers and Healthy Babies”, as well. So, we have managed to reach almost 4 million mothers so far.

Our children are vaccinated; we keep our promise for a healthier future

g) Immunization Programs: Vaccines

In 2002, the vaccination rate was 78 % for targeted children group. This rate was even below 50% in some provinces in the South-eastern region. In 2008, vaccination rate reached to 96 % countywide. We accomplished a rate over 80% even in regions with the lowest vaccination rates.

Graph: 19

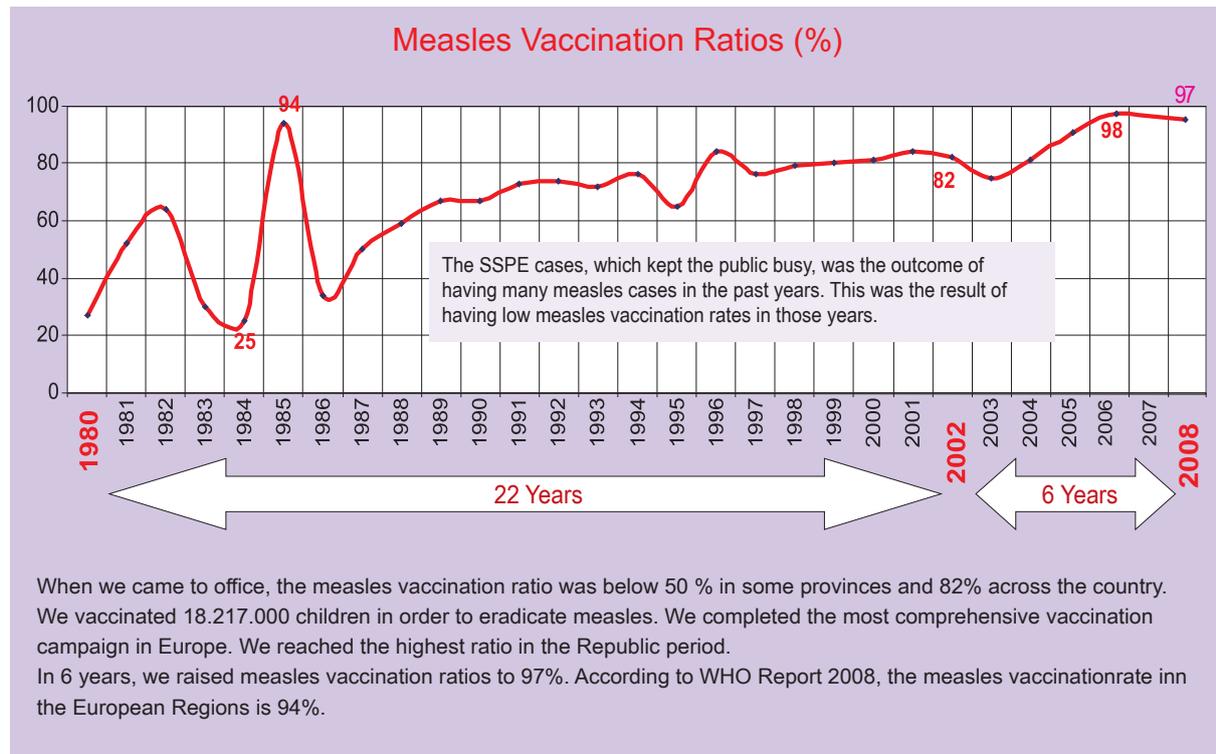


While the budget allocated for vaccination in 2002 was 14.000.000 TL in 2008, it reached to 161.000.000 TL. The rubella, mumps and meningitis vaccinations, which were not included in the standard vaccination program formerly, are included in the program. Fivefold combined vaccine (diphtheria, acellular pertussis, tetanus, Hemophilus influenza type B and inactive polio virus) is introduced. The necessary activities for the implementation of conjugated pneumococcus vaccine was completed in November 2008. The source allocated for this implementation is 44 million TL (20 million from overall budget, 24 from the central revolving fund). With this source, the budget allocated for vaccines will reach to 205 million TL by the end of the year.

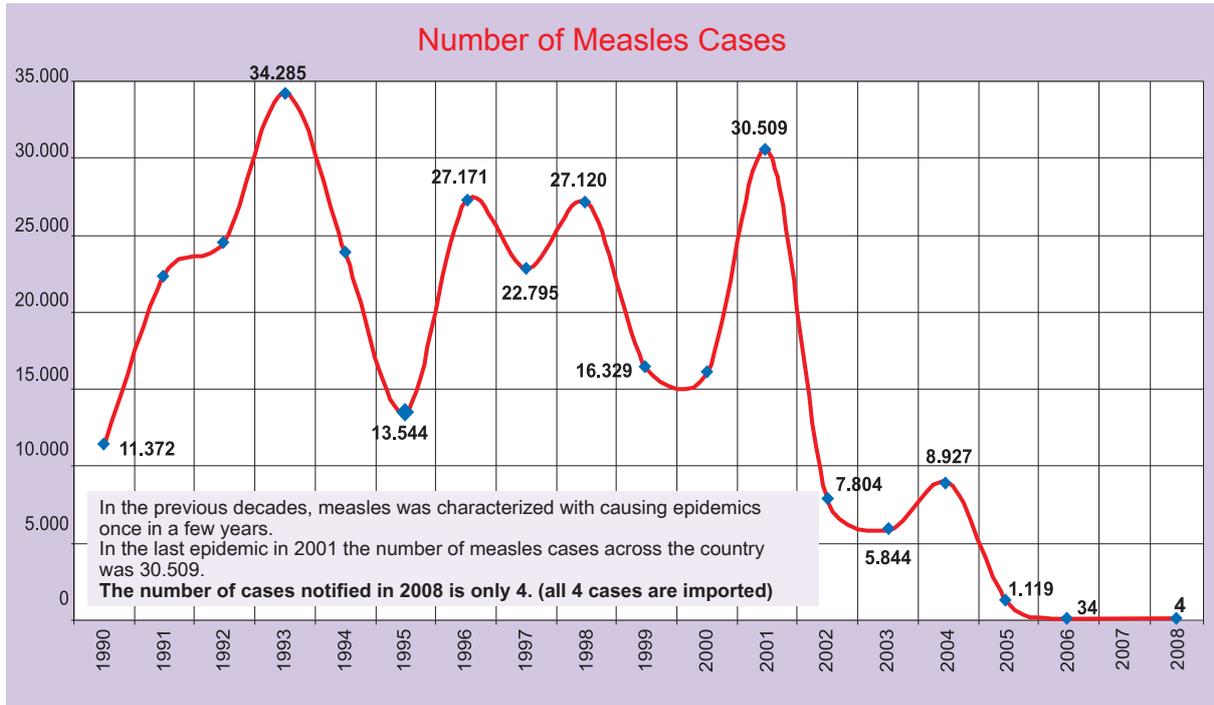
In order to eradicate measles, a big vaccination campaign was carried out covering the years 2003-2005 and 18.217.000 children were vaccinated. The vaccination ratio of the campaign was 97 %. The target population of the campaign is the biggest of the Republic Period and Europe.

Those works gave results in a short period and while there were 7.804 measles cases in 2002, this decreased to 4 in 2008. Thus, there has been no child case until January 2009.

Graph: 20



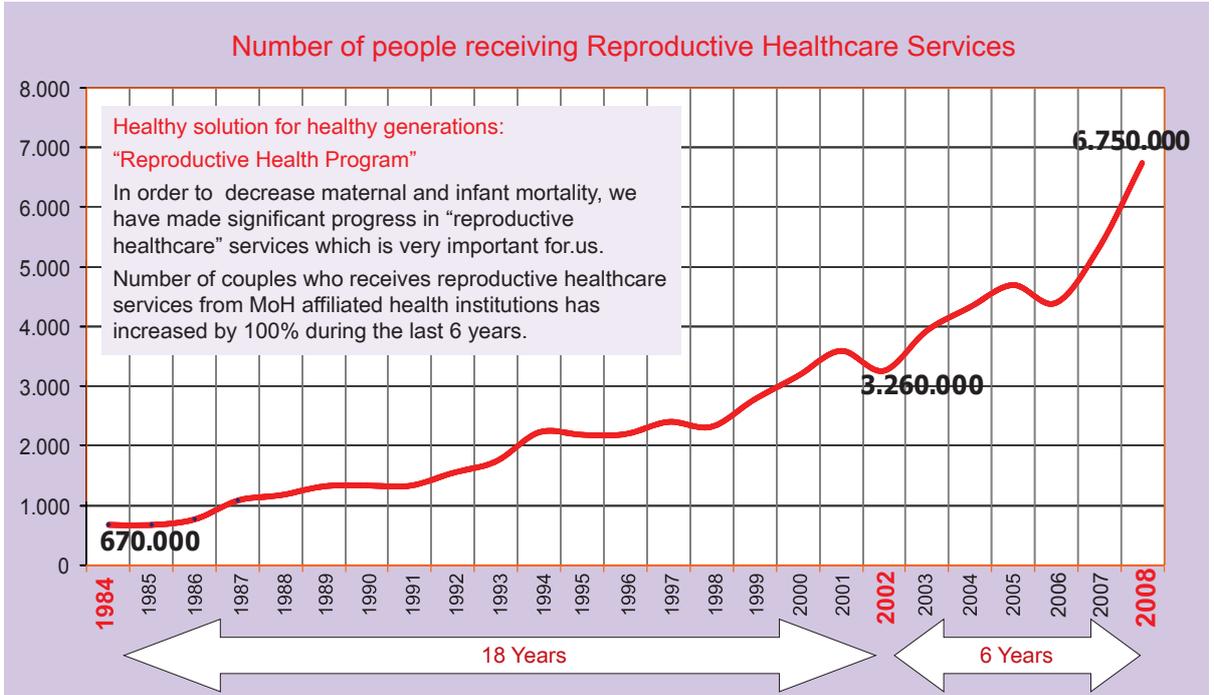
Graph: 21



h) Sexual and Reproductive Health Program

Turkish Sexual and Reproductive Health Program is implemented in cooperation with the European Union in order to increase the utilization and accessibility of services in the field of sexual and reproductive health to improve service quality to

Graph: 22

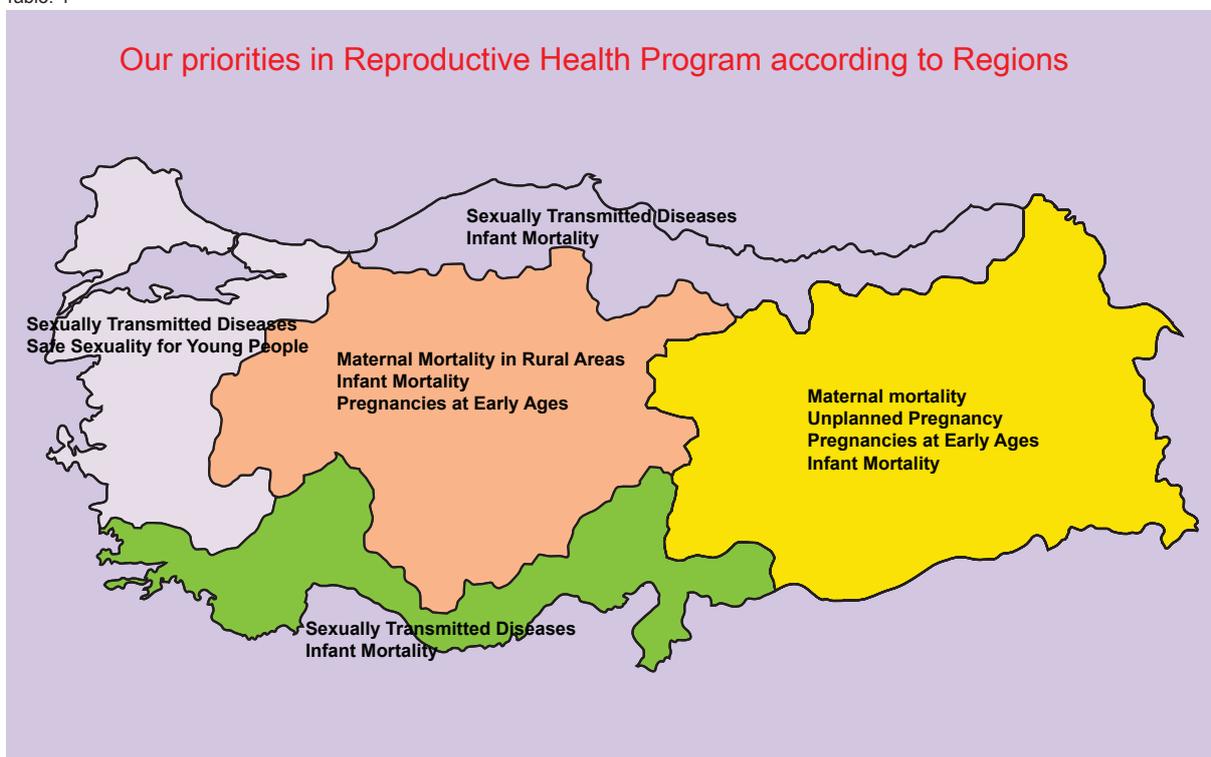


support the MoH-conducted studies and to strengthen the collaboration with the NGOs. In 2002, 3,260,000 couples benefited from the reproductive health care services in the MoH-affiliated facilities. In 2008, the number of couples reached to 6.750.000.

In order to decrease maternal and infant mortality, we have achieved a significant progress in the “reproductive healthcare services” which is very important for us.

Number of couples benefiting from the reproductive healthcare services from Ministry’s health institutions has increased by 70% during the last 5 years.

Table: 4



Ministry of Health and Turkish Armed Forces collaborated on offering trainings on reproductive health and family planning targeting male population. In this respect, trainer’s training was given to 4.000 military health care personnel so that they can provide Reproductive Health and Family Planning Counselling Services and Trainings to military personnel and non-commissioned soldiers serving at Turkish Armed Forces. Through these trained personnel, soldiers in every units are given reproductive health trainings. Hence, every year 500,000 young men attend reproductive health trainings before they complete their military service. Since April 2004, more than 2 million military men and noncommissioned officers have received this training.

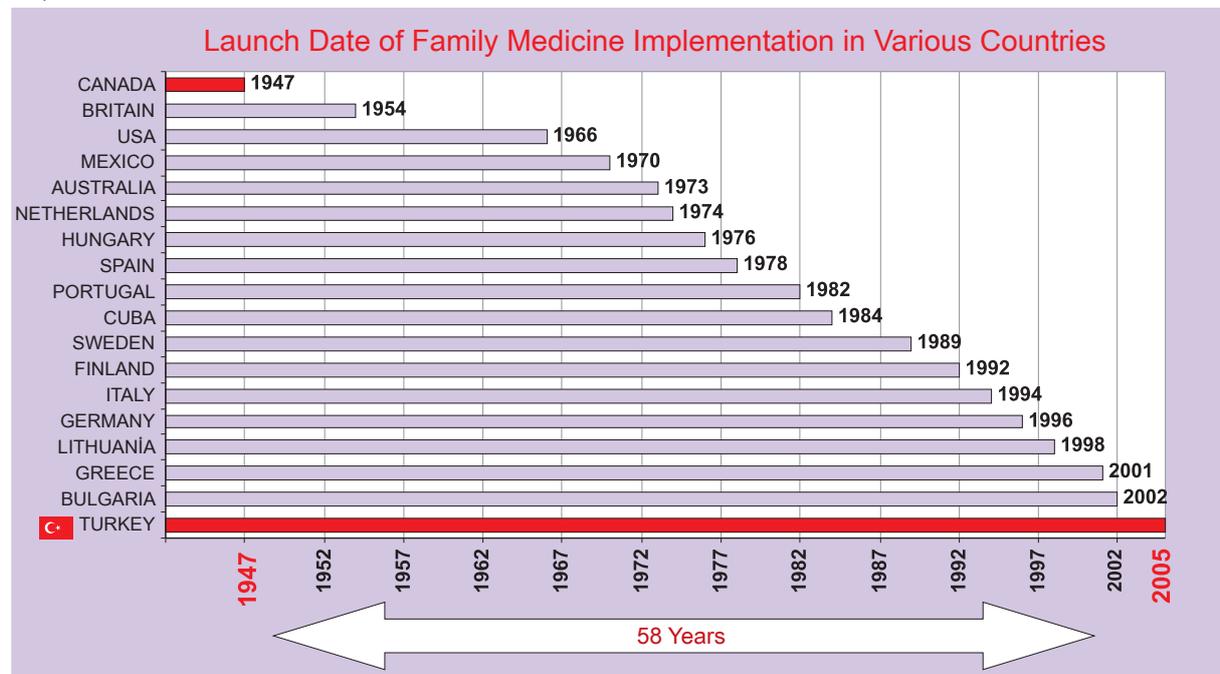
A New Era in Health

4. Transformation in the Primary Health Care Services: Family Medicine

We have mentioned before that Health Transformation Program puts humans at the centre of the service. This principle means that when planning the system and providing the services, the system will take into consideration the human who benefits from the services, and his/her needs, demands and expectations. Given the fact that health is produced within the family first, the health of the individual is addressed within the concept of “family health”. We know that sharing responsibilities and “single approach” to individuals in primary health care services will increase the rate of success. Preventive services for individuals and primary diagnosis and curative services being conducted by the physicians chosen by citizens have enabled to have more close relationships between family members and the family physician, thus the role of primary health care physician’s and his personnel’s role in health training, prevention of diseases and promotion of health, have been identified better.

The terms of general practitioner, family doctor and family physician have the same meaning in the program. These all refer to physicians who are specially educated for providing services in the primary care.

Graph : 23



A family physician is responsible for health, health problems and diseases of all members in a family (from the fetus of pregnant woman to the oldest member of the family). All health problems of the applicant are dealt within the scope of the primary health care services. If the problems of the patient can not be solved through primary health care services, then the patient is referred to a specialist or a dentist in which, a family physician plays a coordinator's role. Therefore, a family physician is the health consultant of patients, s/he is the one who guides patients and defends patients' rights.

Central Role In Health Care System: Family Medicine

The family physician is close to residences of families and is easy to access. The family physician knows the society in every way for which s/he provides services and evaluates patients' family, environment and employment relations. Family physician is the one who knows the best about the health status, living conditions of all family members and how preventive health care services and health trainings could be delivered to them. Family physician evaluate patients' situation as a whole taking into consideration the risks, health conditions, psycho-social environment and current other acute or chronic health problems.

According to Prof. Dr. Nusret Fişek "Preventive care services, out-patient and home care services for individuals should be conducted as integrated. (...) Most simple example of this integrated model is the contemporary family medicine system.

Contemporary family physicians examine children periodically and vaccinate them and train mothers about child healthcare. They also examine elder people and pregnant women and give necessary advice. They train family members on domestic and personal hygiene. They treat family members who get ill and refer them to a specialist or hospital if necessary."

From now on, your physician will be a member of your family.

In order to create an effective chain of referral, it is a pre-requisition that people have the right to receive primary health care services from a physician whom they choose and trust. This pre-condition is highly related with the issue of strengthening primary health care services and the quality of services provided by family physicians. In this respect, family physicians, as coordinators of the health care system, should prevent false referrals, disorders and unnecessary health expenditures. Family medicine, in this respect, prevents waste, excessive workload in secondary healthcare facilities, long waiting lists and patients' suffering.

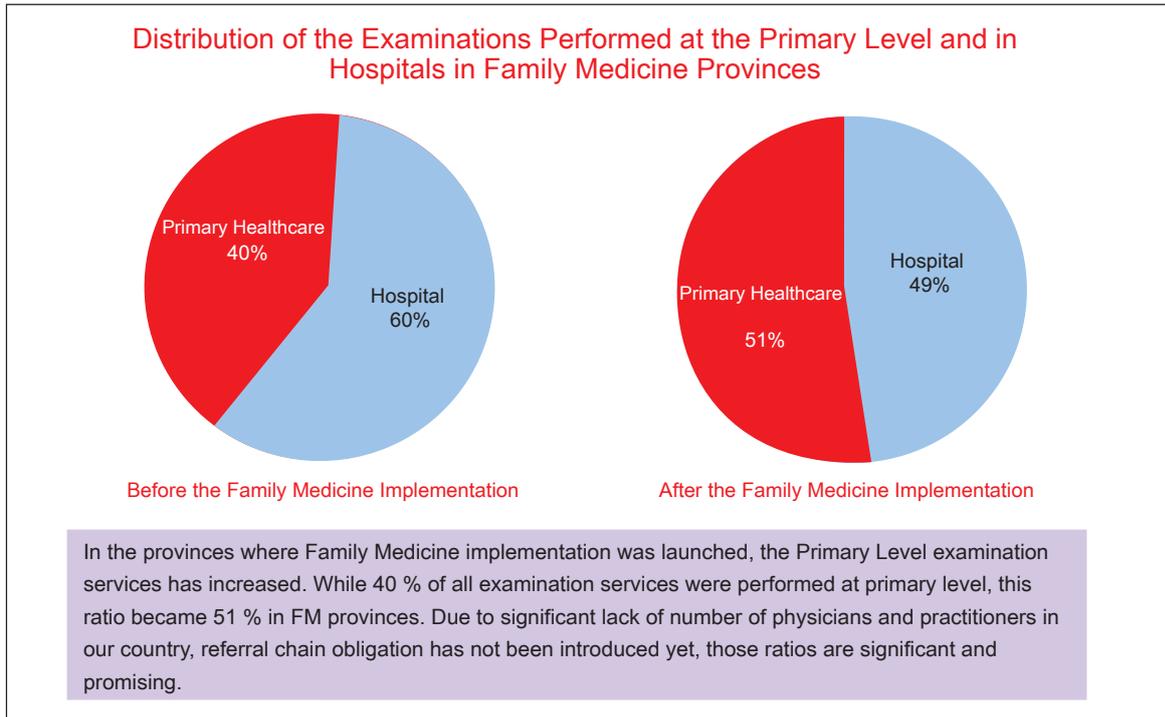
A very intense study was carried out in order to achieve this important goal of the Health Transformation Program. Family Physicians Counselling Committee was set up with the participation of professional organizations and academicians. The committee prepared the training curriculum for physicians to take part in the field of family medicine. The program consists of two stages. First stage targets short-term adaptation training. Second stage targets long-term training on update and promotion of professional knowledge.

Community Health Centres were established in order to provide more effective and productive health services by gathering primary care under a single roof except for preventive, diagnostic, curative and rehabilitation services for individuals. These centres give free-of-charge logistic support to vaccination campaigns, mother and child care and family planning services in accordance with the program identified by the Ministry of Health. They also supervise family physicians. Thus, both family health and community health care services were unified and, primary health care structure was integrated. As the process moves forward, family physicians will be employed in family health centres and public health specialists in community health centres.

Turkish Grand National Assembly enacted the Law on Pilot Implementation for Family Medicine in November 2004. Pilot implementation was first initiated in Düzce in October 2005. Then implementation was launched in 2006 in Eskişehir, Bolu, Edirne, Adıyaman, Denizli, Gümüşhane, in 2007 in Elazığ, Isparta, Samsun, İzmir, Bartın, Sinop, Amasya and in 2008 in Bayburt, Çorum, Manisa, Osmaniye, Karaman, Karabük, Adana, Burdur, Kırıkkale, Yalova, Bilecik, Kırşehir, Çankırı, Kastamonu, Erzurum, Kayseri and Tunceli. So, 19 million people were brought under the coverage of family medicine in 31 provinces.

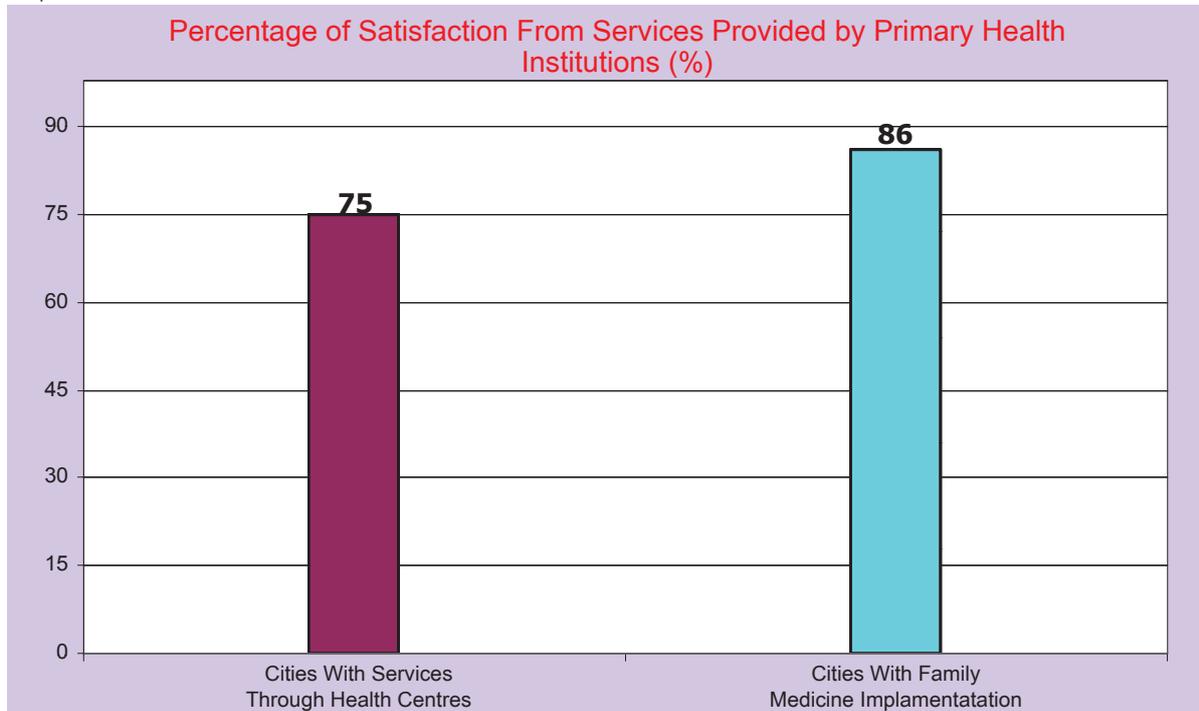
Family medicine implemetations, with its preliminary results being succesful, put primary healthcare services at the top of the public agenda, and makes primary healthcare attractive and thus facilitates widespread provision of preventive healthcare services. Success of the system in firstly initiated provinces is reducing the number of patients visiting hospitals and alleviating excessive workload at hospitals. At the same, physicians who are employed in primary care are re-gaining the professional respect that they already deserve. For now, the practice is supported by in-service training programs. However, the system will promote the training of family physicians who will provide these services in long-run. This condition will increase the reliability of primary care services.

Graph: 24



According to a survey conducted in 2008 regarding the family medicine implementation, people were asked to what extent they were satisfied with the family medicine services given so far and their feedback pointed out a high level of satisfaction.

Graph: 25



Preventive and Primary Healthcare Services are now

Free-of-charge

Today all our citizens can get all kinds of services from all primary healthcare institutions without being asked for a security document across the country.

A New Era in Health

5. Change of Mentality in Hospital Care Services

a) Avoiding Discrimination in Health: Uniting Public Hospitals under Single Umbrella

The principle of efficiency, one of the objectives of the Health Transformation Program, is described as production of more services with the same resources by decreasing current costs in accordance with the resources. It is also emphasized in the program that distribution of human sources, management of materials, rational use of medicines, health management and preventive medicine are assessed in this scope. Productivity will be better achieved by inclusion and integration of all domestic sector sources in the system.

The principle of uniting all hospitals under one umbrella aims at using all resources which are providing health services for the sake of public. In this period, Social Insurance Institution hospitals were transferred to MOH hospitals, obstacles on the accessibility of the patients to hospitals have been eliminated and discrimination has been terminated among people. Hospitals, which suffered from unbalanced workload in the past, are opened to all patients regardless of whether they are covered by the Social Insurance Institution, Pension's Fund or Green Card. Today, all hospitals do provide health care services to all people in a balanced way and without any discrimination.

Most people, who had difficulty in access to health care services formerly, have already had the opportunity to make use of these services whenever they need. Termination of the discrimination among Social Insurance Institution and state hospitals has not only provided choice opportunity for people but also been a very equitable implementation in terms of access to services for users who had the right but could not utilize health care services in the past, although they were paying premiums and thus were covered by the insurance system.

Single base and
single roof in
health

b) Decentralization of Hospitals:

Efficiency increased due to authority transfer to hospitals, flexibility in management, introducing freedom in using self-resources and also introducing the supplementary pay-for-performance to staff from the revolving funds. Health institutions have started to become patient-centred service institutions.

In order to alter the clumsy structure of public hospitals, private sector services are outsourced primarily for imaging services and others, as well. So, health service structures have started to improve. Thus, the imaging services and queues for medical tests are shortened in a great deal. Differentiation in management models have been terminated by unifying all Social Insurance Institution and public hospitals under the Ministry of Health's shelter.

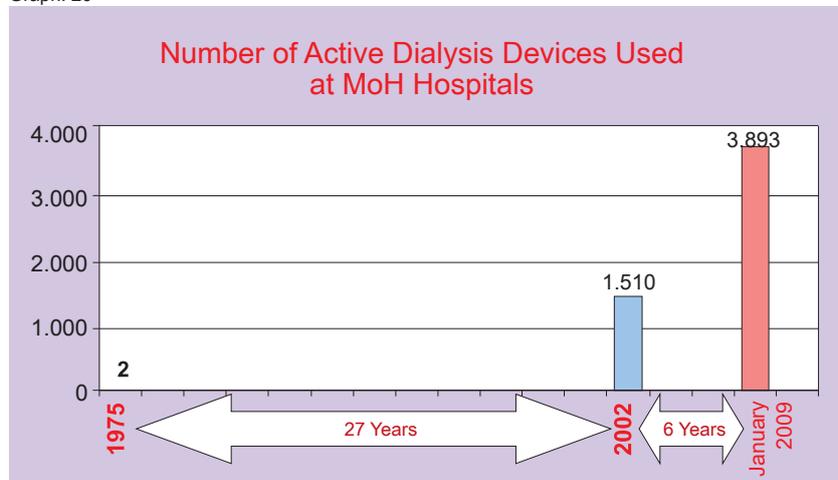
Hospitals in Turkey, which receive more autonomy every other day and which are already managed on-site, are becoming autonomous public facilities. In the last 5 years, all of the hospitals has built their own data processing infrastructure and kept their services under record. Supplementary payments are met by the revolving funds. More than 35,000 contracted personnel are employed at hospitals and the salaries of 18.500 are paid from the hospitals' own revolving funds.

State hospitals do not have to wait for years for having the necessary equipments for service any more. They are given the chance to outsource service from private sector. Thanks to this, hospitals can give services without putting burden of investment on public and meet the cost of these services by their own revenues. .

c) Restructuring in hospital services

In the framework of the Health Transformation Program, public hospitals no longer lack any devices. The number of dialysis machines at state hospitals was 1,510 in 2002 and the number has increased to 3,893 by January 2009.

Graph: 26



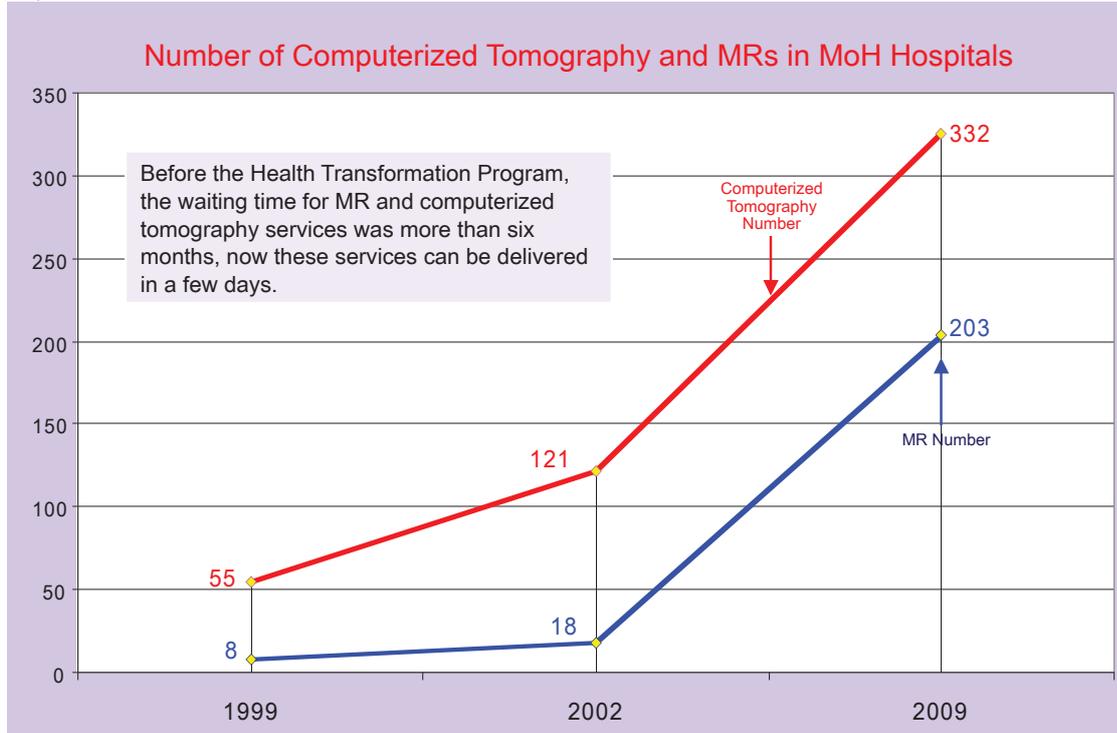
In 6 years we increased the number of active dialysis devices by 2.5 times.

Today we deliver on-site or mobile dialysis service in all districts.

Note: The figure for 2002 includes Social Insurance Institution facilities

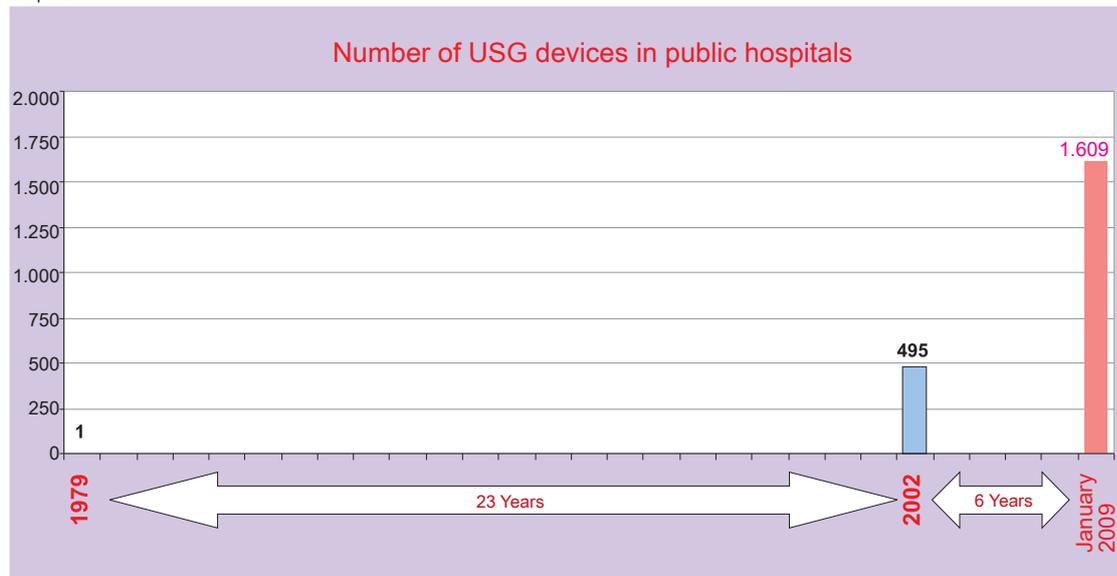
The services in state hospitals are provided in the form of public-private partnership. In 2002, there were only 18 MRI devices in all public hospitals. This number has increased to 203 in 2008 and the number of computer based tomography devices was increased from 121 to 332.

Graph : 27



Note: The figure for 1999 and 2002 includes Social Insurance Institution hospitals

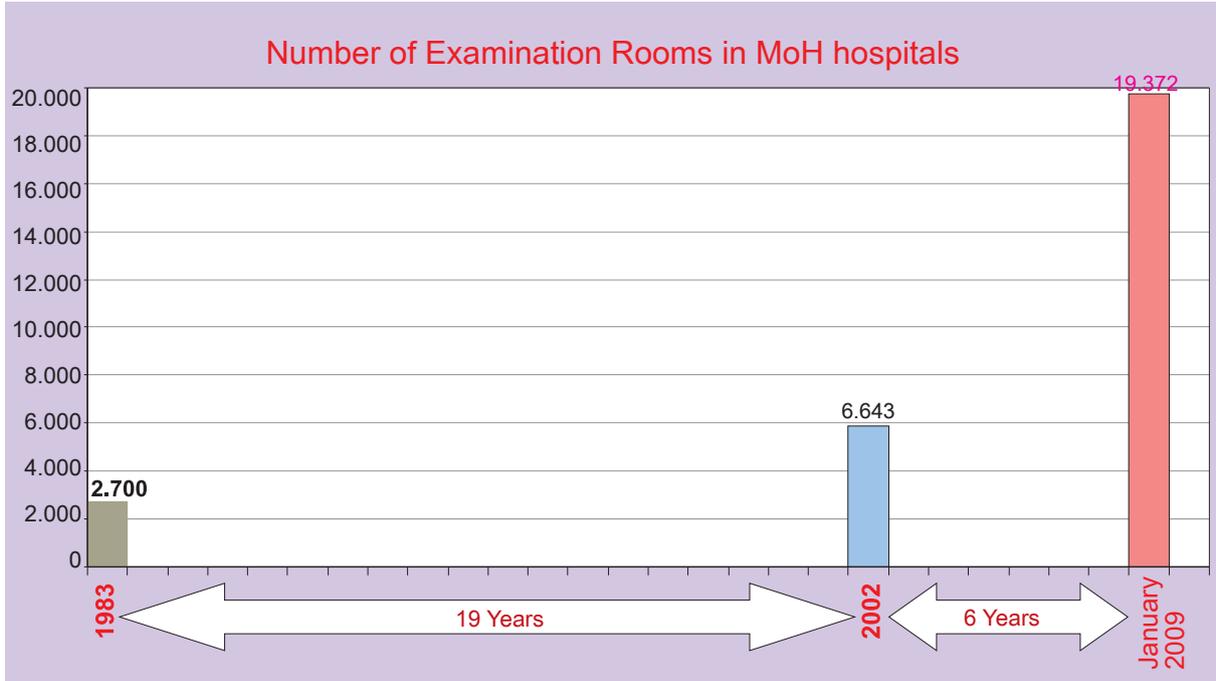
Graph: 28



Note: The figure for 2002 includes Social Insurance Institution facilities

In 2002, only 20 % of state hospitals had electronic information systems and this rate increased to 100 % in 2006. By late 2002, the number of examination rooms allocated for physicians was 6,643 and this increased to 19,372 by 2009, in other words increased 3 times.

Graph: 29



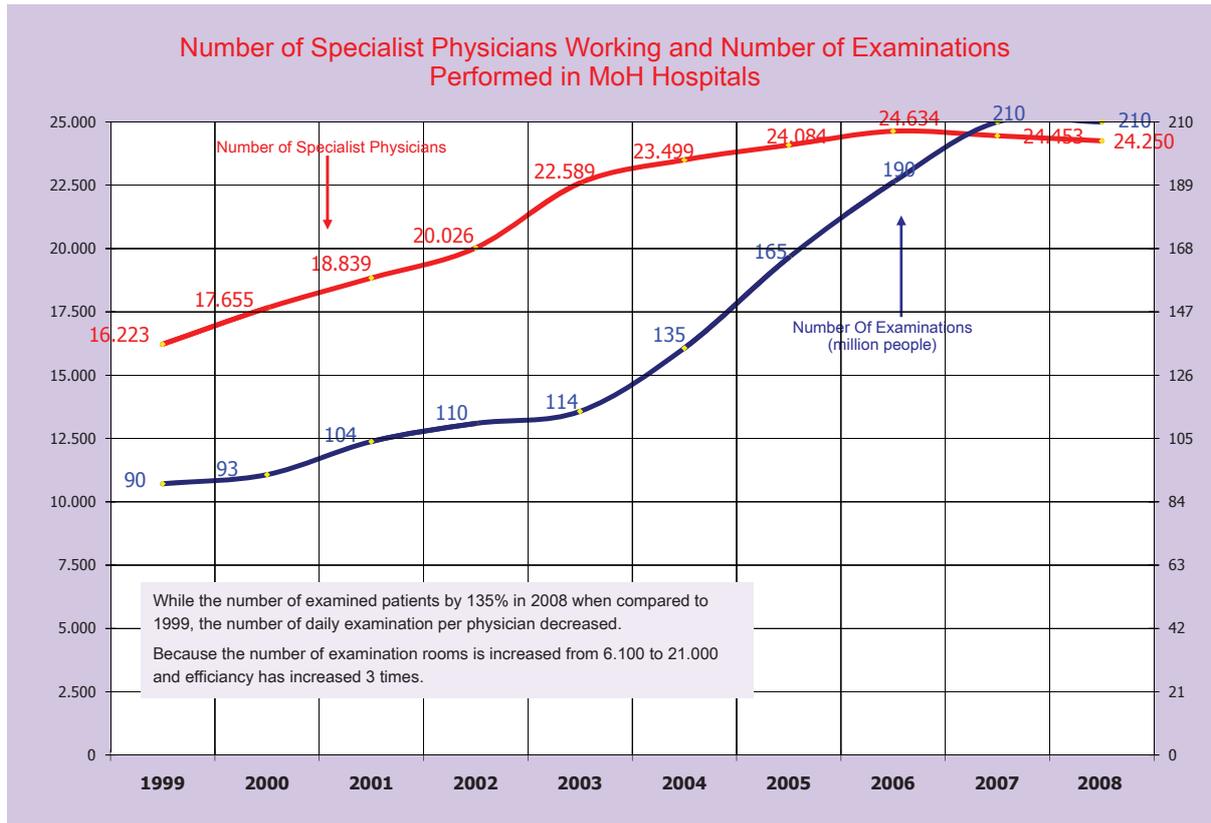
Note: The figure for 2002 and before includes Social Insurance Institution facilities

From hospital doors to examination rooms

Idle facilities are activated by the “an examination room for each physician” principle. In parallel to this, while 110 million patients were examined at state hospitals (including Social Insurance Institution hospitals) in 2002, this number was noted as 210 million in 2008.

The number of Oral and Dental Health Centres was 14 in 2002, and we increased it to 122 in 81 provinces.

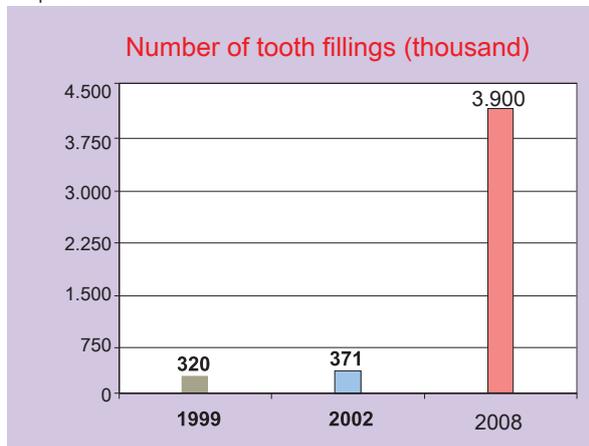
Graph: 30



Note: The figures include the specialist physicians working and the examinations made in Social Insurance Institution hospitals.

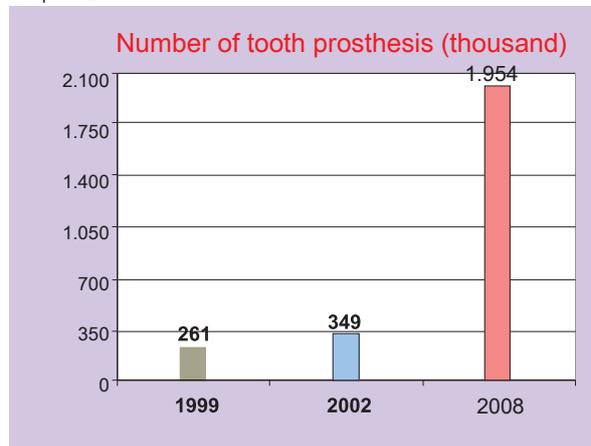
When compared to the 2002 figures, the number people receiving dental care services in Oral and Dental Health Centres and state hospitals has increased by 10 times for tooth filling and 9 times for tooth prosthesis in 2006.

Graph: 31



Note: The figures for 1999 and 2002 include those of Social Insurance Institution hospitals

Graph : 32

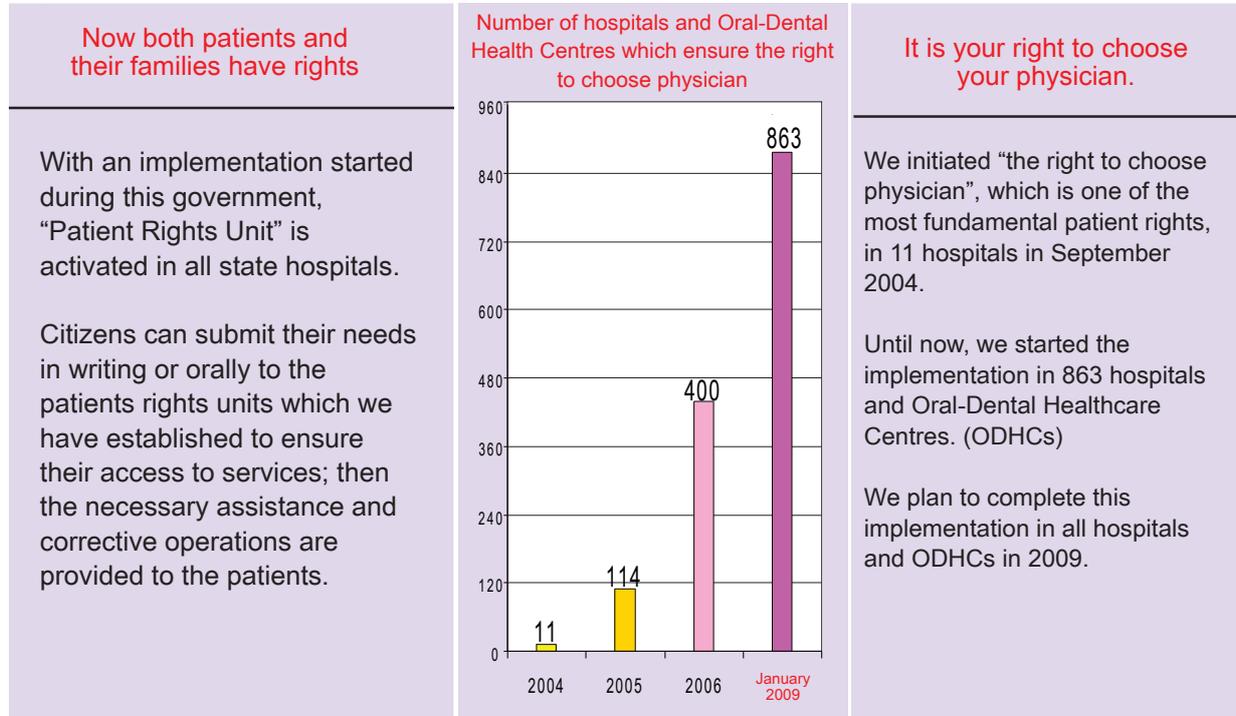


Note: The figures for 1999 and 2002 include those of Social Insurance Institution hospitals

When compared to 2002 figures, the number of tooth fillings and tooth prosthesis performed in state hospitals in 2007 increased by 10 times and 9 times respectively.

We target a health care system in which patients' rights are not violated, patients are informed at all stages of treatment and their consent is taken, confidentiality is respected, patients are provided with all kinds of curative services without discrimination and also a system where patients can choose their physician and health facility. As required by the relevant legislation, "Patient Rights Units" have been activated in all public hospitals.

Graph: 33



Now it is your right to receive service

You can reach the Ministry of Health directly

Through ALO SABIM 184

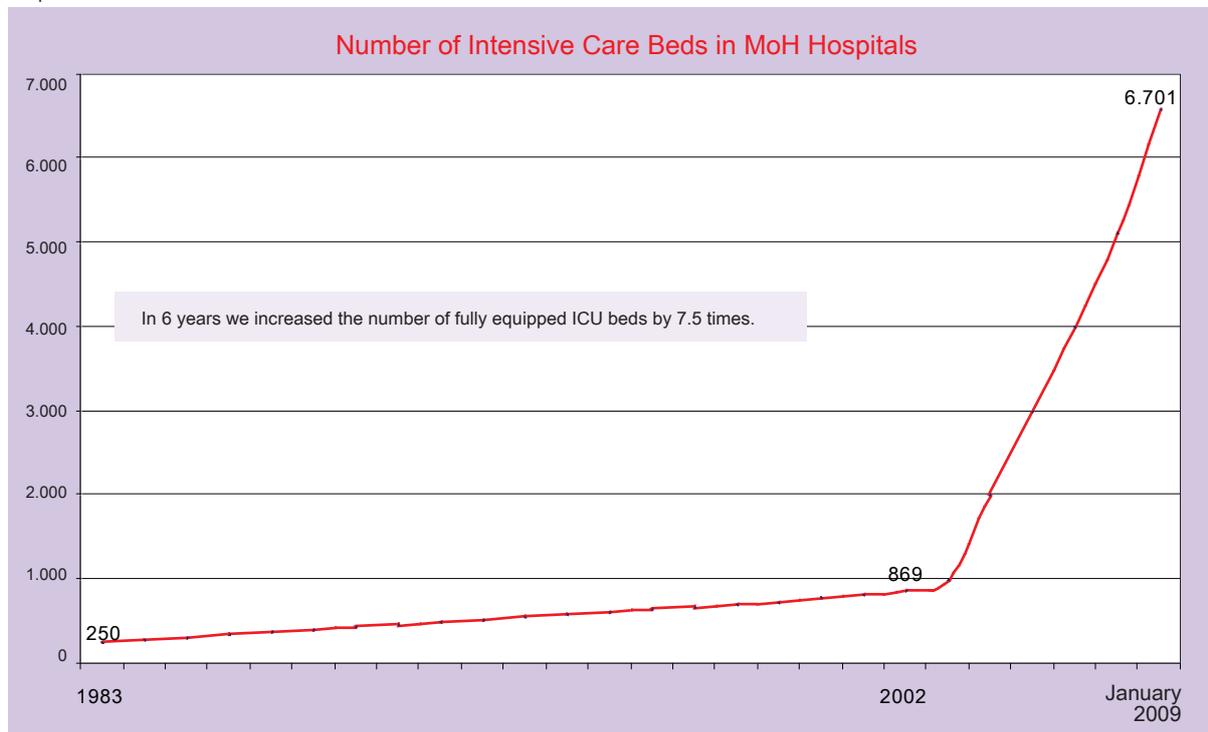
- We are at your service 24/7 with 52 operators.
- We solve the 90% of the applications in the first 24 hours.
- For the cases which cannot be solved immediately, we resolve the issue and then inform the citizen.
- Every year we resolve 1 million applications to SABIM.

In the last 6 years, 1,249 health facilities were opened. 402 of these are hospitals and side buildings. The constructions of the buildings, which could not have been completed for many years, are completed. The number of patient beds added was 20,000. 80 % of the patient rooms built in this period has private bathrooms and toilettes. Remaining 20 % are due to the projects which were started before but not revised technically. The number of patient rooms with private bathrooms and toilettes was increased from 10,000 to 24,500, which refers to a share that increased from 9 % to 19 %.

Intensive care units are being re-animated.

In 2002, the number of fully equipped intensive care beds was 869 and it has increased to 6.701 by 2009 January.

Graph: 34



Note: The figures for 2002 and before include those of Social Insurance Institution hospitals. Number of newborn beds is not included.

d) Prevention of Hospital Infections

In spite of the developments in medicine, hospital infections are important problems across the world. Diseases with serious progress which cause mortalities pose a threat first to patient safety and then visitors, non-health personnel and public health. Through the measures taken, it is possible to reduce the prevalence of hospital infections which extend the inpatient duration and cause financial burden on the country's economy.

Hospital infection is an important problem for our country as for the world. However serious studies have been conducted for 40-50 years in developed countries, the related studies and the administrative support were very poor in our country except for the specialty fields. The activities within this scope have been started in September 2004 by our Ministry.

The legislation studies addressing hospital infections were completed between the years 2005-2007; the implementations are being conducted under the “Regulation on Infection Control in the Inpatient Treatment Institutions” (11.08.2005–25903 Official Gazette).

The activities are executed in accordance with the opinions and decisions from the “Scientific Advisory Board for Hospital Infections” consisting of the experts from different medical schools and training and research hospitals.

One of the important instruments for the development of quality service presentation is to provide trained man-power compatible with the features required by service delivery. In accordance with the related Regulation, each inpatient treatment institution shall have the responsibility to assign one infectious diseases and clinical microbiology expert with (preferably) national/international certificate per 1000 beds, an infection control nurse with an infection control nurse certificate granted by the Ministry per 250 beds.

To date, 145 infection control physicians and 365 infection control nurses have been awarded National Certificate as a result of the infection control trainings conducted since 2007.

The first National Standard “Ventilation and its Control in the Hospitals” have been prepared through the Scientific Advisory Board.

As a result of our serious activities conducted within the scope of hospital infections, we have access to the national data and we can develop national policies since 2006.

In accordance with the related Regulation, hospital administrations shall be obliged to submit their annual activity reports each year, including the hospital infection rates and surveillance results to the Ministry by the end of February at the latest. With the support of the Scientific Advisory Board, our Ministry developed the “National Hospital Infections Surveillance System” in order to centrally collect and analyze the hospital infection data, evaluate the data and provide feedback, develop policies aiming at the control and prevention of hospital infections.

The data on hospital infections were collected in 2005 – 2007 through internet and by postal service with the use of forms.

The number of inpatient treatment institutions which notified their reports was 937 whereas it increased to 1113 in 2007. In 2006 there was the Infection Control Committee in 91.0 %, Infection Control physician in 89.1 %, Infection Control Nurse in 92.8 %, Infection Control Program in 74.9 % of the inpatient treatment institution. In 2007 these figures raised to 91.7%, 92.8%, 94.6% and 80.6% respectively.

Likewise, invasive device born infection surveillance carried out in 2006 was in 18.4% of the institutions this figure was raised to 26.2% in 2007. The infection surveillance in surgery was conducted in 37.7 % of the institutions.

Today hospital infection rates are classified and their percentiles are recorded. Hospitals are now able compare their surgery, invasive device and department infection rates with international figures. Additionally anti-microbiological resistance rates are evaluated as well.

Updated hospital infection data are collected and analyzed through the web based UHESA (the National Web for Hospital Infections Surveillance) launched in August 2007 by the Ministry. Hospitals enter the hospital infection surveillance data via the codes assigned by the Ministry for themselves and access to their own hospital infection data. The participation of all the inpatient treatment institutions linked to the Ministry of Health into the UHESA has been obligatory since May 2008. The data on hospital infections from other inpatient treatment institutions, which are not a member of the web network, will be collected at the end of the year as integrated to the UHESA. In a well operating surveillance system, standard data collecting forms and standard diagnosis criteria are required. The national hospital infections surveillance forms of the Ministry, the “Pocket Book” including the standard diagnosis criteria, the “Guide on the National Hospital Infections Surveillance” have been delivered to the inpatient treatment institution and published on the website of the Ministry.

In order to access to hospital infection surveillance data appropriately and timely, the Ministry provide support services via telephone, e-mail and the Infection Control Consultation Line forum established on the website for all the institutions within working hours.

The studies are continued in order to reach the adequate number in terms of assistant health personnel –especially the number of nurses- assigned for infection control.

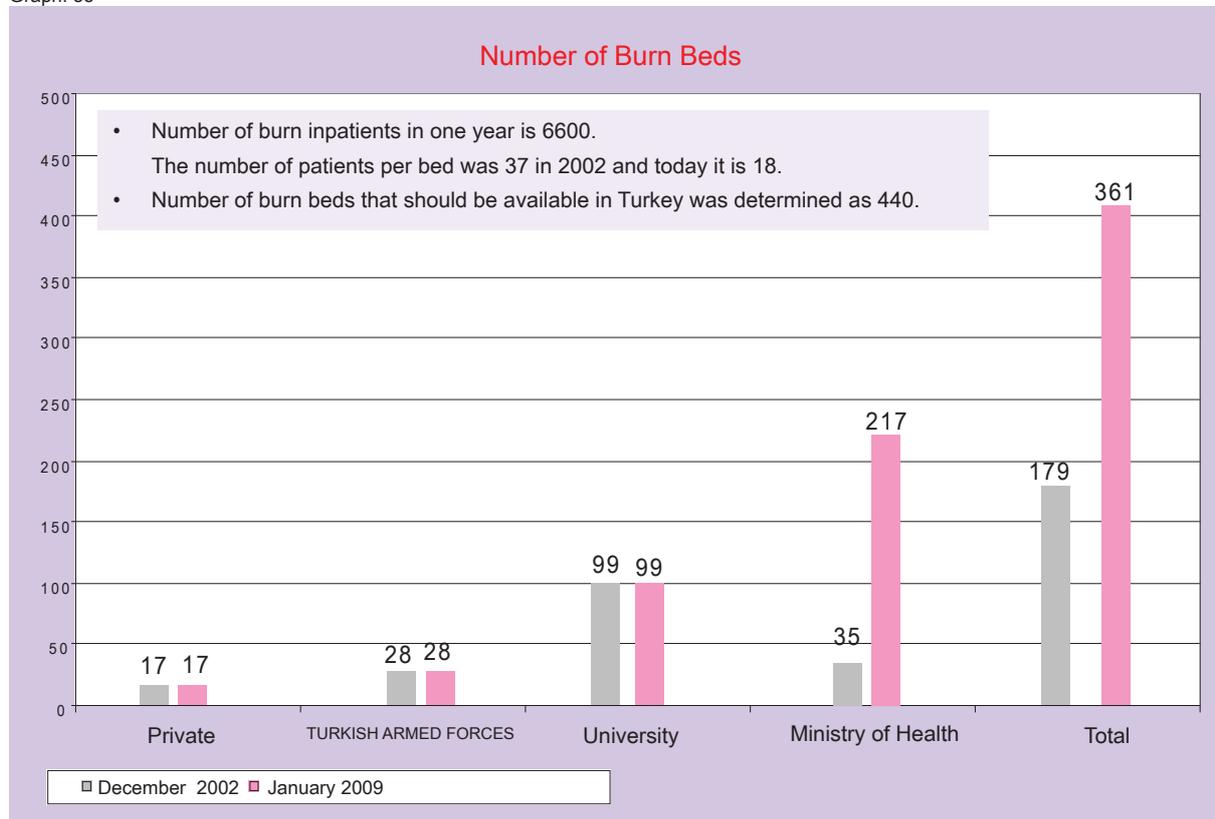
The quality of patient care will be improved through effective control of hospital infections and there will be significant decreases in health costs.

e) Private Hospitals are Open to Everybody

Health Transformation Program envisages to include all sectoral sources in our country in the system and thus to ensure harmonization and enhance productivity. Hospital

unification under single roof was a concrete step taken to this end. Another step taken is including private sector investments in the system in order for patients to benefit from these facilities in scope of their own insurance schemes. Now, all sources (both private and public) in the country are open to public use without discrimination. The State hospitals being qualified enough to compete with those in private sector affected the increase in their service quality which will be recognized more gradually. Private health care facilities now serve to those who are covered by public insurance which has decreased the workload of state hospitals. So, the excessive workload which was mostly undertaken by public sector in the past is shared with private health care facilities and health care services provision is this facilitated.

Graph: 35



At the same time, recording system has increased in private health sector. As a consequence, share allocated to public sector over value produced has increased. On the other hand, through this implementation the private health sector has been accelerated. Significant investments have been realized in this field. In order to protect the citizens, additional fees charged by the private hospitals are limited. Those last implementations direct the majority of the private hospitals to a transition towards becoming “public hospitals”. Private health institutions are in harmonization stage with this process.

A New Era in Health

6. Performance-Based Supplementary Payment, Quality and Accreditation

Before the Health Transformation Program, hospital personnel used to take a very little share from the revenue of hospital services provided by them. Because this kind of supplementary share payment was not directly related to the service, provided health services' efficiency, registration or return of service cost did not concern most personnel except for few managers which then led to an overall negligence in the field.

In previous implementation, theoretically the personnel could get a supplementary payment up to 100 % of their basic salaries. The new implementation, on the other hand, offers an extra payment varying from 150 % to 800 % depending on different professions and work styles.

Health Transformation Program states that performance indicators would be developed and performance-based payment systems would be established. The new implementation, in this context, has brought some changes in many respects. First, a system was set up by bringing the work and monetary contribution in parallel which would ensure more productive use of time and potential. It is more equitable that service producers have a share as much as they produce. We observed that such an additional income ensured the efficient use of time and potential in the institutions. The very first benefit of this system is that the services provided in hospitals has become measurable. The second benefit is the evaluation and reflection of these services to service providers. In training hospitals, not only services provided to patients but also resident training, scientific studies, publications are also accepted as performance criteria as well. Thus, residents' trainings and scientific studies are encouraged.

Some other major characteristics of the system are that health care personnel is awarded according to the level of deprivation of their work place and preventive care practices are emphasized as performance criteria.

Performance-Based
Supplementary Payment:
A System Which Awards
Those Serving to People

As a result of the performance-based revolving fund payments, personnel has extended work hours voluntarily and operating rooms are started to be used for longer times. Most specialist physicians have preferred to close their private offices and begun to work full time at the hospitals. This implementation, as it enables the efficient service satisfaction, has played an important role to overcome the workload created by the increasing patient demand at the hospitals. By the beginning of 2003, the share of full-time practitioners was 11 %, and this has reached 75 % thanks to these implementations. Thus, the productivity of the physicians in Turkey, where there is a shortage in their number, has increased in the public hospitals.

Graph: 36



When we came to office, only 2.200 of the specialists were working full time.
As a result of "Performance based supplementary payment" system, now 18.087 specialists are working full-time in the public sector.

- Payment-for-performance refers to the payment depending on the services provided, and we use it as an incentive instrument which increases service supply and efficiency.
- It has become a significant factor in motivation to meet the demand.
- Avoiding leakages in the recording system, inexpensive provision of supplies and decrease in waste subsidize the performance based payment system to a large extent.
- The implementation provided a regular recording system. While 20% of our hospitals had automation system in the past today the rate is 100%
- Outstanding decrease is achieved in waiting lists.
- Referrals to upper level facilities are at reasonable level now.
- Income-expenditure balance of health enterprises are monitored carefully.
- Today we are much more capable of fighting with unfair practices known as a "under the table payment".

Performance based supplementary payment implementation played an important role in raising the motivation in meeting the increasing service demand. This practice has facilitated a regular registration system. In the past, only 20 % of hospitals used to have electronic database system whereas it is available at 100 % hospitals, now. Thanks to this implementation, waiting hours are mainly shortened; referrals to upper level facilities are lowered to reasonable levels and the income-expenditure balance of health institutions are monitored carefully. In addition to these, another important factor is the self-subsidy of the performance based payment system with avoiding leakages in the recording system, inexpensive provision of supplies and decrease in waste.

Health Transformation Program aims sustainable quality development. We developed the performance-based payment system which is peculiar to our country. Then, as a second step we added the quality dimension through the legislations on “Institutional Performance and Quality Improvement” which is based on quality in health service provision. Thus, hospital evaluation system has been established which facilitates the assessment of access to health care services, infrastructure and procedures, measurement of patient’s satisfaction and the degree of the achievement of determined goals. Thus, supplementary payment made to personnel depends not only on quantity of services produced but also on the results of measurements of the above mentioned titles, in other words quality.

Institutional Performance and Quality Development legislation was amended by taking the implementation results into consideration and thus the quality dimension of the system have changed and improved gradually. Within the framework of the Institutional Performance and Quality Development works, important novelties have been brought into the agenda of the health agencies and institutions in the field of service quality standards and institutional performance assessments in 2008.

In order to ensure the coordination of the quality management projects initiated for ensuring efficient, effective and quality services in the MoH hospitals and to provide health accreditation unity in the country, the first MoH Quality Coordination Unit has been established. Afterwards, “Performance Management and Quality Criteria Development Department” has been established under Strategy Development Presidency in order to execute the performance implementation and the quality works. Finally an independent “Performance Management and Quality Development Department” has been opened for service within the Ministry because of its role in the Health Transformation Program, and its importance with respect to identifying the direction of quality development works of the health institutions and agencies and, relevant activities are continued in the said departments.

Thus, activities have been initiated to meet an important need of the health sector. Our Ministry has undertaken the leader role in the quality activities, which used to be rather in the agenda of the private health institutions in the past and was limited. For the last three years quality works have been gaining gradually more places in the agenda of the public hospitals and are becoming a part of all processes.

In the process, the quality studies in public hospitals were accelerated and at the first stage the Directive on Institutional Performance Assessment and Quality Development was implemented. Thus, a regular inspection system has been developed for hospitals in order to provide access to health services, to audit infrastructure and service process and to measure the satisfaction level of patients and patient relatives.

The said Directive was implemented for a significant period of time and, the Directive and its results were analyzed in the light of the feedback received and the data gathered, revised in a different and comprehensive dimension and published under the name of “Health Performance and Quality Instruction” to be implemented in health agencies and institutions.

In comparison to the previous quality legislation, the last directive has comprehensive changes with respect to the quality implementation in health and it covers arrangements not only for the MoH institutions but also for the private, university and other public hospitals.

In this framework;

* “Service Quality Document” can be given to the MoH hospitals, and to the other public, university and private healthcare institutions upon their request, if they meet the conditions required by the rules and procedures to be set forth by the Ministry. In this way, voluntary quality documentation in public and private health sector is moved to a new dimension.

* Extensive “Service Quality Standards” are identified to evaluate all the services delivered in the hospital.

* Specific “Service Quality Standards” are identified for the Oral and Dental Healthcare Services which did not have specific service quality standards.

* “Employee Satisfaction Questionnaires” are developed to be implemented in the institutions.

Perfection in service,
quality in health

* Service quality standards are identified for 112 Emergency Services.

* Specific efficiency indicators are developed for all health institutions and agencies.

PERFORMANCE MANAGEMENT IN HEALTH

We began to implement the performance measurement and supplementary payment system in order to improve healthcare services by measuring individual performance to promote high quality and efficient service provision and to motivate health workers in 10 pilot provinces in 2003. The relevant regulations were carried out in accordance with the outcomes and feedback from these 10 pilot provinces. Since the beginning of 2004 this policy has been implemented in all health agencies and institutions affiliated to the MoH . In one year's time, an integrated inspection model was formed through institutional performance and quality development methods.

We altered the definition of "quality" in public health via performance based supplementary payment system. While quality used to be defined by service providers as a result of supply oriented approach, now demand dominates the supply. Patient oriented approach in public health has increased the focus on patients and a brand new quality concept has been put on the agenda.

Through this policy, services provided have been registered, the leakages in the system have been avoided and the majority of the physicians preferred working full time in public hospitals.

This policy has increased both patient and personnel satisfaction as it has increased service efficiency in the health institutions by through performance based payment which foresee supplementary payment parallel to the service they provide.

The said legislation grades the hospitals and the other healthcare institutions, and those grades are renewed in every inspection period. When the public hospitals association is established, continuous hospital inspection and grading will be implemented in the light of the quality works. In addition, as a natural result of an integrated performance and quality development system related to reimbursement principles, private and university health institutions can also be included within the scope of this implementation.

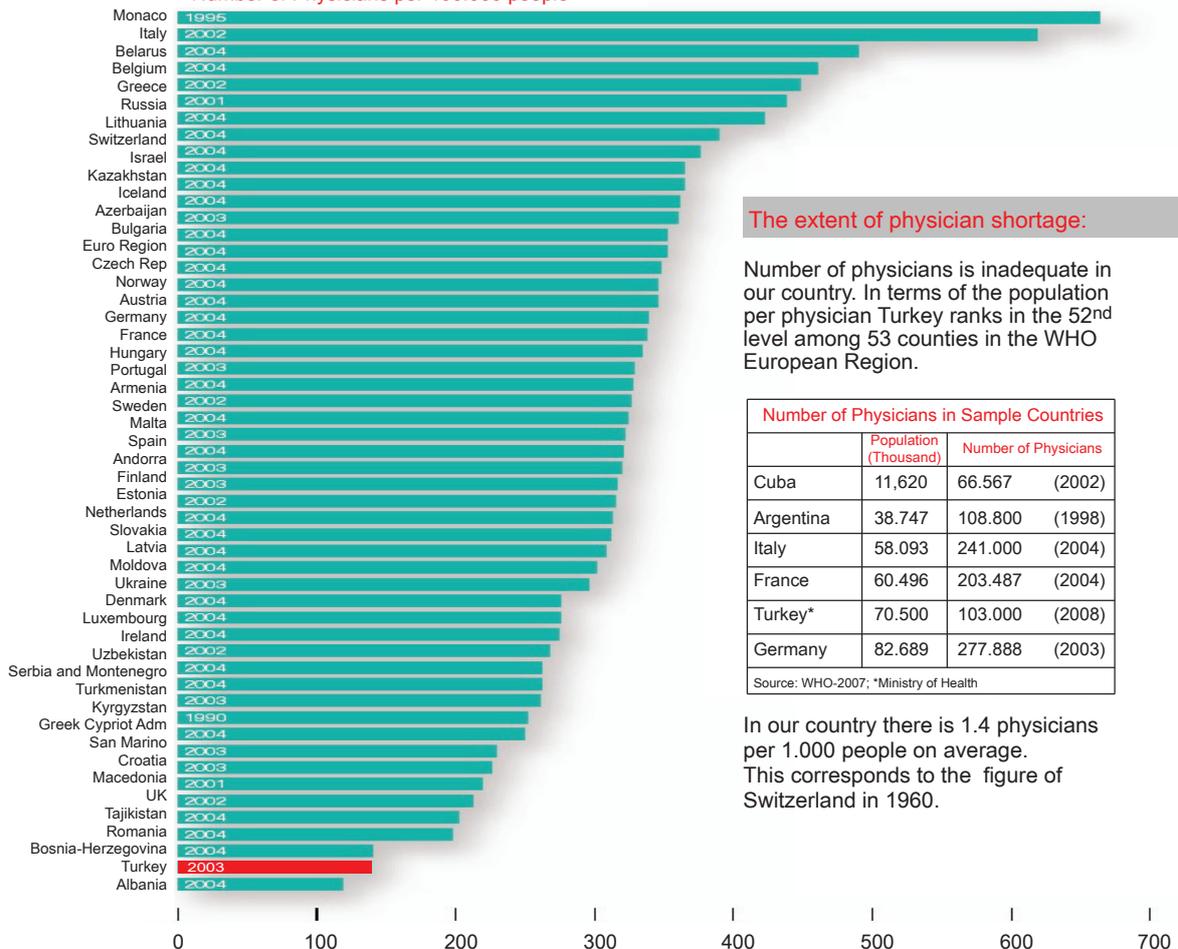
A New Era in Health

7. Human Resources Management in Health

a) Human Resources Situation Detection and Solution Planning

Before the Health Transformation Program, there were significant inefficient approaches to health human resources in Turkey. The misconception suggesting “the availability of excessive number of physicians” used to be in the agenda. There was a similar approach to the number of nurses as well. However the real important principle of “quality in education” was used as an excuse in order to shadow the need to increase numbers. At the beginning of the transformation, attention was drawn to the insufficiency in those numbers by the Minister of Health and the Ministry.

Graph: 37 **Number of Physicians per 100.000 people**



The extent of physician shortage:

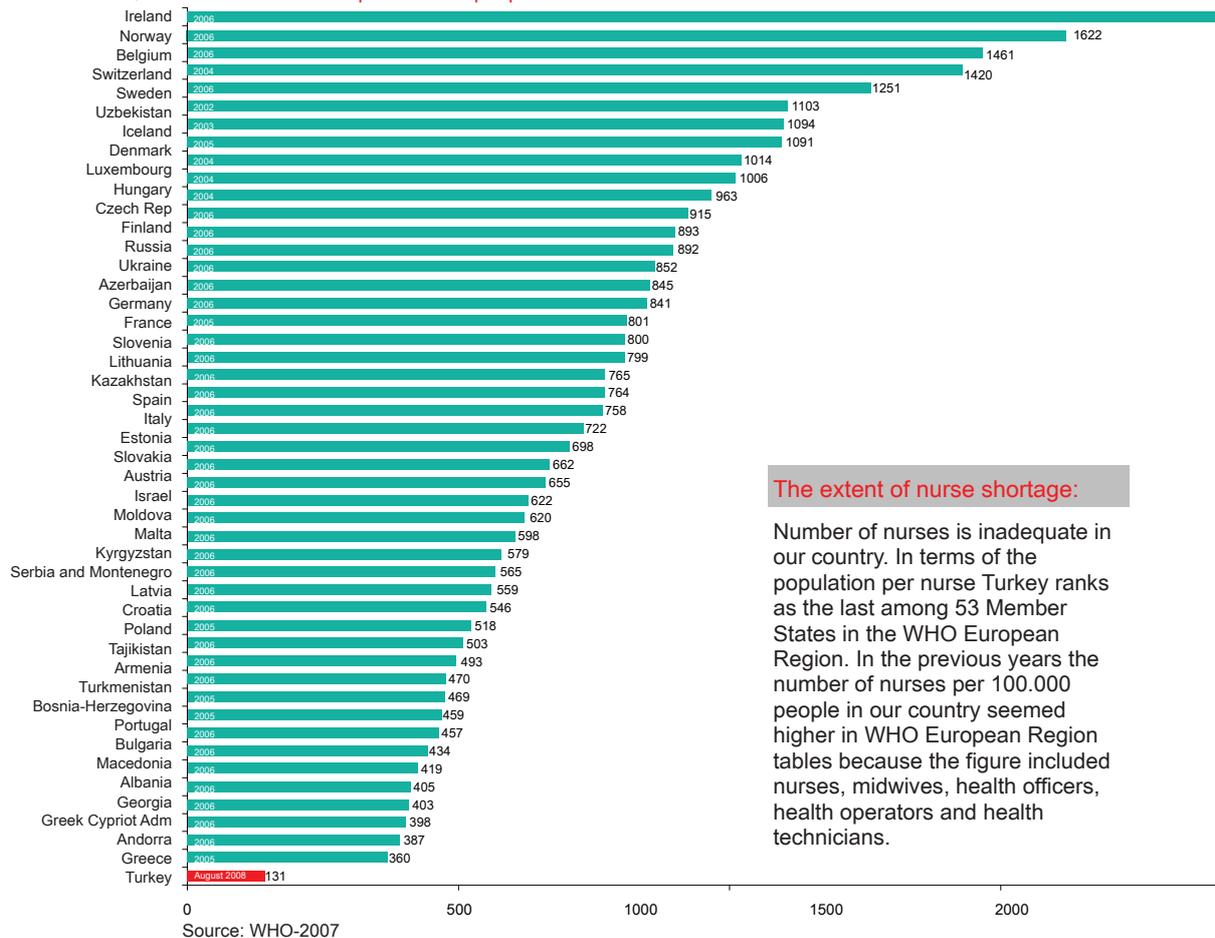
Number of physicians is inadequate in our country. In terms of the population per physician Turkey ranks in the 52nd level among 53 countries in the WHO European Region.

Number of Physicians in Sample Countries			
	Population (Thousand)	Number of Physicians	
Cuba	11,620	66.567	(2002)
Argentina	38.747	108.800	(1998)
Italy	58.093	241.000	(2004)
France	60.496	203.487	(2004)
Turkey*	70.500	103.000	(2008)
Germany	82.689	277.888	(2003)

Source: WHO-2007; *Ministry of Health

In our country there is 1.4 physicians per 1.000 people on average. This corresponds to the figure of Switzerland in 1960.

Graph: 38 Number of Nurse per 100.000 people



The extent of nurse shortage:

Number of nurses is inadequate in our country. In terms of the population per nurse Turkey ranks as the last among 53 Member States in the WHO European Region. In the previous years the number of nurses per 100.000 people in our country seemed higher in WHO European Region tables because the figure included nurses, midwives, health officers, health operators and health technicians.

It is important to raise the numbers of the health personnel particularly of the physicians and the nurses without compromising education quality in health human resources. In terms of the number of physicians per hundred thousand, Turkey ranks at the bottom of the WHO European Region. The situation is no different for the nurses, physiotherapists, and many other health professionals.

The needs of the population and the increasing demand for the healthcare services make it inevitable to increase the number of the physicians and the nurses. At the same time, the education quality must be preserved and even be improved. The number and competency of lecturers in the medical faculties in Turkey are sufficient for this.

Numbers of physicians and nurses are inadequate in our country.

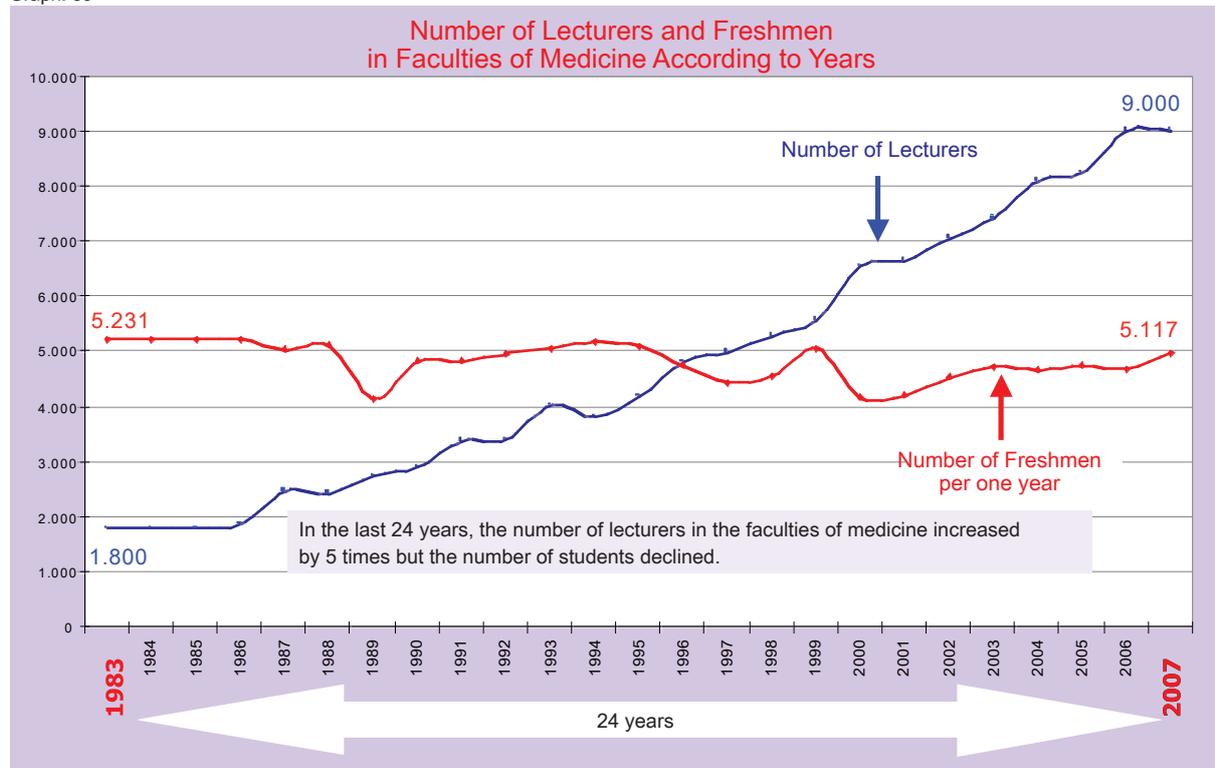
Table: 5

Number of Students per Lecturer in Faculties of Medicine in Various Countries					
Country	Population (Million)	Number of Faculty of Medicine	Number of Lecturers	Number of Medical Students	Number of Medical Students per Lecturers
Germany	82,6	36	3.550	79.866	22,5
Spain	41,9	28	2.500	36.049	14,4
Italy	58	39	12.583	148.157	11,8
France	60	44	5.847	62.921	10,8
Slovakia	5,4	3	893	6.561	7,3
Slovenia	2	1	285	1.717	6
Finland	5,2	5	698	3.583	5,1
Denmark	5,4	5	1.570	6.598	4,2
Turkey*	70,5	52	9.020	32.985	3,6

Source: Ministry of Foreign Affairs; *The Ministry of Health

Our country is in WHO European Region. When the average of this region is taken as the basis, there should be 14.000 graduates from the faculties of medicine every year according to the population we have. However, the annual number of graduates is the 1/3 of the European average (around 4.500).

Graph: 39



In the light of those facts, the School of Public Health has started a work with the participation of the relevant sectors in May 2006. An assessment analysis was conducted with WHO and Harvard School of Medicine and published as a book titled “Human Resources in Health and Current Situation Analysis”. A workshop was held on 22-24 April 2007 in order to evaluate the findings and analyze the policies, the outcomes of this workshop were published under the name of “ Human Resources in Health and Policy Dialogue Workshop”. MoH, in collaboration with the Higher Education Council (YÖK) and SPO, published the Turkey Health Workforce Situation Report in March 2008. Health human resources planning and training are the constitutional roles of those institutions and it is very promising that those institutions meet at a common ground. Among the first fruitful examples of this collaboration are the increase by YÖK for student quota for the Medical Faculties by 30 % and for the Nurse Vocational Schools by 15 % in 2008. The quotas increased to 6.000 for the Faculties of Medicine and 14.000 for the Nurse schools (Health College and Nurse Vocational Schools) in 2008.

Assuming that our population will become 83 million in 2023 with the current projections, we think that it is necessary to increase the quotas gradually in the coming years and to have 13.000 new students to the Faculties of Medicine and 23.000 new students to the Nurse Schools every year.

In this way we will be able to get close to the European average with 200.000 physicians and 400.000 nurses in 2023. With those figures we will have 250 physicians and 500 nurses for every 100.000 people. The same approach is important for the physiotherapists and many other health disciplines.

The following requirement estimation is considered convenient for 2023:

- In 2008, the number of admission to physician per capita was around 6,3. We expect that this number will reach 7-8 per year in the following 15 years. As stated above, Turkish population is projected to reach 83 million in 2023. So the total number of applications is expected to reach 664.000.000 in 2023. (83.000.000 x 8 = 664.000.000)

For a qualified and reliable health service delivery, a physician should allocate averagely 15-20 minutes for a patient. Assuming that the family physicians and the specialists of the outpatient institutions allocate 17 minutes for each patient, it



would be reasonable to aim at meeting the requests of 25 patients a day. Given the fact that for outpatient admissions, a physician works for 7 hours a day; $420 \text{ min}/17 = \sim 25$).

- There are approximately 220 workdays a year $664.000.000 / 220 \text{ days} = 3.018.181$ admission/day needs to be realized.
- $3.018.181 / 25 = 120.727$ physician / day rate is found. (i.e. in 2023 we will need 120.000 physicians who will be examining patients at the same time).

The figure of 120.000 is only the required number of the family physicians and the specialists physicians examining patient in outpatient institutions at the same time. When the other services such as community health services, training services (trainers and trainees), inpatient services, surgery and intensive care services, laboratory services, researches etc are considered, it is seen that the number which will really meet the needs is 200.000 physicians.

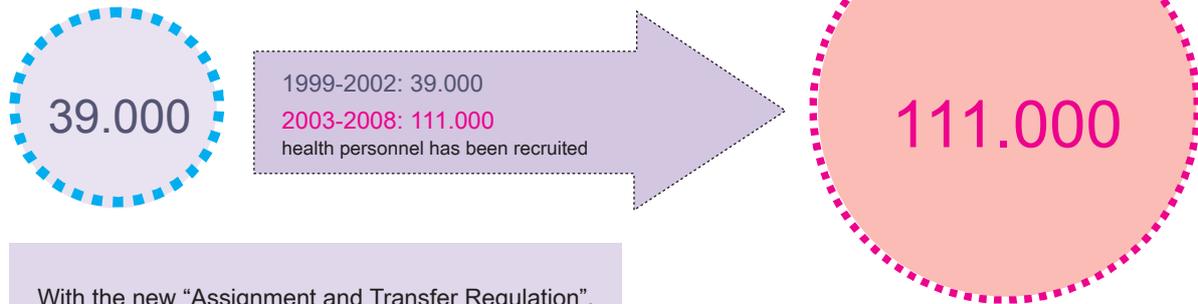
It is also necessary to add that the inadequate number of physicians is unable to optimally meet the service supply and this hardens the distribution of the physicians geographically, increases the cost of the physician supply excessively, results in unnecessary test and polypharmacy practices, and as a result increases the costs.

b) Breakthrough in Health Human Resources Employment

111,000 new health personnel were employed during the last 5 years in public health institutions. 16,000 contracted personnel are assigned in less developed areas which had no personnel in the past. In this way, the gap between the best province and worst province rates were diminished (for specialists: from 1/14 to 1/3.5; for practitioners: from 1/9 to 1/2,7; and for nurses and midwives: from 1/8 to 1/3,8). In the next few years, distribution of health care personnel between the best and the worst provinces will be more equitable by the compensation activities. Another recruitment model is the recruitment of the staff working for outsourced services such as housekeeping, information processing, security, and catering. The number of these personnel was 25.000 in 2002 and it is 98.000 as of January 2009.

In 2002, the number of personnel working in MoH and Social Insurance Institution hospitals was 272.000 and it reached 414.000 as of January 2009. (This figure includes the ones recruited directly by the public and also the ones recruited through outsourcing.)

Significant Breakthrough in Employment



With the new “Assignment and Transfer Regulation”, regions and service groups were formed and a fair personnel distribution has been obtained.

Service point criteria are defined and thus, personnel assignments are based on an objective principle.

A more strict inspection system is introduced for excuse cases.

Speculations are eliminated as the assignments are realized by computerized lotteries.

We continue to implement a realistic personnel distribution plan based on the target population, service region, physical structure and the service delivery features of the health institutions.

c) Transparency in Personnel Assignment

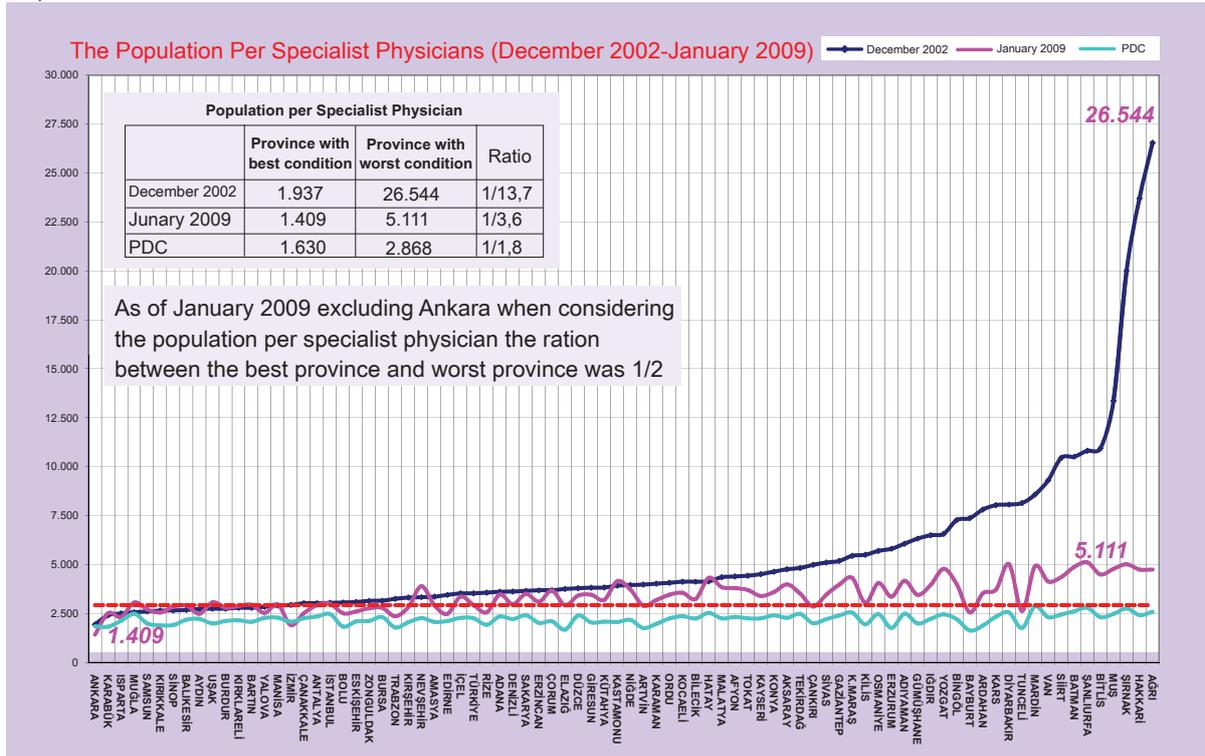
It is known that imbalanced personnel distribution was one of the most important problems in our country in the previous period. One of the priorities of the Health Transformation Program is to alleviate regional differences in personnel distribution, by setting realistic standards based on titles in personnel employment to establish a system assuring objectivity and equity in assignment and transfer of the personnel.

We do not deprive less developed regions

In order to encourage personnel to work in priority development regions, the law No: 4924 is adopted. So, working in areas where personnel show less interest is encouraged. Thanks to this policy, more than 7,000 new health personnel were assigned in the East and Southeast Regions.

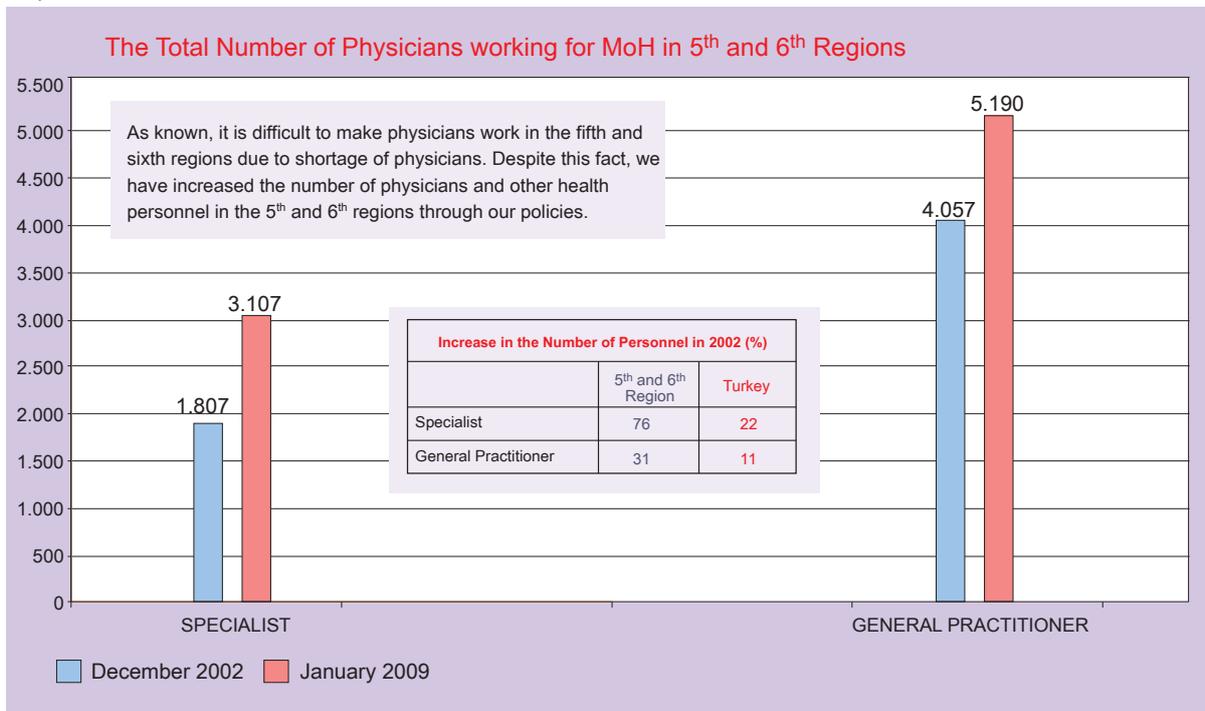
In addition to shortages, the physicians tend to work in metropolitan cities and therefore this makes it more difficult to employ physicians in less developed regions. Within the framework of the access to health services by everyone, physicians are asked for promoted “compulsory” services.

Graph: 40



Considering former incomplete and insufficient compulsory service implementations, we have made an acceptable and sustainable arrangement by identifying different working durations and higher payment policies particular to less developed areas.

Graph: 41



Note: Figures for 2002 include Social Insurance Institution health facility physicians.

Directive on Assignment and Transfer was prepared, which avoids nepotism in personnel assignment and enables balanced distribution of health personnel working for the MoH. In very first appointments, specialist physicians, general practitioners, dentists and pharmacists are appointed by a computer-based lottery and other personnel is appointed by a central examination conducted in accordance with general provisions. In the new implementation, personnel appointment and transfer proceedings are based on the “service points” that depend on work places and periods. A more strict supervision system was set up for excuse cases. Assignments to be made in accordance with “service-point” and through computerized lottery have put an end to favouritism and nepotism pressures on politicians and bureaucrats as well as unfair practices and speculations. Thus, a noteworthy success is achieved in the fair and balanced distribution of health personnel all over the country.

d) Health Personnel Training

Adaptation trainings are given to family physicians and nurses to be assigned in primary care. The curriculum for the longer second period has already been finalized and training materials are almost completed.

Primarily, there is mobilization process in place to train current directors. On one hand, regional training meetings are held on technical issues, and on the other hand, School of Public Health gives systematic health management trainings on internet.

So far, within the scope of those trainings, 6.500 students (500 of them were directors) benefited from the system. Being a modern technology product providing information on internet, the distant learning system is used for the first time in the Republic Period and, it aims at training the director, director candidates and the specialists in the health institutions. The training web address is www.hm-uses.gov.tr.

The Law on Nursing, which enables the nursing-training program to be offered at university level to catch international standards and help nursing services turn into a scientific discipline in patient care, is adopted. However nursing education in colleges in the transition period will continue due to the great need. Relevant arrangement includes this notion, too.

It is seen that with the help of Health Transformation Program and various other factors, there is a decrease in the infectious diseases and also the character of the disease burden has started to change significantly. For this reason, the education curriculum of the health professions should be revised and updated.

A New Era in Health

8. National Drug Policy

a) Reduction in Drug Prices

One of the observations by the Health Transformation Program is that increases in medicine prices were not evidence-based in the past. The Ministry of Health, on behalf of the public, is responsible to determine the relevant norms and standards about pharmacy and pharmaceutical services. It is also competent and obliged to carry out inspections in this field and to encourage rational use of medicines in cooperation with other relevant institutions and organizations.

As for pharmaceutical pricing, the need for developing a method which all parties would agree on is clearly emphasized in the program. “The Decision on Pricing of Medicinal Products for Human Use” dated 2004 removed the disturbance and negative aspects and enabled transparency in pricing of pharmaceuticals. Thus, significant decreases are achieved in pharmaceutical prices. Now the prices of pharmaceuticals are at the lowest level in Europe. Discounts ranging from 1 % to 80 % are obtained for approximately one thousand products.

In order to relieve the burden of the Public Finance, headed by the Ministry of Finance, a Reimbursement Commission has been established. This Commission has enabled “The Single Reimbursement System”. Upon a consensus among reimbursement institutions, the principle of payment for drugs up to 22% of the lowest bioequivalent drug is adopted.

With this implementation, some medical firms that are out of this circle have diminished their prices voluntarily in order to benefit from the public reimbursement system. Eventually, a significant saving has been achieved for public finance.

Leading to another important reduction in pharmaceutical prices, the VAT rates for medicine have been reduced to 8 % from % 18. Negotiations between the public social security institutions, the sole purchaser and the sector, enabled a number of decreases, and lowered the cost of pharmaceutical prices on public.

“Price Decree” dated 1984:

Prices were based on the firms’ cost statements, it was not practically possible to investigate the cost of particularly the imported pharmaceuticals, and market prices were determined by adding the costs and the profit rates.

By the new decree dated 6 February 2004 of our government

Reference Price System introduced a transparent, measurable, objective criteria and gradual profits which will decrease the burden on the public. We established the structure which includes the reimbursement institutions in the decision making process.

Regulating the Pharmaceuticals’ prices with the Reference Price System

- * We take 5 EU member countries which have the lowest pharmaceutical prices and are followed, as the reference
- * We identify the maximum price of any pharmaceutical in our country by taking the lowest price within those 5 countries as the basis. (reference price)
- * We follow the prices with IMS data, and we demand approved documents from the relevant country when necessary, and we determine them by asking our embassies .
- * In the framework of this implementation, we realize price reduction between 1% and 80% on approximately 1000 products.

Annual Public Savings made through reference price system:
1 Billion TL

Table: 6

Public Pharmaceutical Expenditures in 2002 prices (million TL) and Amount of Consumed Pharmaceuticals (million boxes)

	2002	2003	2004	2005	2006	2007	5 Years Increase In (%)
Public pharmaceutical Expenditure (TL million)	5.232	5.428	5.601	5.173	5.944	6.056	16%
Pharmaceutical Consumed (million box)	699	769	856	1.212	1.272	1.399	100%

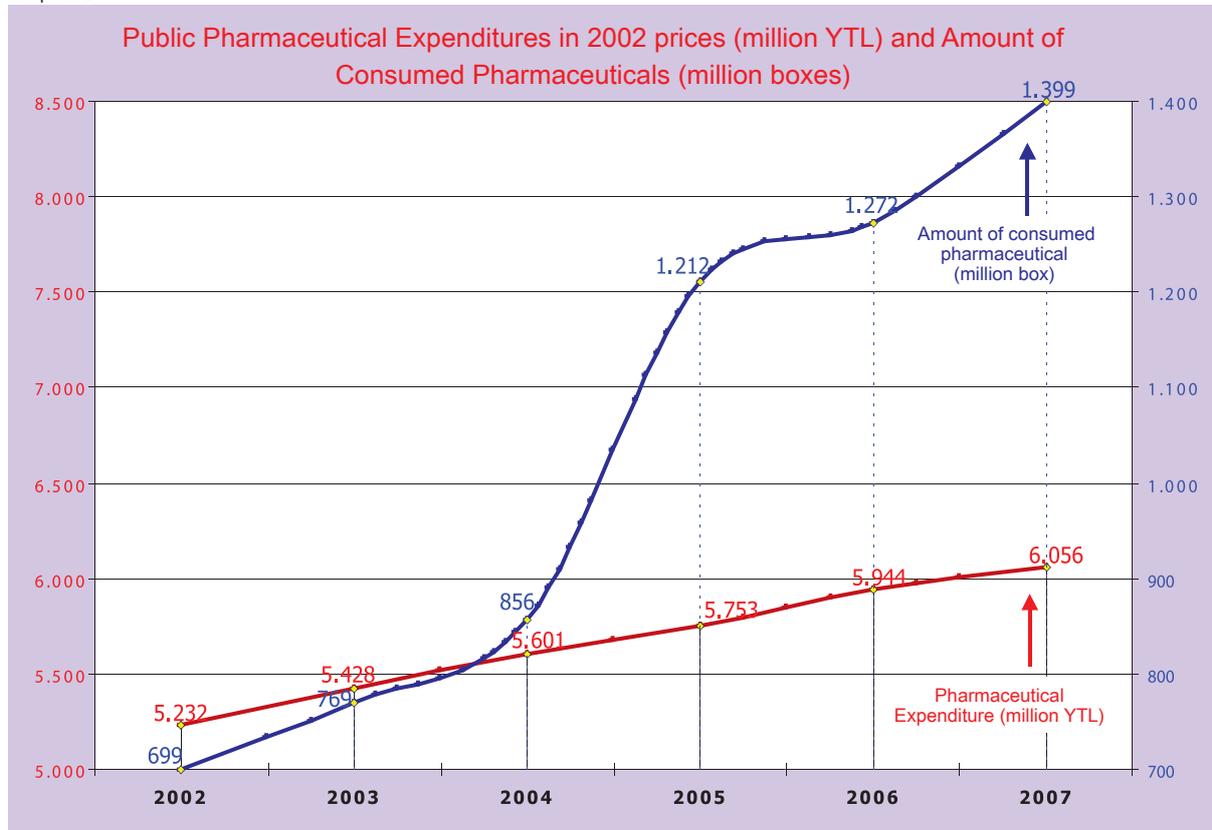
Thanks to our pharmaceutical policies, the amount of medicines consumed in 5 years increased 100 % and the public pharmaceutical expenditure real increase was only by 16 %.

We used the savings achieved by our pharmaceutical policies for ensuring public’s easy access to pharmaceutical. Social Insurance Institution enrollees and green card holders can now get their pharmaceutical from all pharmacies.

b) Opening pharmacies to everybody

People now do not encounter any difficulties in accessing pharmaceuticals (especially people covered by Social Insurance Institution and the Green Card) by reflecting the advantages gained by drug prices directly to our citizens. In the Health Transformation process, decisive steps have been taken to ensure easy and economic access to medicines and the result of those steps are observed by the public closely.

Graph: 42



People covered by the Social Insurance Institution had to obtain their medicine from a limited number of hospitals and some of them could not obtain their medicine for this reason and some had to pay for the medicines out of their pockets. Now they are also free to obtain their medicine from any pharmacy like the other Turkish citizens. With the changes in the Green Card legislation, Green Card holders are also included in the out-patient treatment system; hence they are free to obtain their medicine from any pharmacy.

All these implementations have eliminated the discrimination dividing people into categories.

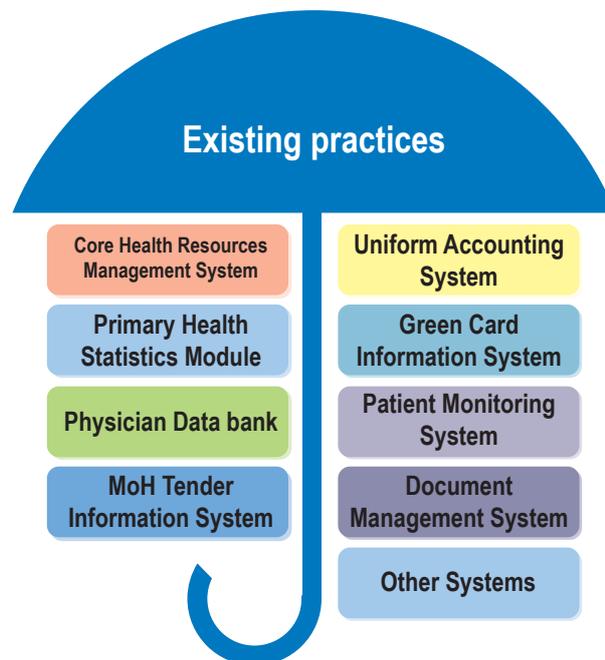
c) Rational Drug and Material Management

Institutional structuring preparations are continuing.

A New Era in Health

9. Health Information System

It has been emphasized that an integrated information system is needed in order to harmonize all the components of the Health Transformation Program. It is known for sure that health system policies and administrative decisions should be based on information.



Health information system cannot be built solely by making investments in technologies. The establishment of the system depends on national and international health informatics standards, coding, classification and terminology identification, integration of the data collected from different institutional levels, and making this information usable in the decision making processes.

From data collecting
to data processing...

Primarily the standard definitions of institutions contacted in providing health services, the data banks of physicians, international disease classification, medicine and medical product codes have been identified and used in the sector after harmonization.

Family Medicine Information System, which is a pioneer of the electronic patient recording and a limited scale example of the health information system, has been implemented. In this way, so far, we have started to keep the Electronic Health Records of 17 million citizens in the Family Medicine provinces so far.

We have introduced the Uniform Accounting System. Through the Core Health Resources Management System we have ensured that all managers get accurate and up-to-date information support for monitoring and directing human, material and financial resources.

Through the MoH Tender Information System, it is possible to see the tender results for the procurement of medicines, devices, materials and services in all MoH Provincial Health Directorates, all hospitals, and Hygiene Regional Directorates.

Through the Green Card Information System, the green card holders are included in the Pension's Fund prescription control system. Pharmaceuticals and International Disease Classification codes are implemented. National Health Data Dictionary and Minimum Health Data Sets have been prepared for the first time in health informatics and Health Coding Reference Server is implemented.

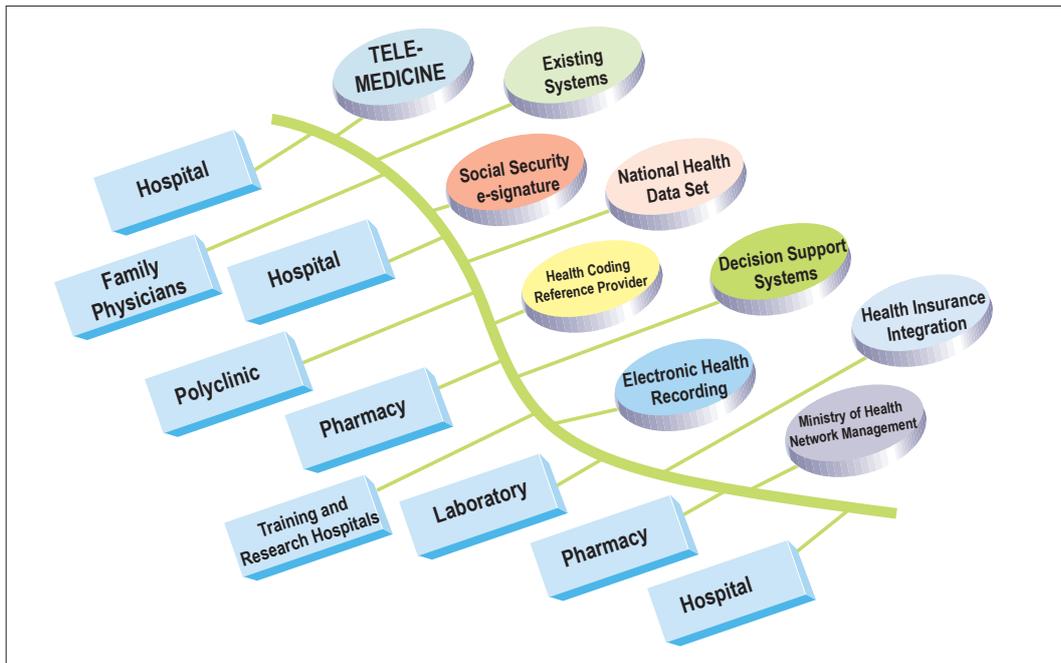
Again for the first time, Organ Transplantation and Tissue Data Bank is established in order to find the most suitable organ for the citizens waiting for organ transplantation and to prevent illicit organ transplantation.

Through the Physician Data Bank, the diploma and the specialty information of all physicians during the Republic Period are registered.

Through the Tele-medicine Project, distant reporting service was provided in the field of screening with the use of information and communication technologies and a total of 18 hospitals are included in the process consisting of 11 sender and 7 receiver hospitals in the field of tele-radiology, tele-pathology and the coverage is increasingly expanded.

National Health Information System /e-Health Project, completed the infrastructure works for the establishment of a health information system covering all health services and all actors of the health system. According to the Minimum Health Data Sets included in the National Health Data Dictionary, the project aiming at gathering electronic health records from all hospitals is implemented and in the near future health data will be collected in this way.

Decision Support System, which provides analysis, reporting and statistic support for the Health Policy makers, planners and decision givers, is activated. In this way, it will become possible to do epidemiologic and demographic analysis addressing the burden of disease. Saglik-NET portal is also set off for service for the citizens, information officers and health workers.



Under the coordination of SPO; Ministry of the Interior Affairs, our Ministry, Social Security Institution and TUBİTAK-UEKEA execute various activities such as:

- a) With the e-identity (smart card) project, both the citizens and the physicians will have access to the health records safely and violation of personal confidentiality will be prevented.
- b) With the e-prescription project, paper prescription will disappear and the prescriptions will be processed in the electronic environment.

The preparations for those projects are completed and their pilot implementations have been started in Bolu province in 2008.

The pilot implementation of the Central Hospital Appointment System and the Central Call Centre project will be started in 2009 in order to increase the citizen satisfaction and to increase the efficiency and the quality of the health services delivered at the hospitals. It is important to start and follow this implementation with a comprehensive understanding which is very different from the unsuccessful examples of the past.

A New Era in Health

10. Rationalism in Investments

A detailed health inventory has been created through the Health Transformation Program by assessing all the health investments so far. Public health investments are re-planned. The financial, medical and technical analyses of investments are elaborated. These planning procedures have been carried out on-site at district, province and region levels together with the local administrators. The projects have been re-arranged in accordance with the priority and importance level and, a more rational utilization of investment budgets is ensured.

We conducted "Turkish Health Inventory" study.

We re-evaluated financial, medical and technical analysis of investments.

We made planning through on-site inspections and in collaboration with local administrators on district, provincial and regional level.

We classified projects with regards to priority and significance.

So, we made rational use of budget which was allocated for investments.

Health Investments Completed between November 2002-January 2009					The Amount Spent For Health Investment, Maintenance And Medical Equipment between the years 2003-2009 (Million TL)				
Hospital	Hospital side buildings	Health centers	other	Total	Overall Budget	Revolving Fund	Province Special Admin.	TOKI	Total
211	191	752	95	1.249	3.274	3.360	753	207	7.594

Table: 7

Table: 8

Within the 6 years during our office, we spent 7.594.000 TL on investment, maintenance and medical equipment. We opened 1.249 health investments in to service, of which 402 are hospitals and side buildings.

We prepared the legislation which will enable investments to be realized with public private partnership for the construction of new "patient focused" hospital buildings and hospital campuses and for the revision of some old buildings.

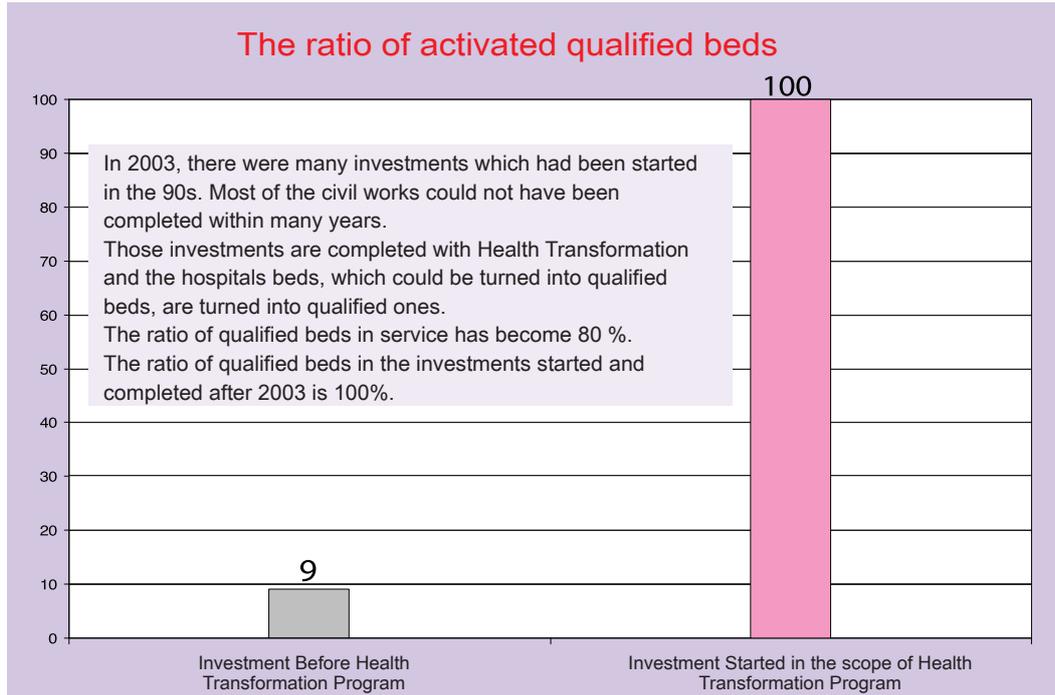
Table: 9

Increase in the number of qualified patient beds in MoH hospitals	December 2002	January 2009
Number of patient beds	107.307	128.600
Number of qualified patient beds	10.100	24.500
The share of the qualified patient beds within the total patient beds	9	19

Note: December 2002 figures include Social Insurance Institution SSK hospital bed numbers.

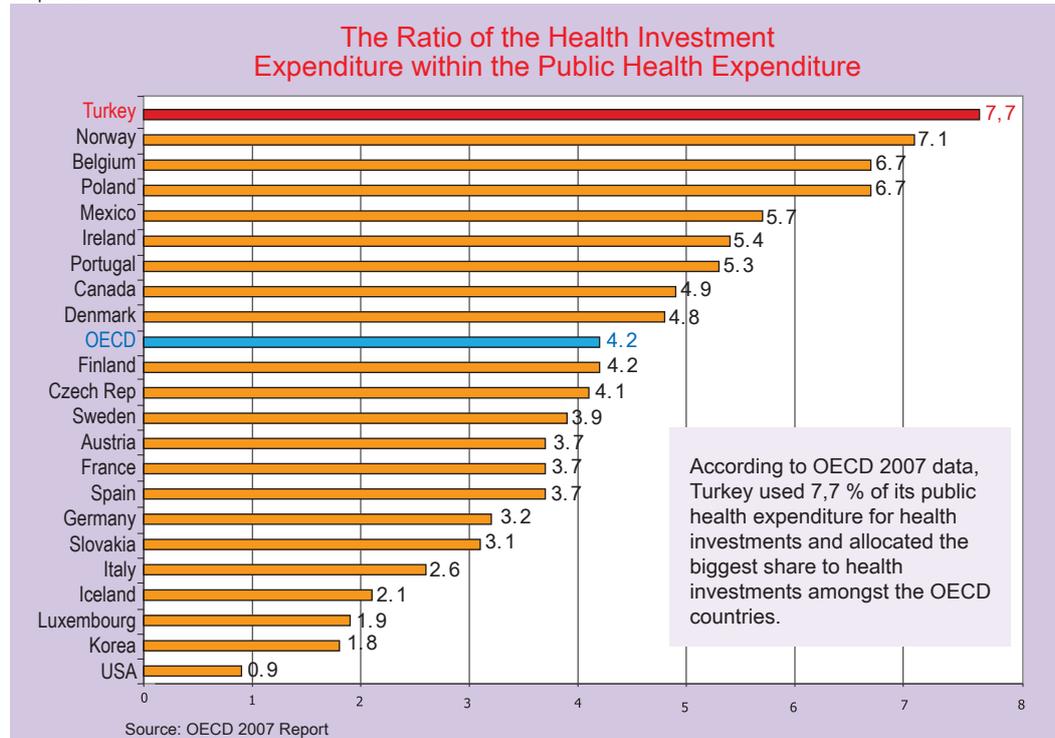
*Qualified bed: the patient bed which is in the rooms which was at most 2 patient beds, toilet and bathroom, TV, phone, fridge, dressing cabin, dining table, locker, sofa bed/chair.

Graph: 43



In fact, the number of beds per 100 thousand people in Turkey is 285 and this figure seems sufficient in the framework of the new tendencies in the world. However, the existing beds will be replaced by qualified beds and we will continue to make the investments which will establish the modern structures alongside.

Graph: 44



A New Era in Health

11. A Health City for Each Health Region

In most of the developed countries the health systems are structured so as to cover the whole population in the framework of quality standards and equality principles.

Though approaches might differ, the financing and organization responsibility of the health services is shared between the central and provincial authorities but in general the central government is the main determiner.

In terms of health planning, in Denmark, local administrations and municipalities plan the health fields under the supervision of the central government. In the UK, national and regional planning are managed by the central government with the participation of the local authorities. In France, regional hospital associations plan the hospital service within the framework determined by the central government. In Germany, state governments plan the hospital capacities in the framework of the national and regional legislation. In Canada, the planning is under the responsibility of the regional managements by taking the national framework into consideration in some cases.

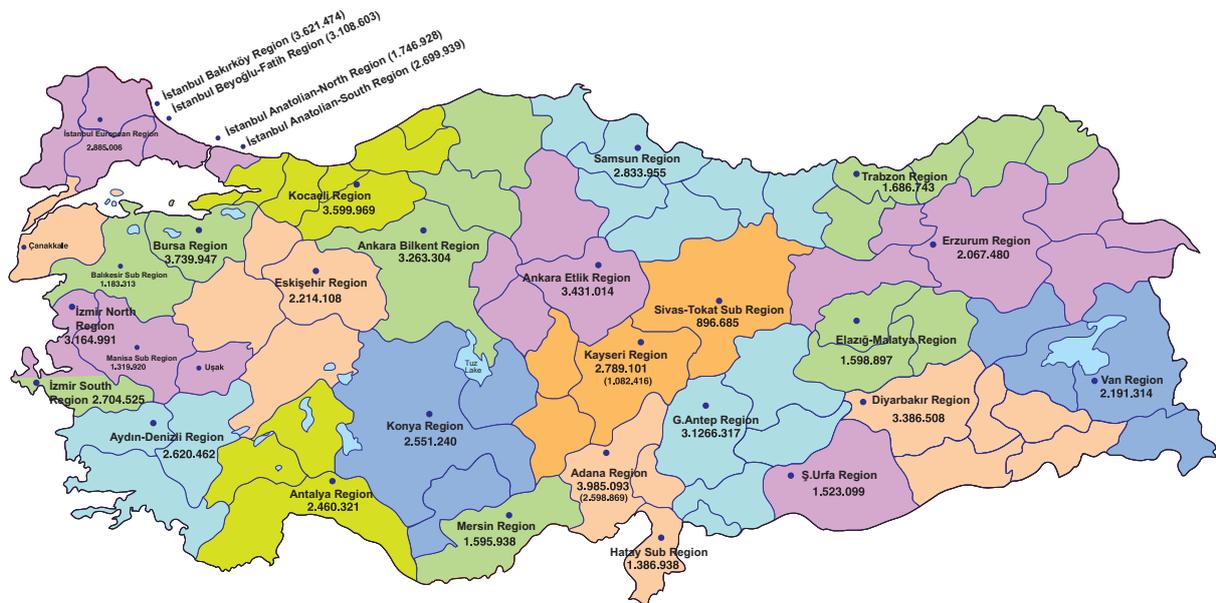
In Canada, France and Germany, the hospital planning covers both the public and the private hospitals. In fact the private institutions are subject to permission within the scope of the planning in order to expand their activity areas. On the other hand, countries like Denmark and the UK limit their plans with the public hospitals.

In our country, opinions were taken from the provincial institutions by the Ministry for the regional health plans, attention was paid to the assessments and observations regarding of the central institutions locally taking into account the population, geographical structure, the covered area, distance to the centre, transportation, local needs and existing health inventory.

Reference hospital/campuses are planned in order to meet the needs for health education, institutional guidance and reference centre in their regions. Before the Health Transformation Program, the delivery of health service was structured with the induction method from bottom to top as health houses, health centres, district hospitals, province hospitals and regional hospitals; after this planning the deduction method is envisaged by taking the reference centre as the basis.

In Turkey, the locations of health campuses are identified and the allocation of those locations is accelerated. 27 main regions and their sub-regions are identified and correspondences are completed or continuing for the allocation of areas for 17 regions, and area selection works are continuing in 10 regions. One of the main purposes of the health campuses project is to focus on increasing the total bed and service area quality instead of the number of beds. In each region, along with meeting general bed needs of that region, hospital beds with specialty specifications like rehabilitation, mental health, oncology, cardiovascular and etc services are planned to be activated.

For each campus, it is planned to put into service patient beds for rehabilitation, mental health, oncology, cardiovascular and similar purposes along with the general patient beds so as to meet the needs of that region.



Why Hospital Campuses?

Hospital campuses are important:

- For increasing the health service efficiency in our country;
 - To expand the treatment variety across the country,
 - To complete the regional development in the field of health,
 - To increase service quality,
 - To enable the delivery of cost effective health service...

- For the needs of the society;
 - Adequate number of beds and appropriate bed quality,
 - Specialized team working for every parts of the regions,
 - To use new technologies in treatment,
 - To develop new concepts in curative services (daily surgery, day hospital).

- For the patients;
 - To shorten hospitalization,
 - To decrease patient transfers,
 - To decrease hospital infections,
 - To increase patient safety,
 - To increase patient satisfaction...

- For the personnel;
 - To increase staff satisfaction and safety,
 - To increase workforce and service quality,
 - To develop health service performance...

A New Era in Health

12. Evaluation of Provinces: By Scouring 81 Provinces

A significant attention was paid on evaluation of the practices carried out on-site and monitored strictly. To this end, comprehensive field studies have been carried out in this period.



We reviewed and evaluated all health indicators and MoH health facilities in 81 provinces on site.

We made the final report assessments of the provinces with the local managers, local politicians, members of the parliament, local bureaucrats, occupational organization and field coordinators.

Field Coordinators assigned under the Health Transformation Program evaluate and follow the health data of all provinces regularly on site.

The amount of distance Mr. Minister and the field coordinators travelled is 600.000 km during these studies.

In other words, touring around the world 15 times...

All of the 81 provinces were visited without any exceptions. A number of provinces were evaluated for more than once. The problems of provinces were examined with the local administrators and duties were shared in order to solve these problems. We assigned health directors of different provinces in these visits so that they examine other institutions and compare them with their own. Thus provincial evaluation also functioned as an in-service training program. Seeing the satisfaction of our citizens as a result of these efforts is our pride.

We developed in-service training programs out of provincial evaluations.

We assigned health directors of different provinces in these visits so that they examine other institutions and compare them with their own.

Sharing Experiences

Thanks to such studies, health directors took the opportunity to exchange their experiences. We have paved the way for good practices across the country.

Broadening Perspectives

We have enabled our directors to look at cases from different perspectives than they used to have. We facilitated all parties and actors to embrace Ministerial policies within the framework of Health Transformation Program.

Standardization

We have created “common vision” for agencies of similar structures so that they develop common language to adopt similar approaches.

Communication and Consultation

We have created communication and consultation atmosphere in order for health managers across the country to convene, meet and consult each other to solve problems.

A New Era in Health

13. Dynamic and Healthy Foreign Affairs

There are 54 cooperation agreements with 45 countries. 17 of these agreements were signed in the last 5 years.

Minister of Health of the Republic of Turkey presided over the 56th WHO European Regional Committee Meeting in Copenhagen which hosted delegations (consisting of health ministers and senior officials) from 53 Member States of World Health Organization Regional Office for Europe. WHO European Ministerial Conference on Counteracting Obesity was held in Istanbul.



In 2006 Deputy Undersecretary Prof. Dr. Sabahattin Aydın was elected as the member of the WHO Executive Board in 2006 for a term of three years. Prof. Dr. Aydın is the 4th Turkish scientist who has served in the Executive Board since 1948.

Including Mr. Minister Prof. Dr. Recep Akdağ, five nominees and one institution was awarded by the World Health organization for their activities addressing tobacco control in 2008.



Prof. Dr. Recep Akdağ's award was presented by Dr. Marc Danzon, WHO Regional Director for Europe, on 8 July 2008 during the award ceremony held in Ankara.

Medical supplies, medicines, strategy, technical support and medical personnel shared and sent to several places such as TRNC, Naxcivan, Kyrgyzstan, Sudan, North Ossetia, Iraq, Indonesia, Georgia, Afghanistan, Bulgaria, Pakistan, Iran, Palestine, Lebanon, Kosovo, Algeria, and Romania, which suffered from natural disasters such as earthquakes, floods, tsunamis and others.

In 2003-2008 period, 803 health personnel from 25 countries of various levels were trained, as well.

Sustainable aid and cooperation are established especially with Afghanistan, Sudan and Palestine. In addition to the aforementioned countries, close collaboration and support activities will be developed with countries with high health needs including Bangladesh and Yemen in addition to the these countries.

A New Era in Health

14. Re-Structuring the Ministry of Health

Health Transformation Program provides a vision for the Ministry of Health that develops policies and develops, monitors and screens standards; enables effective, efficient and equitable use of national resources allocated to Health; and provides guidance for above mentioned points. As an outcome of this vision, it offers restructuring of institutions under the Ministry in line with principles of decentralization, and envisages a strategic institutional framework that is capable of planning. Thus, the Ministry will fulfil its constitutionally defined duty “centralized planning” of the health sector by the State more effectively. This component of the program aims to realize effective and participatory administration, which is an important principle of modern public administration.

In order to raise the Ministry to the envisaged level, several legislative studies were carried out, starting with preparation of a draft Law on the “Organizational Structure of the Ministry”. Besides, modifications are made on the current legislation. New measures that encourage and promote decentralization are taken. Transfer of authority to provincial authorities on matters regarding authorization and closure of pharmacies, monitoring of marketing and consumption of medicinal products subject to control, opening of health centres and neighbourhood polyclinics; transfer of authority on issues regarding decisions on continuation of extra working hours and intra-provincial transfer of health personnel; legalization of purchase of health services by revolving fund corporations; promotion of health personnel according to performance criteria, and raise of expenditure limit of revolving fund administrators are worth mentioning among those measures. Such implementations are developed in consistency with the spirit of the program.

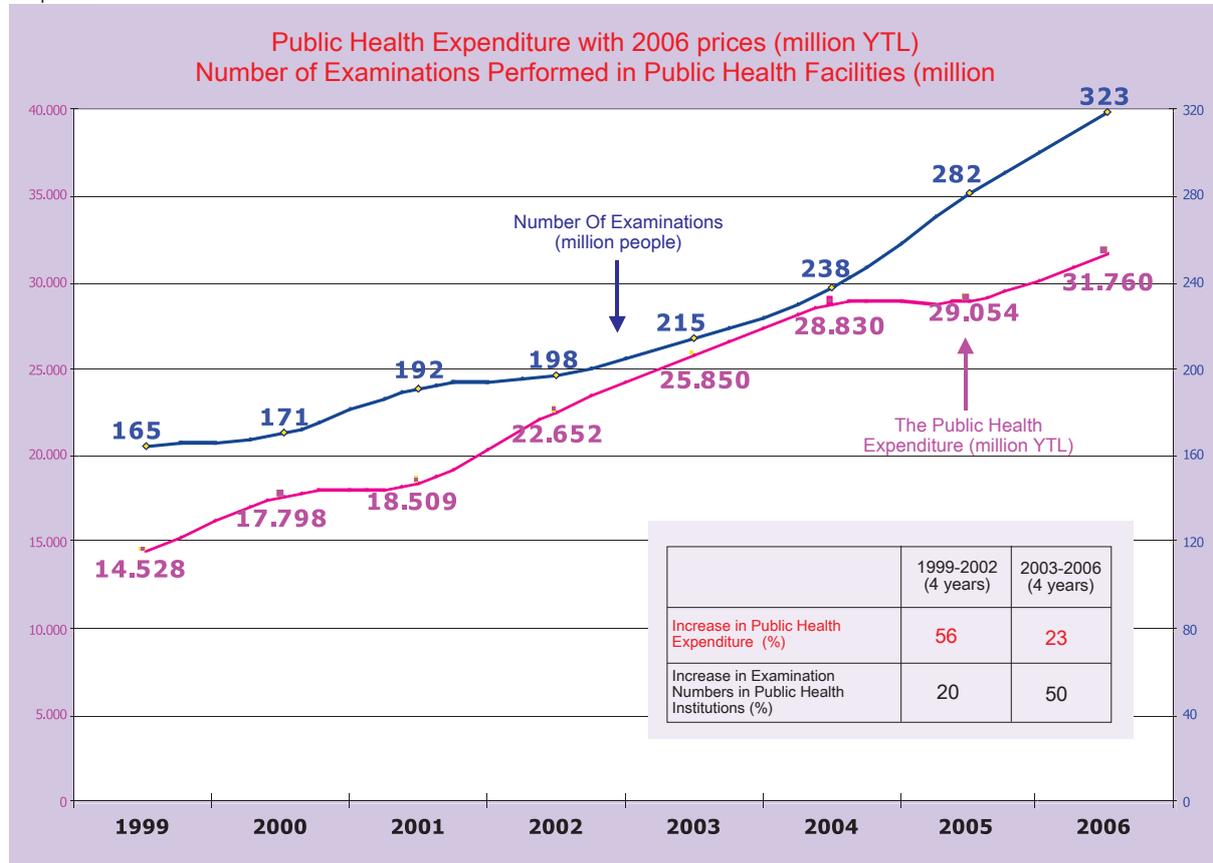
Works are continuing for the new “Organizational Law” for the transformation in which the MoH will focus on fundamental functions such as adopting rules , guidance, auditing.

A New Era in Health

15. Health Expenditures

When we assess health service delivery in terms of figures and quality, it is possible to say that the resources were not used effectively, efficiently and rationally before the Health Transformation Program.

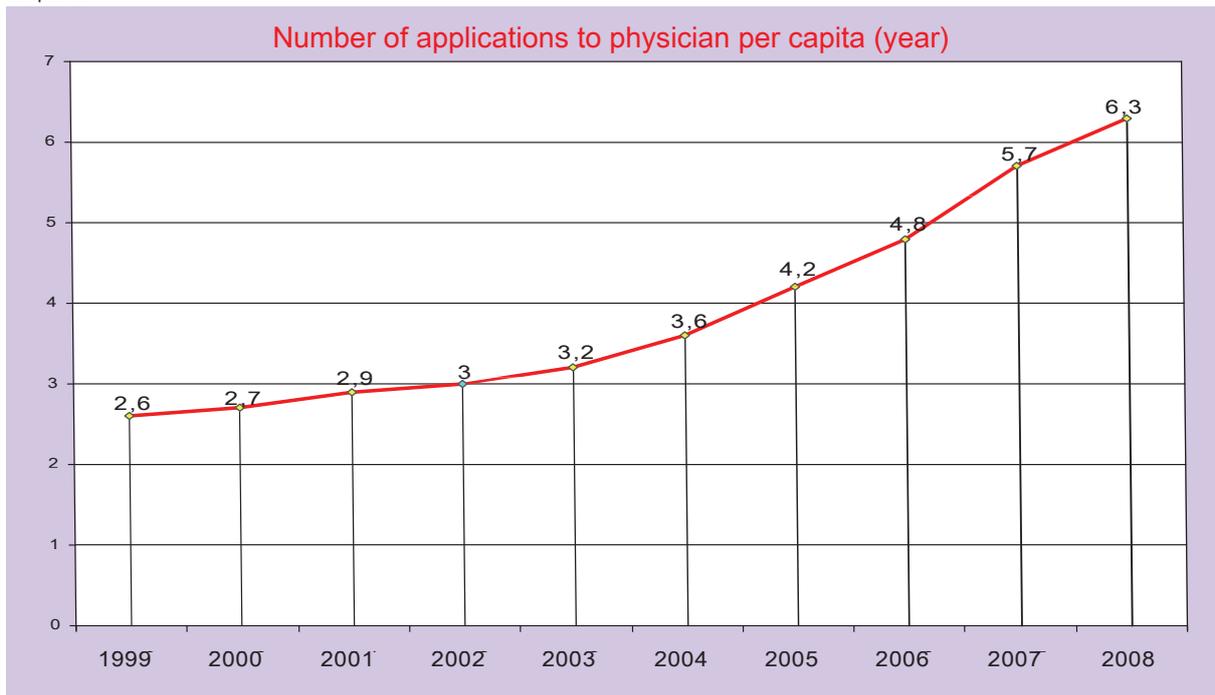
Graph: 45



Health Transformation Program has ensured the optimum use of the resources and established an effective, efficient and equitable health system.

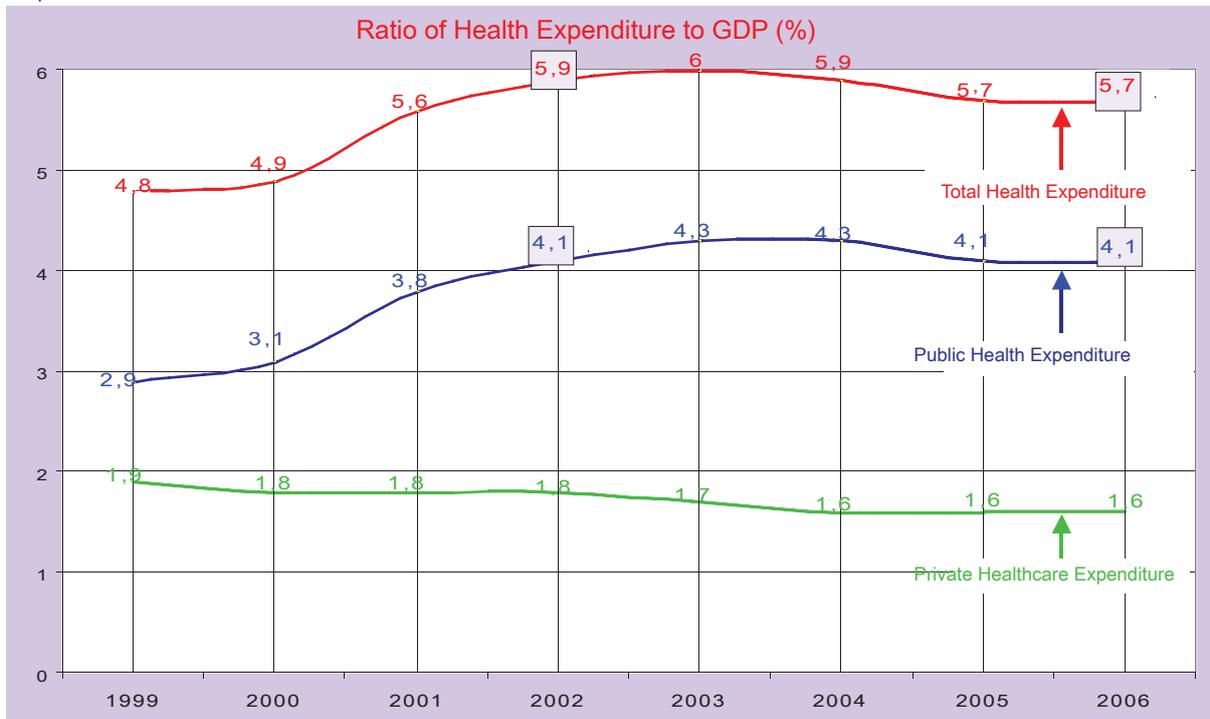
In our country, the number of visits to physicians per capita doubled in 6 years. This is effected in a great deal by the elimination of the obstacles in front of the citizens in accessing pharmaceuticals and health services within the framework of Health Transformation Program. It should be noted that the figures reached in 2008 are still below the European averages.

Graph: 46

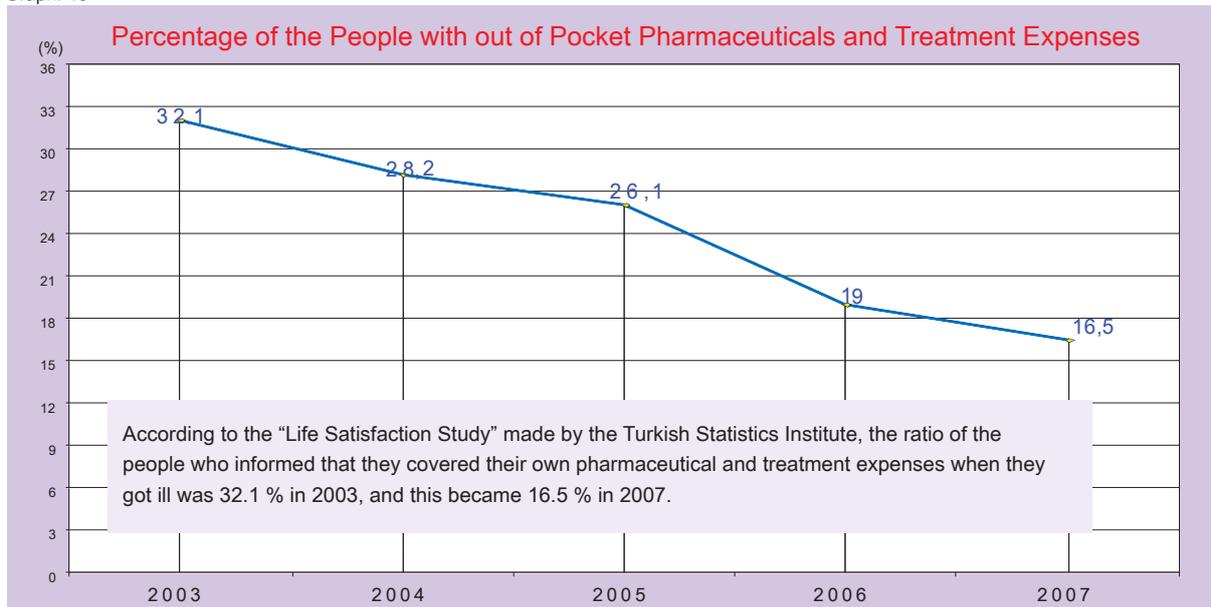


Further improvement of the quality and the quantity of the health services is possible by continuing the optimum use of the resources and increasing the resources allocated for health services (within the framework of the financial facilities of our country).

Graph : 47

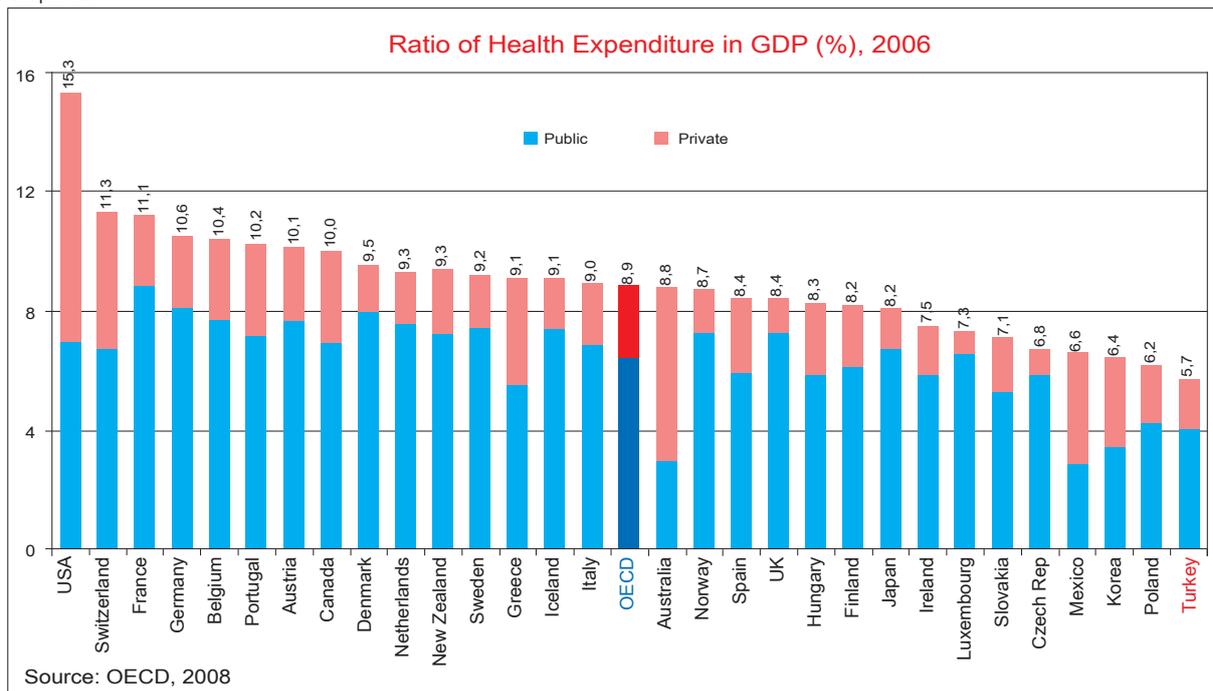


Graph: 48



The share of health expenditure in GDP is the lowest amongst the OECD countries, and our country ranks as the third in terms of lowest public expenditures, but despite those ratios we have reached a position where we are able to deliver effective, qualified and sustainable health service.

Graph: 49



It is widely known that the use of high technology increases health service costs. However, we prevented the high costs that might occur due to the use of high technology in Turkey with the help of our cost effective policies.

CHAPTER 4



Towards New Horizons



Towards New Horizons

The Constitution of the Republic of Turkey describes leading a healthy life as a right and assigned a duty for the government in order to make some arrangements in order to ensure a physically and mentally healthy life for people. While carrying out this duty, it has been envisaged that in order to be used efficiently and in cooperation, all resources, primarily including human resources be planned solely and centrally. Additionally, it is stated in the Constitution that the duty of providing health services shall be executed by benefiting from public and private health institutions and by inspecting them.

Ministry of Health of the Republic of Turkey, since its foundation, works in order to ensure that everybody exercises the right to lead a healthy life by mobilizing the resources of the country in order to treat patients and to improve health. Since the early years of the Republic, there have been significant advancements via the planning, implementation and inspection functions of the Ministry of Health in the issues such as improving human force in the field of health, founding and managing health facilities, fighting against communicable diseases and generalizing the preventive health care services.

In 2003, a series of changes and innovations were put into implementation in order to qualify health services provision in accordance with modern standards and in order to render them more efficient, effective and accessible through the “Health Transformation Program” (HTP) put in effect by the 59th government. The transformation in health contended citizens in terms of the provision of health services and contributed to primary health care indicators as well.

The Strategic Plan of the Ministry of Health, prepared within the scope of the strategic administration and strategic planning granted through the law No: 5018 and under the light of the Health Program Transformation, includes the years of 2009 – 2013. The goals identified in plan and the objectives complementing to them constitute of the common point of the investments and the activities to be executed during the 5 years in order to accomplish the duty (mission) of the Ministry of Health. Strategic aims are the general statements describing the 5-year-activities of the Ministry of Health. For each aim detailed objectives have been determined.

In the following period, it is necessary to emphasize once more that with the aim of sustaining the health care services equally and in good quality, qualified work power such as nurses, physiotherapists and physicians should be adequate in number in the field of health.

a) 2009-2013 Strategic Plan

Preventive and Primary Health Care Services

Strategic Aim 1

To diminish the risks against public health, to prevent and improve health

OBJECTIVE 1.1. To improve health and to ensure that all citizens access to healthy life programs.

OBJECTIVE 1.2. To reduce maternal, infant and child mortality by 40 % in proportion with the current status until 2013 and to improve maternal and child health by benefiting from reproduction health components.

OBJECTIVE 1.3. To ensure that Emergency Health Services and Health Management in Case of Disasters meet the need in an efficient and effective way and to continue to improve them against emergencies, natural disasters, chemical and biological threats.

OBJECTIVE 1.4. To strengthen the primary health care services and to generalize the implementation of family medicine throughout the country until 2010.

OBJECTIVE 1.5. To reduce the prevalence of communicable diseases and the mortalities resulting from such diseases by 25 % until 2013

OBJECTIVE 1.6. To reduce the prevalence of non-communicable diseases and the mortalities due to such diseases by 25 % until 2013 through diminishing the rate of risk factors resulting in non-communicable diseases

OBJECTIVE 1.7. To reduce tobacco-alcohol and substance consumption by 25 % until 2013.

OBJECTIVE 1.8. As the Ministry of Health, to establish sectoral support to increase population rate living in healthy and secure physical environment by 50% until 2013.

Diagnosis and Curative Services

Strategic Aim 2

To improve the execution of diagnosis, curative and rehabilitation services within the framework of effectiveness, efficiency, accessibility and justice.

OBJECTIVE 2.1. To improve mechanisms conducting evidence- based health care services until 2013.

OBJECTIVE 2.2. To continue to improve hospital services.

OBJECTIVE 2.3. To complete the establishment of public hospital associations until 2013.

OBJECTIVE 2.4. To develop regional blood supply services, to ensure that citizens obtain blood supply services without any difficulties and to decrease the rate of total blood use by 5 % until 2011.

OBJECTIVE 2.5. To continue to improve organ, tissue and cell transplantation services

Improving performance management and quality in health

Strategic Aim 3

OBJECTIVE 3.1. To ensure that the National Performance Management and Quality System is continued in an efficient and developing way.

OBJECTIVE 3.2. To ensure that the patient and personnel safety program is generalized until 2010.

OBJECTIVE 3.3. To improve an evaluation system until 2010 in order to evaluate the quality and the performance of the services provided in institutions and establishments and, to improve models so as to form a basis for efficient functioning of hospitals.

Organizational Structuring and Capacity Improvement

Strategic Aim 4

To restructure the central and provincial organization in order to increase productivity, effectiveness and capacity of the public and private health institutions; to plan health human force required for a modern administration concept.

OBJECTIVE 4.1. To clarify the roles of leadership, arrangement, planning and inspection within the scope of restructuring the Ministry of Health until 2011

OBJECTIVE 4.2. To strengthen the strategic management capacity of the Ministry of Health, to implement the performance based budgeting method and the strategic financial methods in the field of health until the end of 2010.

OBJECTIVE 4.3. To continue to improve human resources management in the field of health and to implement these practices based on this approach until the end of 2010.

OBJECTIVE 4.4. To ensure continuity and coordination for in service training programs in order to improve the health services and to increase the efficiency of the personnel.

OBJECTIVE 4.5. To complete the Public and Region Based Health Services Organization (PRBHSSO) until the end of 2011.

OBJECTIVE 4.6. To increase the capacity and productivity of the public and private sector institutions carrying out researches in the field of health.

OBJECTIVE 4.7. To improve the policy of home care policy until the end of 2010.

OBJECTIVE 4.8. To improve the inspection capacity of the Ministry within the framework of the most contemporary concepts.

Services for Pharmaceuticals, Pharmacy and Medical Devices

Strategic Aim 5

To improve pharmaceutical and medical device services, and to improve quality.

OBJECTIVE 5.1. To improve the Turkey Medicine Policy and the idea of rational use of medicines.

OBJECTIVE 5.2. To complete the studies to increase the quality and reliability of medicine, vaccines and biological products until the end of 2011.

OBJECTIVE 5.3. To complete arrangements in order to ensure the execution of scientific studies and promotion of new medicine and medical technology for the public and private sector until the end of 2011.

OBJECTIVE 5.4. To complete and generalize the arrangements with regard to the arrangements to regulate market surveillance and inspection until 2011

OBJECTIVE 5.5. To formulate the national health policies, arrangements and practices in the field of Modern Bio-technology and Bio-security until 2011.

Health Information System

Strategic Aim 6

To establish, manage and improve the National Health Information System/e-Health which will enable accession to effective information in the process of decision making and service provision.

OBJECTIVE 6.1. To complete and generalize the National Health Information System until the end of 2011.

OBJECTIVE 6.2. To determine, improve and implement health informatics standards as a whole until the end of 2011.

OBJECTIVE 6.3. To determine and implement confidentiality, security and privacy principles of the personal and institutional health records until 2011.

OBJECTIVE 6.4. To establish a data warehouse within the scope of decision support system and to launch data mining practices until 2010

OBJECTIVE 6.5. To generalize Tele-Medicine and Tele-Health systems in order to provide remote health services in the field of screening (radiology, pathology, ECG, etc) and to follow the chronic diseases) until 2011.

OBJECTIVE 6.6. To implement value added health informatics projects integrated with the HealthNET and to ensure continuity of the current projects.

Solidarity in Health and Multi-sectoral Health Responsibility

Strategic Aim 7

To improve the services to the level of world standards utilizing from national and international institutions' knowledge, experiences and capabilities. To ensure that policies and activities of all sectors have responsibilities on health.

OBJECTIVE 7.1. To carry out the European Union harmonization/accession process.

OBJECTIVE 7.2. To encourage health parties in order to support the Health Transformation Program

OBJECTIVE 7.3. To reinforce the policy of multi-sectoral health responsibility until 2011.

Cross-border health services

Strategic Aim 8

To increase the capacity of health tourism, tourist health and cross-border health services provision.

OBJECTIVE 8.1. To render Turkey attractive in terms of health services provision by increasing the quality achieved and capacity in health services provisions.

OBJECTIVE 8.2. To plan new studies with the aim of technical and humanitarian aid for various countries, to improve the continuing studies, to establish and manage temporary health units abroad.

OBJECTIVE 8.3. To arrange introductory activities abroad with the institutions providing services in the field of health and to continue to improve commercial cooperation with countries with commercial potential.

Health Security for All

Strategic Aim 9

To ensure health security for all citizens in coordination with other institutions and establishments.

OBJECTIVE 9.1. To ensure coordination with the Ministry of Labour and Social Security, Social Security Institution and other relevant institutions and establishments.

OBJECTIVE 9.2. To complete coordination and standardization studies on sharing health information required for payment with payer institutions until 2010.

b) Studies about to be completed

b1. Public Hospital Associations

Within the scope of the “Administratively and Financially Autonomous Health Managements” component of the Health Transformation Program, the “Draft Law on the Pilot Implementation of Public Hospital Associations” has been discussed by the Commission on Health, Family, Labour and Social Affairs of the Turkish Grand National Assembly and the following draft text has been prepared. The draft is on the agenda of the plenary committee of the TGNA.

Through this draft, hospital administrations will be able to act more independently and flexible in using their resources and capacity and evaluating the economic conditions. Autonomous administrative units will also gain responsibility along with their competency and they will be directed in order to plan their resources, personnel investments, management costs, budget and objectives taking into consideration the strategic work load of the area for which they are responsible. Such a responsible autonomy is thought to result in rational management of resources, efficiency and elaborate budget use.

As a result of the clarification of the principle of “decentralization” through the draft, the significance of inspection increases as well. The understanding of administration and the differences under the scope of inspection correspondingly have been included via preparation of annual performance programs in accordance with the objective, policy, strategic plan and legislation determined by the Ministry of Health. A citizen based, result and objective focused understanding of administration inclined to determine objective rather than problem solution and to emphasize on the future rather than the past has been adopted. Accordingly, an understanding of inspection based on objectives and performance indicators and functioning of the system has gained importance rather than the classical understanding of inspection based on the past and the individuals.

The Ministry of Health, purified from its routine burdens through such steps, will be able to save more time for its actual duties such as strategic thinking, improving future oriented designs, developing missions and visions, shaping basic aim, policy and priorities, establishing measurable success indicators and improving human resources. At this step the transformation in the understanding of administration will be reflected and restructuring of the Ministry of Health will be completed.

By this draft law it is aimed that public health services of good quality will be provided in a more participatory, effective, efficient, rapid way and in a more sensitive manner in order to meet the demand and expectations of citizens.

The Draft Law on the Pilot Implementation of Public Hospital Associations:

Aim , Scope and Definitions

ARTICLE (1) The aim of this law is to determine the relevant principles on the establishment and management of public hospital associations in order to ensure that secondary and tertiary health services are provided in accordance with equality, effectiveness and efficiency and to render these services be of good quality, easy to access, appropriate for the expectations and need of citizens in the pilot provinces to be determined by the Cabinet.

(2) For the implementation of this law, the definitions mean as follows;

- a) The Ministry: the Ministry of Health,
- b) Hospital: The secondary and tertiary health institutions linked to the Ministry under the scope of the association,
- c) Association: The legal person established from the hospitals or hospital groups under the scope of this law,
- d) Secondary health services institution: The health institution where curative services are provided when the diagnosis and the treatment can not be provided by the primary health institutions,
- e) Tertiary health services institution: The senior health institution which patients requiring advanced tests and treatment methods and special treatment are referred to,
- f) Specialist personnel: The personnel assigned for positions requiring a special knowledge, experience or specialty in the fields determined by the Ministry in the units of general secretariat apart from hospital administration as contracted personnel with the title of “specialist” placed in the attached table numbered (I).

Organization and its organs

ARTICLE 2- (1) The secondary and tertiary health institutions, in accordance with the results of the evaluation to be applied within the framework of thirteenth paragraph of this article, are transformed into the association with a statute which is equal to the relevant institution of the Ministry with a legal and real personality upon the proposal of the Ministry and the decision of the Cabinet. The associations are subject to special legal provisions except for issues arranged under the scope of this law. More than one association may be founded in the same province on condition that the size of the service provided is taken into consideration.

(2) The Ministry may establish coordination department for the associations by gathering together more than one association which it will appoint in order to plan health services and investments jointly and to improve cooperation. The decisions taken by the association coordination department shall be consultative and the principles and procedures of working shall be determined by the Ministry. The coordination department shall submit the evaluation report and its proposals on the following issues about the region to the Ministry. The Ministry shall evaluate these reports in accordance with the objective, policy and the strategic plan determined, shall transform them into a regional plan and forward to the associations. The associations shall be obliged to obey these plans in their annual performance program and implementation.

The duties of the coordination department are as follows:

- a) To determine the measures and investment priorities which will remove the differences in development levels between the regions beforehand,
- b) To determine the issues for which more than one province is required to be included due to costs and specialty needs and to carry out service planning,
- c) To determine the issues of good and service procurements which are regarded to be beneficial as central procurement because of its size and to determine the responsible institutions,
- d) To plan the issues requiring regional based planning and coordination such as emergency health services and natural disasters,

(3) The organs of the association consists of the Executive Board, general secretariat and hospital administrations. The Executive Board is the highest decision making organ of the association and it consists of the following members:

- a) A member who has a law degree. S/he shall be appointed by the provincial council.
- b) A certified accountant or an independent accountant to be appointed by the provincial council.
- c) A member graduated from a four-year university. S/he shall be appointed by the governor of the province.
- d) A member graduated from a faculty of medicine. S/he shall be appointed by the Ministry.
- e) A member graduated from a four-year university and experienced in the field of health. S/he shall be appointed by the Ministry.
- f) A member graduated from a four-year university. S/he shall be appointed by the Chamber of Commerce and Industry or by the Chamber of Commerce when these are separated.
- g) A member to be appointed among the Provincial Health Directors or deputy directors, whom shall be determined by the Ministry of Health.

(4) In addition to the general specifications described in the Article 48 of the Law on Civil Servants No 657 Dated: 14.07.1965, except for the representative of the provincial health directorate, the members of the Executive Board shall be experienced in the public or private sector for at least 5 years in field proposed for membership.

(5) The members of the Executive Board and their spouses or blood and bylaw relatives of the second degree shall not establish commercial relationships with the health institutions and establishments linked to the Ministry and the associations shall not be the owner, share holder or responsible manager of the pharmacies and private health institutions and establishments. The members, even if they have quitted their position, shall not utilize from the knowledge they acquired for themselves or for others' interests or disadvantage.

(6) The office principles and procedures of the Executive Board shall be determined by the Ministry. The secretariat services of the Executive Board shall be executed by the general secretariat.

(7) Competent authorities shall notify their members in one month from the notification of the communiqué of the Provincial Health Directorate on the formation of the Executive Board. The Ministry fulfils the positions itself instead of the members which are not notified within this period. The Executive Board shall elect a chairperson and a deputy chairperson by absolute majority during the first meeting. If a person can not be elected on the first day, the following day the election shall be realized once more. If the chairperson and the deputy chairperson can not be elected by the absolute majority of the total member number, the Ministry shall assign chairperson and a deputy chairperson. The members who do not participate meetings three times in a row or who do not participate meetings five times in a year without a valid excuse, the ones losing the membership eligibility criteria or the ones who are considered not fulfilling eligibility criteria are ex mero motu excluded from membership. The period of membership shall be three years. If any membership is finalized in any way, the remaining period will be completed by members to be assigned in the same way. A member may be elected for the Executive Board only for three times. Membership for the Executive Board shall not be an impediment for the actual duties of members.

(8) The Executive Board meets at least twice a month. The chairperson of the Executive Board may call a meeting in case of emergency. The Executive Board meets when the number of participants is one more than the absolute majority and takes decisions by an absolute majority of the total number of members. When the votes are equal, the party for which the head votes for shall be considered to be the majority. Members shall not abstain from voting. The agenda of the Executive Board shall be prepared by the chairperson. Members may propose agenda items in accordance with the opinion of the chairperson or by the absolute majority of the total member number. Other issues apart from these shall not be discussed on. The discussions are entered into minutes or recorded with audio devices. The decisions taken shall be signed by the chairperson and the participant members. The members who are against the decision shall define their justifications in the decision. Universities, occupational organizations, unions, non-governmental organizations, representatives, general secretaries, experts or other relevant persons from the occupational associations of nurses and midwives may be invited by the decision of the Executive Board to the meetings in accordance with the decision of the executive board without the right to vote

(9) The chairperson and the members of the Executive Board participating in the meetings are paid annually in accordance with the principles and procedures defined in the said decision of the Supreme Planning Council for the Public Financial Commitments. For the members assigned from other establishments are paid allowances in accordance with the provisions of the Law on Allowances dated 10.02.1954 and No:6245. The membership for the Executive Board does not require interest in social security institutions.

(10) The general secretariat is the implementation organ of the association. The representative of the association is the general secretariat. Departments of medical services, administrative services and financial services are established under the general secretariat.

(11) The hospitals linked to the association are administered by a hospital director, who is

preferably a physician. Units of chief physician, administrative and financial affairs, and healthcare services are established affiliated to the hospital director. The number of the departments may be increased to four in accordance with the size of the hospitals in accordance with the approval of the Executive Board and delegation of duty is determined.

(12) On condition that the norms and the standards defined by the Ministry is not violated, deputy chief physicians and deputy directors are assigned in accordance with the number identified by the Executive Board.

(13) Hospitals are evaluated in accordance with the methods and principles to be defined by the Ministry on the issues such as patient and staff satisfaction, service infrastructure, organization, quality and efficiency. The evaluation may be carried out through public and private evaluation institutions. Hospitals are graded over 100 according to the results of the evaluation and, evaluation is renewed for a period not less than six months and more than 1 year. When hospitals are classified, these grades are taken into consideration. Hospitals are classified into five groups as (A), (B), (C), (D) and (E) in accordance with their grades. Hospital groups are established in order to facilitate that the hospitals, classified in this way, cooperate via joining their capacities and resources, hence they lead a more rational work. The hospitals with a grade of (C) or a higher degree may be turned into an association. According to the results of the evaluation, in case the association;

- a) lowers to the (E) grade,
- b) lowers to the two level below compared to the previous classification,
- c) lowers to the one level below compared to the previous classification, stays in the same lower level in the second evaluation and fails to raise itself to a higher level in the third evaluation,
- d) fails to get to the level (C) or a higher level in the assigned period in order to remove shortcomings when it lowers to the level (D);

the current Executive Board is annulled and another board is established as soon as possible. Until the new board is established the former Executive Board continues to be in charge or a temporary Executive Board is established.

Duty, authorization and responsibilities

ARTICLE 3 - (1) The duties of the Executive Board are as follows:

- a) To prepare the objective, policy, strategic plan defined by the Ministry and the annual performance program determined in accordance with the legislation,
- b) With a view to executing the services in the association region in a more effective, easy-to-access and efficient way;
 - 1) To prepare proposals for the Ministry in order to establish, close, merge or alter the specification of the hospitals and units through evaluation of current capacities,
 - 2) To plan emergency health services, intensive care units and dialysis units at the regional level,

- 3) To take decisions in provision, outsourcing and efficient dispersion of high technology medical devices of high cost,
 - 4) To improve measures for non-stop service provision,
 - 5) To define new investment needs and to take decisions in maintenance, restoration and modification,
 - 6) To plan personnel and to take decisions in order to define principles on personnel movements,
 - 7) To take decisions on similar issues.
- c) To decide on the budget, balance sheet, annual financial tables, activity reports and investment proposals of the association,
 - d) To decide directly on abdicating from rights and claims, settling down disputes through negotiation or arbitration, applying or not applying for peace, admission, abdication or legal procedures for execution prosecutors in accordance with the lines defined in the central budget law; for higher amounts to decide in accordance with the approval of the Ministry,
 - e) To carry out the procedures in order to sell, hire, hand over or to exchange for any equipment, materials, movables and immovable properties according to the principles defined by the Ministry; to manage in accordance with the assignment objective along with the constructions and facilities assigned for the Treasury and the association; manage, facilitate to be managed or outsource the parts which are apart from the medical items,
 - f) To define expenditures limits and duty and authority dispersion in accordance with the tendering legislation,
 - g) To decide to value available cash properties in the first coming ten banks in accordance with their active sizes,
 - h) Health, legal and advocacy services if needed,
 - i) To plan duties assigned through this law with regard to the personnel employed as contracted personnel for the positions defined in the attached table 1 and in-service training issues for all the associate personnel of the associations,
 - j) To ensure that services are carried out in accordance with the legislation, strategic plan and the performance program and to take measures to improve personnel satisfaction, effectiveness and efficiency and quality standards,

(2) The duties of the secretary general are as follows:

- a) To administer the association in accordance with the objective, policy and strategies, the decisions of the Executive Board and the performance program determined by the Ministry,
- b) To inspect the activities and the procedures of the association, to evaluate its administration system, to monitor its effectiveness of functioning and management processes and to ensure that management quality and efficiency are improved,

- c) To represent the association against legal and real persons and the forensic and administrative authorities, to inform public,
 - d) To ensure coordination between hospitals and other institutions and establishments,
 - e) To submit the budget and investment proposals of the association to the Executive Board and to execute the issues such as tendering and service procurement in accordance with the decisions of the Executive Board,
 - f) To carry out studies in order to render that services based on material and human power within the association region are provided in the most possible efficient and effective way and to submit these studies for the approval of the Executive Board, to execute processes for personnel assignment, appointment and other procedures in accordance with the decisions of the association, to plan scientific studies through training activities, to execute these studies in cooperation and to inspect them,
 - g) To ensure that information processing systems are established and the statistical data with regard to the association are monitored to join the financial tables of hospitals placed within the association and to prepare proposals for the Executive Board on the actions to be taken,
 - h) To ensure that services with regard to patient rights, patient and personnel satisfaction and social need of patients are improved and ethical principles for medical and public officers are applied,
 - i) To plan medical services, health care services, social services and support services and to inspect them,
 - j) To execute accounting services and to accrue the association incomes within the scope of the relevant legislation, to follow up and collect the incomes and claims and to execute expenditure procedures,
 - k) To execute other duties of the association,
- (3) On condition that the decisions taken by the Executive Board are not violated, the general secretary may, when necessary, devolve some of the duties to sub-unit directors through determination of the limits in written. However authorization devolution does not remove the responsibility of the agent carrying devolution.
- (4) The hospital administrator has the duty, authority and responsibilities defined for the general secretariat on the hospital basis and are responsible against the general secretary in order to execute all the services efficiently and in accordance with the legislation
- (5) The personnel assigned for procurement and use of financial resources are responsible for efficient, effective, economic and legal use, accounting, reporting of resources and taking relevant measures in order to prevent misuse.
- (6) The Ministry is responsible to remove hesitations to be encountered in the implementation of this law and to apply regulations needed.

The quality, status and the rights of the personnel

ARTICLE 4 - (1) The general conditions specified in article 48 of the Law No:657 for the personnel to be employed for the positions identified in the table (1).

(2) The secretariat, chairpersons, hospital directors, heads and deputy heads

a) Should be graduated from health sciences, health management, law, public administration, finance, management, accounting, industrial engineering of at least a four year university or from a foreign university admitted to be the equivalent of these departments or have a master's or doctorate's degree in the department mentioned above; assistants of technical heads should be graduated from the departments of civil, electric-electronic, biomedicine or computer engineering,

b) Should have at least 5 years of work experience in the public or private sector,

c) The director of the medical services should be an associate professor or a professor in the field of medicine, a specialist or should have a master's or a doctorate's degree in the field of medicine or have a master's or doctorate's degree in the field of law, public management and health management, or a specialist having a master's or a doctorate's degree; or a clinic or laboratory chief or chief assistant of the head physician of a training and research hospital, in the dental hospitals the chief physician should be trained in the field of dentistry and the assistants should be trained in the field of medicine, dentistry or pharmacy.

(3) The personnel to be assigned as a specialist in the general secretariat should have at least undergraduate degree and a five-year of experience in the public or private sector.

(4) Contracted personnel are assigned for the positions defined in the attached table 1. The Executive Board signs a contract with the general secretary directly and on the proposal of the general secretary with the chairpersons and the hospital directors. Chief physicians and heads are contracted on the proposal of the hospital administrator by the general secretary. The experts and bureau staff are contracted by the general secretary. Chief physicians and deputy chief physicians are contracted by the hospital director on the proposal of the head responsible for deputy heads. The contract periods can not exceed three years. At the end of three years the contracts may be renewed. The contract of the general secretary may be annulled directly. The contracts of other personnel may be annulled before its termination via the decision of the Executive Board on the condition that the proposal of the general secretary is valid. At the end of the two months as of the date the general secretary or the new Executive Board take office, all the contracts of the contracted personnel assigned for the positions defined in the attached table (1) terminate ex mero motu. After one month as of the date the new hospital director takes office, the contracts of the chief physician, heads and assistant chief physicians terminate ex mero motu. The contracts of the aforementioned personnel can be renewed once more. When the contracts of the personnel employed in such positions defined in the attached table (1) are terminated due to any reason, they break off their relations with the association.

(5) When four or more Executive Board members cease to be in charge due to resignation or the reasons defined in paragraph 9 of the Article 6 of this law, new provisions of the Executive Board are applied after assigning new personnel for the positions concerned. In such cases, a new chairperson and a deputy chairperson are elected and the contracted personnel defined in the attached table (1) are assigned and other assignment procedures are carried out.

(6) The ones who fulfil the appropriate qualifications among the personnel employed as civil servants in public establishments and institutions may be assigned for the positions defined in the attached table (1) of their own accord and on the approval of their institution. Such personnel are assumed to do unpaid leave. This personnel continue to be subject to the Law on the Retirement Fund dated 8.6.1949 and No:5434 due to their position for which they are assumed to do unpaid leave . Their services in such positions are evaluated as monthly entitled right and grade. The personnel whose contract has been terminated due to any reason returns to their previous position.

(7) The contracted personnel, who are employed on contractual basis and are not subject to the clause five of this article, are associated with the Law on Social Insurance Dated 17.07.1964 and Numbered 506 in terms of social security.

(8) The monthly salary defined by the Executive Board for the contracted personnel identified in the attached table (1) can not exceed the two-fold for the general secretary, one and a half-fold for the chairperson, one-fold for the specialists, a half-fold for the bureau staff, one and a half-fold for the hospital directors, one-fold for the chief physician and the head and a half for the chief physician and the deputy head of the maximum payment rate determined in accordance with the paragraph (B) of the Article 4 of the Law No: 657 . The association may provide supplementary payment for the personnel within this scope from the incomes obtained through the contribution of the personnel. Taking the service provision conditions and criteria determined by the Ministry into account, the rate and the methods and procedures of such payment are determined based on the title, position, working conditions and period, contribution, performance of the personnel. The amount of the extra payment in a month from the incomes obtained through the contribution of the personnel can not exceed the three-fold for the general secretary and the Chairpersons, one and a half-fold for the specialists, a half-fold for the bureau staff, three-fold for the hospital directors, three and a half fold for the chief physician, three-fold for the deputy chief physician and one-fold for the head and deputy heads of the maximum payment rate determined in accordance with the paragraph (B) of the Article 4 of the Law No: 657. When the amount of the maximum payment rate while assigned in a health institution or establishment of the Ministry for the previous position of the personnel assigned for another position defined in the attached table (1) in the associations exceeds the maximum payment rate of the position in the association, a different contraction payment may be identified through the decision of the Executive Board on condition that it does not exceed the higher one.

(9) The payment for the contracted personnel shall be conducted by the end of the month following the work. No other payments than the items stated above may be made to the contracted personnel and no provisions may be added to the contracts to this effect.

(10) Stamp tax that is required by the service contract shall be covered by the contracted personnel. Other duties, fees, etc. shall be covered by the administration.

(11) The contracted personnel may not involve in another income producing work; may not work in another facility on monthly payment, with wage or as contracted; may not carry on the art or profession privately; may not involve in the activities that are forbidden for the civil servants by the Law no. 657.

(12)The weekly working hours for the contracted personnel are the same for the precedent civil servants.

(13)The provisions for the contracted personnel in the sub-paragraph (b) in Article 4 of the Law No. 657 shall be in effect for the vacations and 'end of job compensations' of the contracted personnel.

Employment and financial rights of the personnel of the Ministry and associations

ARTICLE 5 - (1) Beginning from the date of transformation into association, the services in the hospitals shall be conducted by the personnel employed in accordance with the related legislation except for the ones that are stated in the attached Table (I) and the status of these personnel on the date of transformation into association shall be maintained.

(2) The occupied positions of the revolving fund in the health agencies that are decided to be transformed into associations shall be considered as transferred to the Ministry with their personnel in order to be allocated for the associations on the execution date of the Cabinet Decision. The number, classes, titles and levels of the transferred positions shall be demonstrated in the Cabinet Decision on the transformation into association. These positions shall be considered as excluded from the related part of the attached Table (I) in the Decree Law No.190 on the General Positions and Methods and included in the related part of the Ministry of Health's Provincial Organisation within this Table.

(3) The positions that are demonstrated in the attached Table (I) and the other positions that are stated in the paragraphs above shall be determined by the attachment of the Cabinet Decision which regulates the transformation into association and be allocated for the established association.

(4) In order to provide the balanced distribution of the health personnel among the country, the maximum number to be employed within the associations shall be annually determined by the Ministry also by taking the opinion of the association Executive Board. In case new situations associated with personnel movements emerge during the year, one more determination may be made. In case personnel are employed except for this staff and position number, the authority in charge of assignments and contracts shall be responsible for the expenditure. Assignments or shifting from one association to another or to the other units of the Ministry or from the Ministry units to the associations as well as the use of permanent staff and positions shall be subject for the related legislation and the general provisions.

(5) The personnel who are assigned within the Ministry units may be assigned to the hospitals within the scope of the associations by the Ministry upon the demand from the Executive Board and their will. The financial and social rights of such personnel shall be covered by the associations.

(6) The personnel (except the workers and the personnel stated in the attached Table I) assigned in the hospitals which are transferred to the association in accordance with this Article, shall be given supplementary payment from the association's income provided with the contributions of the personnel. The payment rate, principles and methods shall be determined by the Ministry taking into consideration the personnel's title, duty, working conditions and duration, service contribution, performance as well as the processes such as examination, anaesthesia, invasive processes and working in risky specialty departments and also considering the service delivery requirements and criteria that are determined by the Ministry. The amount of the monthly payment to the personnel from the association's revolving fund income which is provided through the contribution of the personnel shall not exceed 250 per cent of the total of monthly payment (including the supplementary indicator), supplementary payment and any indemnities (excluding

position, representation and duty indemnities) for the privately working general practitioners and dentists. This rate is 500 per cent for the general practitioners and dentists not working privately; 350 per cent for the specialist physicians, the personnel who granted specialty in accordance with the provisions of the Regulation on Specialty in Medicine and specialist dentists working privately; 700 per cent for the personnel who granted specialty in accordance with the provisions of the Regulation on Specialty in Medicine and specialist dentists not working privately; 800 per cent for clinic chiefs and deputy clinic chiefs not working privately; 250 per cent for the pharmacists and 150 per cent for the other personnel. 150 per cent rate may be applied as 200 per cent to the personnel working in the specialty services such as intensive care, delivery room, newborn, infant, burn, dialysis, operating room, bone marrow transplantation unit and emergency services. The amount of the supplementary payment for the contracted personnel shall be determined based on the precedent personnel with the same title and working duration in the same unit and this supplementary payment shall on no account exceed the maximum level of the payment to a precedent personnel. In accordance with Paragraph 7 in Article 4 and this paragraph, the total monthly payment to the personnel shall not exceed 40% of the gross product collected through the contributions of the personnel.

The capital, income, expenditure, budget, accounting and supervision of the association

ARTICLE 6- (1) Shall consist of the Association capital, transferred capital, association profits, donations and aids and Government aids when required. The transferred capital is the paid capital displayed within the transferred budget of the hospitals which are transformed into associations. The process related with the increasing of the association capital shall be executed by the Executive Board.

(2) The income of the association shall be as follows:

- a) Collection of income in return for health services such as examination, diagnosis, treatment and testing, procedure, medical care at home, etc.,
- b) Collection of income in return for the first substance, supplies, manufactured vaccine, serum, prosthesis, etc.,
- c) Collection of income in return for producing medicine, human blood and blood components as well as the other substances that are procured or produced,
- c) Collection of income in return for selling, renting, conducting the transfer or exchange procedures of the association's equipments and supplies, movable goods, immovable properties registered on the association along with the buildings and facilities on them in accordance with the principles determined by the Ministry; operating the immovable properties belonging to the Treasury and allocated to the association along with the buildings and facilities on them, operating, having operated or renting the parts except for medical service areas,
- d) Collection of income in return for the courses, seminars, training, research, publishing and consultancy services on health,

- e) Donations and aids,
- f) Government aids in order to tackle with the differences of financial rights of the personnel, investment allocations and differences between the regions in terms of development,
- g) Other income.

(3) The expenditures of the association shall be as follows:

- a) Payments made to the members of the Executive Board, and any payments and monthly payments to be made (in accordance with the legislation) to the personnel who are transferred to the associations and to be employed,
 - b) Purchasing and outsourcing of any kind of medical, surgical and laboratory equipments, supplies and devices; purchase of consumables and furniture,
 - c) Providing maintenance, repair, construction, medical and technical installations and landscaping,
 - d) Deciding on the purchasing of health services, advocacy and law services when required,
 - e) Purchasing of movables and immovables, establishing limited property rights on the required immovables, leasing them and covering any kind of expenditure on them,
 - f) Purchasing or outsourcing ambulance, hearse and service vehicle or providing them through service procurement as well as their insurance and other expenditures,
 - g) Expenditures made for the transition of the priced products to the free market or other organisations,
 - h) Expenditures made for Research and Development, animal breeding for experimental purposes and facilitating from their products, growing, maintaining and selling the needed agricultural harvest,
 - i) Expenditures made for the preventive medicine, fighting with disasters and outbreaks, etc.,
 - j) Payments made to the foreign assistants who are in specialty training (the payment shall not exceed the amount to be found through multiplying 15.000 indicator number by the monthly coefficient of civil servants),
 - k) Expenditures for service procurement for laboratory, chemical analysis, screening, etc. and use of equipment in return for kit,
 - l) Service procurement expenditures in accordance with the legislation,
 - m) The other expenditures required by the association activities,
- (4) The associations subject to this Law may purchase services from each other or other public agencies and institutions. This purchasing may not exceed the prices established by the related legislation.

(5) The goods and services such as medical equipments, consumables, medicine and office supplies of which central purchasing deemed beneficiary, may be purchased (in bulk) by the Ministry or the Association that is authorised by the Ministry. The Executive Board of each association shall decide on the purchase costs in order to be covered from the association budget. The principles and methods associated with this paragraph shall be determined by the Ministry.

(6) Health agencies under the Ministry may transfer their surplus goods that are purchased using the resources of the association and the revolving fund to each other free of cost or in return of a determined cost. Associations may give goods to each other through lending contracts.

(7) Association budget shall be prepared by the secretariat for each fiscal period. It shall be executed following its determination by the Executive Board. One copy of this budget shall be sent to the Ministry and the Ministry of Finance.

(8) The accounting of the associations shall be kept in accordance with the Law on the Tax Procedure dated /1/1961 and numbered 213. The balance sheets, financial schedules and activity reports shall be sent to the Ministry, Ministry of Finance and the Court of Auditors within the four months following their accounting periods.

(9) Administrative and technical auditing of the associations shall be conducted by the Ministry; financial procedures and activities shall be audited by the Ministry of Finance and the external auditing shall be conducted by the Court of Advisors. In accordance with the results of the auditing;

a) In case the associations hinder their duties and services significantly and this situation threatens public health or in case the Executive Board can not meet three times in a row or can not make a decision, the Ministry may revoke the board and establish a new one.

b) In case fraud is determined in the association's procedures, the related members of the board shall be dismissed and new assignments shall be made by the Ministry. The Ministry may demand the revoke of the contracts of the personnel within the attached Table (1) who are related with the fraud if this demand is not fulfilled within the appropriate period of time, the board shall be dismissed and new board shall be established by the Ministry.

c) The members of the Executive Board who are dismissed within the scope of the evaluation made in accordance with paragraph 13 in Article 2 of this Law or the provisions of this paragraph may not be present in the first Executive Board to be established.

(10) The associations will be the subject of Law on Per-Diem 10/2/1954 dated and 6245 numbered, 5/1/1961 dated and 237 numbered Law on Vehicle, State Procurement Law 8/9/1983 dated and 2886 numbered and Public Procurement Law 4/1/2002 dated and 4734 numbered.

(11) Income of the associations may not be deducted in accordance with Sub-paragraph (k) in Article 18 of the Law dated 24/5/1983 and numbered 2828 as well as the Temporary Article 1 of the Law dated 17/9/2004 and numbered 5234.

12. All payments of the personnel working in the associations are made from the association budget.

13. In order to meet the needs of the associations without sufficient income and to perform the objectives stated in the 6th paragraph of the 5th article of Law No: 209 and dated 4/1/1961, the associations transfer five percent of the amount allocated from the monthly gross proceeds to the Ministry Revolving Fund Central Accounting Unit account.

14. For the associations, whose financial status is convenient, it is the board of directors of the relevant association who has the authority to transfer resources either as a debt or as gratis to the ones whose financial status is not convenient

15. The associations can undertake common commitments for the future years from the association resources in order to procure via service procurement or outsource the continuous services and the high-cost and advanced technology medical devices.

Revoked Provisions

ARTICLE 7 (1) Articles 5, 6, 7 and 8 and Paragraph (a) in Article 9 of the Law dated 7/5/1987 and numbered 3359.

TEMPORARY ARTICLE (1) Chief physician, deputy chief physician, director, deputy director and chief nurse positions within the health agencies which are decided to be transformed into associations shall be revoked by the execution date of the Decree Law on the transformation and shall be considered as dismissed from the related part of the schedule (1) attached to the Decree Law no. 190.

(2) The personnel who work as a chief physician, deputy chief physician, director, deputy director or a chief nurse for the health agencies that are transformed into associations in accordance with this Law, shall be dismissed on the transformation date of the agency. These personnel shall be assigned to positions appropriate for their vested rights in at most three months and they may be assigned to required works until that time. Until the date of their assignment, these personnel shall continue receiving their previous financial rights such as monthly payments, supplementary indicators and any compensation payments (except for the payments for the second duty, proxy duty and revolving fund). Where the new net amount of the contract payment, bonus payment, monthly payment, supplementary indicator payment, any raises and compensation payments (except for the payments in accordance with Paragraph 6 in Article 5) are less than the net total amount of the monthly payments, supplementary indicator payments, any raises, compensation payments and other financial rights that the said personnel received in the last month of their previous position (except for the shift payment, the payments for the second duty, proxy duty and revolving fund), the difference shall be paid as a compensation payment (without being cut) until the difference is corrected. Where there are personnel transferred to the Ministry of Health within the health units that are transformed into associations in accordance with the Law dated 6/1/2005 and numbered 5283, the amounts that are determined in accordance with the Article 5 of the said Law within the transfer date shall be taken into account for the difference compensation payments. The duties of the personnel who carry out the chief physician, deputy chief physician, director, deputy director and chief nurse positions as a second duty ex mero motu.

(3) The needed personnel from the personnel who conduct the accounting works within the hospitals that are transformed into associations and the personnel who are within the permanent

staff of the Ministry of Finance may continue their duty upon the request of the Executive Board and the approval of the Ministry of Finance. The duration of this duty shall not exceed 1 year starting from the date of the transformation. The personnel continuing their duties within this scope shall be facilitated from the payment that is stated in the paragraph 6 in Article 5 with the same principles and methods.

(4) Any movables and vehicles of the hospitals that are transformed into associations shall be transferred to the associations in accordance with the methods and principles to be established jointly by the Ministry of Finance and Ministry of Health. The immovables belonging to the Treasury and that are allocated to the hospitals that are transformed into associations shall be considered as allocated to the associations with the buildings and facilities on them.

(5) The current assets, liabilities and own resources within the balance sheet made up by the date of the transformation of the hospital revolving fund enterprises and the Turkish Higher Specialization Hospital into associations within the scope of this Law, shall be considered as transferred to the association without any other procedures.

(6) The contracts, law suits and execution proceedings shall be conducted by the standing of the associations. All the rights, authority, liabilities, claims and debts shall be transferred to the associations.

(7) The provisions of the Article 5 of the Law no. 3359 (which shall be abolished with this Law) shall be continued to be executed on the Turkish Higher Specialization Hospital until it is transformed into an association within the scope of this Law.

(8) The amount from the revolving fund income that is determined by the Ministry by associating its year with the investment programme shall be continued to be allocated to the accounting units in relation with the associations in order to be used for the completion of the building constructions of the hospitals that are transferred into health associations.

(9) The monthly payments, base monthly payments, seniority payments, family aids, raises and compensation payments paid to the personnel whose monthly payments and other payments are made from the Ministry's budget before the allocation within the group of personnel holding the positions allocated for the associations (in accordance with the Paragraph 3 in Article 5 of this Law) shall be covered by the Ministry's budget beginning from the month of transformation for 5 years.

Enactment

ARTICLE 8- (1) This law shall enter into force on the day of its publication.

ARTICLE 9- (1) The provisions of this Law shall be executed by the Cabinet.

Table No.1**Titles and Numbers of the Contracted Personnel**

Position Title	Position Number
General Secretariat	40
Head of Medical Services	40
Head of Administrative Services	40
Head of Financial Services	40
Specialist	800
Hospital Director	400
Chief Physician	400
Director	1.200
Deputy Chief Physician	1.200
Deputy Director	2.500
Office Personnel	160
Total	6.820

b.2 Full-time working

Full time based working system in the field of health is one of the aims of the Health Transformation Programme. However, before the introduction of the full-time implementation, it was necessary to wait for the completion of some changes that had been in place in order to establish an adequate infrastructure. Particularly organising, service delivery and changes to the personnel policies may be mentioned within this scope.

Unification of all the public sector health agencies and institutions under one umbrella (Ministry of Health) was an important step. Patients' rights for selecting health institutions and physicians were rendered largely applicable through complementary measurements such as "an examination room for each physician". Through the strengthening of the health centre services and generalisation of family health medicine practices, primary health services have ensured a structure allowing all the citizens free-of-charge and equal access. Examination and analysis procedures have accelerated through the implementations such as "service procurement". The productivity of health institutions has been boosted with the incentives like "supplementary payment" and such implementations; the number

of examinations has been doubled even though there has been no significant increase in the number of physicians.

The inadequacy in the number of health human resources is known. However, the problems originating from the instability of distribution have been mainly eradicated. To this end, even most remote places are provided with personnel through methods such as employment of contracted personnel, state's service obligation, employing proxy midwives and nurses. "Personnel distribution schedule" was prepared and the most efficient and fair distribution of health human resources is planned; assignment and transfer system is established in accordance with the objective criteria and thus the implementation has ensured equity and stability.

During the transition to the full-time based system, the regulations which promote to work in the public sector have been included in the Draft. Within this scope, regulations are conducted in accordance with the duty compensation, supplementary payment for non-office hour working, reducing weekly office hours from 45 to 40, regulation and promotion of shift allowances, removing the citizenship requirement for medical profession practice, improvement of mutual working opportunity between universities and public hospitals and facilitating the returning to the public services.

Within the aforementioned framework and through transition to full-time basis system, doctors to allocate their working hours to patients and hence, contributing to efficient, quality and effective delivery of health services which are compatible with the needs and expectations of the public are aimed. The following text is the second version of the draft presented to the opinion of our stakeholders. The evaluations are continued.

Draft Law on the full-time working of the Health Personnel and Amendments to some Laws on Health

ARTICLE 1- Paragraphs 3, 4 and 7 of the Article 5 in Law no. 209 shall be amended as follows:

"Civil servants and contracted workers working in health agencies and institutions paid by the revolving funds, may be allocated supplementary payment from the revolving fund income provided through the contributions of the personnel. Providing that the MoH-identified terms and conditions and criteria of service delivery are considered in the MoH-affiliated agencies, the proportion and principles of such disbursement shall be determined by the approval of the Ministry of Finance and the regulation to be issued by the Ministry of Health depending on a variety of

factors such as personnel title, task, working conditions and duration, contribution to service production, performance as well as some other factors such as whether personnel are assigned in high-risk departments and/or units like medical consultation, anaesthesia, invasive procedures and especially working in risky departments of medical specialty.

In accordance with the provision above, the amount of the monthly payment to the personnel from the revolving fund income which is provided through the contribution of the personnel shall not exceed 500 per cent of the total of monthly payment (including the supplementary indicator), supplementary payment and any indemnities (excluding position, representation and duty indemnities) for the general practitioners and dentists. This rate is 700 per cent for the specialist physicians, the personnel who granted specialty in accordance with the provisions of the Regulation on Specialty in Medicine and specialist dentists; 800 per cent for clinic chiefs and deputy clinic chiefs; 250 per cent for administrative deputy directors of health, hospital directors and pharmacists; 200 per cent for chief nurses and 150 per cent for other personnel. 150 per cent rate may be applied as 200 per cent to the personnel working in the specialty services such as intensive care, delivery room, newborn, infant, burn, dialysis, operating room, bone marrow transplantation unit and emergency services. For the personnel who deserve the payments determined by this paragraph wholly, a supplementary payment not exceeding 50 per cent of the rates in this paragraph may be allocated for his/her non-office hour contribution, excluding the shift hours. The amount of the supplementary payment for the contracted personnel shall be determined based on the precedent personnel with the same title and working duration in the same unit and this supplementary payment shall on no account exceed the maximum level of the payment to a precedent personnel.

In accordance with Article 38 of the Law on the Higher Education in 04/11/1981 dated and 2547 numbered, the personnel who are assigned to the central organisation of the Ministry and affiliated health agencies and institutions shall be facilitated from the supplementary payment for their titles in the Ministry or affiliated health agencies and institutions provided that they do not facilitate from the supplementary payments stated in the same Article. When needed by the health agencies and institutions, health services or auxiliary health personnel from universities or other agencies and institutions may be assigned to part time duties or specific cases with the consent of the related personnel or the institutions. The personnel assigned in such a manner shall be paid from the revolving fund in accordance with the principles of Paragraph 3 and 4.

ARTICLE 2- The following indent shall be added to the sub-paragraph 2, paragraph (a), Article 36 of Law on the Higher Education.04/11/1981 dated and 2547 numbered

“d) Professors and associate professors working in partial status health services and auxiliary health services (excluding animal health) under sub-paragraph (III), Article 36 Law no.657 shall not carry on their profession to produce income or for a cost, except for the duties determined by special legislations and the research-development activities, seminars, conferences and copyrights.”

ARTICLE 3- Paragraph (a) in Article 58 of the Law no.2547 shall be amended as follows:

“At least 35 per cent of the revolving fund gross product collected through the contribution of the academicians in connection with each training, research or implementation unit or department shall be allocated for the tools, supplies and research needs of that institution or

unit. The remaining part shall be distributed to academicians, contracted personnel and civil servants working for the same units under Civil Servants Law No.657 dated 14/07/1965 (including revolving fund management office and revolving fund capital accountants) in faculties, institutes, colleges, conservatories, application and research centres with revolving fund, having regard to their participation in order to make supplementary payment within the rates to be determined by the university's Executive Board. The rates, principles and methods of this payment for the faculties of medicine shall be determined by a by-law which will be issued by the Turkish Council of Higher Education upon the authorisation of the Ministry of Finance having regard to the service presentation requirements and criteria and considering personnel's title, duty, working conditions and duration, duty participation, performance, invasive processes such as examination, operation, an aethesis as well as working in risky specialty departments. The amount of the monthly payment to the personnel from the revolving fund income which is provided through the contribution of the personnel shall not exceed 800 per cent of the total of monthly payment (including the supplementary indicator), supplementary payment and any indemnities (excluding position, representation and duty indemnities) for the academicians with professor and associate professor title working for the units authorised by the Turkish Council of Higher Education upon the suggestion of the Interuniversity Board. This rate is 700 per cent for the assistant professors, specialist physicians, the personnel who granted specialty in accordance with the provisions of the Regulation on Specialty in Medicine and specialist dentists; 500 per cent for the research assistants, general practitioners and dentists; 250 per cent for the hospital directors and pharmacists; 200 per cent for chief nurses, nursing services managers and other managers in the hospital; 150 per cent for other personnel. 150 per cent rate may be applied as 200 per cent to the personnel working in the specialty services such as intensive care, delivery room, newborn, infant, burn, dialysis, operating room, bone marrow transplantation unit and emergency services. For the personnel who deserve the payments determined by this paragraph wholly, an supplementary payment not exceeding 50 per cent of the rates in this paragraph may be allocated for his/her non-office hour contribution, excluding the shift hours. The amount of the supplementary payment for the contracted personnel shall be determined based on the precedent personnel with the same title and working duration in the same unit and this supplementary payment shall on no account exceed the maximum level of the payment to a precedent personnel. Rectors and deputy-rectors and the deans and deputy-deans of the faculties deriving such income may be paid within the framework of the principles of this Article regardless of their direct income making activities. When needed by the faculties of medicine, health services or auxiliary health personnel from public agencies may be assigned to part time duties or specific cases with the consent of the related personnel or the institutions and the approval of the dean. The personnel assigned in such a manner shall be paid from the revolving fund in accordance with the principles of this Article. A supplementary payment shall not be demanded from the individuals for the health services delivered by the academicians.”

ARTICLE 4- The following paragraph shall be added to the Supplementary Article 2 of 26/07/1967 dated and 926 numbered Law on Turkish Armed Forces:

“Physicians, dentists and specialist physicians working under the order of Turkish Armed Forces may privately carry on their profession out of their working hours.”

ARTICLE 5- Article 1 of Law on the Practising Medicine and Dentistry of 11/4/1928 dated and

1219 numbered shall be amended as follows:

In order to practice medicine and to treat patients within the Republic of Turkey, it is required to have a diploma from a Turkish medical faculty or foreign medical faculty whose equivalence is approved by the authority in accordance with the relevant legislation and to have a diploma registered by the Ministry of Health.

ARTICLE 6- Paragraph 2 ad 3 in Article 12 of the Law no 1219 shall be amended as follows:

“The physicians may not practice their profession by establishing doctor’s offices in more than one place. The physicians may perform their profession only in one of the health agencies and institutions determined by the following sub-paragraphs. Principles associated with working for more than one health agency or institution and workplace medicine within the scope of each sub-paragraph shall be determined by the Ministry of Health.

- a) Public agencies and institutions,
- b) Private health agencies and institutions which work through a contract with the Social Security Institution,
- c) Private practice of the profession with the private health agencies and institutions which do not have a contract with the Social Security Institution.”

ARTICLE 7- The following clause shall be added to Article 99 of the Civil Servants Law no.657 dated 14/07/1965:

“However, the radiation dose limits in the by-law that will be issued by the Ministry of Health shall also be considered for the 40 hours duration for the places conducting diagnosis, treatment or research with ionising radiation and the personnel working on these procedures. The precautions for overdose and the recess duration in case of an overdose and other measurements shall be determined by the by-law.”

ARTICLE 8- Additional Article 33 of Civil Servants Law no.657 shall be amended as follows:

“For each shift hour for which no vacation is given (for at least 4 hours continuous shift), shift payments to be calculated as multiplying the indicator figures below by the monthly coefficient shall be paid to the personnel who –except for weekly working hours- have shift in normal, emergency or branch services and who are not allowed to take vacation in return for these shifts in health agencies and institutions. This payment shall not be subjected to a tax or cut except for stamp duty.

The provision of this Article shall be executed for the personnel who works for the inpatient therapy agencies and are within the scope of sub-paragraph (e) in Article 50 of the Higher Education. The personnel who takes necessity shift and not allowed by his/her agency to take a vacation in return (for at least 12 hours continuous necessity shift), shall be paid necessity shift payment as 50% of the payment stated above for the shifts. The total duration of the necessity shift shall not exceed 120 hours for a month. The payments to be made in accordance with this Article, shall be covered by the agency’s revolving fund income. “

ARTICLE 9- The phrase “and to the personnel who earned specialist title of the branches stated by the Regulation on Specialty in Medicine this Regulation and in accordance with the provisions of this Regulation, physicians, dentists and pharmacists” shall be added following the phrase “the personnel who are assigned to the positions for which indemnity payment with indicators less

	Indicator
a) Clinic chief, deputy chief, head assistant, specialist physician	120
b) Physician, holder of specialty certificate in the branches stated by Specialty Regulation in accordance with the provisions of this regulation, holder of specialty certificate in the same branches through doctorate process	110
c) Dentist	100
d) Health personnel with vocational college education	80
e) Health personnel with high school equivalent education	60
f) Other personnel	40

than 7.000 for position or supreme judge is estimated” within the 1st indent in sub-paragraph (C), Article 1 of the Decree Law dated 27/6/1989 and numbered 375.

ARTICLE 10- (1) The 31/12/1980 dated and 2368 numbered Law on the Compensation and Working Principles of the Health Personnel and,

(2) Article 4 of Law on Practising Medicine and Dentistry 11/4/1928 dated 1219 numbered and shall be abolished.

Temporary Article: The individuals who formerly worked as a permanent staff of the Ministry of Health with health services and auxiliary health services title and quit may be assigned to their former positions upon their demand within the 3 months following the publication of this Law. In case there is no available vacancy for these positions, the personnel shall be assigned to the needed vacancies without any authorisation required.

Enactment

ARTICLE 11, (1) Article 5, 8 and the paragraph 2 in Article 10 of this Law shall enter into force on the date of its publication,

(2) The other Articles shall enter into force on 01/1/2009.

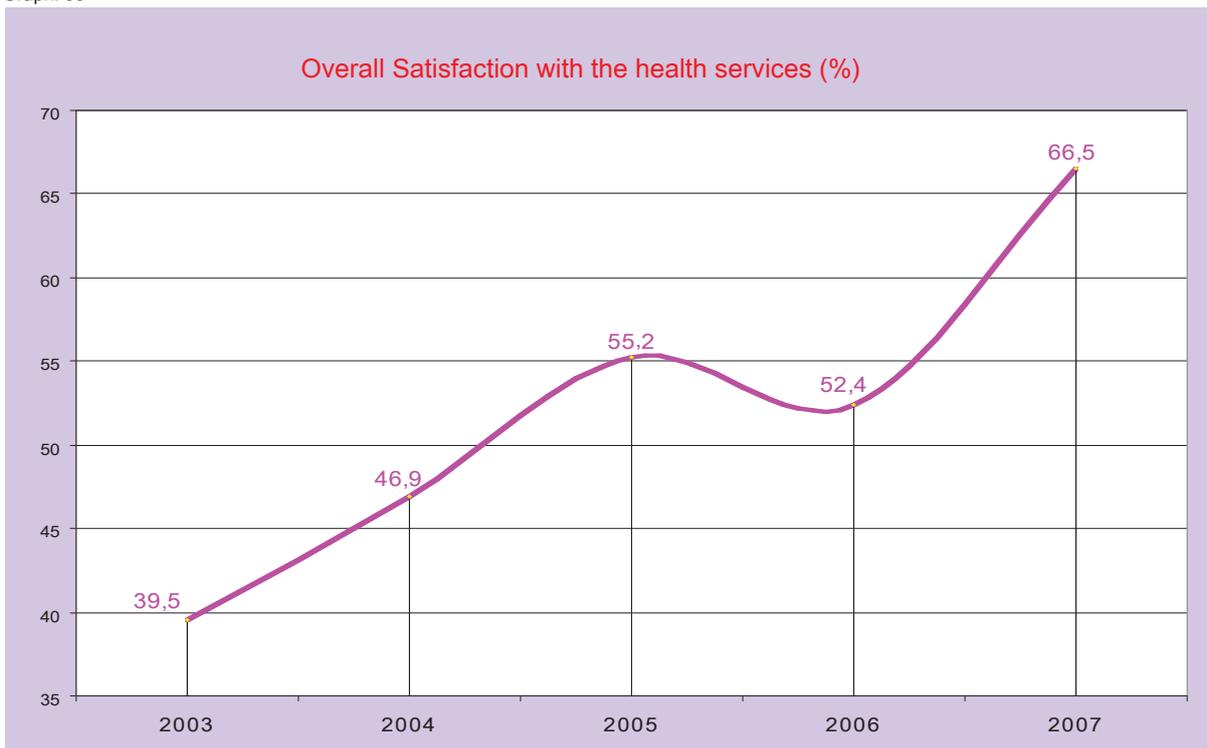
Execution

ARTICLE 12- The provisions of this Law shall be executed by the Cabinet.

Conclusion

*We do not strive to discover what is already discovered,
And we proceed carefully
With our own knowledge and experience,
And with lessons learned from our and others' mistakes.
We started rapid change and transformation,
Since we have a long way to go.
What we all need are people:
hardworking, good-willed, determined and long term people.
Whom we already have
And so will we succeed*

Graph: 50



Source: Turkish Statistical Institute

All was different 6 years ago;

and all will be better 6 years later.

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