KONFERANS SUNUMLARI VE TARTIŞMALAR

TÜRKİYE GENEL SAĞLIK KAPSAMI BAKANLAR KONFERANSI

TURKEY MINISTERIAL CONFERENCE ON UNIVERSAL HEALTH COVERAGE

27-28 HAZİRAN 2013

HAZIRLAYAN
PROF. DR. SABAHATTİN AYDIN

T.C. Sağlık Bakanlığı
Sağlık Araştırmaları Genel Müdürlüğü
Imperial College London
THE LANCET
MEDİPOL UNV ISTANBUL MEDİPOL UNIVERSITY

TURKEY MINISTERIAL CONFERENCE ON UNIVERSAL HEALTH COVERAGE

Organized by
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Istanbul Medipol University
The Lancet

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Prepared by:
Prof. Dr. Sabahattin Aydın

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Hazırlayan
Prof. Dr. Sabahattin Aydın

Yayıncı
İstanbul Medipol Üniversitesi
Unkapanı, Atatürk Bulvarı No:27
34083 Fatih-İstanbul

Mizanpaj
Murat Çakır - Medicom

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İçindekiler

Sunuş

Türkiye Cumhuriyeti Sağlık Bakanlığı, Genel Sağlık Kapsamını gerçekleştirme sürecinde doğru öncelik ve yöntemleri belirleyerek göstermiş olduğu politik kararlılık ve güçlü liderlik sonucunda toplumun desteğini arkasına almayı başarmıştır. Bu anlamda, yaşadığı ülke deneyimini ve başarısını Lancet Dergisi'nde yayımlanan "Türkiye'de Genel Sağlık Kapsamı: Hakkaniyetin Artırılması" özel makalesi ile uluslararası platformda paylaşmayı amaçlamıştır.

Bakanlığımız 27-28 Haziran 2013 tarihlerinde Londra Imperial College, The Lancet ve Medipol Üniversitesi işbirliği ile İstanbul'da düzenlediği "Genel Sağlık Kapsamı Bakanlar Konferansı" ile bu özel makalenin tanıtımını gerçekleştirmiştir. Konferansta ayrıca Bakanlığımız Genel Sağlık Kapsamı konusundaki kararlılığını, konunun önemini uluslararası arenada hem kendi ülke deneyimini paylaşarak hem de farklı ülkelerden gelen deneyim, bilgi ve önerilerin paylaşılmasını sağlayarak göstermiştir.

Bu konferansa Portekiz, Kore Cumhuriyeti, Letonya, Meksika, Endonezya, Moldova Cumhuriyeti, Mısır, Romanya, Pakistan ve Almanya sağlık bakanları veya üst düzey temsilcileri, Ekonomik Kalkınma ve İşbirliği Örgütü (OECD), Dünya Sağlık Örgütü (DSÖ), Dünya Bankası (DB) yöneticileri ve konusunda uzman uluslararası akademisyenler konuşmacı olarak katılım sağlamışlardır.

Konferansa Afganistan, Arnavutluk, Avusturya, Azerbaycan, Birleşik Arap Emirlikleri, Bosna Hersek, Brezilya Burkina Faso, Burunei, Demokratik Kongo Cumhuriyeti, Endonezya, Fil Dişi Sahilleri, Filistin, Gana, Gine, Güney Afrika, İsrail, İsviçre, İtalya, Japonya, Kamerun, Karadağ, Katar, Kırgızistan, Komorlar, Kongo Cumhuriyeti, Kore Cumhuriyeti, Letonya, Maldivler, Meksika, Mısır, Moldova Cumhuriyeti, Mozambik, Nijer, Özbekistan, Pakistan, Portekiz, Romanya, Somali, Sudan, Tunus, Türkmenistan, Uganda, Yemen ve Tayland'dan da üst düzey katılım olmuştur.

Konferansta ülkemizde sağlık konusunda hizmet kalitesinin nasıl arttırıldığı, hizmetlerin erişilebilir hale getirildiği, Türkiye'nin gösterdiği politik kararlılık ve hükümet olarak sağlık alanında nereden nereye geldiğimiz vurgulanmıştır. Ayrıca düzenlenen "Genel Sağlık Kapsamı", "Mali Kriz Dönemlerinde Genel Sağlık Kapsamının Sürdürülebilirliğinin Sağlanması", "Orta ve Düşük Gelirli Ülkelerde Genel Sağlık Kapsamının Artırılması", "Genel Sağlık Kapsamında Acil ve Afet Yönetimi" ve "Küresel Sağlıkta Yönetişim Zorlukları" panelleri ile ülkelerin deneyimlerini paylaşması ve tartışması için uygun platform sağlanmıştır.

Gelecekte ülkemiz adına böyle gurur verici başarıların paylaşılmaya devam etmesini temenni ederim. Konferansın düzenlenmesi sürecinde Bakanlığımıza vermiş oldukları değerli destek ve katkılarından dolayı Londra Imperial College, The Lancet ve Medipol Üniversitesi'ne, katılım ve paylaşımlarından dolayı değerli konuşmacılara, tüm katılımcılara ve emeği geçen herkese teşekkürlerimi sunarım.

Prof. Dr. Uğur DİLMEN
Sağlık Araştırmaları Genel Müdürü

Önsöz

Bilindiği gibi ülkemizde Sağlıkta Dönüşüm Pogramı adıyla 2003 ylında başlatılan bir sürece tanıklık ettik. Bu süreç, sağlık sektöründe taşların yerinden oynatıldığı, sevinen ve üzlenlerin olduğu, taraftarının ve karşıtlarının buluduğu bir reformlar zincirini kapsamaktadır. En azından sağlık sektörü, halkın talep ve beklentileri doğrultusunda şekillenmiş, sağlık bir politika alanı olarak siyaset güdeminde yerini almıştır. Cumhuriyetimizin ilk yıllarında Refik Saydam imzasını taşıyan temel sağlık politikalarından sonra, 50'li yıllarda Behçet Uz'un sağlık planlamaları, 60 sonrası Nusret Fişek ve sağlıkta sosyalizasyon harketi yakın dönem sağlık poltika tarihimizin önemli köşe taşlarını oluşturmaktadır. Son 10 yılda Recep Akdağ'ın izlerini taşıyan ve çok tartışma fırsatı yakaladığımız Sağlıkta Dönüşüm Programının da köşe taşlarının sonuncusunu oluşturduğunu iddia etmek yanlış olmaz sanırım.

Yıl 2013. Türkiye'nin gezi olayları adı altında ün bulan eylemlerle dünyada gündeme geldiği günlerde the Lancet dergisinin editörü Richard Horton dergide arda arda ülkemiz hakkında yorumlar yazdı (Horton R: Offline: Testing Turkey›s European "transformation". The Lancet, 381 (9862): 188, 2013; Horton R, Lo S: Turkey›s democratic transition to universal health coverage. The Lancet, 382 (9886): 3, 2013; Horton R: Offline: The Turkish paradox. The Lancet, 382 (9886): 12, 2013). Editörün dikkatini ülkemize çeken şey ayı günlerde bu dergide yayımı kabul edilen Türkiye'de uygulanan sağlık politikaları ve sonuçlarının tartışıldığı bir makaleydi (Atun R, Aydın S, Chakraborty S, Sümer S, Aran M, Gürol I, Nazlıoğlu S, Özgülcü Ş, Aydoğan Ü, Ayar B, Dilmen U, Akdağ R: Universal health coverage in Turkey: enhancement of equity. The Lancet, 382 (9886): 65-99, 2013). Makale, İmperial Collage, London ile İstanbul Medipol Üniversitesinin desteğinde Sağlık Bakanlığı Sağlık Araştırmaları Genel Müdürlüğünce yürtülen bir proje çerçevesinde bir yıla yakın süren yoğun bir çalışmanın ürünü olarak ortaya çıkmıştı. Türkiyede uygulanan sağlık politikalarının panoramasını çizdikten sora son on yılın sağlık reformlarına odaklanan bu çalışma, ulusal ve uluslararası kuruluşlarca ilan edilen veriler çerçevesinde çıktıları irdeliyordu. Özellikle 1993-2008 yılları arasında Hacettepe Üniversitesi Nüfus Etütleri Enstitüsünce gerçekleştirilen Türkiye Nüfus ve Sağlık Araştırmaları verileri çerçevesinde sağlıkta genel kapsayıcılığın gerçekleşme durumunu tartışmaya açıyordu.

Makalenin Lancet'te online yayınlandığı günün hemen ertesinde, 27- 28 Haziran günlerinde İstanbul'da birçok ülke temsilcisinin katıldığı bir etkinlikle lansmanı yapıldı. Konferansa Dünya Sağlık Örgütü, OECD, Dünya Bankası gibi uluslararası örgütlerin temsilcilerinin yanı sıra birçok ülkenin Sağlık Bakanı veya üst düzey yöneticieri katıldı. Bu lansman toplantısında Rifat Atun çalışmanın özetini sunarken, genel sağlık sigortasına, yani genel sağlık kapsayıcılığına giden yolculuğun 2003'te değil, gerçekte 1945'te Sosyal Sigortalar Kurumunun kurulmasıyla başladığını ifade ediyor. Altmışlı yıllardan beri devletin hedefleri arasına giren genel sağlık sigortası uğraşının günümüze uzanan uzun yolculuğunu Aşık Veysel!in "Uzun ince bir yoldayım" dizesiyle özetliyor. Elli yıllık bir tecrübe ile ulaşılmak istenen bu uzak hedefin aslında hakkaniyet olduğunun altını çiziyor. Bilindiği gibi aşık Veysel o devirde Türkiye'de birçok kişinin yakalandığı su çiçeği hastalığının kurbanlarından biri olarak gözlerini kaybetmişti. Atun'un ifadesiyle kör olmasına ragmen, düçar olduğu karanlıkta Anadolu'nun güzelliklerini görebiliyordu.

Bu uzun ve ince yoldaki seyahat 2003'ten sonra büyük bir ivme kazandı. Türkiye'de hızla hayata geçirilen sağlık politikaları nerdeyse toplumun tamamını etkilemiş oldu. Son derece hızlı işleyen bu sürecin, zaman zaman sancılara yol açmış olsa da, halkın beğenisini kazandığı bir gerçektir. Belki gerçekleşemelerini de bu hızına borçludur. Hikayeyi Atun şöyle anlatıyor: "Herşey çok hızlı seyretti. Unutamadığım bir anım var; Joe Kutzin de o toplantıdaydı; ayrıca Estonya ve Tayland'dan arkadaşlarımız vardı. Tayland da evrensel sağlık kapsayıcılığına nasıl ulaşıldığını konuşuyorduk. Uzun bir yolculuktu, 15 ila 20 yıl süren bir yolculuk. Bakan bey ve Sabahattin beyin "Güzel ama bizim bu kadar vaktimiz yok ki, biz bunları 18 ayda gerçekleştirmeliyiz" dediklerini hatırlıyorum. Bu sözler karşısında şaşırmış ve oturup kalmıştık. Ama oldu işte! 18 ay sonra Sağlık Bakanlığı, Dünya Sağlık Örgütü ve Avupa Gözlemevinin katılımıyla bir toplantı yapıldı; Joseph Figueras ve Julio Frenk de oradaydı. O gün Genel Sağlık Sigortası Kanunu kabul edilmişti. Gerçekten memnuniyetle belirteyim ki, herşey çok hızlı oldu."

Gerçekten ikibinli yılların ilk yarısı sağlık politikaları konusunda yoğun teorik tartışmaların yürütüldüğü, bazı uygulamaların hızla hayata geçirildiği, bir kısmının pilot uygulamalarının yapıldığı bir dönem oldu. Bu programın önemli bileşenlerinden biri genel sağlık sigortasıydı. 2006 yılı Mart ayı sonunda Sosyal Güvenlik Yasa Tasarısının Bütçe Plan Komisyonundan da onaylanarak geçtiği günün hemen ertesinde Dünya Sağlık Örgütünün desteğiyle Sağlık Bakanlığı Strateji Geliştirme Başkanlığınca İstanbul›da «Türkiye›de Sağlık Hizmetlerinin Finansmanında Genel Sağlık Sigortası ve Sağlık Bakanlığı›nın Yeniden Yapılandırılması» başlıklı uluslararası bir toplantı düzenlenmişti. O zaman Sağlık Bakanlığı Müsteşar Yardımcısı sıfatıyla benim yaptığım «Sağlık Bakanlığını Etkili Stewardship İçin Yeniden

Yapılandırma: Planlarımız ve Uygulamadaki Zorluklar» başlıklı sunum ile Sosyal Güvenlik Kurumu Başkan Vekili Tuncay Teksöz'ün «Genel Sağlık Sigortasına Geçiş Hazırlıkları» adlı sunumu ana tartışma konularını oluşturuyordu. Bu toplantıda birçok uluslararası uzmanın yanı sıra, Rıfat Atun, Josep Figueras, Joseph Kutzin, Julio Frenk de görüşlerini paylaşmışlardı. Toplantının uzmanlar arasında çalıştay şeklinde geçen beyin fırtınası niteliğindeki ilk oturumunun deşifrelerini yapıp türkçeye çevirerek kitapçık halinde yayımlama şansım oldu (Genel Sağlık Sigortası ve Sağlık Bakanlığının Değişen Rolü, Sağlık Bakanlığı, Ankara 2007). İşte Rıfat Atun'un sözünü ettiği 18 ay sonraki gerçekleşme toplantısı buydu. Gelecekte Türk sağık sistemini araştıranların nerden nereye gelindiğini görebilecekleri bir kıyaslama ölçütü sunması bakımından o topantı notlarının önemine işaret etmek isterim.

Küresel sağlık politikaları liderlerinin yakın takibi ve gözlemi altında yürütülen bu süreç, belki icraatların kendileri kadar yapılan çalıştaylar, üretilen fikirler, araştırılan ve gidilip görülen örnekler, beğeniler, karşı çıkışlarla oluşturulan ulusal poitikalar ve bunların dökümante edildiği onlarca kaynakla gelecekte daha sükunetle analiz edlebilecek ve yargılanacaktır.

Bu son konferans, görevine yeni başlamış bulunan Sağlık Bakanımız Mehmet Müezzinoğlu'nun son on yılın sağlık politikalarını özetleyen açış konuşmasıyla başladı. İki gün süren altı oturum yapıdı. Sağlığa Gene Bakış konulu ilk oturumu Lancet dergisinin baş editörü Richard Horton yönetti. Oturumda Dünya Bankası yöneticisi olan eski Hindistan Maliye Bakanı Sri Mulyani Indrawati, OECD Genel Sekreter Yardımcısı Yves Leterme, Eski Sağlık Bakanımız Recep Akdağ ve Dünya Sağlık Örgütü Sağlık Sistemleri Finanasmanı Koordinatörü Joseph Kutzin görüşlerini aktardılar.

İkinci oturum konferansın ana konusu olan Türkiye Sağlıkta Dönüşüm Programı ve sonuçlarının ele alındığı Lancet dergisindeki makalenin tanıtımına ayrılmıştı. Yine Lancet'ten Richard Horton'un yönettiği bu oturumda makalenin ilk yazarı olan Londra Imperal Collage ve Harvard School of Public Health öğretim üyesi Rifat Atun detaylı bir sunumla çalışmayı aktardı. Oturumda yapılan çalışmayla ilgili görüşlerini açıklayan diğer panelistler, Dünya Sağlık Örgütü Avrupa Bölge Direktörü Zsuzsanna Jacob, Medipol Ünivrsitesinden ben ve Harvard School of Public Health Dekanı ve eski Meksika Sağlık Bakanı Julio Frenk idi.

Ardından OECD ve Dünya Sağlık Örgütünün birlikte düzenledikleri iki Bakanlar Oturumu gerçekleştirildi. Mali Kriz Dönemlerinde Evrensel Sağlık Kapsayıcılığının Sürdürülmesi, konulu oturumu Avupa Sağlık Sistemleri ve Politikaları Gözlemevi Direktörü ve Dünya Sağlık Örgütü Sağlık Politikaları Ofisi BaşkanıJosep Figueras Josep Figueras yönetti. Portekiz Devlet Bakanı Manuel Ferreira Teixeira, Leonya Sağlık Bakanı Ingrida Circene ve Kore Cumhuriyeti eski Sağlık ve Refah Bakanı Choi Won-young bu oturumun konuşmacılarıydı. Diğer Bakanlar oturumu Harward Üniversitesi öğretim üyelerinden William Hsiao'nun yöneticiliğinde gerçekleştirildi. Düşük ve Orta Gelir Grubu Ülkelerde Genel Sağlık Kapsayıcılığının Tesisi başlıklı bu oturumda, Meksika Sağlık Bakanlığında Ekonomik Analizler Müdürü Nelly Aguilera Aburto, Endonezya Sağlık Bakan Yardımcısı Ali Ghufron Mukti ve Moldova Ulusal Sağlık Sigortası Fonu Genel Müdürü Mircea Buka konuştular. Daha çok interaktif geçen bu oturumda birçok ülkenin yetkilisi de görüşlerini paylaşma fırsatı buldu.

Konferansın ikinci gününün Genel Sağlık Kapsamı Bağlamında Acil Durum Yönetimi başlığını taşıyan ilk oturumuna Pakistan Sağlık Bakanı Sania Nishtar başkanlık etti. Bu oturumda Dünya Sağlık Örgütü Doğu Akdeniz Bölge Direktörü Ala Alwan ana konuşmacı olarak yer adı. Endonezya Sağlık Bakan Yardımcısı Ali Ghufrom Mukti, Mısır Sağlık Bakan Yardımcısı İbrahim Mustafa ve Tükiye Cumhuriyeti Sağlık Bakan Yardımcısı Agah Kafkas oturumun panelistleriydi.

Rifat Atun'un başkanlığında yapılan kapanış oturumunda Julio Frenk ve Almanya Federal Sağlık Bakanlığı, Avrupa ve Uluslararası Sağlık Politikaları Genel Müdür Yardımcısı Udo Scholten'in değerlendirme konuşmaları oldu. Ne yazık ki bu oturumn kayıtlarındaki teknik aksak nedeniyle konuşmalar deşifre edilemedi.

Konferans Türkiye Cumhuriyeti Sağlık Bakan Yardımcısı Agah Kafkasın kapanış konuşması ile sona erdi.

Ayrıca, konferansla ilgili Sağlık Bakanı Mehmet Müezzinoğlu, Eski Sağlık Bakanı Recep Akdağ, Imperial College'den Rıfat Altun, Lancet Dergisi Editörü Richard Horton›un katılımıyla ortak bir basın toplantısı düzenlendi.

Türkiye sağlık sitemindeki gelişmeleri konu alan ve Lancet dergisinde yayımlanan makalenin lansmanı vesilesiyle düzenlenen bu konferans, sağlık sistemleri konusunda uluslararası düzeyde uzman birçok konuşmacının görüşlerini açıkladığı bir ortam olmasının ötesinde Türkiye Sağlık Bakanlığını yeni bırakan ve aynı bakanlığa yeni oturan iki bakanımızın bir arada görüşlerini paylaşmaları açısıdan da ayrı bir öneme haizdi.

Bu kitap, konferansın konuşmlarının deşifre edilmesi sonucu oluşmuştur. Yukarıda sözünü ettiğim toplantı notlarından oluşan Genel Sağlık Sigortası ve Sağlık Bakanlığının Değişen Rolü adlı kitapçıktan yaklaşık 7 yıl sonra ortaya çıkan önemli bir belgeyi teşkil etmektedir. İleride Türk sağlık sistemindeki değişikliğin serüvenini araştıranlar için önemli bir kaynak teşkil edeceği ve kıyaslama imkanı sunacağı kanısıdayım. Konuşmalar ingilizce veya türkçe olduğu gibi aktarılmış, tercüme

cihetine gidilmemiştir. Son dönem sağlık politikaları hakkında ileride söylenecek çok şey olacaktır. Bu süreç, bireysel liderliğini sağlık liderliğine devşirmiş fedakarca çalışan bir ekip çalışmasının izlerini taşımaktadır. Olumlu ve olumsuz tecrübelerimizden alınacak dersler vardır. Nitekim bu konferansa konu olan makale de konuya bu açıdan yaklaşmaktadır. Konferans notlarını inceleyenlere kolaylık sağlaması amcıyla toplantı esnasında katılımcılara dağıtılan makalenin orijinal çıktısı ve türkçe çevirisi de son bölüm olarak eklenmiştir.

İkinci oturumun başında Richard Horton'un da işaret ettiği gibi, Türkiye Cumhuriyeti vatandaşlarının uluslararası başarılarını içselleştirmede güçlük çeken, bunu kabul edilemez bulan ve mutlaka yaptığımızın iyi olmaması gerektiğine inanan "vatandaşlarımız" olagelmiştir. Mutluluğu başarısızlıkta, gelişmeyi kabullenmişlikte, atılımı atalette aramak gibi bir zaafımız var. Özellikle başarıyı kabullenmekte zorlanan akademik camiadaki özgüven probleminin ülkemizin hakettiği atılım hızını yavaşlattığını düşünüyorum. Türk sağlık sisteminin uluslararası farkedilirliği karşısında bu tutumun yansımalarını görmek şaşırtıcı olmayacaktır. Kendimize olan güvenimizi kazandıkça gayretlerimizin ürüne dönüşmesi ve ülkemizin dünya listelerinde daha saygın yere ulaşması umudumuzu koruyoruz.

Bilindiği gibi sosyal medya hayatımıza fazlaca girmiş durumdadır. Ortamın heyecanının yansıtması bakımından konferans esnasında sosyal medyadaki ilginç paylaşımlardan bazıların aktarmak istiyorum:

Sağlık Bakanı Mehmet Müezzinoğlu (@ MuezzinogluDR); "Ülkemiz için önemli bir toplantı olan "Türkiye Genel Sağlık Kapsamı Bakanlar Konferansı"ndayız"

TBMM Sağlık, Aile, Çalışma ve Sosyal İşler Komisyonu Başkanı Necdet Ünüvar (@necdetunuvar); «İstanbul›da TC SB, Imperial College, The LANCET, Medipol Üniversitesinin düzenlediği Sağlık Bakanları Konferansındayım»

İstanbul Sağlık Müdürü Dr. Ali İhsan Dokucu (@ Aliihsan_Dokucu); "Türkiye sağlık sisteminin bir gurur gününe daha günaydın. Son on yılda yapılan reformların uluslararası tescili bugün. Londra İmparial College ve The Lancet Dergisi ile Sağlık Bakanlığı - Medipol Üniversitesi organizasyonu 20 civarı sağlık bakanı ve 300 davetli önünde sunuluyor. The Lancet dergisi ilk kez saglık hizmetlerinde ülkemizin bu başarı hikayesini 35 sayfalık bir inceleme makalesi ile uluslararası camiaya sunuluyor. Moderatör Richard Horton, Recep Akdağ'ı ve sağlık reformları hakkında da başarıyı övüyor. Tüm parametrelerde iyi gidiş var.»

Sağlık Bakanlığı İletişim Koordinatörü Osman Güzelgöz (@osmanguzelgoz) ; "Turkey Mınısterıal Conferance On Unıversal Health Coverage- Türkiye›nin Sağlık Reformu adına çok önemli bir toplantı. Sn. Bakanımız, önceki Bakanımız, Sağlık Komisyonu Başkanımız, Müsteşarımız, Bakan Yardımcımız ve değerli konuklarla önemli bir toplantıdayız"

Lancet Editörü Richard Horton (‖ @richardhorton); "An interesting time to launch this... The past and the current Ministers of Health in Turkey. Great concern about our press conference today.....Rifat Atun presents his findings on Turkey›s health success story to 300 international and national delegates..... Turkey: from Ottoman Empire to democracy, though perhaps more fragile than we might imagine.... A health system cannot be divorced from its political or economic context. Which makes Turkey today so interesting.... The key changes implemented in Turkey›s Health Transformation Programme.... A manifesto for managing health in times of economic crisis, courtesy of Josep Figueras..... Key challenges for Turkey›s health system, from Rifat Atun..... And the lessons learned from Turkey....Here is the whole Turkey paper. Sit down with a warm drink. It›s a gripping story."

Prof. Dr. Sabahattin Aydın

Welcome Speech
Açış Konuşması

Mehmet Müezzinoğlu

Çok değerli Sağlık Bakanları, bakan yardımcıları, DSÖ ve OECD yöneticileri, değerli Çalışma Bakanlığı mensupları ve meclisimizin değerli komisyon başkanı ve milletvekilleri, uluslararası kurum ve kuruluşların temsilcileri, ulusal ve uluslararası değerli basın mensupları, hanımefendiler beyefendiler,

Misafir ülke sağlık bakanları ve temsilcilerinin yanı sıra bu alanda otorite sayılacak onlarca konuğa ülkemiz adına ev sahipliği yapmaktan son derece mutlu olduğumu ifade ediyor, hepinize hoş geldiniz diyorum.

AK Parti hükümetlerinin sağlık hizmetlerinde son 10 yılda yaptıkları reformları ve elde ettikleri başarıları siz kıymetli konuklarımızla paylaşmanın gururunu yaşıyoruz. Sağlık ve ona dair her şeyi dünya ölçeğinde ele alacağımız bu konferans bilgi ve tecrübe paylaşımı açısından büyük bir önem arz etmektedir. Kıymetli misafirler, sağlık sistemleri; halkın sağlık düzeyini yükseltmek için sağlık hizmetlerini etkili, kaliteli, karşılanabilir maliyette, erişilebilir ve toplum tarafından kabul görecek tarzda sunmayı hedefler. Hedeflenen sonuçlara ulaşabilmek için de, kaynakların verimli, etkin kullanılması, hizmet alanların mali risklerden korunması ve hizmetin kesintisiz sağlanması gerekir. Hızla değişen dünyamızdaki bilimsel ve ekonomik gelişmeler, ülkelerin farklılaşan demografik yapısı, sağlık sorunlarının değişimi ve maliyetlerindeki artışlar, bu konudaki politikalarımızı, sürekli yenilemeyi kaçınılmaz kılmaktadır. Sağlık hizmetlerinin sürdürülebilirliği açısından, yeniliklere açık olmak, dahası yeniliklere uyum sağlayabiliyor olmak hayati bir önem arz etmektedir.

Türkiye 2002 yılından itibaren çok yönlü değişim ve gelişim yaşadı. 2002 yılında iktidara gelen ak parti hükümetlerimiz ve sayın başbakanımızın kararlı adımlarıyla, insan ve hakkaniyet odaklı sağlık hizmeti anlayışı gerçekleştirildi. Bu anlayışın geliştirilmesinde, değerli katkıları için başta Sayın Cumhurbaşkanımıza ve Türkiye Büyük Millet Meclisi'ne teşekkür ediyorum. "Bir sağlıklı nefesin bedeli olamaz. Önce devlet değil, önce insan diyeceğiz" diyerek, insan odaklı sağlık politikalarının geliştirilmesine öncelik tanıyan Sayın Başbakanımızın etkili liderliği, vizyonu ve siyasi kararlılığı en güçlü desteğimiz olmuştur. 2000'li yıllardan önce sağlık sistemimizde, hizmet sunumu, finansman, hizmete erişim, insan gücü ve bilgi sistemleri alanlarında problemler yaşanıyordu. Hükümetimizin insan ve hakkaniyet odaklı etik anlayışı sayesinde, bütün vatandaşlarımızın kaliteli sağlık hizmetlerine eşit biçimde erişmeleri, temel hedefimiz olmuştur. Bu hedefimizi gerçekleştirirken, sağlık hizmetlerinde finansman, ödeme, organizasyon, düzenleme, sunum ve geri bildirim gibi parametreler yönetim anlayışımızın temelini oluşturmuştu.

Bakanlığımız, sağlık hizmetleri sunumunda ve yönetiminde gelişmiş ülkelerin seviyesine ulaşmış, 2012 ve 2013'te Dünya Sağlık Örgütü'nün, dünya sağlık asamblesi toplantılarında, Türkiye, örnek ülke gösterilmiştir. 112 acil hizmetleri, koruyucu ve temel sağlık hizmetleri, ücretsiz gezici sağlık hizmetleri, kanser erken teşhis tarama ve eğitim merkez'leri, aile hekimliği uygulaması, bulaşıcı hastalıklarla mücadele gibi alanlarda ilerlemeler sağladık. Sağlığın teşviki ve geliştirilmesi programlarımız ile birlikte, sağlıklı yaşam konusunda farkındalık oluşturmaya yönelik projelerimizi de uygulamaya başladık. Yanlış beslenme, sigara ve alkol kullanımı, obezite ve diyabetle mücadele, organ bağışı gibi alanlardaki farkındalık programlarını hayata geçirdik. Ayrıca, beden sağlığı kadar önemli gördüğümüz ruh sağlığını geliştirmeye yönelik eylem programımızla, sağlık hizmet sunumunu geliştirerek sürdürmeye devam ediyoruz. Finansmandan sigortacılığa, yatırımlardan hastane hizmetlerine, aile hekimliğinden, koruyucu hekimliğe, sağlığın geliştirilmesi faaliyetlerine kadar sağlık hizmetlerinin bütüncül bir yaklaşımla yönetilmesi gerektiğini düşünüyoruz. İnsan gücü ve sağlık hizmet sunumunda, öncelikli olarak insanımızın ve sağlık çalışanlarımızın memnuniyetini esas alıyoruz.

AK Parti hükümetlerinin iktidara geldiği 2002 yılından bugüne yaşanan gelişmeleri ifade etmek gerekirse, kamu hastanelerini tek çatı alında birleştirmek amacıyla, 2005 yılında, Sosyal Sigortalar Kurumu'na bağlı tüm sağlık tesisleri sağlık bakanlığı bünyesine dâhil edildi. 2008 yılında emekli sandığı, BAĞ-KUR, SSK gibi farklı kamu sosyal güvenlik kuruluşları, sosyal güvenlik kurumu adıyla tek çatı altında birleştirildi. Ödeme gücü olmayan ve 18 yaşın altındaki tüm vatandaşlarımızı prim ödeme şartı aramaksızın genel sağlık sigortası kapsamına aldık. Yine bunun yanı sıra sağlık sigortası olsun ya da olmasın herkesin acil, salgın hastalık, iş kazası ve meslek hastalığı durumlarında her türlü sağlık yardımlarından ücretsiz yararlanmasını sağladık. Böylece vatandaşlarımızın sağlık hizmetinden hakkaniyetli bir şekilde faydalanmaları sağlanmış oldu. Sağlık hizmetlerinin sunumunda bölgeler arasındaki eşitsizlik büyük oranda giderildi. Birinci basamak sağlık

hizmetleri, aile hekimliği uygulaması ile güçlendirildi. Aile hekimlerine sorumlu oldukları bölgede, mobil sağlık hizmeti, evde sağlık hizmeti, cezaevi ve çocuk bakım evlerine periyodik ziyaretlerde bulunma sorumluluğu getirilmiştir. Tüm vatandaşlarımız koruyucu sağlık hizmetleri ve aile sağlığı hizmetlerinden ücretsiz yararlanmaktadır. Hastaneler teknolojik olarak yenilenerek kapasiteleri artırılmıştır. Sağlık hizmeti sunumundaki hakkaniyetin artırılmasına yönelik bu girişimler, anne ve bebek ölümlerinde belirgin bir iyileşme sağlanması ile etkisini göstermiştir. 2002 yılında her 1000 canlı doğumda 31,5 olan bebek ölüm hızı 2011 yılında 7,7'ye düşmüştür. 2002 yılında her 100.000 canlı doğumda 64,0 olan anne ölüm hızı 2008 yılında 18,4; e2010 yılında 16,4'e; 2011 yılında 15,5'e düşmüştür. 2002 yılında sağlık kuruluşlarında gerçekleşen doğum oranı % 75 iken, 2011 yılında bu oran 94'e yükselmiştir. Ülkemiz bütün bu uygulamalarda başarılı olup sağlık alanında rol model olmuştur. Bu süreçte Türkiye'nin göstermiş olduğu siyasi kararlılık, liderlik fonksiyonunu doğru şekilde yürütmesi ve toplumun desteğini almış olması bu başarıda önemli paya sahiptir. Başarıların devamlılığı finansal sürdürülebilirliğin sağlanabilmesine bağlıdır. Bu anlamda da Türkiye başarısını kanıtlamıştır. Toplam sağlık harcamalarının gayri safi yurtiçi hâsıla (GSYH) içindeki oranı 2002 yılında olduğu gibi 2011 yılında da değişmeyerek %5,4' de kalmıştır. Kamu sağlık harcamalarının gayri safi yurtiçi hâsıla içindeki payı ise 2002 yılında %3,8 iken 2012'de %4,4'e yükselmiştir. Büyük ve başarılı bir dönüşüme rağmen kamu sağlık harcamalarında gayri safi yurtiçi hasıladaki paydan sadece %0,6'lık bir artışın olması, Türkiye'de finansal sürdürülebilirliğin sağlandığının bir kanıtıdır. Ayrıca 2023 yılında Türkiye gayri safi milli hasılanın %6'sının sağlık harcamalarına ayrılacağı öngörülmüştür. Amerika birleşik devletlerinde şu anda bu oranın %18 olduğu, Almanya ve Fransa'da ise %12 olduğu düşünülürse Türkiye için sağlık harcamaları konusunda finansal sürdürülebilirliğinin sağlanacağını tekrar söylemek mümkündür.

Değerli katılımcılar, her ülkenin evrensel sağlık kapsamını geliştirmede kendisine has öncelik ve yöntemleri olmalıdır. Her ülkenin evrensel sağlık kapsamını gerçekleştirmede kendine has öncelikleri ve yöntemleri olmalıdır. Türkiye Cumhuriyeti Sağlık Bakanlığı, sağlık hizmetleri sunumundaki doğru öncelik ve yöntemleri başarıyla seçmiş olup, yaptığı uygulamalarla da toplumun desteğini arkasına almayı başarmıştır. Birçok açıdan faydalı sonuçlar doğuracağına inandığım bu konferansta, mali kriz dönemlerinde bile sağlık programlarının aksatılmadan nasıl sürdürülebildiğini, yönetim yerine yönetişim ve inovasyondaki hızlı gelişmelerin nasıl şekillendiğini hep birlikte değerlendireceğiz. Ben, ülkem adına, sizlerle böyle büyük bir organizasyonda bir arada bulunmaktan duyduğum memnuniyeti bir kez daha belirtmek istiyorum. Huzurunuzda, Türkiye'nin sağlık hizmetlerinde geldiği noktada büyük emeği bulunan, öncelikle sayın başbakanımıza, 10 yılı aşkın bir süre ülkemizin sağlık bakanlığını yapan yol arkadaşım sayın Prof. Dr. Recep Akdağ'a, sağlık sistemimizi dinamik bir yapıya kavuşturan sağlık yöneticilerimize ve çalışanlarımıza huzurlarınızda teşekkür ediyorum. Bilgi ve tecrübenin paylaştıkça artacağına inanan insanlar olarak, burada, iki gün boyunca, küresel sağlık politikalarına ciddi katkılar sunacak çalışmalar yapacağımıza inanıyorum.

Tekrar hepinize hoş geldiniz diyor, saygılar sunuyorum.

General Health Scope
Sağlığa Genel Bakış

Moderator: *Richard Horton*

Richard Horton

Good morning. My name is Richard Horton and I am the editor of a medical journal called the Lancet. I would like to extend my deep thanks to colleagues here from the Turkish Ministry of Health for the extra-ordinary generosity in organising and leading this symposium today in conjunction with Medipol University and Imperial College London. I would like to make a few opening remarks if I may before inviting this distinguished penal to office and observations on this subject of our meeting this morning.

First, I would like to try to answer the question why is a medical journal, the Lancet, such an enthusiastic partner in this event today. The Lancet was founded a very long time ago, in 1823. And, like any scientific institution, it was created to inform the medical and scientific community about developments in medicine and public health. But the Lancet was founded at a moment of extra-ordinary political change in the United Kingdom, a moment of enlightenment. It was a time where there were rapid political reforms. And so the Lancet was founded not only to inform but also to help reform. The founding editor of the Lancet, Thomas Wakley, wrote about how it was an arched window to let in light. As well as a sharp surgical instrument to cut out what was bad not only for medicine but also from society. In the 21st century, we interpret this as being a mandate for us to be a little like NGO, a non-governmental organization, for knowledge-trying to connect the world's best scientists and researchers to policy makers and political processes. And for the past decade, exactly during the time of the health transformation programme, we have been trying to forge a science based approach to global health; not alone, but with wide and diverse group of academic partners. Trying to study and amplify the experience that countries have gone through in terms of the health and development. We began, at the invitation of my good friend Julio Frenk when he was Minister of Health in Mexico with the study of Mexico's health reforms to Seguro Popular. And since then, we have had the privilege of working with governments in China, India, Brazil, South Africa, Japan, Pakistan, the Occupied Palestinian territory and across regions as diverse as Europe or South East Asia. To trying learn lessons from health systems reform.

So here we are in Turkey, and I think we have very special lessons to learn from the Turkish experience. And it is very important to try and apply the very best principles of scientific evaluation to Turkish reforms. When these reforms have been described elsewhere they have created considerable discussion. Perhaps one might even say controversy some have may claims perhaps the results that have been presented haven't told full and accurate picture. Some could even express an astonishment "how could a county make such a rapid progress in such a short period of time!"

It is very important the meeting we have today and tomorrow because Turkey does have an exceptionally important story to tell the world. And thanks to my colleague Rıfat Atun who will be presenting a little later this morning together with his team; we published today a scientific robust quantitative and previewed assessment of Turkey's astonishing success. It is a very important lesson that we are going to learn here because, to some, particularly perhaps to economists, health is seen as merely a function of wealth. In other words, health will inevitably improve providing we have economic success. But what Turkey's story shows is that it does matter what policies you choose and how those policies are implemented and how they are sustained for the health sector. And that is good news and bad news. It is good news because shows that governments do matter; governments can change the trajectory of health irrespective of the economic situation. The bad news is the governments do matter; in other words, the wrong decisions can lead to bad results. And what we are going to hear about today and tomorrow morning is ten-years of good government and good policy making can lead to such extra-ordinary change. And the changes really are extraordinary as we will hear. And we have a fabulous panel to give us some opening reflections and context about what has taken place in Turkey. And I am going to invite our panellists to speak one after the other and then we will be going to make a little discussion. I am going to begin with our first panellist who is Sri Mulyani Indrawati who is the former Minister of Finance from India and he is currently managing director of the World Bank.

Sri Mulyani Indrawati

Thank you Richard!

I would like to also thank the government of Turkey for inviting me and my institution to participate in this ministerial conference on a topic that is so vital to the global community. It is certainly appropriate and since this morning we heard we are gathering here in Turkey

for this conference because Turkey's progress in the health sectors can be our important lesson for many countries across the globe. The trajectory of Turkey's change has been remarkable and I am quite honoured to sit here next to Mr Akdağ who actually also is the designer of this remarkable achievement.

In five decades the life expectancy rose from 50 years to 75 in 2009. And with 2015 the MDGs looming on the horizon and many global conversations has been taking place on achieving the millennium development goal. Turkey has already met its MDGs four and five targets. Infant mortality has dropped from 31.5 in 2002 to 7.7 person per one thousand life birth in 2015, just over Western European average. And of course, an indicator, maternal mortality fell from 61 to 15.5 which has already been mentioned by minister earlier per ten thousand life birth in the same period. 96 % of Turkey's people are covered by health insurance. Its green card programme over good financial protection to vulnerable household. When the global economic crisis was revising Europe, the green card programme ensure that fewer household had to forgo medical care. This is compared to those without health insurance. But access alone is not enough. Turkey achieved a combination of universal access, financial protection, and high patient satisfaction. Out of pocket payment for health account for approximately 16 % of total health spending; it is above the same ratio as Western Europe. And 76 % patient reported that they were satisfied with health care services in 2010. This is up from 40 % in 2003.

All these achievements in Turkey's health system are particularly relevant today. Especially when we all face an unparallel momentum in the global post-war universal health coverage but at the same time the global economy is facing with a challenging environment of recovery from the financial crisis. Access to quality and affordable health services is central to ending extreme poverty and building share prosperity. Worldwide, out of pocket health spending forces one hundred million people into extreme poverty every year and inflicts severe financial hardship to another 150 million. To free the world from absolute poverty in 20-30 as now the World Bank is under the leadership of president Kim launching this last spring countries must ensure that citizen have access to the quality affordable health services they need. This is one of the reasons why Turkey's example is compelling. It shows that with determination and good leadership in health it can be done.

Of course this is not easily filled. It is important to balance on the one hand quality, coverage, and affordability and on the other hand financial sustainability. A citizen across the world put great value in health services according to the World Bank and EBRD Life in Transition survey. Health was people's top priority for government spending in 22 out of 29 country in Europe and Central Asia. Expectation for a strong government rule in this sector are high and this is exactly what Richard mentioned earlier. From the policy makers' perspective, investment in health is an investment in the countries' future. It improves labour productivity which is critical for sustainable economic growth. But the course can be substantial particularly when governments face significant fiscal constraint as we can see in the neighbouring country everywhere here. One of the key talents confronting policy maker is how to meet the growing demand for health care without imposing an undue burden on household or to the government by debt even though public spending in health in Europe and Central Asia varies from just over one percent to nearly seven percent of GDP. In every country there is a scope for making better use of existing resources. As former finance Minister which Richard mentioned earlier in the country that also aspired to achieve universal health coverage I am keenly aware of the difficulty of doing so with limited fiscal resources.

We must define the limit of what universal health coverage is and what is not. First, it is not a system where all services are covered. Second, it is not a system where everybody contributes equally. Given budget constraint, government support must prioritise the poor and the vulnerable. And third, efficiency, valuable money, and structural reform in service delivery have to be part of the equation for making coverage affordable.

Let's take the case of Turkey and Thailand, the two comparable examples that illustrate how these three principals were applied. First, there are limits of what is covered. In Thailand, a less was developed to determine which services are covered. Revision to the benefit packets are largely based on cause-effectiveness. In Turkey, the benefit covered under the Green Card programme expanded progressively as resource become available. Second, targeting should focus on the poor and vulnerable. Turkey's Green Card programme benefits low income households without social insurance and other vulnerable groups. Similarly, in Thailand, the universal coverage schemes target those without formal insurance. And both Turkey and Thailand have some co-payment or premium for beneficiary to increase individual responsibility in the demand for health. Third, supply-side reforms are needed to create fiscal space for increase coverage. I cannot really emphasize on this aspect enough. To eliminate duplication and to reduce administrative course, Turkey unified a health insurance team under one roof. It relied on one agency to negotiate lower price for medical services for all citizens. And in addition, new payment mechanisms for provider were introduced to increase efficiency and quality. And this is also similar in Thailand where the similar measure was adopted.

So in conclusion, there are many path of achieving universal health coverage. What work in one country cannot always be applied to the other. However, we find inspiration and idea in success story because there is always an opportunity to improve any system. That in my view requires committed, credible leadership focus on improving outcome. The future of health system also depend on producing knowledge on what works and what does not and making decision on hard evidence. So today's event is very very important certainly for that kind of forum. The World Bank group is committed to creating and sharing that knowledge through our function and our engagement with many countries in the world. We are depending our work on understanding not only what but also on how effective health system function. We are focusing our effort on the science of delivery. Countries with success story like Turkey can suddenly help by sharing that knowledge broadly. Our goal is to support country in taking advantage of what knowledge as they embark on the journey to universal health coverage. Together we can work to ensure that every person in every country has the opportunity to lead a healthy and productive life.

And let me add before I close, health care should never be a matter of politics. Everyone deserves to be treated in medical centre, in hospital are on the street. Thank you.

Richard Horton

Thank you so much. I will just want to recognize two things. First, the World Bank team here, in Turkey made an important contribution to the analysis that we are discussing today and tomorrow. And secondly, I would like to welcome my friend and colleague Tim Evans who is now in day three of his role as leading the health nutrition in population the vision of the Bank team here with us today.

The second speaker is Yves Leterme who is deputy secretary general of OECD. Yves perhaps I could invite you to make a few opening reflections about your thoughts on Turkish success.

Yves Leterme

Thank you very much! And of course want to start by thanking the Turkish government and minister that people that organize this very important and useful meeting. I am delighted to be here on behalf of the OECD representing the secretary general together with Stephanus Carpeta, Franceso Colombo and (39.13) so forth.

Ladies and gentlemen, as our world economy, quite slowly, recovers from the worst economic crisis of all times and in a contexts on long standing rise of inequalities we have a unique opportunity to pursue new economic growth model that is more inclusive and sustainable. This means that we have to re-centre our policy priorities and strategies and insure access to health care for all as the one of the most important. The challenge is how to ensure the fair provision not only of universal health care but of high quality universal health care for large number of people in a large number of countries.

Few remarks... First of all we can see that in fact universal health care is within rich, which is very positive, almost all member states of the OECD have achieved universal health care. And as a consequence, life expectancy today is almost 80 years on average in OECD countries again of over eleven years since 1960. Emerging economies including India, Indonesia, China, and South Africa are moving towards universal coverage. For instance it took just three years, only three years, between 2009 and 2011 for China to expand the health coverage to 95 % of its enormous population. Rwandan experience, for instance, shows that even developing countries with limited resources can make great strides towards a health system for all. We can look forward to our time Indonesia distant future when the great majority of the world's population in fact will have the access to basic health services. But, ladies gentlemen colleagues, there is still room for a significant improvement and no room at all for complacency. Access to basic health care without the risk of catastrophic costs indeed remains a real issue in many countries. This for instance, not unusual in Sub-Saharan Africa that only a tiny fraction of the population is covered by a government insurance programme; in Nigeria for instance, it is only 3 %, in Kenya 7 %. In the other side, there is the problem of the unaffordable health care which is still an issue which affects us all. Even in very wealthy countries like Australia, New Zealand, Germany for instance, around one out of ten in a population reports skipping medical tests treatment or follow up because of the cost.

Second remark, health coverage is good politics of course, is a matter of fairness but is also good economics. There is indeed an economic case for countries to invest even more than today in universal health care. Universal health care does more than just share the fruits of growth more fairly. It also shares the opportunities to benefit from growth. And the availability of access to affordable health care gives people in fact a stake in the health of their economies and it gives the economies a stake in the health of the people. Fewer people will be excluded from the market economy because of ill health and a fewer people will be impoverished because of the costs of health care. Some little examples, because OECD is about figures increasing a nation's life expectancy by year could potentially increase the GDP of per capita that country by 4 % in the long run. Maternal and new born mortality leads to, in terms of US dollar, 15 billion and

lost potential productivity globally every year. And an OECD report called Fit Not Fat refund that preventing obesity costs as little as US dollars 5 to 20 thousand per life year gains, far less then many of the medication technologies currently in use.

So what are our lessons on universal health coverage? Let me highlight three of them. First, it is better to start by providing maximal financial support for a few carefully selected services, and then, step by step, expand the reach of services discovered over time rather than trying to cover too many services very early on. Focusing on such essential services like vaccination basic pharmaceuticals and primary care is for instance a hallmark of this group from the Mexico which has reduced the proportion of households with catastrophic expenditures on health by 55%. Second lesson, thinking about value for money in terms of the expenditure and health care, thinking about value for money as important at an early stage of health system development as it is for more mature health systems. Nobody wants to or should have to pay more for less. For instance, studies show that in United States and Australia, only about half of old patients treated received appropriate care; either too much care or too little. Last but not least at lesson, it is vital to embed health care quality and patient safety from the start. Health care quality is critical in establishing the value of health care as well as maintaining the public's trust. This can be done by tracking quality of care and understanding why differences in care exist. For instance, screening programmes, guidelines, health spending etc. Our data, our OECD data, show that thirty-day mortality for patients admitted with the heart attack has decreased by 40% over the past ten years in all countries thanks to improvements in acute hospital care. And of course, we want to see more of this type of trends. Coming then to the example of Turkey or distinguished host, let me round off my comments indeed by talking about this experience. We have just released OECD reviews of health care quality (He shows the book). In fact this is a preliminary version, but it is here. Ladies and gentlemen as was said before, over the past decades this country, Turkey, has implemented a really remarkable set of health reforms. Of course, the achievements of the health transformation programme under the distinguished tutorship of Professor Akdağ, who had been the minister of health in Turkey for eleven years, is impressive. Really impressive! And I was delighted to hear how the minister Müezzinoğlu is really intense to build on this very great foundation. Now that Turkey's health care system is so to say more mature within that most urgently place in your focus on improving service quality and monitoring outcomes. Since beyond maternal and child health, relatively little is known about how well this system in this country here really performs. Turkey, the government has focused, with very good reasons, on getting more health care delivered to citizens. It has designed a remarkable tool to reward high productivity and it has taken admirable strides in getting providers into underserved regions. Indeed, today even the most rural parts of Turkey and Eastern Anatolia now have a supply of primary care doctors per head of population on above the national average. The situation which is much improved from a decade to go. With more, to our opinion, more needs to be done if the system is to deliver better health to citizens, more quality. The very quality of the services provided, the access to best medicines, technologies and train staff are really crucial. And this message, quality health care matters, is of importance beyond the borders even of this country.

Ladies and gentlemen, to conclude, within inclusion of OECD that we can help. The next few years will be globally speaking crucial in determining progress towards universal health coverage, universal health care well beyond, indeed today's OECD constituency, OECD member states. And OECD stands ready to help countries to achieve universal health care for instance our development aid committee can help countries to identify and mobilize aid to those devoted to health we will be working with our partners of course Mrs Chan, the WHO and also with World Bank over the next two years to identify the really best approaches to improving quality of health care. And we've initiated a new network to promote high quality care in Asia and Pacific region and already to set up similar initiatives in the rest of the world. So Mr Richard lets me stop here once again congratulating and thanking the government of Turkey.

Richard Horton

Thank you. There is a phrase in my country, United Kingdom, that "every political career ends in failure". Our next speaker show that in Turkey that is not the case. Recep Akdağ, the former Minister of Health and the current deputy of the Turkish Grand National Assembly, let and built the remarkable transformation team a decade ago the results of which we are talking about today. It was my pleasure, just a few weeks ago, the World Health Assembly to witness the presentation of an international award to Recep Akdağ for his leadership in health, leadership in health, not just in Turkey, but also as a global symbol to other countries. And it is my hope that now in his post-ministerial career he will become the chief diplomat the chief ambassador to amplify the lessons of Turkey's health reform programme to the rest of the world. Please give a worm welcome to Recep Akdağ.

Recep Akdağ

If you don't mind, I would like to speak in Turkish since we have interpreters.

Herkese hoş geldiniz diyorum. Bugün gerçekten çok seçkin bir toplulukla birlikteyiz. Değerli sağlık bakanımız, uluslararası kuruluşlardan çok kıymetli katılımcılar, değerli bakanlarımız, birçok ülkeden bakanlarımız ve üst düzey yöneticilerimiz var, bilim adamları burada ve önemli bir konuyu konuşuyoruz. Sağlığı konuşuyoruz. Herkesin sağlık hizmetlerine nasıl erişebileceğini konuşuyoruz. Dolayısıyla, gerçekten önemli bir toplantıdayız. Katılımlarınız için herkese çok teşekkür ediyorum, başarılar diliyorum.

Türkiye'deki Sağlık Dönüşüm Programı konusunda bana süre verseniz herhalde bir tam gün konuşabilirim. Aslında konuşacaklarımızın çok önemli bir bölümünü Lancet'te değerli arkadaşlarımızla birlikte kayıt altına aldık. Bu kayıt altına alma sorumluluğunu, hassasiyetini gösteren Lancet editörüne ve ekibine çok teşekkür ediyorum. Çünkü gerçekten tecrübelerin paylaşılması bütün insanlık için önemli. Türkiye'de de biz on yıl içerisinde çok kıymetli bir tecrübe yaşadık diye düşünüyorum. Müsaade ederseniz ben Türkiye'deki dönüşümün üzerinde çok durmayacağım. Bizden sonraki panelistler bu konu üzerinde de ayrıntılı olarak duracaklar. Ben bugün biraz ezberleri bozmak istiyorum. Şöyle bir hususu hayal edelim; sabah kalktınız evinizin önündeki aracınız çalınmış. Polis istasyonuna gittiniz, istasyonda büyük bir kalabalık var, kuyruk var; aracı çalınanların kuyruğu. Size dediler ki, "Aracınızı aramak için üç ay sonrasına randevu veriyoruz, kusura bakmayın şimdi çok kalabalık burası. Ama bizim dedektiflik büromuz var, buradaki polis memurları ve komiserler olarak. Akşam oraya gelirseniz bir hafta içerisinde aracınızı buluruz. Karşılığında bize şu kadar para ödemeniz lazım." Bunu herhalde hiçbirimiz kabul etmezdik. Ya da asayiş konusunda buna benzer uygulamalar olsaydı hükümetlerin karşısına çıkar bunu kabul etmeyeceğimizi ifade ederdik. Çünkü bunu bir hak olarak görüyoruz. Yönetimler de, hükümetler de bunu kendilerinin temel bir görevi olarak görüyorlar. Ama her nedense ağır bir hastalığı bile olsa insanların hala bazı ülkelerde ceplerinden ciddi para harcayarak kendilerini ya da yakınlarını tedavi ettirmeleri bekleniyor. Ben bu anlayışın değiştirilmesinin universal health coverage konusunda son derece önemli olduğuna inanıyorum. Önce etik bir zemin üzerinde önemli bir karar vermeliyiz. Evet Dünya Sağlık Örgütü, yıllar önce "health for all" diye herkes için sağlığın gerekli olduğunu sloganlaştırdı. Fakat biliyoruz ki dünyadaki gerçek böyle değil. O halde bizler, sağlıkla ilgili yöneticiler, politikacılar, bilim adamları bütün dünyayı, Birleşmiş Milletler'i ve hükümetleri sağlığın temel bir insan hakkı olduğu konusunda ikna etmeliyiz. Bence mesele buradan başlıyor. Hükümetlerin bütçeleri var ve bu bütçelerden çeşitli alanlara kaynak aktarılıyor. Sağlık bu alanların başında gelmelidir. Ve eğer sağlığın finansmanını konuşacaksak, mutlaka primlerle oluşturulan bir risk havuzu gereklidir ama bundan daha da önce mutlaka hükümetlerin sağlığa para aktarması gerekmektedir.

Finansmana baktığımızda iki ana modelin olduğunu görüyoruz. İngiltere, Kanada gibi ülkelerde vergiye dayalı bir finansman varken Amerika Birleşik Devletleri'nde tamamen özel sigortacılığa dayanan bir finansman var. Gerçi orada da devlet bütçesinden ciddi bir destek veriliyor. Diğer birçok ülkede de primlere dayalı sigorta sistemi var; ama özellikle fakir ülkeler açısından primlere dayalı sigorta sistemlerinin oluşturulmasının ben çok zor olduğuna inanıyorum.

Kısa bir süre önce Harvard'da değerli dostum Julio Frenk'in önderliğini yaptığı bir Ministerial Leadership programında çeşitli bakanlarla bir araya geldik. Universal health coverage konuşulurken en fakir ülkelerde bile sağlık sigortacılığını yine konuşuyoruz; o toplantıda da konuştuk. Orada da söyledim, şimdi de söylüyorum; yoksul ülkelerde ve gelişmekte olan ülkelerde mutlaka hükümetler ve donör kaynaklar sağlığa gerekli parayı ayırmalıdır. Bu insanların en temel hakkıdır. Türkiye'de biz bunu yapabildik. Başta başbakanımız olmak üzere hükümetlerimiz, ekonomimizin de güçlenen pozisyonuyla birlikte, sağlığa daha fazla para ayırmayı kabul ettiler. Gerçi oransal olarak gayri safi yurt içi hasıladan ayrılan pay anlamında çok ciddi bir artış olmadı. Ama ülkenin ekonomisi geliştiği için oransal bir artış oldu ve biz de sağlıkla ilgili yöneticiler olarak bu parayı çok iyi kullandık. Para ayırmak önemli; kuşkusuz parayı iyi kullanmak da önemli. Ve hakkaniyet: herkese bu hizmetin ulaştırılması, kanaatimce çok önemli. Bir ülkenin insanlarının orta gelirli olanlarına, zengin olanlarına iyi bir sağlık hizmeti ulaştırmak o ülkede iyi bir sağlık hizmeti sistemi oluşturduğunuz anlamına gelmiyor. Mutlaka yoksulların sağlık hizmeti alabileceği bir sistem kurmanız lazım. biz Türkiye'de bunu da başardık. Bugün ülkedeki 76 milyon insan gerek acil hizmetler için, gerek koruyucu hizmetler için gerekse tedavi edici hizmetler için herhangi bir engelle karşılaşmadan hizmet alabiliyorlar. Bu konuda politika geliştirirken paydaşlar düşünülecek olursa, en önemli paydaşın vatandaşın bizzat kendisi olduğu unutulmamalıdır.

Bir iki hafta kadar önce değerli bir uluslararası yöneticiyle konuştum. Türkiye'de bir değerlendirme yapmaktaydı. Çeşitli paydaşlarla görüşmüştü, benimle de görüştü. Ama halktan hiç kimseyle görüşmemişti. Ona şunu öğütledim; "En önemli paydaş olan halkla da mutlaka karşılaşın ve görüşün." Biz politikacılar buna çok önem vermeliyiz. Kuşkusuz bu popülizm anlamına gelmiyor. Söz konusu sağlık olduğunda herhangi bir ihtiyacın vatandaş tarafından arzulanması, karşılanmasını istenmesi çok tabiidir ve biz de bunu karşılamak zorundayız. Dolayısıyla burada vatandaşın,

özellikle katastrofobik harcamalardan korunması son derece önemlidir. Sağlık öyle bir alan ki, hiç beklemediğiniz bir anda eşiniz, çocuğunuz, anneniz, babanız kanser olabilir, kalp ameliyatına ihtiyaç duyabilir. Ve eğer sistem size yterince hizmet sağlamıyorsa, bir anda bütün hayatınız bütün ailenizin geleceği yok oluyor. Başka hiçbir şeye benzemiyor bu. Vatandaşların katastrofobik harcamalardan korunması ve hakkaniyet içerisinde bir hizmetin verilmesi, kanaatimce, son derece önemlidir.

Bunun için de özellikle gelişmekte olan ülkelerin dikkat etmesi gereken hususlar vardır. Tecrübelerime dayanarak bunların birkaçından bahsetmek isterim. Örneğin, özelleştirme bu ülkelerde çok dikkatle takip edilmelidir. Eğer kontrolsüz bir özelleştirme olursa zaten genelde kıt olan insan kaynaklarını özel sektör emebilmektedir. Böyle durumda halkın büyük çoğunluğuna hizmet imkanı tamamen ortadan kalkmaktadır. Diğer bir açıdan baktığımızda, insan kaynaklarının geliştirilmesi hususunda çok uzun süreli eğitimlere dayalı klasik batılı eğitim modelleri gelişmekte olan ülkelerin ihtiyaçlarını asla karşılayamayacaktır. Biz bu ülkelerde daha kısa süreli eğitimlerle sahanın ihtiyacı olan sağlık elemanını yetiştirmek zorundayız. Belki bunlar sahaya çıkıp hizmet vermeye başladıktan sonra eğitimleri atırılarak mükemmelleştirilebilir. Buna benzer şekilde , ülkelere özel çözümleri mutlaka bulmak ve bunları gerçekleştirmek gerekiyor.

Bir sağlık reformu yapmak istiyorsanız, sağlık yöneticileri olarak mutlaka teknik ve politik çalışmaları beraber yapmanız gerekiyor. Ben bunu hekimlik pratiğine benzetiyorum. Ben kendim de hekim kökenliyim, bir pediatristim; birlikte çalıştığım arkadaşlarımın hepsi değil ama önemli bir bölümü de hekim kökenliydi. Biz hekimler önce bir hastayı muayene edip incelemeler, değerlendirmeler yaparız; hastalığı teşhis ederiz, o hastadaki hatalığı ortaya koyarız;. Sağlık sistemi için de bu geçerlidir. Doğru teşhis koymak daha sonra doğru tedavi yapmak için son derece önemli. Yaygın bir deyiş var tıpta: hastalık yoktur, hasta vardır. Dolayısıyla hiçbir ülkenin sistemi ya da önceden geliştirilmiş teoriler bütün ülkelere birlikte uygulanamaz. Evet, genel prensipler mutlaka var ama bu prensipleri ülkelere şahsileştirmek gerekiyor. Bunun için de o ülkeyi iyi tanımak gerekiyor. Uluslararası kuruluşların bir ülkenin sağlık sistemini inceleyip katkı verebilmesi veya çıkarımlar ede edebilmesi için o ülkenin sağlık sistemini iyi bilen elemanlarıyla oturup ciddi biçimde çalışmaları gerekiyor. Ancak bu şekilde ilerlemek mümkün olacaktır.

Şunu ifade edeyim; konuşmamın sonuna geliyorum. Türkiye'de olduğu gibi bütün dünyada aslında universal health coverage'ı başarabiliriz. Bunun için donör ülkelere, başta Dünya Sağlık Örgütü olmak üzere uluslararası kuruluşlara da çok önemli görevler düşmektedir. Daha önce bu dönüşümü başarabilmiş olan Türkiye gibi ülkelere büyük görevler düşmektedir; tecrübe paylaşmak bu yolda ilerleyen ülkelere mutlaka büyük bir katkı sağlayacaktır. Burada özellikle Dünya Sağlık Örgütü'nün daha operasyonel bir rol oynaması gerektiği kanaatini taşıyorum. Son olarak şunu belirtmek istiyorum. Sağlık alanında bir dönüşüm için mutlaka teoriler gereklidir ama bu teoileri pratiğe geçirmek ancak sahada yoğun bir şekilde çalışmakla mümkündür. Biz Türkiye'de bunu 10 yıl boyunca yaptık. Kuşkusuz, bu 10 yıl boyunca yapılan işlerin sürdürülebilir olması önemlidir. Ben Türkiye'de finansal sürdürülebilirlik açısından bir problem görmüyorum. Böyle bir sıkıntımız kesinlikle olmayacak. Ama mutlaka sistemi ayakta tutmak lazım. Özellikle paydaşlardan kendi menfaatleri halkın menfaatleriyle çatışanlara karşı önlem almak lazım. Bazı paydaş gruplarının çok ciddi lobi güçleri var ve bu lobi güçleri halka verilecek hizmet açısından her zaman problemli olabilir, Türkiye'de de, diğer ülkelerde de. Tabii ki bundan sonraki dönemde de Türkiye bu konuda gerekenleri yapacaktır. Buna yürekten inanıyorum.

Ben konuşmamı teşekkürlerle bitirmek istiyorum. Özellikle, 10 yıl birlikte çalıştığım Başbakanımıza… Gerçekten eğer bir ülkenin başbakanını veya başkanını ikna edememişseniz, meseleye bizzat sahip çıkılmamışsa, arkanızda hükümet ve parlamento yoksa başaramazsınız. Bu desteği alabilmek için de başlangıçta hızlı değişimler yapmak gerekiyor. Bu birbirini destekleyen bir çember gibi. Siz hızlı iyileştirmeler yaptıkça arkanızda halkın desteği ve diğer politikacıların desteği artıyor. Bu destek arttıkça da yeni değişimler yapma imkanını buluyorsunuz. Dolayısıyla, Sayın Başbakanımıza, birlikte çalıştığım hükümetlere -ben birkaç hükümetle çalıştım biliyorsunuz- parlamentolara ve bakanlık merkezindeki ve sahadaki çok değerli sağlık yöneticilerine, mesai arkadaşlarıma çok teşekkür ediyorum. Gerçekten onlar çok yoğun çalıştılar. Uluslararası kuruluşlara çok teşekkür ediyorum. Ama kuşkusuz en büyük teşekkür sağlık çalışanlarınadır. Sayısı kısıtlı olmasına rağmen büyük bir fedakarlıkla dönüşümün ruhunu onlar paylaştılar. Bu da bir dönüşüm ve yeni sağlık sistemi için çok önemli. Kuşkusuz bazı çatışmalarımız oldu. Ama genel anlamıyla düşündüğümüz zaman sağlık çalışanlarının da bu ruhu kavradıklarını biliyorum. Aksi takdirde başaramazdık. Şunu söyleyerek bitiriyorum, son cümlem; bütün değerli bakanlara ve bu işle ilgili kişilere sesleniyorum: evet, bu başarılabilir bir hususdur. Eşitlik içerisinde bir universal health coverage başarılabilir bir iştir. Buna inanmak ve ciddi bir biçimde birlikte çalışmak zorundayız.

Katılımınız için tekrar hepinize teşekkür ediyorum.

Richard Horton

Thank you so much. Our finally speaker represents an organization WHO which has been at the forefront of

putting universal health coverage top of the global health political agenda. Indeed not just top of the global health political agenda but top closer to the top of the past 2015 political agenda too. So it is my pleasure to introduce Joseph Kutzin who is the coordinator for health system's financing based on the World Health Organization.

Joseph Kutzin

Thanks Richard, and thanks also to the other colleagues on the panel. It is a bit humbling to appear representing WHO in this way but I will try to do my best and also to pick up hopefully on some of the themes that the other panellists have mentioned.

I really wanted to talk about three things here. First, what WHO is doing and how we approach universal health coverage; secondly, importance of partnership in carrying this forward. And third, with a little bit reference to what Richard just said how we see the connection between universal health coverage and sustainable development.

First and I think the most important things we can do as an organization is try to clarify concepts and despite the world health report, despite all the attention given to universal health coverage there are still a lot difference interpretations of what this means in different places. So, let me say what we mean in WHO. For us, it means that all people can get tthe services they need of good quality and without a fear of financial ruin as a result. Now there is a few things in that definition. One is to be clear on services that we are not just talking about treatment but also prevention, palliation, and promotion in personal and public health services. Second and where the difficulty comes in is that the definition includes all services and all people means that this is a wonderful aspiration but not very operational. And this has been a challenge because as the manager director from the World Bank has said it does not mean all services for everyone, everything free. So we use this term of "moving towards universal coverage" with the idea quite concretely that the definition of universal coverage includes three objectives within this which is to reduce the gap between the need for and the use of services, to improve quality, and to improve financial protection. And moving towards these objectives as relevant everywhere even the richest country has some gap between the need for and use of services. So in many ways it is not really possible to fully achieve these objectives. But it is possible to move towards them and I think that is the relevant issue. So as we work at country level and as Professor Akdağ said what is the actual practice here. I think it is to say, given our understanding of the current system in a country, given the wider context-the fiscal situation, the political situation-what are the changes that can be made in the health system to move a greater attainment of those three objectives in the next five to ten years. And that in a way is a means to transform the broad inspirational statement of universal health coverage into something more practical and operational. Now to support this and based on the technical and practical experience of WHO, we are really working on all aspects of health systems to help countries move in this direction. As just some examples we know we have guidance for selecting essential medicines and using them rationally; we have approaches to improve the quality and reorganize the delivery of services moving towards more integrated and holistic care; we have a lot of focus on improving public health services, population awareness of healthy behaviours and so forth. And of course, in my area, we do have a lot of support being provided on health financing. So there is really a range of different topics that we are engaging on and number of the speakers mentioned the importance of efficiency and this one of the areas we also highlighted in the world health report. The way I could phrase it is that we don't know any country in the world that can simply spend its way to universal coverage. So, attention to efficiency is really essential from the beginning in order to sustain progress because we don't know what will happen in the coming years and the wider fiscal situation. There is always room for improving the use of resources and getting more on these three objectives: more health, more equity in service use, more financial protection from our available resources.

So, one thing is that we have seen that our report on health financing for universal coverage, the World Health Report 2010 has been very popular. I was given the numbers that it is downloaded in 604000 times from the internet. I don't know how many of those were by WHO staff but probably only a small percentage. We have also received an enormous number requests, more than 80 countries have come to us since that report was written and I want to point out this is not just low and middle income countries, we are working with upper, higher income countries as well particularly in the European region on the response to the economic crisis. So I think this has been something again that the concept of universal health coverage has been shown to be applicable there as well.

One of the messages from t is work is that we don't have a blue print for moving towards universal coverage and the statement is that you know the path must be home grown. This is true but at the same time there are some co-principles and lessons learned some country experience about ways to move and ways not to move. This is I think one of the real opportunities that a conference like this can offer. I wanted to just say that one area that end in many ways I used to argue that at least in WHO health financing was a harm reduction

programme which was how to avoid policy harm and avoiding mistakes that other countries have made in a way. And very much I think, this was again acquiring some of the comments of the previous speakers. I think one of the pitfalls that we have seen many low and middle income countries fall into was to initiate reforms by focusing first on people working in the formal sector by creating insurance schemes for civil servants or other formal sector workers. Now this approach really derives from the historical experience of the development of the public policy on coverage in Europe. I mean the initial motivation for Bismarck had to with improving labour productivity and reducing unrest at the workplace. This is no longer the motivation. And if one goes in this direction as many countries have and we have observed this is problematic because, now and especially after the Second World War we started hearing about the right to health, this was in the WHO constitution in the universal declaration of human rights, many national constitutions. I have heart this like many things I do in health financing, I first heard it from Julio Frenk in Mexico which was making this point that it is no longer the case that equal access to health care is a right derived from labour force studies. It is right derived from being a human being. So the point of universal coverage is that the universal means universal. They should have changed how technical assistance and approach supported in low and middle income countries on health financing reform was applied. But in fact much of this assistance over the past thirty years was based on copying the historical model from Europe, of basically starting with the formal sector and then scaling up. But this was wrong in a way philosophically because the underlying rationale is different but also we are in a very different context now. Now, there is really something to defend in health care given the advance of medical technology and so the initially covered groups want to protect and expand their access to the latest medicines and technologies. So rather than these programmes evolving out to cover more people they tend to concentrate more on these well organized populations and hence their entitlements and subsidies. And in an effect, in the name of increasing insurance coverage actually move away from universality in a sense by widening the gap between the haves and have nots.

Fortunately we have many alternative examples that have emerged Turkey as a leading one. I think in moving away through this reform programme of moving away from organizing the system and financial arrangements by social grouping and integrating into a common pool. We have this type of approach in many other parts of the world that is emerging as well. And really an alternative to the way things had been done. So I see it (he shows Recep Akdağ) is great to have meeting here, where that example can be shown.

Now I wanted to say couple of things on the partnership side. One is clear that well obviously WHO has key role to play just as Ministries of Health do. WHO cannot do it alone. And in particular again going seeking in my own technical area and financing, I haven't seen any country in the world where the Ministry of Health on its own can implement health financing reform. It always involves Ministry of Finance to some degree and requires a good collaboration. And both at country level and then at the international level this is reflected in some important collaboration we have with the World Bank. For example in February we co-hosted a meeting, a Ministerial meeting, on universal health coverage together with the World Bank. And also, with our colleagues from the OECD through the senior budget officers of network. That brings together, health and finance specialists from governments. So there is important critical partnerships there. We are also working very closely, with bilateral and some multilateral agencies, through the providing of health initiative. One anecdote of how I think this movement has developed is last week I was in Kenya for a meeting with thirteen African countries on health financing strategy development that we jointly organized, together with the World Bank and with the support of among others the German and the British development agencies. And I think it may be the first time that in a health financing event we have co-sponsored by the founders of these two classical models and different classical models. So we are able to bring the German and British systems together for that work. So I think there is hope.

Last, I just wanted to say a few words on the wider context not so much on the post 2015 agenda. The important point as others just said that health is important for sustainable development. Yes, health contributes to the economic growth as others have said but health on its own is an independent and important element of welfare. So in a way this is critical that health, in its own right is important as well as its contribution to other objectives. So a good health system will offer protection as well against the risk of becoming impoverishing. So this is also, this combination of the value of health as well as the role of financial protection why we continue to advocate for being included in the post 2015 development agenda.

So, thanks very much.

Richard Horton

So let me thank for this fabulous speakers for giving us the insights into not just Turkey's success but the broader context of Turkey's success.

Turkey Health Transformation Program, The Lancet Publication
Türkiye Sağlıkta Dönüşüm Programı, Lancet Yayını

Moderator: *Richard Horton*

Richard Horton

Now we can have some fun! I am going to go into a level deeper into this reform programme and its results. So now I can say what has really been said about this reform programme before today. When I started researching what has taken place in Turkey over the past decade, when I was first invited to take part in this process I discovered there was an enormous controversy surrounding what has happened in Turkey. And let me read you some of the words describing the messages coming out of Turkey about its health reform:

"Propaganda", "It does not reflect the truth", " Imaginary outcomes", "Overestimates", "Self flattery", "The present statistics are beyond the figures actually are", "Unreliable".

So, the message that was coming out was not believed by many people not only outside of Turkey but actually many health professionals inside of Turkey which made an urgency of conducting an independent assessment of what has taken place over the past decade so very important. And so it is a huge pleasure and honour to introduce my good friend and colleague Rıfat Atun, professor at Imperial College London and also in Harvard to give you a description of the fabulous work he has conducted over the past 6 months with a superb team of national and international scientists. Please give Rıfat Atun a very warm welcome this morning.

Rıfat Atun

Thank you Richard, distinguished ministers, heads of international agencies, distinguished delegates colleagues and friends.

It is an immense privilege to be able to present the findings of the analysis on the universal health coverage reforms in Turkey. This has been a very ambitious project just like the universal health coverage itself, the health transformation programme. Because we were inspired by the work of Professor Felicia Marine Knaul and Professor Julio Frenk in their study of Seguro Popular in Mexico, the paper published in the Lancet at the end of 2012. And inspired by that we repeated a similar study drawing on regress data. But from concept to conference it took 8 months. It was a very ambitious project and at the end we not just an English version of the study but also a translation in Turkish. The product we have published by the Lancet actually today was a product of teamwork. And I would like to acknowledge the excellent contributions of my colleagues Professor Sabahattin Aydın, Sarbani Chakraborty, Safir Sümer, Meltem Aran, İpek Gürol, Serpil Nazlıoğlu, Şenay Özgülcü, Ülker Aydoğan, Banu Ayar, Uğur Dilmen and of course Professor Recep Akdağ who was the architect of the health transformation programme. Bu I was very fortunate to work just not with one incredible team but two incredible teams. And the second incredible team was that from Lancet that I got to know very closely not just Richard as leadership of Lancet but also in global health has not become legendary but he has a really incredible team; Selina Lo, Hannah Jones, Clive and many others have made it all possible. They made everything look so effortless. So, we are here today. And the study is about equity. It is about universal health coverage and its contribution to citizen's rights and achieving equity for the Turkish population. And equity has been an important theme in Turkish culture, going back to the Ottoman times. The four principles of the Ottoman Empire which are necessary for an orderly empire to be sustained and to progress: the state, the treasury, the citizens and justice. And justice of course embodies equity. All of these together form the circle of equity. And these principles were also reflected in the young Republic of Turkey that began in 1923 and then the subsequent 1982 Constitution that articulates fundamental rights of Turkish citizens and social justice.

So we use the framework that draws on the World Health Report 2000 but also the work of Professor Bill Shaw and other colleagues in Harvard in analysing health systems. First, we looked at the context because you heard from the honourable minister today and other panellists that context is very critical. So we analysed what the context leading up to the health transformation programme in 2003 was. Then we looked at the changes in each of the health system functions, the inputs into the system; the governance and organization, the financing, and resource management which collectively are used to develop public health care and service delivery, health care services for the benefit of citizens in an equitable, efficient, effective, and responsive manner. And these then translate into our health system goals. Both the level and distribution of health, financial disprotection and also importance of user satisfaction which provides the legitimacy that governments need to continue and sustain reforms. So using this framework we first of all analysed the context. Well the context was very interesting and I am currently doing some work in Latin America and it is very interesting that many of these contextual factors are also shared by a number of Latin

American countries in shaping health reforms. 1980s and 1990s in Turkey were characterized by economic and political instability. Although there was a strong will from various governments to reform the health system, and many laws were developed, they were not either executed or passed by the parliament or were not implemented. This instability, I remember actually as a child, these were called the lost years of Turkey. In fact I should thank this instability because it is one of the reasons why I went to England to study medicine rather than to Hacettepe University where my uncle was a professor. So, it was a positive benefit for me but certainly not a positive benefit for Turkey.

And this instability let to inadequate and inequitable distribution of financing in health system, absolute shortages, and poor distribution of physical as well as human resources and as a result huge inequities in health outcomes. Three to four fall differences in under five mortality, infant mortality and maternal mortality ratio- the areas that the health reforms in 2003 onwards targeted. And not surprisingly the citizens were not satisfied with the health system, high level of dissatisfaction. So, the journey to universal health coverage begins not in 2003 but actually in 1945. So, it is a long journey beginning with the social insurance organisation in 1945 followed by the social health insurance for retired civil servants, then the first national ten year health programme that was declared then the very important law on the socialization of health then establishment of Bağkur (Social Security Organization for Artisans and the Self-Employed) followed by the recognition of universal health coverage as a right and responsibility of the state. In 1982, then the Green Card scheme that was established but not really did not take off function. And finally in 1996 a series of laws on financing institutions, now an organization of the health sector. So, the new government of 2002 have a legacy and did have a legacy to build on including many of the laws that have been developed by previous administrations. But the journey was long. And I would like to, perhaps very befittingly use a quote from Aşık Veysel that says that "I am in a long and narrow road". Many of the audience Turkish may know this. And 49 years on these roads was travelling to reach that distant goal. And that goal is to achieve equity. And Aşık Veysel, himself was actually blinded by small pox as were many people affected in Turkey in his times. Bu although he was blind he was able to see the beauties of Anatolia in this darkness that he was subjected to.

And the inequities in Turkey have been going on for a long time. And this is a map of the socio-economic level of development ranging from high development index, as you can see mainly concentrating in the west and southwest of Turkey, then progressively getting less well developed as we go towards the Central Anatolia and then to the East and South East. And these socio economic inequalities were reflected in health outcomes too. So the health transformation programme begun to address these inequities that was the objective to have the citizens at the centre of the reforms built on the past but develop a comprehensive strategy informed by global experience and evidence. And I remember very early days I had the privilege of being part of the very dynamic health transformation team. The team was seeking evidence from Mexico, from Estonia, from Thailand, from Slovenia, from many other countries that were visited to find out what was happening. So there is really a grand strategy with continuous monitoring and learning with flexible implementation combining strategic and structural changes with short term tactical solutions, for quick fixes in order to improve the health system to gain user satisfaction. And focus on user satisfaction was the key because that determine the receptivity of the context and legitimacy of the changes that were being introduced. So this was a transformation programme underpinned by a robust strategy. And the programme has built on the past of the work in Turkey and has achieved a number of key changes alone each of the health system functions. In terms of governance, the right of citizens was emphasized with a number of systems and instruments introduced to enhance provider accountability.

Being a physician of course this doesn't always good on well we don't like to be told what to do unfortunately but sometimes we need to ensure that we are accountable to the citizens, and to the state and to the other stakeholders. As part of the governance changes, the role of the Ministry of Health was redefined from having an operational role to more of a situational and leadership role.

In health financing, there are major changes as was discussed earlier. Increasing health expenditures, as the minister articulated and investments in the health system more importantly consolidating the highly fragmented health insurance systems under a general, unified health insurance scheme with the expansion of benefits and levelling up of the benefits for everyone to the best that were available. And the coverage increased, quite dramatically from almost 2.3 million to more than 11 million people under the Green Card scheme in 2011. The resource management was applied in such a way as to birth expanded staff numbers but also using the instruments such as contracting to expand implementing opportunities in the east and also the less served parts of the country.

And as a result, we see an expansion of primary health care services in particular but also a hospital care specifically for events that lead to catastrophic expenditures. We also see an expansion of emergency

in hospital services, specifically those aim to address maternal and neonatal emergencies to bring down the very high levels of maternal mortality as well as the mortality in neonates and the infants.

So what has happened as a result of these changes as part of this long journey? We can see that from 1990 onwards, after period of flat lining then a short increase in the total health expenditures. (We are using US dollars purchasing parity to demonstrate the rapid changes.) As a result of increased investments in the health system; increased expenditures and coverage of health insurance which is actually my next slide. In 2011 even the poorest segments had very similar coverage levels to the richest segments. This is quite a remarkable achievement. Not surprisingly, one of the key facts of this improvement in health financing as well as increased coverage was that out of pocket a health spending as a share of non-food household expenditures at different budget households actually declined. As you can see for three budget thresholds of 15 percent, 25 percent and 40 percent compared to 2003 declines in all three segments.

And a remarkable success story is the expansion of the health workforce which is still needs to expand. I heard in the prime minister's statement today that almost numbers we have 6900000 or so. But from 1993 from 224000 and 256000 the numbers more than doubled to reach 570000 in 2012. But more importantly it is not just about the numbers. It is getting the people in the right place. So if you look at the population covered by specialist physicians by province in 1990 to 2010 the red areas are where those low provision of health staff; so low ratio of health staff to population. Actually, one can note that in 2000 the situation actually got worse compare to 1990 as a result of the instability and the economic crises in the late 80s. But in 2010 we can wee a rapid improvement in coverage including in the most underserved areas. So this is specialist physician's. We see a similar picture for populations covered by general physicians, nurses, and midwifes combining together with improved coverage in the most underserved areas.

So as a result, the coverage of key services increased. And here we look at the coverage in urban and rural populations and this is the anti-natal visits attended by health staff. And also the first and the fifth quintiles; the richest and poorest quintiles... As you can see, after very little improvement up to 2003 there is a very sharp increase with the outcomes will be the coverage reaching in the rural and underserved populations to those of richer and urban populations. Similarly, anti-natal visits attended by health staff whose education is lower compared to well educated population and whose first mother tongue is not Turkish. You can see improvements again with closure of this huge gap in terms of coverage levels. Similarly, in the percentage of births in a health facility attended by health staff looking at the socio economic background of the mothers and their wealth we can see again a narrowing of the differences and improvements for the rural as well as the first quintile the poorest population; and this is women whose education levels are lower and first mother tongue is not Turkish we can see improvements again with narrowing of the differences between the riches and the poorest and the socio-economically disadvantaged. As the result of improvements in coverage we also see most importantly improvement in outcomes. This is immunization coverage uptake and what is interesting here is there is actually a worsening of the situation between 1993 to 1998-2003 as a result of inability to implement the reforms and the economic crisis then a sharp increase, both for immunization for all eight vaccine by different socio-economic groups. And this has a positive effect of actually registering improving outcomes. So the under-five mortality declines and the differences become very narrow in fact they converge. Similarly infant mortality sharply declines. Look at the differences here and look at what happens in 2008, the sharp changes in 2003. Obviously the trajectory is positive in most instances but the bigger scenes is able to demonstrate in our economic analysis come after 2003 as a results of increased insurance coverage but more importantly increased insurance coverage combine with expansion of benefits and health services. The two needs to go hand in hand to ensure improve access. Just having one or the other is not going to work. This is a key lesson from the Turkish health reforms.

And I said satisfaction of user is critically important. When the reforms in 2003 we can see compared to five key services provided by the public sector that includes health, insurance coverage, social insurance and pensions, education, legal and judiciary and public security and order health is the worst performer. At less than 40 percent satisfaction of the population. But steadily, this satisfaction levels increase more so than any other public service to reach the levels enjoyed by the public security and other services. So, not only do we have improvements in relation to health insurance coverage, reduction in catastrophic expenditures improve health outcomes but also users are satisfied.

One can I think comfortably conclude that the achievements are no less than remarkable. Great success story... But there are important lessons to be learned but also future challenges. And I would say that actually the work is beginning now. The hard work has been done, wonderful platforms has been established, systems have been put in place but the key challenge is to sustain universal health coverage as the population ages as we have political stability and economic stability around the world. So the key future challenges for

future governments for Turkey are to upkeep or sustain the health insurance coverage and the benefits. There is still an unfinished equity agenda. The differences have narrowed dramatically. That is a great success of the years of work Turkey has achieved in this journey to universal health coverage but differences do exist and they need to be addressed. The quality and safety needs to be maintained and improved consistently as in other countries of course. We need to revive public health and the health system to manage chronic diseases that are affecting now many countries that are middle and low income countries. We need to ensure that the fiscal space is there to sustain investments in health. So sustain the increases in the health expenditure. And we need to manage public expectations. Turkey has a young population and they expect their rights just as health rights. And governments need to respond these expectations. And more importantly we need to ensure that the health work is cultivated and supported so that we can create a knowledge-based health system. Which creates an opportunity for Turkey because Turkey now can begin to see investments in health system not just as an expenditure but actually an investment as part of the dynamic economy it has. Health sector accounts for 15 to 20 percent of public sector expenditure, or the government budgets typically but between 5 to in the US 16 percent of gross domestic product so it is a huge part of the economy. And it is a four trillion dollar industry a year. So Turkey can play an important role if Turkey can rethink its health system as a system for innovation and developing new products and services. And Turkey, moving up to 2023 can also have an ambitious to have an important role in global health as we have heard today. To work with countries that are also implementing universal health coverage to learn from the lessons and experience Turkey as had over the last ten years.

So for me, there are ten lessons. This is my final slide. First of all, the context is important. Context is critically important because one of the reasons why the reforms were successful was that there was a receptive context, their expectations for change. And then the receptive context for the changes were introduced. Secondly, health was part of the democratization process which is still continuing in Turkey. Health is seen as a fundamental right with a focus on citizens and citizens' rights. Political stability was important. The lost years of 1980s and 1990s gave way to stable number of governments over the years. Associated with that is economic growth and stability, then, very able transformation team. That led the process from the context to design the implementation and ongoing learning to make changes at midway or throughout the reform process to improve what has been implemented. So there was sustained leadership not just at the start, but also at the midpoint and at the end. And as honourable Minister Recep Akdağ said the enhanced role of health within the government is critically important with support from other line ministries which enabled of course the increased expenditures in health because increasing more in health means less on education or other sectors. The budgets, resources are limited of course. I think what was impressive about the health transformation programme was the flexible implementation approach with ongoing learning; combining strategic and tactical inputs, and the spirit of implementation. Things were done very rapidly. I will never forget an important moment we had, Joe Kutzin was also part of that meeting, we also had colleagues from Estonia and Thailand and we were talking about how we took Thailand to universal health coverage. And it was a long journey, 15 to 20 years or so. I remember the Minister and Sabahattin Bey saying "hmm that is very good but we have no time. We need to do this in 18 months." We almost fell off our chair. But it happened! 18 months later, there was a meeting that Julio Frenk attended combined by the Ministry of Health, the World Health Organization, European Observatory Joseph Figueras was there at that time. That day the law on health insurance was passed. So things that happen very rapidly to our surprise and of course to our delight. And most importantly, I think a take home message from these reforms is that it is critically important to have not just expansion of financial coverage but at the same time expand the service delivery and the distribution of services to the most vulnerable population. So, financing combined the service delivery is really what made the change and we are able to demonstrate this with our economic analysis.

Thank you very much for your attention.

Richard Horton

Thanks so much Rıfat for your explanation and description of your powerful analysis. We are very fortunate today to have very strong representation from the World Health Organization which has been underlined in this morning's panel Professor Felicia Marine Knaul has demonstrated superb leadership globally respective universal health coverage. And it is my really great pleasure to introduce Zsuzsanna Jacob who is the regional director of the World Health Organization's European office and who has the immense responsibility not only for thinking about Turkey in terms of WHO's responsibility but 53 nations in her particular region. Zsuzsanna, welcome.

Zsuzsanna Jacob

Thank you very much Richard, good morning everybody; Excellency minister of health Mehmet Müezzinoğlu, Professor Akdağ, Excellencies ladies and

gentlemen. First of all it is a real pleasure for me to be here today and to speak to you on this very important event. And I would like to start by thanking the Turkish government for organising this.

The Turkish example clearly shows us what you can achieve with a vision and strong political commitment with leadership and partnership. This initiative of Turkey enjoys full support of WHO and we are happy to work together with the Minister to further develop the vision and also to be your partner in the implementation. Before I turn to the Turkish model let me also say a few words about universal health coverage to confirm some of the key messages that came out from the previous panel and also to confirm the strong political commitment of WHO to this initiative.

Universal health coverage is at the heart of WHO's work. It was extensively discussed at the recent worthiest assembly and we would like to see this in the post 2015 development agenda. Why? It is because universal health coverage is a practical expression of WHO's concern for equity and social justice and it has to reinforce the links between health, social protection, and economic policies. And that as we heard from Joe Kutzin universal health coverage combines two fundamental components: access to services needed to achieve good health which includes for us also prevention and health promotion but also the financial protection that prevents ill health leading to poverty. And as we heard from the managing director of the World Bank this morning, we have hundred million people in the world who live in extreme poverty because of out of pocket payment. This figure, ladies and gentlemen, in European region with the 53 member states is 16 million. 16 million people in the European region empowered because of out of pocket payment and this is not acceptable. So with this introduction, I would like to congratulate the Turkish government for the success of the Turkish health transformation programme over the last ten years and the significant progress that has been made in this country towards universal health coverage. The Turkish model can be very well used also in the other member states of the European region but indeed in the world. And there are very significant lessons we have learned from this experience.

I would like also to thank Lancet, particularly to you Richard for this excellent article today and of course Professor Atun because this access to promote the concept. And that is very significant.

So back to the Turkish model what I would like to say is that you can achieve a lot if health is a priority, if there is a clear political commitment to health, and also to meet the health needs of the population not only in terms of health status but also in terms of health care. and the Turkish example also shows that investing into health is investment into the future development of the country. And if you just look at the health indicators which I won't repeat because we heard it also from Professor Atun and other speakers this morning. This has indicators and then improvement. They speak of thousands of words and Richard let me assure you that indicators are here, the figures are here and there has been significant progress whether you look at the WHO estimates or you look at the real time figures that come from Turkey to the health for all data base you can see a very very significant progress. And that is extremely important.

In my view, there are two key secrets to this progress and I would like to highlight some of these and I am very pleased to see that in the last slide of professor Atun that many of the secrets to the success from our perspective and your perspective are the same. And I think that there has been a significant progress here in the governance in the way how the whole health system and health issues have been governed in Turkey. And I would like to raise five elements of this. First of all, you obviously need a vision, a vision that is evidence based but which also has clear values and principles. Values like for example the health as a fundamental human right and the principles like the principles solidarity, equity but also support to the most vulnerable and the equity issues. The second issue is that it is not enough to develop a vision you also have to implement it. It is easy to say but it is difficult to do. And in the case of the Turkish health transformation programme there was a very strong leadership in the Ministry of Health and he led every element of the health transformation programme to make sure that it is fully implemented and the Ministry of Health also had a committed reform team around him which he also said in his presentation and that was the success. And there was also a very good sequencing of the various reform initiatives. The third issue is that it is quite important to have close collaboration with many of the other sectors and partners because for example if you want to lower tobacco use or alcohol you cannot do it without an inter-sectoral collaboration and quite a significant work has been done to so called health in all policy and whole of government approach. But all these would not have happened if health had not been a priority for the Turkish government programme and if you did not have the high level of support and leadership coming from the prime minister and the president of the country. And finally, Turkey took a people centred approach to improve access and quality but also to reach out to how to reach to the most vulnerable groups. From the WHO perspective, I would like to thank to both ministers to Minister of Health during the past ten years, professor Recep Akdağ for the excellent and the close collaboration with WHO and also for adopting so many evidence based policies and strategies that were approved by our

governing bodies. And I would like to underline the word evidence-based because in my view that was a second secret to the success. At the same time, I would like to thank very warmly to the current Minister of Health, Doctor Müezzinoğlu for the continuity, for the sustainability, for supporting the further development and the implementation of this programme and taking on new initiatives like for example to include public health functions into primary health care, to include public health functions into the health system more broadly to respond to the present challenges of the chronic diseases. And Mr Minister, WHO whole heartedly support this initiative and our mission during the last 10 days was a clear evidence of this and we are with you in the further development and in implementation of the programme. We used in the last worthiest assembly, last year to inform the member states in Geneve what you can achieve from a programme like this I plan to do the same in the regional committee which will take place in İzmir, in September, in Turkey to bring the achievements to the attention of the member states. And for your information, we are using the Turkish example in the global learning programme of the WHO on national health policies and strategies.

WHO Europe has an extensive collaboration with Turkey. This includes also the health system performance assessment through which we evaluated the health transformation programme two years ago and we distributed the outcome of this evaluation to the regional committee. This clearly shows the extent to which Turkey has translated the values and principles of the Tallinn Charter into action in this country. And on the 17th of October which is the fifth anniversary of Tallinn we will update the evidence and decide, together with member states on the strategic directions and again the Turkish example will be used. Also in 2012 the Minister of Health requested support from WHO to reformulate the strategic plan which resulted in the health for all strategic plans 2013 and 2017 which is a true reflection of the health 2020 European policy framework which aims to further improve the health outcomes and to eliminate the inequities. Whereas in the European region we have been doing very well to improve the health outcomes and in the last 30 years we gained about 5 years in life expectancy. We have been doing very badly when it comes to equity and particularly inequities in health. And that is a main policy direction that we take till the 2020.

So to close, let me say thank you for the excellent work and we are fully behind you to continue. There are a few issues which I think are extremely important. One is the continuity the other one is the sustainability. Then of course continue with the health men power development, the universal health coverage until it is fully implemented and to make sure that we take care of the present disease burden of the MCDs. And obviously we would like to use the experience and Professor Akdağ personally as an ambassador of WHO.

Thank you.

Richard Horton

Thank you very much Zsuzsanna. I also would like to recognize the presence of Ala Alwan who is the regional director of the Eastern Mediterranean office of WHO. It is great to have you here. Thank you very much and I know you will be staying with us until tomorrow as well. Our next commentator is a very important person because of the part he has played in the past ten years, Sabahattin Aydın. Although he is today Rector of Medipol University in Istanbul, from 2002 to 2009 he was the undersecretary of the Ministry of Health. He had a very influential role in shaping the reforms.

Sabahattin Aydın

Thank you very much Richard. You started the panel by quoting some interesting words from those who criticize what has been happening in Turkey, the reforms and the publications. Being one of the members of the transformation team and also being a member of this research team I think I have right to feel free to criticize also. So, with your permission, I would like to make some critiques on the presentation of Rıfat.

Actually he summarized what has been published today in the Lancet very clearly. And I am afraid those who followed this presentation carefully got quite clear ideas so that they will not need to read the article in the Lancet. This is the bad side of the story. But if you noticed that presentation, although the figures are given up to 2011, they were not all used in the analysis. The data used for the analysis trying to show the outcomes of equity were before 2008. The period from 2003 to 2008 is just the first half of the health transformation programme period. So actually the outcomes obtained and shared with you today are the outcomes of the first half of health transformation programme. From the analysis given in this publication, we don't know exactly the real outcomes of the second half of the period in terms of equity. However, figures from the international agencies and figures of the Ministry of Health show us that they improved further. So I think in terms of equity, we need to further analyse the second period of the health transformation programme. And maybe Richard will give us a chance to publish the second article in the Lancet for the analysis of the second half of the health transformation programme.

I will just draw your attention to another point. In the last slide of Rıfat's detailed presentation which is about lessons learned, actually he gave some clues about that.

Achieving success, of course is difficult, but what is more difficult is sustaining that success. And this gives us more responsibility, as the Ministry of Health, to keep and sustain that success. You know from the headlines of that slide about lessons learned some clues are given. And those are achieved after very intensive monitoring and keeping the balances. For instance the supply and demand combination is very important but keeping that balance is very important also. If you expand, for instance, the demand side and you don't improve your supply side, you cannot reach to success. So keeping the balance between them is very crucial.

The share of public and private health provision in the health sector is also very important. If you don't give opportunity for competition you will not be able to improve. But if you leave the competition area to the market measures, then you will lose the control. So you need careful planning for health care facilities and human workforce together with some managed competitions. Similarly, you know many countries have experienced decentralization and then recentralization actions, going forth and back. This is just because they cannot keep this balance very clearly.

In Turkey we have to establish a widespread organization, a horizontal organization to reach even the farthest side of Turkey, to the people living in the most rural area. But on the other hand, if we don't implement vertical programmes that go simultaneously, at the same time reaching all the people who need specialised health care, the problem will not be solved. This is another critical point for the success of the health care system. Keeping these balances we need to monitor very carefully. So from now on, I think the Ministry needs to monitor everything very carefully. So far, the major reforms have been done but it needs fine tunings for keeping these balances. Only some further technical changes may be required depending on the developments that we will experience in Turkey.

I want to stop here because I am aware of the shortage of time. Thank you very much.

Richard Horton

A third commentator is labelled as the dean of the Harvard School of Public Health which is a very distinguished position. But Julio Frenk is far more than the dean of the Harvard School of Public Health. He is the architect of one of the world's most successful health reform programmes in Mexico and demonstrated true global leadership in a way that he not only led that programme but he has been a passionate advocate for the right to health and the delivery of that right to health through universal health coverage. He is also a philosopher of global health. Please welcome Julio Frenk.

Julio Frenk

Thank you Richard, thank you very much.

First of all it is really a great honour and a great satisfaction for me to be here and I want to thank to Turkish government for the kind invitation especially to honourable Minister of Health. There couldn't be a better city in the world than İstanbul to hold this meeting because this meeting is about shared learning and Istanbul represents exactly the convergence and the process among the multiple civilizations over millennia in the way we have reached common understandings among multiple parts of the world. And when I see the honourable ministers here, we are here exactly to do that to learn. I think Turkey has a lot to show and to teach the world in enriching this global dialogue. It is a great privilege to be here. I want to congratulate the Lancet, Rıfat Atun and of course the entire team for this publication. It is also a great source of personal satisfaction for me to be here because I had the honour of meeting Recep Akdağ in 2003 in the World Health Assembly. And the Mexican Parliament had approved exactly one week before our meeting the law that created the universal health insurance in Mexico and we had an opportunity to have a very early conversation he was just starting as Minister of Health of Turkey. So I have been observing and admiring the Turkish process almost since its birth. I said birth because almost like any child be born and grow and mature into a magnificent person. I have had the privilege with respect to Turkish health reform that led to a very intense set of sessions; we hosted the minister in Mexico, some delegations I personally came back to Turkey two times. So it is really fantastic and the certificate of maturity of a health reform is getting published in the Lancet and so Turkey has now become a mature health reform. I am not going to talk anymore because I know we are short on time there is a very complete presentation this afternoon about Mexico. So I am not going to talk about that. I would just like to finish saying how universal this process has been. This is a story of two parallel processes that started more or less simultaneously in the middle of the 20th century, the process of rapid epidemiologic and demographic change going around the world. But we have been victims of our own success. We had an enormous success in dealing with the common infections of young children still an unfinished agenda, not a linear movement many backward movements most notably the effect of AIDS around the world especially in the sub Saharan Africa, but still a story of steady progress towards improving life expectancy which is reflected in improved health conditions more broadly. And a parallel story of the development of increasingly complex health systems... Health systems absorbing larger shares of wealth, improving larger and larger numbers of people engaging

with citizens in a more and more inclusive way.

And the problem we have had is that our health systems have not evolved at the same speed as the change in health conditions. There has been a gap between our progress in transforming health conditions towards conditions that are chronic where chronicity is a major problem; conditions are chronic whether infectious diseases like AIDS and tuberculosis or non-infectious diseases like diabetes, heart diseases, cancer or mental disorders. And our health systems have not kept up, mostly around the world health systems have been underfunded to respond to this changing reality. We have basically dealt with most of the burden that can be addressed through highly cost effective measures like immunisations. We have dealt a huge unfinished agenda but we can see that process moving forward but our health systems not dealt with the challenge of chronicity. And therefore we have underfunded systems, systems that underperform and systems that consistently fall short of citizens' expectations. So this has launched this search for higher levels of coverage but I would just say that in this transition, epidemiologic and demographic transition, we need not to complement with a parallel health system transition. And I see three major stages in universal health coverage that capture the essence of that health system transition. The first stage is universal enrolment. Where we move from having only subsections of the population covered, typically those in the salaried part of the economy to moving to all people covered, all people enrolled. But it is not enough to enrol people and recognize that everyone has to be included. The second stage is universal access which means going from only very minor sets of unspecified services covered to having comprehensive packages of entitlements that are made explicit. But that is also not enough, access is not enough. We need to move to effective universal coverage. And that means going from a system that even though enrols everyone, it has access for everything but still does not pay attention to outcomes, the mention of quality, to making sure that that enrolment and that access translates into actual improved outcomes; improved health and improved financial protection in all its dimensions. Protecting people from the effects of disease and from the effects of treating disease without adequate coverage. This is the grand transition wherein, it is the health system transition that needs to accompany our epidemiologic and demographic transition. And the importance of this is this is happening globally. At different stages, we still have a huge unfinished agenda but most of the world is now way well into this transition. And therefore the importance of shared learning. This is a global public good I will talk about that tomorrow. So today I will just emphasize how important it is for Turkey to host this meeting with partnership to the Lancet and the other partners. Because what we cannot afford to do is not to learn what anybody else is doing. Health reform is a rare occasion around the world and to the extent we fail to learn from that we are condemning ourselves to repeat the mistakes of others and not to learn from the successes of others. And today, Turkey has a lot to show to the world and the world has a lot to learn. And that is why I am truly delighted and honoured to see the maturation of this exemplary effort that Turkey has sustained over the past decade.

Thank you very much.

Richard Horton

Thank you Julio and thanks to our panellists. That concludes the second panel for today.

Ministerial Panel on Sustaining Universal Health Coverage in a Time of Fiscal Crisis (OECD and WHO)

Mali Kriz Dönemlerinde Genel Sağlık Kapsayıcılığının Sürdürülmesi, Bakanlar Oturumu (OECD ve DSÖ)

Moderator: *Josep Figueras*

Josep Figueras

Good afternoon ladies and gentlemen, friends, colleagues, ministers. Thank you very much for joining us after what was next to the lunch. We have a huge competition there to win Istanbul. It is really a huge competition. It is a perfect place to have such a wonderful conference but a place that gives lots of competition because it is such a beautiful and wonderful city. My name is Josep Figueras. I am the director of European Observatory on Health Systems and Policies. The Observatory is a partnership, a partnership which is hosted by WHO and has a number of partners such as World Bank, European Commission and many of the member states today are sitting in the room. Our job is to be knowledge brokers, is to collect evidence and transfer this evidence to policy.

It is to me a real honour to be here, and I am very humbled for being here at this particular moment, having so much expertise both in this panel and having so much expertise here in the room. This is such an important occasion that I feel I am honoured and nervous at same time because I feel I need to take and draw from the expertise around the floor today. And what we agreed with our panellists today is we will make a very interactive session. So I will go down and I will try to involve you as much as possible on the debate.

What is the session about? The session today, this afternoon is a review of the morning after. We had the party, we achieved universal coverage, Sabahattin was saying that actually, how do we sustain that? How do we sustain that in the moments of crisis? Turkey is an extremely well and has benefited over a long period of economic growth which we hope and trust will continue but it has had challenging circumstances to do that. But what do we do when the crisis keeps the fund? What do we do when we have a financial crisis, when we have problems of sustainability? How we maintain this enormous achievements of universal coverage. And to address these questions, first, I am very privileged because I had opportunity to talk them I know, some of them before. We have three extreme panellists. And this is interesting because the three of them define themselves as practitioners. As real policy makers been there is a mundi morning thing, isn't it? We passed policy, we passed legislation, and there is someone where mundi morning that the stars doing the work. And the three of them I think, both the country experiences and their own professional experience complement each other very well and it is a perfect experience for our session.

First, Mr Manuel Ferreira Teixeira from Portugal who is an economist has been in management for many years within the Ministry of Health, now he is a Secretary of State. Very interesting from Manuel is that before that he was the State Secretary for the Budget in the Ministry of Finance. And that is if I may say so an ideal kind of background and a tough one. I guess now Mr Teixeira you have to go back and argue with your colleagues from Ministry of Finance and that is important. You are in a very good position I guess because you know them and their mechanisms. So thank you for being in here Mr Teixeira.

Then we have Minister Ingrida Circene who is yet another practitioner. She defines herself as a doctor. She is still a doctor and she has been in politics very successful for many years. She has been three times in parliament and she has been twice Minister of Health. She has an enormous experience, she is very charismatic. She is what we call a real leader who is implemented major and interesting changes in the health system.

And finally, last but not least, of course in the order we have Choi Won-young who is former Minister for Health and Welfare and now chairman of the Comprehensive Integrative Medicine Institute. So we have economist, we have a doctor, and we have a manager. He defines himself as a manager with a lot of experience managing the processes administration of the Ministry of Health for many years there implementing.

And the three countries as well are very interesting for many many reasons and at different stages in that crisis we are talking about. We have Portugal who suffered the crisis of 2008 who has struggled very effectively put in place very effective reforms to deal with these deficit reduction with IMF conditions, Detriot conditions, and they have very successfully come out of this process. We have Latvia who as the Minister said was had very sharp and very short recession, financial crisis and then came up with enormous growth. We have to remind ourselves that some of the countries that were part of the former Soviet Union suffered a very serious crisis. Minister Circene was saying GDP had fallen about 20-

30 percent in the former Soviet Union breaking. So this crisis absolutely is nothing.

And the Republic of Korea needs to be congratulated for its achievements in reaching universal coverage very quickly as well bringing together the separate sets of insurance, companies, schemes that they manage to bring them together and get the universal coverage which is really to be congratulated. Perhaps you have been affected less by the 2008 crisis but you had major pressures as well in your health system some of them very inflationary like some of the payment systems, primary care, and so on the reform that in some ways is a kind of long term very acute crisis as well.

So the question to you and to our colleagues on the table is how do we sustain coverage and access in times of crisis. And we have three sets of questions that I would like you to to prepare as well because I will ask a question to them first then I will come to the floor to have your contributions sharp and short. And it is all about positive experiences we want to learn about good lessons in managing reform in times of crisis. The first is the short term response. Whether we like it or not this is something unpleasant. What I mean is you have the pressures, crisis, you have to meet the certain deficit targets and you have to cut whatever you can cut. You have to get the money wherever it is. And fortunately in terms of it seem part of equity and in quality there have been many countries which are observatory with the WHO we finished the survey of the European member states looking at the coverage we saw an increase in the use of user charges. Some changes and benefits although the population entitlements is still in the sense of population coverage is still universal coverage in all our countries when the majority were countries. Important question here is what kind of short term responses come into place and how they are managed to safeguard equity and quality on those times. So yes, you may introduce charges but what kinds of mechanisms exemptions are put into place to try to ensure the access of the most vulnerable population. Is there any space now we have lots of experience and what is called now value bases rationing. If we have to cut benefits we have to select those benefits that we know are less effective. So we can have the cake and eat it. We can save some resources at the same time increase the efficiency of the health system. So is it possible to target user charges to the services that are less effective. Is it possible as we seek to cut those benefits in terms of pharmaceuticals on those pharmaceuticals are indeed less effective? There have been all the responses such as wage cuts positive responses like counter cyclical spending, quick response to it one that we would like to have of course the resilience of the system.

Manuel Ferreira Teixeira

Well good afternoon to all. Let me thank to the Turkish government for their kind invitation. It is a pleasure for me to be in this city, Istanbul. It has some similarities with Lisbon I think, the light and the people... I feel good here.

Trying to answer to the questions in fact the crises hit Portugal around 2010. And when there is crisis this means shortage of financing. In 2010 the financial markets get more difficulties and also the hegemons of that public and private become too difficult to in fact finance it. And so the crisis in Portugal is a shortage of financing. This hit very early the national health system. In fact between 2010 and now the budget of services has decreased 10 percent. It is in fact something about 0.5 percent of GDP. Of course if the financing decrease and the health system at the beginning of the adjustments had bad financial situations. The system accumulates the stock of debt at the last quarter of 2010. The health debt in 2010 was about 40 percent of the annual budget, something like 3000 million Euros and this debt in fact is a consequence of chronic deficits. In addition to chronic deficits, the health system at the beginning of the process of adjustments was in a bad financial situation. In these situations financial deficits make more pressures in the system. The disequilibrium becomes more and more disequilibrium. And so if in fact the governments do nothing the system may fail. And for the government in Portugal the question is how to sustain the system. And the answer is to maintain the systems we must cut costs. It is mandatory. I do not know if it is a matter or a carma. But it is mandatory I think. We must cut costs to maintain the system to maintain the universal coverage. And the way we cut costs includes a lot of measures. Essentially in the pharmaceutical policy but also the medical device policy resource, human resource policy and auxiliary exercises and so on and so ever.

In the case of pharmaceutical we think that Portugal manage good transformations. Indeed the governments agree with the pharmaceutical industry should be cut in the public expenditure that based on 1.5 percent of GDP. That was the number in 2010 to 1.1 percent of GDP in 2013 a cut of 0.5 percent of GDP. Something like 900 billions of Euros. And this agreement with pharmaceutical industry includes certain measures. First of all the mandatory use of INN in Portugal, the prescriptions are obligated to be measured to INN. After that we removed all the legal barriers to the entry of generics. This means like 100 of generics that legally in the past were not able to answer in markets but from now on this generics are in the market. And so the height of generics in total medicines in Portugal passed from something like 15 percent to 38 percent in the first quarter of this year. In fact a dramatic increase in the rate

of generics. And finally we changed the reimbursement systems. Right now these systems are functions of five cheapest medicines in each measurement groups. Of course people are free to choose another medicine in each group but if people choose another medicine they pay. It is form of sharing the risks with the citizens.

We have increased sharply what we call the deterrent fee, and deterrent fee is not a co-payment. Deterrent fee is goal for a deterrent demand. It is not a goal to finance the system. It is very important. In fact these moderate fees only account about 2 percent of total financing of the system. But we have sharply increased this moderate fee, we have increased around a hundred percent. But simultaneously we have increased sharply the exemptions. At this moment and far economic reasons about 3 millions of Portuguese are exempted about one sort of our populations and we must add to these exempted for economic reason we messed another class also exempted it. The child, some citizens that have chronic diseases and so on... Almost 50 percent of our populations are indeed exempted.

Josep Figueras

Excellent! Thank you very much, that was very helpful.

Mrs Circene I know that you had the similar experiences with your charges had decreased and you have had a very successful programme is being developed. I know that the World Bank in terms of exemptions could you explain a bit more of those please?

Ingrida Circene

Thank you. First, I would like to say many thanks to Turkish government for possibility to be here and for invitation.

And it is true. What we went through very hard and very deep economical crises and it was a lot of challenges during some years. And it was linked with these economical crises and cuts off budget, cuts off wages, salaries, and also lowering prices of pharmaceuticals. But these challenges are not only due to lack of finances but also due to understanding of the things what is happening. Because our understandings are very different what is access to health care we are saying that our priorities are access and quality. And we were talking about this accessibility to health care services. Then it is possible to question what should we understand from this? Is that computer will be in an each village that neurosurgery will be as health care service in all small towns or maybe it is visits to GP every week or what it is, what does it mean. And so it is not easy. It was also questionable to accessibility to specialist send and screenings and also from health care workers it was a question about what is quality because if we are talking about General Practitioners (GP) system, of course we are paying part what is connected. We see a capitation money and what is included in this part and what is additional criteria. And so it was a lot of different very harder questions when we were discussing how to go through this. And during this time of course global economic recession has posed a major challenge to public health and the health care systems covers including the Latvia looked how to go out from this point. And we see their budget consolidation measures after cutting 22 percent of our budget. It was really dramatic. And the lack of financial resources resulting from the financial crisis has also posed enormous challenges to the government. And of course we went through these very structural reforms for reaching our plans waiting for many years. But these crises made this push and it was bigger possibility to realize a lot of structural reforms and it will be the next question. But as you mentioned we had very very successful cooperation with World Bank and from the 2009 we made social safety net strategy and with help of this strategy it was very good support for poor people. And it was also as promotion of development of cost-effective outpatient health care services because we made these flow of patients from inpatient hospitals to outpatient clinics. It was structurally changing, namely changes by flow of patients and it gave very good result and of course if we are talking about pharmaceuticals there were two things about what I would like to mention now. One is that we changed the percent of reimbursement because we did not have enough money. If we had reimbursement 90 percent we went to 75 to 50 percent. Now we are starting to go out from this and we are changing to the previous but it is not money enough also today but we can say that during this last year we can say that our government, prime minister, and president are saying that is will be priority for next year our health care budget. So I think that this is a result of this promising.

Josep Figueras

It is very very helpful Mrs Circene. This is you have already dealt is an artificial separation of the three points, isn't it? What is short term, long term governance? And I think you put emphasis on where I would like to put emphasis in a minute. On the structural changes you are very successful in integrating care, restructuring primary care. I would like to hear more about that later, in the second question.

Now I would like to hear about the experiences on the demand side, on the access to the services, the coverage in Korea. I know you achieved universal coverage but as the other countries you have a challenge as well with the amount of out of pocket expenditures which may have a negative impact on access. How are you dealing with that?

Choi Won-young

OK, sure. Thank you very much chair. First of all let me extend my gratitude to Turkish government for inviting me to this conference.

I believe that sustainability in a time of fiscal crisis is a timely theme to discuss in this conference. This is because that many countries have already established universal health coverage are striving to enhance sustainability while they are going through temporary or long term fiscal crisis these days. As you know the Republic of Korea also experienced a fiscal crisis resulting from the global financial crisis in 2008. Therefore I think the efforts should be made by Korean government to maintain the universal health coverage will be beneficial to other countries.

Korea provides universal health coverage since 1989 through national health insurance system and medical aid. The national health insurance system is financed by premiums of the insured people which account for 97 percent of the national population. The medical aid is run by the government budget for the people who cannot afford the premiums of the national insurance about the 3 percent of the population benefit from the aid. When the global financial crisis hit the nation in 2008, the real economy shrink, the number of the jobless rose, and the self employed got out of business. As a result, the number of the people who could not afford the premium of the national insurance increased. The Korean government operated a contingent plan to keep the universal health coverage intact. First, as the fiscal status of Korea was in good shape compared to the other nations the government adopted a temporary emergency support scheme. The government expanded the medical aid and at the same time we set aside an additional fund from the government budget to help the temporarily unemployed paid medical expenses. Second, the government implemented a special measure to right of temporarily outstanding premiums for the poor who could not afford the premium in the long term to drop income. Third, the government froze the premiums in 2009 to lessen the burden of households at the time of the economic recession. Forth, the government pursued various measures to cut the spending. We conducted strict reviews on reimbursement claims, reduced the drug prices by about 14 percent and saved approximately 1.5 billion dollars in drug expenditures. And we cut operating costs of the national health insurance cooperation. We also lowered the reimbursement prices for the city etc. And we raised the patients' co-payment in some cases to prevent patients from using treatments excessively. If a patient age with a mild disease that can be hindered by local clinics, goes to larger hospitals such as university hospitals, they are charged higher co-payment for medicines.

Thanks to these efforts Korea successfully ensured universal health coverage during the fiscal crisis triggered by the global financial crisis in 2008. As you well know Korea completely overcame the fiscal crisis. And now under normal conditions we are striving to make qualitative progress in universal health coverage. However, Korea's universal health coverage is expecting a coming crisis for health and challenges to address. I will present these challenges by answering to guiding question later. Thank you very much.

Josep Figueras

Thank you very much indeed. That is very useful. Many many important lessons there in terms of targeting the poor insuring, vulnerable insuring, access to health services in times of crisis, very useful lessons as well from all the participants on pharmaceuticals. In fact looking at the review of response to the financial crisis in our countries, many of them used pharmaceuticals first and re-point.

Thank you very much indeed. I think the last points are very nice take home messages. Governments do matter, governments have choice. It is possible to have a choice and the right choice during moments of crisis. A social contribution with citizens with a consensus with all these stakeholders are I think very important.

Could you bring your hands together to applaud and thank to our panelists. Thank you very much indeed.

Questions and answers

Ministerial Panel on Scaling Up Universal Health Coverage in Low and Middle Income Countries (OECD and WHO)

Düşük ve Orta Gelir Grubu Ülkelerde Genel Sağlık Kapsayıcılığının Tesisi, Bakanlar Oturumu (OECD ve DSÖ)

Moderator: *William Hsiao*

William Hsiao

Good afternoon. Soon you will be relieved from your suffering and you can go for dinner and the cruise, but we still have one exciting session planned for you. And this session is to follow up from the previous session. The previous session was asking the question how do you sustain a universal health coverage system after you have largely achieved it. And the countries that achieved it were mostly higher income countries. And this session focus on the issue that if you have not achieved universal health coverage how do you replicate it, how do you expand and replicate it. So here then, we have three distinguished panellists who are going to be share their experiences with us as well as teaching us some lessons on the pitfalls that they have learned, so you and I could try to avoid it if we are trying to expand and establish universal coverage. And I would like to follow the previous panel's approach by first asking the panellists some questions they can answer, and the questions I have are listed on this screen already and so with the time we have the most we can cover will be three questions. And three panellists we have, they are from very small countries to very large countries and also they are from low-income countries to upper-middle income countries. And so therefore their disease patterns in these countries are also different. But all three countries have adapted social health insurance as a way to finance their universal health coverage. So you should bear in mind, none of them are following the British system let's say like a national health service, they are all adapting three insurance systems. And I'm going to turn to question session over to you, and you can actually ask questions if you want to know more about national health service type of system.

So first of all let me introduce Dr. Nelly Aguilera Aburto. She is the Director of the Economic Analysis in the Healthcare Ministry in Mexico. She received her PhD in economics from one of the best universities in economics and that's University of Chicago. They produced probably largest number of Nobel prizes among their faculty members. And Mexico has more than a 100 million people. And what Mexico had done about ten years ago was to establish a universal health insurance for the one half of the people, because other half already has social health insurance as civil servants or as workers in the organised sector. Today, Mexico is publicized as a country that has already achieved universal health coverage, that's everyone, has been covered.

The next speaker I'd like to introduce Dr. Ali Ghufron Mukti, who is a Vice Minister for Health, but he was an academic before. He is a professor but also he was a dean of one of the outstanding medical schools in Indonesia. Then the government recruited him, went into the government to implement, after the law for universal coverage was passed, they invited him in to be the keepers and to implement the universal health coverage. As you know, Indonesia is a large country, and it has about 200 million people. And it is a low-income country and it is a country with more than 17 thousand islands. So one of the key issues you can address him is how do you get services to every village, every community. They have tremendous amount of experiences and lessons to share with the world.

Last panellist I'd like to introduce Mircea Buka, who is the director general of the national health insurance fund for Moldova. Before that he was a deputy minister of health in the ministry of health. But his own background is lawyer. He is the one who have to track the written national health insurance law for Moldova. So, and they have actually achieved universal coverage, that's everyone in his country of 2.5 million are covered now.

So I would like to pose questions to them, then I'm going to invite you to ask questions, then I'm going to ask the panellists to have some last words about what lessons you want to leave for the audience. What we know, one of the major questions about the universal health coverage is how do you expand insurance coverage as a first step, to have everybody enrolled, or every citizen in your country enrolled. And this of course requires political commitment at the highest level, even like the prime minister, the president, the cabinet under the ruling political party. So one of the questions I'm going to pose to the panellists is how do you get this political commitment to go ahead and do it in your country. The second major issue is that money is the mother milk of universal health coverage. Without money you cannot provide insurance and provide effective services to the people who are covered. So how did these countries then able to mobilise the funding? And if, like Indonesia, they do not have everyone covered what do they plan

to mobilise that additional money so they can achieve this universal health coverage? That's a first question I want to pose to them, but then let me go on with the two others and then they can answer all three or any one in particular. As already said by several speakers, particularly by John Cusinne earlier, insurance coverage is not equal to effective coverage. I hope by now after 2-3 years of writing and the conferences, you understand insurance does not necessarily provide people with access to the services they need including preventive and curative services. So one of the major issues for every country including my country, United States, we do not have one universal insurance coverage, nor do we have universal effective coverage. 50 million Americans still cannot get access to health services they need when they are ill. So and the many insured people in America, even they are insured they do not have doctors, nurses, clinics available to them. In my city or the new residents moving into Boston cannot find primary care doctors who are willing to be their doctor. And many of them when they are sick, they are to go to the emergency room. So the critical issue then is how do you provide access to health services and the one of course is if you are a low income country you cannot naturally provide all the services that technology allow you to do, even if you are a rich country you probably cannot afford to do that. You have to prioritize. Which services or prevention that is most important for your people particularly to improve the health of your people as well as to prevent people to become bankrupt when they need medical services. So how do you prioritize that's what I'm going to ask the panellists and I'm also inviting you to share your experiences, how do you prioritize, particularly from Africa, because I was recently in Africa, I'm really impressed by several very effective models, how they prioritize their services. Then the services could be there but people actually don't use it, because the quality is not good. Maybe the facility is not clean; maybe the drug supply is not available. These are the common problems for low-income countries. Or the stuff is not adequately trained, so people do not have confidence in the stuff. What would they do? They would go to actually faith healers, indigenous doctors who are not credited for treatment. So to assure access you have to assure quality of the services, at least meet people's reasonable expectations. Therefore, those countries have not adapted, have not achieved universal health coverage, most of those countries have a difficulty with human resources. There are not enough nurses, there are not enough doctors, there are not enough, definitely not enough specialists. Many of you do not even have enough health workers in the field working. These are the people who are trained only for one year after high school. Besides human resources, there are difficulties with drug supply. Many countries cannot establish effective drug supply chains. So these are the questions I would like to ask the panellists as well as ask you to think about. Last panellist, even the facilities are there, drugs are there, often facilities are not appropriately managed. Workers show up for working in the morning, they leave by noontime. Or like in northern province states of India or Pakistan workers do not even show up for work. They only show up on payday. That's a management problem. How do you manage these operations? Last issue, panellists, we may not have time to really cover is equity. Most countries, this was already brought out in the previous session, most countries establish a benefit package for their civil servants and workers in the organised sector. And those benefit packages are very generous, very expensive. You cannot afford it to give poor people, near poor people that same kind of generous package. Thailand has been mentioned here several times; it's pulled out as a world success story. But do you know Thailand has a three-peer system. Civil servants' benefit package cost them four times as much as the people in the middle and lower-middle income. Workers in the organised sector cost two and half times more. So when you embark universal health coverage, this is what John mentioned earlier this morning, one of the things we learned is don't cover civil servants and organised worker sectors with generous benefit package, then you are not be able to achieve equity, I guarantee you for 30-40 years, that's a worldwide experience. And Japan is started out hundred years earlier, but it was only in 1960 Japan able to achieve that. So these are the lessons we want to learn, and discuss and debate. The other one then is if you are going to have a single pair, which like Moldova has, then do we have a single benefit package and also single agency running it. Japan has thousands of agencies but as he said earlier, they only have one fee schedule, that's how they unified it. So with that, sorry, my introduction took longer than I intended, but now let me turn over to the panel, from Mexico, you may want to share your experiences with us.

Nelly Aguilera Aburto

Thank you. Good afternoon. First of all, I would like to thank Turkish Ministry of Health for the invitation and to the Mexican Government to share the recent experiences in universal health coverage of Mexico. I would like to address the first topic, how do we expand universal coverage? Basically, more than giving data or whatever, I would like to address one very important decision any country has to make when trying to expand universal coverage. Mexico is about to reach universal coverage. I mean financially we have reached universal coverage. There are some people outside of coverage left, very few people. But, I think that the most important

thing to reach universal coverage is whether you design a mandatory system or a voluntary system. In Mexico, we have basically two sub-systems, the system based on payroll contributions like the social security base health system and the public system subsidized by the state. And when the Seguro popular was introduced back in 2003, it was voluntary. So it took us 10 years to reach universal coverage more or less. But we could have made a system mandatory from the beginning. Probably, what I have heard is, it was voluntary because it was planned and rolled over to become mandatory gradually. You earned the poorest population to enrol in the system first. And then people, not from the poorest groups but rolling over the program, not so poor population. But now that we have universal coverage, we wonder ourselves what are we doing. Because we have a system that persons have to reenrol in the programme every three years. How we think is this is not efficient any more. If we have the money to have everyone in the system, let's make the system arrived to everyone. We are thinking to change this part of the system, not to make the people reenrol every time, so just make the system arrived to everyone. So this is the kind of topic you have to think about introducing social insurance system making voluntary, mandatory and what do you do when you have reached the universal coverage. Because this reenrolment, it makes, it only increases administrative cost, you have to go to the household, you have to interview the household. And now we think it is not necessary that. That is a key topic that we are thinking now. Just to finish this part, the system was made voluntary because it was designed to have family contributions. So depending on the family income, the family had to contribute to the scheme. 10 years after the programme was implemented, we have realized that it is not very efficient. We collected very little money from the family contributions and the administrative cost of implementing this scheme of interviewing the families, assigning the contribution rate; it was very expensive. So now we are thinking making this easier for the families and for the government. So these are the topics that we are thinking about now once we have reached universal coverage.

William Hsiao

Thank you. So, her point is, well taken that one to finance for the poor and the near poor, Mexico has relied on the general revenues to pay for them, but you have made a voluntary programme and you encountered some serious difficulties and you are thinking to changing them right now. Yes, Dr. Mukti.

Ali Ghufron Mukti

Thank you, thank you Prof. William Hsiao.

Good afternoon. I do not want to explain the part in initial, because it is already explained. But I just would like to explain a little bit about the scheme. So in initial we have at least four schemes; civil servant scheme, and then organised formal sector schemes, and then local government initiative schemes, and for the poor and near poor schemes. But the problem for the poor and near poor, it is very difficult to know who are the poor, who are the near poor, who are the near rich; it is not easy. So therefore, now we have the same time and first time to have database, based on central bureau of statistics. 40 per cent of the lowest income, and the number is 96.7 million people. So therefore, the real people who are poor actually only 29,200 thousands but we make double, so the government pay the premium for the poor and near poor up to now 86.4 million people. And it was started when we face crisis in 1997 actually, but then in 2004 because we have critical mask and some of experts to advocate the legislative body to make the law, social security law, and we also advocate the labour association, they have the right. Then legislative has the law. After the law, debate is still there. But then in 2011 actually, we have law on social security administrative agencies, then we stopped. So that is the political commitment. Then the government actually do not want to increase this little bit, so therefore we advocate to the vice minister of the finance, if you do not increase the budget, then it is up to you, I will not be responsible if doctors will strike, so please increase the budget. Then the budget now increased 1.6 Williamion US dollars. It means usually we only have 2.2 percent of the national budget, now it increased to minimum 3.3 percent of the budget. It is the fund. So now we are talking about how to provide quality of the services. First, we make the numbers, calculate how many beds we need, we need 247 thousand beds, and then we invite private sector to invest. So within two years, the hospitals increased to 500 hospitals. Also we make primary health care strengthening. The doctors when they finish their education, they have to have internship, and they have to take national competence exam and we make accreditation for primary health care. Usually, obviously accreditation is only for hospitals, but now for doctors and primary health carers, they have to make accreditation. At least competences we have to find, so the primary health care doctors minimum have to be able to diagnose 144 diagnoses. So therefore, the competences, education then we directed into that direction. Of course, human resources, we give scholarships especially for specialists, 3500 specialists we give scholarships across the country. And this candidate of specialist has to be from the area where there is a lack of specialist and they have to go back to the area where they assigned. And then, of course, we have conducted out and keep incentive to be able to distribute especially to the remote areas, and of course it is not easy. Then we

also to make sure the local government, especially health district office working and we make decentralized. So that decentralized government has to monitor and they have to be responsible including the transportation cost. Now, we talk about the drug supply. Drug supply, briefly, sometimes lack of drug and sometimes very expensive. Therefore we establish what we call it in the procurement, e-catalogue. E-catalogue with the prize and the name of the drug. Then, if the factory or company will provide the drug, they have to be able to make sure the availability and also the distribution to the remote areas. Then I think about the equity. So of course now, because we have at least 5 schemes, we are trying to make jump to be single scheme and it should be operationalized, implemented at least 1st January of 2014. And we make road map, so start from 2014 it should be operationalized, the benefit package now can be varied, but year by year and maximum in 2019 all the minimum benefit package should be the same and it should be comprehensive. Now, we are trying fast to have single payer, and then pay using the articles for the hospitals and capitation for primary health carers, and then trying to make sure, of course the quality is there, it is our plan and some we already established. Thank you.

William Hsiao

Thank you for that very comprehensive explanation of what Indonesia is doing. Before I turn to Dr. Buka, let me just try to summarize, because he is going to give us a different experience. Both Mexico and Indonesia telling us, they are giving priority to include, bringing in the poor people. To bringing in the poor people, the government has to fund the premiums for the poor people. And in Indonesia, they threaten the minister of finance, if you do not increase our budget; the doctors might go on strike. And apparently, you believe he made a difference in his decision. So it is a political leveraging they use to get minister of finance to pay attention. The other part is that they rely on the supply side, on the delivery side, they try to draw in the private sector, to provide some services, and then they pay them a particular fee schedule as standardized. Then, you also really talked about, they are not able to standardize or five different levels of benefit package to the highest level. So Indonesia is only to say everyone will have the same basic benefit package, above this benefit package there will be tears, for those who already have a lot of more. So I hope it already brought out the issue of equity, brought out some issues on access and also on the funding. So now let me turn over to Dr. Buka.

Mircea Buka

Thank you distinguished professor Hsiao, distinguished guests. I want to thank the minister of health of Turkey for invitation to this important conference. And I will try to make simple my speech, to make this description quiet simple about our Moldovan model of health insurance, we call it health insurance. This model was established into south and implemented all over the country. So we have only 9 years of its implementation. I want to emphasize it was not easy to shift from a Soviet model of Semasko financing system to another so-called Bismarckian model social health insurance. But we had very strong political commitment at the time into southern territory and we had very good consensus between all stakeholders, doctors, patients, politicians, and leaders, parliamentarians and so on. So everybody had the same idea that we need to change something in our system in order to achieve universal health coverage. So on January 1, 2004 we started this new model. Why I said that this model is simple? Because we have only one single insurance company, we call it insurance company. However, we collect sources from two parts. One part is from salaries based on payroll tax, like in Mexico. So now we have tax of 7 per cent applied on salaries. Another big part is coming from the state budget from the general revenues from taxation, and it is about 12 per cent of overall country budget. So the country, state budget is paying 12 per cent from its budget to cover people that are not employed. So employed people are paying by themselves, unemployed people are covered by the state. Majority of our population, about 57 per cent is covered by the state. There are retired people, disabled people, children up to 18 years; totally we have 15 categories of vulnerable people covered by state. Our system is based on the main principle of solidarity. What means that a young person is paying for elder one, a healthy person is paying for less healthy, and a rich person is paying for poor person. When we speak about equity, we can say that it does not matter how much you pay for health insurance in Moldova, you will obtain the same standardized benefit package. So we have one package for everybody in our country. That's why I said our scheme is quiet simple. And this package, the list of services our company is buying every year is approved by the government. Our agency is publicly owned, is a governmental agency and we sign contracts every year with all providers in Moldova, either public or private. So all of them sign contracts with us, we buy medical services and pharmaceutical services for our population. When we speak about universal health coverage, we have challenges as well. In Moldova, now we have 82 per cent of our population covered by insurance scheme. We started with 63 per cent in 2004, and during these 9 years it increases the share to 82 per cent. But we still have 18 per cent of the population not covered by insurance scheme. But we cover for them a so-called essential package of services.

We cover 100 per cent primary care, we cover emergency care, and we cover a small list of reimbursed drugs and medicines for all people in the country. But for insured persons, we cover, additionally, hospitals, we cover outpatient care, and different services and other investigations that we buy every year. So during these 9 years, Moldova achieved the coverage of 82 per cent of population, but we have another problem that you might know, the problem that also Moldovan state pays from its budget almost 15 per cent of money for health care. Our GDP is quiet low, that's why we can say that public expenditures in our country are lower than in Western European Countries. And we have only a share of 55 per cent of public expenditures, versus 45 per cent of private or out of pocket expenditures in the country. So we can cover only 55 per cent of the needs of the population.

Other services are paid out of pocket including drug stores, pharmacies, so they buy a lot of drugs from pharmacies that are not included in the list of reimbursed medicines. So this is a problem, but it is a problem based on the level of our economy. We cannot pay more than that we already pay. Moldova pays every year more than 11 per cent of our GDP for health care. You can compare with other European richer countries that pay 9 per cent of GDP for health care. I had what my colleague from Indonesia said that only 3.3 per cent you pay from your budget, and you can see in Moldova the figure is a little bit better, 12 per cent f the budget is paid for health care services. So these are the basic features of our system in Moldova, one benefit package, one single payer, funds increasing every year, so we started with 600 million leu now we have about 4 Williamion leu, during 9 years we have an increase by 6 times of our funds. Of course medical treatment or health care is very expensive and it is difficult to manage these funds and to cover all services, but we try to balance every year to balance the package. We cannot accept deficit for our funds excepting the years we face financial economic crisis. Now we are in the situation, Moldova faces financial crisis, but we try to keep our funds, we try not to reduce the costs, we try to fulfil our contracts with all the providers using our reserves. Moldovan fund has a special fund, reserve fund, and from this reserves collecting in better years we manage to cover the deficit that can occur during financial or other type of crisis in every country. So that's a short presentation of our system. If you have questions, I would be glad to answer them.

William Hsiao

Thank you. You can see Moldova started out because their whole economic system was being transformed and they actually were able to obtain a political consensus in 2003, shifting from a previous socialistic country system to a social insurance system. But they did not have any body covered in that time, so they were able to achieve one benefit package for everyone, a minister by one agency. And there he explained they have building the modern methods like starting up contingency reserves and so forth to cutting the fluctuations in the economic changes. Let me push two of you for one more question, than I am going to open up to (audiences). Here Moldova is having one benefit package and one agency, both your countries (Mexico and Indonesia) now have several agencies, what is your plan and what's the challenge to bring everybody to the same benefit package or into one agency to administer that? Let me just alert you, when you have mother born agencies administering, administrative cost can run very very high. And every agency has its own rules. So providers can play off one against another, that's one of the major problems United States have, that's why we spent 25 per cent of our national health expenditures for administrative expenses, not for health care. 1 dollar out of 4 is spent for administration, that's why I want to pose this question to you.

Nelly Aguilera Aburto

Thank you. As I said before, in Mexico we have basically two subsystems; the social security based health insurance and subsidised Seguro Popular insurance. Although we have invested a lot of money to the second subsystem, we have not been able to equalise both of the systems. What is the major barrier? It is money. It will cost us probably almost 1 point of GDP to equalise both of subsystems. We think we are not going to be able to equalise both soon. We will have to live with these inequalities in the years to come and discuss the issue of money. For your second question, the one of the single payer, we think that the problem in Mexico is fragmentation; we have the social security and we have the subsidised systems. Our plans, we want to have a unique fund, probably it's not going to be single payer, but it's going to be a single fund. And in the long run, it could be single payer, but not in the short run. These are our plans. We are not sure that we will going to be able to achieve this, we need constitutional amendments for single fund. But these are our plans, basically having different insurers on the single fund. Thank you.

William Hsiao

Thank you, that's very helpful. So you are planning but it's rather difficult to really unify everything.

Ali Ghufron Mukti

So first, we use through the law. So the law stipulated that it should be one fund and single fund and single payer. So therefore, then we made the road map. The roadmap starts in 2014, the single payer has to be operationalized and up to maximum 2019 have to be

finished. So in many aspects, first organisations should be merged to the one, then second about the benefit package, it should be standardised, then third is about the premium, premium also should be standardised of course, and make a consensus. Of course it is not easy. Until now, two parts are not yet agreed but the government already agreed. So then the challenge is that especially local government initiative schemes, because the money, the collected money is there, and when now trying to merge to be single fund, single payer; so they are a little bit reluctant. And of course this fund will have the power, especially when they are trying to have campaigns for running as the governor or as the mayor. So they can campaign to the population, if they vote there will be some kind of free, and we will cover you all. So they have this power, so it is a little bit difficult to merge. Therefore we made the road map, and then step-by-step, but then in the year 2019 this should be already merged to be single payer.

William Hsiao

Thank you, that's very helpful. I just want to add a footnote for Indonesia. Indonesia received a great deal of technical assistance from the World Bank and WHO outside. When they designed this reform package early in the 2000s, and passed the law in 2004, they really draw on the worldwide lessons, what not to do. That's why they put in the law, you are going to have one single payer. They learned, if you have allowed for many funds, you are really going to waste your resources as it was made the system very inefficient. Moreover, you did also found one, you probably learned also just by reading as was consultancy you have built in.

Mircea Buka

Yes professor, I want to agree with you. At that time, we had very good advisers, both from the World Bank and from WHO. And I think many or almost all the recommendations we used preparing this scheme, of course it is our local model, we can say it is a Moldovan model, but anyway you are correct that we need to know what is good and what is bad in other countries. And that stage of advice from WHO and the World Bank was crucial for Moldova to convince politicians to accept this model.

William Hsiao

Thank you. Now let me try to turn over to the audience. Maybe some of you would like to share your experience or you may have questions for them. I know some ministers are here and you want to know what to do yourself.

Yes, please give your name please.

Question 1:

Size ve katılımcılara, sunuculara teşekkür ediyorum. İsmim Hüseyin Çelik. Türkiye'deki genel sağlık sigortasının oluşturulmasında görev aldım. Bize hep şunu sordular, Türkiye'deki sistem İngiliz sistemi midir ya da Alman sistemi mi, hangisi diye, aslında biz bir Türk sistemi oluşturduk, üçüncü bir yapı diyelim. Bu da vergili ve primli sistemin bileşkesiydi, yani çalışanlar ve varlıklı olanların prim ödediği, yoksullar içinse priminin devlet tarafından ödendiği bir yapı. Bence buna Türk sistemi diyebiliriz diye düşünüyorum. İlave bir şey daha yaptık, elde edilen primin yüzde 25'i kadar devlet katkısını da sistemin içine koyduk. Yani bir açık oluşmasını beklemeden devlet katkısını da sisteme ilave ettik.

Şimdi bu sistem 2008'de yürürlüğe girdi, 2006'da kanun çıkmıştı ama geçiş dönemi 2008'e kadar sürdü. Ve 2008 yılı onuncu ayında kanun uygulanmaya başladı ve tüm nüfusu kapsayacak şekilde 1.1.2012 tarihinde yürürlüğe girdi. Yani daha önce yeşil kartlıların da sisteme dahil olması geçiş dönemiyle birlikte 1 Ocak 2012 yılını buldu. Ve ilk defa sistemin bütünü hakkında dataların oluşması, primin, gelir ve giderlerinin nerede buluştuğunu görmek ve geleceğe yönelik öngörüde bulunmak 2012 yılı itibariyle realize oldu. Sistem bugün de detaylı bir şekilde konuştuğumuz ve birçok ülkeye de örnek gösterilebilecek çıktılarıyla gerçekten hepimiz için gurur verici olarak sürdürülüyor. Şimdi sistemin özüne baktığımız zaman toplumun sağlık ihtiyaçlarını karşılamak için bireylerden parayı peşin alıyoruz, ister prim olsun ister vergiyle parayı peşin alıyoruz. Ve o elde edilen bütçeyle genel sağlık sigortasının finanse edilmesini sağlıyoruz. Fakat otelcilik sisteminde olduğu gibi bireylerin parayı peşin ödemesi daha sonrasında sistemin içine girdikten sonra tüketim alışkanlığını doğal olarak tahrik ediyor ve bireylerde sürekli tüketme alışkanlığı yaratıyor ve bu Türkiye'de de şu anda yaşanıyor. Ben hem moderatör olarak size hem de sunum yapan kişilere sormak istiyorum, bu vatandaşın her şey peşin ödendiği için bir süre sonra bedava olarak algılanan, sanki hiçbir bedel ödemeden sağlık sisteminin finanse edildiği her şeyin sunulduğu algısının yönetimi çok kritik hale geliyor. Bu kuşkusuz politikacılar açısından çok cazip bir şey, her şeyi size bedava sunuyorum ve bunun karşılığında da sizden oy istiyorum algısı çok güçlü bir politika aracı haline geliyor ve bunun cazibesine kapılarak giderek bunun beslendiği ve bir süre sonra vatandaşların da karşılıksız olarak, vergi ya da prim ödemeksizin sürekli hak talebinin oluştuğu bir yapıya doğru yavaş yavaş sistem kayıyor.

Evet biz geçmiş on yıllık dönemde çok ciddi reformlar yaptık ama gelecek on yıllarımızı, çocuklarımızı ve torunlarımızı da düşünerek sistemin sağlam ayaklar üstüne basmasını da sağlamak durumundayız. En yakın komşu ülkelerimizde yaşadığımız öngörüsüz sağlık harcamalarının ve diğer kamu harcamalarının ne tür

felaketlere de yol açtığını çok iyi gördük, 2001 yılında bu krizi biz de çok derin olarak yaşadık. O yüzden ben sizden bir Harvard halk sağlığı profesörü olarak hem de diğer katılımcılardan bu konudaki deneyimlerinizi ve Türkiye'nin gelecek on yılına yönelik öngörülerinizi özellikle rica ediyorum. Teşekkür ediyorum.

William Hsiao

Thank you. Do you have any harder questions? I hope the panel is getting ready to answer, let me take some more questions. And then we will come back to you.

Question 2:

(Translated from French)

I express my endless thanks for letting me talk. Actually some of my concerns were expressed just before, it was said that inclusion of all treatments in the coverage is utopian in terms of the limits of the social insurance coverage package, for this reason can you make an explanation about the minimum package we must include in the coverage mandatorily?

Moreover, it was just said that inclusion of everything in the coverage is dangerous, the concept of additional package was presented according to this, what is the most suitable approach for the best execution of the additional package? Should it be procured by private persons or regulated under the State system?

Lastly, one of my concerns as just explained is the measures taken for the risks of excessive consumption, but the issue should not be restricted with consumption risks because it carries a great risk morally in terms of patients. Besides, there are also the risks of prescriptions to an excessive extent in our country. Service professionals desire to benefit from the system by applying to easier ways to cover the expenditures, namely they ask these losses to be compensated by imposing the debts of customers who cannot pay into the system. What are the measures taken in this issue? Because all these concerns may endanger the system.

William Hsiao

You can see both questions are about the benefit package design as well as how do you really able to sustain universal health insurance after even you are able to achieve it. And so we will come back to that, let me take one more question, I see you are anxious, before we turn to the panel for some answers.

Question 3:

Thank you very much. I am Hans Kluge, the Director of Health Systems at WHO Europe and also special representative of the regional director on multi drug-resistance tuberculosis. So my question is to my colleague and friend Dr. Buka from Moldova. First of all, congratulations to the government of Moldova for what we see is a success story in universal health coverage in challenging circumstances, as you say so, and limited means. So this is largely thanks to the political commitment. So my question is Moldova has made great strides towards universal health coverage and still doing so, if we look at the disease birth, we know for example that multi drug-resistance tuberculosis is still a big challenge. How does the ministry of health sees to mainstream TV control programme bringing into the mainstream of the health system strengthening and the universal health coverage, so to get this important disease control programs into the drive towards universal health coverage? Thank you.

William Hsiao

All right. Before we take more questions or comments, how about to turn to the panel? One is how do you actually design the benefit package, can you cover everything free? And then is it sustainable? Then we will return to Moldova.

Ali Ghufron Mukti

Thank you very much. First of all, I think in initial we are trying to design the benefit, we divided into actually four, but basically two; first medical need and non-medical benefit. For medical benefits, actually it is covered as long as the doctors decide that it is plastic surgery or another type of, you know, convenient things, it is not really covered. So it is the basic thing. The question is then how, of course, to monitor and to make, you know, more cost effective? First, then we set up, what we call it, technology assessment team, which will assess whether the new drug included in the national formulary will be cost effective comparing to the existing drug and technology or not. It is the first time. Then the second, we set up, what we call it, medical board team. The function is to make utilisation review. To review using prospective review, concurrent review and retrospective review, whether actually the treatment is medically needed and it is really logical or not. And if not logical, they will make some kind of, you know, this incentive. And then we also try to make actually, what we call it, if the resistant to fraud then we make little bit cost setting so to reduce the demand. So this is what we are doing. Of course, it is not easy and we are worried also if then people are moving from promotion prevention type of behaviour to more to consumption. So therefore we are making more strengthening in, you know, advocating people to make sure that you make healthy. So promotion and prevention should be allocated enough money in ministry of health and district, also provincial office. Thank you.

William Hsiao

Thank you. Dr. Aguilera?

Nelly Aguilera Aburto

Thank you. I would like to add some comments to what Mukti just said. Something that we think had really working in Mexico is to have a say like a different benefit packages, one for prevention and promotion, one for primary and second level care, and then one benefit package for high cost diseases. Who does think it has woke? It can really help you to control cost, I mean in this terms. If you have the list of high cost diseases, it really helps you to control cost. It is not very good in terms of equity or client satisfaction, but you are facing a lot of demand and financial pressures. We really think that you have to distinguish very well these three packages. The nature of financing each of these packages different. And this is what we do in Mexico. The second level package is financed by per capita amount to the local insurance providers and high cost diseases are paid on a case by case basis. So this helps us a lot.

William Hsiao

Thank you for sharing what Mexico is doing. You are really dividing the benefit packages to different types, prevention, primary care and the catastrophic. Yes, Dr. Buka?

Mircea Buka

Thank you. I also want to answer all the questions. First of all, thank you to Dr. Hans Kluge for his words about my country, about Moldova, about what we do in our reforms, it is not easy in such a poor country. But it is interesting from one point of view to make reforms in a poor country. Asking to a question about multi drug-resistant tuberculosis, it is a problem, it is a big problem for Moldova, we have a quiet big burden of tuberculosis in the population. I will answer based on two parts. First of all, from providers' side, we try to buy everything and we pay from our funds for everything they can offer to our population including labs, including all services. And we now have a new fund, development fund, and we pay to renovate and reconstruct all the facilities and to invest in new equipment to tackle this disease. And from another side, from the funds' side, we have different funds in Moldova. The global fund is paying for certain drugs, almost all drugs that we use treating multi drug-resistant TB and other types of TB according to dots and dots+ scheme. And we have our funds paying for modern schemes of treatment, paying for increased salaries for doctors, and paying for different social packages for our patients in order to attract them to the treatment schemes. Many of these patients are coming from socially vulnerable groups of population. And it is not easy to keep them in this treatment scheme, especially when this scheme is lasting very long, 24 months or less, but it is quiet long to keep them involved. I want to emphasize the leadership role of ministry of health. Ministry of health had very good platform based on national TV programme approved by the government, and in this discussion platform are included all stakeholders, all intra-state institutions including NGOs, because NGOs are now very largely involved in the process of TB treatment in our country. I want to also to answer to the question of Mr. Celik from Turkey and our colleague from Democratic Republic of Congo. I understand you, I understand that the perceptions of free services can be, we can say that sometimes maybe it is not good, but let's think about people that cannot afford to pay, about people that in case we introduce co-payment, we will punish them, and they cannot pay for such services. Our colleague from Congo said that its universal health coverage is a utopia, I don't think so. 90 per cent of health care services are covered in our country, of course there are services not covered and can be used other schemes like complimentary insurance or supplementary insurance, but the main, the majority, the great majority of health care services can be covered through mandatory health insurance or other type of insurance schemes in every country. About overconsumptions, of course you can use this co-payment mechanism, and Moldova for instance have co-payment for medicines in pharmacies, for medicines in order to avoid this overconsumption of drugs. Thank you.

William Hsiao

I hope you got some answers for Democratic Republic as well as for Turkey. Let me just add, highlight one point they are saying which they did not elaborate, one way to try to contain your cost the inflation is by changing the payment methods to providers. If you pay a per capita to your physicians in advance, then they will not actually over treat the patients, the danger is they will under treat the patients, they will not ask the patients, they will not over proscribe drugs to patients, they might under proscribe. But then you have ways to deal with that. It is only under the fee for service payment system, you actually promote over proscribing, over treatment; because that every additional service they do they receive additional revenue. So you can look at from the so-called from that demand side, but you can also look from the supply side. What kind of payment system you use? Just add that, but it is a very difficult issue. I can speak for advanced nations. Every advanced nation that I know of is under financial pressure, not just because of economic crisis. Before economic crisis, there were already very rapid increase in health care cost partly because aging of the population. But partly it is because of medical technology. Expensive technologies are advancing, developing very fast. So every country is

seeking a way to address that and some countries then use the economic crisis to try to cut back the benefits. But that's probably is only on the margins you can do some of these. But my personal advice to you is, for developing, low income and middle-income countries, don't promise everything. Once you promise everything, you cannot ever take back. You do it promising modest amount like in Indonesia or in Mexico. Indonesia says I am only promising you these basic services. And then when you have the ability to finance more, you can expand. But when you promise everything, when you try to take them back, people become very very angry. So I can give you that personal part. So let me turn to the last question, and then we need to bring this session to close. I am sorry because at 6 o'clock we have a bus picking us up. Yes?

Question 4:

Thank you very much professor. My name is Viktor Fukri, I am from the United Arab Emirates. First of all, thank you for the government of Turkey, Ministry of Health, for this very important ministerial conference on universal health coverage. My question is to you or someone from the panel. In case of public health emergencies, unexpected, unusual public health emergencies, like Sars, like H1N1, who is going to pay this William, is it by the health insurance or by the government to cover this, especially in case it will need hospitalisation, I see very costly treatment. Thank you.

William Hsiao

There is one anxious hand up there, let me just, ok that's a last question we can take. Then you can give the wrap up, take it home lessons.

Question 5:

Thank you very much. I am Dr. Gazi İsmail from Yemen. And I would like, first of all, to thank Turkish Government and the Turkish Ministry of Health for inviting us and giving us this opportunity to benefit and learn from the experiences of many countries. My question focuses on the role that can be played by the private sector or private insurance companies, either alone or together with merged with government initiative schemes to achieve universal health coverage, particularly in countries where political commitment is not that strong and where resources are not adequate to achieve the subjective. Thank you.

William Hsiao

Anyone of you would like to answer one of these questions and then we can move on to the wrap up.

Ali Ghufron Mukti

First about the role of private insurance. In initial we are trying to, first we called it public-private partnership. So in the health infrastructure, we invite private to invest and to build infrastructures. But for private insurance, those who are not satisfied with the public system or with the minimal system, then they can buy the complimentary benefit package to the commercial health insurance, and we use what we call it, coordination of benefit, something like that. Then second is about the public health emergency. Of course it is a big thing. But our experienced minister of health and the government are also responsible for this. But of course it depends on the scope. If the scope is still small, it is the responsibility of health insurance carrier, but if it is huge with many guesses, then the government is responsible. But we already divided the task. The government will pay all the promotion and prevention, but when the guesses are good at the hospital, it is the responsibility of health insurance carrier except if there is emergency or outbreaks with its huge guesses and huge money involved. Then the government will also take care of that. Thank you.

William Hsiao

You got some answers with this. Do you want also?

Nelly Aguilera Aburto

I think your question is very important, the role of the private insurers. In Mexico, half of the health spending is private and it is mostly out of pocket. So when the Minister Mercedes Juan presented her agenda for structural reform in Mexico, she and her team were ambitious for the participation of private health insurance under the single fund. Probably it was the most debated part of the proposal, the role of the private insurers. Today, probably it is not our priority although we believe it can help a lot, to private spending instead of having pure out of pocket spending. But it is a very very debated topic. Thank you.

William Hsiao

Thank you. Oh, you also?

Mircea Buka

Briefly about private insurance. In our case, only our company can perform mandatory health insurance, for private insurers they can do only complimentary insurance, not mandatory insurance. About emergency in Moldova, we cover all types of emergencies, but in case of, as you said the outbreak of different pandemic, we have a special fund, reserve fund, and we cover such type of services and all of them.

William Hsiao

I just want to turn back to panel, each one has two minutes to give you some critical lessons, you want to leave for the audience. But before I do that, I will advice you; if you are thinking of using private insurance, not regulated very much, just use United States as your guide. What will happen? So United States walk ahead of you for decades, so you know the consequences. But if you want to limit private insurance to some modest or complimentary, then look at the Great Britain. Great Britain does have 8 per cent of people having private insurance, but their national health service can stay stable. So we consider in the academic world, when private insurance exceeds about 20 per cent, you create a very unstable system for the whole country. So it is a dangerous thing. You are playing with the fire. Fire is very useful but you better know how to control that fire.

Ali Ghufron Mukti

Ok, I think I would like to conclude or just remark of my presentation, first it is about the commitment. I think political commitment is very very important. This is the first. But this should be translated into the budget, into the funding, into the money. Then second is about the same idea, it is not easy to make, same idea where we are going, so therefore we have to make a road map which should be agreed and consensus among all the stakeholders. So and then we can use this road map as the guideline where we are going. Then, human resources in health, also human resources in health insurance is very important to be prepared. Then the last one is of course health infrastructures, including human resources, it should be developed as soon as possible and should be able to provide high quality, efficient health care.

Nelly Aguilera Aburto

Ok, thank you, I just want to finish my comment saying that the easiest part of health reform is financial part, I think, even though it is very difficult, it is the easiest part. And we believe the most difficult part is the organisational and functional aspects. In Mexico, we achieved financial coverage for everyone, but we faced challenges in translating this financial coverage in effective access and quality. We are facing challenges in tightening or linking more the financial support for everyone to outcomes. These are very complex issues. You have to change structure, you have to change incentives, you have to change functions. And probably this is very important to know, one you reached financial coverage for everyone, then you have to start all the reforms again in the structural and functional part.

Mircea Buka

I would say three points. First of all, it does not matter what type of model we have, insurance as a type of financing models. It is important to be close to the universal health coverage, make a simple model, and then shift step by step to a complex one, and don't forget about equity, about the social dimension of all these reforms and measures that we implement, and about the poorest part of the population, and finally discourage informal payments, it is a problem for Moldova, and try to decrease gradually private payments increasing step by step public expenditures for health. Thank you.

William Hsiao

Let us give a hand to the panellists; I don't have anything to add for that.

Managing Emergencies in The Context of Universal Health Coverage
Genel Sağlık Kapsamı Bağlamında Acil Durum Yönetimi

Moderator: *Sania Nishtar*

Sania Nishtar

Good morning ladies and gentlemen. I have the privilege of welcoming you to the first preliminary of the second day of this exciting conference which focuses on Turkey's attempt to institutionalize universal health coverage. The focus of the session is on the management of emergencies and the imperatives that it creates for health system's planning and achieving universal health coverage objectives at the same time. We have got an hour and a half for the session and we are already let running fifteen minutes late.

Joint here, on the panel with me are Dr Ala Alwan who is the WHO regional director for the Eastern Mediterranean Region. He will be delivering the keynote speech this morning and needs no introduction. We also have with us on the panel Ali Ghufrom Mukti, vice Minister of Health from Indonesia. His Excellency, İbrahim Mustafa vice Minister of Health from Egypt, the secretary of State Minister of Health Mr Raed Arafat, and the Deputy Minister of Health of Turkey Mr Agah Kafkas.

I am not going to make any framing comments this morning and I would like to go right away into the session by giving the floor to Dr Ala Alwan for his keynote speech.

Ala Alwan

Thank you very much Dr Nishtar and good morning to you all, your Excellencies ladies and gentlemen. Let me start by thanking to the Ministry of Health of Turkey for inviting me to this very important event. I would also like to congratulate the government of Turkey for the great achievements they have made in the universal health coverage what has been achieved here in ten years. This is very inspiring and there are many lessons for countries to learn; those countries that are committed to move in the same path. But coming from a region with so many crises probably why I was delighted to deliver a presentation on emergencies in the context of universal health coverage. So I will provide some examples from my region which is the Eastern Mediterranean region. I also, in my WHO career in charge of, for three years, WHO's work in emergencies and crises. So I will try to also give some impressions, my own impressions based on my limited experience on some of the key aspects related to this subject.

We are all currently witnessing a humanitarian crisis in Syria as it unfolds with unprecedented magnitude and catastrophic humanitarian impact both inside Syria and also in a number of neighbouring countries. And we continue to follow other acute crises as well as chronic emergencies in many parts of the world. We have all seen the destructive effects of natural disasters like the recent floods across the central Europe and each year we anticipate the after effects of hurricanes, tornados, rains and forest fires that regularly effect the countries around the globe. We know that these emergencies result in an enormous loss of life and enormous suffering. And the emergencies reflect a major impediment to universal health coverage and therefore insuring that health care reaches all people affected by the emergencies is definitely a great challenge to the global health today.

Let me focus on the initiative magnitude of emergencies and crises. An over 10 year period from 2001 to 2010 we had an average more than seven hundred natural and manmade emergencies occurring globally every year effecting approximately 2.7 million people around the world and causing 130 thousand deaths annually. We know also that almost half of these deaths occurred in less developed countries with limited capacity to prepare for an effective emergency response. This shows the progressively increasing magnitude of natural disasters over the last decade. But the magnitude of manmade crises is equally serious and according to the World Bank over 1.5 billion people or about one quarter of the world's population currently live in countries affected by violent conflicts.

Emergencies also impose a huge burden on socio economic development. And it is reported that in the year 2011 there was the greatest loss in history reaching about 386 billion as a result of physical damage caused by only natural disasters. And in 2010 alone it is estimated that more than 18 billion dollars were spent on the provision of a humanitarian assistance around the world. So a huge amount of money, imagine the substantial impact of these funds had instead been invested in improving the health system, resilience and these countries and also socio economic development of vulnerable communities. This is the big picture in my own region, WHO Eastern Mediterranean Region which I serve as the regional director. 13 out of the 23 countries in the region are currently experiencing complex humanitarian emergencies which actually affect about 14 million people which is the equivalent of about 8 percent of the population of this region.

The Eastern Mediterranean Region is also where more than 55 percent of world's refugees originate. According

to a new report by UNSER out of 7.6 million people who became refugees in the year 2012 more than 4 million are originated from this region; Afghanistan, Somalia, Iraq, Syria and Sudan. And although this is the highest number reported since the year 1994 this figure is already outdated and obviously the worsening situation in Syria being a major factor in this deterioration and the increasing number of refugees in the region. The damage to health system as you can imagine is enormous.

Access to basic services, public health functions is impeded. And the damage to the health system takes many forms. Health infrastructure itself may be destroyed, medical staff may be killed or displaced and the increase health needs of the effected populations and the reduced supply result in shortages of equipments, medical equipment supplies and essential medicines. Power, fuel and water supplies may also be scarcely available or may be interrupted frequently or completely lost. And the damage can be very sudden. And the good example here is the Pakistan earth quake on the 7th of October 2005. In a few seconds, the population of 4 million people were displaced with almost complete collapse of the health system in the affected areas. And obviously hundred thousands of people were out of reach. On the other hand, the more protracted emergency situations become the more likely populations will suffer from social and societal disruption from infectious diseases, acute malnutrition, trauma. We know Arafat, who will be in the panel and will be talking about response to trauma. And also life threatening complications of chronic diseases, disabilities, and mental health conditions.

Let me now focus on health relief and health care during emergencies. As you know universal health coverage has three dimensions. The first is coverage for all people which actually means extending coverage to those who are not covered. And the second is coverage with all essential services and this means prevention, health promotion, treatment and rehabilitation services. And the third is coverage with financial risk protection and reducing cost sharing so that these services do not expose the use of the financial hardship. And universal health coverage obviously means that all situations are covered including emergencies. The principles of all people and equal access are very much consistent with the humanitarian principles. These principles were universally accepted by countries and they were the basis for the emergency management and the humanitarian reform that was endorsed by the United Nations General Assembly in the year 2005. And these principles you can see here are inter-sectoral action, neutrality, solidarity, equity, social justice, participation, accountability, and reliability and obviously the fundamental right to health for all. This actually means that universal health coverage in its three dimensions is an integral part of humanitarian principles. Now the big emergency is the international community plays an important role and in these situations and based on these principles humanitarian health relief has three basic pillars which are strengthening of health systems, improved financing, and strengthened partnerships as well as coordination through the establishment of what we call is the health cluster which is one of the key elements of the United Nations humanitarian reform and it includes national and international players working together with the government to respond the crisis and also to support their recovery following their crisis and emergencies. These services specifically involve the basic public health interventions like strong surveillance, early warning systems, immunisation, safe water and sanitation as well as access to primary health care which is supported by referral systems to secondary and tertiary facilities.

It is also important to mention that building blocks for a well functioning health system like governance, leadership, effective workforce, information, essential medicines technology, and infrastructure for health care delivery are as crucial to emergency management as they are to universal health coverage. And in international context, the United Nations' health cluster approach assures that these areas including the measurements of performance and accountability are addressed. So clearly, the same principles applied to emergency management as to universal health coverage. And the goal in both cases is to provide a package of essential health services to all those in need and that is free at the point of use.

So my key message is that universal health coverage during emergencies can be achieved if the humanitarian principles are adhered to by national and international sectors and effective emergency is put in place and implemented on the ground. However, sadly, this is not the case. We have major impediments. We usually see in real life and during emergencies were actually impede coverage with basic health services.

There are major gaps and much suffering in lives lost because of these major gaps. So why is this not happening in emergent situations and what are the obstacles to effective management of emergency services? These are some of the key gaps that currently exist in managing emergencies as far as health care and access to health care is concern. First and foremost is the lack of risk and vulnerability assessment and preparedness. Emergencies as you know are the ultimate test of the health systems' resilience, sustainability, and robustness. And it is the ultimate test of national emergency preparedness planning. Second is the lack of security which results in the destruction of infrastructure. We have many examples where security impedes coverage. And again the Syria crisis and the situation in many violent conflicts are examples of how lives are lost and necessarily and

disease prevailing because of lack of access. People may be prevented from reaching treatment by hostilities by insecurities on the roads. Lack of or difficult transport, lack of haulage, fear or a host of other related issues. Health professionals cannot reach the people in need and one example in one government in Syria, 70 percent of the health workers in heavily affected areas reported difficulties in accessing their workplace due to insecurity. And unfortunately we have several sad examples of health care workers being killed or being kidnapped as they report to work. Ambulances have been damaged and stolen and there are many examples in many countries including Syria. And there happen also instances of tracks carrying humanitarian supplies and essential medicines being attacked and hijacked. Insecurity is a major issue impeding access to health a care. The third include other causes of difficult access. Nearby health facilities may collapse, they may become unsuitable and unusable and despite the humanitarian principles that I mentioned earlier the cost of obtaining treatment may actually rise considerably during emergencies. People may have to compete to access available medical services and supplies. And we know about user's fees which have been imposed during some chronic emergencies we know that they will impede access to essential health care services. Closure of government facilities may also force people to report to the private sector and they may become vulnerable to exploitation. And being in remote places with difficult road access as was the case in many natural disasters is another reason for lack of coverage. And fourthly funding. If adequate preparedness and planning have not been put in place a state may have to call on the international community to help during emergency response. And funding mechanisms for immediate international response may be available the longer the emergency goes on the more need there is for sustainable means of funding. And here again users fees which may be applied in normal circumstances impede access to health care and will have to be paid during an acute chronic emergency. Fifthly supply. Lack of medical supplies and mainly essential medicines. And although emergency health kits are normally provided during acute crises and these are readily available and they are immediately shipped to areas where crisis happen. The life saving medicines and supplies for chronic diseases for maternal and child health care and for mental and psycho social disorders are often lacking. And this is one of the key examples that we see in one of the key lessons that we learn when we deal with emergencies. They are often forgotten or they are inaccessible. This gap has been encountered in almost all recent large scale emergencies. And sometimes the international community itself impedes from delivery of badly needed supplies. There are examples and one of the key examples is when sanctions are imposed. Immunization programmes face major difficulties because of interruption of vaccine supplies and life saving treatment of chronic diseases like diabetes of cancer. There are some examples of war infections also in a country preventing entry of commodities or discriminate in who or to where they should be distributed. And finally, the lack of attention to urgent needs of people with non communicable diseases and other chronic conditions; maternal new born and child health, and psycho social disorders.

So ladies and gentlemen let me conclude with some points on the way forward. It is clear that universal health coverage in emergency management in health is based on the same principles. It is also clear that universal health coverage during emergencies can be achieved if the humanitarian principles are adhered to and if they are implemented on the ground. But there are impediments and there are gaps as we saw and these need to be overcome. These impediments require action by both countries and by the international community. Countries will need to be better prepared for emergencies. They need to invest in strengthening resilience of their health systems. And we have a number of countries that have proven that this is very effective. We have also an important consideration for countries to take into account and this is international experience in the lessons learned in crises and emergencies have to be addressed. The impediments that I have mentioned in relation to chronic diseases and in relation to maternal and new born child health, psycho-social services are keen. And in the global level the international community should establish stronger coordination. They should also learn from experiences, particularly in the last 8 to 10 years, since the implementation of the UN humanitarian reforms. And obviously more lives can be saved and much suffering prevented if we learn from these experiences. I want to highlight the fact that Turkey is one of the countries that have the best experience in responding effectively to crisis. And I hope that we will hear some examples from the deputy minister of health in his intervention.

Lastly I want to go back to our region and just briefly outline what the member states of the Eastern Mediterranean Region are doing. The member states have endorsed in the regional committee which is the annual meeting of ministries of health a strategic vision that is aimed at increasing the resilience of countries to emergencies to disasters and also to other crises and subsequently ensuring effective public health response to risks and the threats. And these include offering supports to countries and developing clear policies and legislation in this area based on an all hazard multi-sectoral and whole health approach and paying special attention to the safeguarding of facilities and the health workforce in times of emergencies and crises. Additional readiness

measures are being taken by the regional office which include maintaining regional emergency stock files, training a cadre of response experts, and encouraging the establishment of inter-country mutual support, and solidarity arrangements and agreements in times of crises. so the evidence base for the health emergency and disaster risk management is being strengthened including lessons learned best practices and economic assessment. And obviously the ultimate goal is to provide country and regional self reliance in the area of emergency and crises management and to establish efficient solidarity mechanisms in order to support the achievement forgo which is improved health through universal health coverage. Thank you very much.

Sania Nishtar

Thank you Dr Alwan for your very illuminating framing keynote for the session. I think it was entirely appropriate. And thank you setting out the geographic quantum, the economic magnitude, the scale of the human suffering and the imperatives for the health system's planning that emergencies bring in their wake. And I think there were two take aways from your presentation which I found it illuminating. The first was the fact that emergencies don't have to be a need for you reaction. There has to be an element of preparedness in grained within the body politic of a country system. So you need to look at emergencies very pre-emptively, very systemically and you need to put the necessary preparation in order. And the second take away from your presentation Dr Alwan was that emergencies in the context of health system's planning and universal health coverage just not have to be viewed exclusively from the international health regulations' scope. Where we focus preferentially on emerging and re-emerging infections and public health emergencies which may be accidental or deliberate. But that there is another aspect of public health planning with respect to emergencies that have to do with natural calamities such as floods that have to do with political crises with internal displacements, and your initial slide actually put everything into perspective. So thank you for outlining a very holistic picture of what emergencies in terms of the imperatives that they create for health system's planning. I think this is a perfect frame for the discussion we would like to have with Minister Mukti. Because in Indonesia in 2004 we had tsunami unfortunately claiming 200 thousand lives which was totally and tragically unprecedented. And two years thereafter there was the Merapi Eruption with also significant death. So can you Minister Multi expand further Dr Alwan's presentation and bring some grand lessons to the floor in terms of how Indonesia was able to respond and what kind of lessons does that have for the international community.

Ali Ghufrom Mukti

Thank you very much. Ladies and gentlemen, as you know that 2004 Indonesia had the most devastating natural disasters in the modern world with the biggest number of death victim causing 200 thousand death. Of course in that situation it was not yet well plan. So therefore I think lesson learn we can get it. And as you mention also that after two years we had the Merapi Month Eruption and causing 5000 death also. Therefore how we respond in 2005 an initial government has established what we call it the Disaster Respond National Coordinating Board. This was led by vice president and this role of board is to formulate and determine policies and coordinate the implementation among ministries at central level and provide standard until elections toward the disaster respond efforts. As a member of this Board Minister of Health is responsible for the management of disaster cause health crises at central level assisted by our senior official at Minister of Health and the duties and authorities of the Minister of Health is to formulate policies, provide standard and direction as well as coordinate the crises respond and other health problems before, during as well as after the disaster. The implementation involves related governments as well as non-government community and not only local community, national as well as international communities. Again in our experience international communities and also international agencies from many countries like Japan and Turkey-also Turkey as you know came and built houses in Jakarta. Therefore, again the formulation, policy, and management should be really effective and should be planned in it funds. Therefore both form of offices, the technical offices in form of the health and the communicable diseases control, technical units in the region with the role to facilitate the management of incoming and outgoing health resources assistance by means that harbours, airports and also border areas have been quarantined. So in the operation, there provided an assistant of region Ministry of Health has established 9 centres of health crisis to provide assistance.

We have had this role to accelerate and bring closer the function of health assistance and it is equipped with trained human resources for health and facilities; material, drug, as well as other medical supplies. So we have 9 regions in the province and district disaster response as particularly is an organization which is responsible at the province level and usually it is done by the governor or the mayor. So then we established certain policies. First its disaster caused victims should be as soon as possible, be provided with maximum and humanly health services, and initial intervention during the emergency response period is management of medical emergency toward the injured victims and

identification of death victims at the health facilities, then health services in health facilities during disasters should be optimally done appropriately. Then coordination of implementation of disaster caused health response should be gradually conducted starting from district or municipality level, province and then the central and may be assisted as I mentioned by various parties including from international communities, international agencies, as well as of course countries.

The health assistance from inside as well as outside the country should follow the standards and procedures of the ministry of health and other related ministers. Delivery of information, it is very important, related to the health response and disaster should be issued by local health office as member of the district, disaster respond national coordinating board. Otherwise, if many mass media write you are deficient to give information without single source they will be very confusing. Then conduct regular monitoring and evaluation that should be participated by all parties involved and implementation of health control and a time of informing about respective activities. So in accordance with the response of disaster caused health particularly in the emergence respond period and rehabilitation Indonesia now has we call it technical guidelines for crisis respond on disaster since 2007.

It is expected to strengthen the disaster risk reduction programme in the health sector and disaster emergency management as a whole for these sectors in applying sustainability in reducing the risk by having good preparation and effective response to emergencies and disaster according to the updated standard operating procedures in Indonesian districts. So it will guide health personnel, internal agencies, national and international NGOs, international communities as well as other parties to manage disaster as well as the main activities such as first management crisis respond including organization, management of assistance as well as data management and information on crisis response. Then health services first must address victim health care response, this include the planning and initial action first at referral health care and evaluation of secondary health care both. Then primary health care is requested. This includes surveillance, protection, and control diseases, immunization, infection control, provide clean water and sanitation, emergency management of nutrition, management of mental health, management of reproductive health as well as management of logistic and health supplies. Then identification of death victims in disaster, and it is also not easy for experts together with all experts then monitoring an evaluation.

Lastly, because our approach is health insurance, when we talk about the universal health coverage, calculating the risk means calculating the premium based on the risk. But in the case of disaster, so we may not calculate how much is the premium. So therefore, during the emergency respond period is this responsibility by law, responsibility of the national disaster authority. But then after the emergency response period, if the case is still hospitalized this time it is responsibility of insurance. So we all it is spread like that. In our case, since we have not yet the policy, every victim was under the responsibility of the ministry of health. We call it insurance for the new poor. We use that money to cover all the victim hospitalized. Thank you very much.

Sania Nishtar

Thank you Minister. And it is interesting how you focus again on the handling of an insurance premiums during disasters because even yesterday in one of the afternoon panels when we were talking about the handling of universal health coverage during the time of financial crises. It was handling of the insurance premiums into different interventions within that space that came into very much into spot lights. So it seems that this is the key area from the universal health standpoint that needs to be focused on. Did you Minister Mukti experience any specific problems that you would like to share with the audience?

Ali Ghufrom Mukti

During the emergency response period many assistants and logistics are coming so sometimes we cannot coordinate and organize in well manner. Therefore, some victims may have too many assistance where many others there is no one who give the assistance on that.

Sania Nishtar

Thank you for highlighting that because an emergency's coordination is one of the major problems and I come from Pakistan we experienced in 2005 an earthquake 70 thousand deaths. You know the floods of 2010 and 2011 where geographic areas equal to half of Europe were inundated, the acute massive issues from mobilising support and whereas there is a lot of intent as part of the international community and the indigenous citizens to come and help. But coordination is a major challenge. I would like to ask you Dr Alwan your experience about the 2005 earthquake in Pakistan because you had just stepped in as the ADG of the Emergency Department and the work you put on the ground in that time has actually become a gold standard for mobilising coordination in emergencies. We would really like you to tell a little about that.

Ala Alwan

Thank you. As you said Dr Nishtar coordination is the

key and the coordination is one of the key gaps that we see in emergency response. I mentioned in my presentation the UN humanitarian reforms that were endorsed by the United Nations General Assembly in 2005. I think that was a very important development because one of the key areas of focus in the humanitarian reform process is the importance of strengthening coordination. And one key approach is of course the establishment of the health clusters. Health clusters include of course is led by the government, it includes all players, national, regional and international players. They are led by the government coordinated by WHO, they include UN agencies, non-governmental organizations and also other governments. So the first time that the humanitarian reforms were actually implemented was during the Pakistan earth quake crisis in October 2005. And October 2005 actually witnessed the first time the health cluster approach was implemented was established at the local level in Muzaffarabad and other affected areas, at national level was established in Islamabad, and at the global level it was established in Geneva coordinated by WHO. Since then we had a number of experiences in health cluster while we have not been able to overcome all the difficulties in terms of coordination I think this approach has been extremely useful in strengthening the capacity of the all stakeholders working together in emergency response. So I think it is one of the very positive experiences we have had in the last eight years.

Sania Nishtar

Thank you Dr Alwan. You know it is very inspiring to hear from the architect of that initiative how governance reforms for humanitarian disasters with the Pakistan case led to the institutionalization of that approach which is so successfully adopted. Minister Kafkas, what was your experience in the Turkey earthquakes of 2011 and 1999? Did you see international partners mobilising support through arrangements? What was your overall experience particularly in relation to what the Minister Mukti has just outlined?

Agah Kafkas

Teşekkür ediyorum. Katılımcıları saygıyla selamlıyorum. Hepimizin bildiği gibi insan hayatından daha değerli hiçbir şey yok. İnsanın doğanın gücü karşısında da çaresizliği ortada. Bunun en acımasızını da deprem felaketleriyle yaşıyoruz. Bu bölümde baktığımız zaman Türkiye 1999'da çok acı bir deprem yaşadı Marmara Bölgesi'nde ve adeta biz sistem olarak, devlet olarak sistemin altında kaldık, enkazın altında kaldık. Yeterli müdahaleleri zamanında yapamadık ve büyük acılar yaşadık. Türkiye 2003'te AK Parti iktidarıyla yeni bir döneme başlayıp; demokrasisinde ve ülkesinde bir durum tespiti yapıp yeniden yola çıktığı bir dönemde acil durum ve afet yönetiminde de önemli bir başlangıcı gerçekleştirdi. Ve ülke genelinde afet ve acil durumlara müdahale etmek üzere gönüllü sağlık personelinden oluşan Ulusal Medikal Kurtarma Ekibi'ni kurduk. Kurduğumuz bu yapı dünya üzerinde en kısa sürede en fazla personele sahip olan medikal kurtarma ekibi oldu. Ekiplerimiz deprem başta olmak üzere acil durum ve doğal afetler sonrasında medikal hizmetleri hızlı bir şekilde yerine getirmek üzere eğitildi. Bugün itibariyle yurt içinde ve yurt dışında profesyonel anlamda medikal kurtarma ve müdahale hizmetlerinde görev alabilecek, eğitilmiş 5000 ülke personelimiz var.

2011 Van depremine geldiğimiz zaman depremin olduğu andan itibaren bakanlığımızdaki Acil Afet Koordinasyon Merkezimiz ki bu merkez de dünyadaki bütün afetler anında haber kanalları tarafından izlenmektedir. Deprem uyarı merkezleri ile direk bağlantılıdır ve bütün ekiplerimizin hareketleri normal zamanlarda da hava ambulanslarımız, kara ambulanslarımız, acil müdahale ekiplerimizin hareketleri anında orada takip edilebilecek teknik alt yapıya sahiptir. Van'da deprem olduktan yirmi dakika sonra hasta nakline, üç saat sonra ameliyatlara başlama imkanımız oldu. O dönem hatırlıyorum sayın bakanımız Recep Akdağ Erzurum'da bir toplantıdaydı, üç saat sonra sayın bakanımızın liderliğinde sağlık bakanlığı kurtarma ekipleri gerekli tedbirleri almış durumdaydı.

Depremden önce yaptığımız bir başka çalışma da deprem kuşağındaki hastanelerimizin yenilenmesine öncelik verilmesiydi. Yani Van depreminde başarılı olmamızın sırrı depremden önce orada güçlü bir eğitim araştırma hastanesini, depremden etkilenmeyecek ve deprem izalötürleriyle donatılmış bir hastaneye sahip olmamız bizim için büyük bir avantaj sağladı tabii. Anında seyyar hastanelerimiz kuruldu ve hiçbir talimata gerek kalmaksızın bölgedekiler başta olmak üzere bütün ekiplerimiz otomatik hareket ederek müdahale alanına ulaştılar ve biz adeta burada bir ekiplerimizi test etme imkanını da elde etmiş olduk. Tabii depremden sonra da bu ekiplerde eksik varsa sorun varsa ayrıca tespit ettik. Örneğin bizim müdahale ekiplerimiz sadece müdahale ve insanı kurtarmaya yönelikti ama kendi personelimizin ve ekiplerimizin konaklayacağı, insani ihtiyaçlarını gidereceği bir altyapımız yoktu. Bunun bir eksiklik olduğunu tespit ettik ve bu süreçten sonra yapılanmamızda bu eksikliğimizi giderecek şekilde organizasyonunu yaptık. Acil durum ve afetlerde müdahale kapasitemizi dünyanın değişik ülkelerinde paylaştık ve paylaşmaya da devam ediyoruz. Endonezya'dan Pakistan'a, Afganistan'dan Haiti'ye kadar birçok ülkede yaşanan deprem ve doğal afetlerde yardım çalışmalarından bulunulmuştur. Sudan'da kurduğumuz Sahra Hastanesi bölgede yaşayan kardeşlerimizin sağlık hizmetini sunmaktadır. 2011 yılından itibaren Somali'de

bir mobil hastanemiz, şu anda kalıcı bir hastanemiz de inşaatı bitti açılmak üzere sağlık personeliyle birlikte sağlık hizmeti sunmak üzere orada bulunan kardeşlerimizin yaşadığı sıkıntıları ortadan kaldırmak için elimizden gelen gayreti gösteriyoruz. Hemen yanı başımızda Suriye'de bir insanlık dramı yaşanmaktadır. Yaklaşık 3 milyon Suriyeli vatandaş evlerini ve yurtlarını terk etmek zorunda bırakılmıştır ve bir soykırımla karşı karşıyadır. Bunlardan yaklaşık 1,5 milyonu bölge ülkelerine sığınmış durumdadır. Bunlardan 200 bin tanesi Türkiye'de oluşturduğumuz kamplarda misafir edilmektedir. 150 binin üstünde insanımız da şehirlerde ailelerin yanında misafir edilmektedir. 150 binin üstünde insan da gelip Türkiye'den zaman zaman sağlık yardımı alıp, tedavilerini yaptırıp giriş-çıkış yapmaktadırlar, Suriye'ye geri dönmektedirler. Halen bu kamplarımız, sekiz şehirde on yedi kampta bu hizmetleri veriyoruz. Önce bu kamplardaki çadırlarda hizmeti verdik şimdi oralarda oluşturduğumuz hastanelerimizde acil sağlık hizmeti, poliklinik, diş sağlığı, laboratuar ve görüntüleme hizmetlerini kesintisiz veriyoruz. 1 milyon 200 bin muayene yaptık, 24 bin hastayı hastanelerde tedavi ettik, 15 binin üzerinde Suriyeli'nin ameliyatı gerçekleştirildi, 3664 tane Türkiye'de, bizim kamplarımızda ve hastanelerimizde doğum yaptı. Biz Türkiye olarak Suriye'deki kardeşlerimizin her türlü ihtiyacını karşılamak için samimiyiz. Sınırımızdan geçen insanların ırkına, dinine, mezhebine ve inanç gruplarına, etnik yapılarına hiç bakılmaksızın; muhalif midir ya da başka bir siyasi görüşte midir buna bakılmaksızın, kaç kişi geldiğine bakılmaksızın her gelen kabul edilmiş ve her gelene kucağımız açılmıştır. dünya insanlığının da bu noktada Suriye'de yaşanan bu drama seyirci kalmamasını, oradaki bu insanlık dramına duyarlı olmaları gerektiğinin altını bir kez daha çizmek istiyorum. Suriye'de akan bu gözyaşlarına ve çığlıklara dünya insanlığı kulak vermelidir, duymalıdır bu feryadı diye düşünüyorum.

Her insanın yeterli sağlık hizmetlerine ve sağlığın güvenliğe ulaştırılmasına ihtiyacı vardır. Bu temel ihtiyaç acil durumlarda ve afetlerde de karşılanması gereken en önemli zorunluluktur. Türkiye sahip olduğu ciddi kapasite ve tecrübeyle uluslar arası krizin yönetiminde vazgeçilmez bir ortaktır. Ülkemizin acil durum ve afetlerdeki sağlık hizmetlerinin gelmiş olduğu noktaya ulaşmasında katkısı olan özellikle tüm sağlık çalışanlarımıza şükranlarımı sunmak istiyorum. Dünya Sağlık Örgütü'nün uluslar arası sağlık tüzüğünde belirttiği gibi ülkeler acil durum ve afetlerdeki yönetimleri için kapasitelerini geliştirmek zorundadırlar. Bu bilgi birikimi ve tecrübemizden insanlığa hizmet sunmak adına faydalanmak isteyen ülkelere kapımız sonuna kadar açık olduğunu belirtir her türlü işbirliğine hazır olduğumuzu ifade eder sizleri saygıyla selamlarım.

Sania Nishtar

Thank you Minister. That was a very inspiring story to hear that Turkey was actually able to learn from the 1999 disaster that it built its capacity incrementally but surely that it used that experience to show its ability not only to help itself during the time of subsequent crises in 2011 and thereafter but also reach the countries in need. The example of Indonesia is illustrative, I can vouched that Pakistan was helped on many occasions, and you yourself is well told how you reached Syria. I know that very officials from Ministries of Health are here. Would anybody like to share an experience with us or something that needs to be shared with the floor at this point?

Asad Ramlawi

Thank you. I want to give some of our experience in Palestine. During the First and Second Intifada there was hundreds and hundreds of days of closures. Here I am going to speak about some natural disasters, emergency and routine health services delivery. And it was difficult really to health access for hospitals. It was difficult even for the normal delivery to reach hospitals. And the rates of mortality in newborns and mothers increased. And we trained at that time on how to deal with emergency. We trained our nurses, midwives, and the medical personnel and we brought them with kids for emergency delivery and we succeeded to control the new born mortality and the mother mortality. Another important issue is chronic diseases. Patient suffering of chronic diseases need usually rare medication. When there is no access there is no drugs there is increased of complications and morbidity and mortality. And at that time we succeeded also to provide them supplies of drugs for at least 3 months. This was increase of the burden of Ministry of Health but we succeeded to control the morbidity and mortality. During the emergency you have sometimes something that you are not thinking about like dog bites, snake bites, scorpion sting that are available only in the hospitals. And in our region usually we see these problems frequently and we succeeded to find certain satellites here and there to provide these centres with certain snake vaccine or anti-scorpion or even with what is needed to have an immediate emergency. Also we trained our people, our staff to have how to deal with emergency. We trained nurses, midwives, doctors and health staff, not only doctors because in the remote area health access availability is not easy. You have to deal with anyone dealing with health. And unfortunately this you have to prepare yourself before not during the emergency because not easy. And one was speaking about coordination that was mentioned by his Excellency Dr Alwan that cooperation is one of the significant point but also the weak point. And coordination we coordinate with all staff in our clinics in all regions and all places.

There was not only the governmental stuff even for private or NGOs to have a free access for everyone to deal or work in our clinics. These things really were very important to decrease the morbidity of the emergency. Another important point that we succeeded to do at that time was the vaccination coverage. Vaccination coverage was not affected because during even that closure we succeeded to provide vaccine. But as was mentioned by Excellency Dr Alwan the electricity was cut, no electricity and the fortune was not easy to be controlled. After the closure we did a small survey to see the immune response and unfortunately immune response was 58 percent that vaccination coverage was 100 percent but the immune response was 58 percent and with the huge combine to vaccinate all people to involve during delivery.

These are examples to be taken into consideration as an indirect effect of coverage. Thank you very much.

Sania Nishtar

Thank you Dr Ramlawi who is the Director General of Health in Palestine. I think that emergencies and disasters is such an area where each one of us has a lot of stories to share. We really want to open up our attention to the problems in unique situations and the lessons that they exist with respect to sharing of experiences. I would like to thank to organizers for putting this on the programme because all of us have lots of things to share with each other and I am sure that offline all you will continue to do that. Dr Ramlawi's intervention also brings us to another aspect of managing emergencies with respect to universal health care because there are these unforeseen geographic events and we had examples from Indonesia and from Turkey and they create their own imperatives. But there is an aspect of day to day management with respect to emergency care and the imperatives are slightly more emergent should I speak when there are smouldering issues when there is a situation of conflict, when they are deteriorating law and order situations emergency institutional arrangements of universal health care have to adopt to those situations, special circumstances have to come into play. And I would really like to go to the Secretary Arafat from Romania with a very specific question of the need for deliberating which is been raised by Dr Ramlawi. How do you tackle with these things in Romania very specifically?

Raed Arafat

Thank you very much. I think that disaster response and major emergencies response is very well linked to daily emergency response in any country. I don't believe that a country can have very good disaster response but has a lousy emergency response system everyday. If you don't have a well structured emergency system for a day to day work you will not have a good response when you have a disaster. You need a very well trained system for everyday work in order to be able to respond to major incident to mass casualty incidents as well as to earthquakes.

What we did in Romania is first of all as a system we created a fully integrated system where the Ministry of Health cooperated directly with the Ministry of Interior but also with other ministries like Ministry of Defence and other organizations to offer a fully integrated emergency care system. 20 years ago we started a model and this model in 2007 we started spreading it. The model goes from access into the system through a single number to all country going towards disaster preparedness and how we managed a mass casualty incident and so on. But there are several issues we think that are very important when we talk about universal coverage. In Romania when we wrote the law on emergency care in 2006, we wrote a phrase which says "emergency care is a right for each citizen and it is the duty of the state". So from the beginning we said that emergency care is a right. And it is not a right only when there is a disaster. It is a right in every days of life. Why did we write this? And why did we do this?

We look at how health systems are evolving. And we see that more and more we are talking about who is going to pay this, who is going to pay that, who is going to take money out of their pockets, how are we going to ensure this... If you are going to ensure people, insurance does not pay for those without insurance. So who is going to pay for them? If we look at our whole health system it is all based on those who are paying and who paid. But when it comes to an emergency can we put such a condition when they come to the emergency department or when they dial 112 and call for help? Can we tell them "are you insured" "no" "sorry we are not coming" and hang off your phone? You cannot! Can you throw them away from hospital and tell them I am not going to see you in the emergency department? You cannot! Though there are some people that suggest this and when we looked at his in Romania and how we are funding emergency care we took the decision to fund in emergency care at least at the level of pre-hospital emergency care and emergency departments fully from the state budget and to cover everyone. So we don't ask anyone "are you insured or not", "do you have money to pay for this or not". So whatever is the case which is coming into the emergency sector that we will be dealt with if it is an emergency of course if it is an acute issue that we decide it is not threat for that patient and the state budget is covering for this issue.

Then we started looking at what is happening in the country. And we looked at very high mortalities in certain sectors and I am going to use the sector which is not included in disasters maybe but it is a big issue for

us which is hearted myocardial infections. Romania had the highest mortality in the EU, 13.7 percent two and a half years ago. We started looking why is this happening. And we saw that the insurance when they are dispersing the hospitals they are paying them much less than the real cost to treat a myocardial infection. So hospitals were not treating many times. They were not even giving thrombolysis they were not taking patients to cath lab unless they have money to pay for the stand or for the cost of the materials. So we started a programme two and a half years ago. And we said the state budget will cover for all the materials for cath labs and for thrombolysis and we will start following up what is happening with myocardial infections. In two years and a half from less than 15 percent of patients getting to cath labs and getting stands for primary care or getting thrombolysis may be they were about 30 percent. Now we have over 55 percent of myocardial infections getting to cath labs and we dropped the mortality from 13.7 to 8.4 percent in two and a half years. That is about 50 percent. So is this a good thing to do? Economically if we are talking to accountant they will say you it is a huge cost. But we are talking to an economist they will tell you that this is a very good investment because in fact we are preventing further complications for these diseases and we are reducing long term costs for patients have myocardial and are not being properly treated or those who are dying early. So this is one issue.

When we go to another issue we had economical crises and we started having the IMF visiting us and slowly they started looking at the emergency departments and they were saying "your system has whole in it, the emergency department because everything is 'controlled'. Primary care physicians are controlled. You have to co-pay them or you have to do something. Ambulatory care is controlled. Your emergency system is open you have to put co-payment is your emergency system." And this was over one year fight with the IMF to say no. And we said no and we succeeded not to allow them to push on this to the politicians, to the political sides, to the ministers and so on. But why is it not good to put co-payment on emergency care? And why universal system should be unconditioned to emergency care? Because if we look at our systems in Romania our primary care system is failing. Primary care physicians don't want to care for their patients at any time. They want to care in a programme between eight o clock in the morning or even nine o clock in the morning to afternoon. They call themselves family practitioners they take care only that member of the family who comes to visit them. They don't follow up what is happening in the family for example. But they work only eight hours a day they don't care what we say to them they are private, they are liberal so we cannot impose a lot of things on them. They don't go into house visits, they don't work on weekends, they don't work during vacations, and they don't receive uninsured patients unless it is a special category, children and so on. So the problem is if we are looking at that type of care and we impose another access limit to the emergency department we will have a lot of vulnerable people that are not getting any kind of care at any moment. Or they will be getting it very hard. So if we look at the population coming to emergency rooms we will see that those who are major emergencies, critical emergencies are from all categories of the society; rich, poor, medium class and so on. But if we look at to those who are coming for less urgent issues but acute issues we will see that they are the vulnerable people and the poor people that are coming. Still when we are seeing them we proved to the IMF when discussed that maybe about 20 percent of them are being admitted which means that they decided they are in emergency they came to hospital and they were emergency. So what I want to say here is when we had discussions we were told OK. We will put the co-payment. I am insisting on this because I know that they imposed it on some countries and it is going on in some countries. But what they told us they said "OK when people come to the emergency department if they are in emergency you don't take money from them. But if they are proved to be abusing the emergency department then you put them to pay". So our question was what do you mean by abusing the emergency department. They said well if they are coming when they should not. We said OK but they are not doctors to know if they should or should not coming. They feel they have an acute issue, they have headache or I don't know what which may be something serious. And this is the only place in the whole health system which is open 24 hours for them to come and seek help. So why do you want us to punish them? They are not doctors, they didn't study medicine to know what they have is really an emergency or not. It is my duty as a doctor to see if it is an emergency or not and then to say OK this is not urgent you can go home and see your doctor tomorrow and so on.

So I know that in one of the countries they imposed this and what happened is the following. Children were considered to be emergencies if they have more than three dysenteric stools. So they imposed this and they said OK if the child has three or more, it is an emergency they don't pay; if it is less the family have to pay one pound or one dinar or one something. And my colleagues from that country told me that within two months all children had four and up so they were lying. So people adapt to this. If you are putting conditions on access to care what you risk is that people will not discover what really cover emergency. They know that kistrin is an emergency 80 percent of your patients will coming in initially tell you I have kistrin so that they don't pay. It is a very hard issue

it is a very important issue to look at on daily work and in case of disasters and so on. I think that we need to look at emergency care from the fact that it is most of the times the only door where people can access to health care in a certain moment without delay and it is also the gates keeping where you can tell them OK it is not emergency you can go now and go through the normal system and so on.

The final issue, they told me that it costs too much in the emergency department. So we did some calculations. They said you have to move patients to the primary care because they cost too much in the emergency department. We see in Romania 3 million 500 thousand cases in our emergency departments per year. The population of Romania is 20 million and out of the 3 million 500 thousand there are about 20 percent to 25 percent admissions per year. So they told us 30 percent of your patients should not be coming there. And we said OK, we don't take money per patient in the emergency departments it is budgeted for materials, for salaries, for equipments, for investigations but we don't pay tax for patient. So if we take 30 percent we take out it 100 thousand patients. Where do you want us to send them? To the GP. The GP taxes you per patient. So each patient they see they want a certain amount of money. And most of the time when they see they need extreme ultrasound or something they still send them to the emergency department or to the ambulatory care. But you pay the second type. Seeing that number of patients in the emergency department if we take them out we will not lessen the budget of the emergency department because we are not spending too much money on the simple cases. We are spending too much money on the difficult cases and those which cost. But if we take them and divert them towards the primary care we kick them out of the emergency department. We will risk not discovering the real emergencies in some of these cases given the fact that maybe 15 percent of them get admitted. And the second thing is that we are going to pay more money in the health sector but I don't know if it is for better quality or for better thing except that saying that OK we are taking them to primary care.

So I think that emergency care is really part of it can be even be considered part up to a certain level of public health and primary care. It is not the specialized care as some people may be induced to say. The other issue is that the emergency care is not universal and does not have universal access you may find that you are losing people you are losing cases when you can really treat them in time and save them in time. So I think again at the end that it is still a right. This is the only thing we can offer to our population is the right to be seen when they consider they have an emergency. Thank you very much.

Sania Nishtar

Thank you Secretary Arafat for this very important dimension and for bringing it on to the table because whenever we talk about universal health coverage it is about a set of different financing instruments of which insurance is the most salient when we talk about coverage and entitlements with a set of inclusions and exclusions and gaps and so forth. And within that entire discussion the imperatives were financing day to the emergency is and of course mass casualties is usually lost. So I think it is extremely commendable that you were able to protect your state budgets for emergency care as part of IMF negotiations which goes to show that countries really need to know what their own policy frameworks have to be and the need to negotiate their own terms of engagement with international multilateral frameworks. So my commendations to your government for having secured death for your people because funding emergencies in health care system as part of universal health coverage is an ethical issue. It is an issue of right. So I think what you are able to achieve, your country was really remarkable. I mean I would like to go to you Minister Ibrahim now because Egypt has been very much in the eye of the storm particularly with reference to mass political convenings. Tahrir Square, Arab Spring is in point. What kind of discussions happen around the cabinet with reference to preparedness, setting aside budgets, potential emergencies for mass casualties... Is this something that resonates policy makers? What kind of measures have you been able to put in place? What are the lessons learned? I am sure the audience would love to hear from you.

İbrahim Mustafa

Yes, good morning. In Egypt it is obligatory to receive emergency for the people in the emergency room. Whether it is NGO or private or public. And then the country had to imburse the money to these places. Before revolution we had 25 thousand injured cases, most of them are car accidents. And within these people we had 7 thousand deaths. This means that we have about 28 percent deaths from the emergency which is a high rate. Egypt, after revolution, I mean now, Tahrir square we have lost 2700 deaths in ten days. And we had 20 thousand Egypt person. I mean emergency and the ambulance in Egypt is very alarming now. We are paying about 2 billion pound for these emergency cases and some of them need more further treatment. We have I mean some lessons, we have learned a lot in this period. One of the lessons that we have to take care not to refer all the people. We have to build up a frontline evacuation centre, we have to know about gases, bolides, and types of it and molotovs or other types because for example the gases used by the police causes irritation in the eyes. And it, we used I mean to refer these cases to the hospitals

which is troublesome. But we discovered that only any alkaline solution will resolve the problem.

So I mean, after that we try them to understand what are the bolides, gases are used and how we can deal and differentiate. Some of it are not very harmful and some of it are very dangerous. So we have also to understand that not to use them in police or army emergency tools over people because people don't like to deal with them. And also we have to cooperate with NGOs and volunteers. It is important to cooperate also was relief agencies. We have to bring with us and this is very important, psychiatrist doctors because many people are in panic. They don't have a true disease but they are in panic. So you don't have in this evacuation centre the time to talk to people and to come them. You have all these I mean to use doctors and staff of soft impersonality with very calm persons because people are very tense and very tough and very nervous.

Also you have to be aware of the media and politician because they will not help you. In the contrary, they will cause you very big problems. And important also is you have to make a big treat to mobilize doctors and team or to transport victims. This is important to manage. When you are doing a good job it is a big harmony. It is a big success story. So emergency is a big test for any universal health coverage. It is a big test if you want to make single test this is emergency. If you can deal with GIS, GPS, HIS for the hospitals with the call centre referral system and health team and supply team in harmony you have done a big success story. Thank you.

Sania Nishtar

Thank you Minister Ibrahim. I think it is a wonderful note to end on that the emergencies are actually are litmus test of the government's resolve of the capability within the system of the robustness of supply chain and of the ability of the staff at any given point to manage different actors within the system and I think Minister Ibrahim very rightly alluded to different actors to which usually we do not accord our attention for instance the media, the opinion shapers, the civil society and so on and so forth.

This has been an amazing discussion and I wish we had more time to engage the audience but we are not getting into borrowed time from the coffee break since we started 15 minutes late I will extend the session to another five minutes. Any 30 second quick reactions from the floor?

Mamouth Nahor N'Gawara (Translated from French)

I am the Minister of Health of the Republic of Chad and I want to share the experience of Chad in the issue of universal social with the ministers present here. Firstly I want express my thanks to Turkish health minister for organizing such a conference. Moreover, benefiting and getting inspired from the experiences of Turkey and Esteemed Ministers in this field is a very important opportunity for us and so we are very happy.

Chad tried to enforce the universal social insurance beginning from 2007. The situation of Chad is highly complex, for example the treatments are free of charge, it is a very large country settled on 1.284.000.000 m2 in total but it has a population just equal to 12 million. I leave the dispersed population density to your discretion. Rural population is 75% and priest and migrant population is 5% and more than half of this priest and migrant population is an immigrant community among the neighbour countries such as Sudan, Republic of Central Africa, Cameroon, Nigeria, Niger. In this context, implementation of such a policy is so complicated.

The experience of Chad in this subject started with stage one in 2007, we identified 3 target populations to make targeted therapies free of charge first of which was pregnant women, defenceless children and elderly people between 0-5 age, all treatments, especially emergency treatments are free of charge for them. In addition to this, we also identified some endemic diseases, treatment of which is also provided free of charge such as tuberculosis, AIDS, lepra and all endemic nature tropical diseases.

Chad invested 18-19 million dollars for free of charge treatments between 2008 and 2012. For example, 7.6 million dollars were spent to cover the cost of free treatments in 2013. We created a roadmap to specify the characteristics of this country, by this way we will be able to access to the specified target gradually without making a generalization. Namely, our country is composed of desert, savannah and forestry areas, for this reason we must ensure social security in every area based on the concentration of population dispersion. In addition to this, protective and free of charge treatments such as vaccine must be provided for all segments of the society.

I do not want to enter into details, I just want to state that this initiative entered into force in our country and I believe that we can further strengthen this initiative by being inspired by the experiences of other countries.

Thank you.

Sania Nishtar

This pretty much brings us to the end of the session. And I think this has been an extremely useful session because we have had an informal discussion about the various forms and shapes of emergencies and the imperatives that they create for the universal health coverage's initiatives in health systems. So there is what is relatively well known in the space of emergencies and those are diseases those are incidents that come from the framework of the international health regulations for

which global norms are relatively well established. And we put them to one side. But other than those there are aspects related to day to day emergency management which need to be taken into consideration as part of planning for universal health care initiatives. And I think the comments from Romania and some of the comments from the colleague from Palestine were extremely illustrative and in terms of the imperatives that need to be taken into consideration and some of the policy handles that are out there to address relevant situations. Then at the third level I refer back to Dr Alwan's first slide; there are the catastrophic events. Some of the catastrophic events do cause mass casualties such as earthquakes such as pandemics but there are other catastrophic events that may not cause mass casualties but they do in fact rack health systems. For example when floods happen emergency matters come into play and people are evacuated and the casualties are minimised. But then on the other hand there is no stopping of the inundation of health facilities and disruption of supply chains and the racking of the health system which create the need to intervene in terms of health system's building.

So there are these different aspects that need to be taken into consideration. And from the discussions that we have had at this penal there are clearly different interventions in each of the health system's domain that need into come to play in appropriate time. Perhaps we didn't talk much about some of the innovative financing instruments for which there is also space. So in the time of disasters new partnership funds can be created that swaps can come into place so the bad debts of country can be swapped for money is that come from the view of support for emergencies, solidarity levies can be imposed. That is a huge part of discussion in that space where innovative financing policy interventions come during the time of emergencies. One of us around the penal and I think it was his Excellency the minister from Turkey who highlighted the importance of volunteers. And I think back from our experience in South Asia as well in large populations where disasters happen volunteers really come out to the floor. And volunteers provided services. But if the country does not have frameworks to harness their potential then you lose that opportunity. So innovations in the space of financing, out of box thinking where harnessing the potential of human resource is concerned, creating the enabling governance frameworks, a snapshot which was provided by Dr Alwan measures to secure the supply chain. And the coordination mechanisms are all the salient hallmarks which have to be facted into preparedness and if they are not facted into preparedness then they will not come into play at the time of need.

And I think that I would really like in closing to come back to the experience of Turkey in having learned from their 1999 earthquake and I would like to end by congratulating you for the manner in which you come to the help for help of countries around the world at the time of the crises based on the capacity that has been developed. And I think with that I would like to thank you all for being with us and I would like to thank you all for being part of this conversations. Please join us for the coffee break.

Universal health coverage in Turkey: enhancement of equity

Rifat Atun, Sabahattin Aydın, Sarbani Chakraborty, Safir Sümer, Meltem Aran, Ipek Gürol, Serpil Nazlıoğlu, Şenay Özgülcü, Ülger Aydoğan, Banu Ayar, Uğur Dilmen, Recep Akdağ

Turkey has successfully introduced health system changes and provided its citizens with the right to health to achieve universal health coverage, which helped to address inequities in financing, health service access, and health outcomes. We trace the trajectory of health system reforms in Turkey, with a particular emphasis on 2003–13, which coincides with the Health Transformation Program (HTP). The HTP rapidly expanded health insurance coverage and access to health-care services for all citizens, especially the poorest population groups, to achieve universal health coverage. We analyse the contextual drivers that shaped the transformations in the health system, explore the design and implementation of the HTP, identify the factors that enabled its success, and investigate its effects. Our findings suggest that the HTP was instrumental in achieving universal health coverage to enhance equity substantially, and led to quantifiable and beneficial effects on all health system goals, with an improved level and distribution of health, greater fairness in financing with better financial protection, and notably increased user satisfaction. After the HTP, five health insurance schemes were consolidated to create a unified General Health Insurance scheme with harmonised and expanded benefits. Insurance coverage for the poorest population groups in Turkey increased from 2·4 million people in 2003, to 10·2 million in 2011. Health service access increased across the country—in particular, access and use of key maternal and child health services improved to help to greatly reduce the maternal mortality ratio, and under-5, infant, and neonatal mortality, especially in socioeconomically disadvantaged groups. Several factors helped to achieve universal health coverage and improve outcomes. These factors include economic growth, political stability, a comprehensive transformation strategy led by a transformation team, rapid policy translation, flexible implementation with continuous learning, and simultaneous improvements in the health system, on both the demand side (increased health insurance coverage, expanded benefits, and reduced cost-sharing) and the supply side (expansion of infrastructure, health human resources, and health services).

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Imperial College London, London, UK (Prof R Atun FRCP); **Harvard University, Harvard School of Public Health, Boston, MA, USA** (R Atun); **Medipol University, Istanbul, Turkey** (Prof S Aydın MD, S Chakraborty PhD, S Sümer MSc); **Development Analytics, Istanbul, Turkey** (M Aran PhD); **London School of Hygiene and Tropical Medicine, London, UK** (I Gürol PhD); **General Directorate of Health Research, The Republic of Turkey Ministry of Health, Ankara, Turkey** (S Nazlıoğlu MPhil, S Özgülcü MD, U Aydoğan MSc, B Ayar MD, U Dilmen MD); **and The Grand Assembly of the Republic of Turkey, Ankara, Turkey** (Prof R Akdağ MD)

Introduction

Universal health coverage (UHC) is an important way to expand access to effective health-care services, reduce financial hardship during illness, and improve health outcomes.[1] In addition to appropriate legal provisions, which mandate access to necessary health services,[2] UHC needs to be underpinned by a well-functioning health system that provides high quality, affordable, accessible, and efficient health services.

Recent experience from middle-income countries, including China,[3] Mexico,[4] and Thailand,[5,6] shows that expanded pre-pooled financing mechanisms, such as health insurance or social insurance, help to improve access to health-care services, while providing financial protection. Cross-country analyses suggest that, in general, broader health coverage and pooled financing lead to expanded access to necessary care, with improvements in population health, particularly for poor people.[7]

Additionally, many other middle-income countries, such as Brazil, Indonesia, the Philippines, Turkey, and South Africa, have sought to address inequalities in access to health care and in health outcomes through UHC by introducing pre-pooled health insurance schemes and health system-strengthening programmes. 22 low-income and middle-income countries are actively pursuing policies to achieve UHC.[1] Hence, experience from different settings is crucially important to address the evidence gap[7] on introduction of UHC and its effects on health service access, financial risk protection, health outcomes, and user satisfaction. Evidence from Turkey is especially timely for countries pursuing reforms to achieve UHC because, after 30 years of slow progress, since 2003 Turkey has been able to design and implement wide-ranging health system reforms[8] to achieve UHC that substantially reduced inequities in health financing, health service access, and outcomes.

Key messages

- The Health Transformation Program in Turkey has introduced major changes to health system functions of stewardship and organisation, financing, resource management, and service delivery to achieve universal health coverage (UHC).
- UHC led to rapid expansion of health insurance coverage and access to health-care services for all citizens, especially for the poorest population groups. In particular, access and use of key maternal and child health services improved to help substantially reduce under-5, infant, and neonatal mortality, especially for socioeconomically disadvantaged households.
- Turkey shows the effectiveness of UHC as a platform to achieve health system goals and improve equity, with an enhanced level and distribution of health, fairness in financing with reduced catastrophic health expenditures, and substantially improved population satisfaction with the health system.
- Simultaneous improvements in the health system, on both the demand side (increased health insurance coverage, expanded benefits, and reduced cost sharing) and the supply side (expansion of infrastructure, health human resources, and health services), were crucial to accomplish improvements in use and outcomes.
- Economic growth provided the fiscal space for increased health expenditures to achieve UHC. Political stability, sustained leadership, a committed transformation team, positioning of health as a fundamental right, creation of a receptive context, a comprehensive transformation strategy, rapid policy translation, a flexible implementation approach with ongoing learning, and the combination of demand-side and supply-side changes were crucial factors that enabled the introduction of UHC.

Correspondence to:
Prof Rifat Atun, Imperial College Business School and Faculty of Medicine, Imperial College London, London SW7 2AZ, UK
r.atun@imperial.ac.uk

See Online for appendix

We traced the trajectory of changes in Turkey in the journey towards UHC. We used a proprietary analytic framework (figure 1 and appendix p 1) that draws on previous studies[9,10] to provide a systems view[11–13] of the contextual drivers of changes in the Turkish health system, transformations introduced in health system functions, and their effects on health system goals. We used qualitative and quantitative research methods, including documentary and policy analysis, and interviews with key stakeholders (appendix pp 2–13) to analyse transformations in key health system functions aimed at addressing inefficiencies and inequities in the Turkish health system and at achieving UHC. In particular, we analysed the transformations in governance and organisation, financing, resource management, and service delivery functions from 2003 onwards—the period coinciding with the Health Transformation Program (HTP) that rapidly intensified efforts towards UHC.

We used quantitative analysis, including econometric methods (appendix pp 2–13), to explore how the HTP and UHC helped to address three major health system problems in Turkey: inadequate and inequitable health financing with a fragmented health insurance system, low insurance coverage for the poorest populations, and high out-of-pocket expenditures; inequitable distribution of health infrastructure and human resources that led to inequalities in health service access; and inequities in health outcomes, with east–west, poor–rich, and rural–urban divides. We used maternal and child health services (antenatal care by trained staff, births in a facility, births attended by trained staff, and immunisation uptake) and health outcomes for children (under-5 mortality, infant mortality, and neonatal mortality) as tracers for health system performance because these areas were a priority for the HTP and for which reliable cross-sectional population data over time are available. We could not study changes in chronic illnesses, despite their importance, since reliable cross-sectional or trend data are scarce.

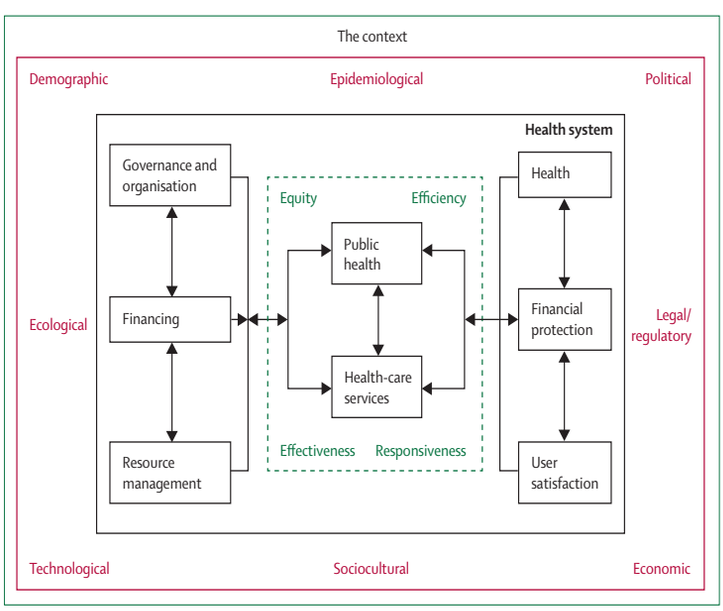

Figure 1: Framework for analysis

This report is organised into six sections. After this introduction, we provide a historical overview of key health system changes in Turkey and an analysis of the context preceding the HTP. In the third section, we explore the design and implementation of the HTP. In the fourth section, we present key findings for the achievements of the HTP in relation to health system organisation and governance, health financing (health insurance coverage and targeting poorer segments of the population, out-of-pocket expenditures, and financial protection), human resource management, and service delivery. In the fifth section, we present an analysis of the equity effects of the HTP and UHC on health service use and health outcomes, including an assessment of user satisfaction with the health system. Finally, we summarise the key findings and achievements of the HTP, placing them within the broader UHC literature, and discuss the sustainability of UHC in Turkey, identifying the key risks, challenges, and opportunities that lie ahead. We discuss the lessons learned from the UHC experience and explore how Turkey could be positioned in global health as we approach the 100th anniversary of the Turkish Republic in 2023.

Turkey: analysis of the context

Turkey: key facts

The Republic of Turkey was created in 1923, after the end of the Ottoman Empire, the roots of which date back to 1299. At its largest, the Ottoman Empire covered parts of Europe, Asia, the Middle East, and Africa. Turkey is now an upper-middle-income country of 75·6 million people in 81 provinces, at different stages of socioeconomic development (figure 2), and straddles Asia and Europe. Turkey has undergone rapid economic growth in the last decade, and has the demographic benefit of a young and growing population, although socioeconomic differences exist within the country (appendix p 14).

Despite economic and political challenges in the 1980s and 1990s, population health indicators in Turkey continued on a positive trajectory through the 1990s. The average life expectancy at birth in Turkey increased by 15·4%, from 65 years in 1990, to 75 years in 2009, which is higher than the percentage increase achieved in other emerging economies with a similar level of socio-economic development (E7 countries): India (+12·1%, from 58 to 65 years), Brazil (+9·0%, from 67 to 73 years), China (+8·8%, from 68 to 74 years), Mexico (+7·0%, from 71 to 76 years), Indonesia (+4·6%, from 65 to 68 years), and Russia (–1·4%, from 69 to 68 years; figure 3).[14] In recent studies of the Global Burden of

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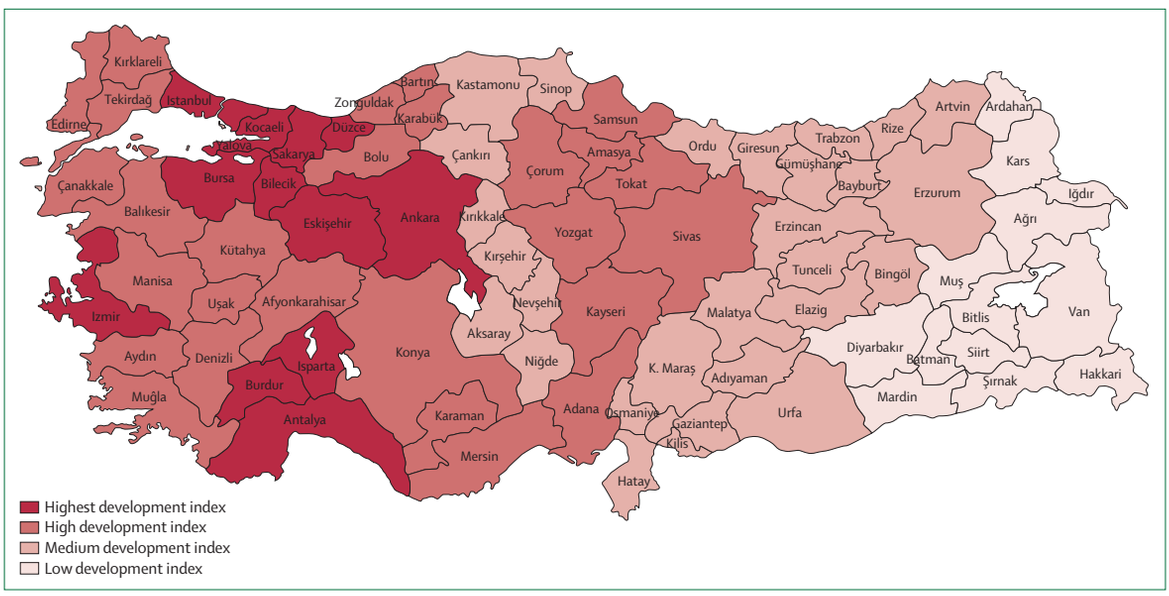

Figure 2: **Provinces in Turkey grouped according to socioeconomic development index**
The socioeconomic development index uses ingredients analysis to develop a composite index by bringing together population-based representative survey data from 2009 and 2010 on 61 parameters grouped into eight categories, namely: demographic (five parameters); education (six); health (five); employment (eight); competitiveness and innovation capacity (15); fiscal capacity (seven); access (six); and life satisfaction (nine). Provinces are ranked into four categories according to the socioeconomic development index score: highest, high, medium, and low development index. Data are from The Republic of Turkey, Ministry of Development, Directorate General of Regional Development and Structural Adjustment; Monitoring, Evaluation, and Analysis Department, Level 2 zones, socioeconomic development ranking, May 1, 2013.

Disease 2010, estimated life expectancy (healthy life expectancy) in Turkey increased from 63·7 years (55·3 years) for men and 70·9 years (60·1 years) for women in 1990, to 71·2 years (61·8 years) for men and 77·7 years (66·0 years) for women in 2010.[15]

According to interagency estimates from WHO, the World Bank, the United Nations Children's Fund, and the United Nations Population Fund,[16] the maternal mortality rate in Turkey decreased from 67·0 per 100 000 livebirths in 1990, to 51·0 in 1995, 39·0 in 2000, 28·0 in 2005, and 20·0 in 2010. These values are broadly similar to those from the Turkish Ministry of Health,[17] which estimates a decrease in maternal mortality from 61·0 per 100 000 livebirths in 2003 to 15·5 per 100 000 livebirths in 2011. Figure 4 shows that the percentage decrease in maternal mortality in Turkey between 1990 and 2010 was greater than that reported in other E7 countries in the same period, including China (69·2%, from 120 to 37), India (66·7%, from 600 to 200), Indonesia (63·3%, from 600 to 220), Russia (54·1%, from 74 to 34), Brazil (53·3%, from 120 to 56), and Mexico (45·7%, from 92 to 50).[16]

In 1990, immunisation coverage for the combined diphtheria, tetanus, and pertussis vaccine; oral polio vaccine; and measles vaccine was 74%, 74%, and 67%, respectively, and decreased in 1995 to 66%, 65%, and 67%, respectively. Coverage increased in 2000 to 85%, 85%, and 86% respectively, and again in 2005 to 90%, 90%, and 91%, respectively. By 2010, coverage had reached 97% for all three vaccines.[18]

According to the United Nations Children's Fund, under-5 mortality in Turkey fell sharply from 72 per 1000 livebirths in 1990, to 15 in 2011, and infant mortality fell from 60 per 1000 livebirths in 1990, to 12 in 2011.[19] The reductions in under-5 and infant mortality achieved by Turkey in 1990–2010 were greater than those achieved

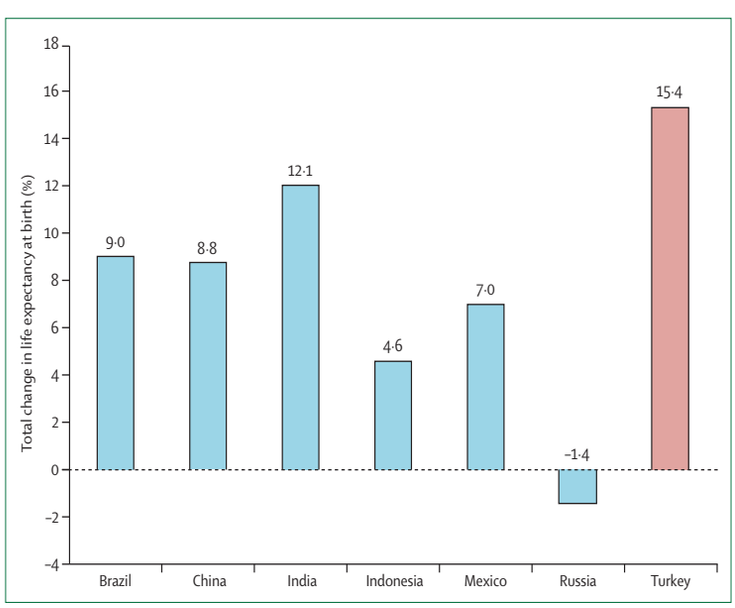

Figure 3: **Percentage change in life expectancy at birth (years) in Brazil, China, India, Indonesia, Mexico, Russia, and Turkey, 1990–2009**
Data are from reference 14.

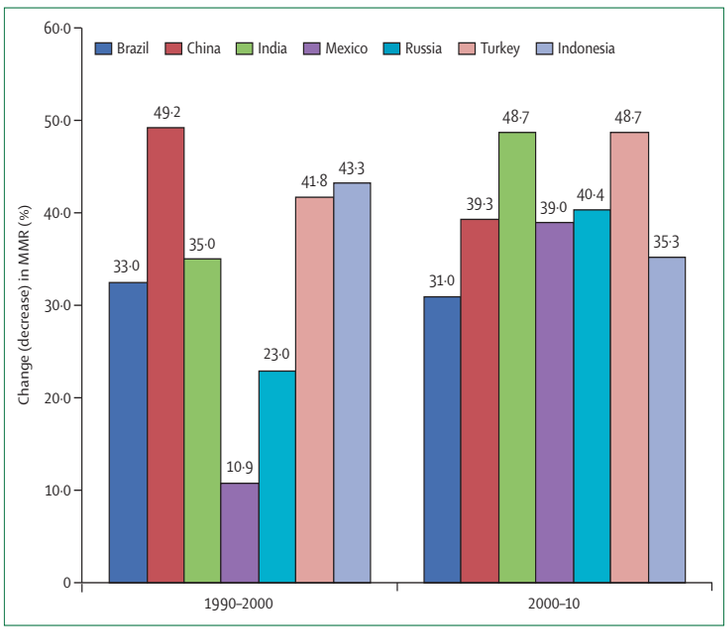

Figure 4: **Percentage change in maternal mortality ratio in E7 countries, 1990–2010**
MMR=maternal mortality ratio. Data are from reference 16.

by other E7 countries (figure 5).[20] Interagency estimates of infant mortality are broadly similar to the Turkish Ministry of Health data (with the exception of the most recent estimates), which suggest that infant mortality in Turkey fell from 29·0 per 1000 livebirths in 2003, to 7·7 per 1000 livebirths in 2011.[18]

Between 1990 and 2010, the burden of disease in Turkey from all causes decreased steadily from around 40 000 disability-adjusted life-years per 100 000 population in 1990, to 36 000 in 1995, 30 000 in 2000, 28 000 in 2005, and 27 000 in 2010. The burden of communicable, maternal, neonatal, and nutritional disorders decreased rapidly from about 15 000 disability-adjusted life-years per 100 000 population in 1990 to roughly 4000 in 2010. The reduction for non-communicable diseases was more modest, with a fall from around 22 000 disability-adjusted life-years per 100 000 in 1990, to 20 000 in 2010.[21]

Historical overview of key changes in the Turkish health system

In Turkey, the journey towards UHC began in 1945 with the establishment of the Social Insurance Organisation for blue collar workers, followed in 1949 by the creation of the General Employees Retirement Fund for retired civil servants and their dependants. From 1946 onwards, the Ministry of Health and Social Affairs adopted an active role in the provision of preventive and curative health services, and in 1954 undertook administrative responsibility for hospitals and primary health-care centres (panel 1).

From 1960 onwards, UHC was a state objective in 5-year state plans. The 1961 Law on the Socialization of Health promoted the establishment of an integrated health service scheme with a three-tiered health system managed by the Ministry of Health and Social Affairs. In 1971, Bağ-Kur (the social health insurance scheme for self-employed people, artisans, and organised groups) was established, which extended insurance coverage further to groups who were not covered previously. In 1982, the new constitution provided state guarantee for citizens' rights to health insurance and health services—aimed at accelerating initiatives to achieve UHC—and was followed in 1987 by the Basic Law on Health to operationalise these rights; however the law was only partially implemented (panel 1).

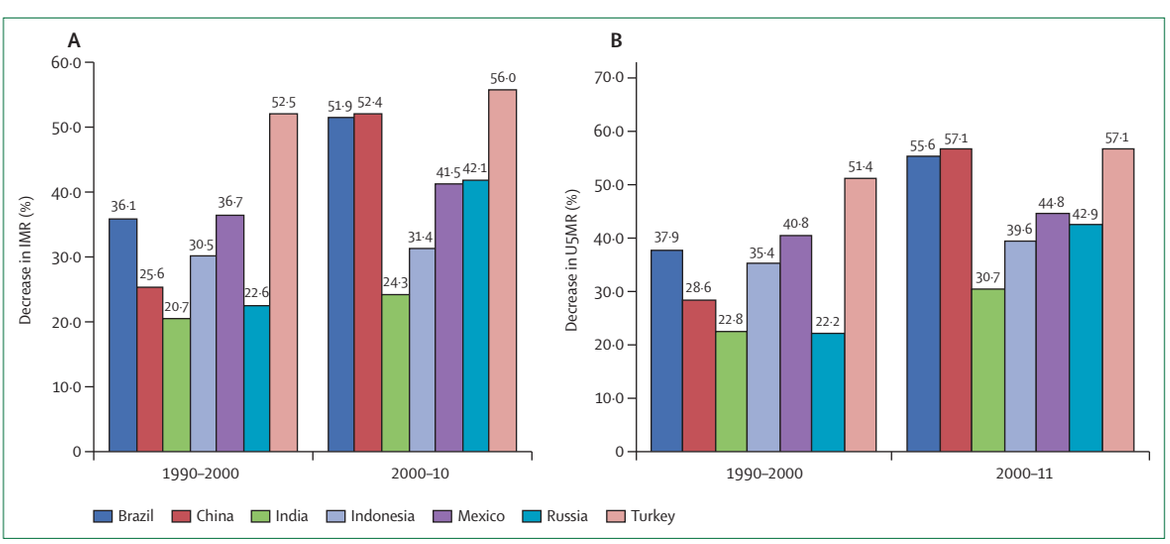

Figure 5: **Percentage change in infant mortality and under-5 mortality rates in E7 countries, 1990–2010**
(A) Percentage change in infant mortality rate. (B) Percentage change in under-5 mortality rate. IMR=infant mortality rate. U5MR=under-5 mortality rate. Data are from reference 20.

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Panel 1: **Key developments in the Turkish health system—a historical overview**

1920–29
- 1920: The Turkish Ministry of Health and Social Affairs (MOHSA) is established after the inauguration of the Turkish Grand National Assembly in 1920 (law no. 3) with a focus on public health

1930–49
- 1945: Social health insurance (Social Insurance Organisation) is established for blue collar workers
- 1946: The first national 10-year health plan is developed
- 1949: Social health insurance for retired civil servants

1950–59
- 1952: Mother and child health division established in the Ministry of Health
- 1953: Mother and child health development centre established, with support from WHO and the United Nations Children's Fund
- 1953: The Turkish Medical Association is established
- 1954: MOHSA assumes a role in the provision of curative services, initially with MOHSA-established model hospitals, and begins training of health workforce
- 1954: Health facilities belonging to provincial and municipal administration are placed under MOHSA administration, managed by provinces
- 1954: The first national 10-year health programme is declared (which is the cornerstone for planning and organisation of the Turkish national health service)

1960–79
- 1961: The Law on the Socialization of Health is adopted, promoting an integrated health service scheme, and establishing a three-tiered health system (health house, health centre, and district hospital), managed by MOHSA
- 1965: The Law of Population Planning is adopted, with pro-natalist policies
- 1971: Bağ-Kur (social health insurance for self-employed people, artisans, and organised groups) is established

1980–89
- 1982: The new constitution reconfirms the importance of the state in protecting the health of the population and in ensuring universal health coverage, including through a unified social health insurance system
- 1987: Basic Health Law is enacted, prescribing a narrower role for the Ministry of Health in service provision and a focus on regulation, but is not fully implemented because of partial rejection of the law by the Constitutional Court

1990–99
- 1992: National Policy Forum is held, with broad stakeholder involvement
- 1992: The Green Card scheme (health insurance for households outside the formal health insurance schemes) is introduced as an interim measure until the creation of a unified health insurance scheme
- 1993: the Law of Health Law, Ministry of Health structure and responsibilities, Provincial Health Administration, General Health Insurance is developed
- 1996: The laws on health financing institution establishment and process, primary care health services, and family medicine, hospitals, and health entities are developed
- 1998: The law of personal health insurance system and health insurance administrative presidency is developed
- 1999: The draft law of health fund institution is developed
- However, the above laws are not enacted because of a political stalemate in the Turkish Grand National Assembly

Political and socioeconomic context preceding the HTP

The 1990s in Turkey were characterised by a series of weak and indecisive coalition governments. Consequently, in the 1990s, economic development, as measured by real gross domestic product (GDP) growth, was not stable or sustained, with economic cycles of boom and bust. For example, between 1990 and 2002, the real GDP contracted substantially in 3 years, with declines of 5·5%, 3·4%, and 5·7% in 1994, 1999, and 2001, respectively. Between 1990 and 2002, GDP income per person increased slowly, but stagnated between 1997 and 2002, when Turkey experienced rampant inflation, with annual inflation rates ranging from 20% to 70%. Unemployment increased from 1995 onwards, and grew especially rapidly after 1999 when the rate rose from 6·5% in 1999, to 10·5% in 2002. Between 1995 and 2002, the proportion of employed people in the age group 25–54 years decreased from 60·5% to 54·6% (table 1).[22]

In the early 2000s, Turkey had an average Gini coefficient of 0·43, which indicates wide income inequalities, and ranked 29th out of the 30 Organisation for Economic Co-operation and Development countries, ahead of only Mexico. In 1998, about 60% of women in the lowest wealth quintile had incomplete or no primary education, which is almost five times higher than the rate reported in women from the wealthiest quintile. The employment rates for women fell steadily from 32·9% in 1990, to 26·6% in 2002, which reinforced inequalities further (table 1).[22]

In the 1990s, for successive governments grappling with political instability, economic shocks, runaway inflation, rising unemployment, and social discord, the health sector was not a priority. Hence, few major health policies could be implemented. In 1993, the Council of Ministers approved five separate laws on universal health insurance, family medicine, hospital autonomy, and institutional reforms aimed at transitioning the Ministry of Health to become an effective steward of the health sector. However, these laws could not be enforced because of political differences in the Turkish Grand National Assembly (panel 1).

	Real GDP growth (%)	GDP per person (present US$ prices)	Consumer price index (all items)	Un-employment rate (%)	Employment rate (%) for age group 25–54 years	Employment rate (%) in women
1990	9·3%	5744	0·3	8·2%	61·6%	32·9%
1991	0·9%	5885	0·6	8·5%	61·6%	33·7%
1992	6·0%	6261	1·0	9·0%	61·0%	31·9%
1993	8·0%	6793	1·6	8·6%	58·0%	25·8%
1994	–5·5%	6440	3·3	7·6%	59·8%	30·4%
1995	7·2%	6922	6·3	6·6%	60·5%	30·2%
1996	7·0%	7441	11·4	6·8%	60·1%	30·3%
1997	7·5%	8181	21·2	6·9%	59·0%	28·0%
1998	3·1%	8439	39·2	7·7%	59·2%	28·5%
1999	–3·4%	8046	64·6	6·5%	58·2%	28·9%
2000	6·8%	8724	100·0	8·4%	56·7%	26·2%
2001	–5·7%	8178	154·4	10·3%	55·5%	26·3%
2002	6·2%	8217	223·8	10·5%	54·6%	26·6%

Data are from reference 22. GDP=gross domestic product.

Table 1: **Key economic indicators in Turkey, 1990–2002**

In 1992, the government introduced the Green Card scheme for poor households with incomes below the national minimum and for families on social assistance, financed from general budget revenues. The scheme was not integrated with other health insurance schemes such as the Social Insurance Organisation (covering active and retired workers from the formal sector), the Government Employees Retirement Fund (covering retired civil servants), Bağ-Kur (covering self-employed people), and the Active Civil Servants Insurance Fund (covering civil servants in work and their dependants). The Green Card scheme provided some coverage for inpatient hospital care, but not for outpatient-based consultations, diagnostic tests, or drugs. Unlike the other four insurance schemes, the Green Card scheme was administered by the Ministry of Health, but without a system for means testing or for the identification of people entitled to health insurance. Rather than a population-based insurance system, the Green Card scheme functioned as a means of providing funding for uninsured poor individuals who could not meet hospital inpatient costs. However, the absence of an organised insurance system meant that many families did not have access to the scheme. Hence, many poor families had low access to health services and endured the high cost of outpatient drugs, whereas a mixed system of insurance coverage and insurance entitlements developed for those covered by one of the schemes.

In 1999, a major earthquake in the Marmara region of western Turkey, which resulted in an estimated 17 000 deaths and left 500 000 people homeless,[23] exposed the government's inability to manage natural and man-made disasters and led to widespread societal discontent. Turkey entered the new millennium with growing public expectations of the government. The population demanded decisive policies that would advance citizens' democratic rights; improve health and education services; and address social unrest, high inflation, and rising unemployment. The population discord with the socioeconomic situation was apparent in the dissatisfaction with the health system. A population life satisfaction survey undertaken by the Turkish Statistical Institute in 2003 showed that only 39·5% of the population were satisfied with health services—lower than that for social insurance (40·2%), legal and judiciary (45·7%), and public security and order services (57·9%).[24]

In the late 1990s and early 2000s, the Turkish health system faced major problems, especially in three areas. The first related to inadequate and inequitable financing of the health system. In Turkey, for most of the 1990s, health expenditures averaged 3·8% of the GDP, which is well below the levels attained by Organisation for Economic Co-operation and Development countries (7·4% of GDP) and by countries with similar incomes.[25] Low health expenditures were compounded by an inequitable and fragmented health insurance system. The five insurance schemes had different benefit packages and disparate contractual arrangements with health-care provider organisations, leading to substantial inefficiency and inequity. Additionally, a small private sector existed, with its own system of private insurers and health-care providers. However, even for people with insurance, access to health services was difficult because of an absolute shortage of health human resources. Furthermore, dual practice by hospital specialists reduced the capacity of public services for insured people, with many patients diverted to private practice—even for interventions for which they were entitled. Unsurprisingly, in the 1990s, out-of-pocket expenditures accounted for 28–30% of total health expenditures.[26] In 2003, only 66·3% of the population was covered by health insurance. Just 12% of the poorest expenditure decile benefited from the Green Card scheme, which in 2003 covered 2·5 million people.[27]

The second problem in the Turkish heath system related to an absolute shortage and inequitable distribution of physical infrastructure and health human resources. In the 1990s and early 2000s, Turkey had the lowest number of doctors and nurses per 100 000 population, and one of the lowest nurse to doctor ratios in Europe.[28] In 1990, there were 0·9 physicians per 1000 population, which increased to 1·3 per 1000 population in 2000. This ratio was lower than the numbers in the E7 countries of Brazil, China, Mexico, and Russia, but higher than those in India and Indonesia.[29] The human resource shortages led to inequalities in health service delivery and access, with east–west, rural–urban, and poor–rich divides. Absolute staff shortages, low salaries, and few incentives created difficulties in attracting and retaining health workers in the poorer eastern regions of the country. Ineffective performance management led to low productivity and ineffective use of available capacity. Prevailing dual

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practice by physicians meant that in 2002, in addition to their public duties, about 89% of hospital specialists engaged in private practice to boost their incomes.[30]

The third and the most serious problem related to inequities in health outcomes, especially between the deprived eastern areas and the more developed western regions of the country (figure 2), among the richer and poorer segments of the population, and across rural and urban areas. For example, in 1998, under-5 mortality rates were 75·9 per 1000 livebirths in the east and 38·3 in the west of Turkey; these inequities still persisted in 2003.[31,32] Economic instability and underperformance of the health sector created expectations for major changes in the health system. However, arguably, the most important driver of change in the health system was the dysfunctional political environment, which no longer catered for the needs of the rapidly evolving country. The general elections in 2002 returned a parliamentary majority for the Justice and Development Party, which ended a decade of poorly functioning coalition governments. The new government, which had inherited an economy in crisis, created an urgent action plan to introduce a structural transition programme in the economy, with health as a priority sector. In 2003, the Ministry of Health designed and introduced the HTP, which sought to establish the right to good health and UHC as an integral part of citizenship.[33]

Acceleration of the journey to UHC in Turkey: implementation of the HTP

To build on and accelerate efforts that began in the 1960s, the HTP articulated a comprehensive strategy to achieve UHC by strengthening key health system functions of governance, financing, and service delivery. The HTP adopted a rights-based philosophy and set out to improve public health, expand access to health insurance for all citizens, ensure provision of high-quality health services, and develop a patient-centred health system to rectify the inequalities in access to health services and in health outcomes, especially for women and children. We now discuss the approach adopted by the Turkish Government in the design, implementation, and monitoring of the HTP.

Leadership and political commitment

From the outset, a transformation leadership team, comprising the Minister of Health, undersecretary, deputy undersecretaries of health, and departmental directors, was involved in the planning, design, implementation, monitoring, and refinement of the HTP. The team, which benefited from support of the Prime Minister and the cabinet, remained with the HTP for almost 10 years, providing continuity and institutional memory for the changes. An operational change team based at the Ministry of Health supported the leadership team. The leadership team provided sustained engagement in the HTP, with the minister visiting 81 provinces at the start to meet provincial governors and health directors to discuss and agree HTP implementation plans. These initial visits were followed by regular attendances at provincial meetings that included field coordinators and local stakeholders and at which HTP implementation was discussed in detail. In about 340 visits to provinces, the minister and the senior transformation team could witness the implementation challenges directly and listen to local concerns about implementation bottlenecks and the support provided by the Ministry of Health teams.

The direct communication channels established with the provincial directors enabled two-way sharing of information between the implementation groups and the transformation leadership. The information received was rapidly actioned by relevant Ministry of Health teams, which created an environment of trust. Rapid response to problems provided incentives for information sharing, fostered ongoing learning with continuous improvement, and helped rapid implementation of the HTP.

A comprehensive strategy informed by evidence

A system-wide approach underpinned the design and implementation of the HTP. From the outset, the HTP leadership sought to identify problems in health system functions and in health outcomes. Comprehensive and carefully sequenced changes were then designed to improve governance and organisation, financing, resource management, and service delivery. The changes in health system functions were implemented systematically during a 10-year period (panel 2), with a flexible approach to implementation regulated by regular intelligence on the receptivity of the context to the changes introduced.

The design of the HTP was informed by evidence and global experience from countries such as Belgium, Cuba, Denmark, Estonia, Finland, Mexico, Thailand, and the UK. The Ministry of Health successfully established ongoing collaboration with international agencies and a cadre of national and international experts. In addition to international evidence, the HTP invested in generation of new local evidence—for example, studies of access and efficiency of the Turkish health sector were used to identify health system bottlenecks.[34] The National Health Accounts Study (2002–03)[35] provided a new and comprehensive picture of health financing and expenditures in Turkey, including out-of-pocket expenditures. The evolving disease burden was mapped through the 2004 Turkey Burden of Disease Study.[36]

In addition to the studies undertaken at the start of the HTP to establish baselines, the transformation leadership invested in studies to regularly appraise HTP implementation and health systems performance. For example, in 2008 a joint Organisation for Economic Co-operation and Development–World Bank study,[37] and in 2011 a study assessing primary health-care level,[38] were used to assess HTP progress. In line with the Tallinn Charter recommendations,[39] the performance of the

Panel 2: **Towards universal health coverage: key developments in the HTP, 2002–12**

- 2002: Justice and Development Party includes "improving access to health services" (urgent action plan) in its election platform.
- 2002: Justice and Development Party is elected with a strong parliamentary majority in the Grand National Assembly.
- 2002: Ministry of Health Decree (on the first day of the new government) to eliminate involuntary incarceration in hospitals of patients who cannot meet health-care expenses. The decree forbids hospitals from withholding the bodies of deceased patients when families are unable to meet hospital expenses.
- 2003: The Health Transformation Program (HTP) is designed, building on work done in the previous decade, including elements of the Basic Health Law. Implementation of the HTP begins.
- 2003: Introduction of higher salaries and performance incentives for hospital clinicians to encourage voluntary transition from dual practice to full-time working. Major expansion of the voluntary transition in 2005.
- 2003–04: Active and retired civil servants are allowed to use private hospitals. Ambulance services declared free.
- 2003–04: Green Card benefits expanded to include outpatient benefits and pharmaceuticals. Conditional cash transfers were introduced, covering 6% of the population (for pregnant women and children from the most disadvantaged households), to encourage use of maternal, neonatal, and child health services.
- 2004: Contract-based employment introduced for health-care personnel in rural and less developed regions. Performance-based payments piloted in ten Ministry of Health hospitals.
- 2004: Major changes in pharmaceutical policy, including changes to pricing and to value-added tax. International reference price system introduced, replacing the cost-plus model to reduce the price of drugs.
- 2004: Patient Rights Directive introduced in 2003 is implemented. Patient Rights Units established in hospitals. Electronic systems for patient complaints and suggestions introduced.
- 2004: User choice of health-care providers (hospitals, primary care centres, and physicians) introduced.
- 2005: Hospitals belonging to the Social Insurance Organisation (146 hospitals) integrated with Ministry of Health hospitals. The total number of hospitals managed by the Ministry of Health reached 840 in 2011.
- 2005: Contract-based family medicine with performance-based contracting piloted in Düzce province.
- 2006: Universal health insurance is legally adopted as a part of broader social security reforms. Health expenditures start to grow and global budgets (budget ceilings) are introduced for Ministry of Health facilities to moderate growth in services to address unmet need.
- 2006–10: Contract-based family medicine scaled up in all 81 provinces of Turkey.
- 2007: Cost-sharing for primary health-care services abolished. Primary health care available for all citizens free at the point of delivery.
- 2008: Social Security Institution established as a single organisation for financial pooling and purchasing. The Social Insurance Organisation, Bağ-Kur, and the General Employees Retirement Fund join the Social Security Institution.
- 2008: Free availability of emergency services and intensive care services (including neonatal intensive care) for the whole population extended from public hospitals to all hospitals, including private hospitals with and without Social Security Institution contracts.
- 2008: National air ambulance service introduced and is available to the whole population free of charge. Major expansion in 2010.
- 2008: Cost-sharing in private hospitals for complex conditions (eg, burns, renal dialysis, congenital anomalies, cancer, cardiovascular surgery, and transplant surgery) abolished.
- 2009: Mobile pharmacy services introduced to improve access in rural areas.
- 2009: Tracking system for drugs introduced.
- 2009: Central hospital patient appointment system introduced. Major expansion in 2011.
- 2010: Active civil servants join the Social Security Institution.
- 2010: The Ministry of Health strategic plan for 2010–14 developed.
- 2010–11: Taxes for cigarettes and alcohol raised.
- 2010–12: Laws on Hospital Autonomy and Restructuring the Ministry of Health for a stronger stewardship function are adopted. Public Hospital Authority and Public Health Institution established; Law on Full-Time Practice of University and Health Personnel and Amendments is adopted, paving the way for full-time practice in legal terms.
- 2012: The Green Card scheme joins the Social Security Institution and unified social health insurance is fully implemented.
- 2013: The Ministry of Health strategic plan for 2013–17 is developed.

Turkish health system was systematically assessed by WHO and the Ministry of Health,[40] using a set of WHO-specified indicators related to health system functions, intermediate health outcomes, and health system goals.[41]

Continuous monitoring and learning

The assessments undertaken jointly with the Organisation for Economic Co-operation and Development, the World Bank, WHO, and academic institutions enabled

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objective assessment of HTP progress and helped to identify emerging challenges. These studies were complemented by continuous monitoring of HTP implementation through the field coordinator model—a multisectoral approach that emphasised inclusive assessment locally, collaborative deliberation, problem solving, and lesson learning.

In the field coordinator model a team of physicians were deployed rapidly in implementation sites across the country. With primary goals of improved health outcomes and equity, the field coordinators had two major roles: to perform internal audit function in provinces, and to contribute to institutional capacity building throughout Turkey for the implementation of the HTP. These physicians collaborated with provincial governments, professional associations, and local health management staff to gather information about emerging issues and benchmark progress at different implementation sites. Visits by the field coordinators included assessment of primary health-care facilities (health posts, tuberculosis control dispensaries, mother and child health-care centres, family medicine centres, and community health centres), hospitals, and dental care centres. A patient-centred approach, expanded access to care, and improvement of primary health-care service quality were the foci of assessments. Regular meetings were held in every province to discuss assessment findings, review progress, provide learning from experience of other provinces, and generate local solutions to solve implementation bottlenecks.

The field coordinator model was effective in rapid identification of implementation challenges and in provision of suitable solutions. For example, at the early stages of HTP implementation, constraints emerged in the capacity of line agencies to interpret the elaborate content of the HTP and to adhere to tight implementation schedules. Close collaboration with provincial governments and local professional associations helped to mobilise additional capacity beyond the health sector to meet implementation targets.

Findings from field monitoring were used to provide monthly reports to the transformation leadership on the challenges identified and lessons learned from the implementation sites so that the leadership could modify the speed and scope of HTP rollout in provinces.[42]

Flexible implementation: strategic and tactical actions

An important feature of the HTP was its emphasis on flexible implementation that balanced strategic and tactical actions. A two-pronged implementation approach characterised the HTP: the first prong emphasised incremental and tactical changes that were aimed at rapid and visible health sector improvements, and the second focused on strategic activities aimed at major structural reforms that needed legislation by the Grand National Assembly. This approach ensured so-called quick wins through tactical moves, enabling citizens to benefit immediately from changes, and thereby gaining essential public support from the stakeholders. In parallel, institutional changes and structural reforms were pursued strategically in a sequenced way, to take advantage of political and legal windows of opportunity. For example, on the first day of the new government, the Minister of Health issued a decree to eliminate involuntary incarceration in hospitals of patients who were unable to meet health-care expenses. The same decree also abolished the practice of withholding the bodies of deceased patients when families were unable to meet hospital expenses—a tactical change welcomed by the general population.

In 2004, Green Card benefits were expanded to include access to outpatient services and drugs and aligned with benefits offered by other health insurance schemes, with rapid expansion of coverage in the uninsured poor population. In 2005, hospitals managed by the Social Insurance Organisation were brought under the stewardship of the Ministry of Health—an essential step for major structural reforms that sought to establish a purchaser–provider split by separating the financing and provision functions of the Social Insurance Organisation. This transition in managerial control was achieved, despite strong opposition from the Social Insurance Organisation and labour unions.

The increased population approval for the HTP gained by these tactical moves helped to legitimise the HTP, increased support from the Prime Minister and Cabinet of Ministers for the programme, and strengthened the negotiating position of the Ministry of Health within the government.

Focus on user satisfaction and the receptivity of context for change

The transformation leadership commissioned regular focus group research and stakeholder analyses to assess the acceptability of the changes introduced by the HTP to various population segments and their receptivity to change. The results of focus groups and stakeholder analyses were used to refine the scope of the HTP, public communications, and the speed of implementation.

Focus group research and stakeholder analyses were augmented by annual household surveys undertaken by the Turkish Statistical Institute based on statistically representative samples for the country. These surveys assessed household living conditions, individual happiness, life satisfaction, and expectations of public services (health services, social services, social insurance, education, legal and judiciary, and public security and order). The surveys provided an indication of general levels of satisfaction in the country and population responses to reforms introduced by various ministries.[43] The Ministry of Health also asked the Turkish Statistical Institute to undertake detailed health satisfaction surveys to assess population satisfaction with the health system and their views on health service quality, health service

access, and system responsiveness. The health satisfaction survey also elicited user perceptions about bottlenecks in health services, challenges, and consumer expectations.[44] The Ministry of Health and the cabinet discussed these findings regularly to fine-tune implementation of the HTP, to improve responsiveness of health services, and to meet user expectations.

The HTP: health system changes and achievements

Health system governance and stewardship

Defining of citizens' rights to health and enhancement of provider accountability

The Directive on Patient Rights[45] was introduced in 2003, with effective implementation in 2005, and helped to operationalise the Patent Rights Legislation[46] that was enacted in 1998, but not implemented. The directive defined patient rights to health insurance and health services, and specified provider obligations in relation to patient rights, information provision, confidentiality, and patient consent for health interventions, and also provided citizens with the right to choose health-care institutions, hospital doctors, and family physicians.

Several new mechanisms established through the directive enabled service users and citizens to directly express their views on the quality, responsiveness, and availability of health services, including the challenges encountered, their degree of satisfaction, and their expectations. These new mechanisms included direct communication through a telephone hotline (expanded in 2010 to include social media) of complaints and suggestions to the Ministry of Health Communications Centre (SABIM), the Prime Ministry Communication Centre (BIMER), patient rights units in public hospitals, and patient rights communication units in primary health care. The complaints made to BIMER and SABIM are communicated to patient rights units to be resolved locally at the hospital involved or are taken to patient rights boards established in every province for advice on course of action—for example, to pursue administrative or legal avenues to resolve the complaint if there is a breach of directive provisions. These changes were combined with awareness-raising activities and training of citizens in health rights, with almost 2 million citizens trained in 2010 and a further 3·6 million in 2011. These new mechanisms have enhanced provider accountability to citizens—accountability that was all but absent before the HTP.

The new mechanisms, which enabled direct communication between users and the Ministry of Health, provided much-needed intelligence about user satisfaction and expectations. However, some health staff perceived these governance changes to be an impingement on professional freedoms, with complaints that the authority of doctors with patients had been compromised. Health workers also complained of reduced respect from patients. In response, the Ministry of Health introduced a web-based system for health staff to raise concerns directly with the Minister of Health, inquire about new policies, suggest solutions, and share experiences. However, despite these efforts, discontent remains among some health staff, which the Ministry of Health needs to address.

Redefinition of the role of the Ministry of Health

A key objective of the HTP was to redefine the role of the Ministry of Health, by strengthening its stewardship functions and by delegating operational responsibilities to new agencies. Between 1987 and 2002, attempts at streamlining the role faltered, as the Ministry of Health continued on its trajectory of expansion that started in 1954 (panel 1). Although a framework for restructuring of the Ministry of Health was approved at an early stage in the HTP by the Grand National Assembly, implementation could not proceed because the president vetoed the Law on Public Administration, which underpinned the framework.

Between 2003 and 2010, the Ministry of Health's role expanded further when it assumed management responsibility for Social Security Institution hospitals and for the Green Card scheme. However, in 2010, with the introduction of the Ministry of Health Restructuring Law and the Law on Autonomous Hospitals, the ministry's role was streamlined to focus on policy and strategy development, intelligence, health system performance assessment, oversight of accountability, and intersectoral coordination. Operational responsibilities related to public health, contracting, health service delivery, and technology assessment were delegated to new autonomous quasi-public agencies, operating at an arm's length from the ministry (appendix p 15). With the introduction of the unified General Health Insurance scheme, the newly established Social Security Institution undertook the management of the Green Card scheme (panel 2).

Health system financing

The HTP sought to address two major financial shortcomings. The first related to low health expenditures and the second to the inequitable and fragmented health insurance system, with low coverage of the poorest populations and high out-of-pocket costs that led to catastrophic expenditures.

Increasing health expenditures

In 1990, total health expenditure in Turkey was 2·7% of GDP (US$155 in purchasing power parity terms), but by 2008 it had increased to 6·1% of GDP ($913), similar to that achieved by E7 countries for which average health expenditures were 5·2% of GDP (figure 6).[47] Health expenditures increased especially in 2003–08 (figure 6), coinciding with the introduction of the HTP and a period of sustained economic growth, which provided the fiscal space[48] for increased public sector investment (panel 3). In 2003–08, annual growth rates for health expenditures were 10% in fiscal years 2003–04 and 2004–05, 14% in 2005–06, 8·7% in 2006–07, and 1·3% in 2007–08. During 2000–08,

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Figure 6: **Total expenditure on health per person, 1990–2008 (US$ purchasing power parity)**
Data are from reference 25.

the growth in health expenditures was largely driven by increasing public sector funding, which rose from 63% of total health expenditures in 2000, to 73% in 2008. In 2000–08, public sector funding for health increased at an average annual growth rate of 9·1% (range 4·7–14·8%). In 2010, of the E7 countries, Turkey had the greatest proportion (75·2%) of the total health expenditures coming from public sources compared with 47·0% in Brazil, 53·6% in China, 29·2% in India, 49·1% in Indonesia, 48·9% in Mexico, and 62·1% in Russia.[47] Public investments in health infrastructure increased ninefold in nominal terms from 603 million Turkish lira (TL) in 2003 to more than TL5·4 billion in 2008. Similarly, private sector investments in health infrastructure increased almost 13-fold from around TL100 million in 2003 in nominal terms to almost TL1·3 billion in 2008.[49]

Consolidation of the health insurance schemes into unified general health insurance

Before the introduction of the HTP, five health insurance schemes existed in Turkey (the Social Insurance Organisation, the Government Employees Retirement Fund, Bağ-Kur, the Active Civil Servants Insurance Fund, and the Green Card scheme). Each of these schemes had developed separately over time, with different contribution amounts and varying benefits packages (appendix p 16). The Green Card scheme had low coverage rates, both because it functioned not as a proper insurance scheme, but rather as a financial rescue operation for poor patients who could not meet inpatient hospital costs, and because no system existed to identify potential beneficiaries to actively encourage them to join the scheme. Inadequate benefits offered by the Green Card meant the scheme was not attractive to citizens. To achieve UHC, from 2004, the HTP established mechanisms to identify citizens entitled to the scheme, to increase insurance coverage among the poorest deciles, and to expand the scheme's benefits.

In 2006, the Grand Assembly ratified the Social Insurance and the General Health Insurance Law (panel 2) to bring together the five health insurance schemes within a unified General Health Insurance scheme integrated within the Social Insurance Organisation with synchronised benefits. The law was opposed by the Turkish Medical Association and the unions representing medical professionals, and was challenged in the constitutional court. The law was amended three times before implementation could begin in 2008, with the Social Insurance Organisation, Bağ-Kur, and the Government Employees Retirement Fund transferred to the newly established Social Security Institution. In January 2010, the Active Civil Servants Health Insurance Scheme was also transferred to the Social Security Institution, followed by the Green Card scheme in 2012, with shared benefits, to establish the unified General Health Insurance scheme (appendix p 16).

The expansion in Green Card coverage and benefits was underpinned by increased health expenditures,

Panel 3: Key elements of the benefits package covered by the unified General Health Insurance

The benefits package includes:

- Personal preventive health care (free of charge and financed from the general government budget)
- Inpatient and outpatient services, including for medical examinations, diagnostic tests, and procedures; all medical interventions and treatments after diagnosis; follow-up and rehabilitative services; organ, tissue, and stem cell transplantation; emergency care; and medical care
- Inpatient and outpatient maternal health care (antenatal care, delivery, neonatal care, and postnatal care with all medical examinations, diagnostic tests, and procedures)
- All medical interventions and treatments after diagnosis of women's disorders, follow-up services, abortion, surgical sterilisation, emergency care, and medical care
- Inpatient and outpatient oral health care, including oral and dental examinations, diagnostic tests and procedures, all medical interventions and treatments after diagnosis, tooth extraction, conservative dental treatment and endodontic treatment, follow-up services, oral prostheses, emergency services, and orthodontic treatment
- In-vitro fertilisation services, for up to two treatment cycles
- Blood and blood products, bone marrow, vaccines, medicines, prostheses, medical goods, and medical equipment, including their installation, maintenance, repair, and renewal services
- Diseases that need treatment abroad
- Free (at point of delivery) health care and dental care provision for children less than 18 years of age, irrespective of their insurance status
- Pharmaceuticals and medical devices

The benefits package excludes:

- Aesthetic interventions not related to work accidents or congenital anomalies
- All interventions not classified as medical services by the Ministry of Health
- Treatment of foreigners with pre-existing chronic diseases

Panel 4: New targeted health programmes for women and children introduced by the Health Transformation Program

- Accelerated efforts to improve immunisation uptake among children younger than 5 years through the family medicine-centred primary health-care model that began in 2005 and expanded to all 81 provinces of Turkey by the end of 2010, which introduced a performance-based payment for achievement of high immunisation rates among children
- Implementation of an expanded programme of immunisation by increasing the number of antigens from seven in 2002 (BCG, combined diphtheria–pertussis–tetanus, oral polio, measles, and hepatitis B) to 13 in 2012 with the addition of *Haemophilus influenzae* type b, rubella, mumps, pneumococcal conjugate vaccine, varicella, and hepatitis A
- Free predelivery hostel services near maternal care units for women in rural and difficult-to-reach areas
- Conditional cash transfers for antenatal and postnatal and newborn follow-up (including immunisation)
- Implementation of new neonatal services, including neonatal emergency care and air ambulance for maternal emergencies, additional newborn screening for hypothyroidism and biotinidase to complement screening for phenylketonuria and hearing problems
- Enhanced nutritional support during pregnancy and early childhood, including folic acid and iron supplements for pregnant women, and vitamin D and iron supplements for children
- Implementation of an improved monitoring system in the prenatal and postnatal period for women and for child health and development
- Expansion of neonatal intensive care programme, financed from extended health insurance benefits

contributions from general government revenues (to the Social Insurance Organisation, then to the Social Security Institution) to cover the premiums of beneficiaries, and expansion of public and private health-care providers. The creation of the Social Security Institution brought clarity to purchaser and provider roles, with the institution established as the purchaser of health services from public and private providers. The consolidation of the five insurance schemes created a unified risk pool to more effectively share, across all income groups, the risks associated with health-care costs and catastrophic payments.

The unified General Health Insurance now provides a comprehensive benefits package with reimbursement for a range of preventive, diagnostic, and curative services (panel 3 and appendix p 16). Preventive health services and contract-based family medicine services, which are freely available to users, are not insurance based, and their costs are met by the general government budget (panel 3). In addition to the benefits under the unified General Health Insurance, the Ministry of Health extended targeted health promotion and prevention programmes for the general population—especially for women and children—provided to users free of charge (panel 4).

Expansion of health insurance coverage for the poorest people: health expenditures for the Green Card scheme

Between 2004 and 2009, coinciding with the introduction of the HTP, expenditures for Green Card holders increased almost fivefold from TL1·2 billion in 2004 to TL5·51 billion in 2009. In the same period, spending for Social Insurance Organisation beneficiaries doubled from TL13·2 billion in 2004 to TL28·9 billion in 2009

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(table 2). In 2004, the health spending per person for Green Card holders at TL176·0 was around half the amount (TL323·0) spent for Social Insurance Organisation beneficiaries. However, by 2009, the expenditures for Green Card beneficiaries had increased to TL570·7 per person, converging with the amount (TL590·3) spent for Social Insurance Organisation beneficiaries (table 2).

Enhancement of equity: health insurance coverage by nominal per-person expenditure deciles

Government financing of non-contributory health insurance for the poorest deciles and increased coverage of contributory health insurance by richer deciles enabled expansion of the Green Card scheme and the introduction of a unified General Health Insurance scheme.

In 2003, only 24% of the poorest decile was covered by insurance (12% by obligatory insurance for those in active employment and 12% by the Green Card scheme). By 2011, health insurance coverage for the poorest decile had increased to almost 85% (about 60% through the Green Card scheme, 24% through obligatory health insurance, and the rest by private insurance; figure 7).

Health insurance coverage has improved for all expenditure deciles. For example, coverage for the second decile increased from 38% in 2003 (roughly 8% Green Card scheme, 29% obligatory health insurance, and the rest by private insurance) to 84% in 2011 (about 33% Green Card scheme, 50% obligatory health insurance, and the rest by private insurance). In the higher income deciles 4–10, insurance coverage has increased from 47–90% in 2003, to 85–96% in 2011 (figure 7). In a comparison of 2003 and 2011, the largest increases in health insurance uptake were achieved for deciles 2, 3, and 4, with increases from 29% to 50%, from 40% to 65%, and from 53% to 75%, respectively (figure 7).

Enhancement of equity: improved targeting of the Green Card scheme

In 2003, the Green Card scheme covered only 2·4 million people (3·6% of the population of Turkey, when about 19 million people [29% of the population] were classified as poor). The expansion of benefits (depth of coverage; see panel 3 and appendix p 16) was accompanied by rapid expansion in 2004–05 of the number of Green Card beneficiaries that almost quadrupled from 2·4 million people in 2003 to 8·3 million in 2005, then increased to around 10·2 million people by 2011, which accounted for 13·8% of the total population (when around 11·8 million people [16% of the population] were classified as poor). Targeting of poorer deciles also improved. In 2003, only 33% of the poorest expenditure decile (decile 1) was covered by the scheme, but by 2011 this proportion had increased to 42%. Between 2003 and 2011, for deciles 1 and 2, Green Card targeting improved from 54% to 65% (appendix p 17).

	Estimated number of people reporting obligatory insurance	Registered Green Card holders	SIO spending per person (nominal million TL)	SIO spending per person (nominal US$)	Green Card spending (nominal million TL)	Green Card spending per person (nominal US$)	SIO spending per person (nominal TL)	Green Card spending per person (nominal TL)
2004	40 708 000	6 852 000	13 150	230·7	1206	125·7	323·0	176·0
2005	44 061 000	7 256 000	13 607	237·5	1809	191·8	308·8	249·3
2006	47 583 000	8 279 000	17 668	265·2	2910	251·1	371·3	351·5
2007	47 612 000	9 355 000	19 983	322·8	3913	321·8	419·7	418·3
2008	50 103 000	9 338 000	25 404	390·0	4031	332·1	507·0	431·7
2009	48 900 000	9 647 000	28 863	393·5	5506	380·5	590·3	570·7

Data are authors' calculations, based on SIO annual reports and Household Budget Surveys. Insured SIO population is estimated from the Household Budget Survey 2004–09. SIO=Social Insurance Organisation. TL=Turkish lira.

Table 2: **Per-person spending for SIO and Green Card scheme, 2004–09**

Enhancement of equity: improved financial protection and reduced catastrophic expenditures

Expansion of the Green Card scheme coincided with increased benefits, including coverage of outpatient drugs and reduced cost-sharing for many health services. Inadequate benefits had previously deterred people from joining the scheme. With the HTP, emergencies, intensive care, and complex procedures (a typical cause of catastrophic expenditures) were made free for beneficiaries.

Analysis of out-of-pocket expenditures across the five expenditure quintiles who had access to the Green Card scheme shows that overall, medical expenditures (including those for pharmaceuticals, outpatient services in secondary and tertiary hospitals, and medical devices—for all of which small cost-sharing exists) decreased for all quintiles. For the lowest-income quintile (quintile 1), medical expenditures as a percentage of health expenditures fell substantially from 63·2% in 2003, to 49·4% in 2011. Similar, albeit less substantial, decreases were recorded in income quintiles 2, 3, 4, and 5. Consequently, medical expenditures for quintile 1 are now closer to those in quintiles 2, 3, 4, and 5 (appendix p 18). Overall, health expenditures as a proportion of non-food spending decreased (from 3·1% in 2003, to 2·4% in 2011). For the lowest-income quintile, a small increase from 2·4% to 2·8% occurred (appendix p 18).

Importantly, expansion of the Green Card scheme helped to reduce catastrophic health expenditures. In 2003, the mean head count, which measures the incidence of spending, at 15%, 25%, and 40% of total non-food health expenditures was 0·050, 0·022, and 0·009, respectively, and decreased two-to-threefold by 2011 to 0·029, 0·012, and 0·003, respectively (figure 8).

Human resource management

To address absolute shortages and inequitable distribution of health staff in the health system, the HTP introduced four major human resources initiatives. The first initiative, which was implemented after agreement

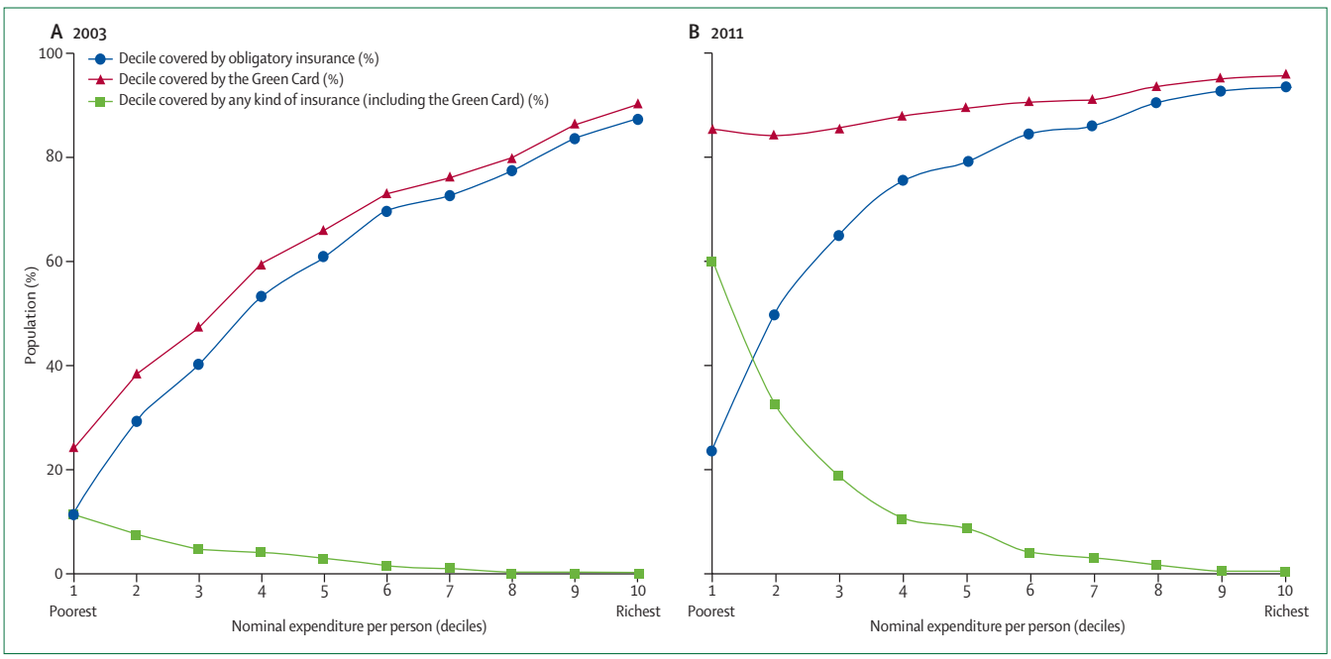

Figure 7: **Population by nominal per capita expenditure decile reporting any type of health insurance, 2003 and 2011**
(A) 2003. (B) 2011. Data are from the Turkey Household Budget Survey 2003–2011, and the Turkish Social Security Institute (appendix pp 2–13). The analysis is updated from reference 27.

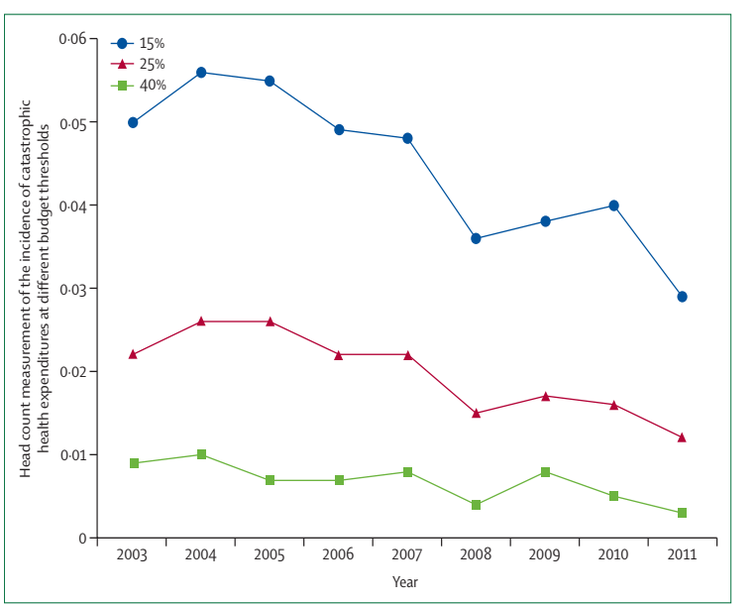

Figure 8: **Head count for out-of-pocket health spending as a share of non-food household expenditure, at different budget thresholds**
Data are from the Turkey Household Budget Survey 2003–2011, and the Turkish Social Security Institute (appendix pp 2–13).

with the higher education council, increased the number of places at universities and higher institutions to train doctors, nurses, midwives, and other health personnel. The annual intake of medical students increased from 5253 in 2003, to 8438 by 2010, with similar increases for nurses, pharmacists, and other health professions. In 2007, training of nurses was restricted to universities. New medical graduates and newly qualified specialist doctors had to undertake compulsory service and spend 300–500 days in different regions of Turkey that had a high need for doctors, especially in rural areas, east, and southeast Turkey. The second initiative introduced higher salaries and performance-related incentives in hospitals and for primary health-care providers, with the opportunity to substantially increase remuneration of health workers. The third initiative introduced new personal contracts with health staff and outsourcing of health services, underpinned by new decrees introduced in 2003 to expand staff availability in regions where recruitment and retention of health workers was difficult. New contracts offered higher salaries and performance-related pay.[50] Furthermore, new decrees introduced changes to general civil service law (which governed the employment terms and conditions for public sector health staff), with flexibilities for health-care institutions during recruitment of new staff.[51]

The fourth initiative introduced a new law in 2010, which required that doctors employed in public institutions (Ministry of Health hospitals and university hospitals) work full-time and do not engage in parallel private practice. This new law was resisted by some clinicians who had private practices and who also worked in university hospitals and large public hospitals in conurbations.[52] After the changes, a few clinicians resigned from university teaching hospitals, and more did so from large public hospitals in major cities, such as Istanbul and Ankara.

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These human resource initiatives enabled the Ministry of Health to rapidly increase the number of staff it employed from 256 000 in 2002, to 507 000 by 2012. Between 2002 and 2012, the number of outsourced health staff increased almost 12-fold, from 11 000 to 126 000 (figure 9). Between 2004 and 2010, the number of specialist physicians increased from about 53 300 to 63 600, and the number of general practitioners increased from 33 300 to 38 800. In 2004–10, the number of nurses increased from 82 600 to 114 800, and the number of midwives increased from 42 700 to 50 300. Similarly, the number of auxiliary personnel increased from 57 700 in 2004, to 94 400 in 2010.[53]

The new human resource policies collectively helped to address staff shortages in the Turkish health system and reduce inequities. For example, in 1990, there were 856 people per specialist physician in west and central regions of Turkey and 43 668 people per specialist in the east region. The ratio of specialist doctors in the west and central regions to the east region was 51:1. In the year 2000, there were 749 people per specialist physician in the west and central regions and 25 178 in the east region; thus, the ratio of specialist physicians between the regions decreased to 34:1. In 2010, the number of people per specialist physician declined to 559 in west and central regions and to 2705 persons in in the east region, with the ratio of specialist physicians among regions narrowing to 5:1 (figure 10).

Similarly, in 1990, the number of people covered by a general physician in northern and eastern regions was 1745 and 6628, respectively, with a ratio of 4:1. By 2000, the difference had widened, with 1288 and 5747 persons covered per general physician respectively in northern and eastern regions, with the ratio worsening to 5:1. However, by 2010, the number of people covered in northern and eastern regions by a general physician had fallen to 1396 and 2291, respectively, and the ratio narrowed to 1·6:1 (figure 11).

In 1990, the number of people covered by a nurse or midwife was 414 in the northern region and 2404 in the east region, with a 6:1 regional ratio between the best and the worst served regions. In 2010, the number of people covered per nurse or midwife was 235 people in the central region and 826 in the east region, with the ratio between the best and the worst served regions improving to 3·2:1 (figure 12).

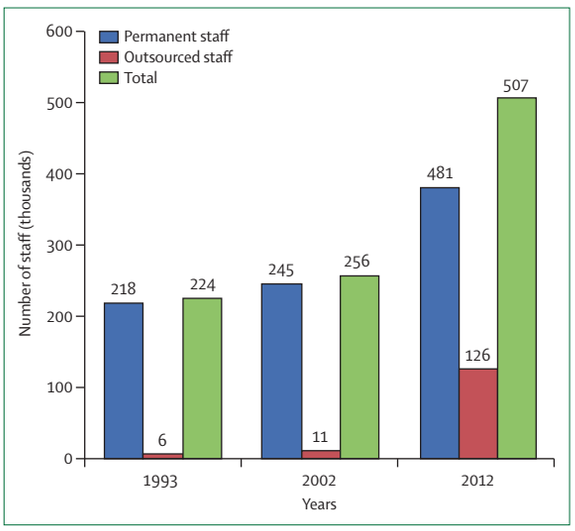

Figure 9: **Number of clinical and administrative staff employed or contracted by the Ministry of Health in Turkey, 1993–2012**
Data are authors' analysis based on data from Ministry of Health, General Directorate of Health Services, and *The Ministry of Health of the Republic of Turkey Health Statistics Yearbook*, 2011.[17]

Service delivery

Expansion of primary health-care services

Before the HTP, primary health-care services in Turkey were organised as a three-tier system, in accordance with the 1961 Law on Socialization of Medicine. The first tier was so-called health houses, staffed by midwives (covering a population of 2000–2500 people). The second tier consisted of primary health-care centres (covering 5000–10 000 people in villages; 10 000–30 000 people at the district level; or 30 000–50 000 people at the provincial level), staffed by teams comprising a physician, a nurse, and a midwife (with a health technician and an administrator in larger centres). The third tier, at provincial levels, included additional health centres that catered for mother and child health and family planning, and dispensaries for tuberculosis control. However, an absolute shortage of infrastructure and health staff, and variable staff skills, characterised the primary health-care level.

In 2005, the HTP introduced a family medicine-centred primary health-care model, with a focus on increased resources in three areas—physical resources, human resources, and human resource capacity.[54] With this model, each family doctor or family practice offered a larger set of services than did health houses or traditional primary health-care centres to a maximum registered population of 4000 citizens. About 20 000 new family medicine teams were established after 2005. Infrastructure was upgraded and expanded—most of the health houses were kept and, along with health centres, refurbished or converted into family medicine centres. By 2011, 6250 new family centres had been established.

From 2005 onwards, family physicians were engaged in contracts to provide primary health-care services, with expanded preventive activities, and women and child health services. Additionally, they were responsible for providing mobile health services to people registered with them and living in rural areas, and homecare services for patients unable to travel to clinics, along with services to nursing homes, prisons, and child care centres through regular visits.

The findings from the controlled before and after study undertaken as part of this study (appendix pp 2–13), which explored services provided by primary health-care physicians before (phase 1) and after

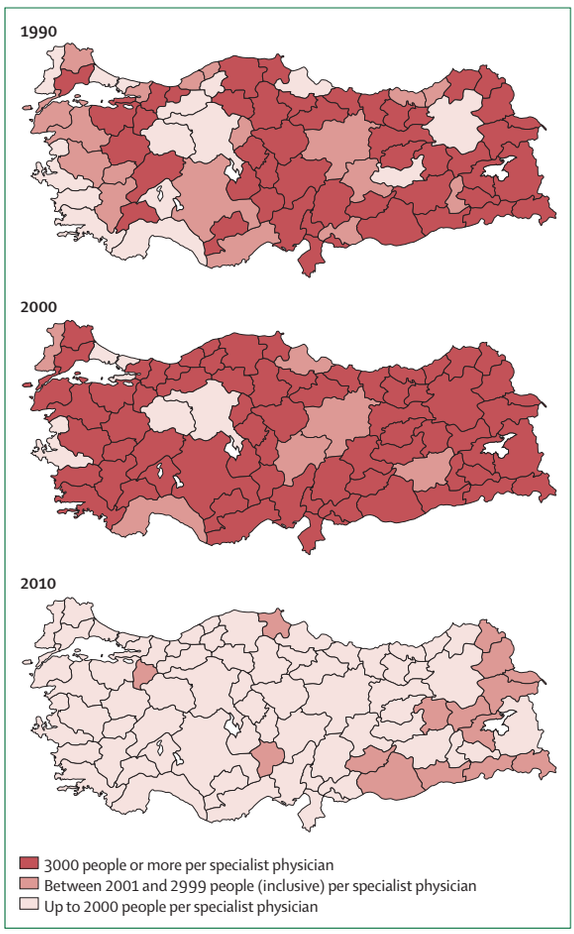

Figure 10: **Population covered per specialist physician by province in 1990, 2000, and 2010**
Provinces are grouped according to the grouping used in Demographic and Health Survey regions. Data are authors' analysis based on data from Ministry of Health, General Directorate of Health Services, The Ministry of Health of the Republic of Turkey.

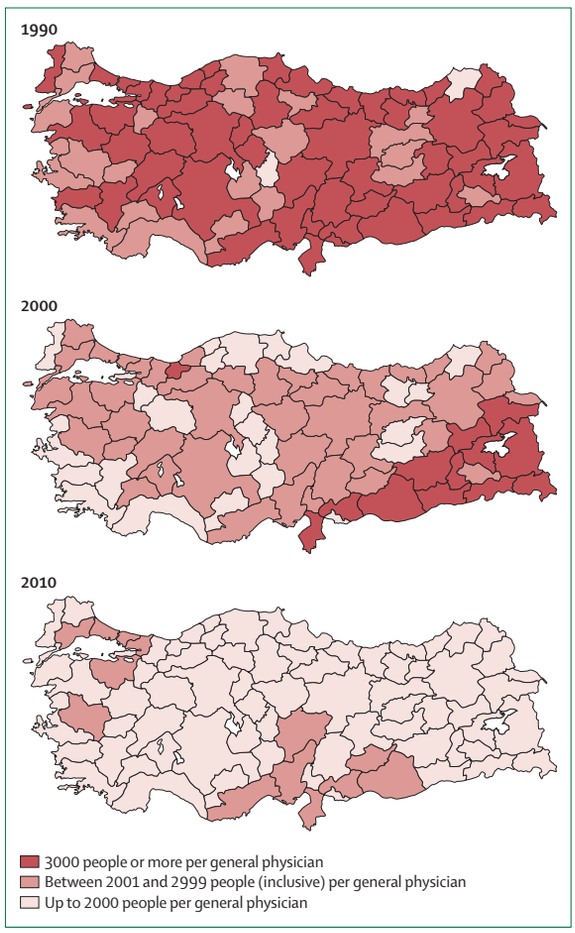

Figure 11: **Population covered per general physician by province in 1990, 2000, and 2010**
Provinces are grouped according to the grouping used in Demographic and Health Survey regions. Data are authors' analysis based on data from Ministry of Health, General Directorate of Health Services, The Ministry of Health of the Republic of Turkey.

(phase 2) the introduction of the new family medicine model, showed substantial improvements in the availability of key maternal and child health services after the introduction of the model. The immunisation services provided on a daily basis by the primary care physicians surveyed increased from 60·6% in phase 1 to 91·4% in phase 2. The improvements in the availability of in-house and mobile immunisation services were significantly higher in pilot sites than in control sites (p=0·04 and p=0·01, respectively). The general availability of antenatal services on a daily basis was 97·0%. Mobile service availability for antenatal care provided by the primary health-care physicians decreased substantially from 78·8% in phase 1 to 54·1% in phase 2 as the availability of daily services increased in phase 2 (from 93·9% to 95·6% in control regions and from 93·9% to 98·1% in pilot regions), but no statistically significant differences were reported between pilot and control sites. Almost all primary health-care units provided family planning services on a daily basis in both phases (table 3).

Additional econometric analysis from the controlled before and after study, using difference-in-difference estimates, shows that primary health-care physicians were more likely to be involved in first contact management of diseases commonly encountered in primary health care (OR 1·27, 95% CI 1·12–1·44), in the management of maternal and child care (OR 1·70, 95% CI 1·15–2·52), and in the diagnosis (OR 1·13, 95% CI 1·00–1·28), treatment initiation (OR 1·41, 95% CI 1·21–1·65), and monitoring (OR 1·45, 95% CI 1·25–1·69) of long-term disorders in pilot provinces than in control provinces in the second phase of the HTP family medicine rollout (table 4).

With increased staffing, improved infrastructure, and new contracts for family physicians that included incentives, the volume of primary health-care services (number of visits) increased from 74·8 million in 2002 to 244·3 million in 2011.[55]

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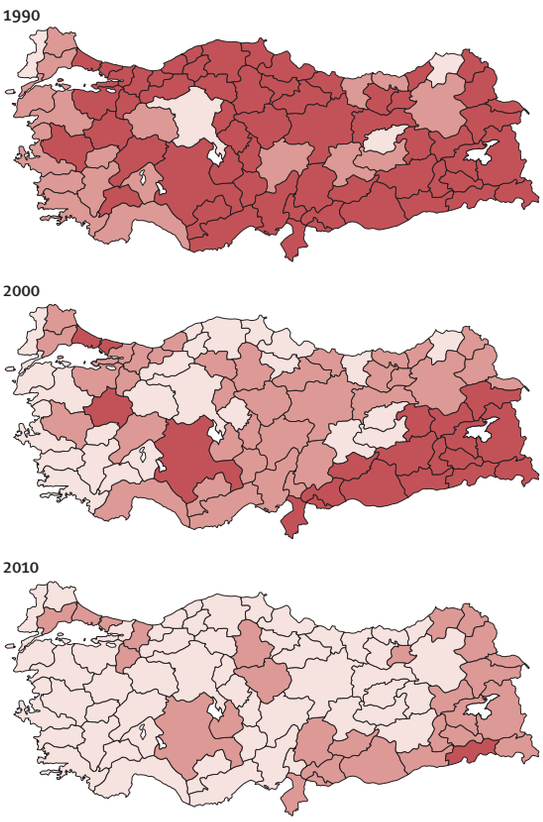

Figure 12: **Population covered per nurse and midwife by province in 1990, 2000, and 2010**

Provinces are grouped according to the grouping used in Demographic and Health Survey regions. Data are authors' analysis based on data from Ministry of Health, General Directorate of Health Services, The Ministry of Health of the Republic of Turkey.

	Phase 1 (%)	Phase 2: control (%)	Phase 2: pilot (%)	Pilot×Phase 2 (β_3), odds ratio (95% CI)
Immunisation services				
Services provided on a daily basis	60·6%	89·0%(%)	93·4%	4·97 (1·10–22·6)
A system to monitor immunised children	100·0%	95·6%	97·2%	NA
Mobile immunisation services	61·6%	52·7%	62·3%	2·48 (1·24–4·92)
Antenatal care services				
Services provided on a daily basis	93·9%	95·6%	98·1%	NA
A system to monitor pregnant women	100·0%	97·8%	97·2%	NA
Mobile antenatal services	78·8%	62·6%	46·7%	1·01 (0·49–2·13)

Data are authors' analysis of data from task profile survey of primary care physicians in family medicine pilot and control regions. The specifications for the regression model that uses difference-in-differences are given in the appendix pp 2–13. NA=not available because insufficient variation in services in the time period studied and between control and pilot regions to estimate odds ratios.

Table 3: **Key maternal and child health services provided in phases 1 and 2 of family medicine-centred primary health-care reforms in pilot and control regions**

	Number of activities per service category	Pilot×Phase 2 (β_3), odds ratio (95% CI)
Application of medical technologies	8	0·89 (0·73–1·08)
First contact management	26	1·27 (1·12–1·44)
Prevention		
Patient based	6	1·24 (0·92–1·67)
Population based	6	0·87 (0·70–1·07)
Maternal and child care	5	1·70 (1·15–2·52)
Long-term disorders		
Diagnosis	20	1·13 (1·00–1·28)
Treatment initiation	18	1·41 (1·21–1·65)
Monitoring	20	1·45 (1·25–1·69)

Data are authors' analysis of data from task profile survey of primary care physicians in family medicine pilot and control regions. The specifications for the regression model that uses difference-in-differences are given in the appendix pp 2–13.

Table 4: **Effect of the introduction of family medicine on medical skills and scope of health services provided by primary health-care physicians**

Expansion of emergency and hospital services to address maternal and neonatal emergencies

During the HTP, the number and capacity of human resources increased substantially, with a more equitable distribution of health staff across the country than existed previously. Family medicine-centred primary health-care services were developed in all provinces. Emergency ambulance services were expanded substantially, including the air ambulance service for complex emergencies. These emergency services, which are provided free of charge, also responded to obstetric and neonatal emergencies. By 2008, accident and emergency services and intensive care services were made freely accessible in all public and private hospitals. Moreover, blood transfusion services were developed further, with a rapid response system for maternal emergencies. Collectively, these changes led to increased service access to maternal and child health services and have helped to reduce maternal, under-5, infant, and neonatal mortality. New staff contracts, increased remuneration, and better working conditions have helped to attract and retain staff in poor and underserved areas.

During the HTP, the number of hospitals providing neonatal services expanded sixfold, from 141 in 2002, to 906 in 2011. The expanded benefits in the General Health Insurance scheme included free services (in both public and private providers) for maternal emergencies, neonatal services (including neonatal intensive care), and services for management of congenital anomalies.

Expansion of hospital capacity and services

The number of hospital beds in Turkey increased gradually from 105710 in 1990 (1·87 beds per 1000 population) to 134950 in 2000 (1·99 beds per 1000 population), and increased sharply thereafter with the HTP to 194504 in 2011 (2·6 beds per 1000 population). Between 1990 and 2011, the number of beds per 1000

population rose almost twofold, from 80 403 to 121 297 in Ministry of Health hospitals and from 16 817 to 34 802 in university hospitals.

In line with HTP objectives to improve emergency services and services for complex disorders, between 2002 and 2011, the number of intensive care unit beds in Ministry of Health hospitals increased more than tenfold from 869 to 9581, in university hospitals from 353 to 3890, and in private hospitals from 992 to 7506. In total, across the public and private sectors, the number of intensive hospital beds increased ninefold from 2214 in 2002, to 20 977 in 2011.[55]

Use of both public and private hospitals was an explicit strategy within the HTP to expand the hospital sector and use the country's available capacity effectively. By 2010, the Social Security Institution had established contracts with 421 private hospitals to provide general diagnostic and curative hospital services, with copayments by users. Furthermore, these private hospitals provided free services for emergencies, burns, intensive care, cardiovascular surgery, neonatal care, congenital anomalies, organ transplantation, cancer care, and renal dialysis. The volume of hospital services (number of hospital visits) provided by the private sector increased from 5·7 million (4·6% of the total 124·3 million services) in 2002, to 59·1 million (17·5% of the total 337·8 million) in 2011.[55] The number of private sector hospital beds increased almost tenfold from 3361 in 1990 (0·06 per 1000 population) to 31 648 (0·42 per 1000 population) in 2011, with a rapid increase after 2005 to accommodate the increased patient volumes after the service contracts established by the Social Insurance Organisation with accredited private sector hospitals to provide services for insurance beneficiaries.

The expansion of the private sector was accompanied by increased government regulation. Whereas the Ministry of Finance introduced stringent financial oversight and controls over private hospitals, especially taxation, the Ministry of Health introduced new regulations on the accreditation, manpower planning (with capacity ceilings), and quality standards. Additionally, both ministries monitor user satisfaction and complaints with private hospitals, and intervene when necessary. Almost 90% of large private hospitals established contracts with the Social Insurance Organisation and then the Social Security Institution, who act as the purchaser of services and monitor service volumes and claims closely to identify excess or unwarranted claims, with penalties and reduced compensation against such claims. Increased oversight and regulation by the Ministry of Finance, the Ministry of Health, and the Social Security Institution has been facilitated by the introduction of new government decrees on private sector administration, health-care service quality standards, special health services, in-vitro fertilisation, transplantation services, and intensive care services. Ministry of Health circulars or communiqués have been issued in relation to implementation of health service standards.

New regulations were introduced in 2008 to moderate the growth of the private sector and movement of health staff from the public to the private sector. New regulations specified private sector hospital capacity and annual increases in number of beds, services provided, and staffing numbers.

Between 2002 and 2011, the average length of hospital stay decreased in the three major groups of hospital providers: from 8·6 to 5·8 days in university hospitals (tertiary units treating more complex cases); from 5·7 to 4·3 days in Ministry of Health facilities (mainly secondary care units); and from 3·1 to 2·0 days in private sector hospitals (which cater for privately insured patients and those with health insurance). On average, hospital length of stay fell from 5·8 days in 2002 to 4·1 in 2011, whereas the bed occupancy rate increased from 59·4% in 2002, to 65·6% in 2011.[56] However, the effect of these efficiency gains on service quality has not been measured.

Public health

In the aim to achieve UHC, the HTP prioritised a range of public health interventions to address high smoking rates and health risk factors such as physical inactivity and obesity. New public health and community-based programmes have been introduced to address the growing disease burdens from mental illness and diabetes mellitus. The HTP has also invested in the development of rapid response capability and in strengthening health system resilience to manage natural and man-made disasters. We do not discuss these initiatives and programmes in detail, but panel 5 provides a brief summary.

Effect of the HTP and UHC on access to maternal and child health services and child mortality

Analysis of the Turkish Demographic and Health Survey 1993–2008 shows that the use of maternal and child health services improved substantially throughout Turkey in this period, and especially in 2003–08. Improvements occurred in all regions of the country, especially after 2003 in the less well-served east region, rural areas, and in socioeconomically disadvantaged groups (table 5).

Improvements in access to maternal and child health services and enhanced equity

Antenatal care

Overall, from 1993 to 2008, the probability of receiving antenatal care during pregnancy increased from 63·0% to 93·4%, with the most significant increase in use between 2003 and 2008. The use of antenatal care rose by 3·1 percentage points from 1993 to 1998, by 8·5 percentage points from 1998 to 2003, and by

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Panel 5: **Public health interventions and initiatives to develop health system resilience to natural and man-made disasters**

Tobacco control

In 2004, Turkey became a signatory of the WHO Framework Convention for Tobacco Control, which was approved by the Grand National Assembly that year. In 2007, the Prime Minister launched the National Strategy for Tobacco Control (2008–12). In 2008, a comprehensive tobacco control law introduced a complete ban on smoking in public places, prohibited mass media advertising, and banned the promotion and sponsorship of all tobacco products.[57] In 2010–11, the tax on tobacco products was increased to 78% of cigarette costs, meeting the levels recommended by WHO.[58] These interventions have helped to reduce daily smoking prevalence in the Turkish adult population (those aged 15 years or older) from 32·1% in 2003, to 23·8% in 2012.[58] Turkey was the first country to fully implement the WHO Empower strategy for tobacco control, with initiatives targeting behaviour change of tobacco users.[59,60]

Obesity management

In 2010, about 34·6% of the population in Turkey was overweight and 30·3% was obese.[17] As part of the Health Transformation Program, the Ministry of Health introduced the Healthy Diet and Active Life Program of Turkey 2010–14 and for 2013–17, to raise population awareness of obesity, to promote a healthy diet, and to encourage regular physical activity.[61] Specialist teams have been established under the auspices of the Ministry of Health to fight obesity and in each province, directly accountable to provincial governors, to encourage active lifestyles and healthy nutrition.[42]

Mental health

In 2007, Turkey had the lowest number of psychiatrists per 100 000 population (one per 100 000), the third lowest number of psychiatric beds (12 per 100 000 population), and the fourth lowest number of admissions (115 per 100 000 population) in Europe. Mental health nurses accounted for only 1% of the total nurse workforce.[62] The management of mental health has focused on hospital-based care, with 4000 of the 6000 beds for mental illness located in eight specialised regional psychiatric hospitals.[63]

According to the Global Burden of Disease Study, in Turkey, between 1990 and 2010, major depressive disorder and anxiety disorders increased by roughly 50%. In 2010, major depressive disorder was the third largest cause of disease burden in terms of disability-adjusted life-years, and anxiety disorders were in the top ten leading disorders for disability-adjusted life-years.[64] In 2011, the Ministry of Health launched a National Mental Health Action Plan 2011–23,[65] with the aim to establish 240 community mental health centres by 2015, each serving a population of 300 000 people.[66] The plan aims to strengthen the provision of mental health services for adults, children, and adolescents; to reduce stigma associated with mental illness; to eliminate violence against women; to stop child abuse; and to prevent suicides and prevent post-traumatic distress and mental disorders after natural disasters and trauma. Its objectives for 2011–16 are to: improve rational prescribing for mental illness; increase the number of psychiatric beds (reducing beds in specialised psychiatric hospitals and increasing beds in general hospitals); shift hospital-based services to the community by expanding community-based mental health centres and outpatient services; expand the number of secure psychiatric beds in newly planned hospital campuses; increase the number of mental health professionals; and integrate mental health services within primary health care.[65]

Development of health system resilience to natural and man-made disasters

The 1999 Marmara earthquake in western Turkey caused unprecedented death, damage, and suffering, with immense economic, political and social consequences. The government, severely criticised by the population for its inability to mount an effective response, established a General Directorate of Turkish Emergency Management in 1999.[67]

In 2004, the Ministry of Health developed Disaster and Emergency Coordination Centers, equipped with portable facilities and systems for communicating with 81 provinces and international rescue teams. From 2004, new national medical rescue teams were formed, with 4847 volunteers trained and certified by 2011.[68] In 2009, the Prime Minister's Disaster and Emergency Management Presidency was created, focusing on disaster preparedness and rescue operations,[69] while the Ministry of Health concentrated on medical management of rescued people, establishing a comprehensive and integrated response capability to manage natural and man-made disasters.

In contrast to the Marmara disaster, the responses to the Van earthquake in 2011 (which measured 7·2 on the Richter scale) was rapid and comprehensive—the first emergency and rescue teams arrived in the affected area within 30 min, the Minister of Health arrived within 3 h to supervise the response, and within a few hours the Ministry of Health had established a hotline to coordinate communication flow with patient relatives. About 250 people were rescued from the collapsed infrastructure and rubble, mostly within 24 h of the earthquake,[70] with around 1700 patients with major physical and psychological trauma evacuated to regional hospitals by airlift and land transport.[71] More than 13 000 households were provided with tents and screened for injury, and around 5000 people were provided with psychosocial counselling. Public health interventions were implemented to prevent the emergence of communicable diseases, with a strict disease surveillance regime for foodborne and waterborne diseases.[70]

From 2011 onwards, an effective response was also mounted to address the Syrian refugee crisis, coordinated by Prime Minister's Disaster and Emergency Management Presidency and the Turkish Red Crescent Society.[72] By March, 2013, almost 230 000 Syrian refugees were housed in purpose-built facilities in southeast Turkey and provided with food, shelter and free medical assistance,[73] as well as a weekly subsistence allowance for each refugee.[74]

18·8 percentage points from 2003 to 2008. Striking increases occurred in rural areas, in eastern Turkey, and in low-asset quintiles. For example, although the use rate for the poorest quintile was 36·1% in 1993, this rate increased to 36·8% in 1998, to 44·9% in 2003, and then leapt to 84·1% in 2008. Between 2003 and 2008, the increase in use of antenatal care for the poorest quintile was a striking 39·2 percentage points. For the richest asset quintile, the use rate was 90·9% in 1993 and increased to 99·0% by 2008. Similarly, in women living in the east region or rural areas, those who do not speak Turkish as their mother tongue, and those women with

	Antenatal visit (%)				Proportion of births in a health facility (%)				Proportion of births attended by trained staff (%)				Immunisation uptake (all) (%)			
	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008
Location																
Urban	73·2%	74·4%	83·6%	96·4%	73·0%	76·4%	84·2%	91·8%	80·8%	81·9%	85·1%	94·1%	74·8%	49·5%	62·6%	78·4%
Rural	48·8%	51·2%	56·8%	87·7%	42·2%	61·0%	60·9%	74·1%	52·8%	67·6%	62·2%	76·2%	52·3%	38·3%	34·0%	63·8%
Region																
West	85·4%	83·7%	89·7%	97·2%	80·4%	86·7%	92·0%	93·4%	88·0%	89·2%	90·4%	95·8%	76·5%	50·3%	64·3%	79·3%
South	75·5%	73·6%	83·4%	95·9%	64·0%	69·3%	79·0%	90·1%	75·9%	84·2%	83·4%	90·5%	81·1%	56·8%	63·2%	75·5%
Central	59·4%	71·8%	82·1%	95·6%	64·2%	82·6%	90·1%	94·2%	72·2%	85·6%	91·0%	96·1%	64·9%	52·5%	59·7%	82·1%
North	63·1%	58·5%	82·5%	93·3%	66·8%	77·9%	87·3%	92·2%	71·6%	83·1%	81·6%	91·1%	62·5%	60·0%	60·5%	77·3%
East	35·1%	43·3%	54·1%	84·0%	30·3%	47·8%	54·1%	61·8%	41·4%	53·4%	57·1%	65·8%	41·6%	25·1%	35·3%	51·9%
Mother's education																
No education	36·9%	36·0%	45·0%	81·7%	32·2%	41·3%	42·7%	61·1%	42·7%	49·8%	47·1%	65·8%	47·8%	31·6%	22·5%	58·0%
Primary education	69·7%	70·1%	78·4%	94·1%	68·1%	75·9%	83·6%	89·3%	76·6%	82·3%	85·0%	91·2%	69·9%	45·1%	59·9%	75·5%
Secondary education or higher	89·9%	91·1%	96·2%	99·0%	86·5%	92·5%	94·6%	93·5%	93·5%	94·0%	91·6%	95·1%	81·9%	61·2%	65·3%	78·1%
Mother tongue																
Non-Turkish	39·0%	43·9%	53·2%	86·7%	27·7%	42·6%	50·0%	66·8%	39·3%	51·9%	53·9%	71·2%	37·3%	25·7%	33·1%	59·6%
Turkish	70·0%	75·9%	86·0%	96·4%	69·6%	83·4%	90·4%	94·0%	77·7%	87·9%	90·0%	95·4%	72·2%	53·6%	62·9%	79·3%
Asset quintile																
Asset quintile 1	36·1%	36·8%	44·9%	84·1%	33·0%	45·7%	50·4%	67·1%	43·1%	52·2%	53·0%	70·4%	48·0%	30·3%	29·0%	54·9%
Asset quintile 5	90·9%	94·8%	97·0%	99·0%	90·0%	95·1%	96·9%	92·4%	94·0%	93·2%	93·8%	94·6%	84·4%	70·4%	71·1%	79·0%
Mother's health insurance																
SIO	77·0%	83·1%	91·4%	97·0%	76·8%	85·5%	92·6%	92·3%	83·7%	89·5%	91·1%	93·8%	76·4%	55·1%	67·5%	78·7%
Green Card	29·7%	55·6%	56·6%	87·4%	37·8%	67·3%	63·0%	72·2%	56·8%	71·7%	63·0%	77·1%	20·0%	32·7%	38·8%	60·0%
None	52·8%	55·5%	64·3%	90·0%	47·7%	61·1%	64·7%	83·2%	57·9%	68·4%	68·8%	83·5%	56·2%	41·1%	42·5%	72·8%
Total	63·0%	66·1%	74·6%	93·4%	60·1%	70·9%	76·3%	85·7%	69·0%	76·8%	77·4%	88·0%	65·0%	45·3%	53·2%	73·7%

Data are authors' analysis of data from the from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13). Sample consists of children younger than 5 years for the first three analyses, and children between 12 months old and 24 months of age for immunisation. A fully immunised child has received the following vaccines: BCG; diphtheria–tetanus–pertussis 1, 2, and 3; polio 1, 2, and 3; and measles. SIO=Social Insurance Organisation.

Table 5: **Use of health services analysed by location, region, socioeconomic groups, and health insurance (1993–2008)**

no formal education, use of antenatal care increased substantially from 2003 to 2008 (table 5 and figure 13A).

Use of health services during birth

Analysis of health-care use during birth (defined as whether birth took place at a public or private hospital and whether it was attended by skilled health personnel—a doctor, midwife, or nurse) showed that the percentage of births taking place at a health facility increased from 60·1% in 1993 to 85·7% in 2008. Use of health services during birth increased most substantially for the poorest asset quintile and in rural or remote areas. In rural regions, the probability of delivering at a public or private health facility was 42·2% in 1993, increased to 61·0% in 1998, remained stable at that level in 2003, and then underwent a large increase to 74·1% in 2008. Similarly, for the poorest asset quintile, use of health facilities during birth increased from 33·1% in 1993 to 45·7% in 1998, with most of the improvement from 50·4% to 67·1% occurring between 2003 and 2008 (16·7 percentage points; see table 5 and figure 13B). In 1993, only 69% of births in Turkey were attended by skilled staff, but by 2008 this proportion had increased to 88%. For the poorest quintile, the probability of the birth being attended by skilled staff increased from 43·1% in 1993, to 70·4% in 2008, with the largest change (a 17·4 percentage point increase from 53·0%) between 2003 and 2008. Similar improvements were noted for mothers with no education and for those whose mother tongue was not Turkish (table 5 and figure 13B).

Childhood immunisations

The probability of having a complete set of childhood immunisations deteriorated in Turkey between 1993 and 1998 from 65·0% to 45·3%, and then improved to 53·2% in 2003, with a large increase to 73·7% in 2008. In rural areas, immunisation rates decreased through 2003, and then improved substantially from 34·0% coverage in 2003 to 63·8% in 2008 (table 5 and figure 13C).

From 2003, in the most disadvantaged and remote areas, we find a convergence in access to services across quintiles and across urban–rural regions. In addition to poorer households, women living in the east region of

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Turkey, less well educated women, and women whose mother tongue is not Turkish (and these women's children) experienced substantial rises in use of maternal services and immunisation coverage (table 5 and figures 13A, 13B, and 13C).

Changes in under-5 mortality, infant mortality, and neonatal mortality

Improvements in equity of access to health services in Turkey have emulated the sharp and significant reductions in under-5, infant, and neonatal mortality. The under-5 mortality rate decreased from 52·7 per 1000 livebirths in 1993, to 18·9 in 2008. For the overall population, for the poorest quintile, and in rural or remote areas, the largest percentage point reductions in under-5 mortality rates occurred between 2003 and 2008 (table 6).

In 1993–2008, under-5 mortality in urban areas decreased from 44·4 per 1000 livebirths in 1993, to 18·0 in 2008. In rural areas, the fall was more notable, from 63·9 per 1000 livebirths in 1993, to 20·7 in 2008. In the richest quintile (quintile 5), the under-5 mortality rate fell from 18·0 per 1000 livebirths in 1993, to 11·4 in 2008, whereas that for the poorest quintile (quintile 1) decreased sharply from 84·5 per 1000 livebirths in 1993, to 23·6 in 2008. Between 1993 and 2008, and especially after 2003, the differences in under-5 mortality rates between rural and urban areas, between the poorest and the richest quintiles, and between women with no education and those with secondary or higher education, narrowed substantially, with convergence to similar rates (figure 14).

The under-5 mortality rate in Turkey decreased in all Turkish Demographic and Health Survey regions. In the North region, the rates fell from 39·6 per 1000 livebirths in 1993, to 10·6 in 2008. In the East region, the mortality rate declined from 62·8 per 1000 livebirths in 1993, to 27·7 in 2008 (table 6).

The reductions in infant mortality resembled those reported for under-5 mortality, falling from 48·2 per 1000 livebirths in 1993, to 16·6 in 2008. Between 1993 and 2008, and especially after 2003, the differences in infant mortality rates between rural and urban areas, between the poorest and the richest quintiles, and between women with no education and those with secondary or higher education narrowed substantially, with convergence to similar rates (figure 14).

Between 1993 and 2008, infant mortality rates fell in all of the five Turkish Demographic and Health Survey regions of West, Central, North, South, and East Turkey. The infant mortality rate fell in the West region from 40·8 per 1000 livebirths in 1993, to 9·4 in 2008. In the East region, the level decreased from 56·1 per 100 livebirths in 1993, to 22·9 in 2008. Similarly, from 1993 to 2008, the neonatal mortality rate fell from 27·1 per 1000 livebirths in 1993, to 13·3 in 2008. In the North region, the neonatal mortality rate fell from 15·5 per 1000 livebirths in 1993, to none in 2008. In the East region, the rate fell from 31·4 per 1000 livebirths in 1993, to 18·1 in 2008 (table 6).

	Under-5 mortality per 1000 livebirths				Infant mortality per 1000 livebirths				Neonatal mortality per 1000 livebirths			
	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008
Location												
Urban	44·4	38·5	26·9	18·0	40·3	34·4	22·8	16·3	27·0	23·7	15·5	13·3
Rural	63·9	62·3	45·8	20·7	58·9	52·8	38·9	17·4	27·3	30·0	20·7	13·2
Region												
West	43·3	33·1	27·6	11·7	40·8	30·7	21·2	9·4	29·3	27·2	14·8	8·6
South	52·3	38·2	23·7	22·1	48·3	29·0	23·7	22·1	26·8	16·8	16·9	18·1
Central	60·5	48·8	27·0	20·1	54·2	43·6	21·1	19·0	29·0	28·2	10·6	14·2
North	39·6	45·7	53·6	10·6	37·9	40·6	40·2	10·6	15·5	15·2	26·8	0·0
East	62·8	63·3	41·7	27·7	56·1	55·5	37·6	22·9	31·4	31·2	21·5	18·1
Mother's education												
No education	66·7	64·3	53·3	19·6	59·8	57·2	46·4	14·7	26·5	37·4	26·6	11·4
Primary education	55·3	46·4	29·5	18·7	50·9	39·8	24·3	17·1	31·8	23·2	14·6	14·4
Secondary education or higher	15·4	27·1	20·5	18·9	15·4	24·1	17·8	17·0	12·0	19·5	13·3	12·3
Mother tongue												
Non-Turkish	68·4	53·1	44·8	27·6	62·7	45·8	40·6	23·9	31·9	25·6	24·8	20·3
Turkish	47·9	44·4	27·0	15·0	43·8	39·0	21·6	13·4	25·7	26·1	13·2	10·2
Asset quintiles												
Asset quintile 1	84·5	67·8	47·8	23·6	74·9	56·3	39·8	20·5	31·7	26·4	16·7	14·4
Asset quintile 5	18·0	20·7	11·6	11·4	18·0	20·7	8·7	9·5	9·0	18·7	5·8	7·6
Mother's health insurance												
SIO	44·2	38·7	23·1	17·2	41·7	36·4	19·1	15·7	28·4	27·9	14·1	12·3
Green Card	27·0	70·1	49·8	26·3	27·0	60·7	41·7	22·8	27·0	28·0	20·2	18·3
None	60·2	51·6	36·7	14·9	54·0	43·3	31·7	11·6	26·3	25·3	18·6	10·0
Total	52·7	47·1	33·2	18·9	48·2	41·1	28·2	16·6	27·1	26·0	17·2	13·3

Data are authors' analysis of data from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13). Sample consists of children who were born in the 5 years preceding the survey year. SIO=Social Insurance Organisation.

Table 6: **Under-5 mortality, infant mortality, and neonatal mortality rates (1993–2008)**

Effect of household characteristics and health insurance on access to maternal and child health services, and on under-5 and infant mortality rates

To ascertain the effect of the HTP and UHC on access to maternal and child health services and on under-5 and infant mortality, we extended our analysis of the Demographic and Health Survey and ran a multivariate regression analysis, controlling for household socio-economic and geographic characteristics (such as rural *vs* urban location; region of Turkey; income quintile; education of mother; and whether mother tongue is Turkish or not) and access to health insurance at the household level, to see whether the links between household circumstances and use rates weakened over time. We would expect the effect of household characteristics to weaken over time and health insurance

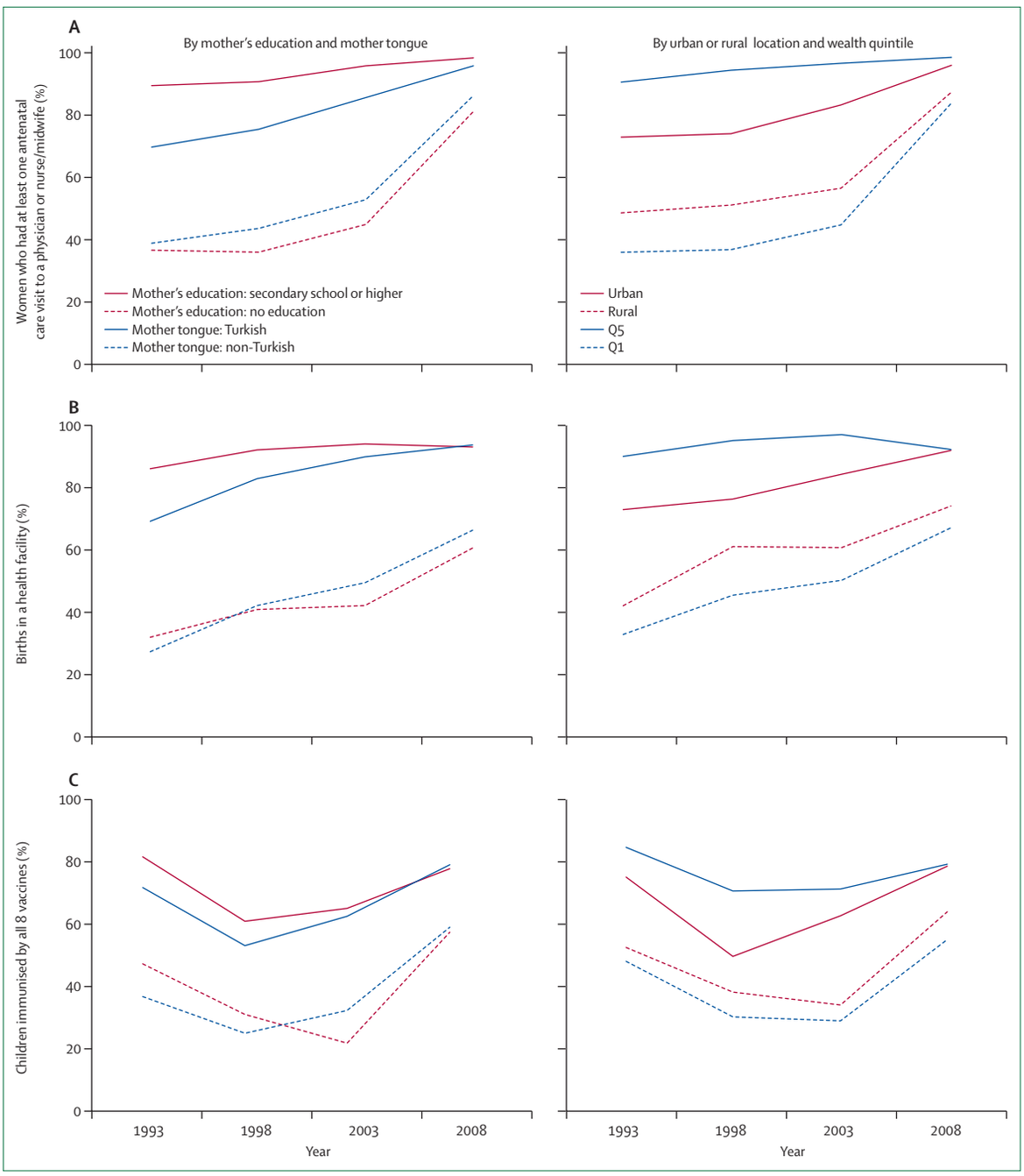

Figure 13: **Access to maternal and child health services, 1993–2008**
(A) Antenatal visits (% of women who had at least one antenatal care visit to a physician or nurse/midwife). (B) Proportion of births in a health facility. (C) Immunisation uptake. Data are authors' analysis of data from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13).

(Green Card coverage) to increase if access to insurance affected access to services. We ran this multivariate regression analysis for four cross-sections of the Demographic and Health Survey data in 1993, 1998, 2003, and 2008 (see table 7).

Table 7 shows that the most disadvantaged group of children (represented by the constant term in the regression) had a baseline probability of being born out of pregnancies where the mother received antenatal care 16·1% of the time, and this value increased for this group of children to 74·9% by 2008, up from 25·4% probability only 5 years previously in 2003. In the regressions, being in eastern Turkey is an omitted reference category: a child born in western Turkey was 25·9 percentage points

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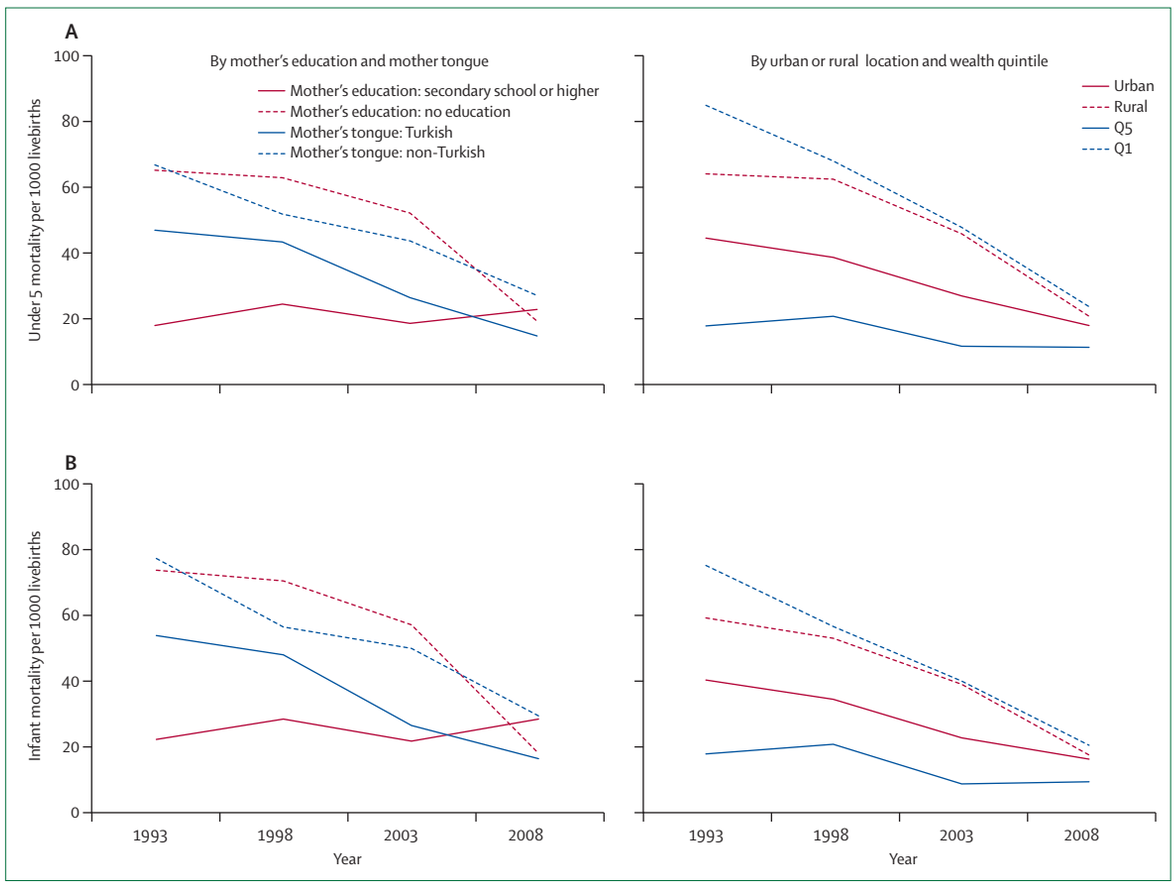

Figure 14: **Under-5 mortality and infant mortality, 1993–2008**
(A) Under-5 mortality rates per 1000 livebirths. (B) Infant mortality rates per 1000 livebirths. Data are authors' analysis of data from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13).

more likely than a child in eastern Turkey to have been in a pregnancy in which the mother received antenatal care in 1993. By 2008, a child in western Turkey was only 4·4 percentage points more likely to have been in a pregnancy where the mother received antenatal care than a child in eastern Turkey. A mother's amount of education was one of the most important determinants of reception of antenatal care in earlier years: for example, a woman who had a secondary school education or higher education degree was 20·7 percentage points more likely in 1993, and 20·3 percentage points more likely in 2003, to have received antenatal care than a woman with no formal education. However, in 2008, the association between a woman's educational attainment and her probability of receiving antenatal care was much weaker, with women with secondary school or higher education degrees being only 7·6 percentage points more likely to have received antenatal care than was a woman with no formal education in 2008.

Similarly, the association between poverty status (proxied in this case by being in the poorest asset quintile in the Demographic and Health Survey data), and antenatal care use also weakened in 2008. A child born into a household in the top quintile was 26·1 percentage points more likely to be born out of a pregnancy where the mother received antenatal care in 1993 than was a child in the poorest quintile. This association remained strong and positive until 2003. In 2003, the coefficient in the regression for being in the top quintile was 25·3 (ie, a child in the top quintile was 25·3 percentage points more likely to have received antenatal care than was a child in the bottom quintile in 2003). However, the coefficient for being in the top quintile declined to 9·0 in 2008.

We found similar results for the health-care use variables during birth (table 7). In 1993, for the most disadvantaged group of children (ie, those without health insurance and living in rural areas of eastern Turkey in households in the poorest asset quintile, whose mothers do not speak Turkish as mother tongue or had no formal education), the probability of being born in a private or public health facility was not statistically significantly different from zero. However, by 2008, this probability for this most disadvantaged group of children rose to 50%. Again, we found that the partial correlation coefficient on being in western Turkey, in urban areas, and in the richest asset

	Antenatal visit attended by health staff				Delivery in a health facility				Immunisation uptake (all)			
	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008
Constant (average for omitted category)	0·161*	0·150*	0·254*	0·749*	0·027	0·214*	0·243*	0·500*	0·216*	0·165*	0·057	0·399*
Location												
Rural	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Urban	0·044†	0·044†	0·096*	NS	0·149*	0·050*	0·099*	0·052*	0·108*	0·015	0·153*	NS
Region												
East	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
West	0·259*	0·177*	0·088*	0·044*	0·180*	0·121*	0·085*	0·055*	0·128†	0·072	0·057	0·138*
South	0·241*	0·157*	0·118*	0·061*	0·114*	NS	0·040†	0·067*	0·226*	0·238*	0·128†	0·137†
Central	0·086*	0·108*	0·058*	0·034*	0·122*	0·113*	0·078*	0·046*	NS	0·167*	0·080	0·124†
North	0·144*	0·090*	0·057*	0·041*	0·187*	0·136*	0·072*	0·059*	NS	0·183†	0·097	0·117‡
Mother's education												
No formal education	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Primary education	0·143*	0·177*	0·149*	0·053*	0·137*	0·121*	0·191*	0·115*	NS	NS	0·216*	0·092‡
Secondary education or higher	0·207*	0·247*	0·203*	0·076*	0·155*	0·186*	0·191*	0·112*	NS	NS	0·192*	NS
Mother tongue												
Non-Turkish	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Turkish	NS	0·051†	0·074*	NS	0·154*	0·206*	0·172*	0·138*	0·188*	0·160*	0·056	0·024
Welfare indicator												
Asset quintile 1	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Asset quintile 2	0·097*	0·125*	0·169*	0·065*	0·066*	0·108*	0·087*	0·111*	NS	0·028	0·074	0·095‡
Asset quintile 3	0·191*	0·244*	0·228*	0·105*	0·148*	0·169*	0·142*	0·117*	NS	0·172*	0·088	0·189*
Asset quintile 4	0·258*	0·268*	0·254*	0·088*	0·216*	0·183*	0·153*	0·104*	0·117‡	0·201*	0·154*	0·171†
Asset quintile 5	0·261*	0·309*	0·252*	0·088*	0·219*	0·200*	0·154*	0·059†	0·127‡	0·336*	0·192*	NS
R^2	0·246	0·274	0·298	0·085	0·277	0·276	0·319	0·192	0·166	0·136	0·213	0·092
Observations	3516	3392	4331	3747	3516	3392	4331	3747	710	699	802	802

Data are authors' analysis of data from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13). Dependent variables are binary values, taking a value of 1 if the incident has been realised, and 0 if the incident has not been realised. Reference categories are having no insurance, rural location, east region, mother has no education, non-Turkish mother tongue, and asset quintile 1. Sample consists of children younger than 5 years for the first three analyses, and children between 12 months old and 24 months of age for immunisation. A fully immunised child has received the following vaccines: BCG; diphtheria–tetanus–pertussis 1, 2, and 3; polio 1, 2, and 3; and measles. The regression analysis controls for health insurance status of the household. NS=non-significant (coefficient is not significantly different from 0 for that year). *p<0·01. †p<0·05. ‡p<0·1.

Table 7: **Use of maternal and child health-care services—multivariate regression analysis results (linear probability model)**

quintile all fell over time. In 2008, a child in the richest asset quintile was only 5·9 percentage points more likely to be born in a health facility than was a child in the poorest quintile, whereas only 5 years previously, this value was 15·4 percentage points (table 7).

The probability of being born with the attendance of skilled health staff also improved over time. Overall, we found that for all variables for use of health services during pregnancy and birth, the association between the circumstances into which children were born became delinked from actual use of services over time as a result of services becoming more widely available to children and households, irrespective of assets and location (table 7). Appendix p 19 reports the results of the linear probability model regression analysis in detail,

For a robustness check, we also ran the same regression analysis with a logistic regression functional form and estimated odds ratios for various population categories (eg, rural/urban, education level, welfare indicator) using services. The odds ratios were similar to those in the linear probability model. In the logistic regression, we omitted the most advantaged group from the regression and compared the odds ratio of the disadvantaged groups with this advantaged reference group. Consistent with the findings in the linear probability model, we found that rural households had increasing odds of using health facilities over time (especially between 2003 and 2008). Similarly, women with low amounts of education (no formal education) had increased odds of delivering at a health facility or their births being attended by trained staff as time progressed. For example, in 1993, a woman with no formal education had odds of 0·317 for her delivery being attended by trained staff compared with a woman with a secondary school or higher education degree. These odds increased to 0·709 by 2008 in comparison to the more educated group. Similarly, for immunisations, we found that in rural areas and among non-Turkish speaking mothers, the odds of completing

	Under-5 mortality				Infant mortality			
	1993	1998	2003	2008	1993	1998	2003	2008
Constant (average for omitted categories)	0·089*	0·085*	0·058*	0·037*	0·081*	0·072*	0·050*	0·032*
Health insurance								
No insurance	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Social Insurance Organisation	NS	NS	NS	NS	NS	NS	–0·001	NS
Green Card	NS	NS	0·021†	NS	NS	NS	0·018‡	NS
Private	NS	NS	NS	–0·025*	NS	NS	NS	–0·022*
Location								
Rural	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Urban	NS	NS	NS	NS	NS	NS	NS	NS
Region								
East	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
West	NS	–0·025‡	NS	NS	NS	NS	NS	NS
South	NS	–0·023‡	NS	NS	NS	–0·025†	NS	NS
Central	NS	NS	NS	NS	NS	NS	NS	NS
North	NS	–0·028‡	NS	NS	NS	–0·023‡	NS	NS
Mother's education								
No formal education	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Primary education	NS	–0·024‡	–0·020†	NS	NS	–0·026†	–0·016‡	NS
Secondary education or higher	–0·023‡	–0·028‡	–0·024†	NS	NS	–0·030†	–0·018‡	NS
Mother tongue								
Non-Turkish	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Turkish	NS	0·021‡	NS	NS	NS	0·021‡	NS	NS
Welfare indicator								
Asset quintile 1	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Asset quintile 2	–0·039*	NS	NS	NS	–0·034*	NS	NS	NS
Asset quintile 3	–0·031†	NS	NS	NS	–0·024‡	NS	NS	NS
Asset quintile 4	–0·048*	NS	NS	NS	–0·043*	NS	NS	NS
Asset quintile 5	–0·056*	–0·028‡	–0·020†	NS	–0·048*	NS	–0·017†	NS
Observations	3638	3474	4483	3852	3638	3474	4483	3852
R^2	0·013	0·010	0·011	0·003	0·011	0·009	0·010	0·003

Data are authors' analysis of data from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13). Dependent variables are binary values, taking a value of 1 if the incident has been realised, and 0 if the incident has not been realised. Reference categories are having no health insurance, rural location, east region, mother has no education, non-Turkish mother tongue, and asset quintile 1. Sample consists of children who were born in the 5 years preceding the survey year. NS=non-significant (coefficient is not significantly different from zero for that year). *p<0·01. † p<0·05. ‡ p<0·1.

Table 8: **Under-5 mortality and infant mortality—multivariate regression analysis results (linear probability model)**

immunisations were 0·584 and 0·432 in 1993, which increased by 2008 to a level that was not significantly different from 1. Thus, by 2008, the odds of these disadvantaged groups receiving a full set of immunisations were on a par with the advantaged groups in the sample (see appendix p 20 for logistic regression analysis results and odds ratios).

The multivariate regression analysis results, controlling for household characteristics and estimating the probability of under-5 and infant mortality for cross-sections of data in 1993, 1998, 2003, and 2008, show that none of the child circumstance variables (except for having access to private health insurance) were significantly correlated with low mortality rates in 2008. Although in 1993, and even in 2003, the mother's educational attainment and the asset quintile of the household were significant determinants of under-5 and infant mortality (with a child in the top quintile and born to a mother with secondary school or university degree being 7·9 percentage points less likely to die before the age of 5 years in 1993), we found that the association between these variables and child mortality was reduced to practically zero by 2008. The results of the multivariate regression analysis with the linear probability model are reported in table 8 and in appendix pp 21–22. As a robustness check, we undertook logistic regression analysis and report findings as odds ratios in appendix pp 23–24.

Effect of UHC and the HTP on access to maternal and child health services, under-5 mortality, and infant mortality

Comprehensive supply-side and demand-side interventions were introduced by the HTP to achieve UHC.

	Antenatal visit	Delivery in a health facility	Delivery attended by trained staff	Immunisation uptake (all)	Under-5 mortality	Infant mortality
Year effects (supply side)						
1993	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
1998	0·011	0·134*	0·103*	−0·160*	−0·005	−0·008
2003	0·108*	0·181*	0·117*	−0·104*	−0·022*	−0·021*
2008	0·355*	0·325*	0·235*	0·092‡	−0·030*	−0·028*
Health insurance (demand side)						
No insurance	Omitted	Omitted	Omitted	Omitted	Omitted	Omitted
Green Card (in 1993)	−0·106	−0·015	0·099	−0·375†	−0·041	−0·034
Interaction between Green Card and year						
Green Card in 1998	0·193†	0·133	0·001	0·361†	0·045	0·042
Green Card in 2003	0·125‡	0·117	−0·039	0·364†	0·061†	0·051‡
Green Card in 2008	0·215*	0·092	−0·001	0·442†	0·028	0·022
Household characteristics	Included	Included	Included	Included	Included	Included
Observations	8302	8302	8302	1610	8583	8583
R^2	0·237	0·255	0·240	0·165	0·011	0·010

Data are authors' analysis of data from the Turkish Demographic and Health Survey 1993, 1998, 2003, and 2008 (references 12–15 in appendix and appendix pp 2–13). Dependent variables are binary values, taking a value of 1 if the incident has been realised, and 0 if the incident has not been realised. Other independent variables included in the regression but not shown here are: location, region (five levels), mother's education (three levels), mother tongue, asset quintiles (five levels), and constant term. Samples for the first three dependent variables consist of children younger than 5 years. Sample consists of children who were born in the past 5 years for mortality calculations, and children between 12 months and 24 months of age for immunisation. A fully immunised child has received the following vaccines: BCG; diphtheria–tetanus–pertussis 1, 2, and 3; polio 1, 2, and 3; and measles.* p<0·01. † p<0·05. ‡ p<0·1.

Table 9: **Effect of universal health coverage and Health Transformation Program on service use, under-5 mortality, and infant mortality—pooled differences in differences (linear probability model) regression analysis results**

On the demand side, the Green Card scheme successfully targeted non-contributory health insurance programmes, increased access to health insurance for the poorest deciles, expanded benefits, and reduced cost-sharing. Expansion of the primary health care and hospital services across the country improved access to health services for insured citizens.

Through difference-in-differences estimation with pooled cross-sections of the Turkey Demographic Health Survey data, we assessed the relative importance of the demand-side and supply-side interventions included in the HTP on the use of maternal and child health services, under-5 mortality, and infant mortality, which we have used as tracers for health system performance. The supply-side effects of the HTP were classified in regressions as the year effect for 2008 (web appendix pp 2–13).

Supply-side effects

For all maternal health service use variables, we show strong and significant year effects for 2008 (table 9). When all household characteristics are controlled for, a child whose information was collected in 2008 was 36·1 percentage points more likely to have their mother receive antenatal care during pregnancy than was a child in 1993. The child was 33 percentage points more likely to be born in a health facility, and 24 percentage points more likely to have had their birth attended by skilled health-care personnel than a child whose data were collected in 1993. Although the year effects for 1998 and 2003 were also significant for these variables, compared with the baseline year of 1993, the correlation coefficient for being born in 2008 showed the largest increase.

For immunisation coverage, under-5 mortality, and infant mortality rates, we also found significant year effects in 2008. In fact, because of deteriorations in immunisation outcomes during 1998 and 2003, negative correlation coefficients were associated with these years for immunisation uptake, whereas that for 2008 was positive. A child whose data were collected in 2008 was 10 percentage points more likely to have a complete set of immunisations at 1 year of age than a child whose data were collected in 1993, when all other child and household characteristics are controlled for. This child was also 2·9 percentage points less likely to die before the age of 1 year, and 3·2 percentage points less likely to die before the age of 5 years (table 9).

Demand-side effects

The interaction between the Green Card and the 2008 year variable was significant for antenatal care use and for immunisations (table 9). This finding suggests that in the presence of Green Card, and in 2008 after the expansion of health services, households were even more likely to benefit from maternal and child health services.

When we used multivariate analysis to assess the effect of the Green Card scheme alone, back in the baseline year of 1993, we found that the effect of the scheme alone was insignificant on many of these outcomes and use indicators (tables 8 and 9). For immunisations, we even found a negative correlation coefficient. Hence, although an effect on use was likely because of improved access through the demand side—through the Green Card scheme—this effect was stronger in the presence of supply-side interventions, for which we found the most significant coefficients on the Green Card, in its interaction with the 2008 year variable, after the service expansion introduced by the HTP (table 9).

The effect of UHC and the HTP on user satisfaction

Our analysis of annual life satisfaction surveys undertaken by the Turkish Statistical Institute showed that from 2003 (when the surveys began), user satisfaction with health services increased substantially. In 2003, only 39·5% of the population was satisfied with health services, whereas by 2011 this proportion had increased to 75·9%.

Increase in satisfaction with health services outstripped increases in satisfaction for public services related to social insurance, education, legal and judiciary, and public security and order. Whereas in 2003 the population was

least satisfied with health services compared with other public services, by 2011 the amount of satisfaction with health services had increased the most (36·4 percentage points) as compared with social insurance (21·4 percentage points), education (15·5 percentage points), legal and judiciary (–6·8 percentage points), and public security and order (21·5 percentage points). By 2011, health services had reached similar satisfaction levels to services for public and security order, for which satisfaction was the highest (figure 15).

Discussion

The HTP accelerated six decades of efforts in Turkey to achieve UHC. With sustained leadership from a committed transformation team, Turkey successfully introduced changes in key health system functions of organisation and governance, financing, resource management, and service delivery. These changes helped to address three major problems faced by the Turkish health system: inadequate and inequitable health financing; inadequate and inequitably distributed health infrastructure and health human resources (and consequent inequalities in health service access); and inequities in health outcomes.

Our analysis shows that UHC, underpinned by the HTP, expanded health insurance coverage, especially for the poorest population decile, and provided financial risk protection. UHC has led to substantial improvements in use of key maternal and child health services, especially for the most disadvantaged population groups, and has helped to reduce under-5, infant, and neonatal mortality, especially in socioeconomically disadvantaged households. New Ministry of Health data suggest that the improvements shown in the analysis of the Demographic and Health Survey for improved service access, and under-5, infant, and neonatal mortality, have continued beyond 2008.[17] The Ministry of Health is planning a new Demographic and Health Survey study in 2013 to quantify the improvements between 2003 and 2013 (ie, when the HTP was implemented).

The case of Turkey clearly shows the effectiveness of UHC as a platform to achieve health system goals and improve equity. Our results suggest that UHC had quantifiable and beneficial effects on all health system goals: improved level and distribution of health, fairness in financing with better financial protection, and increased user satisfaction. Since 2003, population satisfaction with the health services has increased steadily, and has outstripped that for all other public services. These achievements were possible because of simultaneous improvements in both the demand side (increased health insurance coverage, expanded benefits, and reduced cost-sharing) and the supply side (expansion of infrastructure, health human resources, and health services—with more free health-care services, especially those that are likely to trigger catastrophic expenditures).

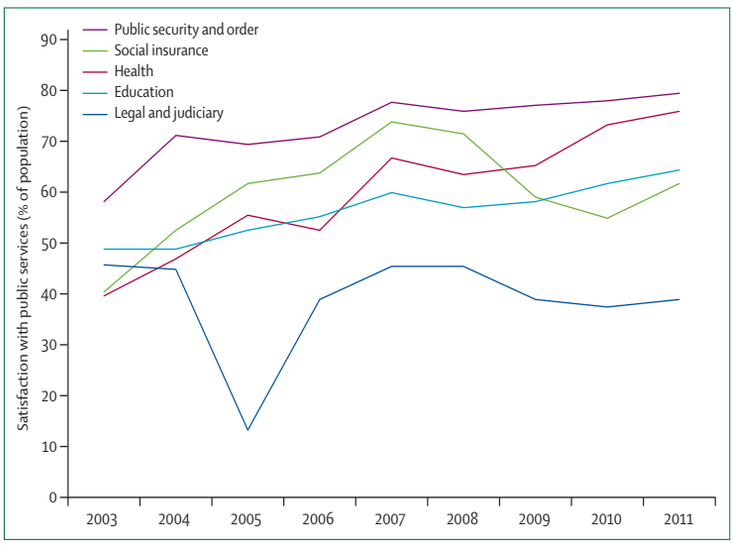

Figure 15: **Satisfaction with health services and other public services in Turkey, 2003–11**
Data taken from reference 24.

Key achievements of the HTP

Organisation and governance

Structural changes introduced in 2003–10 enabled the separation of stewardship, financing, and service provision roles within the Turkish health system, with the Ministry of Health undertaking stewardship duties, and focusing on policy and strategy development, for which new directorates were established. Health service-related operational and supervisory roles were delegated to new quasi-public agencies charged to oversee delivery of public health and personal health services, and the pharmaceutical and medical devices sectors. The newly established Social Security Institution has assumed financial pooling (of funds from health insurance contributions and the government budget) and strategic purchasing functions, with a focus on improving the quality and efficiency of the services contracted from both private and public sector health-care providers. New laws and mechanisms have increased empowerment of citizens in relation to health service providers, with clear articulation of rights to health insurance and services and what citizens should expect from the health system.

Health system financing

The fiscal space created by sustained economic growth in Turkey enabled the government to substantially increase health expenditures. From 2003, total health expenditures as a proportion of GDP increased from 5·3% to reach 6·1% in 2008, with almost three-quarters of this amount coming from the public sector. Private sector investment in the health sector also rose. Furthermore, the fragmented and inequitable health insurance system, which consisted of five insurance schemes each with different benefits, was consolidated

to establish a unified general health insurance scheme with harmonised benefits.

In addition to these improvements, perhaps the most notable achievement of the financial reforms was the rapid expansion of the Green Card scheme and its establishment as an insurance mechanism. The number of people enrolled in the scheme rose from 2·4 million in 2003, to 10·2 million in 2011. Targeting of the Green Card scheme to cover the poorest groups of the population also improved. By 2011, roughly 85% of the poorest decile was covered by the Green Card or another insurance scheme, and 96% of the wealthiest deciles were covered by contributory insurance. Patient cost-sharing for health services was reduced for insurance beneficiaries, with expansion of free health-care services, especially for complex interventions likely to cause catastrophic expenditures, such as intensive care, cardiovascular surgery, renal dialysis, and cancer care. Consequently, out-of-pocket expenditures generally did not rise and catastrophic expenditures decreased.

Human resources and service delivery

The number of health staff almost doubled with the HTP, which enabled expansion of health system capacity. Increased university intake of medical and nursing students and other health professions, raised salaries, performance incentives, new contracting mechanisms for health human resources, and outsourcing of health services underpinned this expansion. The compulsory service for newly qualified doctors and specialists, and the elimination of dual practice among hospital physicians helped to address staff shortages in the public sector and expand capacity of clinical services in hospitals. Regulations, which moderated private sector capacity and growth, ensured public sector staffing needs were met.

The doubling of the number of health human resources in 2002–12 was accompanied by improved service access across the country, especially in eastern Turkey. By 2010, almost 20 000 family medicine teams were established to scale up family medicine-centred primary health care in 81 provinces, to offer a wider range of services than was previously possible. Both public and private organisations now provide health services for Social Security Institution beneficiaries, with better use of the available capacity and resources in the country. Maternal and child health services, including neonatal intensive care, emergency services, air ambulance, and transfusion services, were expanded to further reduce maternal and neonatal mortality.

Our findings suggest that in 2003–08, the simultaneous introduction of comprehensive demand-side (health insurance) and supply-side (human resources and service delivery) changes were more instrumental than socioeconomic and cultural determinants in improving service access and reducing under-5 and infant mortality rates. With the HTP, population coverage of health insurance rose, health benefits for insured people expanded, and out-of-pocket expenditures fell. The uptake of key health services by poorer population segments, and previously underserved populations in eastern and rural areas of Turkey, rose substantially.

Challenges and opportunities for Turkey in further expansion and maintenance of UHC

Many goals have been achieved during the HTP to reach UHC, but much remains to be done to reinforce the gains and sustain UHC underpinned by an equitable, efficient, effective, and responsive health system. A focus on sustainability is crucial, as Turkey and the world follow a post-Millenium Development Goal agenda that emphasises sustainable development.[75]

We have focused on maternal and child health services as tracers to measure the success of the HTP and UHC. These areas, which were a priority for the HTP, had the largest inequities and underachievement, but also had the most reliable data over time. This focus is also an important limitation of our analysis. Data weaknesses in relation to chronic diseases and services for them have hindered systematic analysis of changes in relation to diseases such as diabetes mellitus, hypertension, heart disease, mental illness, and cancers. As is the case for other middle-income countries, chronic illnesses pose a major future challenge for Turkey that needs to be comprehensively addressed in the next phase of UHC.

Upkeep of health insurance coverage and benefits

With the HTP, health insurance coverage in Turkey expanded rapidly. Whereas in 2003 only 24% of the poorest decile was covered by health insurance, by 2011 this proportion had increased to 85%. For the richest decile, health insurance coverage has increased from 90% in 2003, to 96% in 2011. Further expansion has occurred since, but efforts need to be intensified to expand coverage to 100% (for both the Green Card scheme and obligatory insurance). However, as UHC reaches 100% population coverage, appropriate regulatory systems will be necessary to clarify the role of voluntary and additional health insurance.

Turkey has effectively introduced UHC to address unmet need and reduce inequities, especially in relation to maternal and child health. The future scope and scale of UHC need to be aligned with changing health needs, since chronic illnesses, especially diabetes mellitus, cancer, and mental illness, are increasing. As the steward of the health system, the Ministry of Health needs to set clear strategic priorities, with transparent mechanisms to efficiently allocate resources to cost-effective interventions to meet emerging challenges. The newly created Ministry of Health directorates, with responsibility for generation of intelligence and for formulation of strategic policy direction, are well positioned to identify emerging

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needs and set priorities in line with international best practice. Useful lessons can be learned from international experience—for example, from the National Institute for Health and Care Excellence in the UK, which has successfully extended its role beyond health technology assessment to the development of effective guidelines for health and social care.[76]

The unfinished equity agenda

The HTP emphasised citizens' rights to health, social justice, and equity, and reduced stark inequalities between the east and west, the poor and rich, uneducated and educated, and rural and urban populations. However, despite improvements in access to women's health services and maternal mortality ratios, women still face inequalities in other sociocultural aspects of life.[77]

In relation to women's health and gender, Turkey ranks below what should be achieved in view of its degree of socioeconomic development. Future efforts should prioritise women, especially women's education, health literacy, reproductive health rights, social empowerment, and labour participation. Unacceptable violence against women must be stopped. Emerging risk factors related to obesity, heart disease, and women's cancers should be government priorities. The development of the National Action Plan—Gender Equality 2008–13 is an important step in relation to efforts aimed at further improving women's health and reducing gender inequalities.[78]

Quality and safety

The next phase of UHC needs to focus on quality and safety in health care, with use of the regulatory powers of the Ministry of Health and the strategic purchasing power of the Social Security Institution. Both organisations should establish clear quality parameters and undertake transparent benchmarking of health-care providers across the country. Information about the quality of services provided by health-care institutions should be made publicly available by the Social Security Institution, which contracts with these providers and has data for services purchased. Benchmarking and public provision of information about the quality of health services will empower citizens and help to increase accountability of health-care providers. Initiatives by the Ministry of Health that began in 2012 to improve the clinical quality of health-care services, including those for chronic illnesses, are an important step in this direction.

Revival of public health and the health system to manage chronic diseases

Turkey has achieved substantial improvements in maternal and child health and communicable diseases, but the Global Burden of Disease 2010 analysis suggests that the country faces an emerging burden of chronic illnesses, which in disability-adjusted life-year terms has increased by more than 50% between 1990 and 2010. Ischaemic heart disease, cerebrovascular disease, major depressive illness, and cancers account for the top disease types by disability-adjusted life-years. The burden of cancers, mental illness, diabetes mellitus, and musculoskeletal disorders is increasing rapidly. Dietary risk factors, smoking, high body-mass index, high blood pressure, physical inactivity, high fasting plasma glucose, ambient pollution, and high total cholesterol—which contribute variously to cardiac disease, circulatory and respiratory illnesses, and cancer—were the major risk factors accounting for most of the disease burden in 2010.[79] These interacting risks and chronic diseases will bring multimorbidity that needs to be managed in new ways that focus on wellness, risk identification, and mitigation, and primary health care-based long-term prevention, treatment, and care.[80]

An efficient health system is crucial to sustain UHC as Turkey goes through this epidemiological transition with a rising burden of chronic illnesses, disability, and risks of illnesses. To effectively manage future health risks and chronicity, Turkey needs to strengthen its primary health-care system further. Additional investments are needed to increase the number of family physicians and nurses, develop the skill set of staff, and improve the physical and technical resources within primary health care to establish a comprehensive system that provides high-quality services with well-functioning referral and counter-referral systems. In particular, Turkey needs to expand access to community-based prevention and screening programmes for breast and cervical cancer; for chronic illnesses (eg, hypertension, heart disease, diabetes mellitus, and mental illness); and for physical, nutritional, and metabolic risk factors.

To monitor emerging risks for non-communicable diseases, Turkey should consider investment in population data systems. In addition to profiling biological risks, Turkey should develop systems to better measure and manage physical and environmental risks that affect progression of chronic diseases. The high availability of mobile telephone and internet technologies in the country offers opportunities to efficiently capture individual data for prevention, risk modification, and self-management of chronic illnesses.[81–83]

Expansion of fiscal space to continue investments in health

The political and economic stability achieved by Turkey since 2002 looks likely to continue in the near future. Thus far, Turkey has successfully withstood the global economic crisis and has continued to achieve healthy economic growth, which has provided the necessary fiscal space to increase health expenditures, which rose rapidly from 5·4% of GDP in 2000, to 6·7% in 2009, and stabilised thereafter at 6·7% in 2010 and 2011.[84] However, instability in neighbouring Middle East countries is worrying. Combined with the global economic crisis, especially in Europe, the risk of economic volatility is real. Sustained investment in the health sector will need maintenance of government tax and the revenue base. Further tax

increases for tobacco and alcohol products, which have adverse health effects and whose consumption is highly sensitive to price increases, could provide additional revenues for increased investments in the health sector.[85]

Management of public expectations

The transformation in the health system and advances in citizens' rights have increased public expectations, which will probably rise further with increased health literacy and availability of information. In addition to effective regulation to ensure safety and quality of services, the public will probably expect greater transparency and responsiveness from the government, the Ministry of Health, Social Security Institution, health-care providers, and the new agencies involved in the health sector.

Improvements in accountability, a core stewardship responsibility, should be a priority for the Ministry of Health, which needs to ensure independence, objectivity, and transparency, perhaps through the establishment of an independent agency for accountability and responsiveness, which could be based on new effective models such as the Independent Expert Review Group on Information and Accountability for Women's and Children's Health[86] and the Office for Budget Responsibility in the UK.[87]

Cultivation of the health workforce

The HTP achieved rapid expansion of the health workforce, with the introduction of contracting, new employment conditions, and outsourcing. The full-time work regulation eliminated dual practice and expanded public sector capacity to benefit patients, but increased the workload for clinicians in hospitals. Investments are now needed to expand opportunities for professional development and research, to create a committed and well-trained health workforce, especially in the public sector that provides almost 83% of all health services in Turkey.

Although the HTP is supported by most of the health workforce, the Turkish Medical Association has opposed many of the changes introduced. Although the association is a long-time opponent of private practice in the Turkish health system, contrary to this position it also expressed opposition to the changes to dual practice, which introduced full-time work and abolished private practice. They also asked for a reversal of several changes introduced by the HTP—specifically, for the Ministry of Health to provide doctors employed in the public sector with higher fixed salaries without performance-related pay, guaranteed employment, a national health system paid for by general taxation and not health insurance, and free health care at the point of delivery. The Ministry of Health's attempts to include the Turkish Medical Association in policy dialogues and stakeholder meetings have not always been successful, but this organisation's opposition has not hindered the transformation process.

Turkey's role in global health

With sustained economic growth since 2003, in 2012 Turkey emerged as the 17th largest economy (in nominal GDP terms) in the world.[88] Turkey is now a member of the Group of 20 (G20) and E7 countries. To achieve the ambition of becoming the tenth largest economy in the world and to remain competitive as a top-tier economy, Turkey needs to develop a knowledge-based economy that fosters innovation, knowledge creation, and knowledge translation.

A health system for innovation

Like other industrialised countries that have undergone economic transformation, Turkey is transitioning from an agricultural-intensive agrarian economy and labour-intensive manufacturing economy to a knowledge economy that relies on innovation and clusters of knowledge to create industries.[89] During this transition, the health sector, which accounts for an increasing proportion of the GDP and a large share of the government budget, needs to be reconceptualised as a dynamic sector that creates economic development and wealth for Turkey, and is not just an expenditure that brings benefits of improved health, financial risk protection, and user satisfaction.[90–92] Transition from a delivery-oriented health system to a health sector that is a dynamic driver of economic growth needs investment in research, development, and innovation.[93] To create an environment that fosters innovation and knowledge generation, Turkey will need to increase investments in the life sciences sector, especially to build a substantial research infrastructure by bringing together the life sciences industry, universities, and the Turkish health system.[94,95]

Investments in life sciences need to be combined with efforts to raise the profile of research and development among health staff and create incentives for them to engage in such research. Establishment of an innovative and globally competitive pharmaceutical industry will need substantial investment to develop scientific know-how. In view of Turkey's strong manufacturing and service industries, initial health research and development efforts in the country could target innovations in health service delivery and medical technologies to develop low-cost and effective innovations in health-care delivery.

Turkey is well positioned to develop cross-border health (health tourism) because of its geographical location, strong hotel and service industry, new investments in the health sector, and growing private sector. Turkey has already established a presence in cross-border health with a Ministry of Health directorate, which has a target of 500 000 patients by 2015, and $7 billion in revenues. To encourage health tourism, the government has decided to establish free trade areas that provide tax and research and development incentives.[96]

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A leading role in global health

In view of Turkey's success in introducing UHC, and the country's early experience in international health, as a G20 member and an E7 country, Turkey has the opportunity to assume a new role in global health, particularly in relation to development, diplomacy, and security. Since 1992, the Ministry of Health, through the Turkish Cooperation and Coordination Agency Presidency within Prime Minister's Office,[97] has actively engaged in technical and financial cooperation with countries in the Balkans (Bosnia and Herzegovina, and Kosovo), Central Asia (Azerbaijan, Kyrgyzstan, Kazakhstan, Turkmenistan, Uzbekistan, Afghanistan, and Tajikistan), the Middle East (West Bank and the Gaza Strip, Egypt, and Yemen), and Africa (Sudan, Somalia, and other African countries through its Africa Health Programme). Turkey cooperates mainly with other Turkic or Islamic territories or countries. Additionally, Turkey has actively supported global water and sanitation projects, reproductive health and infrastructure programmes, and has provided rescue teams to earthquakes, most notably in Haiti, Indonesia, Iran, and Pakistan. These experiences provide opportunities for Turkey to have an increased role in development, by using the know-how gained in the health sector, especially in relation to UHC. Turkey can also further extend the experience gained from effective management of the Syrian refugee crisis to other countries in the region affected by conflict, to reinforce the country's roles in diplomacy and security. The country's effective management of the avian influenza epidemic in 2006 and successful implementation of pandemic preparedness plans[98] provides a further platform for international cooperation in global health, and for Turkey to have a more active role in health and human security.

Lessons learned

In previous studies, investigators have identified several factors that are crucial for health systems to achieve health and social outcomes, including good governance and political commitment, institutions (including bureaucracies for institutional memory), ability to innovate (especially in service delivery), and capacity to respond to population needs and resilience.[99] In relation to UHC, the importance of political economy has been emphasised in cross-country studies. In particular, political commitment (expressed as a legal mandate), ability to raise higher tax revenues, and greater democracy have been identified as important factors that enable a greater share of GDP being allocated to public health spending, which is crucial to achieve UHC. Evidence also suggests that UHC is more difficult to introduce in divided societies with ethnic, religious, linguistic, or income inequalities.[100]

Several lessons emerge from Turkey's experience of UHC. These lessons are useful for Turkey as the country moves to the next phase of transformation to sustain UHC, but also for other countries that have embarked on a journey to achieve UHC.

Creation of a receptive context

In Turkey, interaction of several contextual factors, including demographic, economic, political, sociocultural, and technological factors, created a receptive context, in which the policy and service delivery innovations introduced through the HTP were considered by the population to be legitimate and timely to address the range of problems in the Turkish health system.[101–104]

Health as a fundamental right

The core principle of HTP, which emphasised human rights and in particular citizens' right to health, resonated well with the public, who wanted improvements in their rights—democracy, education, and health. This focus on human rights probably helped to increase the legitimacy of the HTP and generated widespread public support.

Political stability

The political stability achieved by the Turkish Government, which benefited from a majority in the Grand National Assembly, was an important factor that enabled the transformation. The Grand National Assembly was able to enact many transformative laws developed by the government—in stark contrast with many years of fragile coalition governments characterised by their inability to implement policies. The government, with a mandate from the population, was able to rapidly develop and enact legislations, which were implemented quickly. A committed transformation team at the Ministry of Health, strong prime ministerial support for change, and the leadership and continuity of the Minister of Health and senior management provided the opportunity to execute laws that had been legislated by the Grand National Assembly.

Economic growth and stability

The economic stability and the rapid GDP growth achieved by Turkey in 2003–12 created the much-needed fiscal space for the government to invest in social sectors. In this period of growth, the government could increase health expenditures and investments in the health sector in both absolute and relative terms, while enjoying growth in investments from the private sector. Along with the sustained growth in GDP, new legislation and practices to improve tax collection and balanced economic policies enabled increased tax receipts, a fall in inflation, and reductions in unemployment. Increased government revenues from tax, privatisation proceeds, and foreign direct investment enabled the government to provide financing from general budget revenues to expand Green Card coverage and create a unified general health insurance scheme. Increased employment also helped to expand obligatory insurance beyond the Green Card scheme.

The transformation team

A crucial success factor for the HTP and UHC was the transformation team—a highly committed team that remained together for almost 10 years from 2003 to 2013. The transformation team had an active role in the conception, design, implementation, and monitoring of the HTP, and provided strategic direction, continuity, and institutional memory for the transformation. The team engaged closely with international experts and agencies and provided a bridge between the strategic and operational stages of the implementation. Regular field visits helped to establish strong communication channels between provincial leadership, local implementation teams, and the Ministry of Health.

Sustained leadership

Findings suggest that sustained leadership with high-level support from the Prime Minister,[105] the Council of Ministers, and the Minister of Health was important for the success of the HTP and UHC. Although ministerial differences arose during the design and implementation of the HTP, with strong opposition from some parts of the bureaucracy, these differences lessened as the success of the programme became evident and support for transformation policies increased. As the HTP progressed, broad and sustained support from the cabinet ensured institutionalisation of the changes introduced by the HTP, rather than it being seen as an initiative of the health ministry. This widespread support also helped to anchor health in all policies.

Enhanced role of health within government

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

The success of the HTP enabled health policies to affect the country politics. Health became a major political agenda item for all political parties. The lessons from the HTP were used to inform other major government initiatives. The success of the programme, which led to a rise in user satisfaction, was probably a success factor in the re-election of the government.

Flexible implementation approach with ongoing learning

The flexible implementation approach adopted by the government combined strategic and tactical actions to introduce policies as windows of opportunity arose.[106] As broader strategic and structural changes in the health system were pursued, these changes were combined with highly visible tactical changes that improved user experience of, and satisfaction with, the health system.

The field coordinator model and regular focus groups and surveys enabled rapid identification of implementation challenges. Regular gathering of intelligence, with information sharing between the transformation leadership, the Ministry of Health, and the implementation teams, created feedback loops for effective communication. Many discussion meetings, both locally and centrally, fostered continuous learning and improvement. This learning environment and the flexible implementation approach helped the transformation leadership to continuously modify the scope, speed, and sequence of the transformation, while staying within the strategic framework of the HTP.

Speed of implementation

A crucial factor in the success of the HTP was the speed at which policies were implemented. Once a decision was made or a law enacted, implementation progressed rapidly, according to ambitious implementation timelines that the transformation team monitored weekly. When delays occurred, implementation strategies were changed and local groups or special Ministry of Health teams were assigned tasks to address bottlenecks. Rapid implementation prevented the formation of organised opposition to the changes and helped to overcome bureaucratic resistance. The speed of implementation was legitimised by rapid demonstration of benefits to the users and the public.

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

An important lesson from the UHC experience in Turkey is that comprehensive health system changes on the demand side (health insurance) and the supply side (human resources and service delivery) were instrumental in expanded insurance coverage and in translation of UHC to expanded service access, especially for the most disadvantaged segments of the population.

Our evidence suggests that although improved insurance coverage enhances access, benefits are more likely to be realised and are stronger in the presence of supply-side interventions. Importantly, our results also

show that the combination of demand-side and supply-side changes were instrumental, beyond other determinants, in improving service access and in reducing under-5 and infant mortality rates.

Towards 2023: the 100th anniversary of the Turkish Republic

Turkey aims to become a top-ten country in the world in terms of GDP size by 2023. These economic ambitions need to be represented in relation to health care, in view of the recent UHC experience. As Turkey enters the decade leading to the 100th anniversary of the Turkish Republic, UHC, achieved through the HTP, provides remarkable possibilities for the population's health and wellbeing to improve further. Turkey has developed a strategic plan for the health sector for 2013–17, with targets for 2023. When implementing this plan to further improve the health of the country's citizens, Turkey also has the opportunity to contribute to global health by sharing the experience and know-how gained during the introduction of UHC—a role befitting the country's global economic ambitions.

Contributors

RiA led the research team, study design, data analysis, and data interpretation; and wrote the first and subsequent drafts and the final report. SA and ReA contributed to data interpretation and writing of the drafts. SC, SS, MA, IG, and SN contributed to data analysis and data interpretation and contributed to drafts. SO, UA, BA, and UD contributed to data collection and provided comments on drafts. RiA is the guarantor.

Conflicts of interest

RiA has acted as an adviser and a consultant to the Ministry of Health of the Republic of Turkey, including in the Health Transformation Program, and has undertaken consulting assignments in Turkey for the Ministry of Health of Turkey, WHO, and the World Bank. ReA was the Minister of Health of Turkey from 2002 to 2012. SA was the Undersecretary of the Ministry of Health of Turkey from 2002 to 2009. SC works for the World Bank and was involved in the World Bank-funded Health Transition Project in Turkey. SC is on a secondment to Medipol University. SS, MA, IG, and SN have undertaken analytical consulting assignments for the Minstry of Health of Turkey. SO, UA, BA, and UD are employed at the General Directorate of Health Research, The Republic of Turkey Ministry of Health.

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Türkiye'de genel sağlık kapsamı: Hakkaniyetin artırılması

Rifat Atun, Sabahattin Aydın, Sarbani Chakraborty, Safir Sümer, Meltem Aran, İpek Gürol, Serpil Nazlıoğlu, Şenay Özgülcü, Ülger Aydoğan, Banu Ayar, Uğur Dilmen, Recep Akdağ

Türkiye sağlık sisteminde başarılı değişiklikler getirmiş ve genel sağlık kapsamını gerçekleştirmek için vatandaşlarına sağlık hakkı sağlamış, bu da finansmandaki, sağlık hizmetlerine erişimdeki ve sağlık sonuçlarındaki hakkaniyetsizliklere eğilmeye yardımcı olmuştur. Türkiye'de sağlık sistemi reformlarının gelişimini izlerken Sağlıkta Dönüşüm Programı (SDP) ile çakışan 2003–2013 tarihleri arasında özellikle durmaktayız. SDP, genel sağlık kapsamına erişmek için tüm vatandaşlar özellikle de en fakir nüfus grupları için sağlık sigortası kapsamını ve sağlık hizmetlerine erişimi hızlıca genişletmiştir. Bu makalede, sağlık sistemindeki dönüşümleri şekillendiren bağlamsal unsurlar tarafımızca analiz edilmiş, SDP'nin tasarımı ve uygulanışı incelenmiş, başarılı olmasını sağlayan faktörler belirlenmiş ve bunların etkileri araştırılmıştır. Bulgularımız SDP'nin hakkaniyeti artırmak için genel sağlık kapsamına erişmede önemli bir araç olduğunu, sağlık sisteminin tüm amaçları üzerinde ölçülebilir ve yararlı etkilere yol açtığını, sağlık düzeyini ve dağılımını iyileştirdiğini, finansmanda daha çok adalet ve daha iyi risk koruma sağladığını ve kullanıcı memnuniyetini önemli ölçüde artırdığını göstermiştir. SDP sonrasında, uyumlaştırılmış ve genişletilmiş yararları olan, birleştirilmiş bir Genel Sağlık Sigortası programı oluşturmak için beş sağlık sigortası programı birleştirilmiştir. Türkiye'deki en fakir nüfus grupları için sigorta kapsamı 2003 yılında 2.4 milyon kişiyken, 2011 yılında 10.2milyon kişi olmuştur. Tüm yurtta sağlık hizmetlerine erişim, özellikle de kilit anne ve çocuk sağlığı hizmetlerine erişim ve bu hizmetlerin kullanımı artarak, özellikle sosyo-ekonomik açıdan dezavantajlı gruplarda, anne ölüm oranı ve 5 yaş altı, bebek ve neonatal ölüm hızlarının büyük ölçüde azalmasına katkıda bulunmuştur. Genel sağlık kapsamının gerçekleştirilmesine ve sonuçlarının iyileştirilmesine yardımcı olan birkaç faktör vardır. Bu faktörler arasında ekonomik büyüme, politik istikrar, bir dönüşüm ekibinin öncülük ettiği kapsamlı bir dönüşüm stratejisi, hızlı politika dönüştürme, sürekli öğrenme içeren esnek bir uygulama ve sağlık sisteminde hem talep tarafında (sağlık sigortası kapsamının artırılması, yararların genişletilmesi ve maliyet paylaşımının düşürülmesi) hem de arz tarafında (altyapının, sağlık insan kaynaklarının ve sağlık hizmetlerinin genişletilmesi) eş zamanlı iyileşmeler sayılabilir.

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Imperial College Londra, Londra, İngiltere (Prof R Atun FRCP); **Harvard Üniversitesi, Harvard Halk Sağlığı Okulu, Boston, MA, ABD** (R Atun); **Medipol Üniversitesi, İstanbul, Türkiye** (Prof S Aydın MD, S Chakraborty PhD, S Sümer MSc); **Development Analytics, İstanbul, Türkiye** (M Aran PhD); **Londra Hijyen ve Tropik Tıp Okulu, Londra, İngiltere** (I Gürol PhD); **Türkiye Cumhuriyeti Sağlık Bakanlığı, Sağlık Araştırmaları Genel Müdürlüğü, Ankara, Türkiye** (S Nazlıoğlu MPhil, Ş Özgülcü MD, U Aydoğan MSc, B Ayar MD, Prof U Dilmen MD); **ve Türkiye Büyük Millet Meclisi Ankara, Türkiye** (Prof R Akdağ MD)

İletişim:
Prof Rifat Atun, Imperial College Business School and Faculty of Medicine, Imperial College Londra, London SW7 2AZ, BK
r.atun@imperial.ac.uk

Giriş

Genel sağlık kapsamı (GSK) etkin sağlık hizmetlerine erişimi genişletme, hastalıklar sırasındaki mali zorlukları azaltma ve sağlık sonuçlarını iyileştirmede önemli bir yoldur.[1] GSK'nın gerekli sağlık hizmetlerine erişimi belirleyen, doğru yasal mevzuata[2] ek olarak, kaliteli, ekonomik, erişilebilir ve etkin sağlık hizmeti sağlayan ve iyi çalışan bir sağlık sistemiyle desteklenmesi gerekmektedir.

Çin,[3] Meksika[4] ve Tayland[5,6] dahil, orta gelirli ülkelerden gelen son bilgiler önceden fon toplanarak oluşturulan, sağlık sigortası ya da sosyal sigorta gibi mali mekanizmaların genişletilmesinin sağlık hizmetlerine erişimin iyileşmesine yardımcı olduğunu ve mali koruma sağladığını göstermektedir. Ülkelerin bütününde yapılmış analizler genel olarak daha geniş sağlık kapsamının ve fon havuzlu finansmanın gerekli sağlık hizmetine erişimin genişlemesine ve özellikle fakir bireyler için, toplum sağlığında iyileşmelere yol açtığını göstermektedir.[7]

Bunlara ek olarak, Brezilya, Endonezya, Filipinler, Türkiye ve Güney Afrika gibi orta gelir düzeyine sahip birçok ülke önceden havuz oluşturularak uygulanan sigorta programları ve sağlık sistemini güçlendirici programlar getirerek sağlık hizmetlerine erişimdeki ve GSK sağlık sonuçlarındaki eşitsizliklere eğilmeye çalışmıştır.

Düşük gelir ve orta gelir düzeylerine sahip 22 ülke GSK'ya ulaşmaya çalışmaktadır.[1] Dolayısıyla, farklı ortamlardan gelen deneyimler GSK'nın oluşturulmasındaki bilgi boşluğuna[7] ve sağlık hizmetine erişim, mali riskten koruma, sağlık çıktıları ve kullanıcı memnuniyeti üzerindeki etkilerine eğilmede son derece önemlidir.

Önemli Mesajlar

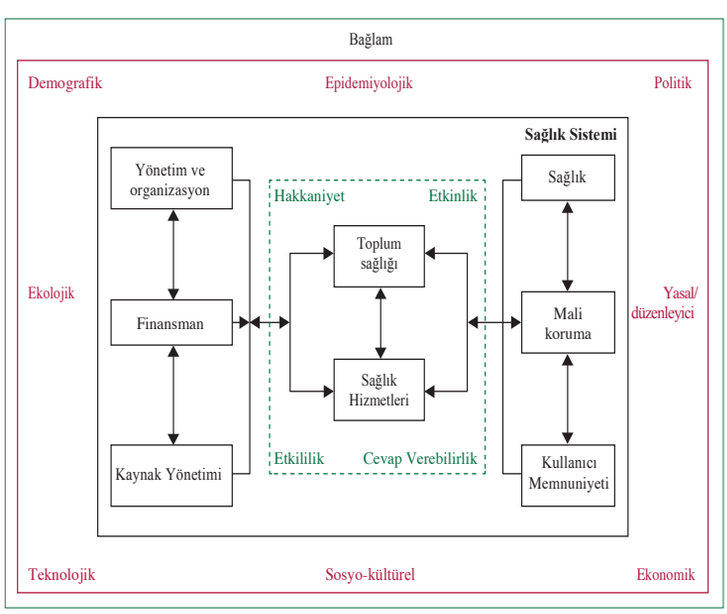
- Türkiye'deki Sağlıkta Dönüşüm Programı genel sağlık kapsamını (GSK) gerçekleştirmek için, sağlık sisteminin mali idare ve organizasyon, finansman, kaynak yönetimi ve hizmet sunumu işlevlerinde büyük değişiklikler getirmiştir.
- GSK, tüm vatandaşlar, özellikle de en fakir nüfus grupları için sağlık sigortası kapsamının ve sağlık hizmetlerine erişimin hızla genişlemesini getirmiştir. Özellikle kilit anne ve çocuk sağlığı hizmetlerine erişim ve bu hizmetlerin kullanımı artarak sosyo-ekonomik açıdan dezavantajlı ailelerde, 5 yaş altı, bebek ve neonatal ölüm hızlarının büyük ölçüde azalmasına katkıda bulunmuştur.
- Türkiye, sağlık düzeyi ve dağılımını ve finansman adaletini artırarak ve yıkıcı sağlık harcamalarını azaltarak, sağlık sisteminin amaçlarının gerçekleştirilmesi ve hakkaniyetin iyileştirilmesi için bir platform olarak GSK'nın etkililiğini göstermiş ve kullanıcıların sağlık sistemi konusundaki memnuniyetlerini önemli ölçüde iyileştirmiştir.
- Kullanımda ve çıktılarda iyileştirme sağlamada, sağlık sisteminde hem talep tarafında (sağlık sigortası kapsamının artırılması, yararların genişletilmesi ve maliyet paylaşımının düşürülmesi) hem de arz tarafında (altyapının, sağlık insan kaynaklarının ve sağlık hizmetlerinin genişletilmesi) eş zamanlı iyileşmeler gerçekleştirilmesi önemli olmuştur.
- Ekonomik büyüme, GSK'ya ulaşmada sağlık harcamalarındaki artış için gereken mali alanı sağlamıştır. Politik istikrar, sürekli liderlik, kendini adamış bir dönüşüm ekibi, sağlığın temel bir hak olarak konumlandırılması, yenilikçi ortam yaratma, kapsamlı bir dönüşüm stratejisi, hızlı politik dönüşüm, sürekli öğrenmeye dayalı esnek bir uygulama ile talep ve arz taraflarındaki değişikliklerin birleştirilmesi GSK'nın oluşturulmasını sağlayan en önemli faktörlerdendir.

Ek için bakınız Online

Türkiye'den edinilen kanıtlar GSK'yı gerçekleştirmek için reformlar uygulayan ülkeler açısından özellikle önemlidir; çünkü Türkiye, 30 yıllık yavaş bir ilerleme sonunda, 2003 yılından bu yana GSK'yı gerçekleştirme yolunda sağlık finansmanında, sağlık hizmetlerine erişimde ve çıktılarda hakkaniyetsizliği azaltacak geniş kapsamlı sağlık sistemi reformları[8] tasarlamış ve uygulamıştır.

Türkiye'nin GSK'ya doğru yaptığı yolculuktaki değişimlerin izlerini takip ettik. Türk sağlık sistemindeki değişikliklerin, sağlık sisteminin işlevlerine getirilen dönüşümlerin ve bunların sağlık sisteminin amaçları üzerindeki etkilerinin bağlamsal unsurlarının bir sistem bakışını[11–13] oluşturmak için, geçmiş çalışmaları temel alan[9,10] özel bir analitik çerçeve (şekil 1 ve ek s 1) kullandık. Türk sağlık sistemindeki ve GSK'yı gerçekleştirmedeki etkinsizliklere ve hakkaniyetsizliklere eğilmeyi amaçlayan kilit sağlık sistemi işlevlerindeki dönüşümleri analiz etmek için, belge ve politika analizleri ve kilit paydaşlarla (ek s 2–13) görüşmeler dahil, niteliksel ve niceliksel araştırma yöntemleri kullandık. Özellikle, 2003 yılından bu yana (Sağlıkta Dönüşüm Programı (SDP) ile çakışan ve GSK'ya yönelik çabaları hızla yoğunlaştıran dönem) yönetim ve organizasyon, finansman, kaynak yönetimi ve hizmet sunma işlevlerindeki dönüşümleri analiz ettik.

SDP ve GSK'nın Türkiye'deki üç ana sağlık sistemi problemini çözmeye nasıl yardımcı olduğunu araştırmak için ekonometrik yöntemler (ek s 2–13) içeren, niceliksel analiz kullandık. Bu problemler parçalara ayrılmış bir sağlık sigortası sistemiyle, yetersiz ve hakkaniyetsiz sağlık finansmanı, en fakir nüfuslar için düşük sigorta kapsamı ve cepten yapılan harcamaların yüksek olması; sağlık altyapısının ve insan kaynaklarının hakkaniyetsiz dağılımının sağlık hizmetlerine erişimde eşitsizliğe yol açması ve doğu-batı, fakir-zengin ve kentsel-kırsal ayrımlarıyla sağlık çıktılarında hakkaniyetsizlikti. Sağlık sisteminin performansının izleyicileri olarak anne ve çocuk sağlığı hizmetlerini (eğitimli personel tarafından doğum öncesi bakım, bir sağlık kurumunda doğumlar, eğitimli personelin hazır bulunduğu doğumlar ve aşılanma seviyesi) ve çocuklar için sağlık çıktılarını (5 yaş altı ölüm hızı, bebek ölüm hızı ve neonatal ölüm hızı) kullandık; çünkü bu alanlar SDP için öncelikliydi ve bu alanlarla ilgili güvenilir, zamana bağlı kesitsel nüfus verileri mevcuttu. Önemli olmalarına karşın kronik hastalıklardaki değişiklikleri inceleyemedik; çünkü bu konuda güvenilir kesitsel veriler ve eğilim verileri son derece enderdi.



Şekil 1: Analiz çerçevesi

Bu rapor, altı bölümde düzenlendi. Bu giriş bölümünden sonra, Türk sağlık sistemindeki kilit değişikliklere tarihsel bir bakışın ve SDP öncesindeki durumun bir analizinin verildiği bir bölüm gelmektedir. Üçüncü bölümde, SDP'nin planlanmasını ve uygulanmasını inceledik. Dördüncü bölümde, sağlık sisteminin organizasyonu ve yönetimi, sağlık finansmanı (sağlık sigortası kapsamı ve toplumun daha fakir kesimlerinin hedeflenmesi, cepten yapılan harcamalar ve mali koruma) insan kaynakları yönetimi ve hizmet sunumuna ilişkin olarak SDP'nin başarılarına yönelik kilit bulguları sunduk. Beşinci bölümde, kullanıcının sağlık sistemi konusundaki memnuniyetinin bir değerlendirmesi dahil, GSK ve SDP'nin sağlık hizmeti kullanımı ve sağlık çıktıları üzerindeki hakkaniyet etkilerinin bir analizini sunduk. Son olarak, SDP'nin kilit bulguları ve başarılarını özetledik ve bunların daha geniş olan GSK literatüründeki yerini belirledik ve Türkiye'de GSK'nın sürdürülebilirliğini tartışarak gelecekteki önemli riskleri, tehlikeleri ve fırsatları belirledik. GSK deneyiminden edinilen dersleri tartıştık ve 2023 yılında Türkiye Cumhuriyeti'nin 100. Kuruluş yıldönümü yaklaşırken Türkiye'nin küresel sağlık çerçevesinde nasıl konumlandırılabileceğini inceledik.

Türkiye: Durum analizi

Türkiye: Kilit olgular

Kökleri1299'a kadar giden Osmanlı İmparatorluğunun sona ermesinden sonra, 1923 yılında Türkiye Cumhuriyeti kuruldu. Osmanlı İmparatorluğu en geniş olduğu dönemde Avrupa, Asya, Ortadoğu ve Afrika'nın bölümlerini kapsamaktaydı. Günümüzde Türkiye, Asya ve Avrupa'yı birleştiren, üst-orta düzey gelirli, farklı sosyo-ekonomik kalkınma aşamalarındaki 81 ilde (şekil 2) 75.6 milyon kişinin yaşadığı bir ülkedir. Türkiye, son on yıl içerisinde hızlı bir ekonomik büyüme gerçekleştirmiştir ve ülke içinde sosyo-ekonomik farklılıklar olsa da, genç ve büyümekte olan bir nüfusun demografik avantajına sahiptir (ek s 14).

1980'li ve 1990'lı yıllardaki ekonomik ve politik güçlüklere karşın, Türkiye'deki nüfus sağlık göstergeleri 1990'larda pozitif bir yörüngede devam etti. Türkiye'de

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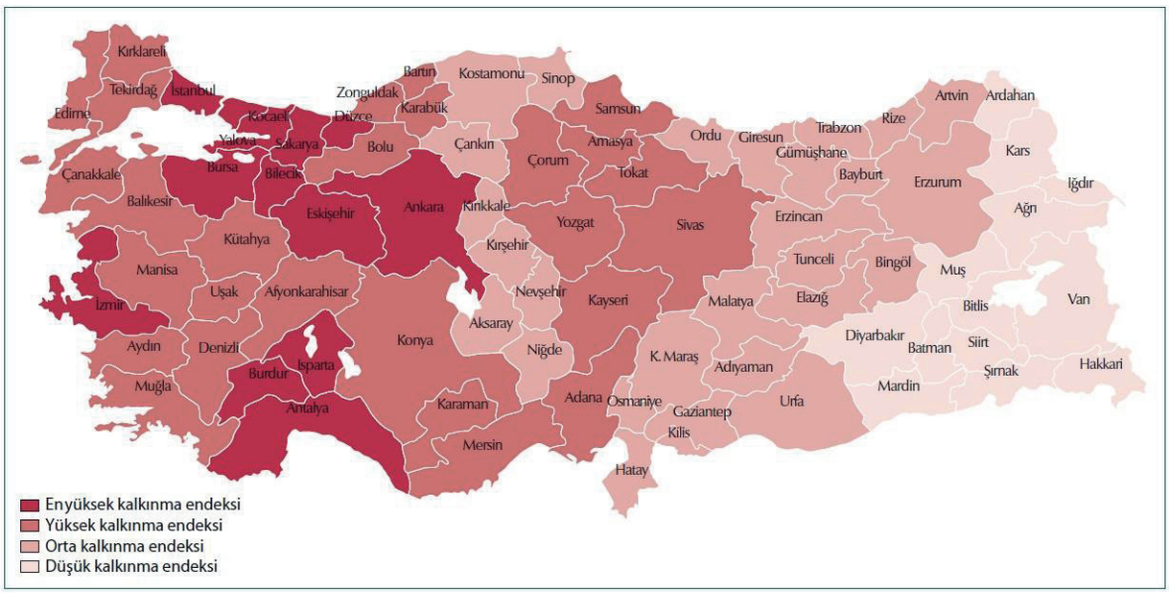
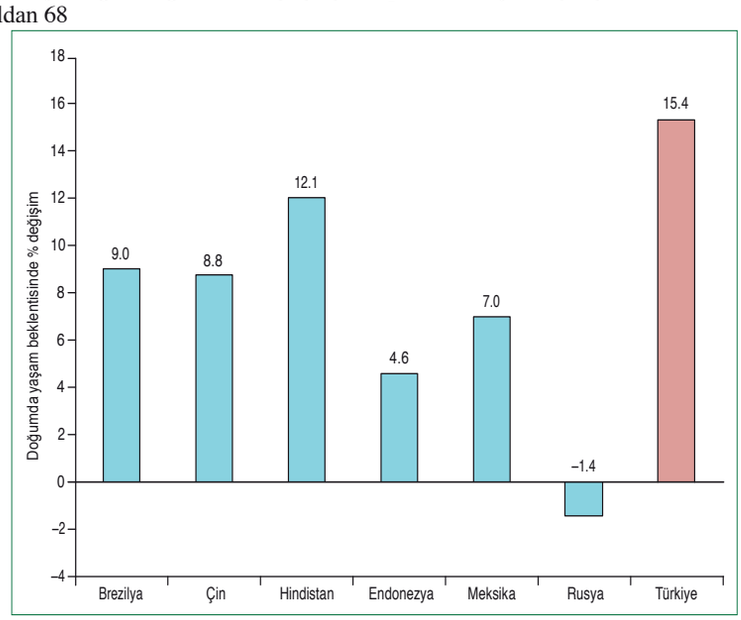


Şekil 2: **Sosyo-ekonomik gelişmişlik endeksine göre gruplanmış olarak Türkiye'deki iller**
Sosyo-ekonomik gelişmişlik endeksi karma bir endeks oluşturmak için, sekiz kategoride gruplandırılmış 61 parametre üzerinde, 2009 ve 2010 yıllarının nüfus bazlı temsil niteliğine haiz etüd verilerini bir araya getirerek bileşen analizini kullanır: Demografik (beş parametre); eğitim (altı); sağlık (beş); istihdam (sekiz); rekabetçilik ve yenilikçilik kapasitesi (15); mali kapasite (yedi); erişim (altı); ve yaşamdan memnuniyet (dokuz). İller sosyo-ekonomik gelişmişlik endeksi puanına göre dört kategoriye ayrılmıştır: En yüksek, yüksek, orta ve düşük gelişmişlik endeksi. Veriler, Türkiye Cumhuriyeti, Kalkınma Bakanlığı, Bölgesel Gelişme ve Yapısal Uyum Genel Müdürlüğü; İzleme, Değerlendirme ve Analiz Dairesi, Düzey 2 bölgeleri, sosyo-ekonomik gelişmişlik sıralaması, 1 Mayıs 2013.

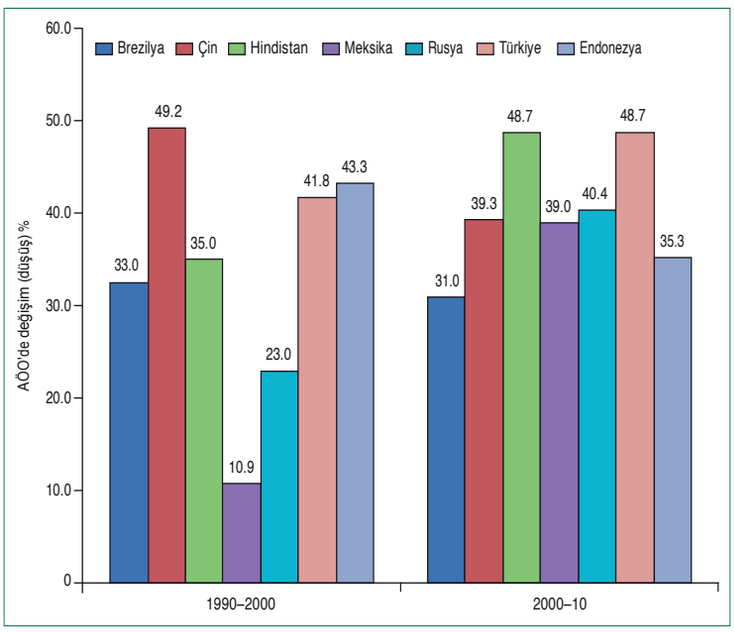
doğumdaki ortalama yaşam beklentisi 1990'da 65 yılken, 2009'da %15.4 artarak 75 yıl oldu ki bu da benzer sosyo-ekonomik gelişmişlik düzeyindeki diğer gelişen ekonomilerde (E7 ülkeleri) elde edilen yüzde artışından daha yüksektir: Hindistan (%+12.1, 58 yıldan 65 yıla), Brezilya (%+9.0, 67 yıldan 73 yıla), Çin (%+8.8, 68 yıldan 74 yıla), Meksika (%+7.0, 71 yıldan 76 yıla), Endonezya (%+4.6, 65 yıldan 68 yıla), ve Rusya (%–1.4, 69 yıldan 68 yıla; şekil 3).[14] Küresel Hastalık Yükü 2010 tar yapılan son çalışmalarda, Türkiye'de tahmini beklentisi (sağlıklı yaşam beklentisi) 1990'da erkek 63.7 yıl (55.3 yıl) ve kadınlar için 70.9 yıl (60.1 yı 2010'da erkekler için 71.2 yıl (61.8 yıl) ve kadın 77.7 yıl (66.0 yıl) olmuştur.[15]

Dünya Sağlık Örgütü (DSÖ), Dünya Bankası, Bi Milletler Çocuk Fonu ve Birleşmiş Milletler Fonu'ndan ajanslar arası tahminlere göre,[16] Türki her 100 000 canlı doğumda anne ölüm oranı 1990 y 67.0 iken, 1995 yılında 51.0, 2000 yılında 39.0 yılında 28.0 ve 2010 yılında 20.0'a düşmüşt rakamlar Türkiye Cumhuriyeti Sağlık Bakan verileriyle büyük ölçüde benzeşmektedir.[17] Bakanlığı da her 100 000 canlı doğumda anne oranı 2003'te 61.0, 2011 yılında ise 15.5 vermektedir. Şekil 4, Türkiye'de 1990 ile 2010 arasındaki anne ölüm oranının düşüş yüzdesini dönemde Çin (% 69.2, 120'den 37'ye), Hindistan (600'den 200'e), Endonezya (% 63.3, 600'den 2 Rusya (% 54.1, 74'ten 34'e), Brezilya (% 53.3, 1 56'ya), ve Meksika (% 45.7, 92'den 50'ye) dahil, d ülkelerinde raporlanandan daha yüksek ol göstermektedir.[16]

1990'da, kombine difteri, tetanos ve boğmaca aşısı; ağızdan çocuk felci aşısı ve kızamık aşısı için aşılama kapsamı sırasıyla %74, %74 ve %67 olmuştur ve 1995'te sırasıyla %66, %65 ve %67'ye düşmüştür. 2000 yılında kapsam sırasıyla %85, %85 ve %86 ve 2005 yılında sırasıyla %90, %90 ve %91 olmuştur. 2010 yılına gelindiğinde her üç aşı için kapsam %97'ye ulaşmıştır.[18]



Şekil 3: **Brezilya, Çin, Hindistan, Endonezya, Meksika, Rusya ve Türkiye'de doğumdaki yaşam beklentisindeki (yıl) değişim yüzdesi, 1990–2010**
Veriler referans 14'ten alınmıştır.



Şekil 4: **E7 ülkelerinde anne ölümü oranındaki değişim yüzdesi, 1990–2010**
AÖO=anne ölüm oranı. Veriler referans 16'dan alınmıştır.

Birleşmiş Milletler Çocuk Fonuna göre, Türkiye'deki 5 yaş altı ölüm hızı 1990 yılında 1000 canlı doğum başına 72 iken 2011 yılında 15'e ve bebek ölüm hızı ise 1990 yılında 1000 canlı doğum başına 60 iken 2011 yılında 12'ye düşmüştür.[19]

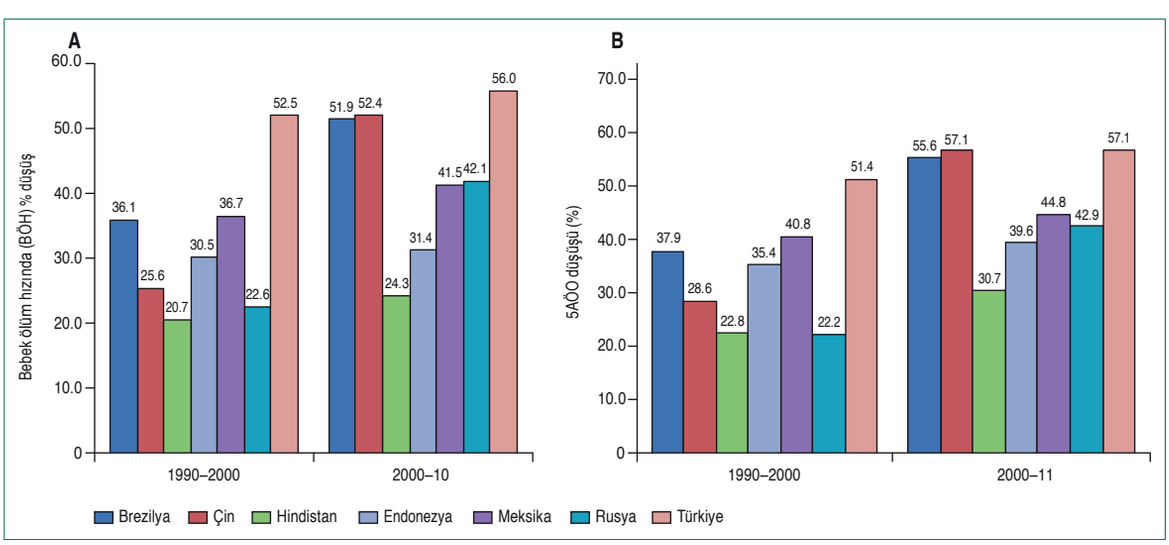
Türkiye'nin 1990–2010 arasında 5 yaş altı ölüm hızı ve bebek ölüm hızındaki düşüşler diğer E7 ülkelerinde elde edilenlerden daha fazladır (şekil 5).[20] Bebek ölümlerine ilişkin ajanslar arası tahminler büyük ölçüde Türkiye Cumhuriyeti Sağlık Bakanlığı verileriyle benzerdir (en son tahminler dışında); bu da Türkiye'deki bebek ölüm hızının 2003 yılında her 1000 canlı doğumda 29.0'dan 2011 yılında her 1000 canlı doğumda 7.7'ye düştüğünü göstermektedir.[18]

1990 ve 2010 yılları arasında Türkiye'deki tüm nedenler için hastalık yükü sürekli olarak düşmüş, 100 000 nüfus başına 1990 yılında 40 000 sakatlığa ayarlanmış yaşam yılı iken, 1995 yılında 36 000, 2000 yılında 30 000, 2005 yılında 28 000, 2010 yılında 27 000 olmuştur. Bulaşıcı, anne, neonatal hastalıkların ve beslenme bozukluklarının yükü hızla azalmış, 1990 yılında 100 000 nüfus başına 15 000 sakatlığa ayarlanmış yaşam yılı iken, 2010 yılında 100 000 nüfus başına yaklaşık 4000 olmuştur. Bulaşıcı olmayan hastalıklardaki azalma daha az olmuş, 1990 yılında 100 000 nüfus başına 22 000 sakatlığa ayarlanmış yaşam yılı iken 2010 yılında 20 000 olmuştur.[21]

Türk sağlık sistemindeki kilit değişikliklere tarihsel bir bakış

Türkiye'de GSK'ya doğru ilerleme 1945 yılında mavi yakalı işçiler için Sosyal Sigorta Kurumunun kurulmasıyla başladı. Bunu 1949 yılında emekli memurlar ve onlara bağımlı olanlar için kurulan Emekli Sandığı takip etti. 1946 yılından sonra Sağlık ve Sosyal İşler Bakanlığı önleyici ve tedavi edici sağlık hizmetlerinin sağlanmasında aktif bir rol benimsedi ve 1954 yılında hastanelerin ve birinci basamak sağlık merkezlerinin idari sorumluluğunu üstlendi (panel 1).

1960 yılından sonra, GSK 5-yıllık devlet planlarında bir devlet amacı oldu. 1961 yılında çıkarılan Sağlık Hizmetlerinin Sosyalleştirilmesi hakkında Kanun, Sağlık ve Sosyal İşler Bakanlığı tarafından yönetilen bütünleştirilmiş üçayaklı bir sağlık sistemi içeren bir sağlık hizmeti programının oluşturulmasını sağladı. 1971 yılında, Bağ-Kur kuruldu (kendi işinde çalışanlar,



Şekil 5: **E7 ülkelerinde bebek ölümü ve 5 yaş altı ölümü hızlarındaki değişim yüzdesi, 1990–2010**
(A) bebek ölüm hızındaki değişim yüzdesi. (B) 5 yaş altı ölüm hızındaki değişim yüzdesi. BÖH=bebek ölüm hızı. 5AÖO=5 yaş altı ölümü oranı. Veriler referans 20'den alınmıştır.

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Panel 1: **Türk sağlık sisteminde kilit gelişmeler - tarihsel bir bakış**

1920–1929
- 1920: 1920 yılında Türkiye Büyük Millet Meclisinin açılışından sonra (3 sayılı yasa) halk sağlığı üzerine odaklanan Türkiye Cumhuriyeti Sağlık ve Sosyal Yardım Bakanlığı (SSYB) kuruldu.

1930–1949
- 1945: Mavi yakalılar için Sosyal sağlık sigortası (Sosyal Sigorta Kurumu) kuruldu.
- 1946: Birinci ulusal 10-yıllık sağlık planı geliştirildi.
- 1949: Emekli memurlar için sosyal sağlık sigortası

1950–1959
- 1952: Sağlık Bakanlığında Anne ve Çocuk sağlığı bölümü kuruldu.
- 1953: DSÖ ve Birleşmiş Milletler Çocuk Fonu desteğiyle, anne ve çocuk sağlığı geliştirme merkezi kuruldu
- 1953: Türk Tabipler Birliği kuruldu.
- 1954: SSYB tedavi hizmetlerinin sağlanmasında rol aldı, SSYB tarafından geliştirilen model hastanelerle başlandı ve sağlık işgücünün eğitimi yapıldı.
- 1954: İl ve belediye idarelerine ait sağlık tesisleri SSYB idaresi altına alındı ve iller tarafından yönetildi.
- 1954: Birinci ulusal 10 yıllık sağlık programı açıklandı. (bu, Türk ulusal sağlık hizmetinin planlanmasında ve organizasyonunda bir köşe taşıdır.)

1960–1979
- 1961: Sağlığın Hizmetlerinin Sosyalleştirilmesi hakkında Kanun kabul edildi ve bütünleştirilmiş bir sağlık hizmeti programına yol açıldı ve SSYB tarafından yönetilen üç-ayaklı bir sağlık sistemi kuruldu. (sağlık ocağı, sağlık merkezi ve bölge hastanesi)
- 1965: Doğumu teşvik eden politikalarla, Nüfus Planlaması hakkında Kanun kabul edildi.
- 1971: Bağ-Kur kuruldu. (kendi işinde çalışanlar, esnaf ve organize gruplar için sosyal sağlık sigortası)

1980–1989
- 1982: Yeni anayasa, devletin birleştirilmiş bir sosyal sağlık sigortası yoluyla halkın sağlığını korumadaki ve genel sağlık kapsamını sağlamadaki önemini tekrar gösterdi.
- 1987: Sağlık Bakanlığına hizmet sağlamada daha dar bir rol veren ve düzenleme işine odaklanmasını getiren Sağlık Hizmetleri Temel Kanunu yürürlüğe girdi, fakat kanunun Anayasa Mahkemesi tarafından kısmen reddedilmesi üzerine tam olarak uygulanamadı.

1990–1999
- 1992: Geniş paydaş katılımıyla Ulusal Politika Forumu toplandı.
- 1992: Birleştirilmiş bir sağlık sigortası programı oluşturulana dek, geçici bir önlem olarak Yeşil Kart programı getirildi. (resmi sağlık sigortası programları dışındaki haneler için sağlık sigortası)
- 1993: Sağlık Yasası, Sağlık Bakanlığının Teşkilat ve Görevleri hakkında kanun, İl Sağlık İdaresi, Genel Sağlık Sigortası yasası geliştirildi.
- 1996: Sağlık finansmanı kurumu kuruluşu ve süreci, birinci basamak sağlık hizmetleri ve aile hekimliği, hastaneler ve sağlık organları hakkında yasalar geliştirildi.
- 1998: Kişisel sağlık sigortası sistemi ve sağlık sigortası daire başkanlığı geliştirildi.
- 1999: Sağlık fonu kurumu kanun tasarısı geliştiriliyor.
- Ancak, yukarıdaki yasalar Türkiye Büyük Millet Meclisindeki bir siyasi tıkanıklık nedeniyle yürürlüğe konulamadı.

esnaf ve organize gruplar için sosyal sağlık sigortası programı) ve sigorta kapsamını daha önceleri dahil edilmeyenleri de kapsayacak şekilde genişletti. 1982 yılında, yeni anayasa vatandaşların sağlık sigortası ve sağlık hizmetleri hakları için devlet garantisi sağladı. Bu, GSK'yı gerçekleştirme yönündeki inisiyatifleri hızlandırmayı amaçlıyordu ve takiben bu hakları işler hale getirmek için 1987 yılında Sağlık Hizmetleri Temel Kanunu çıkarıldı; fakat bu kanun sadece kısmen uygulanabildi (panel 1).

SDP öncesinde politik ve sosyo-ekonomik durum

1990'larda Türkiye zayıf ve belirleyici olamayan bir dizi koalisyon hükümetiyle karakterize edilmekteydi. Bunun bir sonucu olarak 1990'larda gerçek gayrı safi milli hasılanın (GSMH) büyümesiyle ölçülen ekonomik kalkınma kararlı ya da sürekli değildi, ani yükseliş ve düşüş çevrimleri yaşanmaktaydı. Örneğin, 1990 ile 2002 arasında, gerçek GSMH 3 yıl içinde önemli düzeyde geriledi, 1994, 1999 ve 2001 yıllarında sırasıyla %5.5, %3.4 ve %5.7 düşüş oldu. 1990 ile 2002 arasında, kişi başına GSMH geliri yavaş yavaş arttı fakat 1997 ile 2002 arasında, Türkiye'de aşırı enflasyon yaşanıp yıllık enflasyon oranlarının %20 ile %70 arasında değişmesiyle durakladı. 1995 yılıyla başlayarak işsizlik arttı ve özellikle 1999 sonrasında hızla arttı, 1999'da %6.5 iken 2002'de %10.5 oldu. 1995 ile 2002 arasında, 25–54 yaş grubundaki işi olanların oranı %60.5'ten %54.6'ya düştü (tablo 1).[22]

2000'lerin başlarında, Türkiye'nin ortalama Gini katsayısı 0.43 oldu ki bu da büyük gelir eşitsizliklerine işaret etmekteydi ve 30 Ekonomik İşbirliği ve Kalkınma Örgütü ülkesi içinde sonuncu olan Meksika'nın üzerinde, 29. sıradaydı. 1998 yılında, en düşük %20'lik gelir düzeyindeki kadınların yaklaşık %60'ı ilkokulu bitirmemiş ya da hiç okumamıştı ki bu da en üst %20'lik gelir düzeyindeki kadınlar için raporlananın neredeyse beş misliydi. Kadınlarda istihdam oranı 1990 yılında %32.9 iken, sürekli düşerek, 2002 yılında %26.6 oldu ve bu da eşitsizlikleri daha da artırdı (tablo 1).[22]

1990'larda, birbirini izleyen hükümetler siyasal kararsızlık, ekonomik şoklar, aşırı enflasyon, artan işsizlik ve toplumsal uyuşmazlıklarla uğraşırken sağlık sektörü öncelikli olamadı. Dolayısıyla, sadece birkaç ana

	Gerçek GSMH Büyüme (%)	Kişi başına GSMH (günümüz ABD$ fiyatları)	Tüketici fiyat endeksi (tüm kalemler)	İşsizlik oranı (%)	25–54 yaş grubu için istihdam oranı (%)	Kadınlarda istihdam oranı (%)
1990	9.3	5744	0.3	8.2	61.6	32.9
1991	0.9	5885	0.6	8.5	61.6	33.7
1992	6.0	6261	1.0	9.0	61.0	31.9
1993	8.0	6793	1.6	8.6	58.0	25.8
1994	–5.5	6440	3.3	7.6	59.8	30.4
1995	7.2	6922	6.3	6.6	60.5	30.2
1996	7.0	7441	11.4	6.8	60.1	30.3
1997	7.5	8181	21.2	6.9	59.0	28.0
1998	3.1	8439	39.2	7.7	59.2	28.5
1999	–3.4	8046	64.6	6.5	58.2	28.9
2000	6.8	8724	100.0	8.4	56.7	26.2
2001	–5.7	8178	154.4	10.3	55.5	26.3
2002	6.2	8217	223.8	10.5	54.6	26.6

Veriler referans 22'den alınmıştır. GSMH=gayrı safi milli hasıla.

Tablo 1: **Türkiye'de ana ekonomik göstergeler, 1990–2002**

sağlık politikası uygulanabildi. 1993 yılında, Bakanlar Kurulu, Sağlık Bakanlığının sağlık sektöründe etkin bir idareci olmasını amaçlayarak genel sağlık sigortası, aile hekimliği, hastane özerkliği ve kurumsal reformlar konularında beş ayrı yasayı onayladı. Bununla birlikte, bu yasalar Türkiye Büyük Millet Meclisindeki siyasal farklılıklar nedeniyle yürürlüğe konulamadı (panel 1).

1992 yılında, hükümet, gelirleri ulusal minimumun altında olan haneler ve sosyal yardım alan aileler için, genel bütçe gelirlerinden karşılanmak üzere, Yeşil Kart programını getirdi. Bu program Sosyal Sigortalar Kurumu (formel sektörden aktif ve emekli işçileri kapsayan), Devlet Çalışanları Emekli Sandığı (emekli memurları kapsayan), Bağ-Kur (kendi işinde çalışanları kapsayan) ve Çalışan Memurlar Sigorta Fonu (çalışmakta olan memurları ve onlara bağımlı olanları kapsayan) gibi diğer sigorta programlarıyla bütünleştirilmemişti. Yeşil Kart programı, yatan hastanın hastane bakımının bir miktarını kapsıyordu, fakat ayakta hasta konsültasyonlarını, tanı testleri ya da ilaçları kapsamıyordu. Diğer dört sigorta programının tersine, Yeşil Kart Programı Sağlık Bakanlığı tarafından idare edilmekteydi, fakat bu sağlık sigortasına hak kazanan kişileri belirleyecek bir sistem yoktu. Yeşil Kart programı nüfus bazlı bir sigorta sistemi olmak yerine, sigortasız, fakir, yatan hastanın hastane masraflarını karşılayamayacak bireyler için fon sağlama yolu olarak işlev gördü. Bununla birlikte, organize bir sigorta sistemi olmaması birçok ailenin bu programa erişimi olmaması anlamına geliyordu. Dolayısıyla, birçok fakir ailenin sağlık hizmetlerine erişimi az oldu ve ayakta hasta ilaçlarının yüksek masraflarına göğüs germek zorunda kaldı, halbuki programlardan biri tarafından kapsananlar için karma bir sigorta kapsamı ve sigorta hakkı sistemi geliştirildi.

1999 yılında, Türkiye'nin batısında, Marmara bölgesinde büyük bir deprem oldu ve tahminen 17 000 ölümle sonuçlandı, 500 000 insan evsiz kaldı,[23] ve bu, hükümetin doğal ve insan eliyle yapılan afetleri yönetmede yetersizliğini göstererek yaygın bir toplumsal memnuniyetsizliğe yol açtı. Türkiye, yeni binyıla toplumun hükümetten beklentilerinin gittikçe büyümesiyle girdi. Halk hükümetten vatandaşların demokratik haklarını geliştirecek; sağlık ve öğrenim hizmetlerini iyileştirecek ve toplumsal huzursuzluğa, yüksek enflasyona ve artan işsizliğe eğilecek kararlı politikalar talep etti. Halkın sosyo-ekonomik durumla olan uyumsuzluğu sağlık sistemine karşı olan memnuniyetsizliğinde gözlenmekteydi. Türkiye İstatistik Kurumu tarafından 2003 yılında yapılan yaşam memnuniyeti araştırması nüfusun sadece %39.5'inin sağlık hizmetlerinden memnun olduğunu gösterdi; bu, sosyal sigortaya duyulan memnuniyetsizlikten (%40.2), yasama ve yargıya duyulan memnuniyetsizlikten (%45.7), kamu güvenliği ve düzeni hizmetlerine duyulan memnuniyetsizlikten (%57.9) daha düşüktü.[24]

1990'ların sonlarında ve 2000'lerin başında, Türkiye sağlık sistemi özellikle üç alanda büyük sorunlarla karşı karşıya kaldı. Bu sorunların birincisi sağlık sistemindeki yetersiz ve hakkaniyetsiz finansmandı. Türkiye'de, 1990'ların büyük bir kısmında, sağlık harcamaları GSMH'nın ortalama %3.8 kadarı oldu ki bu da Ekonomik İşbirliği ve Kalkınma Örgütü ülkelerindeki (GSMH'nın % 7.4'ü) ve benzer gelir düzeyine sahip ülkelerdeki düzeylerin çok altındaydı.[25]

Düşük sağlık harcamaları hakkaniyetsiz ve parçalı bir sağlık sigortası sistemi ile birleşmişti. Beş sigorta programının farklı yarar paketleri ve sağlık hizmeti sağlayan kuruluşlarla yaptığı farklı sözleşmeleri vardı ve bu, etkin olmayan ve hakkaniyetsiz bir uygulamaya yol açıyordu. Bunlara ek olarak kendi özel sektör sigorta sistemi ve sağlık hizmeti sağlayıcıları olan küçük bir özel sektör vardı. Ancak, sigortalı insanlar için bile, sağlık hizmetlerine erişim zor oluyordu; çünkü sağlık insan kaynaklarında mutlak bir eksiklik vardı. Ayrıca, hastanedeki uzman doktorların hem devlet hem de özel sektördeki ikili çalışmaları sigortalılara verilen kamu hizmetlerinin kapasitesini düşürmekteydi; birçok hasta sigorta kapsamında hak ettikleri müdahaleler için bile özel doktora başvurmaktaydı. 1990'larda cepten yapılan harcamalar toplam sağlık harcamalarının %28–30 kadarını oluşturmaktaydı ve bu hiç şaşırtıcı değildi.[26] 2003 yılında, nüfusun sadece %66.3'ü sağlık sigortası kapsamındaydı. En fakir %10'luk kesimin sadece %12'si Yeşil Kart programından yararlanmaktaydı; bu uygulama 2003 yılında 2.5 milyon kişiyi kapsamaktaydı.[27]

Türk sağlık sistemindeki ikinci problem fiziksel altyapı ve sağlık insan kaynaklarındaki eşitsiz dağılım ve mutlak yetersizlikti. 1990'lı yıllarda ve 2000'lerde, Türkiye'de 100 000 nüfus başına doktor sayısı ve hemşire sayısı en düşük düzeydeydi; bu Avrupa'daki en düşük hemşire/doktor oranlarından biriydi.[28] 1990 yılında, 1000 nüfus başına 0.9 hekim vardı, bu rakam 2000 yılında 1000 nüfus başına 1.3'e yükseldi. Bu oran E7 ülkeleri olan Brezilya, Çin, Meksika ve Rusya'dakinden daha düşüktü, fakat Hindistan ve Endonezya'dakilerden yüksekti.[29] İnsan

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kaynaklarındaki yetersizlik, doğu-batı, kırsal-kentsel ve fakir-zengin ayrımlarıyla birlikte, sağlık hizmetlerinin verilmesinde ve erişiminde eşitsizliklere yol açtı. Mutlak personel yetersizliği, düşük ücretler ve az sayıda teşvik, sağlık işçilerini ülkenin daha fakir doğu bölgelerine çekmekte güçlükler oluşturmaktaydı. Etkili olamayan performans yönetimi, verimliliğin düşük olmasına ve mevcut kapasitenin etkin olmayan bir şekilde kullanılmasına yol açtı. Hekimlerin yaygın olarak hem devlet hem de özel sektördeki ikili çalışmaları, 2002 yılında hastanedeki uzman doktorların yaklaşık %89'unun kamusal görevlerine ek olarak gelirlerini artırmak için özel olarak da çalıştıkları anlamına geliyordu.[30]

Üçüncü ve en ciddi sorun, özellikle ülkenin mahrum kalmış doğu bölgeleriyle daha gelişmiş batı bölgeleri, nüfusun fakir ve zengin kesimleri ve kentsel alanlarla kırsal alanlar arasında sağlık çıktılarındaki hakkaniyetsizliklerle ilgiliydi (şekil 2). Örneğin, 1998 yılında, 5 yaş altı ölüm hızı, Türkiye'nin doğusunda 1000, canlı doğum başına 75.9 ve batısında 38.3'tü ve 2003 yılında bu eşitsizlik hâlâ vardı.[31,32]

Ekonomik istikrarsızlık ve sağlık sektöründeki düşük performans, sağlık sisteminde büyük değişiklik yapılması beklentisini oluşturdu. Bununla birlikte, muthemelen, sağlık sistemindeki en önemli değişim dinamiği, işlevlerini yitirmiş olan ve hızla evrimleşmekte olan ülkenin gereksinimlerine yanıt veremeyen politik çevreydi. 2002 yılında yapılan genel seçimler Adalet ve Kalkınma Partisine parlamentoda çoğunluk sağladı ve bu da on yıl süren ve kötü çalışan koalisyon hükümetlerine son verdi. Kriz içinde bir ekonomi devralan yeni hükümet, ekonomide yapısal bir dönüşüm planı getirmek için acil bir eylem planı oluşturdu ve bu planda sağlık, öncelikli bir alandı. 2003 yılında, Sağlık Bakanlığı vatandaşlığın ayrılmaz bir parçası olarak GSK'yı ve iyi sağlık hakkını yerleştirmeyi amaçlayan SDP'yi tasarladı ve sundu.[33]

Türkiye'de GSK'ya doğru yapılan yolculuğun hızlanması: SDP'nin uygulanması

SDP, 1960'larda başlayan çabaların üzerine yapılanmak ve bu çabaları hızlandırmak için, sağlık sisteminin kilit sistem işlevleri olan yönetim, finansman ve hizmet sunumu işlevlerini güçlendirerek GSK'yı gerçekleştirmek üzere, kapsamlı bir strateji oluşturdu. SDP, hakları temel alan bir felsefe benimsedi ve halk sağlığını iyileştirmek, tüm vatandaşlar için sağlık sigortasına erişimi genişletmek, kaliteli sağlık hizmeti verilmesini sağlamak ve özellikle kadınlar ve çocuklar için sağlık hizmetlerine erişimde ve sağlık çıktılarındaki eşitsizlikleri düzeltecek hasta odaklı bir sağlık sistemi geliştirmek üzere işe koyuldu. Şimdi SDP'nin tasarımı, uygulanması ve izlenmesinde Türk Hükümeti'nin benimsediği yaklaşımı tartışacağız.

Liderlik ve politik adanmışlık

Başlangıcından itibaren, SDP'nin planlanmasında, tasarlanmasında, uygulanmasında, izlenmesinde ve geliştirilmesinde, Sağlık Bakanını, Sağlık Müsteşarlarını ve yardımcılarını ve daire başkanlarını içeren bir lider dönüşüm ekibi rol aldı. Başbakanın ve kabinenin desteğini alan bu ekip, hemen hemen 10 yıl SDP için çalışarak değişiklikler için süreklilik ve kurumsal bellek sağladı. Sağlık Bakanlığında operasyonel değişim ekibi, lider ekibi destekledi. Bu lider ekip SDP ile sürekli ilgilenilmesini sağladı, Bakan, işin başlangıcında il yöneticileriyle ve sağlık müdürleriyle tanışmak ve SDP uygulama planlarını tartışarak fikir birliği oluşturmak üzere 81 ili ziyaret etti. Bu ilk ziyaretleri saha koordinatörlerinin ve yerel paydaşların da katıldığı, SDP uygulamasının ayrıntılı tartışıldığı düzenli il toplantıları izledi. İllere yapılan yaklaşık 340 ziyarette, Bakan ve üst düzey dönüşüm ekibi uygulamadaki güçlüklere doğrudan şahit oldular, uygulamanın darboğazları ve Sağlık Bakanlığı ekiplerinin sağladığı destek konularındaki yerel kaygıları dinlediler.

İl müdürleriyle oluşturulan dolaysız iletişim kanalları, uygulama gruplarıyla dönüşüm liderleri arasında iki yönlü bilgi paylaşımını mümkün kıldı. Alınan bilgiler ilgili Sağlık Bakanlığı ekipleri tarafından hızla eyleme dönüştürüldü; bu da bir güven ortamı oluşturdu. Problemlere verilen hızlı yanıt bilgi paylaşımını teşvik etti, sürekli öğrenerek sürekli iyileşmeyi artırdı ve SDP'nin hızla uygulanmasına yardımcı oldu.

Kanıtların bilgi sağladığı kapsamlı bir strateji

SDP'nin tasarımına ve uygulanmasına sistem boyutunda bir yaklaşım destek oldu. Başlangıçtan itibaren, SDP liderliği sağlık sisteminin işlevlerinde ve sağlık çıktılarındaki problemleri belirlemeye çalıştı. Bundan sonra da yönetim ve organizasyonu iyileştirmek için kapsamlı ve dikkatle zamanlanmış değişiklikler tasarlandı. Sağlık sisteminin işlevlerindeki değişiklikler 10 yıllık bir süre içinde, getirilen değişikliklerin kapsamının kavranması konusunda düzenli istihbarat yoluyla düzenlenen, esnek bir uygulama yaklaşımıyla, sistematik olarak uygulandı (panel 2).

SDP'nin tasarımı için Belçika, Küba, Danimarka, Estonya, Finlandiya, Meksika, Tayland ve BK gibi ülkelerden gelen kanıtlar ve küresel deneyimler bilgi sağladı. Sağlık Bakanlığı uluslararası ajanslarla ve ulusal ve uluslararası uzmanlardan oluşan bir kadroyla sürekli ve başarılı bir işbirliği yaptı. Uluslararası kanıtlara ek olarak SDP, yeni yerel kanıtların oluşturulması konusunda çaba sarf etti; örneğin Türk sağlık sektörünün erişim ve etkinlik çalışmaları sağlık sistemindeki darboğazların belirlenmesi için kullanıldı.34 Ulusal Sağlık Hesapları Çalışması (2002–03)35 Türkiye'de, cepten yapılan harcamalar dahil, sağlık finansmanı ve harcamalarında yeni ve kapsamlı bir tablo sağladı. Artan hastalık yükü 2004 Türkiye Hastalık Yükü Çalışması ile haritalandırıldı.36 SDP'nin başlangıcında temel değerleri belirlemek için yapılan çalışmalara ek olarak, dönüşüm liderliği SDP uygulamasını ve sağlık sistemi performansını düzenli olarak değerlendirecek çalışmalara yatırım yaptı. Örneğin, 2008 yılında, ortaklaşa yapılan bir Ekonomik İşbirliği ve Kalkınma Örgütü–Dünya Bankası çalışması, 37 ve 2011

Panel 2: **Genel sağlık kapsamına doğru: SDP'de kilit gelişmeler, 2002–2012**

- 2002: Adalet ve Kalkınma Partisi seçim platformuna "sağlık hizmetlerine erişimin iyileştirilmesi" (acil eylem planı) konusunu dahil etti.
- 2002: Adalet ve Kalkınma Partisi, Türkiye Büyük Millet Meclisinde güçlü bir parlamento çoğunluğu ile seçildi.
- 2002: Sağlık harcamalarını karşılayamayan hastaların hastanelerde zorunlu olarak tutulmasını ortadan kaldıracak Sağlık Bakanlığı Kararı (yeni hükümetin ilk gününde). Bu Karar, aileler hastane masraflarını karşılayamadığında, hastanelerin ölmüş hastaların bedenlerini tutmalarını yasaklamaktaydı.
- 2003: Sağlıkta Dönüşüm Programı (SDP) geçmiş on yıl içerisinde yapılan çabaların üzerine, Sağlık Hizmetleri Temel Kanununun öğelerini de dahil ederek, tasarlanıyor. SDP'ninin uygulanmasına başlandı.
- 2003: Hastane klinisyenlerinin ikili çalışmadan tam zamanlı çalışmaya gönüllü olarak geçmelerini teşvik etmek için maaş artışları ve performans teşviklerinin getirilmesi. Gönüllü geçişte ana artış 2005 yılında.
- 2003–2004: Aktif ve emekli memurların özel hastaneleri kullanabilmesi sağlandı. Ambulans hizmetleri ücretsiz hale getirildi.
- 2003–2004: Yeşil Kart ayakta hastaları ve ilaçları da kapsayacak şekilde genişletildi. Anne, neonatal ve çocuk sağlık hizmetlerinin kullanımını teşvik için, nüfusun %6'sını kapsayan (en dezavantajlı hanelerin hamile kadınları ve çocukları için) şartlı nakit transferi getirildi.
- 2004: Kırsal ve daha az gelişmiş bölgelerdeki sağlık personeli için sözleşme temelinde istihdam getirildi. Performans temelinde ödemeler Sağlık Bakanlığı hastanesinde pilot uygulamaya konuldu.
- 2004: Farmasötik politikada, fiyatlandırma ve katma değer vergisi dahil, büyük değişiklikler yapıldı. İlaç fiyatlarını düşürmek için, maliyet-artı modeli yerine Uluslararası referans fiyat sistemi getirildi.
- 2004: 2003 yılında çıkartılan Hasta Hakları Yönetmeliği uygulandı. Hastanelerde Hasta Hakları Birimleri kuruldu. Hasta şikayetleri ve önerileri için elektronik sistemler getirildi.
- 2004: Sağlık hizmeti verenlerin kullanıcı tarafından seçilebilmesi sağlandı (hastaneler, birinci basamak sağlık merkezleri ve hekimler).
- 2005: Sosyal Sigortalar Kurumuna ait hastaneler (146 hastane) Sağlık Bakanlığının hastaneleriyle birleştirildi. Sağlık Bakanlığı tarafından yönetilen hastanelerin sayısı 2011 yılında 840'a ulaştı.
- 2005: Düzce ilinde performansa dayalı sözleşmeli aile hekimliği pilot uygulamaya konuldu.
- 2006: Genel sağlık sigortası daha geniş sosyal güvenlik reformlarının bir parçası olarak yasayla benimsendi. Sağlık harcamaları büyümeye başladı ve karşılanmamış ihtiyaçlara eğilmek üzere, hizmetlerde büyümeyi sağlamak için Sağlık Bakanlığı kurumlarında dünya çapında bütçe (bütçe tavanı) getirildi.
- 2006–2010: Sözleşme temelindeki aile hekimliği Türkiye'nin 81 iline yayıldı.
- 2007: Birinci basamak sağlık hizmetlerinde maliyet paylaşımı kaldırıldı. Tüm vatandaşlar için birinci basamak sağlık hizmeti, hizmet verme noktasında ücretsiz hale getirildi.
- 2008: Mali havuz oluşturma ve satın alma için tek örgüt olarak Sosyal Güvenlik Kurumu kuruldu. Sosyal Sigortalar Kurumu, Bağ-Kur ve Genel Çalışanlar Emekli Sandığı Sosyal Güvenlik Kurumuna katıldı.
- 2008: Acil servis ve yoğun bakım servislerinin (neonatal yoğun bakım dahil) tüm nüfus için ücretsiz olması, kamu hastanelerinden Sosyal Güvenlik Kurumu ile sözleşmeli olsun olmasın, özel hastaneler dahil, tüm hastanelere yaygınlaştırıldı.
- 2008: Ulusal Hava ambulansı hizmeti getirildi ve tüm nüfus için ücretsiz sağlandı. Ana genişleme 2010 yılında.
- 2008: Özel hastanelerde kompleks durumlar için (örneğin yanıklar, böbrek diyalizi, konjenital anormaliteler, kanser, kalp damar cerrahisi ve transplant cerrahisi) maliyet paylaşımı kaldırıldı.
- 2009: Kırsal alanlarda erişimi iyileştirmek için mobil eczacılık hizmeti getirildi.
- 2009: İlaçlar için takip sistemi getirildi.
- 2009: Merkezi hastane hasta randevu sistemi getirildi.
- Ana genişleme 2011 yılında.
- 2010: Aktif memurlar Sosyal Güvenlik Kurumuna katıldı.
- 2010: 2010–2014 için Sağlık Bakanlığı stratejik planı geliştirildi.
- 2010–2011: Sigara ve alkol vergileri artırıldı.
- 2010–2012: Daha güçlü bir mali idare işlevi için, Hastane Özerkliği ve Sağlık Bakanlığının Yeniden Yapılandırılması Yasaları kabul edildi. Kamu Hastaneleri Kurumu ve Halk Sağlığı Kurumu kuruldu; üniversitede ve Sağlık Personelinde Tam Gün Yasası ve bunun Değişikleri kabul edilerek, tam gün çalışmanın yasal temeli atıldı.
- 2012: Yeşil Kart programı Sosyal Güvenlik Kurumu ile birleştirildi ve birleşik bir sosyal sağlık sigortası tam olarak uygulamaya konuldu.
- 2013: 2013–2017 için Sağlık Bakanlığı stratejik planı geliştirildi.

yılında yapılan bir birinci basamak sağlık hizmeti düzeyi değerlendirme çalışması,[38] SDP'nin ilerleyişini değerlendirmek için kullanıldı. Tallinn Sözleşmesi tavsiyelerine[39] paralel olarak, Türk sağlık sisteminin performansı, sağlık sistemi işlevleri, ara sağlık çıktıları ve sağlık sistemi amaçlarıyla ilgili, DSÖ tarafından belirlenmiş bir dizi gösterge kullanılarak, DSÖ ve Sağlık Bakanlığı tarafından sistematik olarak değerlendirildi.[40,41]

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Sürekli izleme ve öğrenme

Ekonomik İşbirliği ve Kalkınma Örgütü, Dünya Bankası, DSÖ ve akademik kurumlarla birlikte yapılan değerlendirmeler SDP'nin ilerleyişinin nesnel olarak değerlendirilebilmesini ve ortaya çıkan güçlüklerin belirlenmesini sağlamıştır. Bu çalışmalar -yerel değerlendirmeyi, işbirliğine dayalı müzakereleri, problem çözmeyi ve ders almayı içeren, çok sektörlü bir yaklaşım olan- saha koordinatörü modeli doğrultusunda SDP uygulamasının sürekli olarak izlenmesiyle tamamlanmıştır.

Saha koordinatörü modelinde, bir hekim ekibi ülke çapındaki uygulama alanlarında hızla görevlendirilmiştir. Birincil amaçları sağlık çıktılarının ve hakkaniyetin iyileştirilmesi olan bu saha koordinatörlerinin iki ana rolü vardır: İllerde iç denetim işlevini yürütmek ve Türkiye çapında SDP'nin uygulanışı için kurumsal kapasite oluşturulmasına katkıda bulunmak. Bu hekimler, ortaya çıkan sorunlar hakkında bilgi toplamak ve farklı uygulama alanlarında ilerleyişi belirlemek için il yönetimleriyle, profesyonel derneklerle ve yerel sağlık yönetimi personeliyle işbirliği yapmışlardır. Saha koordinatörlerinin ziyaretleri birinci basamak sağlık tesislerinin (sağlık noktaları, verem savaş dispanserleri, anne ve çocuk sağlığı merkezleri, aile hekimliği merkezleri ve topluluk sağlık merkezleri), hastaneler ve diş sağlığı merkezlerinin değerlendirilmesini içermiştir. Hasta odaklı bir yaklaşım hizmete erişimi genişletmiş ve değerlendirmelerin odağı birinci basamak sağlık hizmeti kalitesinin iyileştirilmesi olmuştur. Her ilde, değerlendirmelerin bulgularını tartışmak, ilerlemeyi gözden geçirmek, diğer illerin deneyimlerinde öğrenmek ve uygulamadaki darboğazları çözmek için yerel çözümler üretmek için düzenli toplantılar yapılmıştır.

Saha koordinatörü modeli uygulama güçlüklerinin hızla belirlenmesinde ve uygun çözümlerin sağlanmasında etkili olmuştur. Örneğin, SDP uygulamasının ilk aşamalarında saha aktörlerinin SDP'nin karmaşık içeriğini yorumlama ve sıkı uygulama zamanlamasına uyma kapasitelerinde kısıtlar ortaya çıkmıştır. İl idarecileriyle ve yerel profesyonel derneklerle yakın işbirliği sağlık hedeflerini yerine getirmek üzere hareketlenmesine yardımcı olmuştur.

Saha izlemesinden elde edilen bulgular, dönüşüm liderliğine belirlenen güçlükler ve uygulama alanlarından edinilen dersler konusunda verilen aylık raporlarda kullanılmıştır ve liderlik illerde uygulanan SDP'nin hızı ve kapsamını değiştirebilmiştir.[42]

Esnek uygulama: Stratejik ve taktik eylemler

SDP'nin önemli bir özelliği, stratejik ve taktik eylemleri dengeleyen, esnek uygulamaya verdiği önem olmuştur. İki çatallı bir uygulama yaklaşımı SDP'yi karakterize etmektedir: Birinci çatal, sağlık sektöründe hızlı ve görünür iyileştirmeleri hedefleyen kademeli ve taktik değişiklikleri vurgulamaktadır. İkinci çatal, Büyük Millet Meclisi tarafından mevzuat çıkarılmasını gerektiren sektörünün ötesindeki ek kapasitenin uygulanmasındaki ana yapısal reformları hedefleyen stratejik etkinliklere odaklanmıştır. Bu yaklaşım taktik hamlelerdeki hızlı kazanımları sağlamış ve vatandaşların yararlardan derhal faydalanabilmesini mümkün kılmıştır ve böylelikle paydaşlardan önemli kamu desteği sağlanmıştır. Buna paralel olarak, politik ve yasal fırsat pencerelerinden yararlanabilmek için, stratejik olarak sırayla kurumsal değişiklikler ve yapısal reformlar gerçekleştirilmiştir. Örneğin, yeni hükümetin ilk gününde Sağlık Bakanı sağlık harcamalarını karşılayamayan hastaların hastanelerde zorunlu olarak tutulmasını ortadan kaldıracak bir karar çıkartmıştır. Bu karar, aynı zamanda aileler hastane masraflarını karşılayamadığında, hastanelerin ölmüş hastaların bedenlerini tutmalarını yasaklamaktaydı ve genel nüfus tarafından hoşnutlukla karşılanan bir değişimdi.

2004 yılında, Yeşil Kart uygulaması ayakta hastaları ve farmasötikleri de kapsayacak şekilde genişletildi ve diğer sağlık sigortası programlarının sağladığı yararlarla hizalanarak, sigortasız fakir halkı kapsayacak şekilde hızla genişletildi. 2005 yılında, Sosyal Sigortalar Kurumu tarafından yönetilen hastaneler Sağlık Bakanlığının mali idaresi altına alındı. Bu, Sosyal Sigortalar Kurumunun finansman ve hizmet sağlama işlevlerini ayırarak, bir alıcı-sağlayıcı ayrımı oluşturmayı amaçlayan ana yapısal reformlar için temel bir adımdı. Yönetsel kontroldeki bu dönüşüm, Sosyal Sigortalar Kurumu ve işçi sendikalarının kuvvetle karşı çıkmasına rağmen gerçekleştirildi.

Bu taktik hamlelerle SDP konusunda kazanılan kamu onayının artışı SDP'nin meşrulaştırılmasına yardımcı oldu, Başbakan ve Bakanlar Kurulunun programa olan desteğini artırdı ve Sağlık Bakanlığının hükümet içerisindeki konumunu güçlendirdi.

Kullanıcı memnuniyeti üzerine odaklanma ve değişim ortamının algılanması

Dönüşüm liderliği, SDP'nin getirdiği değişikliklerin çeşitli nüfus kesimlerinde kabul edilebilirliğini ve bunların değişimi algılayışlarını değerlendirmek için düzenli odak grup araştırmaları ve paydaş analizleri yaptırmıştır. Bu odak grup ve paydaş analizlerinin sonuçları SDP'nin kapsamını, halkla iletişimi ve uygulama hızını düzenlemek için kullanılmıştır.

Odak grup araştırmaları ve paydaş analizleri Türk İstatistik Enstitüsü tarafından ülkede istatiksel olarak temsil niteliğine haiz numuneler temelinde yapılan yıllık hane araştırmalarıyla desteklenmiştir. Bu etütler; hanelerdeki yaşama şartlarını, bireysel mutluluğu, yaşamdan memnuniyeti ve kamu hizmetlerinden beklentileri (sağlık hizmetleri, sosyal hizmetler, sosyal sigorta, öğrenim, yasama be yargı ve kamu güvenliği ve düzeni) değerlendirmiştir. Bu etütler; ülkedeki genel memnuniyet düzeylerinin ve çeşitli bakanlıklar tarafından getirilen reformlara halkın verdiği tepkinin göstergelerini sağlamıştır.[43]

Sağlık Bakanlığı, ayrıca Türk İstatistik Kurumundan halkın sağlık sistemi konusundaki memnuniyetini ve

halkın sağlık hizmetinin kalitesi konusundaki görüşleri, sağlık hizmetlerine erişimi ve sistemin yanıt verebilirliğini değerlendirmek için ayrıntılı sağlık memnuniyet etütleri yapmasını istemiştir. Bu sağlık memnuniyet etütleri, aynı zamanda sağlık hizmetlerindeki darboğazlar, güçlükler ve kullanıcı memnuniyetleri hakkındaki kullanıcı algılarını da ortaya çıkarmıştır.[44] Sağlık Bakanlığı ve kabine, SDP'nin uygulanışını ayarlamak, sağlık hizmetlerinin yanıt verebilirliğini iyileştirmek ve kullanıcı beklentilerini karşılamak için bu bulguları düzenli olarak tartışmışlardır.

SDP: Sağlık sistemindeki değişiklikler ve başarılar

Sağlık sisteminin yönetimi ve mali idaresi

Vatandaşların sağlık haklarının tanımlanması ve hizmet sağlayıcının hesap verebilirliğinin artırılması

Hasta Hakları Yönergesi[45] 2003 yılında getirilmiş, 2005 yılında etkin olarak uygulanmış ve 1998 yılında kabul edilen fakat uygulanamayan Hasta Hakları Mevzuatını[46] işler hale getirmeye yardımcı olmuştur. Bu direktif hastaların sağlık sigortası ve sağlık hizmeti haklarını tanımlamış ve hizmet sağlayıcıların hasta haklarına, bilgi vermeye, gizliliğe ve sağlık müdahalelerinde hasta rızasına ilişkin yükümlülüklerini belirlemiştir ve ayrıca vatandaşlara sağlık kurumlarını, hastane doktorlarını ve aile hekimlerini seçebilme hakkı sağlamıştır.

Bu Yönerge yoluyla oluşan birkaç yeni mekanizma hizmet kullanıcılarının ve vatandaşların karşılaşılan güçlükler, memnuniyet dereceleri ve beklentileri dahil, sağlık hizmetlerinin kalitesi, yanıt verebilirliği ve erişimi konusundaki görüşlerini doğrudan ifade edebilmelerine imkan sağlamıştır. Bu yeni mekanizmalar bir telefon yardım hattı yoluyla şikâyetlerin ve önerilerin Sağlık Bakanlığı İletişim Merkezine (SABİM), Başbakanlık İletişim Merkezine (BİMER) (2010 yılında sosyal medyayı da içine alacak şekilde genişletildi), devlet hastanelerindeki hasta hakları birimlerine ve birinci basamak sağlık hizmeti birimlerindeki hasta hakları iletişim birimlerine doğrudan iletilebilmesini sağlamıştır. BİMER ve SABİM'e yapılan şikayetler ilgili hastanede yerel olarak çözümlenmek üzere hasta hakları birimine iletilir ya da ne yapılacağı konusunda tavsiye almak üzere her ilde kurulmuş olan hasta hakları kurullarına götürülür—örneğin, eğer Yönerge hükümlerine ilişkin bir ihlal varsa, şikayeti çözümlemek üzere idari ya da yasal yollar aranır. Bu değişiklikler farkındalık oluşturma etkinlikleri ve vatandaşların sağlık hakları konusunda eğitilmeleriyle birleştirilmiş, 2010 yılında yaklaşık 2 milyon ve 2011 yılında da 3.6 milyon vatandaşa eğitim verilmiştir. Bu yeni mekanizmalar hizmet sağlayıcılarının vatandaşlara hesap verebilirliğini artırmıştır. SDP öncesinde ise hiçbir hesap verebilirlik olmamıştır.

Kullanıcılarla Sağlık Bakanlığı arasında doğrudan iletişim kurulabilmesini sağlayan bu yeni mekanizmalar, kullanıcı memnuniyeti ve beklentileri konusunda çok ihtiyaç duyulan istihbaratı sağlamıştır. Bununla birlikte, kimi sağlık personeli bu yönetim değişikliklerini mesleki özgürlüklerini sınırlama olarak algılamakta, doktorların hasta üzerindeki otoritelerinin bozulduğundan şikayet etmektedirler. Sağlık çalışanları da hastaların gösterdikleri saygıda azalma olduğundan şikayet etmektedirler. Sağlık Bakanlığı, buna yanıt olarak sağlık personelinin kaygılarını doğrudan Sağlık Bakanına iletmelerini, yeni politikaları sorgulamalarını, çözüm önermelerini ve deneyimlerini paylaşmalarını sağlayacak web bazlı bir sistem getirmiştir. Bununla birlikte, bu çabalara karşın, bazı sağlık personeli arasında Sağlık Bakanlığının eğilmesi gereken bazı memnuniyetsizlikler devam etmektedir.

Sağlık Bakanlığının rolünün yeniden tanımlaması

SDP'nin ana amaçlarından biri Sağlık Bakanlığının, mali idare işlevini güçlendirerek ve işlemsel sorumlulukları yeni organlara devrederek rolünün yeniden tanımlanması olmuştur. 1987 ile 2002 arasında, Sağlık Bakanlığı 1954 yılında başlayan genişleme yoluna devam ettiği için bu rolün düzene sokulması çabaları sonuç vermemiştir (panel 1). Sağlık Bakanlığının yeniden yapılanmasına yönelik çerçevenin SDP'nin ilk aşamalarında Büyük Millet Meclisi tarafından onaylanmış olmasına karşın, bunun uygulanmasında mesafe alınamamıştır; çünkü Cumhurbaşkanı, uygulamanın temelindeki Kamu İdaresi Yasasını veto etmiştir.

2003 ile 2010 arasında, Sağlık Bakanlığının rolü Sosyal Güvenlik Kurumunun ve Yeşil Kart programının yönetim sorumluluğunu üstlenmesiyle daha da genişledi. Ancak, 2010 yılında, Sağlık Bakanlığı Yeniden Yapılanma Yasası ve Özerk Hastaneler Yasasının getirilmesiyle Bakanlığın rolü politika ve strateji geliştirme, istihbarat, sağlık sisteminin performansını değerlendirme, hesap verebilirliğin gözetimi ve sektörler arası koordinasyon üzerine odaklanarak düzenlendi. Toplum sağlığı, sözleşme yapma, sağlık hizmeti verme ve teknoloji değerlendirme ile ilişkili işlemsel sorumluluklar yeni, özerk, Bakanlığın çok yakınında çalışan yarı-kamusal organlara devredildi (ek s 15). Birleştirilmiş Genel Sağlık Sigortası programının getirilmesiyle, yeni kurulmuş olan Sosyal Güvenlik Kurumu Yeşil Kart programının yönetimini üstlendi (panel 2).

Sağlık sisteminin finansmanı

SDP, iki ana mali eksikliği çözmeye çalıştı. Birinci eksiklik, düşük sağlık harcamalarıyla ilgiliydi. İkincisi nüfusun en yoksul kesimlerini tam anlamıyla kapsayamayan, hakkaniyetsiz ve parçalı, cepten ödenen masrafların çok yüksek harcamalara yol açtığı sağlık sigortası sistemiyle ilgiliydi.

Sağlık harcamalarının artması

1990 yılında, Türkiye'de toplam sağlık harcamaları GSMH'nin (satın alma gücü paritesi birimleriyle 155 ABD Doları) %2.7'siydi, fakat 2008 yılına gelindiğinde GSMH'nin (913 ABD Doları) %6.1'ine yükselmiş olduğu

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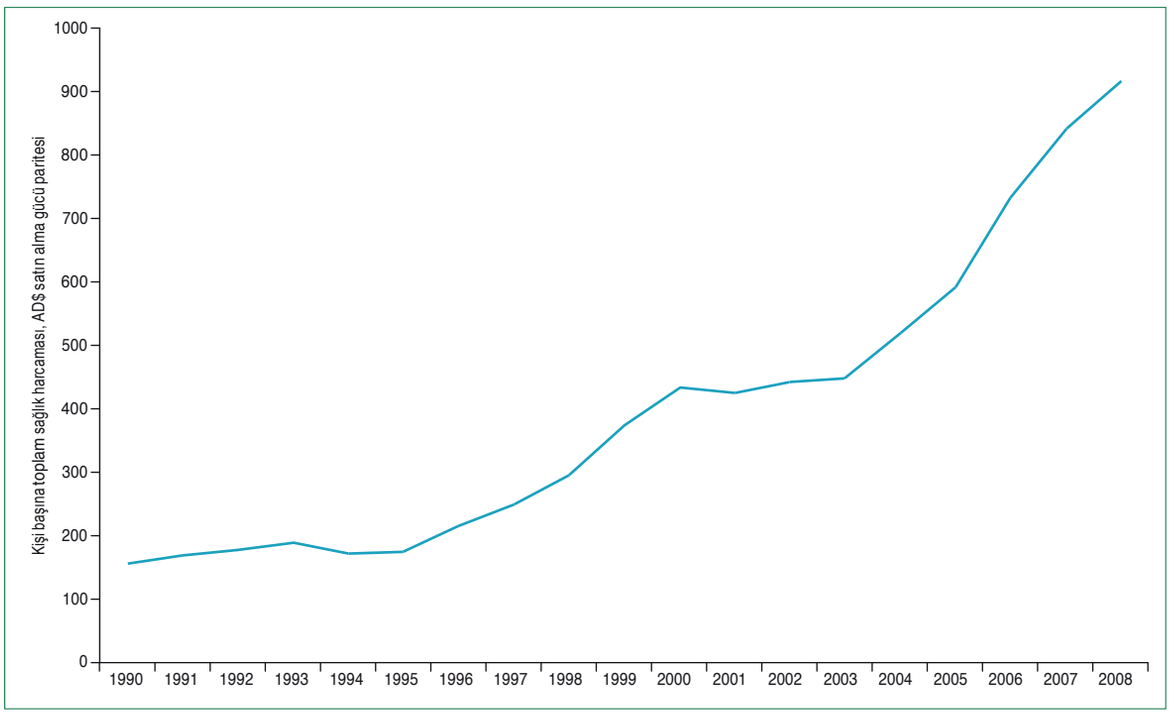

Şekil 6: **Kişi başına toplam sağlık harcaması, 1990–2008 (ABD Doları satın alma gücü paritesi)**
Veriler referans 25'ten alınmıştır.

görülüyordu ki bu da ortalama sağlık harcamalarının GSMH'nin %5.2'si olduğu E7 ülkelerine benzer bir rakamdı (şekil 6).[47] Sağlık harcamaları, özellikle SDP'nin getirilmesiyle ve kamu sektörü yatırımlarının artırılması için mali alanı[48] sağlayan sürdürülebilir bir ekonomik büyüme dönemiyle çakışan 2003–08 döneminde arttı (şekil 6), (panel 3). 2003–08 arasında, sağlık harcamalarında yıllık büyüme oranları 2003–04 ve 2004–05 mali yıllarında %10, 2005–06 mali yılında %14, 2006–07 mali yılında %8.7 ve 2007–08 mali yılında %1.3 oldu. 2000–08 arasında, sağlık harcamalarındaki büyümenin itici gücü büyük ölçüde kamu sektörü finansmanının artması olmuştur; kamu sektörü finansmanı 2000 yılında toplam sağlık harcamalarının %63'ü iken, 2008 yılında %73 olmuştur. 2000–08 arasında, sağlığa yönelik kamu sektörü fonları yıllık ortalama %9.1 (%4.7–14.8 aralığı) büyüme hızıyla artmıştır. 2010 yılında, E7 ülkeleri arasında kamu kaynaklarından gelen toplam sağlık harcamalarının oranı kıyaslandığında, Brezilya'da 47.0%, Çin'de %53.6, Hindistan'da %29.2, Endonezya'da %49.1, Meksika'da %48.9 ve Rusya'da %62.1 iken, Türkiye (%75.2)[47] en yüksek orana sahiptir. Sağlık altyapısına yapılan kamu yatırımları 2003 yılında 603 milyon Türk lirasından (TL) 2008 yılında 5.4 milyar TL'ye, nominal olarak dokuz misli artmıştır. Aynı şekilde, sağlık altyapısına yapılan özel sektör yatırımları 2003 yılında 100 milyon Türk lirasından 2008 yılında yaklaşık 1.3 milyar TL'ye nominal olarak neredeyse 13 misli artmıştır.[49]

Sağlık sigortası programlarının birleştirilmiş genel sağlık sigortasına konsolidasyonu

SDP'nin getirilmesinden önce, Türkiye'de beş sağlık sigortası programı vardı (Sosyal Sigortalar Kurumu, Devlet Çalışanları Emekli Sandığı, Bağ-Kur, Çalışan Devlet Memurları Sigorta Fonu ve Yeşil Kart programı). Bu programların her biri zaman içinde ayrı ayrı, farklı katkı miktarlarıyla ve değişen yarar paketleriyle gelişti (ek s 16). Yeşil Kart programının kapsam oranları düşüktü; çünkü hem gerçek bir sigorta programı olarak değil, yatan hasta hastane masraflarını karşılayamayan fakir hastalar için bir mali kurtarma operasyonu olarak işliyordu hem de potansiyel yararlanıcıları belirleyip programa katılmaya aktif olarak teşvik edecek bir sistem yoktu. Yeşil Kart tarafından sunulan yetersiz faydalar bu programın vatandaşlar için cazip olmadığı anlamına geliyordu. 2004 ile başlayarak, GSK'yı gerçekleştirmek için SDP, programa alınmaya hak kazanan vatandaşları belirleyecek, en fakir yüzde onluk kesim içerisinde sigorta kapsamını artıracak ve programın yararlarını genişletecek mekanizmalar oluşturdu.

2006 yılında, Büyük Millet Meclisi beş sağlık sigortası programını birleştirilmiş bir Genel Sağlık Sigortası programı içerisinde senkronize yararlarla bir araya getirecek Sosyal Sigortalar ve Genel Sağlık Sigortası Kanununu onayladı (panel 2). Türk Tabipler Birliği ve tıp profesyonellerini temsil eden sendikalar bu Yasaya karşı çıktılar ve Anayasa Mahkemesine gittiler. Yasa üç kere değiştirildi ve uygulama 2008 yılında başlatılabildi;

Panel 3: **Birleştirilmiş Genel Sağlık Sigortasının kapsadığı yarar paketinin kilit ögeleri**

Yarar paketi şunları içermektedir:

- Kişisel önleyici sağlık hizmeti (Bedelsiz ve genel hükümet bütçesinden finanse edilir.)
- Tıbbi muayene, tanı testleri ve prosedürler; tanıyı takip eden tüm tıbbi müdahaleler ve tedaviler; izleme ve rehabilitasyon hizmetleri; organ, doku ve kök hücre transplantasyonu, acil servis ve tıbbi bakımlar içeren yatan hasta ve ayaktan hasta hizmetleri,
- Yatan hasta ve ayakta hasta ana sağlığı hizmeti (doğum öncesi bakım, doğum, neonatal bakım ve doğum sonrası bakım, tüm tıbbi muayeneler, tanı testleri ve prosedürler)
- Kadın hastalıklarının tanısını takiben tüm tıbbi müdahaleler ve tedaviler; izleme hizmetleri, kürtaj, cerrahi sterilizasyon, acil servis ve tıbbi bakım
- Yatan hasta ve ayakta hasta oral sağlık hizmeti, ağız ve diş muayeneleri, tanı testleri ve prosedürler, tanıyı takiben tüm tıbbi müdahaleler ve tedaviler, diş çekimi, konservatif diş tedavisi ve endodontik tedavi, izleme hizmetleri, oral protez, acil servis ve ortodontik tedavi dahil olarak
- In-vitro fertilizasyon hizmetleri, iki tedavi siklusuna kadar
- Kan ve kan ürünleri, kemik iliği, aşılar, ilaçlar, protezler, tıbbi mallar ve tıbbi ekipman, bunların kurulması, bakımı, onarımı ve yenileme hizmetleri dahil
- Yurt dışında tedavi gerektiren hastalıklar
- 18 yaş altındaki tüm çocuklar için, sigorta durumlarına bakılmaksızın hizmetin verilme noktasında ücretsiz sağlık ve dental bakım servisi
- Farmasötikler ve tıbbi aygıtlar

Yarar paketi şunları içermemektedir:

- İş kazaları ya da konjenital anormalliklerle ilişkili olmayan estetik müdahaleler
- Sağlık Bakanlığınca tıp hizmeti olarak sınıflandırılmamış tüm müdahaleler
- Önceden var olan kronik hastalıklardan mustarip yabancıların tedavisi

Sosyal Sigortalar Kurumu, Bağ-Kur, ve Devlet Çalışanları Emekli Sandığı yeni kurulmuş olan Sosyal Güvenlik Kurumuna aktarıldı. Ocak 2010'da, Çalışan Devlet Memurları Sigorta Fonu da Sosyal Güvenlik Kurumuna aktarıldı ve 2012 yılında Yeşil Kart programı da yarar paylaşımı ile bunu izleyerek, birleştirilmiş Genel Sağlık Sigortası programı kurulmuş oldu (ek s 16).

Sağlık harcamalarındaki artış, yararlanıcıların genel primlerini karşılamak üzere devlet gelirlerinden gelen katkılar (Sosyal Sigortalar Kurumuna ve sonra da Sosyal Güvenli Kurumuna) ve kamusal ve özel sağlık hizmeti sağlayıcılarının yaygınlaştırılması Yeşil Kart kapsamı ve yararlarının genişletilmesine destek olan unsurlar olmuştur.

Panel 4: **Sağlıkta Dönüşüm Programının kadınlar ve çocuklar için getirdiği yeni, hedefli sağlık programları**

- 2005 yılında başlayan ve 2010 yılına gelindiğinde Türkiye'nin 81 iline yayılmış olan, 5 yaş altı çocuklar arasında yüksek aşılama oranlarına erişim için performans bazlı bir ödeme getiren aile hekimliği merkezli birinci basamak sağlık hizmeti modeli yoluyla aşılama alımını iyileştirmek için gösterilen çabaların hızlandırılması
- 2002 yılında yedi olan antijen sayısının (BCG, karma difteri–boğmaca– tetanoz, oral çocuk felci, kızamık, ve hepatitis B) Haemophilus influenzae tip B, kızamıkçık, kabakulak, pnömokokal konjuge aşı, varicella, ve hepatitis A eklenmesiyle 2012 yılında 13'e çıkarılması
- Ana sağlığı birimlerinin yakınında ve ulaşılması güç yerlerde kadınlar için bedelsiz doğum öncesi barınma hizmeti
- Antenatal, postnatal ve yeni doğanların izlenmesi (aşılama dahil) için şartlı nakit transferleri
- Yeni neonatal hizmetlerinin uygulanması, neonatal acil servis ve maternal acil durumlar için hava ambulansı, yeni doğanlarda fenilketonuri ve duyma problemlerine yönelik taramayı tamamlamak üzere hipertiroidi ve biotinidaz için ek tarama dahil
- Gebelik ve erken çocuklukta besin desteğinin artırılması, gebe kadınlar için folik asit ve demir takviyeleri ve çocuklar için vitamin D ve demir takviyeleri
- Kadınlar için ve çocuk sağlığı ve gelişimi için doğum öncesi ve doğum sonrası dönemde iyileştirilmiş bir izleme sisteminin uygulanması
- Genişletilmiş sağlık sigortası yararlarından finanse edilen neonatal yoğun bakım programının genişletilmesi

Sosyal Güvenlik Kurumunun oluşturulması, satın alıcı ve sağlayıcı rollerine netlik kazandırmış, kurum kamusal ve özel sağlayıcılardan sağlık hizmetleri satın alıcısı olarak oluşmuştur. Beş sigorta programının konsolidasyonu sağlık hizmeti masrafları ve çok yüksek ödemelerle ilişkili riskin tüm gelir gruplarında daha etkin paylaşılmasını sağlayacak birleştirilmiş bir risk havuzu oluşturmuştur.

Birleştirilmiş Genel Sağlık Sigortası şimdi bir dizi önleyici, tanı ve tedavi hizmetleri için ödeme içeren kapsamlı bir yarar paketi sağlamaktadır (panel 3 ve ek s 16). Kullanıcılara ücretsiz sunulan önleyici sağlık hizmetleri ve sözleşme bazlı aile hekimliği hizmetleri sigorta bazlı değildir ve bunların masrafları genel devlet bütçesinden sağlanmaktadır (panel 3). Sağlık Bakanlığı birleştirilmiş Genel Sağlık Sigortası kapsamındaki yararlara ek olarak, genel nüfus—ve özellikle kadınlar ve çocuklar—için kullanıcılara ücretsiz sunulan hedefli sağlık teşvik ve önleme programlarını yaygınlaştırmıştır (panel 4).

Sağlık sigortası kapsamının en fakirler için genişletilmesi: Yeşil Kart programı için sağlık harcamaları

SDP'nin getirildiği 2004 ile 2009 arasında, Yeşil Kart sahiplerinin harcamaları, 2004 yılında 1.2 milyar TL iken

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hemen hemen beş misli artarak 2009 yılında 5.51 milyar TL olmuştur. Aynı dönemde, Sosyal Sigortalar Kurumunun yararlanıcıları için yapılan harcamalar 2004 yılında 13.2 milyar TL iken iki katı artarak 2009 yılında 28.9 milyar TL olmuştur (tablo 2). 2004 yılında, Yeşil Kart kullanıcıları için sağlık harcaması kişi başına 176.0 TL olmuştur ki bu da Sosyal Sigortalar Kurumu (SSK) yararlanıcıları için harcananın yaklaşık yarısıdır (323.0 TL). Ancak, 2009 yılına gelindiğinde, Yeşil Kart kullanıcılarının harcamaları kişi başına 570.7 TL'ye çıkarak, Sosyal Sigortalar Kurumu yararlanıcıları için harcanan miktara yaklaşmıştır (590.3 TL) (tablo 2).

	Zorunlu sigorta raporlayan bireylerin tahmini sayısı	Kayıtlı Yeşil Kart sahipleri	SSK harcaması (nominal milyon TL)	Kişi başına SSK harcaması (nominal ABD$)	Yeşil Kart harcaması (nominal milyon TL)	Kişi başına Yeşil Kart harcaması (nominal ABD$)	Kişi başına SSK harcaması (nominal TL)	Kişi başına Yeşil Kart harcaması (nominal TL)
2004	40 708 000	6 852 000	13 150	230.7	1206	125.7	323.0	176.0
2005	44 061 000	7 256 000	13 607	237.5	1809	191.8	308.8	249.3
2006	47 583 000	8 279 000	17 668	265.2	2910	251.1	371.3	351.5
2007	47 612 000	9 355 000	19 983	322.8	3913	321.8	419.7	418.3
2008	50 103 000	9 338 000	25 404	390.0	4031	332.1	507.0	431.7
2009	48 900 000	9 647 000	28 863	393.5	5506	380.5	590.3	570.7

Veriler yazarın SSK yıllık raporları ve Hanehalkı Bütçe Anketleri bazında hesaplamalarıdır. SSK sigortalı nüfus 2004–2009 Hanehalkı Bütçe Anketleri kullanılarak tahmin edilmiştir. SSK=Sosyal Sigortalar Kurumu. TL=Türk Lirası.

Tablo 2: **SSK ve Yeşil Kart programları için kişi başına harcamalar, 2004–2009**

Hakkaniyetin artırılması: Nominal kişi başına harcama yüzde on dilimleri itibariyle sağlık sigortası kapsamı

En fakir yüzde onluk dilim için katkısız sağlık sigortasının devlet tarafından finansmanı ve daha zengin yüzde onluk dilimlerin katkılı sağlık sigortası kapsamının artması Yeşil Kart programının yaygınlaştırılmasını ve birleştirilmiş bir Genel Sağlık Sigortası programının getirilmesini mümkün kılmıştır.

2003 yılında, en fakir yüzde onluk dilimin sadece %24'ü sigorta tarafından kapsanmaktaydı (aktif istihdamda olanlar için zorunlu sigorta ile %12 ve Yeşil Kart programı ile %12). 2011 yılına gelindiğinde, en fakir yüzde onluk dilim için sağlık sigortası kapsamı neredeyse %85'e ulaşmıştı (yaklaşık %60 Yeşil Kart programı ile %24 zorunlu sağlık sigortasıyla ve geri kalanı özel sigortayla; şekil 7).

Sağlık sigortası kapsamı tüm yüzde onluk harcama dilimleri için iyileştirilmiştir Örneğin, ikinci yüzde onluk dilim için kapsam 2003 yılında %38 iken (yaklaşık olarak %8 Yeşil Kart programı, %29 zorunlu sağlık sigortası ve geri kalanı özel sigortayla) 2011 yılında %84 (yaklaşık olarak %33 Yeşil Kart programı, %50 zorunlu sağlık sigortası ve geri kalanı özel sigortayla). Üst 4–10 yüzde onluk gelir dilimlerinde, sigorta kapsamı 2003 yılında %47–90 iken artarak 2010 yılında %85–%96 olmuştur (şekil 7). 2003 ile 2011 yılları karşılaştırıldığında, sağlık sigortası kullanımında en fazla artış 2, 3 ve 4 yüzde onluk dilimleri için gerçekleşmiştir ve artışlar sırasıyla %29'dan %50'ye, %40'dan %65'e ve %53'ten %75'e gerçekleşmiştir (şekil 7).

Hakkaniyetin artırılması: Yeşil Kart programı hedeflerinin iyileştirilmesi

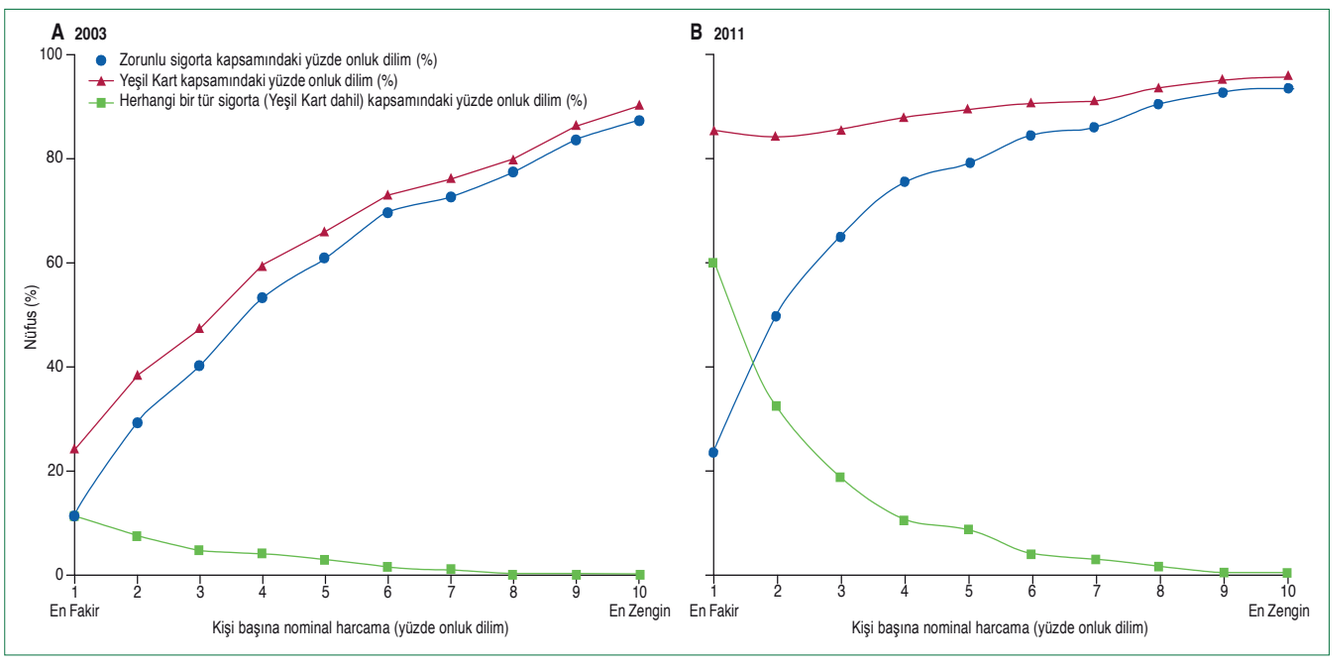
2003 yılında, Yeşil Kart programı sadece 2.4 milyon kişiyi kapsamaktaydı (yaklaşık 19 milyon kişi [nüfusun %29'u fakir olarak sınıflandırılırken] Türkiye nüfusunun %3.6'sı). Yararların genişletilmesine (kapsamın derinliği, bakınız panel 3 ve ek s 16) 2004–05 yıllarında Yeşil Kart yararlanıcılarının sayısının hızla artması eşlik etmiştir: Bu sayı 2003 yılında 2.4 milyon kişi iken neredeyse dört katına çıkarak 2005 yılında 8.3 milyon kişi olmuş, sonra da 2011 yılında yaklaşık 10.2 milyon kişi olmuştur ki bu da toplam nüfusun %13.8'idir (2011 yılında yaklaşık 11.8 milyon kişi fakir olarak sınıflandırılmaktaydı [nüfusun %16'sı]). Daha fakir yüzde onluk dilimlerin hedeflemeleri de iyileşmiştir. 2003 yılında, en fakir yüzde onluk dilimin (yüzde onluk dilim 1) sadece %33'ü sigorta kapsamındaydı fakat 2011 yılında bu oran %42'ye çıkmıştı. 2003 ile 2011 yılları arasında, yüzde onluk dilim 1 ve 2 için, Yeşil Kart hedefi %54'ten %65'e çıkmıştır (ek s 17).

Hakkaniyetin artırılması: Mali korumanın iyileştirilmesi ve çok yüksek harcamalar

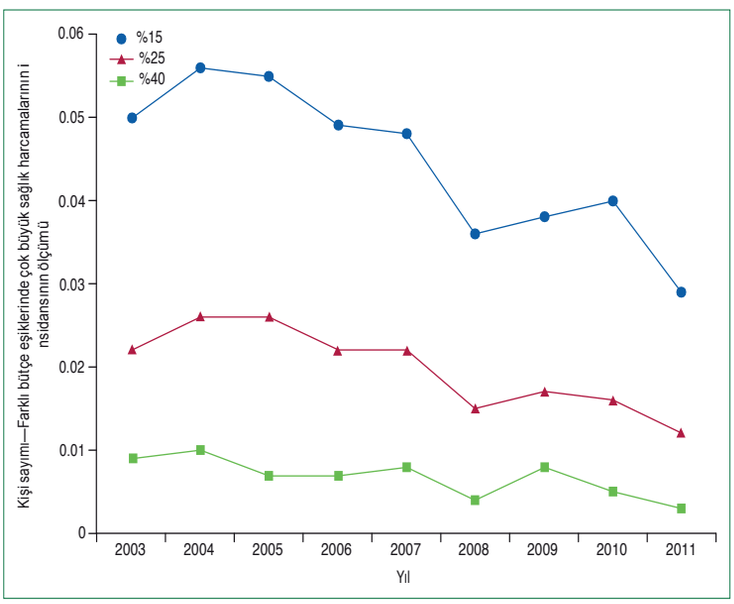
Yeşil Kart programının genişletilmesi birçok sağlık hizmeti için ayakta hasta ilaçlarının kapsam içine alınması ve masraf paylaşımının azaltılması dahil, yararlarının artışı ile çakışmıştır. Daha önceleri yararlarının yetersiz olması bireylerin programa katılmasını önlemiştir. SDP ile birlikte, acil durumlar, yoğun bakım ve karmaşık prosedürler (çok yüksek harcamaların tipik bir nedeni) yararlanıcılar için ücretsiz hale getirilmiştir.

Yeşil Kart sahipleri için, her biri yüzde onluk beş ayrı harcama dilimindeki cepten yapılan harcamaların analizi genelde tıbbi harcamaların (farmasötikler, ikincil ve üçüncül hastanelerdeki ayakta hasta hizmetleri -tıbbi cihazlar için olanlar dahil- bunların hepsinde masraf paylaşımı düşüktür) tüm yüzde onluk dilimler için azalmıştır. En düşük gelirli yüzde onluk dilim için (yüzde onluk dilim 1), tıp harcamalarının yüzdesi olarak sağlık harcamaları 2003 yılında %63.2 iken hızla düşerek 2011 yılında %49.4 oldu. Aynı şekilde, fakat daha az olmak üzere gelir yüzde onluk dilimleri 2, 3, 4 ve 5'te de düşüş kaydedildi. Bunun sonucu olarak, yüzde onluk dilim 1'deki tıbbi harcamalar yüzde onluk dilimler 2, 3, 4 ve 5'teki tıbbi harcamalara yaklaştı (ek s 18). Genel olarak, gıda dışı harcamanın bir bölümü olarak sağlık harcamaları azaldı (2003 yılında %3.1 iken 2011 yılında %2.4). En düşük gelirli yüzde onluk dilim için, %2.4'ten %2.8'e küçük bir artış görüldü (ek s 18).

Önemli olan, Yeşil Kart programının genişletilmesinin aşırı yüksek sağlık harcamalarının azaltılmasında



Şekil 7: **Herhangi bir sağlık sigortasına kayıtlı nominal kişi başına harcamaya göre nüfus, 2003 ve 2011**
(A) 2003. (B) 2011. Veriler 2003–2011 Türkiye Hanehalkı Bütçe Anketleri ve Türk Sosyal Sigortalar Kurumundan alınmıştır (ek s 2–13). Bu analiz referans 27 ile güncellenmiştir.



Şekil 8: **Farklı bütçe eşiklerinde, gıda dışı hane harcamalarının bir parçası olarak cepten yapılan sağlık harcaması için kişi sayımı**
Veriler 2003–2011 Türkiye Hanehalkı Bütçe Anketleri ve Türk Sosyal Sigortalar Kurumundan alınmıştır (ek s 2–13).

yardımcı olmasıdır. 2003 yılında, harcama insidansını ölçen ortalama kişi sayımı 15%, 25%, ve 40% toplam gıda dışı sağlık harcamaları sırasıyla 0.050, 0.022 ve 0.009 olmuş ve iki ya da üç misli azalarak 2011 yılında sırasıyla 0.029, 0.012 ve 0.003 olmuştur (şekil 8).

İnsan kaynakları yönetimi

SDP, sağlık sistemindeki eksikliklere ve sağlık personelinin hakkaniyetsiz dağılımına eğilmek için dört ana insan kaynakları inisiyatifi getirdi. Yüksek Öğrenim Kurumu ile anlaşma yapıldıktan sonra uygulanan birinci inisiyatif üniversitelerde ve diğer yüksek öğrenim kurumlarında doktor, ebe, hemşire ve diğer sağlık personeli eğitimi verilecek yerlerin sayısını artırmıştır. Yıllık tıp öğrencisi alımı 2003 yılında 5253 iken, 2010 yılında artarak 8438 olmuştur, hemşire, eczacı ve diğer sağlık profesyonelleri için de benzer artışlar söz konusudur. 2007 yılında, hemşirelerin eğitimi üniversitelerle sınırlanmıştır. Yeni tıp mezunları ve yeni uzman doktorlara zorunlu hizmet getirilmiş, Türkiye'nin doktor ihtiyacının çok olduğu farklı bölgelerinde, özellikle kırsal alanlar, doğu ve güneydoğu bölgelerinde 300–500 günlük hizmet zorunluluğu konmuştur. İkinci inisiyatif hastanelerde ve birinci basamak sağlık hizmeti sağlayıcıları için daha yüksek maaş ve performansla ilgili teşvikler getirmiş, sağlık işçilerinin ücretlerinin önemli ölçüde artması olanağını sağlamıştır. Üçüncü inisiyatif, 2003 yılında getirilen yeni kararların desteğiyle sağlık işçilerinin işe alınmasının ve elde tutulmasının zor olduğu bölgelerde personel mevcudiyetini artırmak için sağlık personeliyle yeni kişisel sözleşmeler yapılabilmesini ve sağlık hizmetlerinin dış kaynaklardan edinilebilmesini sağlamıştır. Bu yeni sözleşmeler daha yüksek maaşlar ve performansla ilişkili ödemeler sağlamıştır.[50] Ayrıca, yeni kararlar, genel devlet memurluğu kanununa (bu kanun kamu sektöründeki

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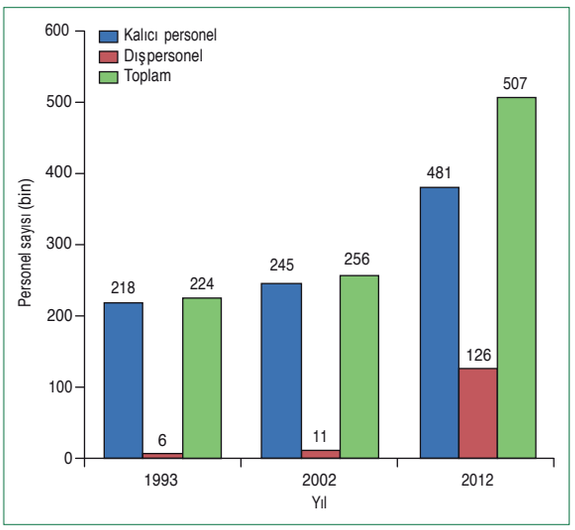
sağlık personelinin istihdam şartlarını belirlemektedir.) değişiklikler getirmiş, sağlık kurumlarına yeni personel alımında esneklikler sağlamıştır.[51]

Dördüncü inisiyatif; 2010 yılında kamu kurumlarında (Sağlık Bakanlığı hastaneleri ve üniversite hastaneleri) istihdam edilen doktorların tam zamanlı çalışmalarını gerektiren ve paralel özel çalışmaları engelleyen yeni bir yasa getirilmesi olmuştur. Bu yasa Özel muayenehaneleri olan ve aynı zamanda üniversite hastanelerinde ve bölge kentlerdeki büyük devlet üniversitesi hastanelerinde çalışan bazı klinisyenler, bu yeni yasaya karşı çıkmışlardır.[52] Değişiklikleri takiben, birkaç klinisyen, üniversite eğitim hastanelerinden ve birçoğu da İstanbul ve Ankara gibi büyük şehirlerdeki büyük devlet hastanelerinden istifa etmiştir. Bu insan kaynağı inisiyatifleri, Sağlık Bakanlığının istihdam ettiği 2002 yılında 256000 olan personel sayısını hızla artırarak 2012 yılında 507 000'e çıkarmıştır. 2002 ile 2012 yılları arasında, dış kaynaklardan edinilen personel sayısı 11 000'den 126 000'e çıkarak yaklaşık 12 katına yükselmiştir (şekil 9). 2004 ile 2010 yılları arasında, uzman hekimlerin sayısı yaklaşık 53 300'den 63 600'e ve pratisyen hekimlerin sayısı 33 300'den 38 800'e artmıştır. 2004–10 döneminde, hemşire sayısı 82 600'den 114 800'e çıkmış, ebelerin sayısı da 42 700'den 50 300'e çıkmıştır. Aynı şekilde, yardımcı personel sayısı 2004 yılında 57 700 iken 2010 yılında 94 400 olmuştur.[53]

Yeni insan kaynakları politikaları Türk sağlık sistemindeki personel eksikliklerine eğilmeye yardımcı olmuş ve eşitsizlikleri azaltmıştır. Örneğin, 1990 yılında, Türkiye'nin batı ve orta bölgelerinde her uzman hekime 856 kişi düşerken, doğu bölgesinde uzman başına 43 668 kişi düşmekteydi. Batı ve orta bölgelerdeki uzman doktorların doğu bölgesindeki uzman doktor sayısına oranı 51:1 kadardı. 2000 yılında, her uzman doktor için batı ve orta bölgelerde 749 kişi, doğu bölgesinde 25 178 kişi vardı; yani bölgeler arasındaki uzman hekimlerin oranı 34:1'e düşmüştü. 2010 yılında, batı ve orta bölgelerde her uzman doktora düşen kişi sayısı 559'a, doğu bölgesindeki 2705'e düşmüştü. Bu bölgeler arasındaki uzman hekim oranı ise 5:1 olmuştu (şekil 10).

Aynı şekilde, 1990 yılında, kuzey ve doğu bölgelerinde bir genel hekime düşen kişi sayısı sırasıyla 1745 ve 6628'di, yani 4:1'lik bir oran. 2000 yılında, bu fark artmıştı, kuzey ve doğu bölgelerinde bir genel hekime düşen kişi sayısı sırasıyla 1288 ve 5747 oldu, oran da kötüleşerek 5:1 olmuştu. Ancak, 2010 yılında, kuzey ve doğu bölgelerinde bir genel hekime düşen kişi sayısı sırasıyla 1396 ve 2291'e düşmüş, oran da azalarak, 1.6:1 olmuştu (şekil 11).

1990 yılında, bir hemşire ya da ebeye düşen kişi sayısı kuzey bölgesinde 414 ve doğu bölgesinde 2404'tü, bölgesel oran 6:1'di. 2010 yılında, bir hemşire ya da ebeye düşen kişi sayısı kuzey bölgesinde 1635'e ve doğu bölgesinde 826'ya düşmüş, oran da azalarak 3.2:1 olmuştu (şekil 12).



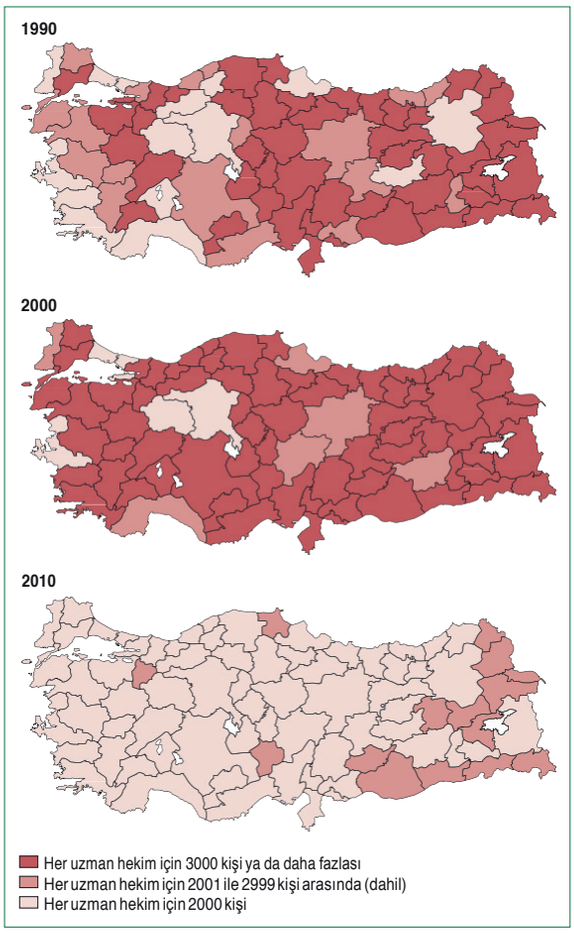
Şekil 9: **Türkiye'de Sağlık Bakanlığı kadrolu ya da sözleşmeli klinik ve idari personel sayısı, 1993–2012**
Veriler, Sağlık Bakanlığı Sağlık Hizmetleri Genel Müdürlüğü ve Türkiye Cumhuriyeti Sağlık Bakanlığı Sağlık İstatistikleri Yıllığı, 2011 referanslarından edinilen verilerden yazarın analizleriyle elde edilmiştir.[17]

Hizmet sunumu

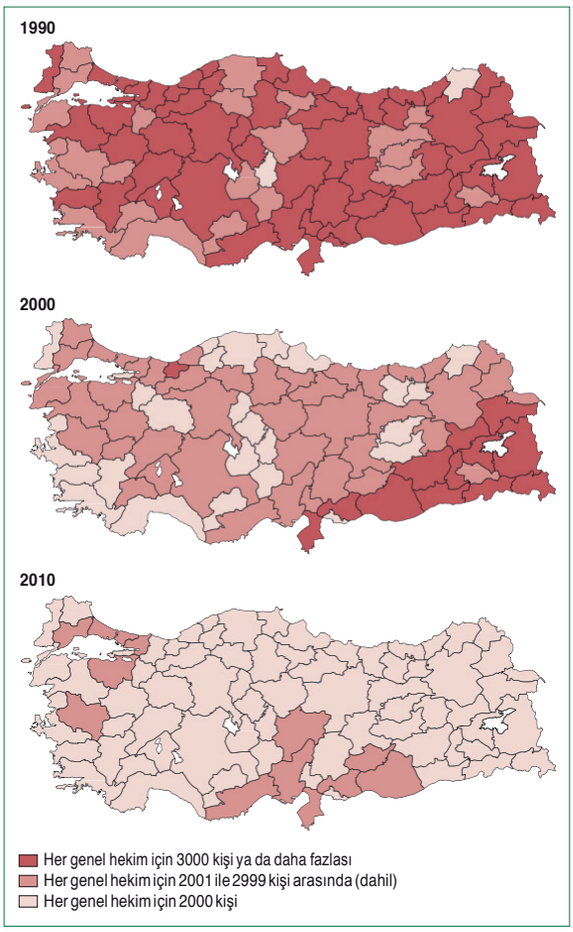
Birinci basamak sağlık hizmetlerinin genişletilmesi

SDP öncesinde, Türkiye'deki birinci basamak sağlık hizmetleri 1961 Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkındaki Kanun uyarınca üç ayaklı bir sistem olarak düzenlenmişti. Birinci ayak, ebelerin çalıştığı sağlık ocaklarıydı (2–2500 kişilik bir nüfusu kapsıyordu). İkinci ayak, birinci basamak sağlık merkezlerinden oluşmaktaydı. (köylerdeki 5–10 000 kişiyi; ilçe düzeyinde 10–30 000 kişiyi; ya da il düzeyinde 30–50 000 kişiyi kapsıyordu) Burada bir hekim, bir hemşire ve bir ebe çalışmaktaydı (daha büyük merkezlerde bir sağlık teknisyeni ve bir idareci ile birlikte).

Üçüncü ayak, il düzeyindeydi ve anne çocuk sağlığı ve aile planlaması hizmeti veren ek sağlık merkezlerinden ve verem savaş dispanserlerinden oluşmaktaydı. Ancak, birinci basamak sağlık hizmeti düzeyini karakterize eden kesin bir altyapı ve personel eksikliği ve değişken personel becerileriydi. 2005 yılında, SDP, üç alanda, fiziksel kaynaklar, insan kaynakları ve insan kaynakları kapasitesi alanlarında artışa odaklanan, aile hekimliği merkezli bir birinci basamak sağlık hizmeti modeli getirdi.[54] Bu modelle, her aile hekimi ya da aile hekimliği uygulaması kayıtlı maksimum 4000 vatandaşa hizmet sunmaktaydı ve bu hizmetler sağlık ocaklarından ya da geleneksel birinci basamak sağlık hizmetleri merkezlerinden daha fazlaydı. 2005 sonrasında, yaklaşık 20 000 yeni aile hekimliği ekibi oluşturuldu. Altyapı güncellendi ve genişletildi, sağlık ocaklarının çoğu korundu ve sağlık merkezleriyle birlikte yenilendi ya da aile hekimliği merkezlerine dönüştürüldü. 2011 yılında 6250 adet yeni aile hekimliği merkezi kurulmuştu.



Şekil 10: **1990, 2000 ve 2010 yıllarında illere göre her uzman hekim için nüfus**
İller, Nüfus ve Sağlık Araştırması bölgelerinde kullanılan gruplamaya göre gruplandırılmıştır. Veriler yazarın Türkiye Cumhuriyeti Sağlık Bakanlığı Sağlık Hizmetleri Genel Müdürlüğünden edindiği veriler analiz edilerek hazırlanmıştır.



Şekil 11: **1990, 2000 ve 2010 yıllarında illere göre her genel hekim için nüfus**
İller, Nüfus ve Sağlık Araştırması bölgelerinde kullanılan gruplamaya göre gruplandırılmıştır. Veriler yazarın Türkiye Cumhuriyeti Sağlık Bakanlığı Sağlık Hizmetleri Genel Müdürlüğünden edindiği veriler analiz edilerek hazırlanmıştır.

2005 sonrasında, aile hekimleri, kapsamlı koruyucu hizmetleri ve kadın - çocuk sağlığı hizmetlerini içeren birinci basamak sağlık hizmetlerini sunmak üzere sözleşmeli olarak istihdam edildi. Bunlara ek olarak, düzenli ziyaretlerle kendilerine kayıtlı ve kırsal alanlarda yaşayan bireylere mobil sağlık hizmeti ve bakım evleri, hapishaneler, çocuk bakım merkezlerinin yanı sıra kliniklere gelemeyen hastalara evde bakım hizmeti, sunmakla yükümlüdürler.

Bu çalışmanın bir parçası olarak yürütülen ve yeni aile hekimliği modelinin getirilmesinden önce (aşama 1) ve sonra (aşama 2) birinci basamak sağlık hizmeti hekimlerince verilen hizmetleri inceleyen, kontrollü çalışma öncesi ve sonrasında edinilen bulgular (ek s 2–13), modelin getirilmesinden sonra kilit anne ve çocuk sağlığı hizmetlerinin ulaşılabilirliğinde önemli iyileşmeler olduğunu göstermektedir. Çalışmada incelenen birinci basamak sağlık hizmeti hekimlerince günlük bazda verilen aşılama hizmetleri 1. aşamada %60.6 iken 2. aşamada %91.4'e çıkmıştır. Evde ve mobil aşılama hizmetlerinin kullanılabilirliği kontrol grubundakilere kıyasla, pilot uygulama grubundakilerde çok daha yüksektir (sırasıyla p=0.04 ve p=0.01). Doğum öncesi hizmetlerin günlük bazda genel kullanılabilirliği %97.0 olmuştur. Günlük hizmetlerin kullanılabilirliği faz 2'de artarken (kontrol grubu bölgelerinde %93.9'dan %95.6'ya, pilot uygulama bölgelerinde %93.9'dan %98.1'e), birinci basamak sağlık hizmeti hekimlerince verilen mobil hizmetlerin kullanılabilirliği 1. aşamada %78.8 iken 2. Aşamada %54.1'e düşmüştür. Ancak, pilot ve kontrol grubu bölgeleri arasında istatiksel olarak anlamlı farklılıklar raporlanmamıştır. Birinci basamak sağlık hizmeti birimlerinin hemen hepsi her iki aşamada da günlük bazda aile planlama hizmetleri vermektedir (tablo 3).

Kontrollü öncesi ve sonrası çalışmasında fark içinde fark tahminleri kullanılarak yapılan ek ekonometrik analizler, birinci basamak sağlık hizmeti hekimlerinin birinci basamak sağlık hizmetinde sık rastlanan hastalıkların ilk teşhis yönetiminde (OR 1.27, %95 CI 1.12–1.44), anne ve çocuk sağlığı hizmetlerinin düzenlenmesinde (OR 1.70, %95 CI 1.15–2.52), ve uzun süreli hastalıklarda tanı (OR 1.13, %95 CI 1.00 –1.28),

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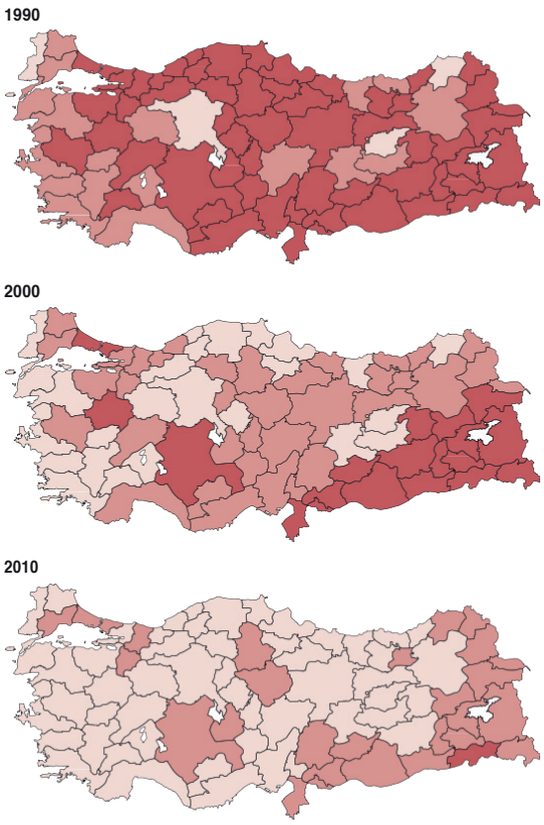

Şekil 12: **1990,2000 ve 2010 yıllarında her hemşire ya da ebe başına kapsanan nüfus**

İller, Nüfus ve Sağlık Araştırması bölgelerinde kullanılan gruplamaya göre gruplandırılmıştır. Veriler yazarın Türkiye Cumhuriyeti Sağlık Bakanlığı Sağlık Hizmetleri Genel Müdürlüğünden edindiği veriler analiz edilerek hazırlanmıştır.

	Aşama 1 (%)	Aşama 2: Kontrol (%)	Aşama 2: Pilot (%)	Pilot* Aşama 2 (β3) Olasılık oranı (95% CI)
Aşılama hizmetleri				
Günlük bazda verilen hizmetler	60.6	89.0 ( )	93.4	4.97 (1.10–22.6)
Aşılanmış çocukları izleme sistemi	100.0	95.6	97.2	NA
Mobil aşılama hizmetleri	61.6	52.7	62.3	2.48 (1.24–4.92)
Doğum öncesi bakım hizmetleri				
Günlük bazda verilen hizmetler	93.9	95.6	98.1	NA
Gebe kadınları izleme sistemi	100.0	97.8	97.2	NA
Mobil antenatal hizmetler	78.8	62.6	46.7	1.01 (0.49–2.13)

NA= yok, çünkü olasılık oranları hesaplanırken incelenen zaman dilimi için ve kontrol ve pilot bölgeler arasında hizmetlerde yetersiz değişiklikler var. Veriler, yazarın birinci basamak sağlık hekimlerinin aile hekimliği pilot ve kontrol bölgelerde görev profili etüdünden elde edilen veriler analiz edilerek hazırlanmıştır. fark içinde farkı kullanan regresyon modelinin özellikleri ek s 2–13'te verilmiştir.

Tablo 3: **Aile hekimliği merkezli birinci basamak sağlık hizmeti reformlarının pilot ve kontrol bölgelerinde 1. ve 2. aşamalarında sunulan anne ve çocuk sağlığı hizmetleri**

	Her hizmet kategorisindeki aktivite sayısı	Pilot* Aşama 2 (β3) Olasılık oranı (95% CI)
Tıbbi teknolojilerin uygulanması	8	0.89 (0.73–1.08)
Birinci temas yönetimi	26	1.27 (1.12–1.44)
Önleme		
Hasta bazında	6	1.24 (0.92–1.67)
Nüfus bazında	6	0.87 (0.70–1.07)
Anne ve çocuk bakımı	5	1.70 (1.15–2.52)
Uzun dönemli durumlar		
Diagnoz	20	1.13 (1.00–1.28)
Tedavinin başlatılması	18	1.41 (1.21–1.65)
İzleme	20	1.45 (1.25–1.69)

Veriler, yazarın birinci basamak sağlık hekimlerinin aile hekimliği pilot ve kontrol bölgelerde görev profili etüdünden elde edilen veriler analiz edilerek hazırlanmıştır. Farklardaki farkı kullanan regresyon modelinin özellikleri ek s 2–13'te verilmiştir.

Tablo 4: **Aile hekimliğinin birinci basamak sağlık hekimlerince sağlanan sağlık hizmetlerinin tıbbi becerileri ve kapsamı üzerindeki etkileri**

tedavinin başlatılması (OR 1.41, %95 CI 1.21–1.65), ve izlenmesinde (OR 1.45, %95 CI 1.25–1.69) ikinci aşama SDP aile hekimliği pilot uygulamasının yapıldığı illerde, kontrol grubundaki illere kıyasla daha yüksek olduğunu göstermektedir (tablo 4).

Birinci basamak sağlık bakım hizmetlerinin hacmi (vizit sayısı) 2002 yılında 74.8 milyon iken, personelin artması, altyapının iyileştirilmesi ve aile hekimleriyle teşvikler içeren yeni sözleşmelerin yapılmasıyla, 2011 yılında 244.3 milyona çıkmıştır.[55]

Annelikle ilgili ve neonatal acil durumlara eğilmek için acil servis ve hastane hizmetlerinin genişletilmesi

SDP sırasında insan kaynaklarının sayısı ve kapasitesi önemli düzeyde artmıştır, ülke çapında sağlık personelinin dağılımı öncekine nazaran daha hakkaniyetli bir hale gelmiştir. Aile hekimliği merkezli birinci basamak sağlık hizmetleri tüm illerde geliştirilmiştir. Komplike acil durumlar için hava ambulans hizmeti dahil, acil ambulans hizmetleri önemli ölçüde artırılmıştır. Ücretsiz sağlanan bu hizmetler aynı zamanda obstetrik ve neonatal acil durumlara da yanıt vermektedir. 2008 yılında, kaza ve acil durum hizmetleri ve yoğun bakım hizmetleri tüm devlet hastanelerinde ve özel hastanelerde serbestçe erişilebilir hale getirilmiştir. Ayrıca, kan transfüzyonu hizmetleri geliştirilmiş, annelik acil durumları için hızlı bir yanıt sistemi oluşturulmuştur. Bu değişiklikler topluca düşünüldüğünde anne ve çocuk sağlığı hizmetlerine erişimin artmasına yol açmış, anne, 5 yaş altı çocuk, bebek ve neonatal ölümlerinin azalmasına yardımcı olmuştur. Yeni personel sözleşmeleri, maaşların artırılması ve daha iyi çalışma şartlarının sağlanması, fakir ve az hizmet giden alanlara personelin çekilmesine ve orada kalmasına yardımcı olmuştur.

SDP sırasında, neonatal hizmet veren hastanelerin sayısı 2002 yılında 141 iken, altı kat artarak 2011 yılında 906

olmuştur. Genel Sağlık Sigortası programında genişletilen haklarla annelikle ilgili acil durumlar, neonatal bakım hizmetleri (neonatal yoğun bakım dahil) ve konjenital anomalilerin tedavisi ücretsiz hale getirilmiştir (hem kamu hem de özel sağlık kuruluşlarında).

Hastane kapasitesi ve hizmetlerinin genişletilmesi

Türkiye'deki hastane yatağı sayısı 1990 yılında 105 710 (1000 kişi başına 1.87 yatak) iken yavaş yavaş artarak 2000 yılında 134 950 (1000 kişi başına 1.99 yatak) olmuştur ve bundan sonra SDP ile birlikte hızla artarak 2011 yılında 194 504 olmuştur (1000 kişi başına 2.6 yatak). 1990 ile 2011 arasında, 1000 kişi başına yatak sayısı iki misli artarak Sağlık Bakanlığının hastanelerinde 80 403'ten 121 297'ye ve üniversite hastanelerinde 16 817'den 34 802'ye çıkmıştır.

Acil servisleri ve kompleks hastalıkların servislerini iyileştirme yönündeki SDP amaçlarına paralel olarak 2002 ile 2011 arasında, yoğun bakım birimi yataklarının sayısı Sağlık Bakanlığı hastanelerinde on misliden fazla artarak 869'dan 9581'e, üniversite hastanelerinde 353'ten 3890'a, ve özel hastanelerde 992'den 7506'ya çıkmıştır. Devlet ve özel sektörlerde toplam yoğun bakım birimi yataklarının sayısı 2002 yılında 2214 iken dokuz misli artarak 2011 yılında 20977 oldu.[55]

SDP içinde hem devlet hastanelerinin hem de özel hastanelerin kullanılması hastane sektörünün genişletilmesine ve ülkenin mevcut kapasitesinin etkin bir şekilde kullanımına yönelik açık bir stratejiydi. 2010 yılında, Sosyal Güvenlik Kurumu 421 özel hastaneyle vatandaşların katkı payı ödeyerek genel teşhis ve tedavi hizmetlerinden faydalanabilmeleri için sözleşmeler yaptı. Ayrıca, bu özel hastaneler acil durumlar, yanıklar, yoğun bakım, kalp damar cerrahisi, neonatal bakım, konjenital anomaliler, organ transplantasyonu ve böbrek diyalizi için bedelsiz hizmet sağladı. Özel sektörün sağladığı hastane hizmetlerinin hacmi (hastane vizitlerinin sayısı) 2002 yılında 5.7 milyon (toplam 124.3 milyon hizmetin %4.6'sı) iken artarak 2011 yılında 59.1 milyon oldu (toplam 337.8 milyon hizmetin %17.5'i).[55] Özel sektör hastanelerinin yatak sayısı 1990 yılında 3361 iken (1000 kişi başına 0.06) yaklaşık on misli artarak 2011 yılında 31 648 (1000 kişi başına 0.42) oldu, 2005 sonrasında ise, Sosyal Sigortalar Kurumu ile akredite özel sektör hastaneleri arasında yapılan hizmet sözleşmelerinden sonra artan hasta hacmini karşılamak, sigorta yararlanıcılarına hizmet sağlamak için hızlı bir artış görüldü.

Özel sektörün genişlemesine devlet düzenlemelerinin artışı eşlik etti. Maliye Bakanlığı özel hastaneler üzerine sıkı bir mali gözetim ve kontrol, özellikle de vergilendirme getirirken, Sağlık Bakanlığı akreditasyon, insan gücü planlaması (kapasite tavanları içeren) ve kalite standartları konularında yeni yönetmelikler çıkardı. Ayrıca, her iki bakanlık da özel hastanelerdeki hasta memnuniyetini ve şikayetlerini izlemekte ve gerektiğinde müdahale etmektedir. Büyük özel hastanelerin hemen hemen %90'ı hizmet alıcısı olarak davranan ve hizmet hacmini ve talepleri aşırı ya da belgelenmemiş taleplere gerektiğinde ceza uygulanabilmesi ve geri ödemenin azaltılması için yakından takip eden Sosyal Sigortalar Kurumu ve daha sonra da Sosyal Güvenlik Kurumu ile sözleşmeler yaptı. Özel sektör idaresi, sağlık hizmetlerinde kalite standartları, özel sağlık hizmetleri, in-vitro fertilizasyon, transplantasyon hizmetleri ve yoğun bakım hizmetleri konularında getirilen yeni hükümet kararları ile Maliye Bakanlığı, Sağlık Bakanlığı ve Sosyal Güvenlik Kurumunun gözetiminin ve düzenlemelerinin artışı kolaylaştı. Sağlık hizmetleri standartlarının uygulanmasına ilişkin Sağlık Bakanlığı genelgeleri ya da tebliğleri çıkarıldı.

2008 yılında özel sektörün büyümesini ve sağlık personelinin kamu sektöründen özel sektöre geçişini düzenlemek için yeni yönetmelikler getirildi. Bu yeni yönetmelikler özel sektör hastane kapasitesini ve yatak sayısındaki yıllık artışları, verilen hizmetleri ve personel sayılarını belirlemekteydi.

2002 ile 2011 arasında, üç ana hastane hizmeti veren grupta ortalama hastanede kalış süresi azaldı: Üniversite hastanelerinde (daha kompleks vakaları tedavi eden üçüncü basamak birimler) 8.6 günden 5.8 güne; Sağlık Bakanlığı hastanelerinde (esas olarak ikinci basamak birimleri) 5.7 günden 4.3 güne; ve özel sektör hastanelerinde (özel sigortalı hastalara ve sağlık sigortası olan hastalara bakan) 3.1 günden 2.0 güne. Ortalama olarak, hastanede kalış süresi 2002 yılında 5.8 gün iken 2011 yılında 4.1 güne düştü, öte yandan, yatak doluluk oranı 2002 yılında %59.4 iken 2011 yılında %65.6 oldu.[56]

Bununla birlikte, bu etkinlik kazanımlarının hizmet kalitesi üzerindeki etkileri henüz ölçülmemiştir.

Halk sağlığı

SDP, GSK'ya ulaşmak için, yüksek sigara içme oranı, fiziksel inaktivite ve obezite gibi sağlık risk faktörlerine yönelik bir dizi halk sağlığı müdahalesine öncelik verdi. Ruhsal hastalıklar ve diabetes mellitusa bağlı hastalık yükü artışına eğilmek için, yeni halk sağlığı ve toplum bazlı programlar geliştirildi. SDP aynı zamanda doğal ve insan eliyle gelişen afetlere karşı sağlık sisteminin dayanıklılığını güçlendirmeye ve hızlı yanıt kapasitesinin geliştirilmesine de yatırım yaptı. Bu girişimleri ve programlar tartışmayacağız; fakat panel 5, kısa bir özet vermektedir.

SDP ve GSK'nın anne ve çocuk sağlığı hizmetlerine erişim ve çocuk ölümü üzerindeki etkisi

1993–2008 Türkiye Nüfus ve Sağlık Araştırmasının analizi bu dönemde ve özellikle 2003–08 arasında tüm Türkiye'de anne ve çocuk sağlığı hizmetlerinin kullanımının önemli ölçüde iyileştiğini göstermektedir. Ülkenin tüm bölgelerinde ve de özellikle 2003 sonrasında daha az hizmet almış doğu bölgesinde ve sosyo-ekonomik açıdan dezavantajlı gruplarda iyileşmeler gerçekleşmiştir (tablo 5).

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Panel 5: **Doğal ve insan eliyle oluşan afetlere karşı sağlık sisteminin direncini geliştirmek için yapılan halk sağlığı müdahaleleri inisiyatifleri**

Tütün kontrolü

2004 yılında, Türkiye, aynı yıl Türkiye Büyük Millet Meclisi tarafından onaylanan DSÖ Tütün Kontrolü Çerçeve Anlaşmasını imzalayan taraflarından biri oldu. 2007 yılında, Başbakan Ulusal Tütün Kontrolü Stratejisini başlattı (2008–2012). 2008 yılında, kapsamlı bir tütün kontrolü yasası ile toplumsal alanlarda tam bir yasaklama getirildi ve kitlesel medyada reklam yapılması ve tüm tütün ürünlerinin tanıtımı, reklamı ve sponsorluğu yasaklandı.[57] 2010–2011 yıllarında, tütün ürünlerindeki vergi sigara maliyetinin %78'ine çıkarılarak DSÖ tarafından tavsiye edilen düzeyler karşılandı.[58] Bu müdahaleler Türk yetişkin nüfusundaki (15 yaşında ya da daha yaşlı) günlük sigara içme prevalansının 2003 yılında %32.1'den 2012 yılında %23.8'e düşmesine yardımcı oldu.[58] Türkiye tütün kullanıcılarının davranış değişikliğini hedefleyen stratejilerle, DSÖ Tütün için yetki stratejisini tam olarak uygulayan ilk ülke oldu.[59,60]

Obezite yönetimi

2010 yılında, Türkiye nüfusunun yaklaşık %34.6'sı aşırı kiloluydu ve %30.3'ü obezdi.[17] Sağlıkta Dönüşüm Programının bir parçası olarak, Sağlık Bakanlığı toplumda obezite farkındalığı oluşturmak, sağlıklı beslenmeyi ve düzenli fiziksel aktiviteyi teşvik etmek için Türkiye Sağlıklı Beslenme ve Hareketli Hayat Programı 2010–2014 ve 2013–2017'yi sundu.[61] Sağlık Bakanlığının yönetiminde obeziteyle savaşmak ve her ilde doğrudan il valilerine bağlı olarak aktif yaşam tarzlarını ve sağlıklı beslenmeyi teşvik etmek için uzman ekipler oluşturuldu.[42]

Ruh sağlığı

2007 yılında, Türkiye, Avrupa'daki 100 000 nüfus başına (100 000 kişi için bir tane) en düşük psikiyatrist sayısına sahipti, psikiyatri yatakları sayısında dördüncüydü (100 000 kişi için 12) ve hastane kabul sayısında sondan dördüncüydü (100 000 kişi için 115). Ruh sağlığı hemşireleri toplam hemşire işgücünün sadece %1'ydi.[62] Ruh sağlığı tedavisi hastane temelinde bakım üzerine yoğunlaştı, 6000 ruhsal hastalık yatağından 4000 tanesi sekiz bölgesel psikiyatri dal hastanesindeydi.[63]

Küresel Hastalık Yükü Çalışmasına göre, Türkiye'de, 1990 ile 2010 arasında, majör depresif bozukluk ve anksiyete bozuklukları yaklaşık %50 arttı. 2010 yılında, majör depresif bozukluk sakatlığa ayarlanmış yaşam yılı birimleriyle üçüncü büyük hastalık yükü ve anksiyete bozuklukları sakatlığa ayarlanmış yaşam yılı için en üstteki on bozukluklardan biriydi.[64]

2011 yılında, Sağlık Bakanlığı, her biri 300 000 kişiye hizmet veren 240 toplum ruh sağlığı merkezi kurma amacıyla Ulusal Ruh Sağlığı Eylem Planı 2011-23'ü[23],[65] başlattı.[66] Bu plan yetişkinler, çocuklar ve ergenler için ruh sağlığı hizmeti sağlanmasını güçlendirmeyi; ruhsal hastalıklarla ilgili damgalanmayı azaltmayı; kadınlara karşı şiddeti ortadan kaldırmayı; çocuk istismarını durdurmayı; doğal afetler sonrasında ortaya çıkan intiharları, travma sonrası stres bozukluğunu ve ruhsal bozuklukları önlemeyi Amaçlamaktadır. 2011–2016 için amaçları şunlardır: Ruhsal hastalıklar için akılcı reçete yazmayı iyileştirmek; psikiyatri yataklarının sayısını artırmak (psikiyatri dalı hastanelerindeki yatak sayısını düşürmek ve genel hastanelerdeki yatak sayısını artırmak); toplum ruh sağlığı merkezlerini ve ayaktan hasta hizmetlerini yaygınlaştırarak hastane bazlı hizmetleri toplum merkezlerine kaydırmak; yeni planlanan hastane yerleşkelerinde güvenli psikiyatrik yatak sayısını artırmak; ruh sağlığı uzmanlarının sayısını artırmak; ve ruh sağlığı hizmetlerini birinci basamak sağlık hizmetlerine entegre etmek.[65]

Doğal ve insan eliyle oluşturulan afetlere karşı sağlık sisteminin direncini geliştirmek

Türkiye'nin batısında gerçekleşen 1999 Marmara depremi eşi görülmemiş ölümlere, hasara ve acıya, çok büyük ekonomik, politik ve toplumsal sonuçlara yol açtı. Halk tarafından etkin bir yanıt verememekle suçlanan hükümet, 1999 yılında bir Türkiye Acil Durum Yönetimi Genel Müdürlüğü kurdu.[67]

2004 yılında, Sağlık Bakanlığı 81 ille ve uluslararası kurtarma ekipleriyle iletişim kurmak için taşınabilir imkanları ve sistemleri olan Afet ve Acil Durum Koordinasyon Merkezleri geliştirdi. 2004 ile başlayarak, yeni ulusal medikal kurtarma ekipleri oluşturuldu, 2011 yılında gelindiğinde 4847 gönüllü eğitilmiş ve sertifikalandırılmıştı.[68] 2009 yılında, afetlere ve kurtarma operasyonlarına hazır olma üzerine odaklanan[69] Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı kuruldu, Sağlık Bakanlığı ise doğal ve insan eliyle oluşturulan afetleri yönetmek için kapsamlı ve entegre bir yanıt kapasitesi oluşturarak, kurtarılan insanların tıbbi tedavileri üzerine yoğunlaştı.

Marmara afetinin tersine, 2011 yılındaki Van depremine (Richter ölçeğinde 7.2) yanıt hızlı ve kapsamlı oldu—ilk acil durum ve kurtarma ekipleri etkilenen alana 30 dakika içinde ulaştı, Sağlık Bakanı müdahaleyi görmek için 3 saat içinde geldi, ve birkaç saat içinde Sağlık Bakanlığı hastaların akrabalarıyla iletişim akışını koordine edecek bir canlı hat oluşturdu. çoğu depremden sonraki 24 saat içinde olmak üzere yaklaşık 250 kişi çöken binaların ve enkazın içinden kurtarıldı,[70] majör fiziksel ve psikolojik travma geçiren yaklaşık 1700 hasta hava ve kara yoluyla bölgesel hastanelere gönderildi.[71] 13 000'den fazla haneye çadır sağlandı ve yaralanma taraması yapıldı, yaklaşık 5000 kişiye psikolojik danışmanlık sağlandı. Bulaşıcı hastalıkların ortaya çıkmasını önlemek için, halk sağlığı müdahaleleri ve gıdayla ve suyla taşınan hastalıklar için sıkı bir gözetim rejimi uygulandı.[70]

2011 yılından sonra, Suriyeli sığınmacılar krizine de Başbakanlık Afet ve Acil Durum Yönetimi Başkanlığı ve Türk Kızılay'ı tarafından koordine edilen etkin bir yanıt verildi.[72] 2013 Mart'ına gelindiğinde, yaklaşık 230 000 Suriyeli sığınmacı güney-doğu Türkiye'de bu amaçla kurulmuş bölgelere yerleştirilmiş ve gıda, barınak ve ücretsiz tıbbi yardım yapılmış[73] ve her sığınmacıya haftalık geçim yardımı sağlanmıştır.[74]

Anne ve çocuk sağlığı hizmetlerine erişimde iyileşme ve hakkaniyetin artması

Doğum öncesi bakım

Genel olarak 1993 ile 2008 arasında, gebelik sırasında doğum öncesi bakım alma olasılığı %63.0'dan %93.4'e çıkmış, kullanımda en önemli artış 2003 ile 2008 arasında gözlenmiştir. Doğum öncesi bakım kullanımı 1993 yılından 1998 yılına yüzde 3.1 puan, 1998 yılından 2003 yılına yüzde 8.5 puan ve 2003 yılından 2008 yılına yüzde 18.8 puan artmıştır. Doğu Türkiye'de ve düşük varlık gruplarında kırsal alanlarda şaşırtıcı artışlar gerçekleşti. Örneğin, en fakir yüzde onluk dilim için kullanım oranı 1993 yılında %36.1 olmasına karşın, bu oran 1998 yılında %36.8, 2003 yılında %44.9 oldu ve sonra da 2008 yılında %84.1'e sıçradı. 2003 ile 2008 arasında, en fakir yüzde onluk dilim için doğum öncesi

	Antenatal vizite (%)				Bir sağlık kuruluşundaki doğumların oranı (%)				Eğitimli personelin bulunduğu doğumların oranı (%)				Aşılama alımı (hepsi) (%)			
	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008
Yer																
Kentsel	73.2%	74.4%	83.6%	96.4%	73.0%	76.4%	84.2%	91.8%	80.8%	81.9%	85.1%	94.1%	74.8%	49.5%	62.6%	78.4%
Kırsal	48.8%	51.2%	56.8%	87.7%	42.2%	61.0%	60.9%	74.1%	52.8%	67.6%	62.2%	76.2%	52.3%	38.3%	34.0%	63.8%
Bölge																
Batı	85.4%	83.7%	89.7%	97.2%	80.4%	86.7%	92.0%	93.4%	88.0%	89.2%	90.4%	95.8%	76.5%	50.3%	64.3%	79.3%
Güney	75.5%	73.6%	83.4%	95.9%	64.0%	69.3%	79.0%	90.1%	75.9%	84.2%	83.4%	90.5%	81.1%	56.8%	63.2%	75.5%
Orta	59.4%	71.8%	82.1%	95.6%	64.2%	82.6%	90.1%	94.2%	72.2%	85.6%	91.0%	96.1%	64.9%	52.5%	59.7%	82.1%
Kuzey	63.1%	58.5%	82.5%	93.3%	66.8%	77.9%	87.3%	92.2%	71.6%	83.1%	81.6%	91.1%	62.5%	60.0%	60.5%	77.3%
Doğu	35.1%	43.3%	54.1%	84.0%	30.3%	47.8%	54.1%	61.8%	41.4%	53.4%	57.1%	65.8%	41.6%	25.1%	35.3%	51.9%
Annenin öğrenimi																
Yok	36.9%	36.0%	45.0%	81.7%	32.2%	41.3%	42.7%	61.1%	42.7%	49.8%	47.1%	65.8%	47.8%	31.6%	22.5%	58.0%
İlkokul	69.7%	70.1%	78.4%	94.1%	68.1%	75.9%	83.6%	89.3%	76.6%	82.3%	85.0%	91.2%	69.9%	45.1%	59.9%	75.5%
Ortaokul ya da daha yüksek	89.9%	91.1%	96.2%	99.0%	86.5%	92.5%	94.6%	93.5%	93.5%	94.0%	91.6%	95.1%	81.9%	61.2%	65.3%	78.1%
Anadil																
Türkçe değil	39.0%	43.9%	53.2%	86.7%	27.7%	42.6%	50.0%	66.8%	39.3%	51.9%	53.9%	71.2%	37.3%	25.7%	33.1%	59.6%
Türkçe	70.0%	75.9%	86.0%	96.4%	69.6%	83.4%	90.4%	94.0%	77.7%	87.9%	90.0%	95.4%	72.2%	53.6%	62.9%	79.3%
Varlık grupları																
Varlık grubu 1	36.1%	36.8%	44.9%	84.1%	33.0%	45.7%	50.4%	67.1%	43.1%	52.2%	53.0%	70.4%	48.0%	30.3%	29.0%	54.9%
Varlık grubu 5	90.9%	94.8%	97.0%	99.0%	90.0%	95.1%	96.9%	92.4%	94.0%	93.2%	93.8%	94.6%	84.4%	70.4%	71.1%	79.0%
Annenin sağlık sigortası																
SSK	77.0%	83.1%	91.4%	97.0%	76.8%	85.5%	92.6%	92.3%	83.7%	89.5%	91.1%	93.8%	76.4%	55.1%	67.5%	78.7%
Yeşil Kart	29.7%	55.6%	56.6%	87.4%	37.8%	67.3%	63.0%	72.2%	56.8%	71.7%	63.0%	77.1%	20.0%	32.7%	38.8%	60.0%
Yok	52.8%	55.5%	64.3%	90.0%	47.7%	61.1%	64.7%	83.2%	57.9%	68.4%	68.8%	83.5%	56.2%	41.1%	42.5%	72.8%
Toplam	63.0%	66.1%	74.6%	93.4%	60.1%	70.9%	76.3%	85.7%	69.0%	76.8%	77.4%	88.0%	65.0%	45.3%	53.2%	73.7%

Veriler yazarın 1993, 1998, 2003, ve 2008 Türk Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13). Numune ilk üç analiz için 5 yaş altı çocukları ve aşılama için 12 aylık ve 24 aylık arasındaki çocukları içermektedir. Tam olarak aşılanmış bir çocuk şu aşıları olmuştur: BCG; difteri– tetanoz–boğmaca 1, 2, ve 3; polio 1, 2, ve 3; ve kızamık. SSK=Sosyal Sigortalar Kurumu.

Tablo 5: **Yer, bölge, sosyo-ekonomik gruplar ve sağlık sigortasına göre sağlık hizmetlerinin kullanımı (1993–2008)**

bakım artışı yüzde 39.2 puan oldu. En zengin yüzde onluk dilim için bu kullanım oranı 1993 yılında %90.9 oldu ve 2008 yılında %99.0'a çıktı. Aynı şekilde, doğu bölgesinde ya da kırsal alanlarda yaşayan ve anadili Türkçe olmayan kadınlarda ve Resmi eğitim almamış kadınlarda, doğum öncesi bakım kullanımı 2003 ile 2008 arasında önemli düzeyde artmıştır (tablo 5 ve şekil 12A).

Doğum sırasında sağlık hizmetlerinin kullanımı

Doğum sırasında sağlık bakımı kullanımının analizi (doğumun bir devlet hastanesinde ya da özel hastanede yapılıp yapılmadığı ve uzman sağlık personelinin– doktor, ebe ya da hemşire– katılıp katılmadığı olarak tanımlanır) bir sağlık kurumunda yapılan doğumların yüzdesinin 1999 yılında %60.1 iken artarak 2008 yılında %85.7 olduğunu göstermektedir. Doğum sırasında sağlık hizmetlerinin kullanımı en fazla en fakir varlık dilimi için ve kırsal ya da uzak alanlarda artmıştır. Kırsal bölgelerde, bir devlet kurumunda ya da özel bir kurumda doğum yapma olasılığı 1993 yılında %42.2 iken artarak 1998 yılında %61.0 olmuştur, 2003 yılında bu düzeyde kalmıştır ve 2008 yılında en büyük artış gerçekleşerek %74.1 olmuştur. Aynı şekilde, en fakir varlık dilimi için, doğum sırasında sağlık hizmetlerinin kullanımı 1993 yılında %33.1 iken artarak 1998 yılında %45.7 olmuştur, en fazla iyileşme ise 2003 ile 2008 arasında gerçekleşmiş, 50.4% iken 67.1% olmuştur (yüzde 16.7 puan; bakınız tablo 5 ve şekil 12B). 1993 yılında, Türkiye'deki doğumların sadece %69'unda uzman personel bulunmaktadır, fakat 2008 yılında bu oran %88'e çıkmıştır. En fakir yüzde onluk dilim için doğumda uzman personel bulunması olasılığı 1993 yılında %43.1 iken artarak 2008 yılında % 70.4 olmuştur, en büyük değişim 2003 ile 2008 arasında gerçekleşmiştir (%53.0'ten itibaren yüzde 17.4 puan). Hiçbir eğitimi olmayan anneler ve anadili Türkçe olmayan anneler için de benzer iyileşmeler gözlenmektedir (tablo 5 ve şekil 12B).

Çocuk aşılamaları

Eksiksiz bir çocukluk aşılamasına sahip olma ihtimali Türkiye'de 1993 ile 1998 arasında %65.0'ten %45.3'e düşmüştür, sonra da 2003 yılında %53.2'ye çıkmıştır, 2008 yılında büyük bir artışla %73.7 olmuştur. Kırsal alanlarda aşılama oranları 2003 boyunca düşmüş, sonra da 2003 yılında %34.0 kapsamdan 2008'de %63.8 kapsama artmıştır (tablo 5 ve şekil 12C).

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2003 ile başlayarak, en dezavantajlı ve uzak alanlarda yüzde onluk dilimler arasında ve kırsal–kentsel bölgeler arasında bir yakınlaşma gözlenmektedir. Daha fakir hanelere ek olarak, Türkiye'nin doğu bölgesinde yaşayan kadınlar, daha az öğrenim görmüş kadınlar ve anadili Türkçe olmayan kadınlar (ve bu kadınların çocukları) anne hizmetlerin kullanımında ve aşılama kapsamında önemli artışlar görmüşlerdir (tablo 5 ve şekil 12A, 12B, ve 12C).

5 yaş altı, bebek ve neonatal ölüm hızlarındaki değişimler

Türkiye'de sağlık hizmetlerine erişimde hakkaniyet değişiklikleri 5 yaş altı, bebek ve neonatal ölüm hızlarındaki keskin ve önemli düşüşleri taklit etmektedir. 5 yaş altı ölüm hızı 1000 canlı doğum başına 1993 yılında 52.7 iken 2008 yılında 18.9 olmuştur. Genel nüfus için en fakir yüzde onluk dilimde ve kırsal ya da uzak alanlarda 5 yaş altı ölüm oranlarındaki en fazla yüzde puan düşüşü 2003 ile 2008 yılları arasında gerçekleşmiştir (tablo 6).

1993–2008 arasında kentsel alanlardaki 5 yaş altı ölüm hızı 1000 canlı doğumda 1993 yılında 44.4 iken 2008 yılında düşerek 18.0 olmuştur. Kırsal alanlarda bu düşüş daha dikkat çekicidir. 1993 yılında 1000 canlı doğumda 63.9 iken 2008 yılında 20.7 olmuştur. En zengin onluk dilimde (5. yüzde onluk dilim) 5 yaş altı ölüm oranı 1000 canlı doğumda 1993 yılında 18.0 iken 2008 yılında 11.4'e düşmüştür, bu sırada en fakir yüzde onluk dilim (birinci yüzde onluk dilim) için 1000 canlı doğumda1993 yılında 84.5 iken 2008 yılında 23.6 olmuştur. 1993 ile 2008 yılları arasında ve özellikle 2003 sonrasında, kırsal ve kentsel, en fakir ve en zengin, öğrenim görmemiş kadınlarla ortaokul ya da daha yüksek öğrenim görmüş kadınlar için 5 yaş altı ölüm hızları arasındaki farklılıklar önemli ölçüde azaldı ve birbirine yaklaştı (şekil 13). Türkiye'deki 5 yaş altı ölüm hızı Türk Nüfus ve Sağlık Araştırması bölgelerinin hepsinde düşmüştür. 1993 yılında kuzey bölgesinde 1000 canlı doğum başına 39.6 iken 2008 yılında 10.6 olmuştur. 1993yılında doğu bölgesinde 1000 canlı doğumda 62.8 iken 2008 yılında 27.7 olmuştur (tablo 6).

Bebek ölüm hızındaki düşüşler 5 yaş altı ölüm hızı için verilenlere benzemektedir, 1993 yılında 1000 canlı doğumda 48.2 iken 2008 yılında 16.6 olmuştur. 1993 ve 2008 arasında, ve özellikle 2003 sonrasında, kentsel ile kırsal alanlar arasındaki, en fakir ile en zengin yüzde onluk dilim arasındaki, ve hiç öğrenim görmemiş kadınlarla ortaokul ya da daha yüksek öğrenim görmüş kadınlar arasındaki farklılıklar önemli ölçüde kalkarak benzer oranlara yaklaşılmıştır (şekil 14).

1993 ve 2008 arasında, bebek ölüm hızları Türk Nüfus ve Sağlık Araştırmasının Batı, Orta, Kuzey, Güney ve Doğu Türkiye bölgelerinin hepsinde düşmüştür. Batı bölgesinde bebek ölüm hızı 1000 canlı doğum başına 1993 40.8 iken bu oran düşerek 2008 yılında 9.4 olmuştur. Doğu bölgesinde, düzey, 1000 canlı doğum düşmüştür. Neonatal ölüm hızı 1993 ile 2008 arasında da aynı şekilde düşüş göstermiş, , 1993 yılında 1000 canlı doğumda 27.1 iken 2008 yılında 13.3'e düşmüştür. 1993 yılında neonatal ölüm hızı kuzey bölgesinde 1000 canlı doğumda 15.5 iken 2008 yılında sıfır olmuştur. Doğu bölgesinde, bu oran 1000 canlı doğumda 31.4 iken 2008 yılında 18.1 olmuştur (tablo 6).

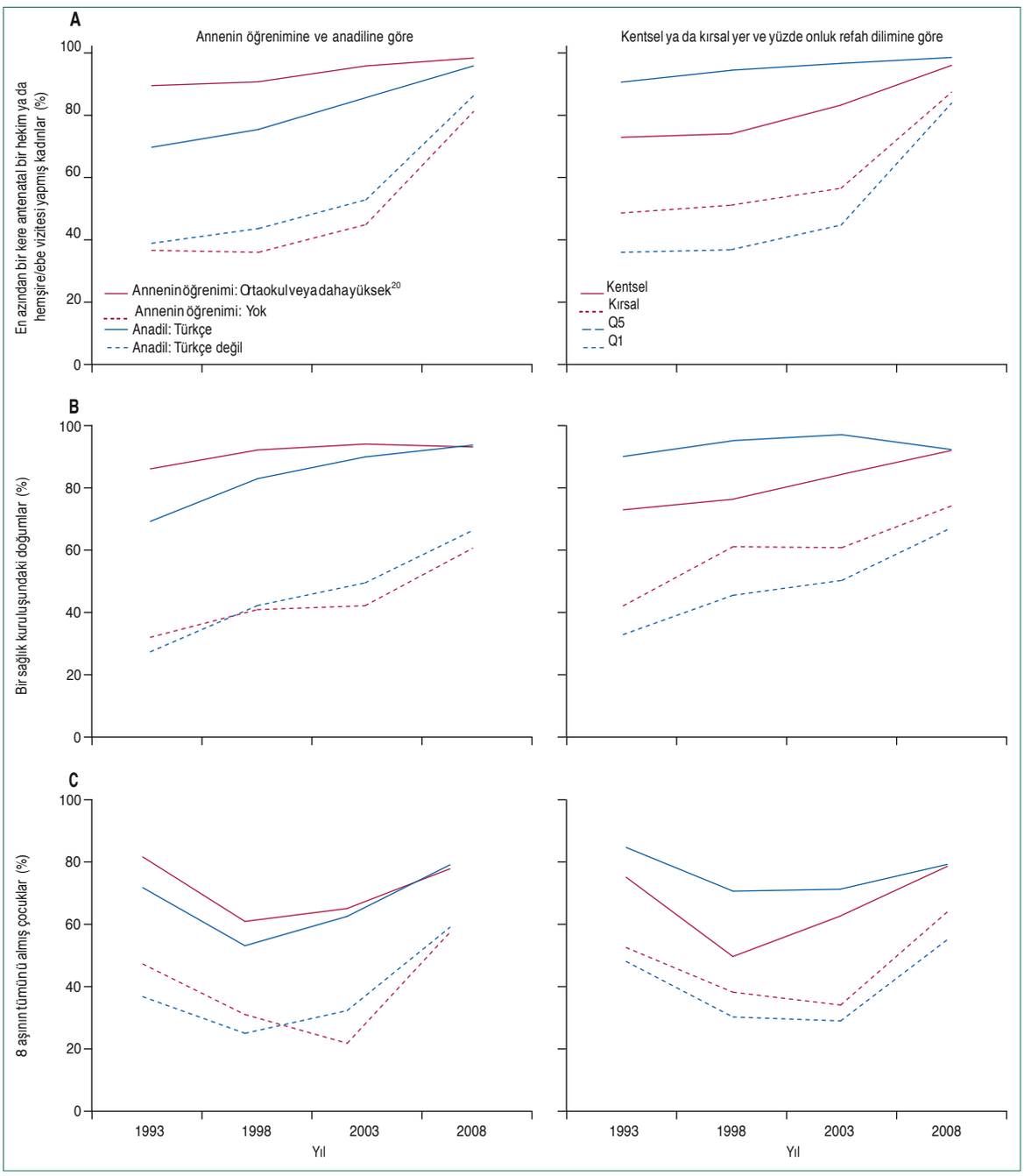
	1000 canlı doğum başına beş yaş altı ölüm hızı				1000 canlı doğum başına bebek ölüm hızı				1000 canlı doğum başına neonatal ölüm hızı			
	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008
Yer												
Kentsel	44.4	38.5	26.9	18.0	40.3	34.4	22.8	16.3	27.0	23.7	15.5	13.3
Kırsal	63.9	62.3	45.8	20.7	58.9	52.8	38.9	17.4	27.3	30.0	20.7	13.2
Bölge												
Batı	43.3	33.1	27.6	11.7	40.8	30.7	21.2	9.4	29.3	27.2	14.8	8.6
Güney	52.3	38.2	23.7	22.1	48.3	29.0	23.7	22.1	26.8	16.8	16.9	18.1
Orta	60.5	48.8	27.0	20.1	54.2	43.6	21.1	19.0	29.0	28.2	10.6	14.2
Kuzey	39.6	45.7	53.6	10.6	37.9	40.6	40.2	10.6	15.5	15.2	26.8	0.0
Doğu	62.8	63.3	41.7	27.7	56.1	55.5	37.6	22.9	31.4	31.2	21.5	18.1
Annenin öğrenimi												
Yok	66.7	64.3	53.3	19.6	59.8	57.2	46.4	14.7	26.5	37.4	26.6	11.4
İlkokul	55.3	46.4	29.5	18.7	50.9	39.8	24.3	17.1	31.8	23.2	14.6	14.4
Ortaokul ya da daha yüksek	15.4	27.1	20.5	18.9	15.4	24.1	17.8	17.0	12.0	19.5	13.3	12.3
Anadil												
Türkçe değil	68.4	53.1	44.8	27.6	62.7	45.8	40.6	23.9	31.9	25.6	24.8	20.3
Türkçe	47.9	44.4	27.0	15.0	43.8	39.0	21.6	13.4	25.7	26.1	13.2	10.2
Varlık grupları												
Varlık grubu 1	84.5	67.8	47.8	23.6	74.9	56.3	39.8	20.5	31.7	26.4	16.7	14.4
Varlık grubu 5	18.0	20.7	11.6	11.4	18.0	20.7	8.7	9.5	9.0	18.7	5.8	7.6
Annenin sağlık sigortası												
SSK	44.2	38.7	23.1	17.2	41.7	36.4	19.1	15.7	28.4	27.9	14.1	12.3
Yeşil Kart	27.0	70.1	49.8	26.3	27.0	60.7	41.7	22.8	27.0	28.0	20.2	18.3
Yok	60.2	51.6	36.7	14.9	54.0	43.3	31.7	11.6	26.3	25.3	18.6	10.0
Toplam	52.7	47.1	33.2	18.9	48.2	41.1	28.2	16.6	27.1	26.0	17.2	13.3

Veriler yazarın 1993, 1998, 2003, ve 2008 Türk Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13). Numune etüt yılından önceki 5 yıl içinde doğmuş çocuklardan oluşmaktadır. SSK=Sosyal Sigortalar Kurumu.

Tablo 6: **5 yaş altı mortalite, bebek ölüm hızı, ve neonatal mortalite oranları (1993–2008)**

Hane özelliklerinin ve sağlık sigortasının anne ve çocuk sağlığı hizmetlerine erişim ile 5 yaş altı ve bebek ölüm hızları üzerindeki etkileri

SDP ve GSK'nın anne ve çocuk sağlığı ile 5 yaş altı ve bebek ölüm hızları üzerindeki etkilerini belirlemek için, Nüfus ve Sağlık Araştırması analizimizi genişlettik ve hane şartlarıyla kullanım oranları arasındaki ilişkilerin zamanla zayıflayıp zayıflamadığını görmek için, hane sosyo-ekonomik ve coğrafi özelliklerini (örneğin kırsala karşı kentsel; Türkiye bölgesi; yüzde onluk gelir dilimi; annenin öğrenimi; ve annenin anadilinin Türkçe olup olmaması) ve hane düzeyinde sağlık sigortasına erişimi



Şekil 13: **Anne ve çocuk sağlığı hizmetlerine erişim, 1993–2008**
(A) Doğum öncesi viziteler (bir hekim ya da hemşire/ebeye en az bir kere bir doğum öncesi bakım vizitesi yapmış kadınların %si). (B) Bir sağlık kuruluşundaki doğumların oranı. (C) Aşılama alımı. Veriler yazarın 1993, 1998, 2003 ve 2008 Türk Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13).

kontrol ederek, çok değişkenli bir regresyon analizi yaptık. Eğer sigortaya erişim hizmetlere erişimi etkiliyorsa, zamana bağlı olarak hane özelliklerinin zayıflaması ve sağlık sigortasının (Yeşil Kart kapsamı) artması beklenir. Bu çok değişkenli regresyon analizini 1993, 1998, 2003 ve 2008 Nüfus ve Sağlık Araştırmasının dört kesitinde yaptık (bakınız tablo 7).

Tablo 7 annenin sürenin %16,1'inde doğum öncesi bakım aldığı gebeliklerden doğma olasılığının taban düzeyinde olduğu en dezavantajlı çocuk grubunun (regresyonda sabit terimle temsil edilmiştir) göstermektedir ve bu değer bu çocuk grubu için 2003 yılında %25.4 olasılık iken yükselerek sadece beş yıl sonra, 2008 yılında %74.9 olmuştur. Bu regresyonlarda

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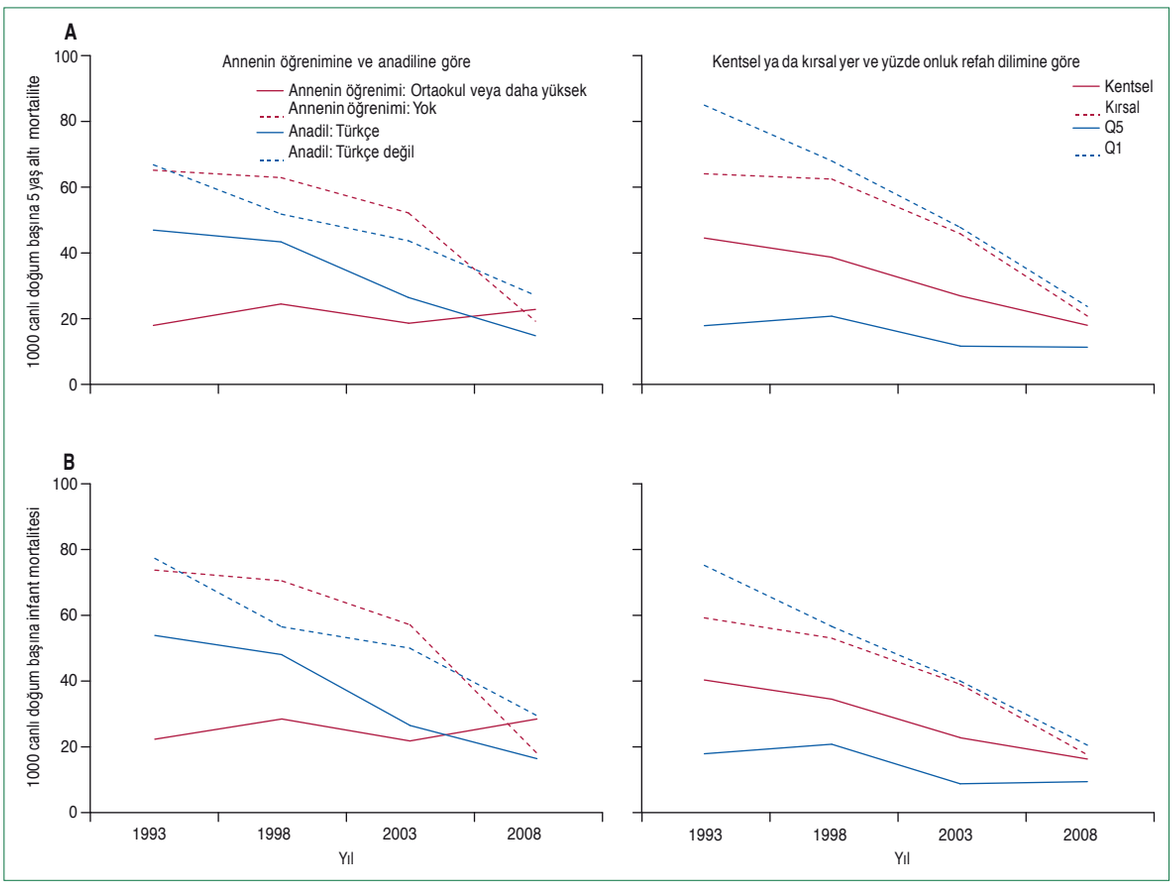


Şekil 14: **5 yaş altı ve infant mortalitesi, 1993–2008**
(A) 1000 canlı doğum başına 5 yaş altı mortalite oranları. (B) 1000 canlı doğum başına infant mortalitesi oranları. Veriler yazarın 1993, 1998, 2003, ve 2008 Türk Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13).

Türkiye'nin doğusunda yaşamak dâhil edilmemiş bir referans kategorisidir: 1993 yılında batı Türkiye'de doğan bir çocuğun, annenin doğum öncesi bakım aldığı bir gebelikten doğmuş olma olasılığı yüzde 25.9 puan daha fazladır.

2008 yılında, Batı Türkiye'deki bir çocuğun, annenin doğum öncesi bakım aldığı bir gebelikten doğmuş olma oranı Doğu Türkiye'deki bir çocuğunkinden sadece yüzde 4.4 puan daha fazladır. Bir annenin aldığı eğitim daha önceki yıllarda doğum öncesi bakım almasının en önemli belirleyicilerinden biri olmaktadır: Örneğin, ortaokul ya da daha yüksek eğitim almış bir kadının doğum öncesi bakım alması olasılığı hiçbir resmi öğrenim görmemiş bir kadının doğum öncesi bakım alması olasılığından 1993 yılında yüzde 20.7 puan fazladır ve 2003 yılında yüzde 20.3 puan fazladır. Bununla birlikte, 2008 yılında, bir kadının öğrenim durumu ile doğum öncesi bakım alması arasındaki ilişki çok daha zayıftır; ortaokul ya da daha yüksek eğitim almış bir kadının doğum öncesi bakım alması olasılığı hiçbir resmi öğrenim görmemiş bir kadının doğum öncesi bakım alması olasılığından 2008 yılında sadece yüzde 7.6 puan fazladır.

Aynı şekilde, fakirlik durumu (Nüfus ve Sağlık Araştırması verilerinde en fakir varlık diliminde olanlar bu kategoriye dahil edilmiştir) ile doğum öncesi bakım kullanımı arasındaki ilişki de 2008 yılında zayıflamıştır. En üst dilimdeki bir hanede doğmuş bir çocuğun, annenin doğum öncesi bakım aldığı bir gebelikten doğmuş olma olasılığı en fakir dilimde doğmuş olma olasılığından 1993 yılında yüzde 26.1 puan fazladır. Bu ilişki 2003 yılına kadar sürmüş ve pozitif kalmıştır. 2003 yılında, regresyonda en üst dilimde olma katsayısı 25.3'tür (yani en üst dilimde olan bir çocuğun annesinin doğum öncesi bakım aldığı bir gebelikten doğmuş olma olasılığı en alt dilimde olan bir çocuğun annesinin doğum öncesi bakım aldığı bir gebelikten doğmuş olma olasılığından 2003 yılında yüzde 25.3 puan fazladır). Ancak, en üst dilimde olma katsayısı 2008 yılında azalarak 9.0 olmuştur.

Doğum sırasında sağlık hizmeti kullanımı değişkenleri için benzer sonuçlar bulduk (tablo 7). 1993 yılında, en dezavantajlı çocuk grubu (yani sağlık sigortası olmayan ve Doğu Türkiye'nin kırsal alanlarındaki en fakir yüzde onluk varlık dilimindeki hanelerde yaşayan, annelerinin anadili Türkçe olmayan ve anneleri hiçbir resmi eğitim almamış olanlar) için, bir devlet kurumunda ya da özel kurumda doğmuş olma olasılığı istatiksel anlamlılık olarak sıfırdan farklı değildir. Ancak, 2008 yılında, bu en

	Sağlık personelinin bulunduğu antenatal vizitler				Bir sağlık kuruluşunda doğum				Aşılanma (hepsi)			
	1993	1998	2003	2008	1993	1998	2003	2008	1993	1998	2003	2008
Sabit (çıkarılan kategoriler için ortalama)	0.161*	0.150*	0.254*	0.749*	0.027	0.214*	0.243*	0.500*	0.216*	0.165*	0.057	0.399*
Yer:												
Kırsal	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Kentsel	0.044†	0.044†	0.096*	NS	0.149*	0.050*	0.099*	0.052*	0.108*	0.015	0.153*	NS
Bölge:												
Doğu	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Batı	0.259*	0.177*	0.088*	0.044*	0.180*	0.121*	0.085*	0.055*	0.128†	0.072	0.057	0.138*
Güney	0.241*	0.157*	0.118*	0.061*	0.114*	NS	0.040†	0.067*	0.226*	0.238*	0.128†	0.137†
Orta	0.086*	0.108*	0.058*	0.034*	0.122*	0.113*	0.078*	0.046*	NS	0.167*	0.080	0.124†
Kuzey	0.144*	0.090*	0.057*	0.041*	0.187*	0.136*	0.072*	0.059*	NS	0.183†	0.097	0.117‡
Annenin öğrenimi:												
Yok	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
İlkokul	0.143*	0.177*	0.149*	0.053*	0.137*	0.121*	0.191*	0.115*	NS	NS	0.216*	0.092‡
Ortaokul ya da daha yükseği	0.207*	0.247*	0.203*	0.076*	0.155*	0.186*	0.191*	0.112*	NS	NS	0.192*	NS
Anadil												
Türkçe değil	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Türkçe	NS	0.051†	0.074*	NS	0.154*	0.206*	0.172*	0.138*	0.188*	0.160*	0.056	0.024
Refah göstergesi:												
Varlık grubu 1	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Varlık grubu 2	0.097*	0.125*	0.169*	0.065*	0.066*	0.108*	0.087*	0.111*	NS	0.028	0.074	0.095‡
Varlık grubu 3	0.191*	0.244*	0.228*	0.105*	0.148*	0.169*	0.142*	0.117*	NS	0.172*	0.088	0.189*
Varlık grubu 4	0.258*	0.268*	0.254*	0.088*	0.216*	0.183*	0.153*	0.104*	0.117‡	0.201*	0.154*	0.171†
Varlık grubu 5	0.261*	0.309*	0.252*	0.088*	0.219*	0.200*	0.154*	0.059†	0.127‡	0.336*	0.192*	NS
R^2	0.246	0.274	0.298	0.085	0.277	0.276	0.319	0.192	0.166	0.136	0.213	0.092
Gözlemler	3516	3392	4331	3747	3516	3392	4331	3747	710	699	802	802

Veriler yazarın 1993, 1998, 2003, ve 2008 Türk Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13). Numune etüt yılından önceki 5 yıl içinde doğmuş çocuklardan oluşmaktadır. Bağımlı değişkenler ikili değişkenlerdir; olay gerçekleşmişse 1 değeri alırlar, olay gerçekleşmemişse 0 değeri. Referans kategoriler şunlardır: Sigortalı olmama, kırsal yer, doğu bölgesi, annenin hiç öğrenim görmemiş olması, anadilin Türkçe olmaması ve varlık grubu 1. Numune ilk üç analiz için 5 yaş altı çocukları ve aşılama için 12 aylık ve 24 aylık arasındaki çocukları içermektedir. Tam olarak aşılanmış bir çocuk şu aşıları olmuştur: BCG; difteri– tetanoz–boğmaca 1, 2, ve 3; polio 1, 2, ve 3; ve kızamık. Hanenin sağlık sigortası durumu için regresyon analizi kontrolleri. NS=anlamlı değil (katsayı o yıl için sıfırdan anlamlı bir şekilde farklı). *p<0.01. †p<0.05. ‡p<0.1.

Tablo 7: **Anne ve çocuk sağlığı hizmetlerinin kullanımı—çok değişkenli regresyon analizi sonuçları (lineer olasılık modeli)**

dezavantajlı çocuk grubu için bu olasılık %50'ye çıktı. Yine, Batı Türkiye'de olmak, kırsal alanda olmak ve en zengin varlık grubu içinde olmak için kısmi korelasyon katsayısının zamanla azaldığını bulduk. 2008 yılında, en zengin varlık grubundaki bir çocuğun bir sağlık kurumunda doğmuş olması olasılığı, en fakir varlık grubundaki bir çocuğun bir sağlık kurumunda doğmuş olması olasılığından sadece yüzde 5.9 puan daha fazladır, öte yandan sadece beş yıl önce bu değer, yüzde 15.4 puandır (tablo 7).

Uzman sağlık personelinin hazır bulunmasıyla doğmuş olma olasılığı da zamanla iyileşmiştir. Genel olarak, gebelik ve doğum sırasında sağlık hizmetlerinin kullanımına yönelik tüm değişkenler için, çocukların doğduğu şartlar arasındaki ilişkinin, varlık ve yere bağlı olmaksızın, hizmetlerin haneler ve çocuklar tarafından daha fazla erişilebilir kılınmasının bir sonucu olarak, zaman içinde hizmetlerin asıl kullanımı ile bağlantısının zayıfladığını bulduk (tablo 7). Ek s 19'da lineer olasılık modeli regresyon analizinin sonuçları ayrıntılı olarak verilmektedir.

Sağlam bir kontrol olması için, aynı regresyon analizini lojistik bir regresyon fonksiyon formu ile ve hizmetleri kullanan çeşitli popülasyon kategorileri (örneğin kırsal/kentsel, öğrenim düzeyi, refah göstergesi) için tahmini olasılık oranlarıyla yeniden denedik. Olasılık oranları, lineer olasılık modelindekilere benzer bulundu. Lojistik regresyonda en avantajlı grubu regresyondan çıkardık ve dezavantajlı grupların olasılık oranlarını bu avantajlı referans grupla karşılaştırdık. Lineer olasılık modelindeki bulgulara uygun olarak, kırsal hanelerin sağlık hizmetlerini kullanma olasılığının zamanla arttığını bulduk (özellikle 2003 ile 2008 arasında). Aynı şekilde, düşük öğrenim düzeyli (hiçbir resmi öğrenim görmemiş) kadınların bir sağlık kurumunda doğum yapma ya da doğumlarında eğitimli personelin bulunması olasılığının zamanla arttığını bulduk. Örneğin, 1993 yılında, ortaokul ya da daha yüksek bir

	Beş yaş altı ölüm hızları				Bebek ölüm hızları			
	1993	1998	2003	2008	1993	1998	2003	2008
Çıkarılan kategoriler için ortalama (Sabit)	0.089*	0.085*	0.058*	0.037*	0.081*	0.072*	0.050*	0.032*
Sağlık sigortası:								
Yok	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
SGK	NS	NS	NS	NS	NS	NS	–0.001	NS
Yeşil Kart	NS	NS	0.021†	NS	NS	NS	0.018‡	NS
Özel	NS	NS	NS	–0.025*	NS	NS	NS	–0.022*
Yer:								
Kırsal	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Kentsel	NS	NS	NS	NS	NS	NS	NS	NS
Bölge:								
Doğu	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Batı	NS	–0.025‡	NS	NS	NS	NS	NS	NS
Güney	NS	–0.023‡	NS	NS	NS	–0.025†	NS	NS
Orta	NS	NS	NS	NS	NS	NS	NS	NS
Kuzey	NS	–0.028‡	NS	NS	NS	–0.023‡	NS	NS
Annenin öğrenimi:								
Resmi öğrenim yok	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
İlkokul	NS	–0.024‡	–0.020†	NS	NS	–0.026†	–0.016‡	NS
Ortaokul ya da daha yükseği	–0.023‡	–0.028‡	–0.024†	NS	NS	–0.030†	–0.018‡	NS
Anadil								
Türkçe değil	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Türkçe	NS	0.021‡	NS	NS	NS	0.021‡	NS	NS
Refah göstergesi:								
Varlık grubu 1	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Varlık grubu 2	–0.039*	NS	NS	NS	–0.034*	NS	NS	NS
Varlık grubu 3	–0.031†	NS	NS	NS	–0.024‡	NS	NS	NS
Varlık grubu 4	–0.048*	NS	NS	NS	–0.043*	NS	NS	NS
Varlık grubu 5	–0.056*	–0.028‡	–0.020†	NS	–0.048*	NS	–0.017†	NS
Gözlemler	3638	3474	4483	3852	3638	3474	4483	3852
R^2	0.013	0.010	0.011	0.003	0.011	0.009	0.010	0.003

Veriler yazarın 1993, 1998, 2003, ve 2008 Türk Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13). Bağımlı değişkenler ikili değişkenlerdir; olay gerçekleşmişse 1 değeri alırlar, olay gerçekleşmemişse 0 değeri. Referans kategoriler şunlardır: Sigortalı olmama, kırsal yer, doğu bölgesi, annenin hiç öğrenim görmemiş olması, anadilin Türkçe olmaması ve varlık grubu 1. Numune etüt yılından önceki 5 yıl içinde doğmuş çocuklardan oluşmaktadır. NS=anlamlı değil (katsayı o yıl için sıfırdan anlamlı bir şekilde farklı). *p<0.01. †p<0.05. ‡p<0.1.

Tablo 8: **Beş yaş altı ölümleri ve bebek ölümleri—çok değişkenli regresyon analizi sonuçları (lineer olasılık modeli)**

öğrenim görmüş bir kadınla karşılaştırıldığında, hiçbir resmi öğrenim görmemiş bir kadının yaptığı doğumda eğitimli personel bulunması olasılığının 0.317 olmuştur. Bu olasılık daha fazla öğrenim görmüş gruba kıyasla, 2008 yılında 0.709'a çıkmıştır. Aynı şekilde, aşılamalar için, kırsal alanlarda ve Türkçe konuşmayan anneler arasında, aşılamaların tamamlanması olasılığı 1993 yılında 0.584 ve 0.432 olmuş, 2008 yılında ise artarak anlamlılık açısından 1 değerinden farklı olmayan bir düzeye gelmiştir. Dolayısıyla, 2008 yılında, bu dezavantajlı grupların tam bir aşılama almış olmalarının olasılığı örneklemdeki avantajlı gruplarla aynıdır (lojistik regresyon analizi sonuçları ve olasılık oranları için bakınız ek s 20).

Hane karakteristiklerini kontrol eden ve 1993, 1998, 2003 ve 2008 yıllarının verilerinin kesitleri için 5 yaş altı ve bebek hızları olasılıklarını tahmin eden çok değişkenli regresyon analizi sonuçları, çocuk durumu değişkenlerinden hiçbirinin (özel sağlık sigortasına erişim dışında) 2008 yılında düşük ölüm hızlarıyla anlamlılık açısından bağlantılı olmadığını göstermektedir. 1993 yılında ve hatta 2003 yılında 5 yaş altı ve bebek ölüm hızlarının önemli belirleyicilerinin annenin öğrenim durumu ve hanenin varlık grubu olmasına karşın (1993 yılında en üst yüzde onluk dilimdeki ve annesi ortaokul ya da üstü öğrenim görmüş bir çocuğun 5 yaşından önce ölmesi olasılığı yüzde 7.9 puan daha azdır), bu değişkenlerle çocuk ölüm hızları arasındaki ilişkinin 2008 yılında pratikte sıfıra düştüğünü bulduk. Lineer olasılık modeli ile kurulmuş çok değişkenli regresyon analizi sonuçları ek s 21–22'de tablo 8 ile verilmiştir. Sağlam bir kontrol olması amacıyla,

	Antenatal vizitler	Bir sağlık kuruluşunda doğum	Sağlık personelinin bulunduğu doğumlar	Aşılanma (hepsi)	Beş yaş altı ölüm hızları	Bebek ölüm hızları
Yıl etkiler (arz tarafı)						
1993 yılı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
1998 yılı	0.011	0.134*	0.103*	–0.160*	–0.005	–0.008
2003 yılı	0.108*	0.181*	0.117*	–0.104*	–0.022*	–0.021*
2008 yılı	0.355*	0.325*	0.235*	0.092‡	–0.030*	–0.028*
Sağlık sigortası (talep tarafı)						
Yok	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı	Çıkarıldı
Yeşil Kart (in 1993)	–0.106	–0.015	0.099	–0.375†	–0.041	–0.034
Yeşil Kart ile Yıl arasındaki etkileşim						
1998'de Yeşil Kart	0.193†	0.133	0.001	0.361†	0.045	0.042
2003'te Yeşil Kart	0.125‡	0.117	–0.039	0.364†	0.061†	0.051‡
2008'de Yeşil Kart	0.215*	0.092	–0.001	0.442†	0.028	0.022
Hane Özellikleri	Dahil	Dahil	Dahil	Dahil	Dahil	Dahil
Gözlemler	8302	8302	8302	1610	8583	8583
R^2	0.237	0.255	0.240	0.165	0.011	0.010

Veriler yazarın 1993, 1998, 2003, ve 2008 Türkiye Nüfus ve Sağlık Araştırması verilerinin analizidir (ek referans 12–15 ve ek s 2–13). Bağımlı değişkenler ikili değişkenlerdir; olay gerçekleşmişse 1 değeri alırlar, olay gerçekleşmemişse 0 değeri. Regresyona dahil edilen fakat burada gösterilmeyen diğer bağımsız değişkenler şunlardır: Yer, bölge (beş düzey), annenin öğrenimi (üç düzey), anadil, varlık grupları (beş düzey) ve sabit terim ilk üç bağımlı değişken için numuneler 5 yaş altı çocukları kapsar. Numune 5 yaş altı ölüm hızı için son 5 yıl içinde doğmuş olan çocukları ve aşılama için 12 aylık ve 24 aylık arasındaki çocukları içermektedir. Tam olarak aşılanmış bir çocuk şu aşıları olmuştur: BCG; difteri– tetanoz–boğmaca 1, 2, ve 3; polio 1, 2, ve 3; ve kızamık..* p<0.01. † p<0.05. ‡ p<0.1.

Tablo 9: **Genel sağlık kapsamının ve Sağlıkta Dönüşüm Programının hizmet kullanımı, beş yaş altı ve bebek ölüm hızları üzerindeki etkileri—Çok değişkenli regresyon analizi (lineer olasılık modeli) sonuçları**

lojistik regresyon analizi yaptık ve bulguları olasılık oranları olarak ek s 23–24'te verdik.

SDP ve GSK'nın anne ve çocuk sağlığı hizmetlerine erişim, 5 yaş altı ve bebek ölüm hızları üzerindeki etkileri

SDP, GSK'yı gerçekleştirmek için kapsamlı arz tarafı ve talep tarafı müdahaleleri getirmiştir. Talep tarafında, Yeşil Kart programı katkısız sağlık sigortası programlarını, en fakir yüzde onluk dilimler için sağlık sigortasına erişimin artırılmasını, yararların genişletilmesini ve masraf paylaşımının azaltılmasını başarıyla hedeflemiştir. Ülke çapında birinci basamak sağlık hizmetleri ve hastane hizmetlerinin yaygınlaştırılması sigortalı vatandaşların sağlık hizmetlerine erişimini iyileştirmiştir.

Türkiye Nüfus ve Sağlık Araştırması verilerinin havuzlanmış kesitleriyle farklılıktaki farklar tahminleri yaparak, anne ve çocuk sağlığı kullanımı, 5 yaş altı ve bebek ölün hızları üzerinde SDP dahilindeki talep tarafı ve arz tarafı müdahalelerin göreceli önemini değerlendirdik ve bunları sağlık sisteminin performansının izlenmesi için kullandık. SDP'nin arz tarafı etkileri regresyonlarda 2008 için yıl etkisi olarak sınıflandırıldı (web ek s 2–13).

Arz tarafı etkileri

Tüm anne sağlığı hizmeti kullanımı değişkenleri için, 2008 yılı için güçlü ve anlamlı yıl etkileri olduğunu gösterdik (tablo 9). Tüm hane özellikleri kontrol edildiğinde, bilgileri 2008 yılında toplanan bir çocuğun annesinin gebelik sırasında doğum öncesi bakım almış olması olasılığı 1993 yılındaki bir çocuğunkinden yüzde 36.1 puan daha fazladır. Bu çocuğun bilgileri 1993 yılında toplanmış bir çocuğa kıyasla, bir sağlık kurumunda doğmuş olması olasılığı yüzde 33 puan daha fazladır ve doğumunda uzman sağlık personeli bulunması olasılığı yüzde 24 puan daha fazladır. 1998 ve 2003 için de yıl etkileri anlamlı olmasına karşın, 1993 yılı tabanı ile karşılaştırıldığında, 2008 yılında doğmuş olma için korelasyon katsayısı en fazla artışı göstermiştir. Aşılama kapsamı, 5 yaş altı ve bebek ölüm hızları için de 2008'de anlamlı yıl etkileri olduğunu bulduk. Aslında, 1998 ve 2003 sırasında, aşılama çıktılarındaki sapmalar nedeniyle, bu yıllarda aşılama alımı için negatif korelasyon katsayıları vardır, halbuki 2008 için bu pozitiftir. Tüm diğer çocuk ve hane özellikleri kontrol edildiğinde, verileri 2008 yılında toplanan bir çocuğun 1 yaşında eksiksiz bir aşılama dizisi almış olmasının olasılığı, verileri 1993 yılında toplanmış olan bir çocuğunkine kıyasla, yüzde 10 puan daha fazladır. Aynı zamanda bu çocuğun 1 yaşından önce ölme olasılığı yüzde 2.9 puan daha azdır ve 5 yaşından önce ölme olasılığı yüzde 3.2 daha azdır (tablo 9).

Talep tarafı etkileri

Yeşil Kart ile 2008 yılı değişkenleri arasındaki ilişki, doğum öncesi bakım ve aşılamalar için anlamlıdır (tablo 9). Bu bulgu; Yeşil Kart varlığında ve 2008 yılında sağlık hizmetlerinin yaygınlaştırılmasından sonra, hane halklarının anne ve çocuk sağlığı hizmetlerinden yararlanma olasılığının daha fazla olduğunu göstermektedir.

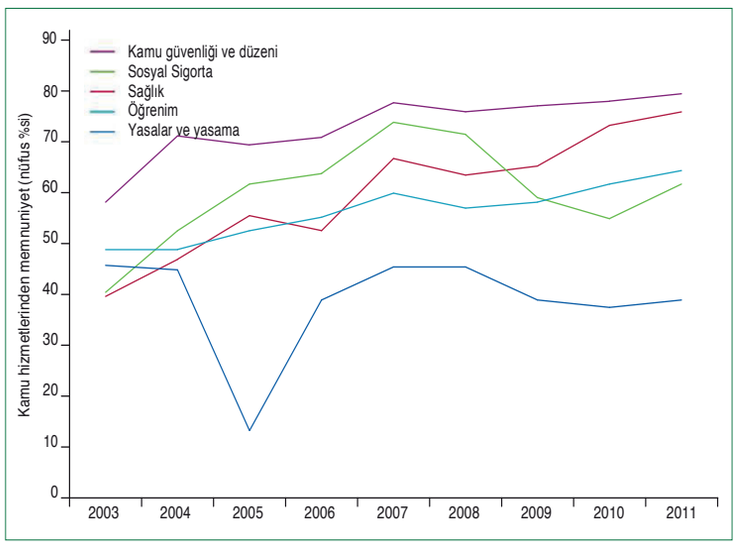
1993 taban yılında tek başına Yeşil Kart etkisini değerlendirmek için çok değişkenli analiz kullandığımızda, programın tek başına etkisinin bu çıktılar ve kullanım göstergelerinin çoğu üzerindeki etkisinin anlamlı olmadığını bulduk (tablo 8 ve 9). Aşılamalar için, negatif bir korelasyon katsayısı bile bulduk. Dolayısıyla, kullanım üzerindeki bir etkinin talep tarafındaki erişimin iyileşmesi sonucu olduğu düşünülse de -Yeşil Kart programı ile- bu etki, Yeşil Kart ile ilgili anlamlı katsayılar bulduğumuz ve SDP ile hizmet sunumunun arttığı 2008 yılı değişkenleri ile ilişkilendirildiğinde arz tarafı müdahalelerin varlığında daha güçlüydü. (tablo 9).

GSK ve SDP'nin kullanıcı memnuniyeti üzerindeki etkisi

Türk Standartları Enstitüsünün yaptığı yıllık yaşam memnuniyeti araştırmaları üzerinde yaptığımız analiz, 2003 yılından sonra (araştırmaların başladığı yıl), kullanıcının sağlık hizmetleri konusundaki memnuniyeti önemli artış göstermiştir. 2003 yılında, nüfusun sadece %39.5 kadarı

sağlık hizmetlerinden memnundu, oysa 2011 yılında bu oran artarak %75.9 olmuştur.

Sağlık hizmetleri konusundaki memnuniyetteki artış, sosyal sigorta, öğrenim, yasalar ve yasama ve kamu güvenliği ve düzeni konusundaki memnuniyeti geride bırakmıştır. Oysa 2003 yılında diğer kamu hizmetleriyle kıyaslandığında, nüfusun sağlık hizmetleri konusundaki memnuniyeti en düşük düzeydeydi, 2011 yılında, sosyal sigorta (yüzde 21.4 puan), öğrenim (yüzde 15.5 puan), yasalar ve yasama (yüzde –6.8 puan), ve kamu güvenliği ve düzeni (yüzde 21.5 puan) konularındaki memnuniyete kıyasla, nüfusun sağlık hizmetleri konusundaki memnuniyeti en fazla düzeyde arttı (yüzde 36.4 puan). 2011 yılında, sağlık hizmetleri memnuniyetin en yüksek olduğu kamu güvenliği ve düzeni hizmetleriyle benzer memnuniyet düzeylerine gelmişti (şekil 15).



Şekil 15: **Türkiye'de sağlık hizmetlerinden ve diğer kamu hizmetlerinden memnuniyet, 2003–2011**
Veriler referans 24'ten alınmıştır.

Tartışma

SDP, Türkiye'de GSK'yı gerçekleştirmek için gösterilen 60 yıllık çabayı hızlandırmıştır. Kendini adamış bir dönüşüm ekibinin sürekli liderliğinde, Türkiye, kilit sağlık sistemi fonksiyonlarında değişiklikleri başarıyla gerçekleştirdi: Organizasyon ve idare, finansman, kaynak yönetimi ve hizmet verme. Bu değişiklikler Türk sağlık sisteminin karşı karşıya olduğu üç ana problemin çözümüne yardımcı oldu: Yetersiz ve hakkaniyetsiz sağlık finansmanı; yetersiz ve hakkaniyetsiz dağıtılmış sağlık altyapısı ve sağlık insan kaynakları (ve bunun sonucu olarak sağlık hizmetine erişimde hakkaniyetsizlik); ve sağlık çıktılarındaki hakkaniyetsizlikler.

Yaptığımız analiz, SDP tarafından desteklenen GSK'nın sağlık sigortası kapsamını özellikle nüfusun en fakir yüzde onluk dilimi için genişlettiğini ve mali riske karşı koruma sağladığını göstermektedir. GSK, kilit anne ve çocuk sağlığı hizmetlerinin kullanımında özellikle en dezavantajlı nüfus grupları için önemli iyileşmeler getirmiştir ve özellikle sosyo-ekonomik açıdan dezavantajlı nüfus gruplarında 5 yaş altı, bebek ve neonatal ölüm hızlarının azalmasına yardımcı olmuştur. Sağlık Bakanlığının yeni verileri hizmete erişimde 5 yaş altı, bebek ve neonatal ölüm hızlarında iyileşmeye yönelik olarak yaptığı Nüfus ve Sağlık Araştırması analizinde gösterilen iyileşmelerin 2008 sonrasında da devam ettiğini göstermektedir.[17] Sağlık Bakanlığı 2003 ile 2013 yılları arasındaki (yani SDP'nin uygulandığı yıllar) iyileşmelerin niceliğini belirlemek için 2013 yılında yeni bir Nüfus ve Sağlık Araştırması yapmayı planlamaktadır. Türkiye örneği GSK'nın sağlık sistemi amaçlarına erişme ve hakkaniyeti iyileştirme konularında bir platform olarak etkiliğini açıkça göstermektedir. Sonuçlarımız GSK'nın sağlık sisteminin tüm amaçları üzerindeki niceliksel ve yararlı etkileri olduğuna işaret etmektedir: Sağlık düzeyinin ve dağılımının iyileştirilmesi, daha iyi mali koruma içeren ve adil finansman ve kullanıcı memnuniyetinin artması. 2003 yılından bu yana, sağlık hizmetleri konusundaki toplum memnuniyeti kararlı biçimde artmış ve tüm diğer kamu hizmetlerinden duyulan memnuniyeti geride bırakmıştır. Bu başarıları mümkün kılan, hem talep tarafında (sağlık sigortası kapsamının artması, yararlarının genişletilmesi ve masraf paylaşımının azaltılması) hem de arz tarafında (altyapının, sağlık insan kaynaklarının ve sağlık hizmetlerinin genişletilmesi – özellikle yoksullaştırıcı harcamaları tetikleyenler olmak üzere ücretsiz sağlık hizmetlerinin artırılması,) eş zamanlı iyileştirmeler yapılmasıdır.

SDP'nin kilit başarıları

Örgütlenme ve Yönetim

2003–2010 yıllarında getirilen yapısal değişiklikler Türk sağlık sisteminde yönetim, finansman ve hizmet sağlama rollerinin ayrılmasını mümkün kılmıştır; Sağlık Bakanlığı yönetim görevlerini üstlenmiş, politika ve strateji geliştirme üzerine odaklanmıştır; bunun için yeni birimler kurulmuştur. Sağlık hizmetiyle ilgili yürütme ve denetim fonksiyonları, toplumsal ve bireysel sağlık hizmet sunumu, ilaç ve tıbbi cihaz sektörlerinin yönetimi ile yükümlü yeni yarı- kamusal kurumlara devredilmiştir. Yeni kurulan Sosyal Güvenlik Kurumu fon havuzlama (sağlık sigortası katkılarının ve devlet bütçesinin) ve stratejik satın alma işlevlerini üstlenerek, hem kamu hem de özel sektör sağlık hizmeti sağlayıcılarla sözleşme bazında yapılan hizmetlerin kalitesini ve etkinliğini iyileştirme üzerine odaklanmıştır. Yeni yasalar ve mekanizmalar, vatandaşların sağlık güvencesi ve hizmeti ile ilgili haklarını ve sağlık sisteminden ne beklemeleri gerektiğini açık bir şekilde ifade ederek sağlık hizmet sağlayıcıları ile ilgili beklentileri konusunda güçlenmelerini mümkün kılmıştır.

Sağlık sisteminin finansmanı

Türkiye'de sürdürülebilir ekonomik büyümenin oluşturduğu mali alan hükümetin sağlık harcamalarını önemli

düzeyde artırmasını mümkün kılmıştır. 2003 yılından sonra, GSMH'nın bir parçası olarak toplam sağlık harcamaları %5.3 düzeyinden artarak, 2008 yılında %6.1 olmuştur; bu miktarın hemen hemen dörtte üçü kamu sektöründen gelmiştir. Özel sektörün sağlık sektörüne yaptığı yatırımlar da artmıştır. Ayrıca, her biri farklı yararlara sahip beş sigorta programının oluşturduğu parçalı ve hakkaniyetsiz sağlık sigorta sistemi birleştirilerek uyumlaştırılmış yararlar içeren, tek bir genel sağlık sigortası programı oluşturulmuştur.

Bu iyileşmelere ek olarak, mali reformların belki de en dikkat çekici başarısı, Yeşil Kart programının hızla genişlemesi ve bir sigorta mekanizması olarak oturtulmasıdır. Bu programa kayıtlı kişi sayısı 2003 yılında 2.4 milyon iken 2011 yılında 10.2 milyona çıkmıştır. Yeşil Kart programının en fakir nüfus gruplarını kapsama hedefi de gelişmiştir. 2011 yılında, en fakir yüzde onluk dilimin yaklaşık %85'i Yeşil Kart ya da bir başka sigorta kurumu tarafından kapsanmaktadır ve en zengin yüzde onluk dilimin %96'sı katkılı sigorta tarafından kapsanmaktadır. Sağlık hizmetlerinde hastanın masraf paylaşımı da sigorta yararlanıcıları için düşürülmüştür; ücretsiz sağlık hizmetleri özellikle çok büyük harcamalara neden olabilecek, yoğun bakım, kalp damar cerrahisi, böbrek diyalizi ve kanser bakımı gibi karmaşık müdahaleler için genişletilmiştir. Bunun bir sonucu olarak, cepten yapılan harcamalar genel olarak artmamış ve çok yüksek harcamalar azalmıştır.

İnsan kaynakları ve hizmet sunumu

Sağlık sisteminin kapasitesinin genişlemesini sağlayan SDP çerçevesinde sağlık personelinin sayısı neredeyse iki katına çıkmıştır. Üniversitelerin daha fazla tıp, hemşirelik ve diğer mesleklerin öğrencilerini almaları, maaşların artması, performans teşvikleri, sağlık insan kaynakları ve sağlık hizmetlerinin dışarıdan alımı bu genişlemenin desteği olmuştur. Yeni kalifiye doktor ve uzmanların zorunlu hizmeti ve hastane hekimleri arasında yarı zamanlı çalışmanın kaldırılması kamu sektöründeki personel eksikliği sıkıntısının giderilmesine yardımcı olmuş ve hastanelerdeki klinik servislerin kapasitesini artırmıştır. Özel sektör kapasitesini ve büyümesini yönlendiren yönetmelikler, kamu sektörünün personel ihtiyacının karşılanmasını sağlamıştır.

2002–2012 arasında sağlıkta insan kaynakları sayısının ikiye katlanmasına ülke çapında, özellikle Türkiye'nin doğusunda hizmetlerin iyileşmesi eşlik etmiştir. 2010 yılında, 81 ilde aile hekimliği merkezli birinci basamak sağlık hizmetini geliştirmek ve öncekilerden daha geniş bir hizmet yelpazesi verilebilmesi için, yaklaşık 20 000 aile hekimliği ekibi kuruldu. Şimdi, hem kamusal hem de özel kuruluşlar, Sosyal Güvenlik Kurumu yararlanıcılarına sağlık hizmeti vermektedir; ülkede mevcut kapasite ve kaynaklar daha iyi kullanılmaktadır. Neonatal yoğun bakım, acil durum hizmetleri, hava ambulansı ve transfüzyon hizmetleri dahil, anne ve çocuk sağlığı hizmetleri geliştirilerek anne ve yenidoğan ölümleri daha da azaltılmıştır.

Bulgularımız 2003–2008 döneminde hizmete erişim ve 5 yaş altı ve bebek ölüm hızlarının iyileştirilmesinde, kapsamlı talep tarafı (sağlık sigortası) ve arz tarafı (insan kaynakları ve hizmet sunumu) değişiklilerinin eş zamanlı olarak getirilmesinin sosyo-ekonomik ve kültürel belirleyicilerden daha fazla etkili olduğunu göstermiştir.

SDP ile birlikte, sağlık sigortasının nüfus kapsamı artmış, sigortalılar için sağlık yararlanımları genişlemiş ve cepten yapılan harcamalar azalmıştır. Daha fakir kesimlerin ve Türkiye'nin doğudaki ve kırsal alanlardaki daha önceleri az hizmet gitmiş alanlarındaki nüfusun sağlık hizmetleri alma düzeyi önemli ölçüde artış göstermiştir.

GSK'nın daha da genişletilmesinin ve korunmasının önündeki güçlükler ve fırsatlar

SDP sırasında GSK'nın gerçekleştirilmesine yönelik birçok amaca ulaşılmıştır, fakat yine de kazanımları güçlendirmek ve hakkaniyetli, etkin ve yanıt verebilen bir sağlık sistemi tarafından desteklenen GSK'yı sürdürmek için yapılması gereken çok şey vardır. Türkiye ve dünya, sürdürülebilir kalkınmayı vurgulayan bir Binyıl Sonrası Kalkınma Hedefi gündemi izlerken sürdürülebilirlik üzerine odaklanmak çok önemlidir.[75]

SDP ve GSK'nın başarısını ölçecek göstergeler olarak anne ve çocuk sağlığı hizmetleri üzerine odaklandık. SDP için öncelikli olan bu alanlar hakkaniyetin ve başarıların en az olduğu alanlardı; fakat geçmişe dönük en güvenilir veriler de bu alanlardaydı. Bu nokta da analizimizin en önemli sınırlamasıydı. Kronik hastalıklar ve bunların tedavisiyle ilgili verilerin zayıflığı diabetes mellitus, yüksek tansiyon, kalp hastalıkları, ruhsal hastalıklar ve kanserler gibi hastalıklara ilişkin değişikliklerin sistematik analizini engellemiştir. Başka orta gelir düzeyli ülkelerde olduğu gibi, Türkiye için de kronik hastalıklar GSK'nın bir sonraki aşamasında üzerinde kapsamlı şekilde durulması gereken ana güçlüktür.

Sağlık sigortası kapsamının ve yararlarının idamesi

SDP ile Türkiye'deki sağlık sigortası kapsamı hızla genişlemiştir. 2003 yılında en fakir yüzde onluk dilimin sadece %24'ü sağlık sigortası kapsamında iken 2011 yılında bu oran artarak %85 olmuştur. En zengin yüzde onluk dilim için, sağlık sigortası kapsamı 2003 yılında %90 iken 2011 yılında artarak %96 olmuştur. O zamandan bu yana daha da genişleme olmuştur; fakat bu kapsamı %100'e çıkartmak için (hem Yeşil Kart programı hem de zorunlu sigorta için) çabaların yoğunlaştırılması gerekmektedir. Bununla birlikte, GSK'nın %100 nüfus kapsamına erişmesiyle, isteğe bağlı ve ek sağlık sigortasının rolünün netleştirilmesi için uygun düzenleyici sistemler gerekecektir.

Türkiye, özellikle anne ve çocuk sağlığına ilişkin olarak karşılanmamış ihtiyaçları karşılamak ve hakkaniyetsizlikleri azaltmak için GSK'yı etkili bir şekilde uygulamıştır. GSK'nın gelecekteki kapsamı ve

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ölçeğinin değişmekte olan sağlık gereksinimlerine göre ayarlanması gerekmektedir; çünkü kronik hastalıklar, özellikle de diabetes mellitus, kanser ve ruhsal hastalıklar artmaktadır. Sağlık Bakanlığının, sağlık sisteminin mali idarecisi olarak ortaya çıkan güçlükleri karşılamak amacıyla kaynakları maliyet etkin müdahalelere tahsis etmek için net stratejik öncelikler belirlemesi gerekmektedir. Bilgi kapasitesi oluşturma ve stratejik politikanın yönünü belirleme sorumlulukları ile yeni oluşturulan Sağlık Bakanlığı müdürlükleri, ortaya çıkan ihtiyaçları belirleme ve uluslararası en iyi uygulamalar doğrultusunda öncelikleri saptayabilme açısından iyi konumlandırılmışlardır. Uluslararası deneyimlerden yararlı dersler alınabilir. Örneğin rolünü sağlık teknolojisinin değerlendirilmesi görevinin ötesine, sağlık ve sosyal bakım hizmeti için etkili rehber ilkelerin geliştirilmesi işine taşıyan İngiltere Ulusal Sağlık ve Klinik Mükemmeliyet Enstitüsünden yararlı dersler alınabilir.

Tamamlanmamış hakkaniyet gündemi

SDP, vatandaşların sağlık, sosyal adalet ve hakkaniyet haklarını vurgulamış ve doğuyla batı, fakirle zengin, eğitimliyle eğitimsiz ve kentle kırsal arasındaki keskin eşitsizlikleri azaltmıştır. Bununla birlikte, kadınların sağlık hizmetlerine erişimindeki ve anne ölüm oranlarındaki iyileşmelere karşın, kadınlar yaşamın diğer sosyo-kültürel yönlerinde hâlâ eşitsizliklerle karşılaşmaktadır.[77]

Türkiye, kadın sağlığı ve cinsiyete ilişkin olarak, sosyo-ekonomik gelişmişlik indeksinde ulaşmış olması gerekenin altında kalmıştır. Kadınlara özellikle de kadınların eğitimine, sağlık okuryazarlığına, üreme sağlığı haklarına, sosyal güçlenmeye ve iş gücü katılımına öncelik vermek için çaba sarf edilmelidir. Kadınlara karşı kabul edilemez şiddet durdurulmalıdır. Obezite, kalp hastalıkları ve kadın kanserleri hükümetin öncelikleri olmalıdır. Kadın sağlığının daha da iyileştirilmesi ve cinsiyet eşitsizliklerinin azaltılması çabalarında, Cinsiyet Eşitliği Ulusal Eylem Planı 2008-2013'ün geliştirilmesi önemli bir adımdır.

Kalite ve güvenlik

Bir sonraki aşamada, GSK'nın Sağlık Bakanlığının düzenleyici güçlerini ve Sosyal Güvenlik Kurumunun stratejik satın alma gücünü kullanarak, sağlıkta kalite ve güvenlik üzerine odaklanması gerekmektedir. Her iki kurum da net kalite parametreleri oluşturmalı ve ülke çapında sağlık hizmeti sağlayıcılarının şeffaf bir şekilde karşılaştırmasını üstlenmelidir. Sağlık kuruluşlarının verdikleri hizmetlerin kalitesi hakkındaki bilgiler bu sağlayıcılarla sözleşme yapmış ve satın alınan hizmetlerle ilgili verilere sahip olan Sosyal Güvenlik Kurumu tarafından toplumun erişimine açılmalıdır. Karşılaştırmalar ve sağlık hizmetlerinin kalitesi hakkındaki bilgilerin topluma açılması vatandaşları güçlendirecek ve sağlık hizmeti sağlayıcılarının hesap verebilirliğinin artmasına yardımcı olacaktır. Sağlık Bakanlığının kronik hastalıklar dahil, sağlık hizmetlerinin klinik kalitesinin artırılması için 2012 yılında başlattığı girişimler bu yönde önemli bir adım teşkil etmektedir.

Halk sağlığının ve sağlık sisteminin kronik hastalıkların yönetimi konusunda yeniden canlandırılması

Türkiye, anne ve çocuk sağlığı ve bulaşıcı hastalıklar konusunda önemli iyileşmeler başarmıştır; fakat Küresel Hastalık Yükü 2010 analizi, ülkenin bir kronik hastalık yükü ile karşı karşıya olduğunu göstermektedir; bu yük sakatlığa ayarlanmış yaşam yılı ile ifade edildiğinde 1990 ile 2010 arasında %50'nin üzerinde artmıştır. Sakatlığa ayarlanmış yaşam yılına göre, iskemik kalp hastalıkları, serebrovasküler hastalıklar, majör depresif rahatsızlık ve kanserler en baştaki hastalık tipleridir. Kanserlerin, ruhsal rahatsızlıkların, diabetes mellitus ve kas-iskelet bozuklukların yükü hızla artmaktadır. 2010 yılında kalp hastalıklarına, dolaşım ve solunum hastalıklarına ve kansere çeşitli şekillerde katkıda bulunan diyetle ilgili risk faktörleri, sigara içme, vücut-kütle indeksinin yüksek olması, yüksek kan basıncı, fiziksel inaktivite, yüksek açlık plazma glukozu, çevre kirliliği ve yüksek toplam kolesterol, hastalık yükünün büyük bir bölümünü oluşturan başlıca risk faktörleri olmuştur.[79] Birbirleriyle etkileşim içinde olan bu riskler ve kronik hastalıklar iyilik hali, risk belirleme ve azaltma ve birinci basamak sağlık hizmetine dayalı uzun süreli korumaya odaklanmış yeni yöntemlerle yönetilmesi gereken çoklu morbiditeye neden olmaktadır.[80]

Türkiye bu epidemiyolojik değişimden artmakta olan kronik hastalıklar, engellilik ve hastalık riski yükü ile geçerken, GSK'yı sürdürmek için etkin bir sağlık sisteminin olması son derece önemlidir. Gelecekteki sağlık risklerini ve kronikliği etkin bir şekilde yönetmek için, Türkiye'nin birinci basamak sağlık hizmeti sistemini daha da güçlendirmesi gerekmektedir. Aile hekimlerinin ve hemşirelerin sayısının artırılması, personelin becerilerinin geliştirilmesi ve birinci basamak sağlık hizmeti içindeki fiziksel ve teknik kaynakların iyileştirilmesi için, iyi işlev gören sevk ve karşıt sevk sistemleri olan, kapsamlı bir sistem oluşturmak amacıyla, ek yatırımların yapılmasına ihtiyaç vardır. Türkiye'nin özellikle meme ve servikal kanser, kronik hastalıklar (örneğin hipertansiyon, kalp hastalıkları, diabetes mellitus ve ruhsal hastalıklar) ve fiziksel, beslenme ve metabolik risk faktörleri için toplum bazlı önleme ve tarama programlarını genişletmesi gerekmektedir.

Türkiye, bulaşıcı olmayan hastalıklar için ortaya çıkmakta olan riskleri izlemek için nüfus veri sistemlerine yatırım yapmayı düşünmelidir. Türkiye, biyolojik risklerin profilini çıkarmaya ek olarak, kronik hastalıkların ilerlemesini etkileyen fiziksel ve çevresel riskleri daha iyi ölçmek ve yönetmek için sistemler geliştirmelidir. Ülkede mobil telefon ve internet teknolojilerinin yüksek düzeyde mevcut olması, kronik hastalıkların kendi kendine yönetimi, önlenmesi ve risk modifikasyonuna yönelik bireysel verileri elde etmek için fırsatlar sunmaktadır.[81–83]

Sağlık yatırımlarına devam etmek için mali alanın genişletilmesi

Türkiye'nin 2002 yılından bu yana gerçekleştirdiği siyasi ve ekonomik istikrarın yakın gelecekte devam edeceği görülmektedir. Şimdiye dek, Türkiye küresel ekonomik krize karşı başarıyla durmuş ve sağlıklı bir ekonomik büyüme gerçekleştirmeye devam etmiştir; bu da sağlık harcamalarını artırmak için gereken mali alanı sağlamıştır. Bu alan 2000 yılında GSMH'nın %5.4'ü iken, hızla yükselerek 2009 yılında %6.7 olmuş, bundan sonra da 2010 ve 2011 yıllarında %6.7 değerinde sabit kalmıştır.[84] Bununla birlikte, komşu Orta Doğu ülkelerindeki istikrarsızlıklar kaygılandırıcıdır. Ekonomik volatilite riski, küresel ekonomik krizle, özellikle de Avrupa'daki ekonomik krizle birleştiğinde gerçektir. Sağlık sektörüne sürdürülebilir yatırım, hükümet vergilerinin ve gelir tabanının korunmasını gerektirecektir. Sağlık üzerinde olumsuz etkileri olan ve tüketimi fiyat artışlarına karşı son derece hassas olan tütün ve alkol ürünleri için tekrar vergi artışları sağlık sektörüne yatırımın artırılması için ek gelirleri sağlayabilir.[85]

Halkın beklentilerinin yönetilmesi

Sağlık sistemindeki dönüşüm ve vatandaşların haklarındaki gelişmeler halkın beklentilerini artırmıştır; sağlık okuryazarlığı ve bilgilerin artmasıyla bunlar muhtemelen daha da artacaktır. Hizmetlerin güvenliğini ve kalitesini artırmak için etkin düzenlemeye ek olarak, toplum muhtemelen hükümetten, Sağlık Bakanlığından, Sosyal Güvenlik Kurumundan, sağlık hizmeti sağlayıcılarından ve sağlık sektöründeki yeni aktörlerden daha fazla şeffaflık ve yanıt verebilirlik bekleyecektir.

Sağlık Bakanlığı için hesap verebilirlikte iyileşme ve çekirdek bir mali idare sorumluluğu öncelikli olmalıdır; Bakanlığın, belki de hesap verebilirlik ve yanıt verebilirlik için bağımsız bir kurum oluşturma yoluyla, bağımsızlığı, nesnelliği ve şeffaflığı sağlaması gerekir. Bu kurum İngiltere'deki Kadın ve Çocuk Sağlığı için Bilgi ve Hesap Verebilirlik konusunda Bağımsız Uzman İnceleme Grubu[86] ve Bütçe Sorumluluğu Bürosu[87] gibi yeni, etkili modelleri temel alabilir.

Sağlık işgücünün yetiştirilmesi

SDP, sözleşme yapma, yeni istihdam şartları ve dışardan satın alma getirerek sağlık işgücünün hızla genişlemesini sağlamıştır. Tam zamanlı çalışma düzenlemesi, iki işi birlikte yürütmeyi ortadan kaldırmış ve kamu sektörünün hastalara yarar sağlama kapasitesini geliştirmiş, ancak, hastanelerdeki klinisyenlerin iş yükünü artırmıştır. Artık profesyonel gelişim ve araştırma fırsatlarını geliştirmek, Türkiye'deki tüm sağlık hizmetlerinin yaklaşık %83'ünü sağlayan kamu sektöründe adanmış ve iyi eğitilmiş bir sağlık işgücü oluşturmak amacıyla yatırımlara ihtiyaç vardır.

SDP, sağlık işgücünün çoğunluğu tarafından desteklense de Türk Tabipler Birliği, getirilen değişikliklerin çoğuna karşı çıkmıştır. Bu Birlik uzun süreden beri Türk sağlık sisteminde özel hekimliğin karşıtı olmuştur ve yarım zamanlı çalışmadaki özel hekimliği kaldırarak tam zamanlı çalışma getiren değişikliklere karşı olduğunu ifade etmiştir. Birlik, aynı zamanda SDP tarafından getirilen birçok değişikliğin ortadan kaldırılmasını istemiştir, özellikle de Sağlık Bakanlığının kamu sektöründe istihdam edilen doktorlara performans ilişkili ücret olmadan, daha yüksek sabit maaş, garantili istihdam, sağlık sigortasıyla değil, genel vergilendirmeyle ödenen ulusal bir sağlık sistemi ve hizmet sunma noktasında bedelsiz sağlık hizmeti sağlamasını istemektedir. Sağlık Bakanlığının Türk Tabipler Birliğini politika diyaloglarına ve paydaş toplantılarına dahil etme çabaları her zaman başarılı olamamıştır, fakat bu örgütün karşı çıkışı dönüşüm sürecini durdurmamıştır.

Küresel sağlıkta Türkiye'nin rolü

2003 sonrasındaki sürdürülebilir ekonomik büyümeyle, 2012 yılında Türkiye dünyadaki 17. büyük ekonomi olmuştur (nominal GSMH terimleriyle).[88] Türkiye şimdi Grup 20'nin (G20) ve E7 ülkelerinin bir üyesidir. Dünyadaki onuncu büyük ekonomi olma hedefini gerçekleştirmek için ve üst düzey bir ekonomi olarak rekabetçi kalabilmek için, Türkiye'nin yenilenimleri, bilgi üretimini ve bilgi çevrimini besleyen bilgi bazlı bir ekonomi geliştirmesi gerekmektedir.

Yenilenim (inovasyon) için bir sağlık sistemi

Ekonomik dönüşüm geçiren diğer sanayileşmiş ülkeler gibi, Türkiye de tarım yoğunluklu ve emek- yoğun bir üretim ekonomisinden endüstriler oluşturmak için yenilenime ve bilgi kümelerine dayanan bir bilgi ekonomisine geçmektedir.[89] Bu geçiş sürecinde, GSMH'nin gittikçe artan bir bölümünü ve devlet bütçesinin büyük bir payını temsil eden sağlık sektörünün sadece sağlığın iyileştirilmesi fayda sağlayan, mali risk koruması ve kullanıcı memnuniyeti getiren bir harcama olarak değil, Türkiye için ekonomik kalkınma ve refah oluşturan dinamik bir sektör olarak yeniden canlandırılması gerekmektedir.[90–92] Hizmet sunumuna yönelik bir sağlık sisteminden ekonomik büyümenin dinamik itici gücü olan bir sağlık sektörüne geçiş araştırma, geliştirme ve yenilenim alanlarında yatırım gerektirir.[93] Türkiye'nin yenilenimini ve bilgi üretimini besleyen bir ortam oluşturması için yaşam bilimleri sektöründe yatırımlarını artırması, özellikle de yaşam bilimleri endüstrisini, üniversiteleri ve Türk sağlık sistemini bir araya getiren, bir araştırma altyapısı oluşturması gerekir.[94,95]

Yaşam bilimlerine yatırımın sağlık personeli arasında araştırma ve geliştirme profilini yükseltme çabalarıyla birleştirilmesi ve sağlık personelinin böylesi araştırmalarla uğraşması için teşvikler oluşturması gerekir. Yenilenimci ve küresel açıdan rekabetçi bir ilaç endüstrisinin kurulması

için bilimsel bilgi birikimi geliştirme amacıyla önemli yatırımlar yapılması gerekir. Türkiye'nin güçlü üretim ve hizmet endüstrilerine sahip olduğu göz önünde bulundurulduğunda, ülkedeki başlangıçtaki araştırma ve geliştirme çabaları sağlık hizmetinde daha düşük maliyetli ve etkili yenilenimler geliştirmek amacı ile sağlık hizmet sunumu ve tıbbi teknoloji alanlarını hedefleyebilir.

Türkiye coğrafi yeri, güçlü otel ve hizmet endüstrisi, sağlık sektöründeki yeni yatırımları ve büyümekte olan özel sektörü nedeniyle, sınır ötesi sağlığı (sağlık turizmi) geliştirmek için elverişli bir konumdadır. Türkiye, zaten 2015 yılı itibarıyla 500 000 hasta ve gelir olarak 7 milyar ABD$ hedefleyen Sağlık Bakanlığı ile sınır ötesi sağlıkta varlığını ispat etmiştir. Sağlık turizmini teşvik için, hükümet vergi ve araştırma ve geliştirme teşvikleri sağlayan serbest ticaret alanları oluşturmaya karar vermiştir.[96]

Küresel sağlıkta lider rol

GSK'yı getirmedeki başarısı ve uluslararası sağlıkta önceki deneyimleri ışığında, Türkiye, bir G20 üyesi ve bir E7 ülkesi olarak, küresel sağlıkta özellikle de kalkınma, diplomasi ve güvenliğe ilişkin olarak yeni bir rol edinme fırsatına sahiptir. 1992 yılından bu yana, Sağlık Bakanlığı, Başbakanlığa bağlı Türk İşbirliği ve Koordinasyon Ajansı Başkanlığı[97] yoluyla, Balkanlar (Bosna-Hersek ve Kosova), Orta Asya (Azerbaycan, Kırgızistan, Kazakistan, Türkmenistan, Özbekistan, Afganistan ve Tacikistan), Orta Doğu (Batı Şeria ve Gazze Şeridi, Mısır ve Yemen) ve Afrika'daki (Sudan, Somali ve Afrika Sağlık Programı yoluyla diğer Afrika ülkeleri) ülkelerle teknik ve mali işbirliği konularında aktif olarak çalışmaktadır. Türkiye, esas olarak diğer Türk ve İslam bölgeleri ya da ülkeleriyle işbirliği yapmaktadır. Bunlara ek olarak, Türkiye küresel su ve sanitasyon projelerini, üreme sağlığı ve altyapı programlarını aktif olarak desteklemiş ve depremlere, özellikle Haiti, Endonezya, İran ve Pakistan'a kurtarma ekipleri göndermiştir. Bu deneyimler Türkiye'nin sağlık sektöründe, özellikle de GSK'ya ilişkin olarak edindiği bilgi birikimi kullanılarak kalkınmada artan bir rol alması için fırsatlar sağlamaktadır. Ayrıca Türkiye, Suriyeli sığınmacılar krizinin etkili yönetiminden edindiği deneyimi, çatışmadan etkilenen bölgedeki diğer ülkelere de yayarak ülkenin diplomasi ve güvenlikteki rolünü güçlendirebilir. Türkiye'nin 2006 yılındaki kuş gribi krizini etkin bir şekilde yönetmesi ve pandemi hazırlığı planlarını[98] başarıyla uygulamış olması da küresel sağlıkta uluslararası işbirliği ve Türkiye'nin sağlık ve insan güvenliğinde daha aktif bir rol üstlenmesi için bir başka platform sağlamaktadır.

Alınan dersler

Araştırmacılar, geçmiş çalışmalarda, sağlık ve toplumsal sonuçlara ulaşabilmek için sağlık sisteminde, iyi idare ve politik kararlılık, kurumlar (kurumsal bellek için bürokrasiler dahil), yenilenim yeteneği (özellikle hizmet sunumunda), halkın gereksinimlerine ve direncine yanıt verebilme kapasitesi dahil, çok önemli çeşitli faktörler belirlemişlerdir.[99] GSK'ya ilişkin olarak, siyasal ekonominin önemi ülkelerarası yapılan çalışmalarda vurgulanmıştır. Özellikle, politik kararlılık (yasal yetki olarak ifade edilen), vergi gelirlerinin yükseltilebilmesi ve daha fazla demokrasi, GSK'yı gerçekleştirmede son derece önemli olan GSMH'nin daha fazla bir payının toplum sağlığı harcamalarına tahsisatını mümkün kılan önemli faktörler olarak belirlenmiştir. Ayrıca, kanıtlar, etnik, dinsel, dilsel ya da gelir eşitsizlikleri olan bölünmüş toplumlarda GSK'nın oturtulmasının daha zor olacağını göstermektedir.[100]

Türkiye'nin GSK konusundaki deneyiminden birkaç ders çıkmaktadır. Bu dersler GSK'yı sürdürmek için bir sonraki dönüşüm aşamasına doğru giden Türkiye için yararlı olacaktır, fakat aynı zamanda GSK'ya doğru yola çıkmış ülkeler için de önemlidirler.

Yenilikçi bir ortamın oluşturulması

Türkiye'de; demografik, ekonomik, politik, sosyo-kültürel ve teknolojik faktörler dahil, birkaç bağlamsal faktörün etkileşimi GSK ile getirilen politika ve hizmet sunumu yenilenimlerinin halk tarafından Türk sağlık sistemindeki problemlere meşru ve zamanında eğilme olarak ele alındığı yenilikçi bir ortam oluşturmuştur.[101–104]

Temel bir hak olarak sağlık

GSK'nın insan haklarını, özellikle de vatandaşların sağlık hakkını vurgulayan çekirdek ilkesi, demokrasi, eğitim ve sağlık haklarında iyileşme isteyen halkta olumlu yankı uyandırmıştır. İnsan haklarına olan bu odaklanma muhtemelen GSK'nın meşruluğunun artmasına yardımcı olmuştur ve yaygın halk desteği oluşturmuştur.

Politik istikrar

Türkiye Büyük Millet Meclisinde çoğunluğa sahip olmasından dolayı Türk hükümetinin gerçekleştirdiği politik istikrar dönüşümü mümkün kılan önemli bir faktör olmuştur. Türkiye Büyük Millet Meclisi hükümet tarafından geliştirilen birçok dönüşüm yasasını yürürlüğe sokmuştur -yıllarca devam eden, politika uygulamada yetersiz kalan, hassas koalisyon hükümetlerinin durumuyla tezat bir şekilde-. Halktan aldığı yetkiyle hareket eden hükümet, hızla uygulanan yasaları ivedilikle geliştirebilmiş ve yürürlüğe koymuştur. Sağlık Bakanlığındaki adanmış dönüşüm ekibi, değişim yönünde başbakanlığın güçlü desteği ve Sağlık Bakanı ve üst düzey yetkililerin liderliği ve sürekliliği Türkiye Büyük Millet Meclisi tarafından yasalaştırılan düzenlemeleri uygulama fırsatı sağlamıştır.

Ekonomik büyüme ve istikrar

Türkiye'de 2003-2012 yıllarında gerçekleştirilen ekonomik istikrar ve hızlı GSMH büyümesi hükümetin sosyal sektörlere yatırımı için çok gerekli olan mali alanı

oluşturmuştur. Bu büyüme döneminde, hükümet, sağlık sektöründeki harcamaları ve yatırımları hem mutlak hem de göreceli olarak artırabilmiş, bir yandan da özel sektör yatırımlarındaki büyümeden faydalanmıştır. GSMH'deki sürdürülebilir büyümeyle birlikte, vergi toplamayı iyileştirecek yeni mevzuat ve uygulamalar ve dengeli ekonomik politikalar, vergi gelirlerinde artışı, enflasyonda düşüşü ve işsizlikte azalmayı mümkün kılmıştır. Hükümetin vergi gelirlerinin artması, özelleştirmedeki ilerlemeler ve yabancıların doğrudan yatırımları hükümetin genel bütçeden Yeşil Kart kapsamı için finansman sağlamasını ve birleştirilmiş bir genel sağlık sigortası programı oluşturmasını mümkün kılmıştır. İstihdamın artması da zorunlu sigortanın Yeşil Kart programının ötesine büyümesine yardımcı olmuştur.

Dönüşüm ekibi

SDP ve GSK için çok önemli bir başarı faktörü de dönüşüm ekibi olmuştur; bu, 2003 ile 2013 arasında, neredeyse 10 yıl birlikte olan, son derece adanmış bir ekiptir. Bu dönüşüm ekibi SDP'nin düşünülmesinde, tasarımında, uygulanmasında ve izlenmesinde aktif bir rol üstlenmiş ve dönüşüm için stratejik yön, süreklilik ve kurumsal bellek sağlamıştır. Bu ekip, uluslararası uzmanlarla ve kuruluşlarla yakın ilişki içinde çalışmış ve uygulamanın stratejik ve işlemsel aşamaları arasında bir köprü oluşturmuştur. Düzenli saha ziyaretleri; il liderleri, yerel uygulama ekipleri ve Sağlık Bakanlığı arasında güçlü iletişim kanalları oluşturmaya yardımcı olmuştur.

Liderliğin sürdürülmesi

Bulgular Başbakandan[105], Bakanlar Kurulundan ve Sağlık Bakanından gelen yüksek düzey destekle, liderliğin sürdürülmesinin SDP ve GSK'nın başarısında önemli olduğunu göstermektedir. SDP'nin tasarımı ve uygulanması sırasında bakanlık farklılıkları ortaya çıkmış ve bürokrasinin bazı kısımlarından güçlü itirazlar gelmiş olsa da programın başarısı görünür hale geldikçe ve dönüşüm politikalarına destek arttıkça bu farklılıklar azalmıştır. SDP ilerledikçe, kabineden gelen geniş ve sürekli destek SDP'nin getirdiği değişikliklerin sağlık bakanlığının bir girişimi olarak algılanması yerine kurumsallaşmasını sağlamıştır. Bu geniş destek, aynı zamanda tüm politikalarda sağlığın desteklenmesine yardımcı olmuştur.

Hükümet içinde sağlığın rolünün artması

SDP'nin kilit bir özelliği, halkın genel yaşam şartları ve kamu hizmetleri hakkındaki algısına ilişkin sistematik bilgi toplanmasına verdiği önem olmuştur. Düzenli odak gruplar ve Türkiye İstatistik Kurumu tarafından yapılan yıllık hane halkı araştırmaları hükümete politikalarını ayarlaması için kapsamlı bilgi sağlamıştır. 2003 yılında performansı tüm kamu hizmetleri içinde en kötü olan sağlık hizmetleri SDP ve GSK'nın getirilmesiyle önemli düzeyde iyileşmiştir. Memnuniyet düzeylerinin artması SDP'nin meşruiyetini de artırarak değişim için yenilikçi bir ortam oluşturmuştur ve ayrıca Bakanlar Kurulunda Sağlık Bakanlığının ve Bakan'ının elini de güçlendirmiştir. 2003–2012 arasında, Sağlık Bakanlığı marjinal bir bakanlık (1980'lerde ve 1990'larda durum böyleydi; Sağlık Bakanlığı en zayıf koalisyon üyesine bir bakanlık görevi olarak sunulur ve hemen hemen her yıl değişiklik yapılırdı) olmaktan çıkmış, yıllık bütçe artışlarıyla, güçlü ve iddialı bir bakanlık olmuştur.

SDP'nin başarısı, sağlık politikalarının ülke politikasını etkilemesini sağlamıştır. Sağlık, tüm siyasi partiler için önemli bir politik gündem maddesi halini almıştır. SDP'den edinilen dersler başka büyük hükümet girişimlerine bilgi sağlamak için kullanılmıştır. Bu programın başarısı, kullanıcı memnuniyetinin artmasını getirmiştir ki bu da muhtemelen hükümetin tekrar seçilmesinde bir başarı faktörü olmuştur.

Sürekli öğrenmeyle esnek uygulama yaklaşımı

Hükümetin benimsediği esnek uygulama, fırsat pencereleri ortaya çıktıkça politikaları uygulamaya koymak için stratejik ve taktik hamleleri birleştirmektir.[106] Sağlık sisteminde daha geniş kapsamlı stratejik ve yapısal değişiklikler izlendikçe, bu değişiklikler sağlık sisteminde kullanıcı deneyimini ve memnuniyetini iyileştiren görünür taktik değişikliklerle birleşmiştir.

Saha koordinatörü modeli ve düzenli odak grupları ve saha araştırmaları, uygulama güçlüklerinin hızla belirlenmesini sağlamıştır. Sürekli bilgi toplanması ve bilgilerin dönüşüm liderliği, Sağlık Bakanlığı ve uygulama ekipleri arasında paylaşılması etkili iletişim için geri bildirim döngüleri oluşturmuştur. Hem yerel hem de merkezi düzeyde yapılan çok sayıda görüşme toplantısı sürekli öğrenmeyi ve iyileşmeyi beslemiştir. Bu öğrenme ortamı ve esnek uygulama yaklaşımı dönüşüm liderliğinin bir taraftan SDP'nin stratejik çerçevesi içinde kalırken, diğer taraftan da dönüşümün kapsamını, hızını ve zamanlamasını sürekli değiştirebilmesine yardımcı olmuştur.

Uygulama hızı

SDP'nin başarısındaki çok önemli bir faktör de politikaların uygulanma hızıdır. Bir karar verildikten ya da yasa çıkarıldıktan sonra uygulama, dönüşüm ekibinin her hafta denetlediği sıkı bir uygulama zaman çizelgesine göre hızla ilerlemiştir. Gecikmeler olduğunda, uygulama stratejileri değiştirilmiş ve yerel gruplar ya da Sağlık Bakanlığı ekipleri engelleri belirlemek üzere görevlendirilmiştir. Hızlı uygulama, değişikliklere karşı organize itiraz oluşmasını engellemiş ve bürokratik direncin aşılmasına yardımcı olmuştur. Uygulama hızı kullanıcıların ve halkın elde ettikleri yararların hızla görülmesiyle meşruiyet kazanmıştır.

Kapsamlı talep tarafı değişiklikleri ile arz tarafı dönüşümlerinin birleştirilmesi

Türkiye'deki GSK deneyiminden elde edilen önemli bir ders GSK'nın özellikle nüfusun en dezavantajlı kesimleri için genişletilmiş hizmete erişime yansıtılmasında ve

sigorta kapsamının genişletilmesinde talep tarafında (sağlık sigortası) ve arz tarafında (insan kaynakları ve hizmet sunumu) kapsamlı sağlık sistemi değişikliklerinin etkili olduğunun görülmesidir.

Kanıtlarımız, sigorta kapsamının iyileştirilmesinin erişimi artırmasına karşın, yararların arz tarafı müdahalelerin varlığında daha güçlü olduğunu ve daha iyi algılandığını göstermektedir. Burada önemli bir nokta, sonuçlarımızın aynı zamanda hizmet erişimini iyileştirilmesinde ve 5 yaş altı ve bebek ölüm hızlarının azaltılmasında, talep tarafı ve arz tarafı değişikliklerinin kombinasyonunun etkili olduğunu göstermesidir.

2023'e doğru: Türkiye Cumhuriyetinin 100. yılı

Türkiye, 2023 yılına gelindiğinde, GSMH açısından dünyada en üst on ülkeden biri olmayı amaçlamaktadır. Son GSK deneyimi göz önüne alındığında, bu ekonomik hedeflerin sağlık hizmetleri açısından da temsil edilmesi gerekmektedir. Türkiye Cumhuriyetinin 100. yılına giden on yıla girerken, SDP sonucunda gerçekleşen GSK, halkın sağlığının ve iyilik halinin daha da iyileştirilmesi için önemli imkanlar sağlamaktadır. Türkiye, 2013–2017 için sağlık sektöründe stratejik bir plan ve 2023 için hedefler geliştirmiştir. Ülke vatandaşlarının sağlığını daha da iyileştirmek amacıyla bu plan uygulanırken, Türkiye, GSK'nın gerçekleştirilmesi sırasında kazanılan bilgi birikimini ve deneyimi paylaşarak küresel sağlığa da katkıda bulunmuş olacaktır. Bu, ülkenin küresel ekonomik hedeflerine uygun bir roldür.

Katkıda bulunanlar

RiA, araştırma ekibini, etüt tasarımını, veri analizini ve veri yorumlanmasını yönetmiş, birinci ve sonraki taslakları ve nihai raporu yazmıştır. SA ve ReA veri yorumlanmasına ve taslakların yazılmasına katkıda bulunmuştur. SC, SS, MA, IG, ve SN veri analizine ve veri yorumlanmasına katkıda bulunmuştur ve taslaklara katkısı olmuştur. SO, UA, BA, ve UD veri toplanmasına katkı koymuştur ve taslaklar konusunda fikir vermişlerdir. RiA garantördür.

Çıkar çatışması

RiA, Sağlıkta Dönüşüm Programı dahil, Türkiye Cumhuriyeti, Sağlık Bakanlığı danışmanı olarak görev yapmıştır ve Türkiye'de Sağlık Bakanlığı, DSÖ ve Dünya Bankası için danışmanlık görevleri üstlenmiştir. ReA 2002 ile 2012 arasında Türkiye Cumhuriyeti Sağlık Bakanlığı yapmıştır. SA 2002 ile 2009 arasında Türkiye Cumhuriyeti Sağlık Bakanlığı Müsteşar yardımcılığı yapmıştır. SC Dünya Bankası için çalışmaktadır ve Dünya Bankası tarafından fon sağlanan Türkiye Sağlıkta Dönüşüm Projesinde görev almıştır. SC Medipol Üniversitesinde geçici görevdedir. SS, MA, IG, ve SN Türkiye Sağlık Bakanlığı için analitik danışmanlık yapmışlardır. SO, UA, BA, ve UD Türkiye Cumhuriyeti Sağlık Bakanlığı Sağlık Araştırmaları Genel Müdürlüğünde çalışmaktadır.

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TÜRKİYE GENEL SAĞLIK KAPSAMI BAKANLAR KONFERANSI

TURKEY MINISTERIAL CONFERENCE ON UNIVERSAL HEALTH COVERAGE

27-28 HAZİRAN 2013

Türkiye Cumhuriyeti Sağlık Bakanlığı, yaşadığı ülke deneyimini ve başarısını The Lancet Dergisi'nde yayımlanan "Türkiye'de Genel Sağlık Kapsamı: Hakkaniyetin Artırılması" özel makalesi ile uluslararası platformda paylaşmıştır. Bakanlık, 27-28 Haziran 2013 tarihlerinde Londra Imperial College, The Lancet ve Medipol Üniversitesi işbirliği ile İstanbul'da düzenlediği "Genel Sağlık Kapsamı Bakanlar Konferansı" ile bu özel makalenin tanıtımını gerçekleştirmiştir. Elinizdeki kitap, konferans konuşmalarının deşifre edilmesi sonucu oluşmuştur. İleride Türk sağlık sistemindeki değişikliğin serüvenini araştıranlar için önemli bir kaynak teşkil etme ve kıyaslama imkânı sunma iddiasındaki kitapta konuşmalar İngilizce veya Türkçe olarak olduğu gibi aktarılmış, tercüme cihetine gidilmemiştir. Konferans notlarını inceleyenlere kolaylık sağlaması amacıyla toplantı esnasında katılımcılara dağıtılan makalenin orijinal çıktısı ve Türkçe çevirisi de son bölüm olarak eklenmiştir.

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