6. Provision of services

6.1 Public health

The Constitution gives the Ministry of Health the responsibility to protect and improve public health in Turkey. However, certain aspects of public health require intersectoral collaboration. As will be discussed below, the Ministry of Health leads the process in areas where this collaboration is needed. The Ministry of Health undertakes this responsibility both through its centralized departments and through the provincial health directorates. Prior to the full implementation of the family practitioner scheme nationwide (at the end of 2010), health posts and health centres in rural areas undertook the majority of disease prevention, health education and other public health-related measures. Now, these activities are carried out by population health centres. Centrally, both the General Directorate of Primary Health Care Services and the General Directorate of Maternal and Child Health and Family Planning are responsible for public health. In addition to these, the departments for malaria control, cancer control and tuberculosis control in the Ministry of Health and the Refik Saydam Hygiene Centre Presidency also undertake public health measures.

The Ministry of Health, Ministry of Agriculture and Rural Affairs, the Ministry of Environment and Forestry, and the municipalities are the main organizations responsible for environmental health in Turkey. In the Ministry of Health, the Department of Environmental Health, under the General Directorate of Primary Health Care Services, undertakes the following activities: planning, research, regulation, development and supervision of services related to the protection of water resources; planning research and supervising services related to eliminating or reducing noise and air pollution; regulating public places where people eat, sleep, have recreation and perform cleaning functions; undertaking research, regulation, development and supervision for industrial organizations and all enterprises that can have harmful effects on health; sanitary arrangements for sewage systems, and planning services related to waste, compost or (parasitic) vectors; and controlling pesticides and other

environmental pollutants for the protection of natural resources. The department also collaborates with other related institutions to improve environmental health and it conducts pilot studies at national and international level. In rural areas, the provincial health directorates are mainly responsible for coordinating all health-related activities of public and private organizations within their provincial borders. Environmental health technicians located within health care centres carry out environmental roles and duties.

The Ministry of Agriculture and Rural Affairs also has environmental and health responsibilities and these are coordinated by departments for environment and disaster services, food control services, public health services, and animal health services under the General Directorate of Protection and Control. At the local level, provincial and district directorates undertake these responsibilities. Similarly, the General Directorate of Environment Management, under the Ministry of Environment and Forestry, also has responsibilities in terms of environmental conditions. In addition to these, municipalities have a major role in environmental health.

In the past, there were 39 communicable diseases that should be notified in Turkey and reported from all health facilities. More recently, a group of 60 people from universities and teaching and research hospitals conducted a study to review the communicable disease reporting and notification system using WHO and the US Centers for Disease Control and Prevention publications. The study defined the standard diagnosis criteria for diseases in the context of the Turkish setting. Taking into account recent developments, it produced an updated list of notifiable diseases: 51 diseases with four different notification types (groups A–D) (Ministry of Health, 2004a).

The diseases in group A require data collection from all institutions in the health system, starting from the primary level. Diseases in this group are HIV/AIDS, acute bloody diarrhoea, pertussis, brucellosis, diphtheria, gonorrhoea, mumps, measles, rubella, cholera, rabies and suspected rabies contacts, meningococcal meningitis, neonatal tetanus, poliomyelitis, syphilis, malaria, anthrax, cutaneous leishmaniasis, tetanus, typhoid fever, tuberculosis and acute viral hepatitis. For the majority of these diseases, the patient's first point of contact is the primary care level. The physician notifies the disease, to the extent it can be diagnosed, and initiates the necessary research. Where there are limited opportunities for diagnosis, physicians refer patients or patients directly present themselves to a secondary level health care institution. In both cases, while diagnosing and initiating treatment, the relevant medical personnel must report all patient information to the health authorities (health care facilities notify the Ministry of Health's database electronically, while

family health centres and population health centres notify the provincial health directorate either electronically or by submitting a form). The rationale behind this reporting mechanism is to identify whether there are similar cases among people living in the same neighbourhood and/or to examine the source of the disease. All health institutions across Turkey can notify the diseases in this group (Ministry of Health, 2004a).

Group B diseases must be reported as soon as an outbreak is suspected in accordance with the WHO 1969 International Health Regulations. These are smallpox, yellow fever, epidemic typhus and the plague. These diseases have either never been seen in Turkey or not been seen for a long time. All health institutions must report to the Ministry of Health directly and quickly if there is a suspected case of these diseases. At the international level, only the Ministry of Health has the authority to notify these diseases. There are also diseases that should be notified internationally within the framework of WHO's International Health Regulations (Ministry of Health, 2004a).

Group C diseases are acute haemorrhagic fever, Creutzfeldt–Jakob disease, echinoccoccosis, *Haemophilus influenzae* type b infection, influenza, kala-azar, congenital rubella, legionellosis, leprosy, leptospirosis, subacute sclerotic panencephalitis, schistosomiasis, toxoplasmosis, trachoma and tularaemia. Most of these diseases were added recently to the notification system. These diseases are traced through the "sentinel surveillance" method, although the reasons change according to the disease. Some of the diseases in this group can be defined starting from the secondary level or higher specialist institution or laboratory, and notification from these institutions is sufficient. In the case of an influenza outbreak, the rule is to examine a sufficient sample of cases to identify the agent; therefore, not all cases are examined. In some other cases (Creutzfeldt–Jakob disease, congenital rubella), collecting information and notification at the primary care level does not contribute practically to the surveillance system. Instead, each health institution at the secondary level or above that can provide services for diagnosis and treatment in relation to their specialty capacities are responsible for the notification of these diseases. Consequently, notification of group C diseases is not undertaken through all health care institutions, but only those specified by the Ministry of Health (Ministry of Health, 2004a).

Differing from the other groups, group D defines the notification of "infectious agents". This requires the direct involvement of laboratories in the notification system. The purpose is to collect more information on aetiological agents of some communicable diseases that are still important public health issues, and to be able to undertake advanced epidemiological research. It is

noteworthy that a laboratory can give notification only if it can diagnose with a minimum level of acceptable techniques (Ministry of Health. 2004a). In this group, not the disease but the infectious agent (e.g. *Campylobacter jejuni, Salmonella* spp. and *Entamoeba histolytica*) should be notified. Responsibility for the notification of group D infectious agents rests with laboratories at state hospitals, university hospitals and other public hospitals; provincial public health laboratories; and district and central hygiene laboratories that are authorized by the Ministry of Health (Ministry of Health, 2004a).

Health promotion and public health education activities are mainly the responsibility of the Ministry of Health's General Directorate of Primary Health Care Services, while in-service education activities are the responsibility of the Ministry of Health's General Directorate of Health Education. However, other departments of the Ministry, such as the School of Public Health (*Hıfzıssıhha Mektebi*), provincial health directorates and universities, also undertake these activities. The General Directorate of Primary Health Care Services develops policies and prepares plans for public health education activities, which focus on vaccination, preventive health services, environmental health, food safety, emergency health care services, prevention of tobacco and alcohol usage, prevention of obesity and chronic diseases. The media is also an important actor in these activities, through campaigns on preventive health services including tobacco and alcohol usage, and obesity. In addition, universities, upon the Ministry of Health's request, collaborate in these activities as major sources of information.

At the provincial level, provincial health directorates prepare their annual training plans, considering the needs and teaching requirements within their provinces. Health education for the public is conducted under the coordination of the directorates' training departments with intersectoral cooperation. Although NGOs conduct some small-scale training activities for health improvement, there are no large-scale profit-making or non-profit-making organizations in health education.

The Ministry of Education's Department of Health Affairs also undertakes activities aimed at increasing awareness of certain aspects of health, particularly in schools. The School Health Project carries out screening activities in schools and provides basic health education to pupils. There is also an oral and dental training project; an adolescent training project that covers education on sexual behaviour, well-balanced diet and physical activity, and harmful use of alcohol, tobacco and other substances; a drug addiction control project; and a first-aid training project for school-aged children.

Immunization, family planning and antenatal services are the responsibility of the General Directorate of Primary Health Care Services. Prior to the implementation of the family practitioner scheme, health centres, maternal and child health care centres and dispensaries provided these services in the regions; now family practitioners conduct these activities through family health centres. The regulation of immunization services is among the major responsibilities of the Ministry of Health. The Ministry undertakes this responsibility by following the recommendations of the Immunization Advisory Board, comprising 30 academics, and the recommendations of international organizations.

In the provinces, the communicable diseases branches of the provincial health directorates implement eradication, elimination and control programmes for communicable diseases; undertakes immunization programmes; and monitors these activities within the boundaries of the province. Turkey implements the Expanded Programme on Immunization (*Genişletilmiş Bağışıklama Programı*) aimed at eliminating infant and child deaths and disabilities caused by pertussis, diphtheria, tetanus, measles, rubella, mumps, tuberculosis, poliomyelitis, hepatitis B, invasive pneumococcal diseases caused by streptococcal pneumonia, and other diseases caused by *Haemophilus influenzae* type b. The programme has been evaluated as successful since its implementation and through adding three new conditions (rubella, mumps, *Haemophilus influenzae* type b infection) to the programme in 2006 (Ministry of Health General Directorate of Primary Health Care Services, 2006). By the beginning of 2008, the DaPT-IPA-Hib was added. Turkey now carries out the same vaccine schedule as developed countries (Ministry of Health, 2009a). Since 2008, the pneumococcal vaccine has been included in the routine vaccination scheme. The Ministry of Health also provides a rabies vaccine and antiserum together with other vital antiserums (snake, scorpion, tetanus, diphtheria, etc.). Vaccination is free at public facilities, and vaccines are provided through the general public procurement regulations. The vaccination schedule is displayed in Table 6.1.

Family planning and antenatal services are the responsibility of the General Directorate of Mother and Family Planning and Child Health, which also has branches within the provincial health directorates. Prior to the implementation of the family practitioner scheme, these services were primarily provided by maternal and child health centres and health centres; now family physicians provide these services, but secondary health care institutions can also provide these services (Ministry of Health, 2007a). Health care services at the primary care level are free of charge and there is also some limited support for these services from international organizations such as the United Nations Population Fund and the EU.

Table 6.1
Vaccination schedule for children

	Birth	End of 1 month	End of 2 months	End of 4 months	End of 6 months	12 months	18–24 months	Primary school, 1st grade	Primary school, 8th grade
Hepatitis B	I	II			III				
BCG			I						
DaPT-IPA-Hib			I	II	III		B		
CPV			I	II	III	B			
MMR						I		B	
DaPT-IPA								B	
Oral polio vaccine					I		II		
Diphtheria–tetanus (adult type)								I	II

Source: Ministry of Health, 2010.
Note: CPV: Conjugated pneumococcal vaccine.

Occupational health services are the responsibility of several organizations in Turkey, including employers. At the national level, the General Directorate of Occupational Health and Safety under the Ministry of Labour and Social Security determines policies and monitors their implementation. There are six occupational health and safety centres in the provinces and these centres mainly take measurements (radiation, noise, lighting, etc.) at workplaces upon request and also provide advice and training services. By law, all employers with 50 or more employees should have a health unit with a physician and a sufficient number of auxiliary health personnel. These workplace units should ensure a healthy and safe working environment, determine measures for the prevention of risks and implement and monitor these measures. They also provide first aid and emergency care and refer employees to relevant institutions for further care. However, there are very few workplaces in Turkey with 50 or more employees. In fact, in 2004, 98.7% of enterprises had fewer than 50 employees. In addition, 98% of occupational accidents occurred in enterprises without health units. In such cases, all required health care is covered by the SSI (Ministry of Labour and Social Security, 2008).

Screening in Turkey can be classified as opportunistic. There are national screening programmes for breast, cervical and gastrointestinal cancer, tuberculosis, phenylketonuria and congenital hypothyroid. The last two programmes are organized by the Ministry of Health in collaboration with universities. The increasing burden of cancer and its impact on the health care budget have led to more emphasis on cancer-screening programmes rather than screening of other diseases. The Ministry of Health has established centres for

early diagnosis and screening of cancer in 47 provinces, with support from the EU. There are currently 122 such centres and they aim to screen 35% of the target population in the short and medium term, and at least 70% in the long term (Asian Pacific Organization for Cancer Prevention, 2010). These centres conduct opportunistic screening services and resources are allocated from the Ministry of Health budget. Screening services are provided free of charge. With regard to tuberculosis, mobile screening teams, which had been undertaking their activities under the Department of Tuberculosis Control since 1952, were transferred to the provincial health directorates in 2006. New teams have been added under the new arrangements, thus strengthening radiological tuberculosis screening in community residential areas and within organized communities such as prisons, nursing homes and kindergartens.

The topic of inequalities in health has been high on the policy agenda in recent years. It is widely accepted that health inequalities are a reflection of the overall inequalities within a country. Turkey had a Gini coefficient of 0.40 in 2004 (SPO, 2006) and 0.39 in 2008 (World Bank, 2010), indicating that there is large scope for improvement in this area. With the implementation of the HTP, the country has introduced a number of initiatives to reduce these inequalities, which are directly related to health and health services, but there are also other initiatives aimed at reducing poverty. The Green Card Scheme was the first initiative aimed at covering the health care expenditure of the poor, hence contributing to decreasing health inequalities. The scheme is fully financed by the government budget (see Chapter 3). Initially, the scheme covered only inpatient services but later coverage was equalized with other social security schemes and now it covers all levels of care.

The introduction of the GHIS (in October 2008) can be regarded as a key component of the HTP that will have a positive impact on reducing financial obstacles to accessing health care. According to the NHA study (Ministry of Health RSHCP School of Public Health, 2004), in 2003 Turkey had very high OOP payments (28% of total health expenditure), indicating problems in financial risk coverage. Another study concluded that both formal and informal payments were made by the poorer segments of society (Tatar et al., 2007). After the planned transfer of the Green Card Scheme to the SSI, theoretically, no one will be outside the insurance system. Gradually, the plan is to dismantle the Green Card Scheme and the government will pay the contributions of the population under a specified poverty line; as a result, the poor and the unemployed will have extra protection under the new system. Currently, the GHIS also provides free health care services for all children under 18.

The General Directorate of Social Aid and Solidarity[31] provides an economic and social support fund for citizens experiencing economic and social deprivation. Its provincial branches determine the families in need of assistance and provide both in-cash and in-kind benefits. Until 2004, this fund financed the outpatient fees and prescription charges of Green Card holders, after which these expenses were incorporated into the Green Card Scheme itself. At present, the General Directorate of Social Aid and Solidarity meets the health care expenses of uninsured people and others who do not qualify for a Green Card, as well as the medical needs of disabled people that are not covered by the SSI, such as prostheses, hearing devices and wheelchairs.

There is also a Social Risk Mitigation Project initiated in collaboration with the World Bank in 2001. The project provides direct in-cash support to the poor. The "conditional cash transfer" component of this project falls under the responsibility of the Ministry of Health and the Ministry of National Education. This component covers assistance for citizens who are negatively affected either socially or economically by economic crisis. Within the framework of the project, monetary aid is provided for preschool children aged between 0 and 6 years to benefit from primary care services. In addition, expectant mothers receive cash benefits for prenatal care, deliveries at health care facilities and postnatal care (Prime Ministry General Directorate of Social Aid and Solidarity, 2008).

6.2 Patient pathways: referral and centre-referral system

Until 2003, Turkey had a very complex health care provision and financing system. Patient pathways differed substantially according to the coverage status of individuals. Through the rapid reforms that have occurred since 2003 under the HTP, patient pathways have almost been standardized. Accordingly, SSI beneficiaries can directly access an inpatient or outpatient health care facility using their identity cards. Currently, there is no formal gatekeeping system in place.[32] However, now that the family practitioner scheme has been implemented nationwide, people are encouraged to contact their family physician or to visit a primary care facility first and then to be referred to appropriate secondary or tertiary health care facilities if necessary. Primary care visits are free of

[31] Attached to the Prime Minister's Office (Law No. 5263 of 1 December, 2004).

[32] The formal referral system was abolished in 2007 because of the lack of sufficient primary care doctors who could act as gatekeepers.

charge (i.e. no co-payment is levied) as an incentive. Moreover, co-payments at secondary level facilities are waived if the patient has a referral from a primary care physician.

Patients with a Green Card can apply directly to primary, secondary and tertiary health care facilities (except for university hospitals). The secondary or tertiary health care facilities that provide care for Green Card holders can refer such patients to university hospitals if medically necessary.

6.3 Primary/ambulatory care

Prior to the implementation of the family practitioner scheme in 2010, health centres, health posts and other units such as dispensaries provided primary care services. Since 2011, and the start of a new family medicine system nationwide, family physicians, family health centres and population health centres (in the public sector), doctors' private offices and private clinics are the main providers of primary and ambulatory health care services in Turkey.

Health posts and health centres were the key primary care components outlined in the Law on Socialization of Health Care Services (1961). The socialization model, reflecting the basic health services movement of the 1960s, required the establishment of a health post per 2000 population and a health centre per 5000–10 000 population. However, population size differed in some areas, particularly after periods of rapid urban expansion. Generally speaking, one health centre per 20 000 was established in metropolitan areas, one centre per 10 000 in provincial centres, one centre per 5000 in districts, and one health post per 2500 population in towns and villages. Following the legislation, these units were established as the backbone of the health care system, usually being the first point of contact for patients. Health posts and health centres provided primary health care services. Health posts were staffed by a nurse/midwife and provided mainly maternal and child health care services, basic sanitation, health education and so on. Health centres, by comparison, were a reflection of the "multipurpose health care service in a limited area" model. Accordingly, these centres provided both preventive and curative care. The model covered the whole country in 1984, although, as indicated by the two decades it took to implement changes, there were serious drawbacks that impeded progress (e.g. a lack of human resources). Moreover, there was a certain degree of fragmentation in the delivery of services.

As part of the new family medicine system, family health centres and population health centres have replaced health posts and health centres. They provide, free of charge, preventive and community health care services such as immunization, follow-up of women between the ages of 15 and 49, follow-up of pregnant women and new mothers, infant and child health care, school health services, public health training and similar services. In 2010, there were 6367 family health centres and 961 population health centres across the country (Ministry of Health, 2010, 2011b).

Family health centres are health care facilities where one or more family physicians and allied family health personnel offer family health care services. Apart from focusing specifically on providing primary care services, one of their aims is to reduce costs and to provide flexible working hours for family physicians. Family health centres can be established in eligible areas that meet demographic and transportation criteria set out by the Ministry of Health, with the family physicians signing individual contracts with the Ministry. Family physicians, individually or jointly, can employ other people (allied health care personnel such as midwives, nurses, health officers, medical secretaries), who also sign individual contracts, and can purchase security, cleaning, heating and secretarial services. With the agreement of the Ministry of Health, family health centres can be used for training purposes. This type of group practice is being actively encouraged and is seen to be advantageous with regard to creating solidarity, fostering teamwork and promoting training and service continuity.

A family physician is expected to undertake the following main tasks and responsibilities:

- provide integrated patient-specific preventive health care services and diagnostic, curative, rehabilitative and counselling services at the primary care level;
- provide maternal–child health and family planning services in addition to health promotion and protection;
- make home visits and contact registered patients on their lists within six months of their registration in order to conduct an initial medical assessment;
- provide follow-up and monitoring of registered patients according to age, sex and disease groups (cancer, chronic diseases, pregnancy, newborn, infants, child health, adolescent health, adult health, health for the elderly);

- conduct regular (annual) health checks and medical examinations and update patient records;
- refer patients whose conditions require further diagnostic and treatment options;
- provide primary level preventive health, diagnosis, treatment, rehabilitation and other service for people at home when necessary (for the disabled, elderly or bedridden who are detected during home visits and whose home follow-up is obligatory) or organizing mobile health care services;
- evaluate the feedback on examinations, tests, diagnosis, treatment and hospitalization data of referred patients;
- coordinate secondary and tertiary level treatment and rehabilitation services and home care services; and
- manage family health centres, supervise colleagues and provide them with in-service training.

Population health centres are health facilities that develop and protect people's health and address health-related risks and problems, providing health care services that include health protection and prevention. Under the leadership of district health directorates, they also play a role in evaluating the effectiveness of services and coordinating relations between health care facilities and the other institutions and services in their catchment area to aid public health. In every district, including central urban districts, at least one population health centre is being established under the directorship of the district health directorate. These centres provide services that include diagnostic and medical tests and health services that are not provided by family physicians. In accordance with the Ministry of Health's annual programme, population health centres provide logistical support to family physicians with regard to vaccinations, mother and child health/family and planning. These centres employ public health specialists, who play a vital role in overseeing the centres' public health functions in an integrated manner. Population health centres also function as training and planning centres.

Population health centres carry out the following key activities (among others): registration, statistical collection and planning of public health services; cooperation with universities; monitoring and evaluating services; controlling communicable diseases; controlling noncommunicable diseases; reproductive health services; emergency health services; protective services for accidents and injuries; screening and laboratory services; environmental health services;

occupational health and safety services; disaster services; health promotion; health education services; community life and school health services; and social services.

The restructuring of primary health care delivery is a result of a major initiative under the HTP – the introduction of the family practitioner scheme. Although this policy had been cited extensively as a needed reform measure since the beginning of the 1990s, concrete results have been achieved only since 2003. The scheme was piloted in 2008, with 23 out of 81 provinces participating. In June 2009, the family practitioner scheme was operating in 33 provinces (Ministry of Health General Directorate of Primary Health Care Services, unpublished data 2009) and by the end of 2010 it had been extended to the whole country. In addition, once there are a sufficient number of doctors participating nationwide in the scheme, the government plans to relaunch compulsory gatekeeping in the health system, with family practitioners acting as the first level of contact.[33] Family practitioners are now paid by capitation (receiving an additional performance-based payment where appropriate) and the patient list size is restricted to 4000.

In terms of accessing primary care services, residents within a particular area are expected to visit the relevant family or population health centre to facilitate access to services. Currently, each family practitioner is assigned a population according to his/her location in the provinces. However, after six months, patients can change their family practitioner. There is no limit to the number of times patients can change their family practitioner.

Hospitals also provide ambulatory outpatient services in Turkey. As there is not an effective and active referral system at the moment, the majority of outpatient visits tend to be for problems that could easily be dealt with at the primary care level. The data on outpatient visits are separate for hospitals and primary health care units but it is possible to give the total number of visits by patients in a year.

In 2010, there were 18 279 GPs and 891 specialist physicians (in family health centres), making a total of 19 170 physicians practising at the primary health care level (Ministry of Health, 2010, 2011b). In 2006, the highest number of physicians was in the Marmara region (21%) and the lowest in eastern

[33] Following the experiences of a gatekeeping pilot programme, which made referrals by a family practitioner compulsory in four provinces, the government decided to abolish the programme. Three months into the pilot programme, it was clear that the new gatekeeping responsibilities for family practitioners had negative effects: they increased daily workloads, waiting lists grew, consultation times were decreased to five minutes, preventive care activities were curtailed and the referral rates increased by more than 30%. These problems were mainly caused by the insufficient number of family practitioners.

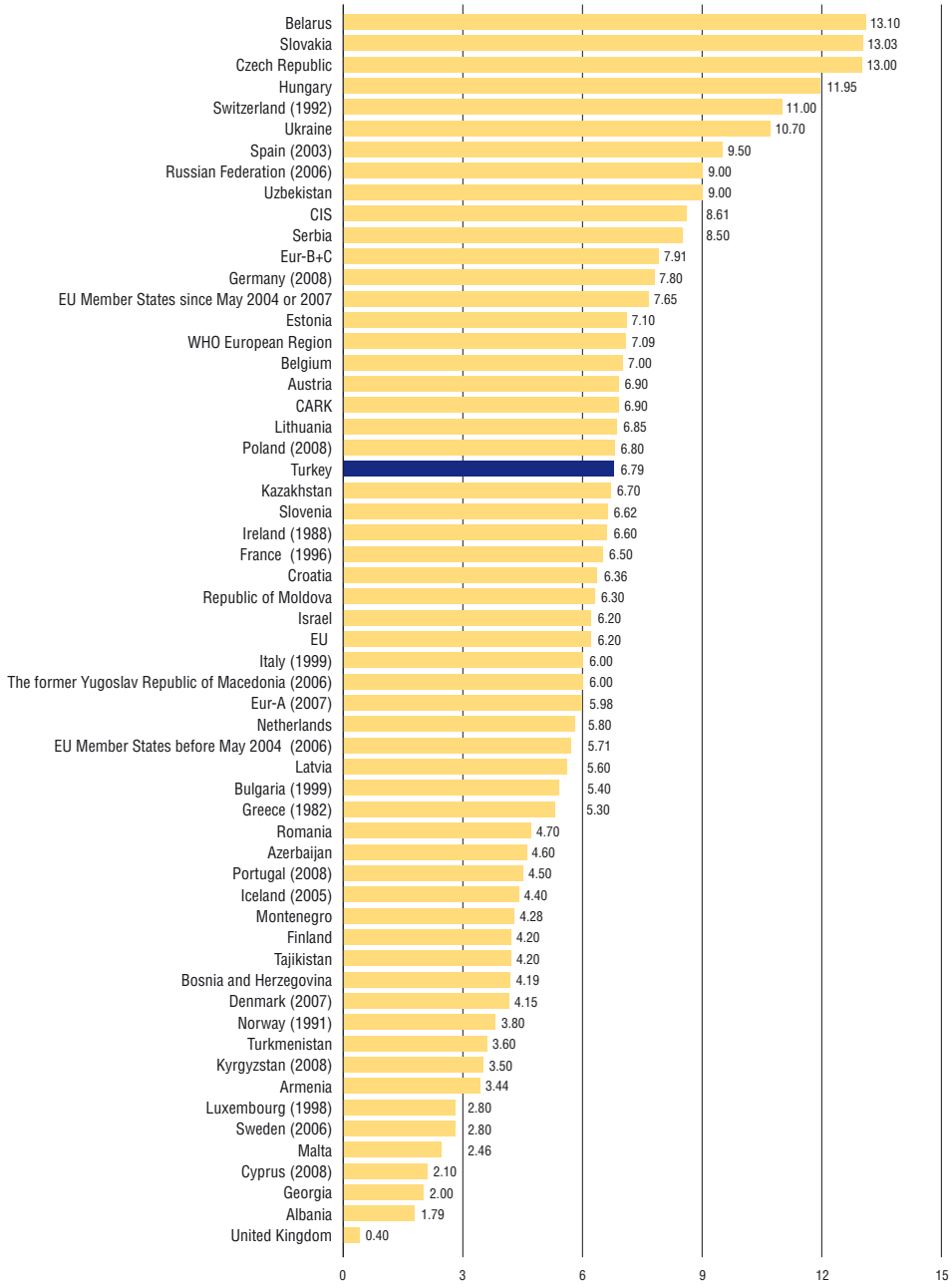
Anatolia (7.3%). The average population per physician was 5061 in the Marmara region, 4846 in south-eastern Anatolia, 4948 in eastern Anatolia and 3021 in the Aegean region. These figures were indicative of the wider inequalities in the distribution of physicians by regions (Ministry of Health General Directorate of Curative Services, 2006). By 2010, the imbalance in the distribution of physicians had improved: the total number of physicians per 1000 population was 1.67 in Turkey, with the highest ratio (2.84) in western Anatolia and the lowest (1.14) in south-eastern Anatolia. Consequently, even the region with the lowest value has come closer to the average (Ministry of Health, 2010, 2011b).

Quality of care has been on the Ministry of Health agenda since the early 2000s. In 2006, TURKSTAT undertook a Satisfaction with Health Care Services survey to explore potential areas for improvement (Ministry of Health, 2006c). There is a quality unit within the General Directorate of Primary Health Care Services whose major responsibility is to plan, implement, coordinate and supervise quality studies undertaken at the provincial and health facility level. A rise in the number of patient visits to health centres now family health centres and a decline in referral rates can be treated as indicators of increasing quality within the primary care sphere. In this respect, the number of per-patient visits to health centres increased from 0.86 in 2001 to 1.46 in 2005. In 2010, the number of visits per person was 2.7. Data on family physicians are also included. The referral rate decreased from 14.4% in 2001 to 10.2% in 2005 (Ministry of Health Gneral Directorate of Primary Health Care Services, 2005). In 2010, the rate was reduced further to 0.4% (Ministry of Health, 2010, 2011b).

The number of outpatient contacts per person has risen dramatically in Turkey over the years. While there were 2.78 annual outpatient contacts per person in 2002, this number increased to 6.28 in 2008, close to the EU average of 6.86 (in 2007). As for the WHO European Region as a whole, the average number of outpatient contacts per person in 2009 is reported as 7.0 (Fig. 6.1).

Fig. 6.1

Outpatient contacts per person per year in the WHO European Region, 2009 or latest available year



Source: WHO Regional Office for Europe, 2011.

6.4 Secondary care: specialized ambulatory care/ inpatient care

Secondary and tertiary care services are predominantly under the control of the Ministry of Health. In 2010, the Ministry of Health owned 58.6% of hospitals and 59.9% of hospital beds (Ministry of Health, 2011b). The Ministry of Health operates both general hospitals (secondary care) and teaching hospitals (tertiary care). Ministry of Health teaching hospitals provide specialist training in all medical branches. In addition, universities owned 4.3% of hospitals and 17.5% of hospital beds in 2010. These are highly specialized and complex hospitals providing services at the tertiary level. However, because of problems with the current referral system, these hospitals are also used by patients as primary level points of contact, impacting adversely on the efficient use of resources.

In 2010, the private sector owned 33.9% of hospitals but just 14.0% of hospital beds. In parallel, private hospitals have seen an increase in the number of patients served, from 4.4 million in 2002 to 46.2 million in 2009, indicating that this sector is more involved in providing outpatient care than inpatient care. The Ministry of National Defence had 2.9% of hospitals and 7.9% of hospital beds in 2010. Before 2004, SSK was also an important partner in the provision of hospital services but since the transfer of its facilities to the Ministry of Health in 2005, the SSK no longer has this function (see Chapters 2 and 3).

Hospital outpatient departments, both public and private, doctors' private offices and private outpatient centres are the main providers of specialized ambulatory medical services. Under the statutory system, outpatient clinics in public hospitals are staffed by physicians and other hospital staff, with physicians being responsible for both inpatient and outpatient care. The SSI purchases health care services from both public and private providers (with the exception of private physicians' services). Outpatient services in public hospitals are paid for by the patient's health insurance scheme (the GHIS or the Green Card), along with the appropriate co-payment; alternatively, OOP fees are paid by patients directly to the hospital's revolving fund (see Chapter 3).

In the private sector, specialist ambulatory care is provided by outpatient clinics in private hospitals, private part-time and full-time practitioners and private outpatient centres. All these facilities are profit-making. Until 2010, physicians had been able to work in both the public and the private sector on a part-time basis; this led to an upsurge in private outpatient centres in recent years, mainly opened by groups of specialists. In January 2010, a new law prohibiting doctors from practising in both the private and public sector

was passed, with financial incentives to keep doctors in public facilities. However, the law was challenged in the Constitutional Court and under the revised arrangements, staff in Ministry of Health facilities cannot work in both the public and private sectors while staff at university medical facilities are allowed to work in their private clinics only after completing their full-time job commitments in the public/university sector (that is, after working the full day there instead of half a day, which until now has been the common practice).[34]

Hospital categories are classified in the Regulation on the Administration of Inpatient Health Care Facilities 2005. Hospitals are defined in the Regulation as facilities where the ill and injured are diagnosed, treated and rehabilitated both as inpatients and as outpatients and where babies are delivered. Hospitals are classified into five groups:

District/town hospitals. These facilities provide health care services at the secondary level of care. They provide inpatient and outpatient diagnosis and curative services, together with delivery rooms and ambulance services. They do not all have medical specialization branches, only essential ones. If patients require advanced diagnostic and treatment facilities they are referred to a higher level facility.

Day hospitals. These facilities provide outpatient care on a daily basis. They have at least five observation beds available 7 days a week/24 hours a day and coordinate services with other hospitals.

General hospitals. These hospitals include all medical departments and have at least 50 beds. They provide fairly complete and comprehensive care. In situations where further attention is needed, the patient is transferred to tertiary care.

Specialist hospitals. These hospitals provide services for specific age or gender groups and for specific diseases. Examples include children's hospitals and oncology hospitals.

Teaching hospitals. These are tertiary hospitals that provide specialty training and undertake research. They can be either Ministry of Health or university hospitals.

[34] As the Court declared its decision in July 2010, currently there is a lack of clarity about how the new arrangements will be implemented and enforced.

Currently, the management of public hospitals is under government control. The chief physician is the manager of the hospital and is assisted by hospital managers responsible for administrative, financial and technical issues and by chief nurses responsible for nursing services. In 1995, with the Basic Law on Health Care Services, the government attempted to grant autonomous status to hospitals and change their management structure. However, as discussed in Chapter 4, the Constitutional Court cancelled some vital provisions of the law and the newly envisaged management structure was only implemented in one pilot hospital in Ankara. Since the beginning of the HTP (in 2003), this issue has taken centre stage once again. A new draft law on hospital autonomy is currently being discussed by parliament.

Under the statutory (public hospital) system, the government employs hospital staff, with the exception of a limited number of contracted personnel who are hired by the revolving fund of the hospital. The government pays the salaries of the staff it employs, and the revolving fund pays the salaries of the contracted personnel. Hospital hotel services, such as catering, laundry, cleaning and diagnostic imaging services, can be outsourced through contracts. Services are purchased according to the rules set out in the Public Procurement Law (2002) and are predominantly paid for by hospitals' revolving funds.

Hospitals are either public or private in Turkey. Private hospitals are predominantly profit-making, although there are some examples of not-profit-making hospitals attached to foundations such as the Foundation for Leukaemia. This foundation owns leukaemia treatment facilities and provides services free of charge.

The rules governing the relationship between primary and secondary care are determined by the HIG (see Chapter 3). In the past, there were different rules for beneficiaries of different health insurance schemes, causing gross inequalities in terms of access. However, in the lead-up to the implementation of the GHIS, reimbursement rules were equalized among all the health insurance agencies. Moreover, since there is currently no gatekeeping system, patients can bypass the primary care level for a referral and go directly to a secondary or even a tertiary care facility. Only Green Card holders need to obtain a referral to access tertiary care. However, once problems with lack of personnel are overcome, the longer-term plan is for family practitioners to play a gatekeeping role and all patients will have to be referred from the primary care level in order to be reimbursed. In the interim, co-payment exemptions are in place to act as an incentive for people to first obtain a referral before accessing secondary and tertiary care.

There are two main public agencies that undertake social care in Turkey. The first is the Social Services and Child Protection Agency (SHÇEK, Sosyal Hizmetler ve Çocuk Esirgeme Kurumu) attached to the office of the Prime Minister. This organization provides social services to children, the elderly and the disabled. Social services can be in the form of institutional care or in-kind and cash benefits. The organization has general facilities for these vulnerable groups and health care is provided if needed. The second is the General Directorate of Social Aid and Solidarity, also attached to the Prime Minister's office (see section 6.1). The Directorate's main aim is to provide social assistance, health care and education services to people in lower socioeconomic brackets, particularly vulnerable groups. Health assistance includes provision of medical devices to the poor and disabled. Before the extension of Green Card coverage, the Directorate met the costs of outpatient and prescription charges for the poor. The Directorate also provides conditional in-cash benefits to mothers of pre-school age children for routine health check-ups.

Home care is in its infancy in Turkey. The Ministry of Health issued a regulation in 2005 outlining the rules and principles for providing home care services in the private sector, including the tasks and responsibilities of home care service providers and inspection rules. Currently, home care services are not covered by social security funds; however, the Society for the Protection of Children, funded by the state general budget, makes payments to disabled dependants in order for them to purchase home care services. In addition, the Society monitors whether or not disabled dependants are provided with the appropriate level of home care services and whether they have access to the services they need.

There is no clearly defined cooperation between secondary care and social care providers and, consequently, the link between the two sectors is very weak. According to the Regulation on the Administration of Inpatient Health Care Facilities 1983, hospitals can have a social worker within their facilities. Social workers should have a university degree in social services and work in collaboration with the chief physician of the hospital. Hospital-based social workers mainly coordinate the social services needed by patients with other related members of the health care team, assess the financial status of patients and collect information for the purposes of granting free or discounted care, organize events to increase patient morale and manage volunteers in the facility. They also coordinate the needs of discharged patients who need continued social care with local agencies. In 2008, 401 social workers worked in Ministry of Health hospitals (Akdağ, 2009).

The integration of primary and secondary care providers is also weak, mainly because of the lack of a referral system. One of the most important dimensions of the HTP, the family practitioner scheme, is designed to meet global standards for primary care. The longer-term plan is to reintroduce the gatekeeper/referral system through the family practitioner scheme. Family practitioners will then be expected to refer patients to secondary and tertiary care and to follow up on patients who have undergone procedures. Currently, tests undertaken at the primary level are often also taken at the secondary level and medical records do not follow the patient. Under the family practitioner scheme, the exchange of information will be a prerequisite.

6.4.1 Day care

The concept of day care is relatively new in Turkey and is mainly provided in hospitals and family health centres. The HIG defines day care as care provided in health care facilities within 24 hours without the application of inpatient rules. The following procedures are classified under day care: chemotherapy, radiotherapy (excluding planning of radiotherapy), all diagnostic and small surgical operations not requiring admission as an inpatient, dialysis and intravenous drug treatments. Day hospitals are facilities providing outpatient care (examination, diagnosis, treatment and medical care) in more than one medical branch on a daily basis. Such hospitals have a minimum of five monitoring beds. Day hospitals either form part of a normal public or private hospital functioning 24 hours/7 days a week or are coordinated by such hospitals. Currently, there are no available data on the proportion of day care undertaken in Turkey. Day-care services are reimbursed by social health insurance.

The SHÇEK provides day care for the disabled. There are family consultancy services attached to this organization and they provide both rehabilitative care to disabled people and counselling services to families.

6.5 Emergency care

The Decree on Emergency Health Care Services (Ministry of Health, 2000) regulates emergency care services. Emergency care is defined as all health care services provided by a health care team trained for this purpose in cases of accident, disease and injury. Emergency care is organized at the ministerial, regional and provincial level. At each of these levels, committees determine the principles of emergency care, organize accident and emergency training and coordinate the activities of various organizations. There is a command and

control centre in each province backed up by a number of stations scattered within the geographical area. In an emergency, citizens call 112 and the command and control centre coordinates the response to the emergency call. The centre assesses emergency calls, prioritizes cases, directs necessary teams to the location and keeps records of all services delivered.

There are three types of ambulance station. Type A stations provide emergency care 24 hours a day and can contain more than one ambulance, teamed with permanent staff. Within type A, there are stations with a physician (type A1) and without a physician (type A2) in the team. Type B stations are integrated into either hospitals or primary health care units. They provide continuous ambulance services, and team members in these stations are permanent staff of the facility (type B1 is attached to a hospital; type B2 is attached to a family health centre). Type C stations provide services only within determined times of the day. When a call is received, an ambulance is directed to the location and the patient is transported to the nearest or most convenient health care facility. Hospitals also have emergency departments that patients can access directly to receive emergency care.

6.6 Pharmaceutical care

Pharmaceutical care has been the most fiercely debated component of health care in Turkey in recent years. The main reason behind this attention is the large share of pharmaceutical spending within the total health care expenditure, and the government's drive to curtail public expenditure. The level of pharmaceutical expenditure will be discussed in detail below. Tatar (2007) provides a detailed account of the Turkish pharmaceutical sector. There are various authorities shaping the different aspects of pharmaceutical policy. The General Directorate of Pharmaceuticals and Pharmacy of the Ministry of Health is the main body responsible for market authorization, pricing, classification and regulation of pharmaceuticals at various levels. The Law on Pharmaceuticals and Medical Preparations (1928) regulates medicinal products, with appropriate updates to meet contemporary developments.

As outlined in Chapters 2 and 3, both the Ministry of Finance and the SSI determine the reimbursement rules, but more recently the SSI, as the main purchaser of pharmaceuticals since the implementation of the GHIS, has taken the lead. The HIG, which the SSI issues annually, identifies the pharmaceuticals that are subject to reimbursement, and the list is published on its web site.

Market authorization is the responsibility of the General Directorate of Pharmaceuticals and Pharmacy within the Ministry of Health, assisted by a number of commissions made up of academics, pharmacologists, clinicians and other experts. Only pharmaceutical companies located in Turkey can apply for a market authorization, and foreign importers make an application for their products through a resident company or a Turkish brand of their own company. The company prepares a dossier with information on safety, efficacy, bioequivalence (for generics), bioavailability (for originals), active ingredient information and the Characteristics of Pharmaceutical Product form, and include information about the authorization status of the drug in other countries. Application documents are first assessed by the Advisory Committee for Authorization of Medicinal Products for Human Use and then by the Advisory Commission for Technology and Pharmacology. Price setting is a part of the marketing authorization process and takes place after the assessment has been conducted by the above committees. For both generics and originals, the pricing procedures (outlined below) and assessments for bioequivalence and bioavailability may occur concurrently or consecutively. After assessment by all the committees, the product is authorized by the Ministry of Health to be placed on the market and a sales permit is issued.

The Turkish Patent Law, valid retrospectively from 1 January 1995, was endorsed on 1 January 1999. This legislation does not contain any provisions for marketing exclusivity or a Supplementary Protection Certificate. Issues around intellectual property rights protection were the main area of conflict between the government and pharmaceutical companies in the early 2000s. After long negotiations and consultations, on 19 January 2005, the Ministry of Health introduced a six-year period of marketing exclusivity under certain conditions. However, the protection brought by this arrangement covers only products registered from 1 January 2005. The protection term begins from the first registration date in any of the EU Customs Union Zone countries and the protection term is limited to the patent terms of the concerned molecule. Marketing exclusivity also covers molecules registered from 1 January 2001 if there is no generic in the Turkish market or no generic application was made as of 31 December 2004 for these molecules.

Direct-to-consumer advertising of prescription and non-prescription drugs is not permitted in Turkey. Companies can only advertise the availability of their products to physicians. Similarly, mail order/internet pharmacies are not permitted.

Like marketing authorizations, the Ministry of Health is the only pricing authority in Turkey, and free pricing is not allowed. There is a pricing committee working within the pricing department of the General Directorate of Pharmaceuticals and Pharmacy. Turkey changed its pricing system from a cost-plus approach to external price referencing in 2004. Pricing decisions are made at the manufacturer level, with wholesaler and pharmacy mark-ups and value added tax (VAT) added later. The prices of original products are determined by using a basket of five EU countries (France, Greece, Italy, Portugal and Spain). The lowest ex-factory price in one of these countries forms the maximum ex-factory price of an original product. If there is no ex-factory price for a product in the reference countries, then the maximum price of the product is the sale price to the wholesaler, calculated by deducting any mark-ups and VAT from the pharmacy retail price. In cases where the ex-factory price of a product is lower in the country from which it is imported, the price in the country of importation is taken as a reference. If the product is authorized and available only in one of the reference countries, the ex-factory price in that country is taken as a reference. In cases where the product is not authorized in any of the reference countries, then the cheapest ex-factory price in the EU is taken as a reference. If the product is not authorized in any of the EU Member States, then the original country of importation is taken as a reference. For generics, prices are set at 80% of the original product and these prices cannot be higher than the original's reference price or the highest price of the equivalent generic in the market. The pharmacy retail price is determined by adding mark-ups for the wholesaler and pharmacies plus VAT (8%).

Wholesaler and pharmacy remunerations are made by tapering mark-ups with strict margins. Accordingly, for the wholesaler, the maximum mark-up as a percentage of ex-factory price is 9% for drugs with an ex-factory price that is less than 10 TL, 8% for drugs between 10 and 50 TL, 7% for drugs between 50 and 100 TL, 4% for drugs between 100 and 200 TL and 2% for drugs that have an ex-factory price of more than 200 TL. Pharmacy mark-ups are 25%, 25%, 25%, 16% and 12%, respectively.

There are also in-cash and in-kind commercial and statutory discounts within the system. In-kind discounts are made both from manufacturers to wholesalers and from wholesalers to pharmacies as free goods. In-cash discounts are important, particularly for injecting competitiveness into hospital procurements. There is no clawback system that returns some of these benefits to the public sector.

A public sector statutory discount is set at the time of pricing both for manufacturers and pharmacies. Regardless of whether products are originals or generics, the discount rate is set at 11% for pharmaceuticals. However, a 4% discount on the retail sale price (including VAT) is applied to pharmaceuticals that cost 3.56 TL (€ 1.70) or less at retail sale. A pharmacy discount is also calculated on this price. A pharmacy discount is applied on the price determined after the manufacturer's discount. Pharmacy discounts are calculated based on the previous year's sales revenue excluding VAT. The rates are 0.5% for pharmacies with annual revenue up to 350 000 TL (€ 168 000), 1% for annual revenue of 350 001–600 000 TL (€ 168 000–287 000), 1.5% for annual revenue of 600 001–900 000 TL (€ 287 000–431 000) and 2% for pharmacies with annual revenue over 900 000 TL (€ 431 000). Companies can apply to the Reimbursement Commission for further reductions.

Turkey has a positive list for the reimbursement of pharmaceuticals. There is an interministerial Reimbursement Committee under the SSI that sets reimbursement principles and lists. Until 2008, these principles and the operation of the committee were not transparent to all stakeholders, but there have been considerable improvements in this area. There is a subcommittee (the Medical and Economic Evaluation Committee) that provides technical support to the main reimbursement committee. More recently, pharmacoeconomic analysis has become a prerequisite for companies applying for reimbursement.

The reimbursement price differs from the market price of the product. In this system, all pharmaceuticals in the positive list are grouped into pharmaceutical equivalent groups by a technical committee. Currently, there are 333 groups. Equivalent groups are based on price comparisons between similar dosages with the same active ingredients for the same indication. The reimbursement price is calculated as the lowest price in equivalent groups and the GHIS reimburses the cheapest price plus 15%. If patients prefer to purchase a prescribed but not reimbursed pharmaceutical, they have to pay the difference themselves. Doctors can prescribe any pharmaceutical regardless of its reimbursement status; however, a pharmacist can substitute it with a reimbursable drug without the physician's approval. Again, where there is any difference in cost between the chosen pharmaceutical and the reimbursable price, the patient pays the difference. There are co-payments and exemptions in the reimbursement system. For active workers, the co-payment is 20% of the prescription charge while for retired people, this rate is 10%. Green Card holders also pay a 20% co-payment. However, if the patient has a chronic disease such as diabetes, hypertension or cancer, the patient receives full reimbursement.

Improving cost-effective consumption of pharmaceuticals has long been on the Ministry of Health agenda. In 1991, the number of pharmaceuticals in one prescription was limited to a maximum of five items; a 10-day treatment period per prescription was introduced and a negative list was established. In 2001, the number of items per prescription was reduced to four. In addition, the 2004 Budget Implementation Guide introduced special restrictions on prescription practices for certain drugs. Some pharmaceuticals were allowed to be prescribed only by specialists under certain conditions. Doctors are not obliged to prescribe generically and must prescribe by brand. Currently, there are no active, organized and systematic attempts to promote generics among doctors, patients and pharmacists. However, the reimbursement policy described above allows for generic substitution by pharmacists.

Since 2001, the Ministry of Health has promoted several training activities under the heading "rational use of drugs". Currently, this topic is also included in the curricula of 18 medical faculties. In addition, the Ministry of Health published the *Diagnosis and Treatment Guidelines for Primary Care* in 2003 (Ministry of Health, 2003a). As discussed in Chapter 4, HTA is in its infancy in Turkey and hence, discussions on this "fourth hurdle" are quite new. Pharmacoeconomics, although discussed extensively in all quarters, is also a new subject. The SSI now requires pharmacoeconomic assessment reports for all new drugs to be reimbursed within the health care system. However, there are some concerns about current human and data capacities to undertake such analyses.

As discussed in Chapter 3, the most accurate data on health care expenditure in Turkey goes back to the 1999 and 2000 NHA studies. In 2000, 25% of total current health expenditure was for pharmaceuticals and 64% of this expenditure was from public sources. Compared with OECD countries, Turkey seems to spend more resources on pharmaceuticals. However, country-specific conditions provide evidence that this expenditure is not "out of control" (Liu Çelik & Şahin, 2005; Tatar, 2007). Although the NHA study was not repeated in subsequent years, TURKSTAT has found similar results in ensuing years. Table 6.2 provides data on drug expenditure for outpatient treatment.

Table 6.2
Drug expenditure for outpatient treatment in Turkey, 1999–2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Health expenditure per person (US$)	95	110	133	144	149	159	165	148	174	189
Public drug expenditure (% public THE)	25.6	27.3	28.5	30.2	29.2	28.6	29.1	36.1	34.6	32.8
Public drug expenditure (% GNP)	1.0	1.1	1.5	1.6	1.6	1.6	1.5	1.4	1.4	1.5
Public drug expenditure (% total drug expenditure)	57.3	61.9	67.6	71.3	71.9	72.2	70.9	73.6	74.4	78.5
OOP payments (% THE)	9.9	9.2	7.9	7.1	6.7	6.5	6.9	8.4	7.6	6.0

Sources: Ministry of Health RSHCP School of Public Health, 2006a, 2009 (unpublished report).
Note: THE: total health expenditure.

The main funding source for pharmaceuticals is the social health insurance system. However, pharmaceuticals also have the highest share in OOP expenditure. Based on the NHA Household Survey, Liu et al. (2005) found that 41.4% of total OOP expenditure was for pharmaceuticals in 2003. There is a share of co-payments in this figure but a considerable amount is attributable to self-medication. Self-medication used to be very common in Turkey. The NHA Household Survey in 2003 revealed that 28% of the Turkish population purchased pharmaceuticals directly from pharmacies when they felt in need of care (Ministry of Health RSHCP School of Public Health, 2006b). A similar conclusion was reached by a study on informal payments (Tatar et al., 2007). The impact of policy changes on this practice is not known. Under normal conditions, this rate would be expected to decrease with radical policy changes improving access to health services and prescribed medicines.

Pharmaceuticals are dispensed only through private pharmacies. The distribution channel is through manufacturers to wholesalers and pharmacies. As of 2005, there were 491 wholesalers and 22 600 pharmacies in the market. There is a high level of competition among pharmacies, but 70% of the market is represented by two wholesalers. Hospitals have their own pharmacies for inpatients. Only Turkish citizens with a diploma from a Faculty of Pharmacy can open a pharmacy. A pharmacist can open only one pharmacy and pharmacy chains are not allowed. There is no explicit policy regulating location or the geographical distribution of pharmacies.

A defined daily dose system is not implemented in Turkey. According to IMS statistics in 2008, antimicrobial medicines occupied first place in usage, with a share of 15%, followed by cardiovascular medicines (9%) (IMS, 2009).

Turkey manufactures pharmaceuticals, with approximately 300 companies operating in the country. Of these, 52 are international. Eleven of these international companies manufacture products in Turkey and the rest are importers. The largest 20 companies control over 75% of the market. National companies are producers of generics. In 2005, there were 138 active ingredients and 3667 products in different forms (approximately 7000) (Kanavos, Costa-Fonta & Ustel, 2005). Generics and domestic products are larger in volume but smaller in value.

In June 2005, Hacettepe University, based on a protocol signed with the Ministry of Finance, Ministry of Health and the Ministry of Labour and Social Security, started a project on devising reimbursement methods for health care services, activity-based budgeting and medical supplies management on behalf of the government. The project, which aims to develop financing methods to control health care costs, has three components. First, the payment structure for hospital services will be revised to a DRG-based payment system. This component has begun implementation. The second component involves a review of the HIG's fee schedule. The third component focuses on developing an infrastructure for pharmaceuticals and medical supplies management. The aim of this component is to establish an information system that facilitates effective management of pharmaceuticals and medical supplies.[35]

6.7 Rehabilitation/intermediate care

Rehabilitative care for patients falls under the responsibility of the Ministry of Health. In 2006, the Ministry had 11 physiotherapy and rehabilitation hospitals, with 10 in 2010 (Ministry of Health, 2011a). In addition, there are physiotherapy and rehabilitation wards in general hospitals. Rehabilitation services for the elderly, disabled and children are the responsibility of SHÇEK, a unit attached directly to the office of the Prime Ministry. More detailed information about this institution is presented in section 6.8. The institution provides rehabilitative care through rehabilitation centres and rest homes. In 2010, there were 72 rehabilitation centres and 97 rest homes scattered around the country (SHÇEK, 2010).

[35] Although the plan was to launch this information system in 2011, the initiative is currently on hold.

6.8 Long-term care

SHÇEK is responsible for planning, managing and supervising systematic and integrated services at local and national level to meet the needs of special groups with economic and social requirements (families, children, the disabled, the elderly and others) (SHÇEK, 2010).

As in other countries, the number of elderly people is growing in Turkey. As a result of rapid changes in the social structure, elderly people have an increasing need for state support and professional services. This need is met by both public and private agencies. However, it should be noted here that traditional family relationships (and ties with other relatives) are still very strong in Turkey, and that the majority of long-term care is still undertaken by family members at home.

Improving services and the development of new services for the elderly are based on three regulations: (1) the Regulation on Nursing Homes, Care and Rehabilitation Centres for Elderly People, (2) the Regulation on Private Nursing Homes and Care Centres for the Elderly, and (3) the Regulation on the Organization and Operation Principles of Nursing Homes to be Established in Public Agencies. The first regulation covers nursing homes, care and rehabilitation centres for the elderly and social services agencies affiliated with SHÇEK. In accordance with the second regulation, private nursing homes take care of people aged over 55 who are in need of social and/or economic assistance and need specialized aid and support. The third regulation aims to identify establishment, operation, supervision and inspection principles for such facilities and to ensure the provision of services such as social, medical, cultural and preventive health services.

As of May 2011, SHÇEK had 98 nursing homes, with a capacity of 9527 people. Private nursing homes are owned by foundations and associations, minorities and individuals. Foundations and associations own 32 nursing homes, with a capacity of 2459; minorities own seven nursing homes, with a capacity of 911, and there are 121 private nursing homes, with a capacity of 4632. Apart from these, there are also nursing homes that are affiliated with other public agencies. Other ministries have six affiliated nursing homes, with a capacity of 2039, while municipalities have 22 nursing homes serving 2104 people (SHÇEK, 2011).

The Regulation on Day Care to be Given within Care Centres for the Elderly and Home Care Services[36] (No. 26960) aims to provide day-care services for the elderly in good health, who live alone or with their families, and for the elderly who suffer from conditions such as dementia or Alzheimer's disease, with an emphasis on improving their living environment and allowing them to enjoy leisure time activities; receive assistance for their social, psychological and health needs; and access professional counselling services. As mentioned in the Activity Plan (SHÇEK, 2009a), five nursing homes for the elderly served about 940 people in total in 2009. In addition, a small-scale, home care scheme was piloted in 2009 in İzmir province and 15 elderly people receive home care at present. The Regulation also introduced home care services for elderly people who are in good mental and physical health, not needing medical care, but who need social support from family members or other relatives. For such people, home care services will provide support to promote good living conditions at home and to assist with daily tasks.

Within the framework of the *International Plan of Action on Aging* (United Nations, 1982), a national committee was established by various representatives of public agencies (including the Ministry of Health, Ministry of Finance, Ministry of Labour and Social Security, local administrations), NGOs and a university (Hacettepe University) under the coordination of SHÇEK and the SPO. This committee conducted studies on the "Status of elderly people in Turkey" and a "National plan of action on aging" covering issues such as the promotion of healthy ageing, creation of a safe, facilitating and supportive environment, and the implementation and supervision of national projects and programmes (see www.shcek.gov.tr).

There have been a number of initiatives over the last few years to develop the quality of services in this area. The Ministry of Health developed diagnosis and treatment guidelines for elderly people within the scope of implementing the family practitioner scheme. In addition, trainers' guidelines for geriatric health have been prepared for trainers to be assigned to public training programmes, and these guidelines will be published soon. A geriatric health instrument kit, which was developed by WHO for use in primary health care services, is being translated and will be provided to family physicians. Inspections are also being carried out at hospitals and population health centres to ensure that facilities are able to offer special outpatient health care services to elderly people. The Ministry of Health is continuing its efforts to issue a circular on positive discrimination for elderly people and has prepared a regulation that primarily

[36] *Official Gazette*, 7 August 2008.

focuses on geriatric health. Finally, the "Elderly platform" was established by 33 participating NGOs on 16 January 2008. The platform aims to conduct research and to provide services and education on age-related issues. As an NGO, the platform also aims to increase awareness of age-related issues, influence public policies and coordinate activities of other related organizations.

6.9 Services for informal or unpaid carers

There are no support services or policies for informal caregivers in Turkey. However, there are certain obligations for family members to look after dependants in their families.

According to the Turkish Civil Code, all citizens are liable to provide a living allowance (assistance) to their children, parents and siblings who would otherwise be impoverished. The level of the assistance is decided according to the social and economic situation of the dependants in question. The level of living allowance is also determined by considering the income level of the payer and the needs of the payee. The Code also states that citizens who are in need of care will be cared for by relevant agencies and that these agencies may request the relatives responsible to cover the costs and expenses of such care. According to the Turkish Penal Code, a citizen abandoning a person who is incapable of self-care because of old age or disease (and, therefore, is in need of protection), will be imprisoned for a period of three months to two years if the neglected person becomes ill, injured or dies as a result of abandonment. Similarly, a citizen who does not help a person incapable of self-care because of old age, disease, injury and/or any other reasons depending on his/her socioeconomic status, or who does not report the case to the responsible authorities, will be imprisoned for up to one year or be given a fine. If a citizen does not help or report a person who is old, ill, injured or in a dependent condition, and if this person dies for any of these reasons, then the citizen can be imprisoned for a period of one to three years.

According to TURKSTAT, 6.8% of the total population was aged 65 or over in 2008. When the number of available places in rest homes is considered (total capacity of 20 970), there was only 1 bed per 232 people in the 65+ age group in 2008. SHÇEK operates three bodies: care and rehabilitation centres, which produce inpatient care and provide disabled persons with services; family counselling and rehabilitation centres, which provide day services; and the provincial social services directorates, which represent the general directorate in provinces and which ensure coordination among institutions. As of August

2009, SHÇEK offered service to 192 419 disabled persons, 186 457 of whom received home care by their families; 4039 received care in the official care and rehabilitation centres, 417 in family counselling and rehabilitation centres and 1506 in private care centres (SHÇEK, 2009b). Given the lack of institutional capacity overall, one can easily estimate that a considerable amount of services are provided by informal carers.

6.10 Palliative care

Palliative care is another dimension of the health care system without a national policy or guidelines in Turkey. Few oncology teaching hospitals have patient-specific palliative care training in their curricula. There are no palliative care units in health care facilities. Similarly, the "hospice" concept is very new and there is no legal framework covering this type of organization.

6.11 Mental health care

In terms of the burden of mental health diseases, mental health is a major public health problem in Turkey. According to the results of the Burden of Disease study completed in 2004, in terms of disability-adjusted life-years, neuropsychiatric diseases came second after cardiovascular diseases, with unipolar depressive disorders causing the most years lost owing to disability (Ministry of Health & Başkent University, 2004). This illustrates that, although Turkey is focusing more attention on cardiovascular diseases and cancer, mental health is still a major public health problem that requires more attention and resources. Furthermore, because of the lack of reliable data, the full extent of mental health disorders in Turkey is not known.

Turkey has both mental health hospitals and mental health wards in general and teaching hospitals. In total, there were 12 mental health hospitals in 2009 across 81 provinces, acting as regional hospitals providing mental health services across the regions. Although general hospitals provide psychiatric services or mental health services, there are not enough beds in general hospitals to adequately address need. In mental health hospitals there were 4692 beds in Turkey in 2010 (Ministry of Health, 2011a, 2011b). There were 57 008 mental health inpatients in 2010 and the ratio of psychiatric beds per 10 000 population was 0.6 for the same year. There was one private psychiatric hospital with a total of 50 beds in 2007. Considering the extent of mental health problems

in the country, this figure is very low, illustrating the lack of resources in Turkey. There was one psychiatrist, one psychologist and one social worker per 100 000 individuals in Turkey in 2006 (Ministry of Health, 2006a). According to data from January 2009, the Ministry of Health deployed 625 psychiatrists; four of them were assigned to primary health care services while the others were assigned to inpatient health care facilities (Ministry of Health General Directorate of Personnel, unpublished data 2009). For the same year, there were 272 psychiatrists practising at university hospitals and 475 practising in the private sector. There were 142 child psychiatrists, 47 of whom work under the Ministry of Health, with 80 practising at university hospitals and 15 in the private sector. There were 998 psychologists and 517 social workers in Turkey.

Turkey has highly institutionalized care, with large hospitals generally acting as places of shelter. In 2006, the Ministry of Health published the National Mental Health Policy Document, which emphasized modern approaches to mental health policy based on the seven modules recommended by WHO (Ministry of Health, 2006a). In 2011, the National Mental Health Action Plan was launched, which reiterated a commitment to offer community-based mental health services. As of September 2011, 26 community-based mental health centres provide services in 24 provinces across Turkey, with plans for a further 236 to be established by the end of 2016. There are also sporadic programmes in place, but these are on a project basis supported by a restricted number of NGOs. This inevitably causes sustainability problems when the NGO withdraws its support from the programme or funding runs out. Moreover, Turkey does not have a strong framework for providing primary care, making it difficult for psychiatric care and mental health issues to be tackled at this level of the health care system. Mental health preventive and promotion programmes do not really exist. Therefore, it could be said that a shift of paradigm is needed to improve the country's mental health care sector, although the difficulties of implementing relevant new policies should not be underestimated.

Turkey does not have a mental health care law per se but provisions relating to mental health issues exist within different legal arrangements such as the Turkish Criminal Code and the Turkish Civil Code. Turkey's first mental health policy document was published in 2006 (Ministry of Health, 2006a), describing how mental health care services should be provided in the future. The policy document makes various promises about improving community care and deinstitutionalization, but no concrete attempts have been made to this end since the policy's publication. The policy document also includes several strategies on financing mental health care services.

6.12 Dental care

Both public and private providers offer dental care in Turkey. Dentists generally practise in their own offices in the private sector, but there are also Ministry of Health dental care clinics. The costs of dental care services are identified annually by the HIG, and a minimum wage scale for the private sector is also determined by the Turkish Dentists Association with Ministry of Health approval. In Turkey, the annual consumption of toothpaste per capita is 85–90 g, and tooth brush consumption is one-third per capita, indicating that there is room for improvement in terms of preventive measures.

Dental care services in the public sector are provided by family health centres, general and teaching hospitals, dental and oral health centres and dental care hospitals. The private sector is mainly organized as private offices or clinics and as units in hospitals. Dental care services are largely financed by the Ministry of Finance, the GHIS, private insurance companies and OOP payments. Services by private dentists are reimbursed by the GHIS if certain conditions, clearly defined in the HIG, are met. The reimbursement price in this case is the public price for the same service. A member of SSI should first contact a public facility to obtain dental treatment. If the public facility refers the patient to a private dentist then the patient is allowed to obtain the service from the private sector. The private sector dentist who carries out any referred work should clearly report on the treatments that have been undertaken and the public sector referring dentist should certify that the treatment was completed properly to claim reimbursement from the SSI.

Chief physicians in public health care facilities can refer patients to self-employed dentists in districts where dentists are not available in public facilities. In the case of such a referral, a representative of the chamber of dentists in that region should confirm that treatment has been completed properly. As fees are based on the public sector fees, usually a patient referred to a private dentist pays the difference between the public and private sector fees.

6.13 Complementary and alternative medicine

Complementary and alternative medicine practices do not have a long history in Turkey. The medical establishment is still very suspicious and resistant to this approach and the area is largely left to the personal views of patients and physicians. Among various complementary and alternative medicine systems, acupuncture has always been the most popular alternative medicine

option in Turkey. In 1988, the Higher Health Council convened and discussed complementary and alternative medicine methods and decided that acupuncture should have a legal framework and should be carried out in a scientific manner. The Ministry of Health established a technical committee in collaboration with universities and the Council defined the rules and principles of acupuncture applications. These rules were updated in 2002 and 2004.

Alternative medicine options other than acupuncture are trying to find a place in the Turkish health care system. Homeopathic products, permitted by the Ministry of Health, are sold in pharmacies but there are no established homeopaths to guide patients on the use of these remedies. All these methods are accepted as complementary to modern medicine and, therefore, are regarded as supportive applications. Some university departments have introduced alternative medicine systems to their curricula. For example, some teaching hospitals teach acupuncture as a supplementary module to interested doctors, and phototherapy and aromatherapy have been introduced into the curricula of some university pharmacy departments.

There is a licensing or certification process only for acupuncture. By law, acupuncturists should have a certificate awarded by physicians and the Ministry of Health. Professionals who are trained at national (certified by the Ministry of Health) or international training facilities should certify the programmes they attended. A committee within the Ministry of Health evaluates these applications and if the course and contents are accepted, an acupuncturist's licence is awarded. The general acupuncture training curriculum takes 480 hours, of which 160 hours of total teaching hours are practical learning. In order to obtain a licence, an acupuncturist should work on at least 30 different cases. Currently, there are approximately 400 physicians with an acupuncture certificate in Turkey and 60% of these are specialists of modern medicine branches. All complementary and alternative medicine practices are paid out of pocket as the GHIS does not reimburse these services.

6.14 Health care for specific populations

In Turkey, basic health care services – together with other services that are provided particularly for vulnerable groups and lower socioeconomic groups – are based on the understanding that Turkey is a "social state". Transitional immigrants, who use Turkey as a bridge to Europe or other developed countries, constitute an example of such groups. The Ministry of Health, with the Ministry of the Interior, undertakes activities within the framework

of the National Work Force to Fight Human Trafficking.[37] In parallel, health care services are free for those covered by specific legislation. According to this legislation, individuals who have been identified as victims of human trafficking and who require medical treatment should be transferred to health care institutions to receive treatment free of charge (CARIM, 2005).[38] In 2005, the Ministry of Health organized a series of meetings with related health care personnel in the provinces and several NGO representatives to establish procedural arrangements to provide health care services free of charge to people discovered to be victims of human trafficking during their stay in Turkey.

The second category under the definition of vulnerable group is homeless children, which has become an important issue in Turkey since the late 1990s. There have been some attempts by ministries, municipalities and NGOs to provide a better environment for these children. The health care costs of children who live and/or work on the street and do not have any social insurance are funded by SHÇEK. There are also "children's and youth centres" providing crime prevention and rehabilitative services for homeless children. These centres generally focus on children who have already committed a crime or are under risk of being involved in crime.

In addition, children under the age of 18 benefit from health care services under the GHIS. Those aged over 65 have access to state-provided health care services through legislation that grants a monthly allowance to this group, the poor and those who have no family members who can provide support, while eligible people on low incomes are provided with health services free of charge through the Green Card Scheme.

[37] Issued through a Cabinet Decision in 2006.

[38] Resolution No. 2003/6565 of the Council of Ministers, 5 December, 2003.