Financing of Health Care Services and Analysis of Health Expenditures in Turkey

Between 2002 and 2013

Mehmet ATASEVER

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Foreword by the Minister

Mehmet MUEZZINOGLU, M.D.
Minister of Health

Health care services have always been regarded as a high-priority issue for the AK Party Governments. In this period, Turkey has made a quantum leap in health and health care services. We have achieved significant success and realized an enormous transformation. Improving the health indicators of Turkey, we have set a global example of success. We have demonstrated that we could overcome any barriers thanks to this enormous transformation. The book, which mirrors the efforts and actions from 2002 to 2013, provides in-depth insight into the resources allocated for health care services and the efforts spared for health service provision so far.

Health care services have taken among the biggest success stories in terms of public services in this period. Without any prejudice to this high level of success, we are continuing our efforts so that Turkey is included in the most advanced countries in the world, pertaining to the use of technology, supply of pharmaceutical industry and availability of well-trained and competent health labor force.

On the occasion of presenting this book to the audience, I would like to extend my most sincere thanks to health employees, primarily, and to all others who invest their time and energy in provision of such quality services in health care.

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Conceptual definitions of the concepts and terms used in this book are explained in the following:

HEALTH EXPENDITURES BY FINANCING AGENTS: Described as the classification of funding resources which are required to finance health care services.

Public Health Expenditures: The amount of health spending covered by social security agencies, central government and other government bodies with the aim of funding health care services.

- **Social Security Institution (SSI) Expenditures:** Data prior to 2007 refer to the sum of all spending covered by the social security agencies such as the SSK (Social Insurance Organization), BAG-KUR (Self-Employed People's Retirement Fund) and Emekli Sandigi or briefly ES (Government Employees' Retirement Fund). Data after 2007 refer to the spending of the SSI. Also, health expenditures are included for government employees since 2010 and for the Green Card beneficiaries since 2012.

  SSK (Social Insurance Organization/SIO) Expenditures on Health: Cover the amount spent by the SIO for health care services before the SIO was devolved to the SSI.

  BAG-KUR (Self-Employed People's Retirement Fund) Expenditures on Health: Cover the amount spent by the BAG-KUR for health care services before BAG-KUR was devolved to the SSI.

  Emekli Sandigi/ES (Government Employees' Retirement Fund) Expenditures on Health: Cover the amount spent by Emekli Sandigi for health care services before Emekli Sandigi was devolved to the SSI.

- **Central Government Expenditures on Health:** Comprised of health spending from the general budget, private budget and regulatory and supervisory bodies' budgets for health care financing according to the Central Government Budget Law. As of late 2013, pertaining to treatment costs of rank and files, the TGNA members, refugees, detainees and prisoners, individuals to use health care services as ordered by bilateral agreements, individuals who are assigned with temporary or permanent cross-border service duties and their dependents, service bills which are not paid by the SSI are still paid from the central government budget. Treatment costs of individuals other than the afore-mentioned have been devolved to the SSI.

  Government Employees' Expenditures on Health: Cover the amount spent by public administrations to meet health care needs of government employees before devolution to the SSI.

  Green Card Expenditures: Comprised of health spending from the Green Card Budget for health care financing for citizens who were not covered by any insurance scheme before devolution to the SSI and not capable to meet their health care expenses, either.

Ministry of Health (MoH) Expenditures on Health: Health spending made from the general budget or private budget by the Ministry of Health (MoH) and its affiliated bodies for health service function (function code-07).

Universities' Expenditures on Health: Health spending made from private budget funds by university-affiliated medical schools, dental schools, health research centers and district outpatient clinics for health service function (function code-07). Salaries paid from the private budget by medical and dental schools are not included since they are classified as training costs.

Other Public Expenditures on Health: Cover health spending from the Social Assistance and Solidarity Foundation, public economic enterprises, military hospitals etc. for health care services.

- **Local Government and Other Public Institutions' and Organizations' Expenditures on Health:** Comprised of health spending from public institutions' and organizations' budgets other than local governments, special provincial administrations, social security agencies and central government. Health expenses of the staff employed in such organizations have been paid by the SSI since 2010.

Private Sector Expenditures on Health: Cover health spending from households, private health insurance companies, private social security funds, non-profit organizations serving households, foundations-owned universities, and organizations under the scope of privatization and other enterprises.

- **Out-of-Pocket Expenditures on Health:** Comprised of direct spending on health from households for cost-sharing, copayment, self-care and other expenditures. Refer to expenditures arising from direct outlay for health care services by health service users.

- **Other Private Sector Expenditures on Health:** Cover health spending from private insurance companies, non-profit private sector organizations and enterprises for health care services.

EXPENDITURES ON HEALTH BY SERVICE PROVIDERS: Described as the classification of health spending from financing agents by service units either producing or providing health care goods/ services.

Ministry of Health (MoH) Facilities' Expenditures on Health: Comprised of health spending from the MoH or its affiliated agencies and affiliated health care facilities. The SSK hospitals' spending before devolution to the MoH are also included.

University Health Care Facilities' Expenditures on Health: Comprised of health spending from university-affiliated medical schools, dental schools, health research centers and district outpatient clinics for health care services. Salaries paid from the private budget by medical and dental schools are not included since they are classified as training costs.

Private Health Care Facilities' Expenditures on Health: Comprised of health spending from private hospitals including foundations-owned hospitals, medical centers, outpatient clinics, private practices and other private health care facilities.

Retail Pharmaceutical Expenditures (Private Pharmacies): Refer to expenditures on health for pharmaceuticals provided by retail sales. Inpatient pharmaceutical spending is not included.

Other Expenditures on Health: Include health spending from health care financing agents for optical, medical device, temporary incapacity spending and allowances received to benefit from health care services etc. temporary incapacity and allowances are not included in other expenditures by the SSI. Allowances are not included in other expenditures by BAG-KUR.

EXPENDITURES ON HEALTH BY FUNCTIONS: Described as the classification of expenditures on health by service functions for which they are used.

Expenditures on Health for Public Health and Family Medicine Services: Refer to expenditures on health aimed at taking measures for individuals and the environment so that individual and community health is protected and promoted. Cover public spending on health care services such as family medicine, immunization, public hygiene, maternal and child care, and population health services etc.

Expenditures on 112 Emergency Care Services: Cover any kind of spending on land, air or marine ambulances, which are specifically equipped to transfer medical care needers to health care facilities and owned or managed by the MoH, in addition to all other current and investment expenditures required for this ambulance service.

Expenditures on Hospital Services: Cover health expenditures on secondary and tertiary care hospitals including outpatient clinical care and health spending for private outpatient clinics, medical centers, medical specialty centers and private practices.

Expenditures on Oral and Dental Care Services: Cover oral and dental care spending from the MoH-affiliated primary health care facilities, oral and dental care centers, hospital dentistry clinics, dentistry schools at public and foundation universities, dentistry clinics at private hospitals and private dental practices.

Expenditures on Retail Pharmaceutical Services: Refer to spending on retail pharmaceutical sales. Inpatient pharmaceutical costs are not included. Cover expenditures undertaken by health service providers for management, planning, organization, coordination and inspection functions relevant to all health care facilities including central administrative units and primary health care facilities.

Expenditures on Administrative Services: Cover spending on management, planning, organization, coordination and supervision in health care services in public and private health care facilities including the central organization and primary care facilities.

Expenditures on Other Health Care Services: Refer to expenditures on health care services which fall within health accounts but cannot be put into a specific category due to inadequate data. Include spending on miscellaneous health care services which are either exceptional to basic functions (such as public health and family medicine services, hospital services and pharmaceutical services etc.) or non-classified (such as travel and/or accommodation costs for access to health care services, optical costs, purchase of medical devices without social security benefits etc.).

EXPENDITURES ON HEALTH BY SPENDING ITEMS: Described as the classification of health expenditures from health service providers by spending items (such as investment, staffing, administration, pharmaceuticals, medical equipment etc.).

Current Expenditures on Health: Expenditures on health care goods and services most of which are continuous, for single-use and create short-term effects.

Staffing Costs: Refer to salaries, bonus payments, shift work wages, social security premiums and allowances paid for health care employees.

Service Procurement Costs: Comprised of the costs incurred by health sector personnel, who are recruited by service procurement contracts, and the materials and stocks they use (such as cleaning stock, food stock etc.). Costs of lab and imaging service procurements are not included.

Pharmaceutical Costs: Comprised of spending on retail pharmaceuticals, inpatient and outpatient treatment pharmaceuticals and immunization service which is provided by the MoH.

Medical Supply Costs: Comprised of health spending on single or limited use medical supplies and equipment, which do not provide cure on their own but are used for diagnostic, curative and care processes instead, in addition to health spending on orthoses and prostheses.

Medical (Laboratory and Imaging) Test Costs: Cover all spending on laboratory and imaging tests in health care sector including costs of health service procurement through contract.

Administrative Costs: Cover spending on management, planning, organization, coordination and supervision in health care services in public and private health care facilities (including the central organization and primary care facilities).

Liabilities: Refer to the shares which some public institutions and organizations are obliged to allocate for others as of 2013, as ordered by law: the MoH's taking 5% share from revenues of the Turkish Association of Public Hospitals - affiliated revolving fund institutions (2,5% for health care facilities in common use by universities and the MoH); the Undersecretariat of Treasury's taking 1% share from revenues of the MoH and its affiliated revolving fund institutions; the Ministry of Family Affairs and Social Policies' taking 1% share from gross revenues of the MoH and its affiliated revolving fund institutions; the Undersecretariat of Treasury's taking 1% share from revenues of university-affiliated revolving fund institutions and university hospitals, stamp taxes and mandatory occupational insurance and pensions; the University Research Fund's taking 5% share from revenues of university-affiliated revolving fund institutions and university hospitals (2,5% for health care facilities in common use with the MoH); premiums paid for mandatory occupational insurance and pensions, and taxes paid by private facilities.

Other Current Expenditures: Comprised of spending from health service providers' on stationary items, fuel, textile supplies, utility bills (gas, water, electricity or phone bills) and rental contracts etc. which are required to maintain service provision.

Unclassified Current Expenditures: Comprised of current health spending other than those listed above.

Investment Expenditures: Comprised of health spending made on capital goods or goods the economic life of which is longer than a year's time - such as buildings, equipment and hardware and motorized vehicles - with the aim of increasing production capacity and improving service delivery.

Construction Expenditures on Facilities: Comprised of investment expenditures on the construction of facilities to be used in health service delivery.

Expenditures on Machinery and Equipment: Comprised of spending on any machinery and equipment provided for use in health service delivery.

Expenditures on Repair and Maintenance: Comprised of spending on effective use of facilities, machinery and equipment utilized in health service delivery.

Expenditures on Ambulance Services: Refer to the MoH spending on procurement of ambulances for 112 Emergency Care Service network and the expenditures undertaken by universities and private health care facilities for ambulance availability which is ordered by the law.

Other Investment Expenditures: Comprised of investment spending other than those listed above.

Preface

In my book titled **"Financing of Health Care Services and Analysis of Health Expenditures in Turkey - Between 2002 and 2013"**, I carried out a comprehensive study which presents a detailed review of the progress that occurred in health expenditures from 2002 to 2013.

Analyzing how health expenditures in Turkey were affected by the policies implemented between 2003 and 2013, the book presents an in-depth discussion and analysis of the progress in management and provision of health care services, as well as putting light on some significant changes made to health care financing and social security network.

Health spending in Turkey are analyzed in four categories in the book: by financing agents, by service providers, by service functions and by spending items, which I believe better suits the Turkish health care system and better reflects its functioning in practice. The classification, which provides readers with an easier understanding of the Turkish health care system from different perspectives, is distinct from other classifications employed by the Organization for Economic Co-operation and Development (OECD) and Turkish Statistical Institute (TurkStat).

The book presents comparative analyses of developments in health spending in graphics and in nominal and real terms by years, by financing agents, service providers, health service functions and spending items.

The book takes the year 2002 as a basis for a better understanding of developments in health spending. Accordingly, the impacts of the health policies implemented in 2002-2013 period are examined, their outcomes are analyzed and efforts are made throughout the book in order to guide relevant parties through the subject by giving them the big picture from different perspectives.

This book is comprised of nine chapters:

Chapter One makes assessment of the Turkish Health Care System and the Pre-2003 Period.

Chapter Two presents a general discussion about developments in the health care system.

Chapter Three presents a detailed discussion about evolution of health expenditures in 2002-2013.

Chapter Four analyzes development of health spending by financing agents and years, in nominal and real terms.

Chapter Five analyzes development of health spending by service providers and years, in nominal and real terms.

Chapter Six analyzes development of health spending by service functions and years, in nominal and real terms.

Chapter Seven analyzes development of health spending by spending items and years, in nominal and real terms.

Chapter Eight provides an in-depth analysis of expenditures on health in 2002-2013.

Chapter Nine makes assessment of the outcomes of the policies implemented in 2002-2013.

To sum up, the book provides readers with a detailed review of the Turkish health care system and health spending in Turkey, giving information on the following: total or per capita spending for financing of health care services in 2002-2013 (discussed in the Chapter 3), sources of funding (discussed in the Chapter 4), service providers funded (discussed in the Chapter 5), health care services funded (discussed in the Chapter 6), spending items (discussed in the Chapter 7), prior situation (discussed in the Chapter 1), events and developments (discussed in the Chapter 2), analyses (discussed in the Chapter 8) and the recent situation (discussed in the Chapter 9).

I consider the book **"Financing of Health Care Services and Analysis of Health Expenditures in Turkey - Between 2002 and 2013"** will fill the gap in the literature on health spending in Turkey, help all stakeholders to better understand financial aspect of the health care sector and to carry out better analyses, as well as enabling decision-makers to make more sound decisions. Also, I wish this book will guide further researches in the future.

Mehmet ATASEVER

Method of Analysis

A number of sources and researches have been used for the method of analysis applied in the book **"Financing of Health Care Services and Analysis of Health Expenditures in Turkey - Between 2002 and 2013".** The expenditures on health, categorized by financing agents and service functions by TurkStat, have been further detailed based on the following methods.

As for distributing health spending by service providers:

- Statistical yearbooks of the SSI and the previously devolved social security agencies (SSK,BAG-KUR and ES) have been used for estimating the amount of funds which were provided for service providers by the social security agencies. In estimating the SSK (the devolved Social Insurance Organization) expenditures on health care facilities, pharmaceutical and other expenses indicated in the statistical yearbooks of the previously devolved organization (SSK) have been subtracted from the spending on health care facilities and contracted physicians and practices. Copayments have been included in private expenditures on health.

- Pertaining to the funds allocated for service providers by central organizations of the public institutions, the Ministry of Health (MoH), Ministry of Finance (MoF), Ministry of Development (MoD), and university data have not been used to estimate the incomes and expenses of the MoH and the universities. Staffing costs of medical schools have been included in the university health spending since they refer to spending made for education purpose. Ministry of Development (MoD) data on public spending on health have been used to estimate health spending on government employees and the Green Card beneficiaries, in addition to other public spending on health.

- TurkStat data on local public health expenditures have been used to estimate the funds allocated for service providers by local governments. As for distribution of the expenditures relevant to hospital services, outpatient treatment facility services and investments by service providers, the distribution ratios, which were indicated in the MoD data on fund allocation for health service providers by other government organizations, were taken as basis. Also, spending on public health programs and their management, which was published by TurkStat, has been included in the MoH expenditures.

- In estimating the funds allocated for service providers from private expenditures on health, the TurkStat data on private expenditures on health have been analyzed by using other data such as the MoH collections from private sector, co-payments for consultations, co-payments for prescriptions and co-payments for pharmaceuticals. Individual revenues of the SSK health care facilities have been estimated by subtracting the SSK pharmaceutical costs from total SSK revenues, as presented in the SSK statistics.

As for distributing health spending by functions:

- For 112 Emergency Care Services, parameters such as the MoH data, number of ambulances and patient transfers have been used. Health spending on air and marine ambulance services has been included since 2009.

- Health spending on public health and family medicine services has been estimated by subtracting the expenditures on 112 Emergency Care Services from the MoD spending on primary and preventive health care services.

- The expenditures on oral and dental care services have been estimated by using the MoH data on general budget and revolving fund spending, and the university dental school data on private budget and revolving fund spending. Spending on oral and dental care services in private sector has been projected by parameters such as the supply of dentists in private sector and private sector dentists as a share of total supply of dentists.

- For spending on administrative services, the MoH studies on the MoH facilities' administrative costs as a share of total administrative expenditures, the share of the administrative costs set out in the "Public University Hospitals Cost Analysis Report 2004*" and in the "Formulation of Cost Accounting System in the MoH Revolving Fund Facilities**", and the data presented in the "Acibadem Healthcare Group Independent Report on Health Care Services" have been employed.

Distribution of health expenditures by spending items have been evaluated in two categories that are current expenditures on health and investment expenditures, from the point of two main qualifiers.

- Current expenditures on health (expenditures for staffing, service procurement, pharmaceuticals, medical equipment and supplies, medical tests, health care management and liabilities, and other current health expenditures and unclassified current expenditures) have been analyzed in nine sub-categories, in details. In making estimations for the MoH Data, the e-budget system, Public Accounts Information System (KBS), Uniform Accounting System (TDMS) and final accounts have been used. Data on university hospitals were used in estimating current expenditures of university health care facilities. For estimating private health care facility data, average spending of the MoH and university health care facilities has been used, in addition to the financial statements of private hospitals and independent assessment reports.

* SAHIN, Assoc. Prof. Ismet,, AKAR, Asst. Prof. Cetin, Public University Hospitals Cost Analysis Report 2004, Ankara, 2007

** BUYUKMIRZA, Prof. Dr. H. Kamil, Project for Formulation of Cost Accounting System in the MoH Revolving Fund Facilities, Report No:3, Ankara, February 2012

- Investment expenditures (construction, machinery-equipment, repair-maintenance, ambulance service and others) have been analyzed in five sub-categories, in details. In estimating investment expenditures from the MoH general budget and revolving funds, the e-budget system, Public Accounts Information System (KBS), Uniform Accounting System (TDMS), and final accounts have been used. The MoH data on health investments did not include the expropriation costs but did include the advance payments from the MoH to the Housing Development Administration of Turkey (TOKI) for health facility constructions and the payments from the MoH to the Ministry of Environment and Urbanization (MoEU). Investment expenditures for university health care facilities have been estimated by adding up the sum of investment expenditures included in health spending from the Ministry of Development (MoD). On the other hand, investment expenditures, which are already included in public investments but the authorized service providers of which cannot be identified, have been classified as "other service providers". Investment expenditures for private health care facilities have been estimated by using TurkStat data on investment expenditures.

The amounts of spending documented in the "Financing of Health Care Services and Analysis of Health Expenditures in Turkey - Between 2002 and 2013" book have been estimated in TRY as of 2013 prices and also denominated in US dollar for nominal values and purchasing power parity for assessment and comparison purposes.

- Nominal values have been converted to the prices in 2013 using the consumer price index of the TurkStat.

- Nominal values have been converted to the US dollars using the end-year average exchange rate of the General Directorate of Budget and Financial Control.

- Nominal values have been converted to the US dollars in terms of purchasing power parity using the purchasing power parity values published by the TurkStat.

Chapter One

Turkish Health Care System and the Pre-2003 Assessment

A. Health Care Services in the Pre-Republic Era

The hospital in Cappadocia built by St. Basil between the years 369 and 372 AD during the Roman Empire and the one by St. John Chrysostom Patriarch of İstanbul (Constantinople) in 398 AD are the first established health care facilities on the territory of Turkey. Health services on Turkish territories, in a real sense, started with the settlement into Anatolia by Turks. Health services in the Seljuk Empire were mostly structured in *madrasa style, and hospitals and medical centers were managed together. In XI. century, the hospital built in Kars by Alparslan was the first hospital in Anatolia founded by Turks. Remarkable progress was made in Anatolia through Seljuk period. During this period, cardiac examination could be performed, pulse and fever control and urinalysis were applied routinely. Hospitals were set up in many parts of Anatolia. Konya, Sivas, Cankiri, Mardin, Kastamonu, Aksaray and Amasya were among the most favorite hospitals built in this period during Seljuk period.

The first hospital of the Ottoman Empire was Yildirim Darussifasi established in Bursa, 1399 by Sultan Yildirim Beyazit. Leprosy Hospital in Edirne (1451), Fatih Darussifasi (1470), Edirne and Hospital (1486), Leprosy Hospital (1514), Hafsa Sultan Darussifasi (1530), Hasseki Darussifasi (1550), Sulaymaniyah Darussifasi (1555), Toptasi Mental Hospital (1583) are the significant hospitals opened up by the Ottomans from this period until Mahmud II's reign.

In Sultan Mahmud II's reign, to meet the health needs of the military and to train the needed personnel, Tiphane ve Cerrahhane-i Amire (surgery school) was established on 14th March 1827, which was a milestone in medical education in Turkey. First military hospitals were built during this period, as well. Other major hospitals built between this period and Republic Era were Haydarpasa Hospital (1845), Zeynep Kamil Hospital (1862), Hospital of Gulhane Military Academy (1898), Sisli Children's Hospital (1899) and Cerrahpasha Hospital (1910).

Common features of the hospitals set up during Ottoman and Seljuk periods are that they were charitable foundations built by the empires' dignitaries and wealthy individuals commissioned for empire.

B. Health Care Services in the Republic Era

After the opening of The Grand National Assembly of Turkey (TGNA), many reforms have been made in health. Health organization policy was undertaken by General Directorate level and subsequently by ministerial level on May 3, 1920 and this mostly scaled up on delivering preventive health care services. In order to meet the need for hospitals, a "numune hospital" was established, by a decision taken in 1924 in each of these provinces: Ankara, İstanbul, Sivas, Erzurum and Diyarbakır. Construction and administration of these hospitals were relinguished to local organizations like municipalities, special administrations and foundations. The first Minister of Health of the Republic of Turkey was Adnan Adivar, MD. The first legal regulation in the field of health was the Law on Forensic Medicine No. 38 issued in 1920.

***Madrasa:** institution of higher education

***Darussifha (or Dar al-shifa):** equivalent of a hospital

After the proclamation of the Republic of Turkey, Refik Saydam M.D., the Minister of Health, contributed enormously to the establishment of health organizations and services during his term of office until 1937. According to the extant data, health services in Turkey were organized in the form of government agencies, municipality and quarantine centers, small sanitary offices, and provided with 86 inpatient treatment institutions, 6.437 hospital beds, 554 physicians, 69 pharmacists, 4 nurses, 560 health officers and 136 midwives in Turkey in 1923. Laws, some of which are still in effect, were passed in this period, as well.

"First Ten-Year National Health Plan" prepared with great efforts was announced by Behcet Uz M.D on December 12, 1946. However, he had to leave the ministry before the Plan was enacted. (As BehCet Uz again became the Ministry of Health in Hasan Saka's government -10.8.1947/10.6.1948- it didn't become enacted due to the cabinet reshuffle even though this Plan was discussed and adopted by Cabinet and in four commissions of the TGNA. The Plan was revoked by Kemal Beyazit M.D., the Minister of Health of the term).

In 1947, Biologic Control Laboratory was established under the Refik Saydam Hygiene Center Presidency and one vaccine station was brought into service and production of intra-dermal BCG vaccine was carried into action. Pertussis vaccine was set to be produced in Turkey in 1948. A 10-bed health center was put up for each 40 villages and it was aimed to provide curative medicine together with the preventive health services during this period. Efforts were spared to assign 2 physicians, 1 health official, 1 midwife and 1 visiting nurse to those centers along with village midwives and village health officers, who would be assigned to serve for a group of ten villages. The number of the health care centers was increased to 22 in 1950 then to 181 in 1955 and to 283 in 1960.

Branch Management of Mother and Child Health was established under the Ministry of Health in 1952. High infant mortality incidence and mortality due to infections in this period led to elaborate the implementation of policies addressing the promotion of population growth. In this framework, impressive progresses were achieved in terms of health centers, maternal hospitals, health facilities for infectious diseases and human health resources development.

As a follow-up to the first Ten Year National Plan, "National Health Programs and Studies on Health Bank" was announced by Mr. Behcet Uz on December 8th, 1954 and it became one of the foundation stones for the health planning and organization in Turkey. In the mentioned Plan, Turkey was divided into 7 regions and it was envisaged establishing a medical faculty in each region and increasing the number of physicians and other health staff (Ankara, Balikesir, Erzurum, Diyarbakir, Izmir, Samsun, Adana). However, National Health Program stipulated dividing health regions into 16 regions (Ankara, Antalya, Bursa, Diyarbakir, Elazig, Erzurum, Eskisehir, Istanbul, Izmir, Konya, Sakarya, Samsun, Adana, Sivas, Trabzon and Van), and the planning was done in this frame accordingly.

In 1924, the hospitals whose managements were relinquished to local governments began to create onerous financial burden upon these administrations than they could take, and due to their inadequate budget, these hospitals became nonfunctional in time. Consequent to this situation, many of these institutions were devolved to Ministry of Health and Social Assistance with a law enacted in 1954. Only some hospitals affiliated with local governments in big cities like Ankara, Istanbul and Izmir were excluded from that case.

In order to establish the infrastructure of human resources, Ege University Faculty of Medicine began accepting students in 1955 right after Istanbul Faculty of Medicine and Ankara University Faculty of Medicine. When comparing the years 1950 and 1960, the number of physicians was increased from 3.020 to 8.214, nurses from 721 to 1658, midwives from 1.285 to 3.219. More than a 100% increase was ensured for all 3 occupations in 10 years. The numbers of hospitals and health centers were increased and within the same framework the increase in the number of beds was also ensured. The number of the hospitals, health centers and beds was also increased, either. The increase was also observed in the number of special service fields such as pediatric hospitals, maternal hospitals and sanatoriums.

By the year 1960, the number of hospital beds per a hundred thousand people increased to 16.6. Along with these positive developments in health institutions and hospital beds, there were very promising improvements in the health indicators, as well. Prominent decreases were seen in the number of tuberculosis-related deaths and infant mortality rate, too. While the tuberculosis related mortality rate was 150 per hundred thousand in 1946, it was decreased to 52 per hundred thousand in 1960. And infant mortality rate was dropped from 233 per thousand in 1950 to 176 per thousand in 1960.

The legislation which carries the legal infrastructures of the non-governmental organizations and some medical occupations to our present day was also drawn up during this period. The Law No. 6023 on the Turkish Medical Association (1953), the Law No. 6197 on Pharmacists and Pharmacies (1953), the Law No. 6283 on Nursing (1954), the Law No.6643 on Turkish Association of Pharmacists (1956) were passed.

Another important law enacted in 1961 is the Law no. 224 on the Socialization of the Health Services. The socialization actually began in 1963. The socialization structure was followed in the way as health posts, health centers, and province and district hospitals were built through a widespread, continuous, integrated and gradual approach. Vertical organizational structures were partially dropped out and structures providing the health care services with different qualities were integrated within health centers. Thus, "Single dimensional service in a wide area" approach, which was an alternate to "Multi-dimensional service in narrow area" principle, was adopted. In 1965, the Law No. 554 on Population Planning was passed. The policy was changed from pro-natalist (increasing the population) to anti-natalist policy (limiting population growth rate).

In 1978, "The Law on the Principles of Health Personnel's Full Time Working" was enacted. And physicians in service of public sector were banned from starting any private practices. But following Turkish coup d'état (12th September, 1980), with "the Law on Amends and Working Principles of the Health Personnel", the former Law was abolished and once again permission for physicians to start out private practices was set free.

The 1982 Constitution entails that citizens do have the right to social security besides, the realization of this right is the responsibility of the state. According to Article 60 of the Constitution, "Everyone has the right to social security, and the State shall take the necessary measures to provide this right and establish the necessary organization". Additionally according to Article 56 of the Constitution, "To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the State shall regulate central planning and functioning of the health services. The State shall fulfill this task by utilizing and supervising the healthcare and social institutions both in the public and private sectors". A provision stating that "Universal Health Insurance may be introduced by law." is also included in this article.

In 1987, Fundamental Law no. 3359 on Health Services was enacted. However, as the regulations to uphold this Law were not made and some of its articles were repealed by the Constitutional Court, the law wasn't fully implemented.

In 1990, a basic plan for the health sector was prepared by the State Planning Organization (SPO) and 1st National Health Congress was held in accordance with this plan in 1992. In a sense, this "Master Plan Study on Health Sector", which was conducted by the MoH and the SPO became the beginning of the health reforms.

Between 1992 and 1993, The First and Second National Conferences on Health were held, and the theoretical studies on health reform were expedited, and Green Card system was founded in 1992 with the Law no. 3816 for the low income citizens who are not covered by social security scheme. Thus, people with low income who do not have adequate economic means to access to health services are ensured to be covered by the health insurance scheme albeit limitedly.

In 1993, Ministry of Health formulated the "National Health Policy" which covers environmental health, and lifestyle, delivery of health services and goals of a healthy Turkey.

The regulations to be made within universal health insurance in 1998 were presented to the TGNA under the name of "the Law on Personal Health Insurance System and the Establishment and Operation of the Health Insurance Institution", yet it couldn't become a law. In 2000, a draft law under the name of "Health Fund" was broached to ministries but was not passed, either.

In November 2002, as Prof. Dr. Recep Akdag assumed his office as Minister of Health, "Health Transformation Program in Turkey" was put into effect by the government in 2003. The program was prepared taking inspiration primarily from the socialization of health services, then past knowledge and experiences and health care reform studies recently carried out and references from all over the world.

On 24 January 2013, Ministry of Health went through changes and Deputy of Edirne, Mehmet Muezzinoglu, M.D. was appointed as the Minister of Health. The studies have been going on to make headway in technology, pharmaceutical industry and in health human resources with the aim of making Turkey compete with the world in the field of health.

Commitment was shown to implement Health Transformation Program and to reach the desired level in the field of health and steps easing citizens' lives were taken with courage and determination and many implementations were put into effect. During this period, SSK hospitals were transferred to Ministry of Health and the benefit package of Green Card for low-income groups were widened, the health services taken in the "outpatient services" and the pharmaceutical expenses of the Green Card holders began to be covered by the state.

The VAT rates on the medicine were reduced and medicine pricing system was changed. Thereby substantial discount in medicine prices was achieved and their burden both on the public and on the citizens was mitigated to a large extent. These arrangements played a prominent role in promoting access to pharmaceuticals.

"112 Emergency Care" services began to be delivered not only in villages but also in cities, and the numbers of stations were increased, ambulances got equipped with latest technology. Sea and air transportation vehicles were integrated into the system.

Preventive health care services and mother-child health care services, in the first place, public health services were strengthened, and family medicine practice, which is among essential elements of modern health, was implemented and it was made widespread all over the country. Comprehensive programs to stop premature deaths and prevent ill-health related to non-communicable, diseases were put into practice. Within this scope, national programs were planned and carried out for certain diseases such as cardiovascular diseases, cancer, diabetes, chronic respiratory tract diseases, stroke, and kidney failures. The indicators for communicable diseases reached the level of the developed countries.

The regions lacking building, equipment or health personnel were regarded as priority areas, and the imbalances related to this issue were eliminated substantially. A total of 2.134 new health facilities including 650 hospital buildings were put into service by the Ministry of Health and during 2003-2013 period, health personnel supply was increased by 357 thousand people and this number reached up 735 thousand with service procurements.

In 2002-2013, while the increase in non-interest general public expenditures was 531%, it was 399% in public health expenditures. Despite this, "Health Transformation Program in Turkey", the world-renowned and a comprehensive transformation program, was implemented and while the level of satisfaction with health services was 39,5% in 2003 and this number went up to 74,7% in late 2013.

C. Assessment of the Pre-2003 Period

Turkish Health System was operating slowly in many ways in late 2002 and this situation led to radical changes and necessary reforms in various fields in the system. With the government change during this period, a new era started for health sector.

When Turkish Health System in late 2002 was analyzed and compared to that of 2013, many significant differences have been observed. These differences are discussed in six different aspects below:

C.1. Health Care Management

C.2. Health Service Delivery

C.3. Health Indicators

C.4. Economic Indicators

C.5. Health Financing

C.6. Health Expenditures

C.1. Health Care Management

Prior to 2003, many organizations were noted to be closely involved within the management of the health sector. Apart from the Ministry of Health, the main government body responsible for determining health policies of the country, three other social security agencies (SSK, BAG-KUR and Government Employees Retirement Fund/ES) were working as semi-independent institutions under Ministry of Labor and Social Security. In this regard, the Ministry of Labor and Social Security, at the same time, had influence on management of health in terms of benefit packages, payment arrangements regarding service providers and occupational health. MoH's role and function concerning health insurance regulations, including social health insurance was not clear. In addition, the Ministry of Finance, Undersecretariat of Treasury, and State Planning Organization used to have a role in the management of health sector pertaining to the planning and decision making for health budgets and capital investments.

As the legislative activities were performed slowly, the process for the laws' adoption was too long in this period. In most cases, proposed legislations were never discussed or adopted. That even though many important health-related plans such as family medicine and universal health insurance had been included in five-year development plan, they didn't become laws during this period can also be considered as a result of this situation.

During this period, primary responsibilities of the Ministry of Health for the health sector were included as:

- To plan and program the health care delivery systems,
- To plan Ministry of Health investments,
- To develop programs for communicable diseases and non-communicable diseases,
- To regulate production of medicines, prescribing process and distribution of them,
- To build and run health care facilities affiliated with Ministry of Health.

As it can be understood from these, too many duties and responsibilities, including its service delivery function overstrained Ministry of Health and this situation weakened its ability to perform its own administrative function effectively.

Prior to 2003, in addition to undersupply of labor in health sector, there was an imbalance in the distribution of the health care personnel across the country. In general, a misperception occurred during this period was that the number of the physicians and nurses had been enough in Turkey. Human resources planning and training and their utilization of these two were handled by separate organizations (planning; Ministry of Health- SPO-*YOK, Training and employment; Universities-Ministry of Health-SSK) however, no effective coordination was achieved between them.

Ministry of Health produced statistics only about its own bodies rather than providing data to the whole sector. Since controlling and organizing the data through data collection and data flow were not well done enough, the statistical records were not reliable. After all, these resulting data could not be transformed into information and wasn't used for administrative purposes. In many places, people's health records were basic like in policlinics' patient records and unsystematically kept files used to get lost. There was no integrated system to keep people's health records, a registry and notification system for diseases couldn't be created to collect and analyze epidemiological data.

The financial management was poor in public hospitals. There was no particular importance for efficiency. Since there was not an effective coordination among the Ministry of Health, SSK, university hospitals, public hospitals and private hospitals, service and investment plannings were not made in line with social needs.

Most of the managers did not have the capacity to use the sources properly, and they lacked the knowledge of "cost" and "business", and they did not have necessary trainings on management. Moreover, there were enough opportunities to motivate the staff on the managers' side. Central and provincial managers were ineligible to run service network. There was a lack of coordination in the central and provincial units were present.

***YOK:** The Council of Higher Education of Turkey.

Understanding of strategic management was not present in health sector at all. The Ministry of Health was trying to provide service as an operator for its own institutions. Yet MoH was not predictive about policy making and developing strategies for the whole sector. There were major problems related to the planning, licensing and the accreditation of health care facilities.

There weren't any contemporary and rational regulations about licensing of medicines, their production and pricing, sales, exports, their presentation and control, research and development activities, or any intellectual property rights to protect the public's rights.

C.2. Health Service Delivery

Prior to 2003, preventive health care services were not valued adequately. The individual to benefit from health service delivery was not cared and his/her demands and needs were not taken into account. Behavior change programs that change individuals' and societies' lifestyles and prevent people from diseases were not included in health service delivery.

Citizens had no right to choose health services in public health service delivery. In other words, citizens could not determine which doctor would examine him/her or which doctor would do the surgery. Sometimes, even after being operated, s/he did not have the chance to meet his/her physician. The patient referral rate of public health facilities to higher levels of care or other health care facilities was rather high. Patient referral process was being made like a routine procedure. Patients had to apply to secondary or tertiary health care institutions and sadly, this became a habit. Whether insured or not, citizens had to go through a private practice to be able to benefit from public hospitals. In order to receive health service, applying for a private consultation initially was a part of the system.

Neither any mechanism for citizens to complain about care or personnel, nor any system to make them claim their own right was available. They did not have the right to choose a physician and home care services were not offered, too.

People were experiencing great difficulties when accessing the medicine. Especially, those people exposed to these difficulties were Green Card holders whose medicine costs for outpatient treatment were not covered, and SSK insurees who had to take their medicines from SSK pharmacies (there were 261 pharmacies all over Turkey back in time) and - sometimes in cases of an unavailable medicine- then had to get it from contracted private pharmacies (3.525 contracted pharmacies across Turkey).

C.2.1. Public Health Care and Family Medicine Services

Prior to 2003, Ministry of Health, public institution responsible for public health, provided free public health care and family medicine services, yet family medicine system was not utilized. The adaptation of the Law on Socialization of Health Services in 1961 is counted as a milestone. Implementation of the system led to the formation of a four-tiered primary health care system. In this system, rural health posts, assigned with midwives, were serving the units of population amounting to 2000-2500 and these posts were the main first contact facilities for rural populations. At the next level, it was planned that there should be rural health centers which served a population of 5 000-10 000 and 1 general practitioner, 1 nurse, 2 midwives and support staff (in total eight staff) were working in these centers. In many regions, there were personnel beyond these standarts, particulary in Eastern and South-East Anatolia.

Later, there were the district health centers, serving a population of 10-30 000 population and with more than one doctor, 1 dentist, 1 pharmacist, several health officers, 1 environmental health technician, laboratory technicians, nurses and midwives. Finally, there were the provincial health centers with 28 staff including 22 health professionals and 6 support staff. The main function of the health centers was to provide comprehensive preventive and primary health-care services to people. This system used to cover the prevention and treatment of communicable and non-communicable diseases; maternal and child health (including immunizations and family planning); public health education; environmental health; patient care; and collecting statistical information on health. In the health-care systems, the health centers were expected to serve as the first-contact point for households and to decide on managing the referrals to higher-level medical institutions.

Apart from this primary health care network run by MoH, there were vertical programs for services such as maternal and child health and cancer, tuberculosis, malaria, each carried out by relevant departments within the MoH.

Delivery of primary health care services was tackled by numerous problems caused by lack of adequate resources and coordination, by low salary of the health personnel, and the minimum level of training.

The referral mechanism wasn't really working. The majority of the population tended to skip primary health care services to be able to receive care directly from higher-level health facilities. Generally speaking, the rate of visits (outpatient) to hospitals was low yet this rate was even lower for primary health care facilities. For example, the average annual number of outpatient visits per capita to receive primary health care services was only 1.1; this number was 2 in hospital outpatient departments.

Another problem was that primary health care managers did not have managerial autonomy. To find a remedy to the financial sources problem, revolving fund system was introduced in 2001 and primary health care facilities were permitted to set cost for the health services provided to insurees. As of 2002, 45 revolving funds for primary health care facilities were managed centrally by primary health care facilities.

Refik Saydam Hygiene Centre Presidency under the Ministry of Health used to manage a large network of public health facilities including disease control labs at the regional and provincial levels. The General Directorate of Primary Health Care was also involved in the provision of public health services. Provincial health directorates were responsible for the implementation of vertical disease control programs at the provincial level. In addition, environmental health officers working in health centers were also responsible for public health programs such as water safety, solid waste disposal, sewerage systems and food hygiene.

Besides, mother and child health centers and family planning centers provided a range of preventive health-care services such as immunization, family planning, breastfeeding promotion and proper nutrition.

Only 20% of the population living in the rural areas was given regular mobile health service. These people had difficulties even in accessing primary health care services (since health service was not provided regularly to the rural areas, the primary health care indicators in these areas were quite negative).

As the organization of the primary health care service was not settled enough, public health care services ceased to be inadequate. Many primary health care facilities, such as tuberculosis control dispensaries, family planning, mother and child health centers, founded for specific purposes, were unable to work effectively.

The access to health care was much easier for urban populations rather than rural populations. 87% percent of the city dwellers were able to go to a health center just by walking, but this rate was only 37% for rural areas. 57% of households nearby the rural areas found it difficult to go to a health center due to its transportation costs. Unfortunately, the cost of health care for those living in rural areas was considerably higher when compared to the city dwellers with higher incomes. According to the TurkStat's report on catastrophic health expenditures, the share of household catastrophic health expenditure is 0,6% in the urban while it is 1,14% in the rural areas, almost doubling that of urban.

C.2.2. 112 Emergency Care Services

Whether they insured or not, all citizens were charged for 112 emergency transfer services before 2003. People in rural areas could not benefit from 112 emergency services, which were already inadequate and uncoordinated in urban areas.

112 emergency transport system was quite poor compared to developed countries. There was no air ambulance system. The number of the ambulances and stations per population was insufficient. In 2002, there was 1(one) 112 emergency station per 137 thousand persons and 1(one) ambulance per 107 thousand persons. Only 383 cases were transported by ambulances and 20% of the population was able to take the advantage of 112 emergency services in 2002.

C.2.3. Hospital Services

In 2002, the MoH was the largest health care provider in Turkey. 47,7% of the hospital beds were owned by MoH. There were secondary care hospitals along with the training and research hospitals that served as the tertiary health institutions under the MoH.

MoH hospitals were mainly financed by two sources: general budget and revolving fund budget. Mostly staff salaries and investment expenditures were provided by allocation item from the general budget. Staff salaries (over 80%) constituted the majority of the allocations from the general budget. Revolving fund budgets were financed by services for the insurees and private health care expenditures. Revolving fund budget provided the hospital managements with more flexibility in terms of its use. The year-end left-over cash resources in the revolving fund budget could be transferred to the following year. Despite this, the decision-making power of the hospital managers over expenditures was very weak when using revolving fund budget. All the decisions related to using the budget spending had to be cleared by the MoH General Directorate of Curative Services, located in Ankara. This centralized management prevented timely supply of needs and also ruled out the managers to take initiative. Public hospitals in Turkey operated as traditional public sector institutions, with a limited financial and management autonomy. Hospitals did not have a regular accounting system and they were not guided by regular financial monitoring. The degree of the informality in public hospitals was very high. They had no stock and asset tracking system. Most managers were oblivious of basic management concepts such as accounting, stock, income, expenses, and cash flow.

There were several malfunctions while billing the services in the hospitals, controlling and collecting money. While public hospitals were continuously having cash flow problem, cash resources were dormant in some other institutions. Hospitals were not able to generate their cash flow and couldn't set maturity periods to the companies they worked with. Naturally this caused operating costs to increase constantly.

Regardless of the quality and quantity of their work, health professionals were paid for by a fixed payment system. Almost all of the physicians working in MoH and SSK hospitals had their own private practices. It was nearly impossible for the citizens to access hospital services without stopping by one of these private practices. This situation caused citizens who used to go to SSK hospitals and university hospitals to beat a path to private practices and spend large amounts of money in order to be able to receive health services in case of serious diseases. According to the TurkStat's report on catastrophic health expenditures, the share of household catastrophic health expenditure was 0,81% in 2002. Insured citizens used to pay for treatment payments and pharmaceutical expenditures completely out of pocket and even informal payments to the health care provider for a surgery had become a part of the payment system. Very few citizens were able to benefit from private hospitals and medical centers by paying very high fees in 2002. Only high-income citizens could access to the health services fully. The situation in university hospitals was not different from other public hospitals. Setting up private practices in universities was not as common as in the other public hospitals. Private practices were mostly set in the university hospitals. With practices called private examination and operations (after 2.00 p.m. on weekdays), faculty members were able to take care of the citizens who demanded private examination in return for a fee paid to the hospitals.

Public hospitals were neglected and almost all of them consisted of wards. In hospitals, the rooms with inbuilt toilet and bathroom were so few that one could count them on the fingers of one hand. In public and private hospitals, some units such as intensive care units, burn units and neonatal units were almost non-existing in terms of quality and quantity. Public hospitals were so poor in terms of medical devices, research and training hospitals were facing the medical device problem in the same way.

C.2.4. Oral and Dental Health Care Services

Prior to 2003, oral and dental health services in Turkey were largely left to market conditions. Citizens had to receive health services especially from private dentists by paying for out of their pockets. Although there were 16.371 dentists in Turkey, 2002, the number of the dentists employed in the MoH was just 20% of these dentists (3.211). There weren't enough dental units for even half of the employed dentists. In 2002, the number of the dental units in use was only 1.071 in MoH. These very few dentists employed by MoH were not provided with the adequate physical facilities and technical equipment to able to serve. The effect of this situation on the services provided in the oral and dental health services as were observed as: the number of the fixed dental prostheses restored in MoH facilities in 2002 was 349 thousand, the number of the dental filling was 371 thousand and the number of the root canal therapy was only 32 thousand. These numbers reflected a very low performance under Turkey conditions.

C.2.5. Access to Medicines, Medical Equipment and Supplies

Before 2003, there were great challenges when accessing to medicines and medical supplies. If the medicines or medical supplies were available in the hospital, these were provided to the inpatients with Green Cards; if not, then they had to supply their own pharmaceuticals and medical supplies. In such case, the citizens with low income had to buy them out of their pocket. The government didn't pay for the medications or medical supplies of the Green Card outpatients receiving examination or consultation and these citizens were referred to social assistance foundations in cities and district centers. In practice, these foundations were unable to meet these needs. For this reason, citizens used to buy these medicines or medical supplies with their own means if they could, or they used to use medical record books of a government official or an insuree with whom they were in touch or they couldn't manage to get their medical needs.

Insured citizens' access to pharmaceuticals and medical supplies was too difficult, too. Even outpatients were to supply their medicines from pharmacies within SSK hospitals. The total access to medicines and medical supplies may not have been likely most of the time after great efforts. Since the most of these pharmaceuticals and medical supplies were not available in SSK hospitals. After beneficiaries got a stamp saying "not available in this pharmacy" they could supply their medicines from private pharmacies limited in number (3.525 pharmacies). However, there were about 18 thousand pharmacies in Turkey in 2002. People who had to obtain their medicines from a limited number of pharmacies also had to wait in long queues. Mostly those beneficiaries couldn't take the risk of waiting in long lines; thus, they used to have their medicines paying out of pocket or they used medical record books of a government official or a person insured by ES with whom they were in touch or they couldn't manage to get their medical needs. In this period average medicine expenditure of an ES insuree was 7-8 times higher than a SSK insuree.

C.3. Health Indicators

Table 1. International Indicators Used In the Assessment of Health Care Services, (2002)

Indicator	Turkey	WHO Regions, 2000		
		European Region	Upper-Middle Income Countries	World
Life Expectancy at Birth (years)	72,5	72,0	71,0	66,0
Infant Mortality Rate (per 1000 live births)	31,5	18,0	30,0	53,0
Under-5 Mortality Rate (per 1000 live births)	40,0	22,0	38,0	75,0
Maternal Mortality Ratio (per 10000 live births)	64,0	29,0	93,0	330,0
Out-of-pocket Health Expenditures as Percentage of Total Health Expenditures (%)	19,8	-	-	-
Level of General Satisfaction with Health Services (%)	39,5	62	-	-

Source: MoH, TurkStat, World Health Statistics 2013

C.4. Economic Indicators

C.4.1. Economic Indicators of Health Care

Table 2. Health-related Economic Indicators, (2002)

Indicator	Turkey	OECD Average	WHO Regions, 2000		
			European Region	Upper-Middle Income Countries	World
Public Health Expenditures as share of GDP (%)	3,8	5,7	-	-	-
Total Health Expenditures as share of GDP (%)	5,4	8,3	8,0	5,4	8,2
Out-of-pocket Health Expenditures per Capita (USD $)	134	-	706	55	278
Total Health Expenditures per Capita (US $)	189	2.568	938	115	482
Out-of-pocket Health Expenditures (PPP USD $/per Capita)	329	1.566	899	116	318
Total Health Expenditures (PPP USD $/per Capita)	466	2.178	1.215	240	564

Source: TurkStat, BUMKO (The General Directorate of Budget and Fiscal Control), World Health Statistics, OECD Health Data 2013

C.4.2. Other Economic Indicators

Table 3. Other Economic Indicators, (2002), (million TRY/USD)

Indicator	TRY	As of 2013 Prices, TRY	USD	PPP USD
Gross Domestic Product	350.476	976.152	232.745	574.238
Central Administrative Budget	119.604	333.122	79.427	195.965
Total Public Resources Allocated to the MoH	5.196	14.471	3.450	8.513
Public Health Expenditures	13.270	36.959	8.812	21.742
Total Health Expenditures	18.774	52.290	12.467	30.760
Non-Interest General Public Expenditures (Excluding Health Expenditures)	79.495	221.410	52.791	130.248
Tax Revenues	59.632	166.088	39.600	97.704

Source: Ministry of Development, Ministry of Finance, MoH, TurkStat

C.5. Health Financing

Heath financing has always been a tough and an important issue to tackle in every country. Health financing has 3 important and interrelated pillars. The first of these is collecting adequate funds for the financing of the health services, the second is pooling the funds on the basis of risk-sharing among payers and the third is using these funds properly to procure or provide the needed health services.

Almost everyone is of the same opinion that countries need to spend on health care services. Yet, one of the main questions, which is controversial and constantly questioned, is about "what should be the level of this spending?". Both structural and situational/periodic factors may be involved in the main determinants of health expenditures. These factors can be defined as; the way health systems are organized and managed, population's health care needs, economic development and per capita income levels, socio-cultural factors, the presence of health insurance, health care providers' behaviors, service delivery and payment models for physician, rising expectations of patients and the population, technological advances, changes through using them, changes in disease tissues, political changes, the increase in the health care needs due to the aging population, and child population growth. The share of these indicators and their effects on health expenditures can vary around the countries.

In most countries, the real important issue for health policy makers is how to guarantee people receiving health care services when they need them and how to protect people against financial risks inflicted by health expenditures.

There are 3 different methods in health financing:

1. Public Finance Model: This model is based on the basis of taxes and premiums. Health services are financed by the general or special taxes (Beveridge Model) or collected premiums (Bismarck model) in this model. There are some other examples in which some part of the financing is done through taxes and some by premiums.

2. Private Finance Model: Health services are financed by private health insurance, medical saving accounts and OOP health expenditures.

3. Mix/Quasi-Public Finance: In this model, public finance and private finance are used together in health financing. In other words, health services are financed by taxes, premiums, private health insurances, and OOP expenditures as in Turkey.

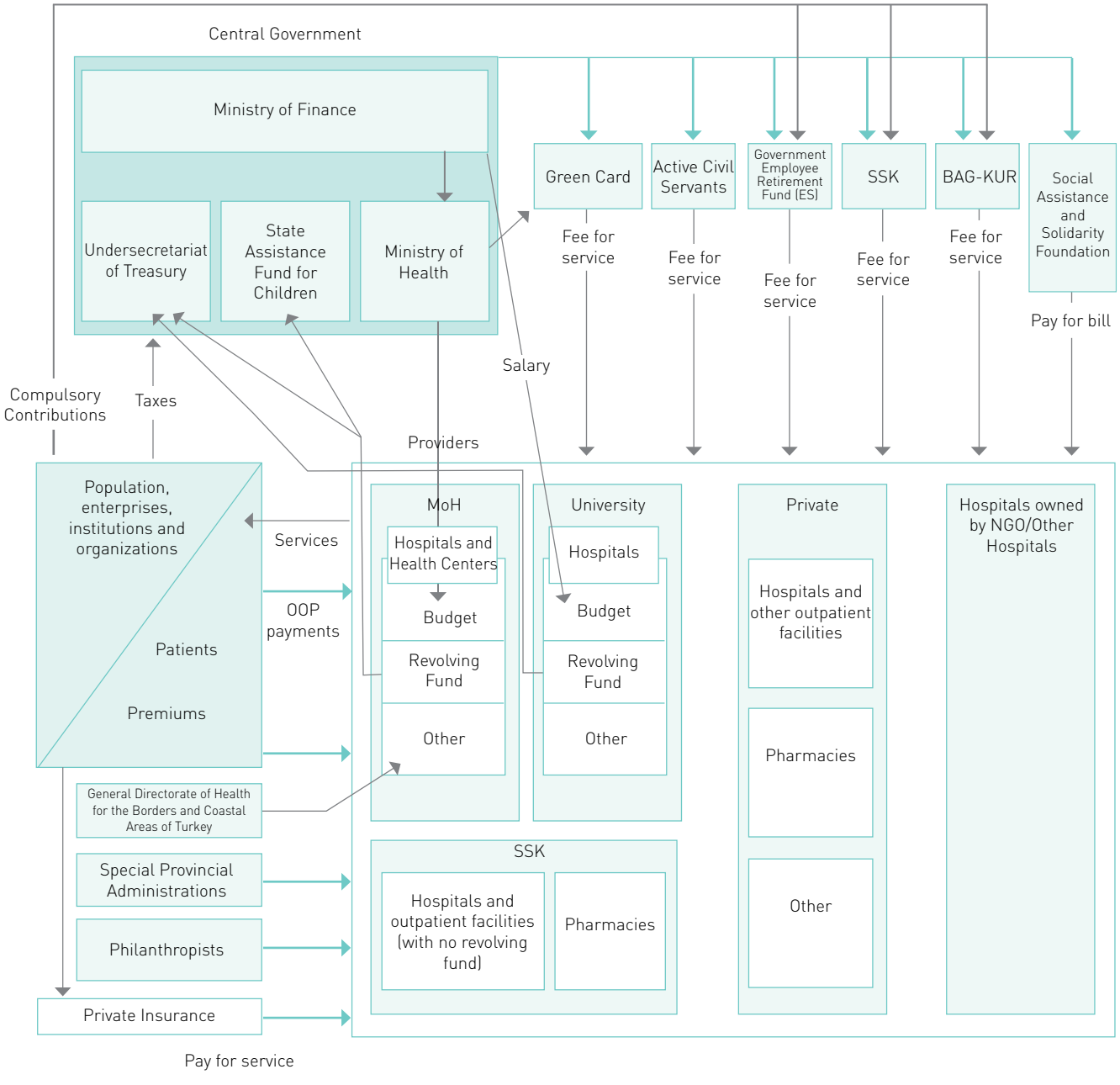
C.5.1. Financial Structure of Health Care System in Turkey

Financing structure of Turkish health system has features of mixed finance. On the one hand, health insurance system (Bismarck Model) was used by certain parts of the population and on the other hand some parts receive public assistance (Beveridge Model) and also private expenditures had a share in systems' financing.

In health financing system in 2002, since the premiums collected were not sufficient, the deficit caused by this was being covered by means of taxes collected. According to TurkStat data, besides these financings, there were private health expenditures that included private health insurance, insurance funds, and sources such as foundation universities (9,5%), and health expenditures of households (19,8%) and though they were on a small scale, they constituted 29,3% of total health expenditure.

Again in 2002, the main source of financing for Turkish health care services was public finance. In particular, almost all of the preventive health care services were covered by the government. In Turkey, 71 TRY of every 100 TRY - health expenditure was covered by the government in 2002. Although the public resources constituted a large portion of health financing, great challenges were experienced when accessing to health services during these years, and high dissatisfaction with the health care services among the citizens (level of satisfaction, 39.5% in 2003) indicates that resources used for health care was actually quite inadequate or there were major problems in functioning of the system or a significant productivity problem in it. In fact, all these three happened at the same time in Turkish health care system. That is, resources allocated to health care were not enough and unit costs for health services were high (proportion of the public health expenditure to GDP is 3,8%. OECD average is 5,7%). It means that the health system was built wrongfully and it was malfunctioning (such as absence of full-time work system and examining room for every physician in health facilities). The system was inefficient (i.e. lack of understanding of performance system and management).

Figure 1. Flow of Funds in the Turkish Health System, (2002)



It would be useful to mention briefly about the history of the social security agencies in Turkey before describing the condition of financing agencies for health financing.

C.5.2. Historical Evolution of Social Security Agencies in Turkey

Turkey's first social security agency founded by the Law which required a mandatory membership was Labor Union established in 1921 with the Law no.151 Law Concerning the Rights of Mine Workers of the Eregli Coal Basin. In the early years of the Republic of Turkey, laws demanding establishment of some pension and assistance funds which were similar to the social security agencies were enacted and though they were narrow scoped for the sake of citizens there were still high in number. The laws enacted in this field and some of the pooled funds can be listed as: Imalati Harbiye Teavun ve Sigorta Sandigi (Aid and Insurance Fund of Military Industry) established by the Law No. 895 of 1926, Devlet Demir Yollari ve Limanlar Idaresinin Memur ve Mustahdemleri Tekaut Sandigi (Aid Fund for Civil Servants and employees of General Directorate of the State Railways and Ports) founded in 1934 by the Law No. 2454 , PTT Telgraf ve Telefon Idaresi Biriktirme ve Yardım Sandigi (Endowment and Aid Fund Postal and Telephone Administration) founded in 1935, Deniz Yollari ve Akay Isletmeleriyle Fabrika ve Havuzlar Idareleri Memur ve Mustahdemleri Tekaut Sandigi (Pension Fund for civil servants and Employees of Sea Transportation and Akay Companies and Pools and Factories Administration) established by the Law No. 3137 in 1937, T.C. Ziraat Bankasi Memurlari Tekaut Sandigi (Pension Fund for TR. Ziraat Bank officers) founded in 1937 by the Law No. 3202, Emlak ve Eytam Bankasi Memurlari Tekaut Sandigi (Pension Fund for Real Estate and Orphanage) founded in 1938, T.C. Merkez Bankasi Memurlari Tekaut Sandigi, Devlet Hava Yollari Umum Mudurlugu Memur ve Mustahdemleri Tekaut Sandigi (Pension Fund for Civil Servants and Employees of the Central Bank of the Republic of Turkey and General Directorate of State Airports).

Law No. 3008 dated 1936 was the first law that established the social insurance agencies and the fundamental principles about social insurances in Turkey. However, this system laid down in the law could not be built until 1945 because of the Second World War. The first law on social insurance branches is the Work Accidents, Occupational Diseases and Maternity Insurance Law dated 27.06.1945 and numbered 4772. It was only after the enforcement of this law, the Work Accidents, Occupational Diseases and Maternity Insurance program was put into effect. In parallel with the aforementioned law, the Law No. 4792 on Workers' Insurance Institution was enacted on 16.07.1945.

By means of this, Law which came into force later on 01.01.1946, Workers Insurance Institution was founded and many funding agencies established till 1945 were brought together. In the year Workers Insurance Institution was founded, Law on Work Accidents, Occupational Diseases and Maternity Insurance Numbered 4772 was put on the agenda. Later, Law on Old-age Insurance No. 5417 in 1950, then Law on Sickness and Maternity No. 5502 in 1951, later Law on Old Age, Disability, and Survivors Insurance No. 6900 in 1957 were enacted. Apart from these regulatory frameworks in social security field, the most important development is the 1961 Constitution. With the Constitution of 1961, for the first time, the term "social security" was put into the constitutional terminology as a concept concerning working life and social policies.

A similar provision that of Article 48 of the 1961 Constitution on social security was, also, included in Article 60, entitled "social security", of the 1982 Constitution. In the said Article, State has taken important task in social security field by way of stating that "Everyone has the right to social security. The State shall take the necessary measures and establish the organization for the provision of social security".

In Turkey, "planned development program" started to be implemented in 1963, the concept "social security" was discussed in the development plans. Finally, it was accepted as the security system developed in order to protect the individuals from possible risks. Development plans contained similar provisions in relation to social security; even today, some arrangements, which are presented as new and crucial, had been involved in development plans for a long period of time. For instance, the idea "social security agencies should be brought under one roof " was mentioned in the First Five-Year Development Plan (1963-1967) for the first time provided that special benefits and conditions of the insurees were taken into consideration, then it was announced as the State's social policy.

With the Law on Retirement Fund No. 5434 (for civil servants) adopted on 06.08.1949 and entered into force on 01.01.1950, retirement funds reaching up to 11 in number were terminated and a more modern and integrated social security system was created based on the principle stating that employees and employers shall pay for their premiums. To run this system single handedly, Government Employees' Retirement Fund was founded. In time, regulations which were involved in several laws relating to the staff recruited in blue collar status were revised following the commencement of the 1961 Constitution which contained special provisions on social security and these regulations were unified within the Social Insurance Law No. 506 dated 17.07.1964. With the entry into force of the this law on 01.03.1965, Workers' Insurances Administration changed its name to Social Insurance Organization (SSK) by bringing new social security rights for the staff recruited in blue collar status. The Social Insurance Agency for Merchants, Artisans and Self-Employed (BAG-KUR) was established with the Law No.1479 dated 02.09.1971, and provisions relating to being insured were put into force on 01.10.1972. Starting from 01.01.1986, health insurance benefits were provided to the insurees subject to this law. With the Law on *Mukhtar Allowances and Social Security No. 2108 Dated 10.09.1977, mandatory insurance of the village and neighborhood mukhtars in BAG-KUR system was ensured. With the Law No. 2229 dated 04.05.1979 Turkish citizens, who weren't registered in any social security agency together with housewives, were given right to be insured in BAG-KUR system. That these insurees ought to have same rights and liabilities with the mandatory insurance beneficiaries was envisaged.

Social Insurance Law For Agricultural Employees No. 2925 and the Law for People Working Independently In Agriculture No. 2926 were adopted in 1983 and important regulations were made in order to guarantee the social rights of those working in agricultural sector.

People's social security rights were regulated via different laws in Turkey. These were the Law No. 506 for staff employed under service contract, the Law No. 1479 for self-employment, the Law No. 5434 for civil servants, Law No. 2925 for agricultural workers employed under service contract and the Law No. 2926 for people working independently in agriculture. In short, insurees' social security rights were regulated by 5 separate laws. In addition to that, people subject to funds clarified in the provisional article 20 of the Law No. 506 used to ensure their own social security rights via own almsdeeds. However, such social security system was disrupting the unity of norms and standards between the right and liabilities of the employees, who were covered by different social security laws.

*__Mukhtar:__ head of a village or neighborhood, usually selected by some consensual or participatory method, often involving an election.

In 1992, the "Green Card" practice was started. The purpose of this program was to provide health care to poor and needy people who cannot afford the cost of health services they receive. When it was first set up, the Green Card system only provided financing for the inpatient health care services and this placed a formidable obstacle in the way of ensuring equity for citizens trying to access to health care services. The Green Card program was considered as a temporary solution until Universal Health Insurance program was started. A district-level commission which was established under the Provincial District Offices used to evaluate and finalize the Green Card applications and determine the eligibility of applicants based on the verification of their incomes.

The treatment and medicine expenditures of the staff employed in the state were not included in ES system, and these expenditures were met by the government budget.

As it can be understood from the social security agencies' structure, whose historical development we have tried to summarize in short, there was a multiple and fragmented health financing in 2002.

C.5.3. Scope and Functioning of Social Security in Turkish Health Care System

Prior to 2003, benefit packages used to differ across fragmented social security systems. For instance, SSK insurees were only able to choose SSK hospitals and pharmacies. On the other side, BAG-KUR insurees and their dependents could receive health care from various health providers including private and public hospitals. However, BAG-KUR insurees and dependents could have the access to health services only if they had paid premiums for at least 90 days before they needed the health service.

ES had the most extensive benefits package among the various health insurance schemes.

Its social security premiums were considerably same with the other health insurance systems. According to estimates made by State Planning Organization (SPO) taking the social security agencies' data into consideration, in 2002, about 85% of the population was covered by health insurance in a way. The remaining 15% did not have any health insurance and they didn't pay for their own social security premiums. Still, these citizens could take advantage of preventive health care services (like vaccination) provided by MoH.

Having covered 46,3% of the population, SSK was the largest insurer. Then BAG-KUR which covered 22,3% of the population ranked second, followed by ES covering 15,4%. Private insurance coverage in Turkey was too low (less than 0,5%). Official data on health insurance coverage does not reflect the real numbers as they were based on estimates rather than the real number of enrolled employees.

During this period, there were three major problems related to the health insurance coverage;

1. Many people were insured with more than one social security agency, and therefore multiple records were showing up in the systems;

2. The number of active members of the population used to indicate the number of registered citizens under the program, but not necessarily regular contributors, who had the right to benefit from social security agencies (this was a particular problem with BAG-KUR),

3. The number of dependents of the insurees was not known with any degree of certainty.

Despite the figures reported by SPO having taken the social security agencies' data into the core, surveys carried out by the MoH in 2002 showed that 67% of the population was covered by health insurance in some way. According to the Turkey Household Budget Survey in 2003, conducted quarterly by TurkStat, the percentage of the population covered by any health insurance was 64%. Both of these two surveys were carried out on a sample which represented Turkish population by statistics. The difference between these official numbers was highly noticeable and also proved that there were biased reporting and estimation problems in official numbers.

On the other hand, it is estimated that about 46% of the labor force was working in the informal sector during this period. As the health insurance coverage was estimated to be around 85%, it is also possible that a substantial portion of informal sector workers could have been covered by the Green Card or as dependents of individuals with health insurance coverage under SSK, BAG-KUR or ES in this period. For example, according to the 2003 Household Budget Survey, only 12% of the poorest decile (according to per-capita expenditure deciles) was covered under the Green Card scheme. Green Card coverage in higher deciles used to range from 1% to 8%.

Table 4. Number of Insured Individuals, (%), (2002-2003)

	State Planning Organization*	Household Health Expenditure Survey
Civil servants	15.4	-
Active workers	–	7.4
ES	–	5.1
SSK	46.3	33.5
BAG-KUR	22.3	11.7
Private funds	0.5	0.4
Green Card	–	8.6
Others	–	0.5
Total insured	**84.5**	**67.2**

Source: Ministry of Development, Economic and Social Indicators and Turkey National Household Health Expenditure Survey (2002-2013), OECD Reviews of Health Systems Turkey (2008).

* SPO Data refers to social security agencies.

Most of the informal payments were paid cash (71%)[1] and these were for outpatient services. To have health insurance neither prevents citizens from making informal payments nor paying out of pocket. In fact, to be able to receive health care services covered under health insurance, first, patients had to visit a doctor's private practice and pay out of pocket (a survey conducted in 2003 with 900 households indicated that 25% of total out-of-pocket expenditures were informal)[1]. Furthermore, the poor paid more for the health services than the non-poor per capita, and unfortunately the elderly paid more than the young.

The equity in the health system was very poor. Unfortunately, it was common in this period that public sector health personnel used to practice in the private sector and physicians used to refer patients to their own practices after office hours, and there were cases in which patients had to buy their own supplies as health facilities had faced with resource constraints.

To sum up, the financing of health expenditures in Turkey had a quite fragmented structure in 2002. To make it simpler, SSK was for citizens working under the labor law, and its pensioners & their dependents; BAG-KUR provided health for self-employed citizens, its pensioners & their dependents and finally retired civil servants and their dependents received health care services from ES. On the other hand, a reimbursement system called Green Card was built for citizens who couldn't pay their own health care costs in order to meet inpatient health care services they received. Health expenses of the civil servants and their dependents were covered by the institutions' budget.

These reimbursement agencies were charged with meeting health costs but their reimbursement policies and coverage of the health services, billing system and other issues were different from each other. Different social security agencies (SSK, BAG-KUR, and ES) had different reimbursement mechanisms. They had neither a common model nor strategies. A payment schedule with methodology and specific pay periods couldn't be created between health care institutions and reimbursement agencies

The organization and management skills of the institutions paying for citizens health costs were quite poor. SSK was the biggest agency for reimbursement of health care expenditures. There were hundreds of hospitals, dispensaries and even pharmaceutical plants in SSK, which was responsible for the financing of 37 million people's health expenditures. However, SSK insurees had many difficulties when accessing health services as well as medicines and medical supplies. Except for the government employees, it was really difficult for other citizens to go a university hospital. As BAG-KUR did not have a contract with most university hospitals, its insurees had to pay for health costs out of their own pockets. These citizens, then, were having great difficulties in reimbursement.

1 OZGEN, Assoc. Dr. Hacer, TATAR, Prof. Dr. Mehtap, Informal Payments in Health Services Financing, Hacettepe Journal of Health Administration, Vol: 11

When people faced with a serious health problem (cancer, transplantation, congenital anomaly, cardio-vascular surgery etc.), they had to spend too much for health costs, which could even impoverish their families in times. According to the TurkStat's report on catastrophic health care expenditure, the share of households impoverished by health care expenditure in Turkey was 0,43% in 2002. In the outpatient treatment of citizens who could receive health services by means of "Green Card" system, tooth extraction, eyeglasses and emergency treatment costs weren't being paid, including treatment, examination and tests.

Billing health care services, provided by hospitals to social security agencies and controlling of these, were problematical.

The coverage of the social security system was quite low. It was really difficult for millions of citizens on a low income to access health care services. Many mothers, children and infants were deprived of primary health care services. Even majority of the insured citizens had difficulty in accessing health services.

In short, it is understood that there were social health insurance systems which were covering for the health expenditures of formal-sector workers, together with a kind of national health service-type of system managed by the MoH. In addition, it is seen obviously that there was a social assistance program covering health insurance for the poor and vulnerable (the "Green Card"), which caused a fragmented health financing and delivery system.

The type of the health insurance was the main determinant for a person to make a decision on getting a health service. When compared to citizens under a health insurance coverage, patients and households who did not have any kind of health insurance tended to go to a health facility to receive health care when they got sick. Lack of health insurance and also underinsurance (limited coverage as in the Green Card program) was common among the poor who lacked formal-sector employment. This indicates how it is important to extend the health insurance coverage of the population to increase financial protection both horizontally and thoroughly.

SSK pensioners and their dependents used to make a 0,8 TRY co-payment for each visit made to physicians. There was no co-payment for inpatient treatment services. As for the medicines prescribed after outpatient treatments, while the co-payment rate was 20% for employees and their dependents covered under SSK, ES and BAG-KUR, it was 10% for pensioners and their dependents.

C.6. Assessment of Health Expenditures (2002)

Health expenditures prior to 2003 must be assessed taking different aspects into account within 4 frames.

- Health Expenditures by Financing Agents
- Health Expenditures by Providers
- Health Expenditures by Functions
- Health Expenditures by Spending Items

C.6.1. Health Expenditures by Financing Agents

Health expenditures by financing agents have been described in detail as in the table below.

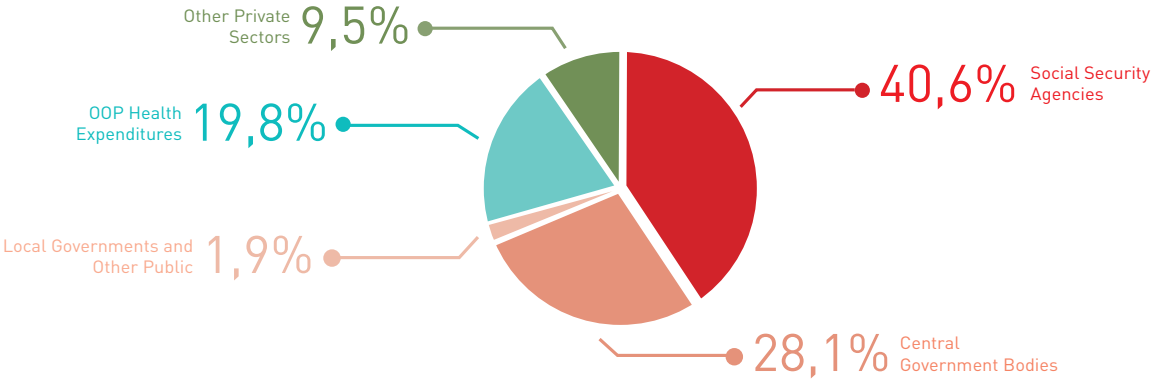
Table 5. Distribution of Health Expenditures by Financing Agents (2002), (million TRY/USD)

Financing Agents	TRY	As of 2013 Prices, TRY	USD	PPP USD	%	%	%
SSK	3.596	10.015	2.388	5.891	47,1	27,1	19,2
BAG-KUR	2.195	6.114	1.458	3.597	28,8	16,5	11,7
ES	1.840	5.124	1.222	3.014	24,1	13,9	9,8
SSI	7.631	21.253	5.067	12.503	100,0	57,5	40,6
Ministry of Health	2.435	6.782	1.617	3.990	46,1	18,4	13,0
Public Employees	1.654	4.607	1.098	2.710	31,3	12,5	8,8
Green Card	538	1.498	357	881	10,2	4,1	2,9
Other Public Institutions	461	1.283	306	755	8,7	3,5	2,5
Universities	195	544	130	320	3,7	1,5	1,0
Central Government	5.283	14.714	3.508	8.656	100,0	39,8	28,1
Local Governments and Other Public Institutions	356	991	236	583	100,0	2,7	1,9
Total Public Health Expenditure	13.270	36.959	8.812	21.742		100,0	70,7
Out-of-pocket Health Expenditures	3.725	10.375	2.474	6.103	100,0	67,7	19,8
Other Private Sector	1.779	4.955	1.181	2.915	100,0	32,3	9,5
Total Health Expenditure in Private Sector	5.504	15.331	3.655	9.019		100,0	29,3
Total	**18.774**	**52.290**	**12.467**	**30.760**			**100,0**

Source: Ministry of Health, Ministry of Development, TurkStat, SSI, Universities

In 2002, 70.7% of health expenditures in Turkey was public expenditures while it was 29.3% for private expenditures.

Graphic 1. Proportion of Health Expenditures by Financing Agents, (2002)



Source: Ministry of Health, Ministry of Development, TurkStat, SSI, Universities

In 2002, 40.6% of health expenditures were spent by social security agencies, 28,1% to central administration bodies, 1.9% to local administrations and other public institutions, 19.8% to OOP, 9.5% to other private sectors.

C.6.1.1. Public Health Expenditures: In 2002, the majority of total financing allocated to health was obtained from public resources (70,7%) and the remaining was from private resources

C.6.1.2. Private Sector Health Expenditures: Private expenditures included OOP payments and private health insurance payments funded by companies and individuals. In 2002, the share of private sector health expenditure was 29,3%. 19,8% of it was OOP payments for health and 9,5% of it was other private sector health care expenditures.

C.6.2. Health Expenditures by Providers

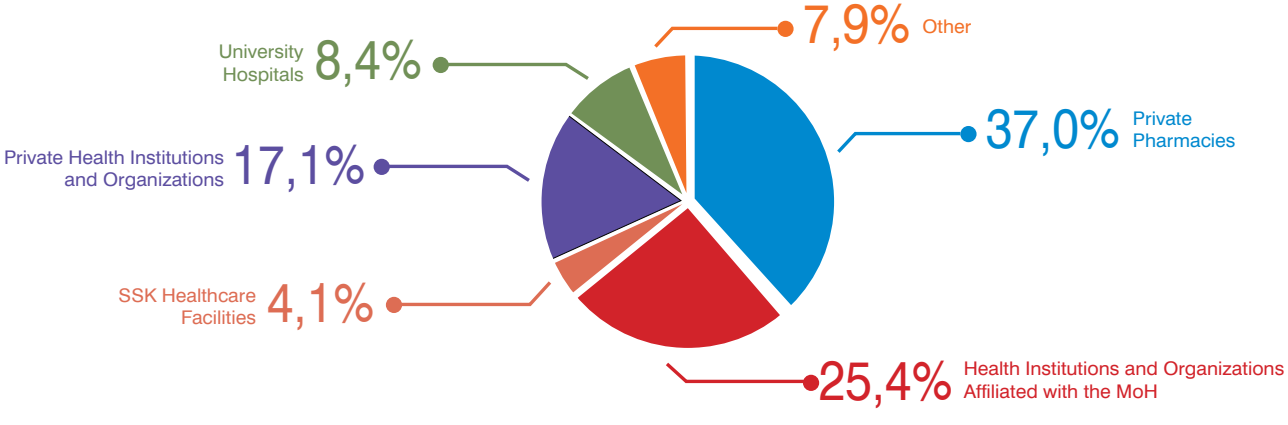
Table 6. Distribution of Health Expenditures by Providers, (2002), (million TRY/USD)

Health Care Providers	TRY	As of 2013 Prices, TRY	USD	PPP USD	%
Private Pharmacies	6.955	19.371	4.619	11.395	37,0
Health Institutions and Organizations Affiliated with the MoH	4.762	13.264	3.163	7.803	25,4
Private Health Institutions and Organizations	3.214	8.951	2.134	5.265	17,1
University Hospitals	1.578	4.395	1.048	2.586	8,4
Other	1.491	4.154	990	2.444	7,9
SSK Healthcare Facilities	773	2.154	514	1.268	4,1
Total	**18.774**	**52.290**	**12.467**	**30.760**	**100**

Source: Ministry of Health, Ministry of Development, TurkStat, SSI

It can be seen that in distribution of health expenditures by providers in 2002, most of the health expenditure was realized in private pharmacies with a 37 percent. This was followed by MoH facilities with 25,4% and private health facilities with 17,1% and finally health facilities of universities and others with 8,4%.

Graphic 2. Distribution of Health Expenditures by Providers (2002)



Source: Ministry of Health, Ministry of Development, TurkStat, SSI

C.6.2.1. Private Pharmacies (2002)

As stated earlier, the access to health care services and medicines was quite difficult. However, the amount paid for medicines provided by retail constituted 37% of health expenditures (payments for pharmaceuticals used by inpatients in hospitals were included in expenditures for hospital care). This figure (37%) was 2 folds higher than OECD average in the same year. In OECD countries, the pharmaceutical expenditures as a share of health expenditure was 18% on the average in 2002.

In this period, SSK, the largest insurance agency, had 261 pharmacies within its body. These pharmacies, took place in all of SSK hospitals and in some units of other health care providers (such as dispensaries). SSK pharmacies, used to purchase pharmaceuticals directly with 10% discount and due 45 days upon the contracts that were to be renewed every year. Having made their co-payments, SSK member supplied their medicines from the pharmacies contracted with SSK body, whose principle was "to choose the cheapest drug among its equivalents"(20% for the active workers and 10% for the retired). The medicines which were prescribed but not found in SSK-owned pharmacies were only obtained from SSK- contracted pharmacies by making co-payment again in same rates. More than 80% of medicine consumptions by SSK was obtained from SSK-owned pharmacies. In 2002, among nearly 18 thousand private pharmacies, SSK had a contract with only 3.525 of them. 325 million TRY were expensed for pharmaceutical cost to private pharmacies and total pharmaceutical cost paid for outpatients and inpatients was 1,879 billion TRY by SSK in 2002. This corresponds to 26% of total pharmaceutical consumption. When we consider the fact that the pharmaceutical expenditure made by ES with its 2.4 million insurees was 1.1 billion during this period, we can understand the problem easily. In 2002, while SSK with its 33 million insurees had 1,879 billion TRY pharmaceutical expenditure, ES insurees-14 times lower than the number of SSK insurees- had 1.1billion TRY annual pharmaceutical expenditure. While SSK's annual pharmaceutical expenditure per capita was 57 TRY, it was 458 TRY for ES. Main reasons behind this situation are; some of these were low pharmaceutical consumption by SSK insurees as they had difficulty in accessing medicines, they had to pay out of pocket or use medical record books of other insurees to get their medicines. Another important reason was that when compared to other insurance institutions, SSK was able to provide medicines with much more affordable price thanks to bulk purchase.

On the other hand ES had a contract with 16.000 private pharmacies across Turkey in 2002. For the outpatient treatments, active workers and pensioners (ES's own members) could access the medicine from ES-contracted pharmacies by making a co-payment (this rate was 20% for active workers and 10% for pensioners). During this period, 60% of the ES' annual health expenditure which was 1,84 billion TRY, was pharmaceutical expenditure (1.1 billion TRY). Pharmaceutical expenditure constituted 60% (1.1 billion TRY) of ES, which had 1.8 billion TRY annual health expenditure.

In 2002, insurees under BAG-KUR could get all their medicines -for outpatient treatments they received-from the contracted pharmacies by making a co-payment for prescription. The co-payment ratio was 20% for active workers and 10% for the pensioners.

Inpatients didn't pay any co-payment for their prescriptions. BAG-KUR provided 8,6 million people with health record books, and 60% of BAG-KUR's annual health expenditure which was about 2,2 billion TRY was pharmaceutical expenditure (about 1,332 billion TRY).

In 2002, with its 2,4 million civil servants and their dependents (5.1 million), the government had approximately 1.654 billion TRY health expenditure and 50% of which was pharmaceutical expenditure (817 million). By social assistance and solidarity funds, 157.7million pharmaceutical expenditure was made for citizens unable to pay for health care services.

C.6.2.2. Ministry of Health Facilities (2002)

In 2002, the amount paid for health care facilities affiliated with the MoH was 25,4% of the total health expenditure. MoH was the most important health care provider and the only institution providing preventive care services in Turkey. There were 654 hospitals, 5,055 health centers, 277 dispensaries, 298 mother and child care and family planning centers and 2,899 health posts working actively under the MoH. MoH was taking an active role in public health services, hospital services, oral and dental health services, 112 emergency health care services and health management.

SSK health care facilities transferred to MoH in 2005 were being financed by SSK. In SSK's primary health care network, there were a limited number of health clinics and dispensaries that were supposed to provide primary care to SSK enrollees. The level of the utilizing primary health care services among SSK enrollees was lower than the national average. This situation reflected the fact that the number of SSK primary health care clinics was limited, so was the access to health. In places where there were no SSK dispensaries, SSK insurees could use MoH health care facilities. However, many workplaces had a doctor providing primary health care to their employees. SSK insurees were mostly receiving health services from (120) hospitals, (200) dispensaries, (11) oral and dental health centers and (2) medical specialties under SSK. Though there were 654 hospitals under MoH, access to health services in these hospitals was quite limited for citizens. They could receive services from university hospital and private hospitals, yet with a limited access and only under specific conditions. Number of the annual consultation of about 33 million SSK insurees was 66 million and the annual number of the consultation by one SSK insuree to a physician was just around 1,8. However, in the same year, the annual number of visits to physicians was 3,1. Considering the fact that the number of visits to physicians annually in developed countries was around 6 in developed countries in 2002, we could understand better how low this number was.

Health care expenditure for SSK health care facilities in 2002 was 4,1% of the total health expenditure.

C.6.2.3. Private Health Institutions and Organizations (2002)

The amount paid for private health institutions and organizations in 2002 was 17,1% of total health expenditure in Turkey. There were hardly private hospital services before 1980s. What was called private health care facility was just physician practice. Activity field of private sector other than these practices was small clinics providing maternity care (prenatal and postpartum) with fewer than 50 beds and with outpatient care services. In 1980s, as a result of the governments' policies providing subsidies to the private sector, there was an increase in the number of private hospitals and clinics. According to data from the Ministry of Health, in the period between the years 1998-2001, it was estimated that there were approximately 11,000 physicians in the private sector and 60% of public physicians were also working in the private sector. Due to the low salaries in the public sector, allowing public sector physicians to work in the private sector was a way of keeping a sufficient number of physicians in public health services. In 2002, there were 271 private hospitals in Turkey. Private institutions were mostly in big cities like Ankara, Istanbul and Izmir. Although social security agencies, such as SSK and BAG-KUR, had contracts with private hospitals providing specialized health services, these private facilities were financed by private expenditures (80,9%).

Although there were some standards for health care providers to follow through their foundation phases, no concrete steps were taken for the measurement of the service process or service outcomes. There was confusion in terms of licensing and accreditation for these providers regarding this issue.

C.6.2.4. Health Care Facilities of the Universities (2002)

In 2002, in Turkey, the amount paid for health care facilities of the universities was 8,4% of total health expenditure. Located in big cities were 50 university hospitals providing outpatient, inpatient services and tertiary health care services. Private practices of physicians in these hospitals, which had 16% of total patient beds in Turkey, was not common as in other public hospitals as in other public hospitals. As mentioned earlier, private practices had already moved into in hospital, which was mentioned before. Citizens could get examined in these hospitals by paying fee for "private examination" in faculty member's (who would treat the patient) account at cashier's desk in hospitals. Also, patients were generally examined by medical residents. In 2002, 39,3% of the financing for these university health care facilities was provided by social security agencies like BAG-KUR, ES and SSK and 43,5% of it by the central government, 6,5% by local governments and other public institutions and finally 10,8% by private sector. The public share for this financing was 89,2%.

C.6.2.5. Other Health Care Providers (2002)

In 2002, in addition to the health care facilities mentioned above and health expenditure was also realized for military hospitals, foundation hospitals, and municipality hospitals together with the health facilities such as imaging centers, labs and opticians. Medical devices and supplies were hardly ever or never provided by hospitals even to citizens with social security insurance thus, citizens had to make OOP payments for these, either.

On the other hand, allowances paid for treatment, payments made by health funds and insurances were also important in this regard. The amount paid for other health care providers constituted a considerable sum in health care expenditures with its 7,9% share.

C.6.3. Health Expenditures by Functions (2002)

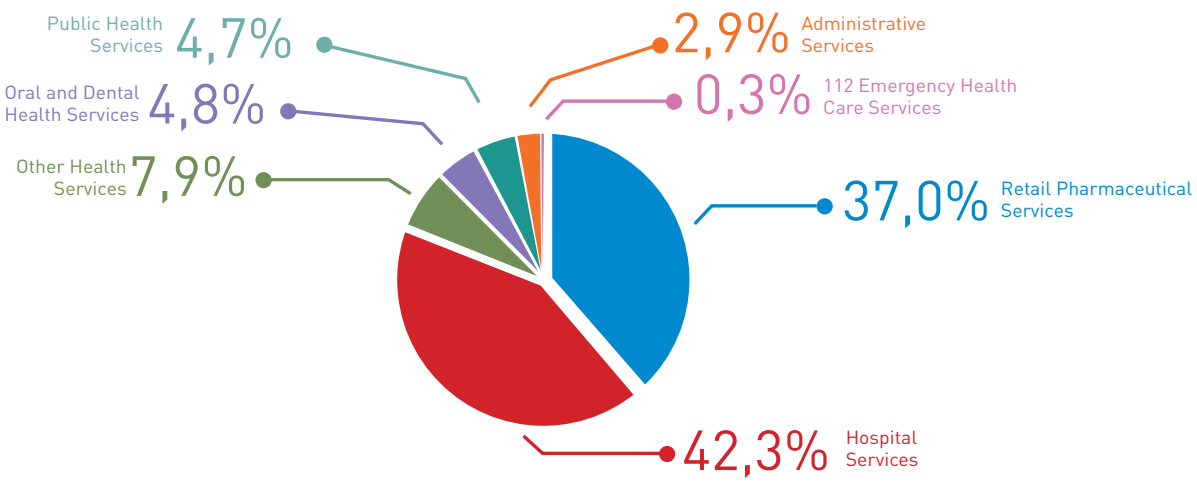
Table 7. Distribution of Health Expenditures by Service Functions, (2002), (million TRY/USD)

Type of the Health Service	TRY	As of 2013 Prices, TRY	USD	PPP USD	%
Hospital Services	7.946	22.131	5.277	13.019	42,3
Retail Pharmaceutical Services	6.955	19.371	4.619	11.395	37,0
Other Health Services	1.491	4.154	990	2.444	7,9
Oral and Dental Health Services	896	2.496	595	1.468	4,8
Public Health Services	885	2.464	587	1.449	4,7
Administrative Services	540	1.503	358	884	2,9
112 Emergency Health Care Services	62	171	41	101	0,3
Total	**18.774**	**52.290**	**12.467**	**30.760**	**100**

Source: Ministry of Health, Ministry of Development, TurkStat, SSI, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group.

When distribution of health expenditure is analyzed by functions of the health care services, it is seen that the hospital services with its 42,3% share constituted the highest amount allocated in 2002, This was followed by retail pharmaceutical services with a 37% share and other health services with a 7,9% share. The shares allocated for oral & dental health services was 4,8% and for public health services was 4,7%.

Graphic 3. Distribution of Health Expenditures by Health Service Functions, (2002)



Source: Ministry of Health, Ministry of Development, TurkStat, SSI

C.6.3.1. Public Health and Family Medicine Services (2002)

Family medicine system was not implemented yet in 2002, Turkey. Public health services were limited and inadequate. General practitioners assigned in public health services were not motivated enough at work due to their present working conditions at that time, their future expectations for their socio-economic status and for a medical specialty. Utilization level of primary health care services was quite low. The number of visits to physicians in primary health care facilities was only 1,1 in a year. Even primary health indicators for maternal and infant mortality were quite poor when compared to the developed countries. In 2002, maternal mortality rate was 64 per one hundred thousand live births and infant mortality rate per one hundred thousand live births was 31,5.

As the regular health service provision was low in rural areas, public health indicators were quite poor. Citizens were reluctant to receive health care service from the primary care facilities and had a tendency to go to hospitals directly. Insufficiencies in primary care caused long waiting lists in hospitals, and increased the service costs decreasing the service quality.

Primary and preventive care services were far from meeting the needs of the country. There were only 6 types of vaccines in the vaccination program 1980 and this number was barely 7 in 2002. Vaccination rate of the targeted child population was 78% across Turkey in 2002. This rate was even below 50% in some provinces of Southeastern Anatolia. Nothing was really done for tobacco use which is a major health problem. In 2002, only 4,7% of the health expenditure was for public health services.

C.6.3.2. 112 Emergency Care Services (2002)

112 emergency care services in Turkey were inadequate and disorganized in 2002. Level of transporting emergency cases to the hospital was quite low in rural areas and only 20% of the rural populations were able to receive this health service. Moreover, patients with no social security were asked to pay for it. In 2002, there were 618 ambulances used in 112 emergency health care services all over Turkey. The number of the cases transported to hospitals was 383 thousand. The number of the medical staff trained for disasters and emergency cases. The share allocated to 112 emergency care services was very low in health expenditure (3 per thousand) in 2002.

C.6.3.3. Hospital Services (2002)

Public sector had nearly 92% of the total bed capacity of Turkey in 2002. There were 2,4 beds per 1,000 people again in this year. Yet, there was a really serious regional disparity when Eskisehir Province in Central Anatolia (Eskisehir had 3,7 beds per 1000 people) was compared to Sirnak Province in Southeastern Anatolia (0,60 beds per 1000 people)

Ankara, Istanbul and Izmir had almost 36% of hospital beds across the country. Also, there were considerable differences in terms of the size of hospitals. For example, while health centers, an important part of the health network, could have 10 beds, this number could rise to 1,800 in the largest public hospitals. Almost half of the hospitals in Turkey were small (with 50 beds or fewer). Hospital visits were directly proportional to its bed capacity and the number of the patients. In Turkey in 2002, approximate hospital occupancy rate was 60% and length of hospital stay was about 5.8 days. There were large discrepancies among regions in number (for example, for hospital occupancy rates could change between 20% and 82%). The occupancy rate in general hospitals was lower than that of specialty hospitals.

Table 8. Data on Turkish Hospitals, (2002)

SECTOR	Hospitals		Beds		Applications to the Physicians		Inpatients		Operations	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
MoH	654	56,6	78.415	47,7	66.231.841	53,3	2.806.588	51,0	518.578	32,4
University	50	4,3	26.341	16,0	8.823.361	7,1	781.990	14,2	307.108	19,2
Private	271	23,4	12.387	7,5	4.454.410	3,6	530.359	9,6	208.578	13,0
SSK	120	10,4	28.979	17,6	43.561.287	35,0	1.363.191	24,7	553.839	34,7
Others	61	5,3	18.349	11,2	1.242.760	1,0	26.135	0,5	10.259	0,6
Total	**1.156**	**100**	**164.471**	**100**	**124.313.659**	**100**	**5.508.263**	**100**	**1.598.362**	**100**

Source: Ministry of Health

Note: Hospital figures of the ministry of national defence (MoD) were included in the number of the beds and hospitals

Occupancy rate was particularly low in district hospitals under the MoH. Due to the qualified staff shortage and the lack of appropriate equipments, these district hospitals were not utilized effectively. In general, occupancy rate in MoH hospitals was lower compared to those of SSK and university hospitals. Though there is no robust data on the quality of care and patient satisfaction regarding this period, qualitative information based on focus group discussions and informant interviews indicates that in terms of patient satisfaction and perceived quality of care, university hospitals ranked first, followed by SSK hospitals. Since underpaid MoH health staff did not have enough motivation for better care of their patients or preferred to spare much of their time working privately (in private practices), MoH hospitals generally ranked the lowest in hospital satisfaction. According to the Life Satisfaction Survey by TurkStat, the level of satisfaction with health care services was 41% for public hospitals, 46,8% for university hospitals and 49,3 for private hospitals.

More than half of the outpatients used to prefer MoH hospitals in 2002. There were also regional disparities in terms of the use of outpatient treatment services. The region which had the lowest number of physician visit was Southeastern Anatolia. This situation revealed the fact that the majority of people in the region did not have health insurance coverage and Green Card did not cover outpatient services.

SSK and MoH hospitals acted as if they had been health providers of two distinct countries. There was an increased inefficiency due to the fact that members of different social security agencies ES, BAG-KUR and SSK were allowed to receive health care services from certain hospital groups.

MoH and SSK hospital had a centralist structure. Hospital supply management and staff management were not flexible and rational. There was not a rational arrangement regarding the money that public and private health care facilities would charge in return for the provision of services

Four physicians working in the public sector used to share one examination room (it was impossible for the other remaining three physicians to meet the patients). On the other hand, citizens were waiting for long hours to get in there to be able to get examined for a few minutes. Overly bureaucratic procedures in public healthcare delivery had already both citizens and health workers stressed out. There was no organization to evaluate the demands and complaints of citizens.

Organ and tissue transplantation was a field in which the citizens were completely abandoned to their fate. Patient referrals were highly common in public health facilities. Patient referral procedures were internalized as a routine by both citizens and physicians as if it was a part of the treatment.

Citizens had no right to choose the services in the provision of health care. That is, a citizen could not even choose the physician he/she would be examined by. There was no right for them to choose their physician; there were no patient rights unit, either. In 2002, 42.3% of health expenditure was for hospital services.

C.6.3.4. Oral and Dental Health Services (2002)

In 2002, oral and dental health services in Turkey were largely left to market conditions. Citizens had to make out-of-pocket payments to the private dentists for their health needs.

Though there were 16.371 dentists in 2002, the number of the dentists employed in Ministry of Health was just 3.211. There weren't enough dental units for even half of the employed dentists in MoH. In 2002, the number of the dental units functioning actively was just 1.071.

These very few dentists employed by MoH were not provided with the adequate physical facilities and technical equipment to be able to serve. In addition to this, dentists had their own private practices like all the other physicians and there was not a payment system that could motive them to work more efficiently. In 2002, only 4,8% of health spending was on oral and dental health services in 2002.

C.6.3.5. Pharmaceuticals (2002)

Citizens had great difficulties when accessing pharmaceuticals in 2002. Even, inpatient's pharmaceuticals were not provided fully. For example; if the pharmaceuticals were available in the hospital, inpatients with Green Cards could get them, if not, then they had to supply their own pharmaceuticals which should have been provided by the hospitals. Citizens with poor income had to buy their medicines paying out of their pocket. The government was not paying for expenses for the outpatient consultations provided to Green Card holders and these citizens were referred to social assistance foundations in cities or district centers. In practice, it was difficult for these foundations to meet these needs. For this reason, citizens used to buy these medicines with their own means if they could, or they used medical record books of an insured government official with whom they were in touch or they could never get their medical needs.

Even insured citizens' access to medicines was difficult. Outpatient prescription drugs were to be obtained from SSK pharmacies. Despite the long struggle of the citizens, it was almost impossible for citizens to access the complete set of medicines they needed. There were no modern and rational arrangements to protect the public rights in relation to intellectual property rights and pharmaceuticals' licensing, production, pricing, selling, exportation, promotion, control, research or development activities. In 2002, a large part of the total health expenditure (37%) was for medicines provided by retail.

C.6.3.6. Health Management (2002)

There was not even a conceptual level approach on the performance/quality management and organization of the hospitals in Turkey, 2002. Hospital manager's power over management process and purchasing or staff was limited. The existing health system let health managers neither think nor act in an entrepreneurial way and take initiatives. There was not only efficiency-based financial management model but also reporting and supervision systems which could hold the managers accountable for their actions

Ministry of Health used to produce information just for its own institutions rather than providing it to the whole sector. Since ample coordination and supervision was not achieved through the data gathering and data flow, the statistical results were not reliable. Ultimately, this data couldn't be converted into knowledge and used for management purposes. The understanding of "strategic management" was not promoted in health sector. Since MoH was focused more on serving for its own organizations, the MoH was insufficient in policy development and stirring the health sector. Data gathering remained limited to just collecting health records and storing them thus MoH couldn't take the advantage of these information systems' main functions; converting the data into knowledge, analyzing this knowledge and supporting the management by using it.

There was no effective coordination between the Ministry, SSK, university hospitals, institution hospitals and private hospitals so service and investment planning didn't use to be done in parallel with social needs. In 2002, 2,9% of health expenditure was for management services.

C.6.4. Health Expenditures by Spending Item (2002)

C.6.4.1. Current Health Expenditure: The largest share in current health expenditure constituting 97,6% of health expenditures was pharmaceutical expenditures.

C.6.4.2. Health Investment Expenditures: The largest share of the investment expenditures in 2002 was the construction expenditures.

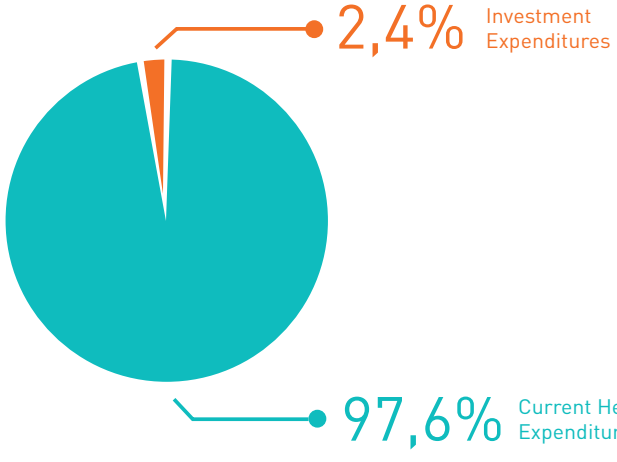
Table 9. Distribution of Health Expenditures by Spending Item, (2002), (million TRY/USD)

Quality of the Health Service	TRY	As of 2013 Prices, TRY	USD	PPP USD	%	%
Current Health Expenditures	**18.331**	**51.056**	**12.173**	**30.035**	**100,0**	**97,6**
Pharmaceuticals	7.290	20.304	4.841	11.944	39,8	38,8
Personnel	4.446	12.382	2.952	7.284	24,3	23,7
Other Current Expenditures	1.844	5.136	1.225	3.021	10,1	9,8
Medical Supplies	1.555	4.331	1.033	2.548	8,5	8,3
Unclassified Spending	992	2.763	659	1.625	5,4	5,3
Service Procurement	921	2.564	611	1.508	5,0	4,9
Health Management	540	1.503	358	884	2,9	2,9
Liabilities	404	1.126	268	662	2,2	2,2
Medical Examination	340	947	226	557	1,9	1,8
Investment Expenditures	**443**	**1.234**	**294**	**726**	**100,0**	**2,4**
Construction	233	650	155	382	52,7	1,2
Tools And Equipment	148	411	98	242	33,3	0,8
Maintenance	46	127	30	75	10,3	0,2
Other	10	27	7	16	2,2	0,1
Ambulances	6	18	4	11	1,5	0,0
Total	**18.774**	**52.290**	**12.467**	**30.760**		**100,0**

Source: Ministry of Health, Ministry of Development, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH.

When Turkish health expenditures are evaluated in terms of spending items, it can be seen that 97,6% of health care expenditures in 2002 consisted of current health expenditures and 2,4% consisted of investment expenditures.

Graphic 4. Distribution of Health Expenditures by Spending Item, (2002)



Source: TurkStat

Chapter Two

Developments in Turkish Health Care System (2003-2013)

Developments in Turkish Health Care System (2003 – 2013)

A number of major developments occurred in the national health care system in 2003-2013 period which are set out in the Annex for a more in-depth review. The most prominent developments are briefly listed in the following:

A. Developments in 2003

- "Health Transformation Program" was put into implementation.
- Mechanisms were introduced so that the system of patients being held in hospitals as pawns due to non-payment of fees was abrogated.
- Free-of-charge ambulatory health care services were extended to all rural areas across the country.
- Total quality management (TQM) was put in place in the MoH-affiliated health care facilities.
- Immunization days were organized in scope of the national measles immunization campaign.
- "Performance-based Supplementary Payment System" was introduced for the MoH-affiliated health care facilities.
- A new employment model on contractual basis peculiar to the Ministry of Health was put into force which targeted improved service delivery in rural and under-developed areas.
- Social security coverage was expanded for government employees and private health care facilities were made accessible.
- Insurees were provided access to both SSK and public hospitals by the "MoH-SSK Protocol for Common Use of Their Health Care Facilities".
- "Ministry of Health Call Center (SABIM)" was established to open up a communication channel with people and "Patient Rights Units" were established for patient claims.

B. Developments in 2004

- "Reimbursement Commission" was set up for reimbursement decisions.
- Conditional cash transfers started. Accordingly, the poorest and the most deprived 6% of the population (pregnant women and children) received cash assistance on condition that they underwent necessary medical examinations.
- The VAT was reduced from 18% to 8% for medicinal products.
- High schools for health professions, which had been affiliated with the Ministry of Health, were devolved to the Ministry of Education.
- Setting reference prices for pharmaceuticals based on the cheapest price in the five EU countries (France, Italy, Spain, Portugal, and Greece) resulted in price reductions of up to 80% in medicinal products.
- "Prevention of Vitamin D Deficiency and Bone Health Protection Program" was launched and free iron drops and Vitamin D support were provided for infants and pregnant women.
- 112 Emergency Care Services were made free-of-charge for people with no social security benefits.
- "Conscious Mothers and Healthy Babies Project" was developed and baby-friendly hospitals were increased in number.
- Free cancer screening and training centers were established in all of 81 provinces.
- The coverage of the Green Card was widened retrospectively for poor people who got sick within 90 days after they had applied for but not received the Green Card benefits yet.
- Costs of the outpatient treatments, medical examinations and tests, tooth extractions, dental prostheses, optical services and pharmaceuticals within the Green Card System were covered by the government.
- "Law on Pilot Implementation of Family Medicine" was enacted.

C. Developments in 2005

- The SSK health care facilities were devolved to the MoH, separating health service delivery from health service financing in the health care sector. The SSK pharmacies were closed down and the SSK beneficiaries were provided access to private pharmacies.
- Pharmaceutical bioequivalence approach was adopted for the ES (Emekli Sandigi/ Government Employees' Retirement Fund) scheme. Accordingly, disbursement was allowed up to 30% of the most inexpensive bioequivalent pharmaceutical.
- The scope of the "Performance-based Supplementary Payment System" implemented in the MoH facilities was expanded to include the organizational and quality criteria as well as others.
- It was ruled that the patient rooms were to be designed as single or double occupancy rooms. Accordingly, patient room design shifted from ward to quality single-room or shared accommodation offering built-in bathroom, television and refrigerator.
- It was ruled that an examination room was to be allocated for each physician in the MoH-affiliated hospitals and patients were granted the right to choose their physicians.
- Establishment of patient rights units and commissions was made mandatory in health care facilities.
- 20% co-payment was collected from the Green Card beneficiaries for pharmaceuticals.
- City or suburban ambulance patient transfers via 112 Emergency Care Service network was made free-of-charge for all people.
- The price ceiling for generic medicines produced from domestic raw materials, which was up to 80% of the originals before, was brought down to 70%.
- Compulsory medical service was re-introduced for physicians.
- The article, which envisaged amendment to the Health Care Services Fundamental Law for the Public-Private Partnership (PPP) model in health sector investments, was adopted in the Turkish Grand National Assembly (TGNA).
- "Family Medicine System" was piloted in Duzce Province on 15 September 2005.
- "Population Health Centers" were set up.

D. Developments in 2006

- A positive list of pharmaceuticals was compiled for common use by all institutions.
- The MoH launched the "field coordination system" for on-site monitoring of practices and suggestions for solutions to relevant problems in the field.
- "Expanded Immunization Program (EIP)" was introduced and covered rubella, mumps and meningitis vaccines.
- It was decided to provide free-of-charge diagnostic, curative, follow-up and preventive care services for tuberculosis patients and their close house contacts.
- "Social Security Institution (SSI) Law No. 5502" came into effect and the social security agencies existing in that period (SSK, BAG-KUR and ES) were unified.
- The price ceiling for bioequivalent pharmaceutical groups, which was up to 30% of the originals until May 15, 2006, was brought down to 22% thereafter.
- Delivery of health care services, which had variations by service providers, were standardized by the Social Insurance Law No. 5510 and the Social Security Institution Law, and mandatory national Universal Health Insurance scheme was established.
- Global budgeting was introduced for the MoH institutions with revolving funds.
- The number of medicinal products in the positive list was reduced and case payment was started for outpatient treatment services.
- A pharmaceutical expenditure tracking system was set up in the SSI and the "MEDULA" system was put into implementation.
- "European Charter on Counteracting Obesity" was signed and "Turkey Healthy Eating and Active Living Program" was developed.
- The national "Neonatal Screening Program" was launched to screen newborns for phenylketonuria and congenital hypothyroidism.

E. Developments in 2007

- The Treasury share deducted from the MoH revenues was reduced from 15% to 1%.
- Snow palette ambulances and marine ambulances were put into service.
- Necessary arrangements were made for collective procurement procedures of the MoH facilities.
- Both SSK and BAG-KUR insurees were allowed to use university hospitals and contracted private health care facilities directly, just like the ES beneficiaries.
- As a result of the trilateral agreement signed between the MoH, MoF and the SSI, lump sum service contracts were introduced to disburse payment for primary health care services.
- Primary health care services were made free-of-charge for all people even if they were not covered by any social security scheme.
- Benefit packages were put into use for inpatients and outpatients in the MoH hospitals, university hospitals and private hospitals having contracts with the SSI.
- The SSI-contracted hospitals were required to provide all health care services for inpatients including medicines and medical supplies & equipment.
- The SSI-contracted MoH, university and private hospitals were required to use the MEDULA system.
- Medical visit and referral forms used in hospital visits were abolished for insurees except for the active employees specified by the Law No. 506. Patients were allowed to visit hospitals using their health cards and official ID cards indicating their citizenship identity number.

F. Developments in 2008

- Financial risk monitoring was introduced for the MoH hospitals according to the relevant criteria identified by the Ministry.
- Arrangements were made so that the MoH-affiliated facilities could purchase goods and services from each other.
- Smoking was banned in all indoor workplaces and public places, including government buildings and public transportation vehicles and taxis, in addition to the ban in certain outdoor areas where cultural, artistic, sports, or entertainment activities were held.
- New licensing procedures were adopted for private health care facilities and establishment of private health care facilities – including health personnel employment – was preplanned.
- A new descriptor called "square code" was put into implementation for pharmaceuticals.
- Pentavalent vaccines were included in the routine immunization program.
- Pneumococcal conjugate vaccine was put into use.
- "Community-based Mental Health Care Services" were launched.
- All health care facilities, which are in charge of delivering emergency care services, were required to accept emergency cases and perform necessary medical interventions.
- It was ruled that private health service providers could charge an extra fee up to 30% above the price paid by SSI for procedures other than hotel services and exceptional health care services.
- Air ambulances were integrated to the ambulance network.
- The SSK, BAG-KUR and ES Laws were abolished and the Universal Health Insurance (UHI) was introduced.
- Copayment was collected for outpatient treatments, amounting to 3 TRY for secondary care facilities, 4 TRY for training and research hospitals, 6 TRY for university hospitals and 10 TRY for private health care facilities.
- Private hospitals were prohibited from extra billing for burn treatments, newborn care, organ transplantations, congenital anomalies, dialysis procedures and cardiovascular surgeries.
- All insurees were provided with the opportunity to receive medical treatment abroad pertaining to the cases that could not be treated in Turkey. As for the SSK and BAG-KUR insurees, the minimum period for premium payment, which was required to receive health care benefits, was reduced from 120 days to 30 days.
- Goods and service procurements by and among the contracting authorities that are under the scope of the Law No. 4734 with a view to providing diagnosis and cure were exempted from the public procurement law.

G. Developments in 2009

- Pertaining to reimbursement for the costs of equivalent pharmaceuticals, the ceiling price was brought down from 22% to 15% of the cheapest medicinal product which had the same active ingredient and could be prescribed for the same indication, too.

- Home care services were started.

- Procurement of and disbursement for health services in the MoH hospitals was ruled by a service procurement contract signed with the SSI and billing was removed after the system was generalized.

- With the aim of ensuring sustainability and predictability for pharmaceutical spending, global budgeting was introduced in the pharmaceutical sector in 2010-2012 period. The manufacturer's price for original medicinal products the generics of which were also available in the market was brought down from 100% to 66% of the reference price in order to meet the global budget targets for medicinal products. 100% of the manufacturer's price was still taken as basis for original medicinal products or products without generics in the market; however, the public discount applied by the SSI was increased from 11% to 23%. While 80% of the reference price was taken as a basis for pricing generic medicines in the past, the threshold was brought down to 66%. While pricing for old medicinal products with more than 20-year market availability was not based on reference prices before, the reference price system was introduced for such products and set up as 100% of the manufacturer's price.

- Price query and average cost estimates were required for the MoH through the Material Resources Management System (MRMS). Maximum Stock Implementation was started and the stock levels were limited to 3 months maximum. "Surplus Movable Property Module" and "Excess Movable Property Module" were developed for disinvestment and avoiding wastage of materials with close expiry dates, resulting in substantial cost savings.

- Staff supply and wage-related standards were developed for the personnel to be employed in the MoH facilities through service contracts and the profit rate was reduced from 20% to 8%.

- "Provincial Stock Pools" were established for the MoH facilities and "Stock Coordination Teams" and "Central Procurement Units" were set up in provinces. All stocks in provinces were pooled in the provincial stock pools. Purchasing power of small-scaled hospitals was limited and their needs were met by large-scaled hospitals. As a result, the number of hospitals, which were authorized to procure medicinal products and medical supplies & equipment, decreased from 835 to 312 and it was ruled that medicinal products and medical supplies & equipment would be procured at the provincial level via framework contracts.

- Mobile pharmacies were opened up in order to facilitate access to medicines for people who lived in rural areas with no pharmacies in the neighborhood.

- "Commission of Pharmaceutical Expenditure Monitoring and Evaluation" was established for systematic monitoring and evaluation of health spending and development of strategies required.

- It was ruled that private health service providers could charge up to an additional 70% of the SSI tariff.

H. Developments in 2010

- Private hospitals were classified and co-payments amounting 30% to 70% were identified by different classes by the "Directive on Rating Private Hospitals and Extra Billing".
- Health service payments for government employees and their dependents were devolved to the SSI.
- "Law on Full-Time Medical Practice for University and Ministry of Health Personnel" was adopted.
- Pays for hour shifts were increased for the health care personnel, from 80 hours to 130 hours per month. The coverage of the shift system was extended for non-health care personnel and shift pays were offered in oral and dental care facilities and in 112 emergency care service network.
- As for physician salaries, partial advance payments were made to physicians from their performance-based bonuses (which were treated as regular earnings) and the SSI premium payments were deducted from these partial advance payments which paved the way for an additional pension for physicians.
- "Medical Malpractice Liability Insurance" was introduced in order to guarantee the right of compensation against physicians in cases of medical malpractice.
- The MoH and university facilities signed a protocol for cooperation and common use of facilities.
- Legal arrangements were made for devolution of the Turkish Red Crescent (KIZILAY) hospitals and medical centers to the Ministry of Health.
- Preliminary efforts were made to set up an "Early Warning and Response System" (EWRS) for monitoring communicable diseases.
- "Central Hospital Appointment System" was piloted.
- "Managerial Performance" was introduced for the managers in the MoH hospitals.
- Ambulance aircrafts were integrated into the air ambulance network.
- It was decided to give 337 million TRY Treasury grant to the university hospitals having financial bottlenecks. Accordingly, 209 million TRY was granted to these hospitals in 2010 and 168 million TRY was granted in 2011.
- Necessary arrangements were completed so that the Green Card holders could receive free dental treatments (such as root canal therapy and dental filling) and emergency and intensive care services in private hospitals.
- "Pharmaceutical Track & Trace System" (PTS) was piloted.

I. Developments in 2011

- With the aim of avoiding financial bottlenecks that were likely to occur from the prohibition of extra-billing for private consultations at university hospitals, an additional fund of 448 million TRY was allocated for the medical school faculty members for once only in 2011.
- The medicines to be used for smoking cessation treatments were provided free of charge.
- Job descriptions were made for health professions which had not been described before.
- Child Monitoring Centers (CIM) were established in order to prevent child abuse and perform proper and effective interventions in cases of child abuse.
- Legal arrangements were made in order to cancel debts of the persons who lost their lives in public hospitals when they were not covered by any social security scheme and not capable of paying for hospital services while being treated.
- Having signed a 10-year protocol with the Ministry of Finance, the MoH became entitled to rent commercial revenue-generating properties (such as cafeterias, canteens and parking lots etc.) in the MoH hospitals and the family medicine centers out to the third parties.
- 112 Emergency Care Personnel were provided charge-free meal service during work hours.
- For original medicinal products, the generics of which were also available in the market, the manufacturer's price was brought down from 66% to 60% of the reference price. Public discount, which was 32,5% for all medicinal products, was increased by 7,5% and reached to 40%. Public discount was increased to 41% for the original medicinal products with no generics or without generics available in the market. While 100% of the reference price was taken as basis for old medicines with more than 20-year market availability in the past, 80% of the reference manufacturer's price was accepted by the respective regulation. The maximum disbursement limit, which was up to 15% of the cheapest medicinal product, was reduced to 10%.
- The organizational structure of the Ministry of Health was redesigned and the MoH organization was restructured as the Ministry of Health, Turkish Public Hospitals Agency, Public Health Institute of Turkey, Pharmaceuticals and Medical Devices Agency of Turkey and the General Directorate of Health for Borders and Coastal Areas of Turkey.

J. Developments in 2012

- Triage procedures were applied in order to determine the amount of co-payments to be collected for outpatient treatments and consultations in emergency care services.
- Health service premiums for the Green Card holders were devolved to the SSI.
- 3 TRY co-payment were collected for prescribing by family physicians.
- The VAT rate on imported raw materials, which were used for medicinal production, was reduced from 18% to 8%.
- The upper limit of extra-billing, which is allowed in private hospitals, was increased from 70% to 90%.
- As a result of collective bargaining, personnel rights of the employees were significantly improved by the "Board of Arbitration".
- The central and provincial organization of the Ministry of Health was re-structured as ordered by the Decree Law No. 663. Accordingly, health directorates were established in districts in addition to those already existing in provinces. Within the provincial organizational structure of the Public Health Institute of Turkey and Turkish Public Hospitals Agency, public health directorates and general secretariats were established in provinces. All the personnel performing in the general secretariats and the directors in hospitals and oral care centers were employed on a contract basis.
- It was decided that the spending on early screenings for cancer (breast, cervical and colon cancers) would be met from the MoH global budget.

K. Developments in 2013

- With the aim of empowering primary health care services, the "Regulation on the Practice of Family Medicine" was issued and identified and regulated working rules and principles for staff in scope of the Family Medicine System.
- Studies and researches were launched in order to adapt the EU Guidelines on Good Distribution Practice to Turkey.
- "Learning Hospital Project", which aims at raising morale and motivation of hospital staff and patients/affiliates going through a long-term treatment process in health care facilities, was designed in cooperation with the General Directorate of Life Long Learning of the Ministry of Education (MoE) and piloted in 13 provinces and 15 health care facilities.
- In the framework of the European Union standards and good clinical practices, the "Regulation on Clinical Researches and Studies" was issued, identifying the rules and principles for conducting scientific studies on humans and protecting the rights of volunteer human subjects.
- "National Action Plan for Rational Drug Use 2014-2017" was developed in order to ensure coordination and collaboration for rational drug use-supporting activities and behavioral changes in correspondents.
- Legal amendments were made to the effective laws allowing academic members to receive bonus payments, which are proportional with their titles and will be paid in return for the extra services they offer after work hours, as agreed by the SSI and regulated by the university executive boards.
- "Directive on Health Care Services to be offered in scope of Health Tourism and Protecting the Health of Tourists" came into effect.
- The ceiling rate for extra billing at private hospitals was increased from 90% to 200% by the Cabinet Decision.
- Using the Prescribing Information System (PIS), feedback has been given to physicians since November 2013 about the prescriptions they have written out.
- Service Provision Standards and On-Site Evaluation Criteria were developed for patient care and hotel services for health care.

Chapter Three

Health Expenditures (2002-2013)

Health Expenditures (2002 - 2013)

A. Health Expenditures by Years

Table 10 presents total health expenditures in Turkey between 2002 and 2013.

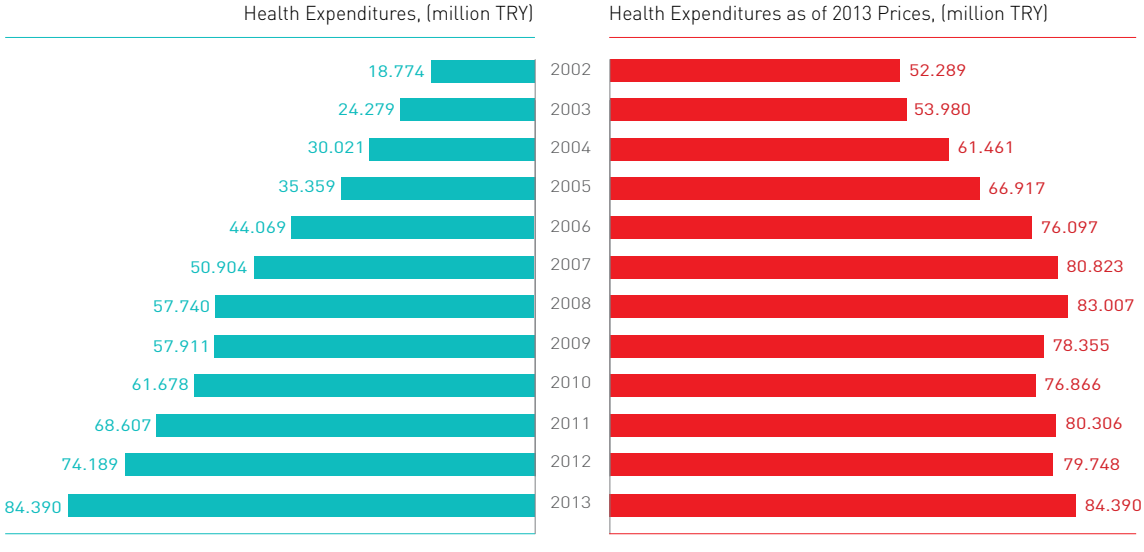
Table 10. Health Expenditures, (2002-2013), (million TRY/USD)

Years	TRY	As of 2013 Prices,TRY	USD	PPP USD
2002	18.774	52.289	12.467	30.760
2003	24.279	53.980	16.261	31.497
2004	30.021	61.461	21.107	37.050
2005	35.359	66.917	26.372	42.568
2006	44.069	76.097	30.793	52.062
2007	50.904	80.823	39.112	58.854
2008	57.740	83.007	44.659	64.872
2009	57.911	78.355	37.434	63.733
2010	61.678	76.866	41.108	65.578
2011	68.607	80.306	41.082	69.516
2012	74.189	79.748	41.388	70.466
2013	84.390	84.390	44.385	76.844
Increase in 2002-2013 (Folds)	3,5	0,6	2,6	1,5

Source: TurkStat

Health Expenditures increased by 350% in nominal terms and by 61% in real terms between 2002 and 2013.

Graphic 5. Health Expenditures, (2002-2013), (million TRY)



Source: TurkStat

B. Health Expenditures as a Share of GDP by Years

Table 11 indicates health expenditures as a share of GDP in Turkey between 2002 and 2013.

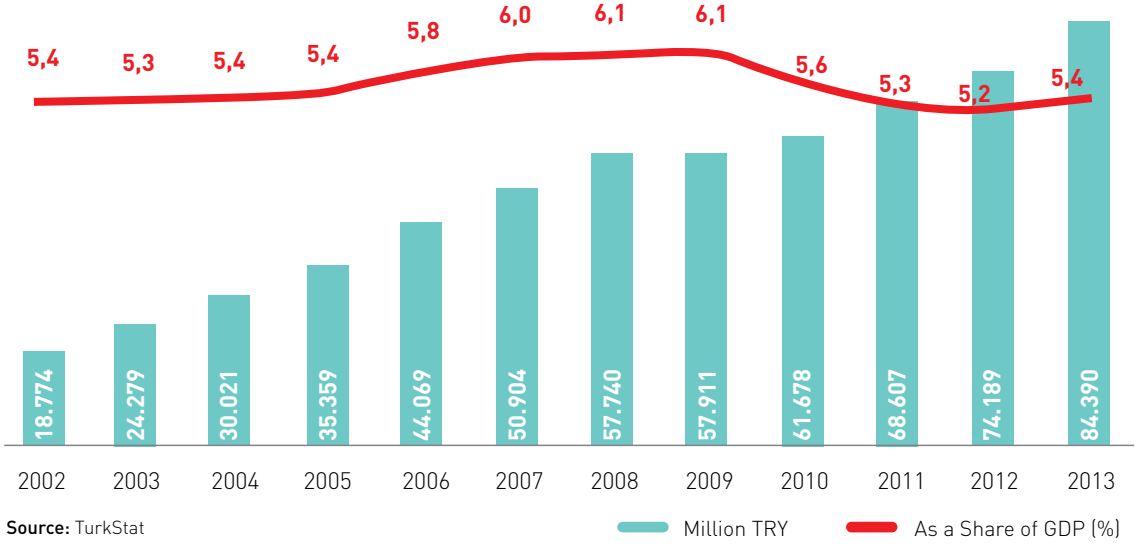
Table 11. Health Expenditures as a Share of GDP, (2002-2013)

Years	Health Expenditures, million TRY	GDP, million TRY	Health Expenditures as a Share of GDP (%)	Health Expenditures as a Share of GDP in the OECD Countries (%)
2002	18.774	350.476	5,4	8,3
2003	24.279	454.781	5,3	8,5
2004	30.021	559.033	5,4	8,6
2005	35.359	648.932	5,4	8,7
2006	44.069	758.391	5,8	8,6
2007	50.904	843.178	6,0	8,6
2008	57.740	950.534	6,1	8,9
2009	57.911	952.559	6,1	9,6
2010	61.678	1.098.799	5,6	9,4
2011	68.607	1.297.713	5,3	9,3
2012	74.189	1.416.798	5,2	9,2
2013	84.390	1.565.181	5,4	-

Source: TurkStat and OECD Health Data

Health expenditures as a share of GDP did not change (5,4%) in spite of the improvements made in health care services over the 2002-2013 period. The percentage, which seems lower compared to the OECD average that was 9,2% in 2012, needs to be evaluated by considering some domestic factors such as the ratio of elderly/child population and supply of health care personnel.

Graphic 6. Health Expenditures as a Share of GDP, (2002-2013)



Source: TurkStat

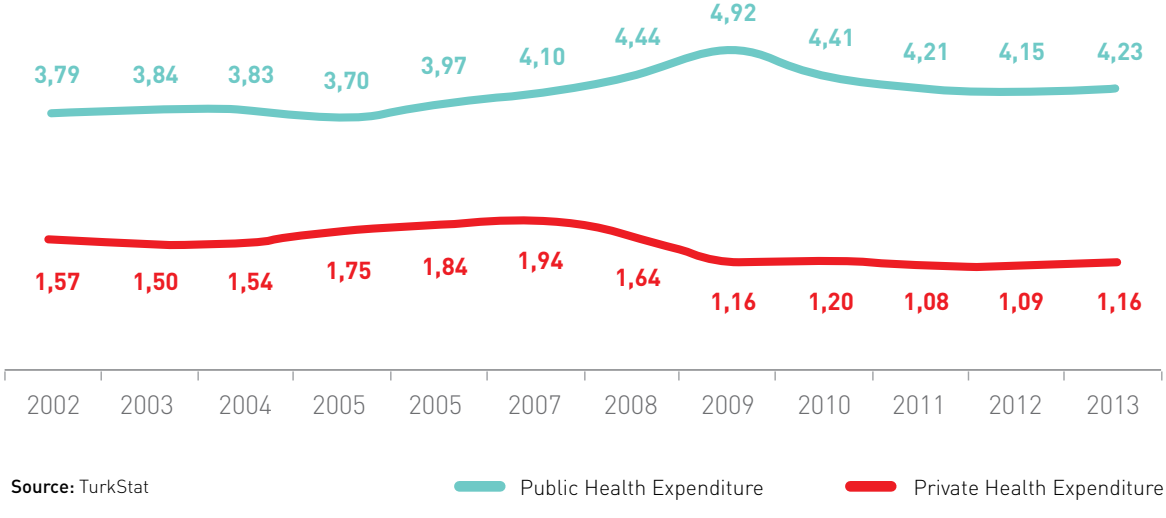
Table 12. Public and Private Health Expenditures as a Share of GDP, (2002-2013), (%)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Public Health Expenditures	3,79	3,84	3,83	3,70	3,97	4,10	4,44	4,92	4,41	4,21	4,15	4,23
Private Health Expenditures	1,57	1,50	1,54	1,75	1,84	1,94	1,64	1,16	1,20	1,08	1,09	1,16
Total Health Expenditures	**5,36**	**5,34**	**5,37**	**5,45**	**5,81**	**6,04**	**6,07**	**6,08**	**5,61**	**5,29**	**5,24**	**5,39**

Source: TurkStat

To compare the year 2002 with the year 2013, health expenditures as a share of GDP (5,4%) did not change in that period whereas the structure of financing did. While 3,8% of health expenditures as a share of GDP was funded by the public sector, the percentage increased to 4,2% in 2013.

Graphic 7. Public and Private Health Expenditures as a Share of GDP, (2002-2013), (%)



Source: TurkStat

Public Health Expenditure

Private Health Expenditure

C. Per Capita Health Expenditures by Years

Table 13 presents per capita health expenditures by years in Turkey between 2002 and 2013.

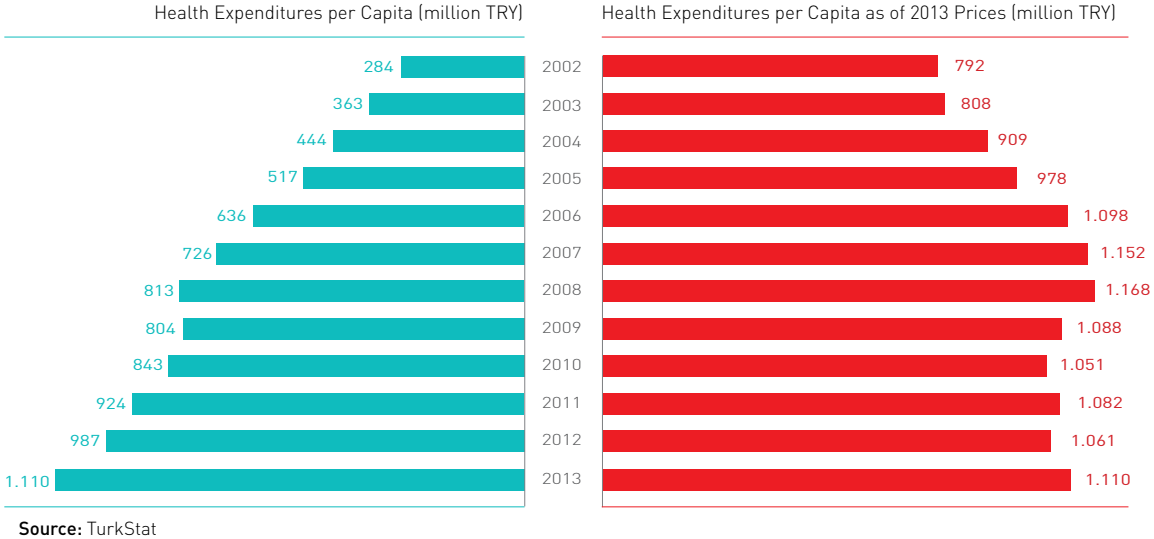
Table 13. Health Expenditures per Capita, (2002-2013), (TRY/USD)

Years	TRY	As of 2013 Prices, TRY	USD	PPP USD
2002	284	792	189	466
2003	363	808	243	472
2004	444	909	312	548
2005	517	978	385	622
2006	636	1.098	444	751
2007	726	1.152	557	839
2008	813	1.168	629	913
2009	804	1.088	520	885
2010	843	1.051	562	897
2011	924	1.082	553	937
2012	987	1.061	551	937
2013	1.110	1.110	584	1.010
Increase in 2002-2013 (Folds)	2,90	0,40	2,09	1,17

Source: TurkStat

Health expenditures per capita increased by 290% in nominal terms and by 40% in real terms between 2002 and 2013. In the same period, health expenditures per capita increased by 209% in US Dollar and by 117% in US Dollar PPP, in parallel with the economic progress in Turkey.

Graphic 8. Health Expenditures per Capita, (2002-2013), (TRY)



Source: TurkStat

Table 14. Public Health Expenditures per Capita, (2002-2013), (TRY/USD)

Years	TRY	As of 2013 Prices, TRY	USD	PPP USD
2002	201	560	134	329
2003	261	581	175	339
2004	316	648	222	391
2005	351	663	261	422
2006	435	750	304	513
2007	492	781	378	569
2008	593	853	459	667
2009	651	881	421	716
2010	663	826	442	705
2011	735	861	440	745
2012	782	841	436	743
2013	871	871	458	793
Increase in 2002-2013 (Folds)	3,33	0,56	2,43	1,41

Source: TurkStat

Public health expenditures per capita increased by 333% in nominal and by 56% in real terms between 2002 and 2013.

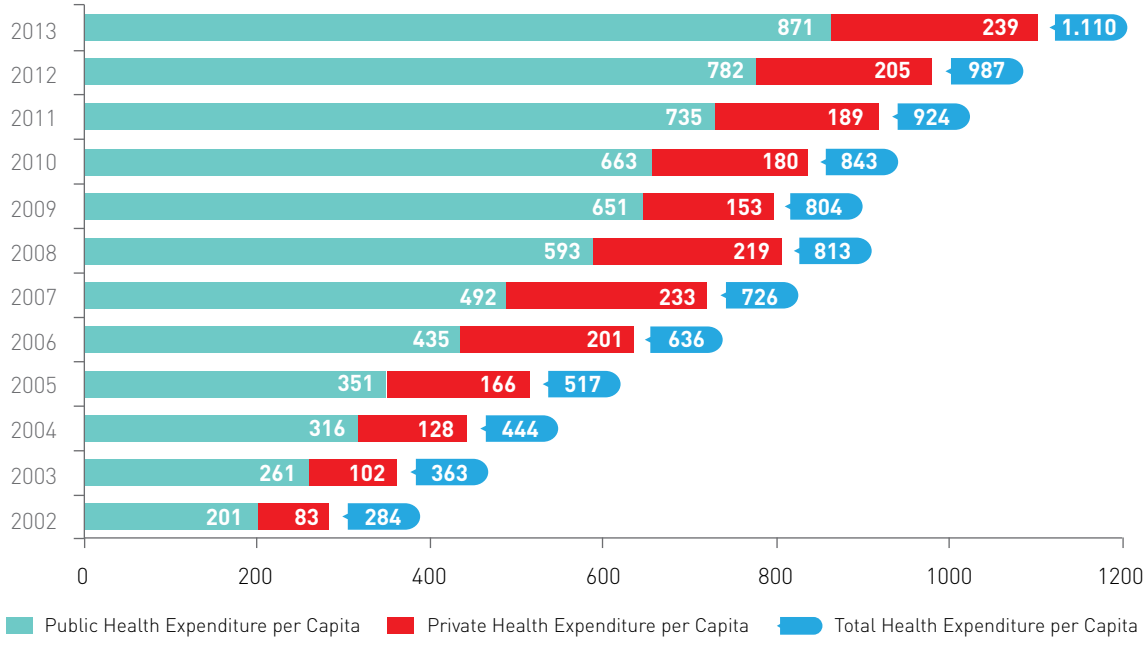
Table 15. Private Health Expenditures per Capita, (2002-2013), (TRY/USD)

Years	TRY	As of 2013 Prices, TRY	USD	PPP USD
2002	83	232	55	137
2003	102	227	68	132
2004	128	261	90	158
2005	166	314	124	200
2006	201	348	141	238
2007	233	371	179	270
2008	219	315	170	246
2009	153	207	99	168
2010	180	225	120	192
2011	189	221	113	191
2012	205	220	114	195
2013	239	239	126	217
Increase in 2002-2013 (Folds)	1,86	0,03	1,27	0,59

Source: TurkStat

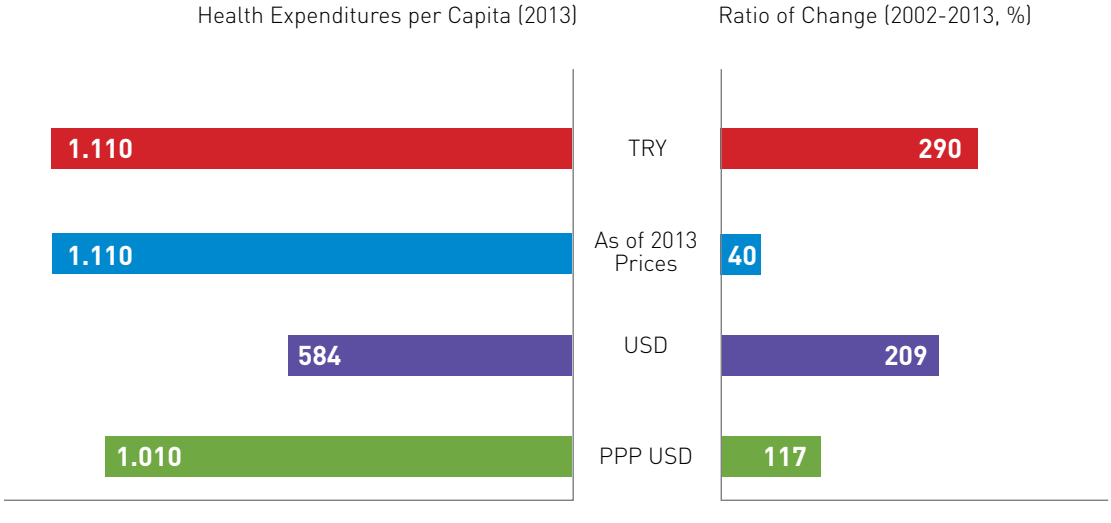
Private health expenditures per capita increased by 186% in nominal and by 3% in real terms within the same period.

Graphic 9. Public and Private Health Expenditures per Capita, (2002-2013), (TRY)



Source: TurkStat

Graphic 10. Change in Health Expenditures per Capita, (2002, 2013), (TRY/USD)



Source: TurkStat

Chapter Four

Health Expenditures by Financing Agents (2002-2013)

Health Expenditures by Financing Agents (2002-2013)

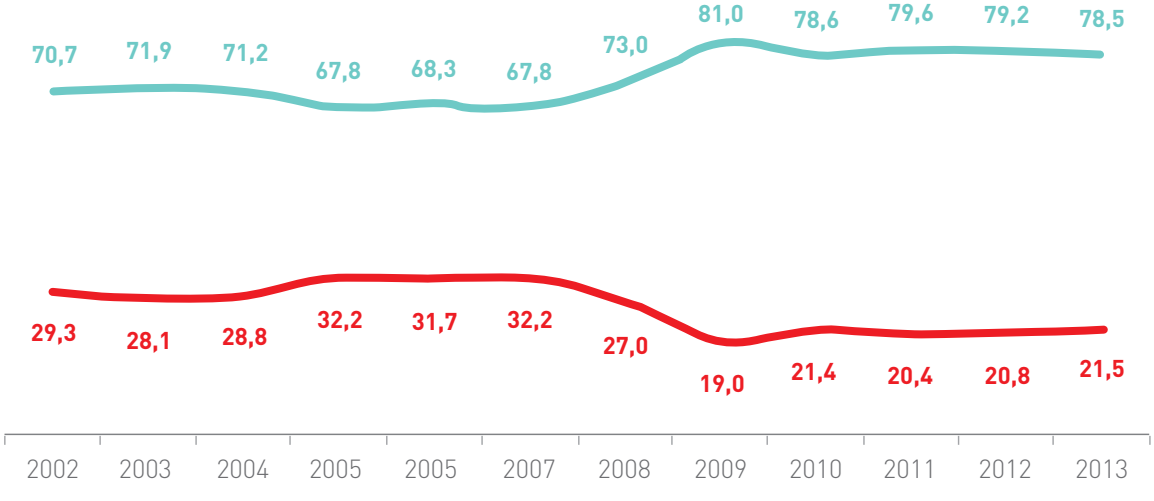
Table 16. Public and Private Health Expenditures, (2002-2013), (million TRY)

Years	Public Health Expenditure	Private Health Expenditure	Total Health Expenditure	Share of Public Health Expenditure	Share of Private Health Expenditure
2002	13.270	5.504	18.774	70,7	29,3
2003	17.462	6.817	24.279	71,9	28,1
2004	21.389	8.632	30.021	71,2	28,8
2005	23.987	11.372	35.359	67,8	32,2
2006	30.116	13.953	44.069	68,3	31,7
2007	34.530	16.374	50.904	67,8	32,2
2008	42.159	15.580	57.740	73,0	27,0
2009	46.890	11.021	57.911	81,0	19,0
2010	48.482	13.196	61.678	78,6	21,4
2011	54.580	14.028	68.607	79,6	20,4
2012	58.785	15.404	74.189	79,2	20,8
2013	66.228	18.162	84.390	78,5	21,5

Source: TurkStat

Significant changes occurred in the financing structure of health expenditures in Turkey between 2002 and 2013. While 70,7% of health spending was financed by the public sector and 29,3% financed by private expenditures in 2002, the public sector share increased to 78,5% and the private sector share decreased to 21,5% in 2013. Public share in financing of health care services increased in Turkey in 2002–2013 period.

Graphic 11. Public and Private Health Expenditures, (2002-2013), (%)

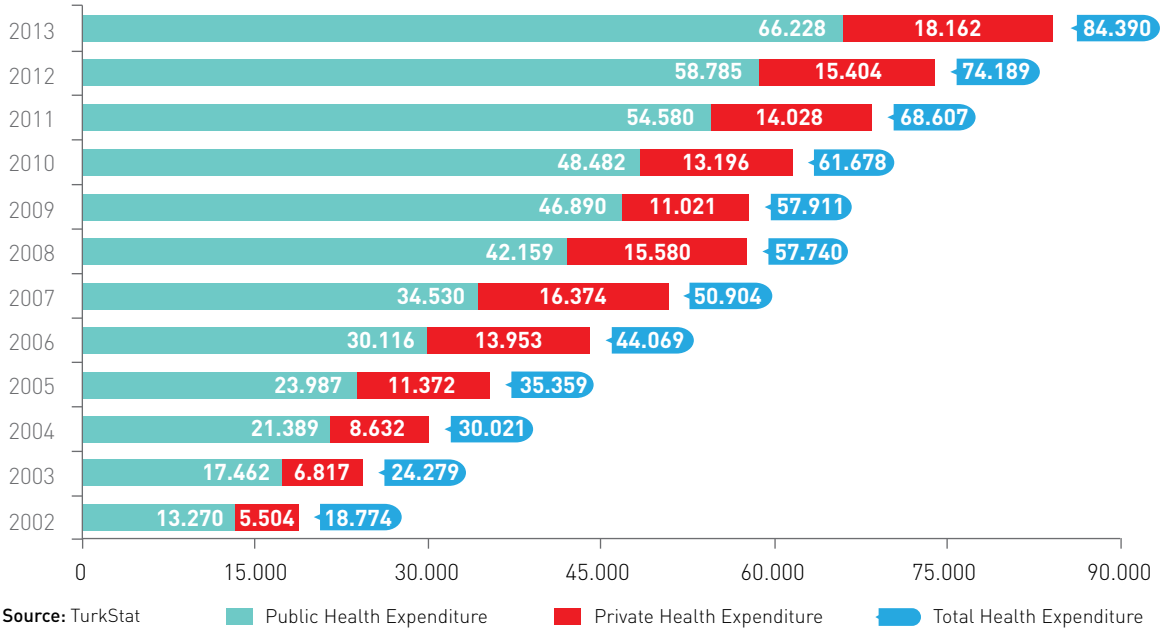


Source: TurkStat

Public Health Expenditure

Private Health Expenditure

Graphic 12. Public and Private Health Expenditures, (2002-2013), (million TRY)



Source: TurkStat

The years between 2002 and 2013 turned out to be a period in which structural changes were introduced for financing agents in the health care sector. Social security agencies were merged and payments for civil servants and the Green Card beneficiaries were devolved to the SSI.

Table 17. Distribution of Health Expenditures by Financing Agents, (2002-2013), (TRY/USD)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security	TRY	7.631	10.662	13.231	14.000	17.667	19.697	25.346	28.277	30.695	34.937	41.630	46.993	5,2
	%	40,6	43,9	44,1	39,6	40,1	38,7	43,9	48,8	49,8	50,9	56,1	55,7	
Central Government	TRY	5.283	6.317	7.659	9.520	11.766	13.966	15.948	17.946	17.209	19.086	16.493	18.425	2,5
	%	28,1	26,0	25,5	26,9	26,7	27,4	27,6	31,0	27,9	27,8	22,2	21,8	
Local Governments and Other Public Institutions	TRY	356	482	500	467	683	867	865	667	577	557	662	810	1,3
	%	1,9	2,0	1,7	1,3	1,6	1,7	1,5	1,2	0,9	0,8	0,9	1,0	
Public Health Expenditures	TRY	13.270	17.462	21.389	23.987	30.116	34.530	42.159	46.890	48.482	54.580	58.785	66.228	4,0
	%	70,7	71,9	71,2	67,8	68,3	67,8	73,0	81,0	78,6	79,6	79,2	78,5	
Out-of-Pocket Health Expenditures	TRY	3.725	4.482	5.775	8.049	9.684	11.105	10.036	8.142	10.062	10.590	11.750	14.156	2,8
	%	19,8	18,5	19,2	22,8	22,0	21,8	17,4	14,1	16,3	15,4	15,8	16,8	
Other Private Health Expenditures	TRY	1.779	2.335	2.856	3.323	4.269	5.269	5.545	2.879	3.134	3.438	3.654	4.006	1,3
	%	9,5	9,6	9,5	9,4	9,7	10,4	9,6	5,0	5,1	5,0	4,9	4,7	
Private Sector Health Expenditures	TRY	5.504	6.817	8.632	11.372	13.953	16.374	15.580	11.021	13.196	14.028	15.404	18.162	2,3
	%	29,3	28,1	28,8	32,2	31,7	32,2	27,0	19,0	21,4	20,4	20,8	21,5	
Total	**TRY**	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

Source: TurkStat

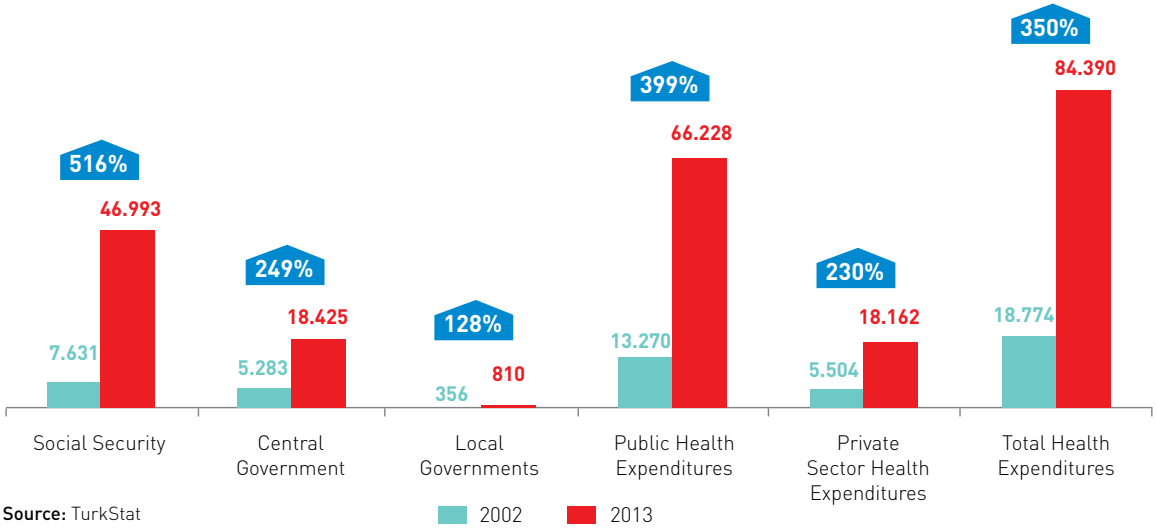
As for the financing agents in the health care sector, the most significant increase was observed in the SSI expenditures in 2002-2013. The SSI expenditures for health had about 5,2-fold increase in 2013 if to compare with 2002 which was primarily due to the devolution of the SSK hospitals to the MoH, permission of access to private hospitals for the SSI insurees, facilitated access to medicinal products and other health care services, coverage of health expenditures by the SSI for civil servants and the Green Card beneficiaries.

Table 18. Distribution of Health Expenditures by Financing Agents (Detailed), (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Insurance Organization (SSK)	TRY	3.596	4.981	6.717	7.458	11.107	SSI (SSK, BAG-KUR and ES included)			SSI (civil servants included)		SSI (Green Card included)		
	%	19,2	20,5	22,4	21,1	25,2								
BAG-KUR	TRY	2.195	3.183	3.719	3.626	3.816								
	%	11,7	13,1	12,4	10,3	8,7								
ES	TRY	1.840	2.498	2.795	2.917	2.744								
	%	9,8	10,3	9,3	8,2	6,2								
Social Security Agencies	TRY	7.631	10.662	13.231	14.000	17.667	19.697	25.346	28.277	30.695	34.937	41.630	46.993	5,2
	%	40,6	43,9	44,1	39,6	40,1	38,7	43,9	48,8	49,8	50,9	56,1	55,7	
Civil Servants	TRY	1.654	2.035	2.524	2.277	2.513	2.807	2.822	3.336	804	280	308	336	-0,8
	%	8,8	8,4	8,4	6,4	5,7	5,5	4,9	5,8	1,3	0,4	0,4	0,4	
Green Card	TRY	538	665	756	1.667	2.911	3.914	4.030	5.473	4.867	5.106	228	1	-1,0
	%	2,9	2,7	2,5	4,7	6,6	7,7	7,0	9,5	7,9	7,4	0,3	0,0	
MoH	TRY	2.435	2.953	3.571	4.847	5.668	6.573	8.062	8.417	10.526	12.156	14.827	16.460	5,8
	%	13,0	12,2	11,9	13,7	12,9	12,9	14,0	14,5	17,1	17,7	20,0	19,5	
Universities	TRY	195	229	379	464	509	605	651	702	824	893	959	1.040	4,3
	%	1,0	0,9	1,3	1,3	1,2	1,2	1,1	1,2	1,3	1,3	1,3	1,2	
Other Public	TRY	461	435	428	264	166	66	384	17	188	651	171	589	0,3
	%	2,5	1,8	1,4	0,7	0,4	0,1	0,7	0,0	0,3	0,9	0,2	0,7	
Central Government	TRY	5.283	6.317	7.659	9.520	11.766	13.966	15.948	17.946	17.209	19.086	16.493	18.425	2,5
	%	28,1	26,0	25,5	26,9	26,7	27,4	27,6	31,0	27,9	27,8	22,2	21,8	
Local Governments and Other Public Institutions	TRY	356	482	500	467	683	867	865	667	577	557	662	810	1,3
	%	1,9	2,0	1,7	1,3	1,6	1,7	1,5	1,2	0,9	0,8	0,9	1,0	
Public Health Expenditures	**TRY**	**13.270**	**17.462**	**21.389**	**23.987**	**30.116**	**34.530**	**42.159**	**46.890**	**48.482**	**54.580**	**58.785**	**66.228**	**4,0**
	%	**70,7**	**71,9**	**71,2**	**67,8**	**68,3**	**67,8**	**73,0**	**81,0**	**78,6**	**79,6**	**79,2**	**78,5**	
Out-of-Pocket Health Expenditures	TRY	3.725	4.482	5.775	8.049	9.684	11.105	10.036	8.142	10.062	10.590	11.750	14.156	2,8
	%	19,8	18,5	19,2	22,8	22,0	21,8	17,4	14,1	16,3	15,4	15,8	16,8	
Other Private Health Expenditures	TRY	1.779	2.335	2.856	3.323	4.269	5.269	5.545	2.879	3.134	3.438	3.654	4.006	1,3
	%	9,5	9,6	9,5	9,4	9,7	10,4	9,6	5,0	5,1	5,0	4,9	4,7	
Private Sector Health Expenditures	**TRY**	**5.504**	**6.817**	**8.632**	**11.372**	**13.953**	**16.374**	**15.580**	**11.021**	**13.196**	**14.028**	**15.404**	**18.162**	**2,3**
	%	**29,3**	**28,1**	**28,8**	**32,2**	**31,7**	**32,2**	**27,0**	**19,0**	**21,4**	**20,4**	**20,8**	**21,5**	
Total Health Expenditures	**TRY**	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

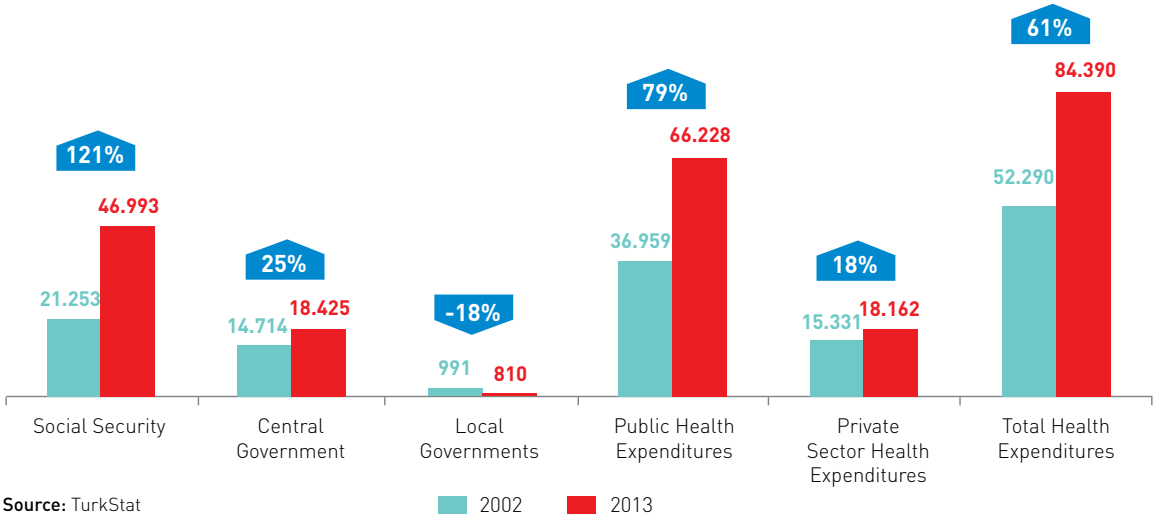
Source: Ministry of Health, Ministry of Development, TurkStat, SSI and Universities

Graphic 13. Health Expenditures by Financing Agents, (2002-2013), (million TRY)



Source: TurkStat

Graphic 14. Health Expenditures by Financing Agents, (2002-2013), (As of 2013 Prices), (million TRY)



Source: TurkStat

In this period, the social security agencies' expenditures for health had the most substantial increase (due to the unification of the social security agencies and expansion of the coverage, particularly). Health care spending of the social security agencies had more than one-fold increase (121%) in real terms compared to 2002.

Health care spending from the central government budget had only 25% increase in real terms and health expenditures of local governments and other public institutions had a real terms decrease. Out-of-pocket expenditures for health and private health expenditures, on the other hand, had only 18% increase in real terms in this period.

A. Public Health Expenditures

Table 19. Public Health Expenditures, (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	13.270	17.462	21.389	23.987	30.116	34.530	42.159	46.890	48.482	54.580	58.785	66.228	4,0
As of 2013 Prices, TRY	36.959	38.824	43.790	45.395	52.004	54.825	60.608	63.443	60.421	63.886	63.190	66.228	0,8
USD	8.812	11.695	15.038	17.890	21.044	26.531	32.608	30.310	32.313	32.682	32.795	34.833	3,0
PPP USD	21.742	22.654	26.398	28.878	35.579	39.923	47.367	51.604	51.547	55.302	55.835	60.306	1,8
Share of Health Expenditures (%)	70,7	71,9	71,2	67,8	68,3	67,8	73,0	81,0	78,6	79,6	79,2	78,5	
Share of GDP (%)	3,8	3,8	3,8	3,7	4	4,1	4,4	4,9	4,4	4,2	4,1	4,2	

Source: TurkStat

The share of public expenditures for health, which was 70,7% in 2002, increased to 78,5% in 2013.

A.1. Health Expenditures of Social Security Agencies

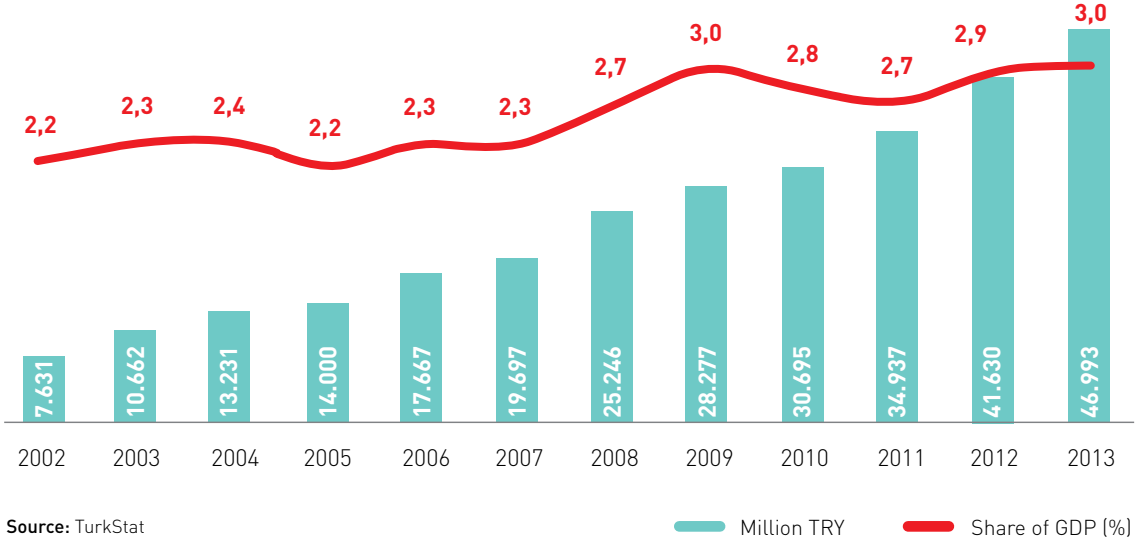
Table 20. Health Expenditures of Social Security Agencies, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	7.631	10.662	13.231	14.000	17.667	19.697	25.346	28.277	30.695	34.937	41.630	46.993	5,2
As of 2013 Prices, TRY	21.253	23.705	27.087	26.496	30.508	31.274	36.438	38.260	38.254	40.894	44.749	46.993	1,2
USD	5.067	7.141	9.302	10.442	12.345	15.134	19.604	18.279	20.459	20.920	23.224	24.716	3,9
PPP USD	12.503	13.832	16.329	16.855	20.872	22.773	28.477	31.120	32.636	35.400	39.541	42.791	2,4
Share of Health Expenditures (%)	40,6	43,9	44,1	39,6	40,1	38,7	43,9	48,8	49,8	50,9	56,1	55,7	
Share of GDP (%)	2,2	2,3	2,4	2,2	2,3	2,3	2,7	3,0	2,8	2,7	2,9	3,0	

Source: TurkStat

From 2002 to 2013, a number of significant changes were made to the composition of health spending. Unification of social security agencies, which had been a long-standing plan, was realized. Health financing was handled carefully and many structural obstacles were removed. Following the unification of the SSK, BAG-KUR and ES under the SSI in 2007 and devolution of health expenditures to the SSI for civil servants in 2010 and for the Green Card beneficiaries in 2013, the SSI share in health expenditures increased from 40,6% in 2002 to 55,7% in 2013.

Graphic 15. Health Expenditures of Social Security Agencies and Share of GDP, (2002-2013)



Source: TurkStat

Social security agencies' health expenditures as a share of GDP increased from 2,2% in 2002 to 3% in 2013.

In the pre-2002 period, three separate social security agencies existed (which were the SSK, BAG-KUR and ES), offering quite different benefit packages.

In the pre-2002 period, the SSK – with its affiliated hospitals and pharmacies - was the second largest service provider in national health care sector. The success of the Health Transformation Program depended not only on withdrawing the SSK from service provision but also on merging separate financing agents under a single roof. With this aim, two years were spent for the preliminary researches and infrastructural arrangements and some important steps were taken soon after.

As an outcome of these preliminary steps, one of the most preeminent reforms was achieved on 19 February 2005 in scope of the Health Transformation Program and all public health care facilities - except for the university hospitals, Ministry of Defense-affiliated hospitals and municipality hospitals - were devolved to the Ministry of Health. Devolution of the SSK hospitals to the MoH meant to separate service provision from service financing in health care sector. The SSK pharmacies were closed down and the SSK insurees were provided access to private pharmacies.

Finally, the Law on Social Security Institution No. 5502 came into effect in May 2006 and the social security agencies (SSK, BAG-KUR and ES) were unified. In June 2006, the Universal Health Insurance (UHI) system was established with the aim of standardizing various benefit packages for all people.

In September 2006, another major step was taken. The Pharmaceutical Track and Trace System was set up in the SSI and the MEDULA system, which refers to an integrated system that helps to collect electronical bills at hospitals and perform reimbursements via the UHI, was activated. The UHI aims at gathering the ES insurees, BAG-KUR insurees, SSK insurees, Green Card holders and the Turkish Armed Forces personnel under a single scheme. MEDULA is the IT component of the UHI. Public hospitals, private hospitals, university hospitals, dialysis centers and many other health care facilities use the UHI MEDULA web services in order to receive reimbursement in return of the provision of health care services and medicinal/medical product services. However, the UHI could not be fully activated in 2006. With a view to the problems that were likely to occur during transition, the effective date of the system was delayed to 1 July 2007 by the Law on Central Government Budget 2007 but the payments, which would be made to these social security agencies in return for service provision, were merged beginning from 2007. Upon this merger, the SSI became the largest authority in paying for health care services.

In addition to the afore-mentioned steps, in June 2006, when the afore-mentioned events were witnessed, a protocol was signed between the MoH, MoF and SSI, suggesting some other changes to the payment system for the MoH – the largest service provider in health care sector in Turkey. Payment system shifted from the fee-for-service payment to global budgeting for the MoH-affiliated health service providers.

As for health service access and utilization, insurees of the SSK and BAG-KUR, both of which were devolved to the MoH like the ES that was previously devolved in May 2007, were provided direct access to university hospitals and contracted private health care facilities.

June 2007 served as a stage for further reforms which improved health expenditures and service quality of the SSI. Upon signature of a contract between the MoH, MoF and SSI, which could be considered as the continuation of the Global Budget Decision taken in June 2006, lump sum payment method was introduced and the system which used to require delivering bills and substitutive documents to reimbursement agencies was cancelled for provision of primary health care services.

The SSI-contracted hospitals were required to provide medicinal and medical products for inpatients. All of the SSI-contracted MoH, university and private hospitals were required to use the MEDULA system. Medical visit forms and referral forms at hospitals were removed for patients except for active employees. Use of health cards and ID cards made hospitals visits easier for individuals.

With the aim of removing shortfalls of the reform, it was ruled in August 2008 that health expenditures of the persons, who held the Green Card and were employed in general budget-funded institutions, would be covered by the SSI in latest 3 years. The UHI, the implementation of which had been postponed for a few times, was launched in October 2008 and the SSK, BAG-KUR and ES were merged.

As an outcome of Global Budgeting, service procurement contracts between the MoH and SSI for payment were expanded - beginning from January 2009 - to hospitals and oral and dental care centers, too. Following primary health care services, the system which used to require delivering bills and substitutive documents to reimbursement agencies was cancelled for the MoH secondary and tertiary health service providers, as well.

Government employees were covered by the UHI in January 2010 and the Green Card holders were covered in January 2012.

Table 21. Health Expenditures of Social Security Agencies (Detailed), (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
SSK	TRY	3.596	4.981	6.717	7.458	11.107	SSI (SSK, BAG-KUR and ES included)			SSI (Civil servants included)		SSI (Green Card included)		
	%	47,1	46,7	50,8	53,3	62,9								
BAG-KUR	TRY	2.195	3.183	3.719	3.626	3.816								
	%	28,8	29,9	28,1	25,9	21,6								
ES	TRY	1.840	2.498	2.795	2.917	2.744								
	%	24,1	23,4	21,1	20,8	15,5								
Total	**TRY**	**7.631**	**10.662**	**13.231**	**14.000**	**17.667**	**19.697**	**25.346**	**28.277**	**30.695**	**34.937**	**41.630**	**46.993**	**5,2**

Source: TurkStat and SSI

As a result, about 5,2-fold increase was observed in the SSI health expenditures in 2013 when compared to 2002.

Table 22. Development of Health Expenditures of Social Security Agencies by Service Providers (2002-2013), (million TRY)

Service Providers/ Years		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH Health Care Facilities*	TRY	1.817	2.998	4.083	3.521	5.442	6.399	7.204	7.307	8.118	10.160	15.784	18.436	9,1
	%	23,8	28,1	30,9	25,2	30,8	32,5	28,4	25,8	26,4	29,1	37,9	39,2	
University Health Care Facilities	TRY	620	827	1.079	1.083	1.325	1.523	2.223	2.529	3.376	3.964	4.927	5.680	8,2
	%	8,1	7,8	8,2	7,7	7,5	7,7	8,8	8,9	11,0	11,3	11,8	12,1	
Private Health Care Facilities	TRY	396	538	743	1.021	1.723	2.345	4.327	4.506	4.959	5.948	6.633	7.148	17,0
	%	5,2	5,0	5,6	7,3	9,8	11,9	17,1	15,9	16,2	17,0	15,9	15,2	
Private Pharmacies	TRY	4.300	5.615	6.399	7.001	8.372	8.858	10.717	13.161	13.547	14.144	13.446	14.765	2,4
	%	56,4	52,7	48,4	50,0	47,4	45,0	42,3	46,5	44,1	40,5	32,3	31,4	
Other	TRY	498	685	926	1.373	805	572	876	773	695	720	839	964	0,9
	%	6,5	6,4	7,0	9,8	4,6	2,9	3,5	2,7	2,3	2,1	2,0	2,1	
Total	**TRY**	**7.631**	**10.662**	**13.231**	**14.000**	**17.667**	**19.697**	**25.346**	**28.277**	**30.695**	**34.937**	**41.630**	**46.993**	**5,2**

* Spending for the SSK health care facilities until 2005 included.

Source: Ministry of Development, Ministry of Health, TurkStat and SSI

To take a glance at the health expenditures of the SSI by service providers in 2002-2013, the most outstanding development is observed in expenditures on private health care facilities. The share of private health care facilities in the SSI health expenditures increased from 5,2% in 2002 to 15,2% in 2013.

The share of the MoH health care facilities also increased from 23,8% to 39,2% while the share of retail pharmaceutical expenditures dropped from 56,4% in 2002 to 31,4% in 2013.

A.2. Health Expenditures of Central Government

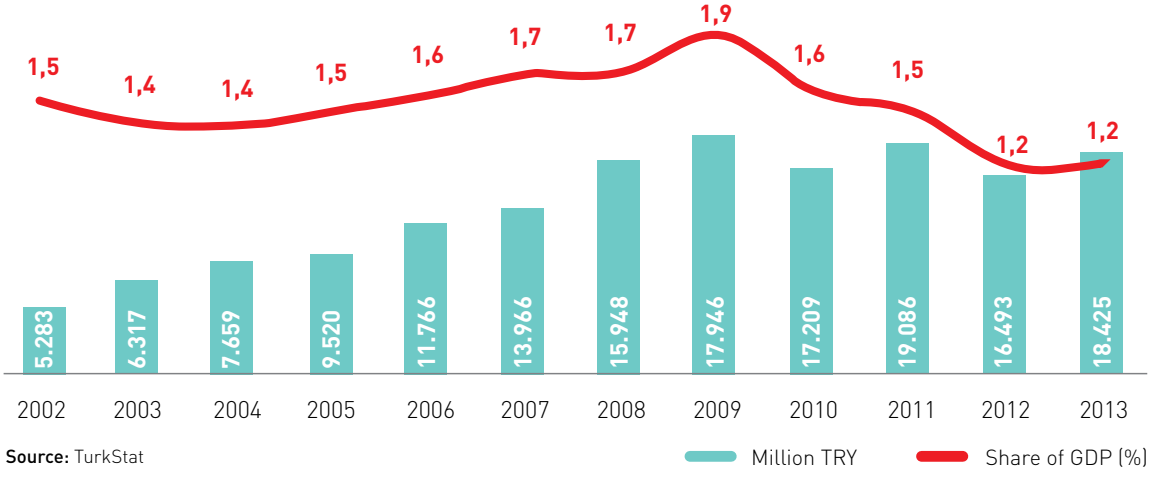
Table 23. Health Expenditures of Central Government, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	5.283	6.317	7.659	9.520	11.766	13.966	15.948	17.946	17.209	19.086	16.493	18.425	2,5
As of 2013 Prices, TRY	14.714	14.046	15.680	18.016	20.317	22.174	22.927	24.281	21.447	22.340	17.729	18.425	0,3
USD	3.508	4.231	5.385	7.100	8.222	10.730	12.335	11.600	11.470	11.429	9.201	9.691	1,8
PPP USD	8.656	8.196	9.452	11.461	13.900	16.147	17.918	19.750	18.297	19.339	15.665	16.777	0,9
Share of Health Expenditures (%)	28,1	26,0	25,5	26,9	26,7	27,4	27,6	31,0	27,9	27,8	22,2	21,8	
Share of GDP (%)	1,5	1,4	1,4	1,5	1,6	1,7	1,7	1,9	1,6	1,5	1,2	1,2	

Source: TurkStat

Health expenditures of central government had 250% increase in nominal terms and 30% increase in real terms between 2002 and 2013. The share of expenditures, which was 28,1% in 2002, dropped to 21,8% in 2013.

Graphic 16. Health Expenditures of Central Government and Share of GDP, (2002-2013)



Source: TurkStat

The share of health expenditures of the central government in GDP dropped from 1,5% to 1,2%.

Expenditures from the MoH central budget, university hospital private budgets and the MoD-affiliated health care facilities' central budget, which were all funded by the central government budget and also constituted the most significant items of health spending in 2002, are still funded by the Central Government Budget. However, the case in 2013 is different from the case in 2002 in that health expenditures of civil servants and the Green Card beneficiaries are covered by the SSI, now. Health expenditures of civil servants have been covered by the SSI since 2010 and health expenditures of the Green Card beneficiaries have been covered by the SSI since 2013.

Table 24. Health Expenditures of Central Government (Detailed), (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Civil Servants	TRY	1.654	2.035	2.524	2.277	2.513	2.807	2.822	3.336	804	280	308	336	-0,8
	%	31,3	32,2	33,0	23,9	21,4	20,1	17,7	18,6	4,7	1,5	1,9	1,8	
Green Card	TRY	538	665	756	1.667	2.911	3.914	4.030	5.473	4.867	5.106	228	1	-1,0
	%	10,2	10,5	9,9	17,5	24,7	28,0	25,3	30,5	28,3	26,8	1,4	0,0	
MoH	TRY	2.435	2.953	3.571	4.847	5.668	6.573	8.062	8.417	10.526	12.156	14.827	16.460	5,8
	%	46,1	46,7	46,6	50,9	48,2	47,1	50,5	46,9	61,2	63,7	89,9	89,3	
Universitieis	TRY	195	229	379	464	509	605	651	702	824	893	959	1.040	4,3
	%	3,7	3,6	4,9	4,9	4,3	4,3	4,1	3,9	4,8	4,7	5,8	5,6	
Other Public	TRY	461	435	428	264	166	66	384	17	188	651	171	589	0,3
	%	8,7	6,9	5,6	2,8	1,4	0,5	2,4	0,1	1,1	3,4	1,0	3,2	
Total	**TRY**	**5.283**	**6.317**	**7.659**	**9.520**	**11.766**	**13.966**	**15.948**	**17.946**	**17.209**	**19.086**	**16.493**	**18.425**	**2,5**

Source: Ministry of Development, Ministry of Health, TurkStat and SSI

In conclusion, health expenditures from the central budget increased by about 2,5 folds in 2013 when compared to 2002.

Major changes occurred in health expenditures from the central government by service providers in 2002-2013. As of 2013, the central government budget comprised of the shares which the MoH and university health care facilities received from the central government budget. To give an example, the MoH share in the central government budget increased from 61,5% in 2002 to 90,1% in 2013.

The share of health expenditures of the central government in GDP dropped from 1,5% to 1,2%.

Table 25. Development of Health Expenditures of Central Government by Service Providers (2002-2013), (million TRY)

Service Providers/ Years		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH Health Care Facilities	TRY	3.250	3.957	4.717	6.223	8.055	9.415	11.012	12.324	13.574	15.040	14.967	16.607	4,1
	%	61,5	62,6	61,6	65,4	68,5	67,4	69,0	68,7	78,9	78,8	90,7	90,1	
University Health Care Facilities	TRY	687	834	1.074	1.210	1.448	1.704	1.747	1.788	1.590	2.189	1.097	1.102	0,6
	%	13,0	13,2	14,0	12,7	12,3	12,2	11,0	10,0	9,2	11,5	6,7	6,0	
Private Health Care Facilities	TRY	192	236	271	269	341	408	552	779	205	70	68	46	-0,8
	%	3,6	3,7	3,5	2,8	2,9	2,9	3,5	4,3	1,2	0,4	0,4	0,3	
Private Pharmacies	TRY	1.140	1.277	1.520	1.728	1.845	2.328	2.515	2.919	1.800	1.759	356	669	-0,4
	%	21,6	20,2	19,8	18,2	15,7	16,7	15,8	16,3	10,5	9,2	2,2	3,6	
Other	TRY	14	13	77	90	78	111	123	136	39	28	5	0	-1,0
	%	0,3	0,2	1,0	0,9	0,7	0,8	0,8	0,8	0,2	0,1	0,0	0,0	
Total	**TRY**	**5.283**	**6.317**	**7.659**	**9.520**	**11.766**	**13.966**	**15.948**	**17.946**	**17.209**	**19.086**	**16.493**	**18.425**	**2,5**

Source: Ministry of Development, Ministry of Health and TurkStat

A.3. Health Expenditures of Local Governments and Other Public Institutions

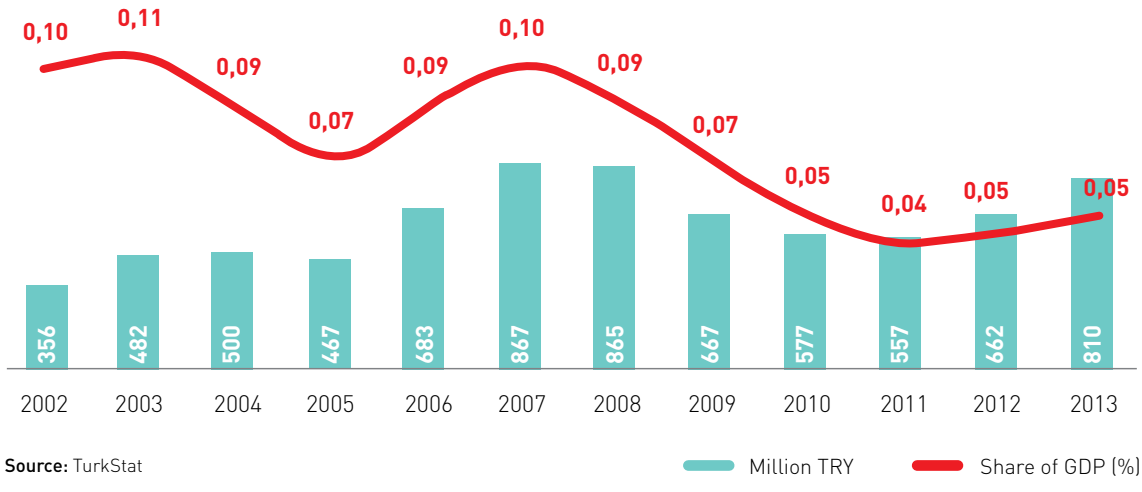
Table 26. Health Expenditures of Local Governments and Other Public Institutions, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	356	482	500	467	683	867	865	667	577	557	662	810	1,3
As of 2013 Prices, TRY	991	1.073	1.023	883	1.180	1.377	1.243	902	719	652	712	810	-0,2
USD	236	323	351	348	477	666	669	431	385	333	370	426	0,8
PPP USD	583	626	617	562	807	1.003	972	734	614	564	629	738	0,3
Share of Health Expenditures (%)	1,9	2,0	1,7	1,3	1,6	1,7	1,5	1,2	0,9	0,8	0,9	1,0	
Share of GDP (%)	0,10	0,11	0,09	0,07	0,09	0,10	0,09	0,07	0,05	0,04	0,05	0,05	

Source: TurkStat

Health expenditures of local governments and other public institutions had 130% increase in nominal terms and 20% decrease in real terms in 2002-2013. The share of local governments and other public institutions in health expenditures, which was noted 1,9% in 2002, was reported to decrease to 1% in 2013.

Graphic 17. Health Expenditures of Local Governments & Other Public Institutions and Share of GDP, (2002-2013)



Source: TurkStat

Health expenditures of local governments and other public institutions as a share of GDP decreased from 0,10% to 0,05%.

Health expenditures of civil servants turned out to be the most important spending item in health expenditures which were funded by local governments, other public institutions and others except for the central government budgets in 2012. Yet, the case is different today in that these expenditures have been funded by the SSI since 2010, pointing out to substantially reduced percentages in spending. Therefore, it could be asserted that the afore-mentioned developments were in parallel to health spending which was primarily funded from the central government budget.

Table 27. Development of Health Expenditures of Local Governments and Other Public Institutions by Service Providers, (2002-2013), (million TRY)

Service Providers/ Years		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH Health Care Facilities	TRY	128	173	175	160	248	322	312	230	226	223	268	332	1,6
	%	36,1	35,8	35,1	34,2	36,4	37,1	36,1	34,5	39,2	40,1	40,5	41,0	
University Health Care Facilities	TRY	102	131	131	131	214	283	275	181	164	152	189	231	1,3
	%	28,6	27,1	26,2	28,0	31,3	32,7	31,8	27,1	28,3	27,3	28,5	28,6	
Private Health Care Facilities	TRY	51	65	65	65	107	142	138	90	82	76	94	116	1,3
	%	14,3	13,5	13,1	14,0	15,7	16,3	15,9	13,6	14,2	13,6	14,3	14,3	
Private Pharmacies	TRY	38	57	64	74	61	30	46	43	4	8	9	8	-0,8
	%	10,6	11,9	12,7	15,8	8,9	3,4	5,3	6,5	0,7	1,4	1,4	1,0	
Other	TRY	37	57	64	37	53	91	94	122	102	98	102	122	2,3
	%	10,4	11,7	12,9	8,0	7,8	10,5	10,9	18,3	17,6	17,6	15,3	15,1	
Total	**TRY**	**356**	**482**	**500**	**467**	**683**	**867**	**865**	**667**	**577**	**557**	**662**	**810**	**1,3**

Source: Ministry of Health and TurkStat

The MoH share in health expenditures of local governments and other public institutions, which was reported 36,1% in 2002, increased to 41% in 2013. The share of university health care facilities and private health care facilities did not change and the share of pharmaceutical expenditures reduced after 2002 and was reported 1% in 2013.

B. Private Health Expenditures

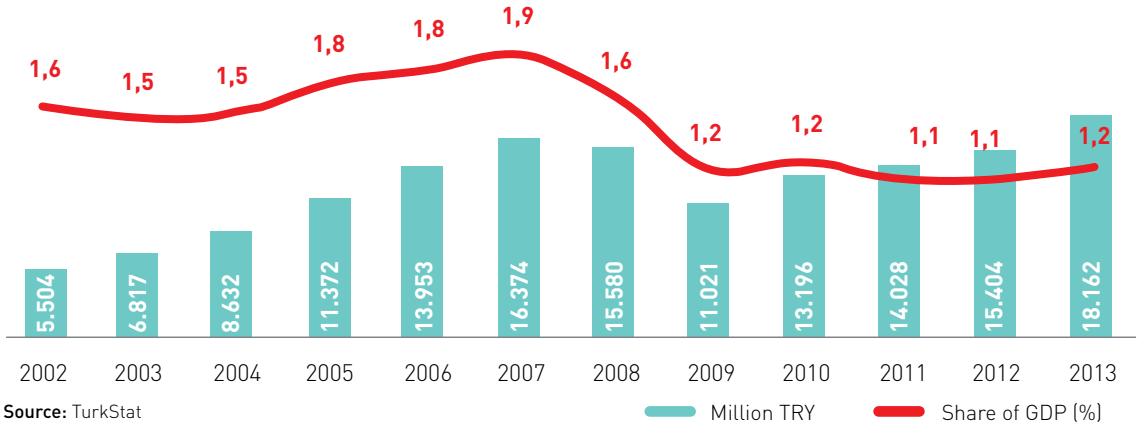
Table 28. Private Health Expenditures, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	5.504	6.817	8.632	11.372	13.953	16.374	15.580	11.021	13.196	14.028	15.404	18.162	2,3
As of 2013 Prices, TRY	15.331	15.157	17.671	21.521	24.093	25.998	22.399	14.911	16.446	16.420	16.558	18.162	0,2
USD	3.655	4.566	6.069	8.482	9.750	12.581	12.051	7.124	8.795	8.400	8.594	9.552	1,6
PPP USD	9.019	8.844	10.653	13.691	16.483	18.931	17.505	12.129	14.030	14.213	14.631	16.538	0,8
Share of Health Expenditures (%)	29,3	28,1	28,8	32,2	31,7	32,2	27,0	19,0	21,4	20,4	20,8	21,5	
Share of GDP (%)	1,6	1,5	1,5	1,8	1,8	1,9	1,6	1,2	1,2	1,1	1,1	1,2	

Source: TurkStat

Significant changes occurred in the composition of private health expenditures between 2002 and 2013. Private health expenditures increased by 2,3 folds in 2013 when compared to 2002. Private health expenditures as a share of total health expenditures, on the other hand, dropped from 29,3% to 21,5%.

Graphic 18. Private Health Expenditures and Share of GDP, (2002-2013)



Source: TurkStat

Private health expenditures as a share of GDP decreased from 1,6% to 1,2%.

Table 29. Development of Private Health Expenditures by Service Providers, (2002-2013), (million TRY)

Service Providers/ Years		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH Health Care Facilities	TRY	340	419	553	558	626	726	801	1.023	1.986	1.553	1.654	2.379	6,0
	%	6,2	6,1	6,4	4,9	4,5	4,4	5,1	9,3	15,1	11,1	10,7	13,1	
University Health Care Facilities	TRY	170	242	242	380	421	602	603	602	790	384	398	455	1,7
	%	3,1	3,5	2,8	3,3	3,0	3,7	3,9	5,5	6,0	2,7	2,6	2,5	
Private Health Care Facilities	TRY	2.575	3.313	3.713	5.191	6.298	8.140	7.226	4.085	4.652	5.912	7.600	8.593	2,3
	%	46,8	48,6	43,0	45,6	45,1	49,7	46,4	37,1	35,3	42,1	49,3	47,3	
Private Pharmacies	TRY	1.477	1.661	2.011	2.610	3.275	3.439	3.176	3.282	3.439	3.751	3.866	4.600	2,1
	%	26,8	24,4	23,3	22,9	23,5	21,0	20,4	29,8	26,1	26,7	25,1	25,3	
Other	TRY	943	1.183	2.113	2.633	3.332	3.468	3.775	2.030	2.329	2.427	1.885	2.135	1,3
	%	17,1	17,4	24,5	23,2	23,9	21,2	24,2	18,4	17,6	17,3	12,2	11,8	
Total	**TRY**	**5.504**	**6.817**	**8.632**	**11.372**	**13.953**	**16.374**	**15.580**	**11.021**	**13.196**	**14.028**	**15.404**	**18.162**	**2,3**

*Expenditures for the SSK health care facilities until 2005 included.

Source: Ministry of Health, TurkStat and SSI

Pertaining to the development of private health expenditures by service providers in 2002-2013, private health care facilities, though having been slightly reduced in number in comparison with 2002, still had the largest share -47,3%- in health expenditures in 2013. However, private spending for health, which was more common for private practices in the past, shifted towards more institutional enterprises such as private hospitals. The share of the MoH health care facilities in private health expenditures increased from 6,2% in 2002 to 13,1% in 2013.

B.1. Out-of-Pocket Health Expenditures

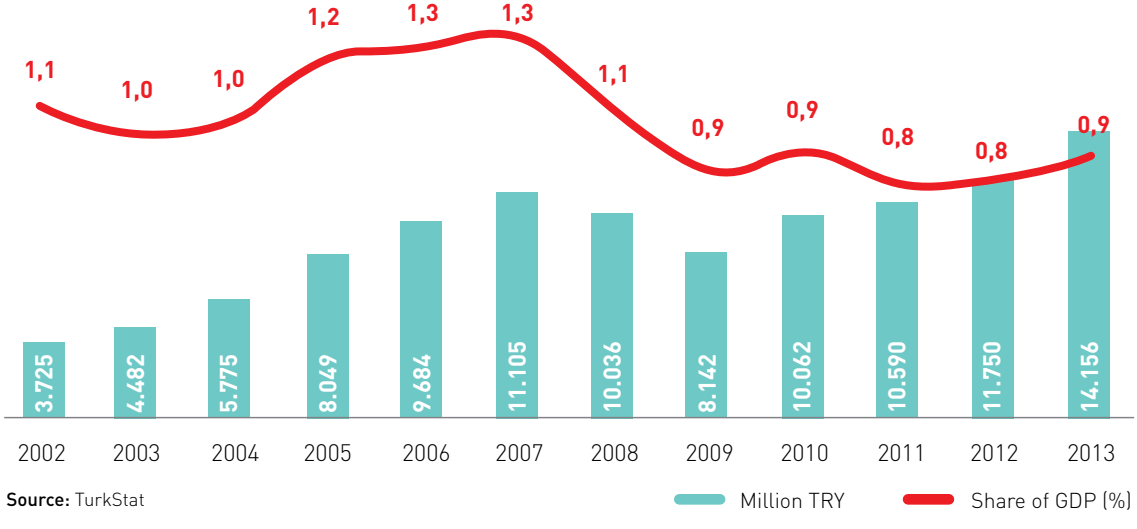
Table 30. Out-of-Pocket Health Expenditures, (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	3.725	4.482	5.775	8.049	9.684	11.105	10.036	8.142	10.062	10.590	11.750	14.156	2,8
As of 2013 Prices, TRY	10.375	9.965	11.824	15.233	16.721	17.632	14.428	11.016	12.540	12.395	12.630	14.156	0,4
USD	2.474	3.002	4.061	6.003	6.766	8.533	7.762	5.263	6.707	6.341	6.555	7.445	2,0
PPP USD	6.103	5.815	7.128	9.691	11.440	12.840	11.275	8.960	10.699	10.730	11.161	12.890	1,1
Share of Health Expenditures (%)	19,8	18,5	19,2	22,8	22,0	21,8	17,4	14,1	16,3	15,4	15,8	16,8	
Share of GDP (%)	1,1	1,0	1,0	1,2	1,3	1,3	1,1	0,9	0,9	0,8	0,8	0,9	

Source: TurkStat

Household health expenditures constituting the biggest spending item in private health expenditures (out-of-pocket spending) as a share of total health expenditures dropped from 19,8% to 16,8%.

Graphic 19. Out-of-Pocket Health Expenditures and Share of GDP, (2002-2013)



Source: TurkStat

Out-of-pocket health expenditures as a share of GDP dropped from 1,1% to 0,9%.

In 2002-2013 period, major steps were taken to improve private health care sector. As a result of these steps, private practices, which were quite common in 2002, were gradually replaced by more institutional enterprises, later.

The government both contributed to scaling up private health care facilities through service procurements and took necessary measures in order to provide financial protection for individuals. For this purpose, it was ruled in June 2008 that private health service providers could charge an extra pay up to 30% of the SSI reimbursement cap maximum for hotel services and other procedures which were not included in exceptional medical services. In December 2009, the ceiling rate was increased to 70% for extra pays depending on service quality. In March 2012, the ceiling rate was re-identified as 90% for extra pays at private hospitals and was finally raised from 90% to 200% in October 2013.

In October 2008, it was ruled that private hospitals could not charge extra fees for burn and cancer treatments, newborn care, organ transplantation services, congenital anomalies, dialysis and cardiovascular surgeries.

On 10 August 2010, the Prime Ministry issued a circular which aimed to manage admission and transfer of emergency cases to public and private hospitals, and coverage of treatment costs. Accordingly, all public and private hospitals were required to attach utmost attention to these issues.

B.2. Other Private Health Expenditures

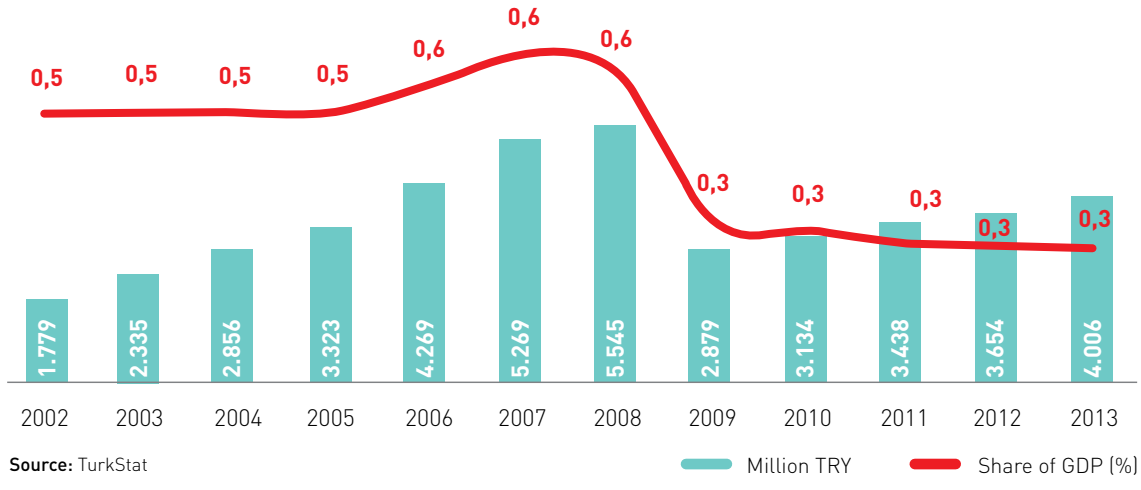
Table 31. Other Private Health Expenditures, (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	1.779	2.335	2.856	3.323	4.269	5.269	5.545	2.879	3.134	3.438	3.654	4.006	1,3
As of 2013 Prices, TRY	4.955	5.191	5.847	6.288	7.372	8.366	7.971	3.895	3.905	4.024	3.928	4.006	-0,2
USD	1.181	1.564	2.008	2.478	2.983	4.048	4.289	1.861	2.089	2.059	2.038	2.107	0,8
PPP USD	2.915	3.029	3.525	4.000	5.043	6.092	6.230	3.168	3.332	3.483	3.471	3.648	0,3
Share of Health Expenditures (%)	9,5	9,6	9,5	9,4	9,7	10,4	9,6	5,0	5,1	5,0	4,9	4,7	
Share of GDP (%)	0,5	0,5	0,5	0,5	0,6	0,6	0,6	0,3	0,3	0,3	0,3	0,3	

Source: TurkStat

The share of other private health expenditures in total health expenditures decreased from 9,5% in 2002 to 4,7% in 2013.

Graphic 20. Other Private Health Expenditures and Share of GDP, (2002-2013)



Source: TurkStat

Other private health expenditures as a share of GDP decreased from 0,5% to 0,3%.

C. Other Events and Developments Relevant to Health Financing

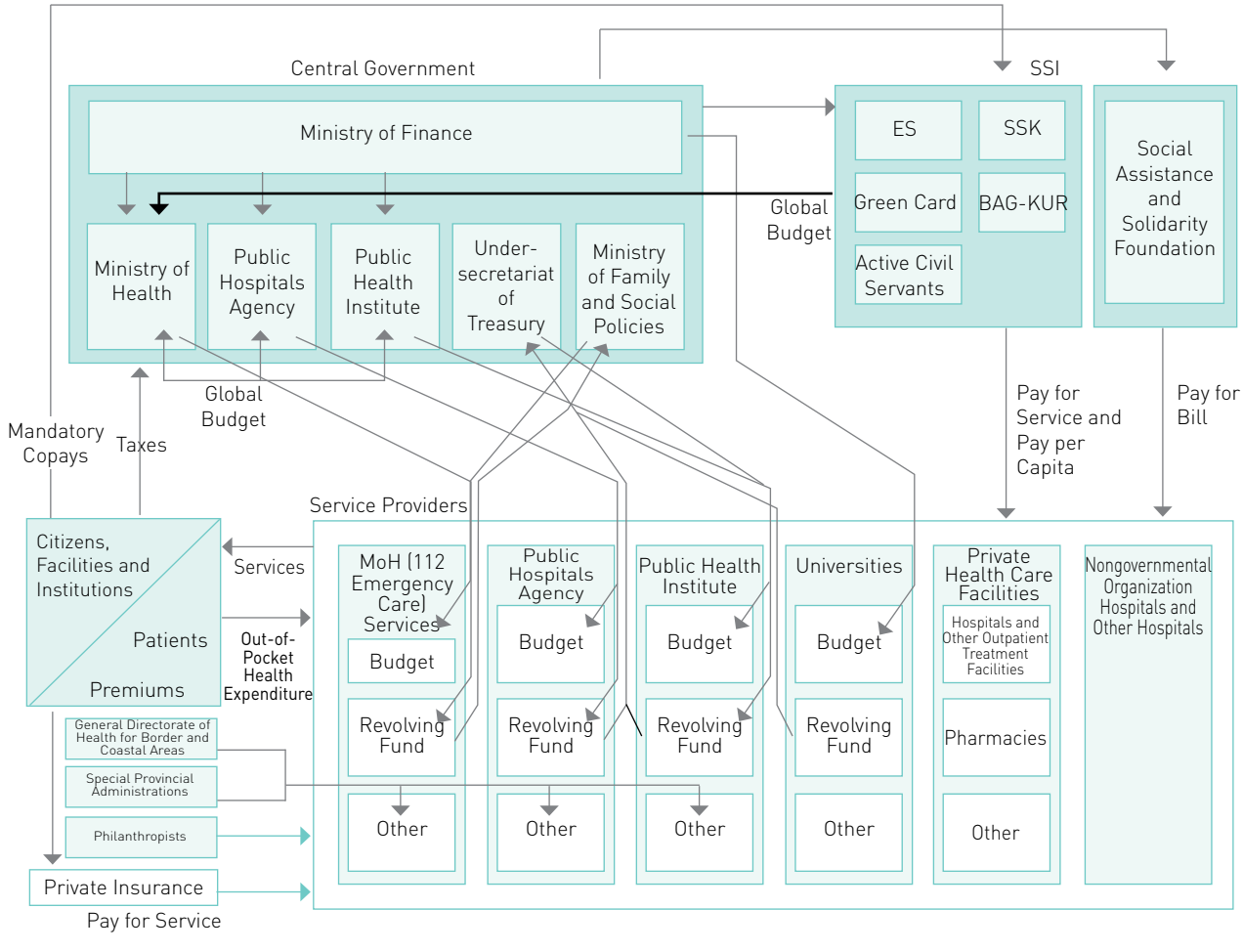
Between 2002 and 2013, also health care financing went through a period of major reforms. Reimbursement Commission was established in 2004 consisting of representatives from the SSI, the Employment and Pension Fund, the MoH, the Ministry of Finance, the State Planning Organization and the Undersecretariat of Treasury. The Commission, which was devolved to the SSI in 2007, was made in charge of setting prices for health care services, medicinal products and other health services reimbursed by the SSI as well as making changes to the SSI benefits package. Pricing Committee on Health Services operates under this commission and is responsible for necessary technical work to facilitate decision-making by the Reimbursement Commission.

In May 2006, the Law No. 5502 was adopted by the Turkish Grand National Assembly. The law, which was meant to accompany the Law 5510 (Law on Social Security and Universal Health Insurance), aimed at unifying the three different social security and health insurance schemes (SSK, BAG-KUR and ES), which seemed to be quite fragmented from 2002 to 2013, into one unified social security administration. It could be asserted that this reform targeted to set up a single pension and health insurance system that would equalize rights and liabilities and ensure financial sustainability.

Implementing this reform, a universal health insurance system was targeted to provide entire population with equal, easy-to-use, accessible and high-quality health care services. Being the first step towards the reform, the Law on Social Insurance and Universal Health Insurance No. 5510 was adopted in May 2006 and would be put into effect on 01.01.2007. However, the enactment of the law was postponed to 01.07.2007, first and to 01.01.2008, later and the law came into effect on 01.10.2008, finally, due to some obstacles such as the annulment of some of its articles by the Constitutional Court and issuance of some additional legislations. The Law No. 5510 unified the norms and standards, and started proper implementation.

In this process, first SSK, BAG-KUR and ES payments were included in the SSI beginning from 2007 which were followed by the government employees' payments being included in the SSI in 2010 and the Green Card payments being included in the SSI in 2012.

Figure 2. Fund Flow Chart in the Turkish Health Care System, (2013)



The Law on Social Insurance and Universal Health Insurance became fully effective and functional once the Green Card payments were covered by the SSI in January 2012. Benefit packages were made compatible for the SSK and BAG-KUR insurees first, for the ES later (in 2007), and for the civil servants under the SSI, finally (in January 2010). Yet, the only benefit package, which is different from the former four, is the one that applies for the Green Card beneficiaries, as of 2012. To give an example, the Green Card holders can visit the Family Medicine Centers and the MoH hospitals freely but cannot receive treatment at university hospitals in most cases if they have not been referred properly. As for visits to private hospitals, only some exceptional cases are allowed (such as emergencies, lack of intensive care units in public hospitals etc).

Utilization of the Health Care System by Non-affording Individuals: In scope of the Law on Social Insurance and UHI, two systems – premium and non-premium – run under the UHI. 12,5% copay is charged for public and private sector workmen, civil servants, contracted civil servants and self-employees in the premium system while 7,5% copay is charged for employers.

Those, who are eligible to benefit from the non-premium system, are identified by the Ministry of Family and Social Policies. Almost all of the non-premium system users are the former beneficiaries of the Green Card System.

The Green Card System was introduced in 1992 by the Law No. 3816 which aimed to provide health service access for people who could not afford. Later, by the Law on Social Insurance and Universal Health Insurance No.5510, which came into effect in June 2006, separate social security agencies were merged, the social security system became simplified, unified and more effective, and plans and efforts were made to provide all citizens with quality health care services. According to the new national health care system designed by the UHI reform, it is planned that every citizen pays a certain amount of premium in proportion with his income and receives quality health care services regardless of the amount of premiums he has paid for.

In scope of the UHI reform, it was planned to take back the authority to implement the Green Card System from the MoH, which had been responsible for the implementation since 2005, and to devolve it to the SSI. By the Law on Social Insurance and Universal Health Insurance No. 5510, which was adopted in 2006, delegation of authority was scheduled for the year 2010, however, devolution was postponed to the date of 01.01.2012 by the Law Dated 16.06.2010 and No. 5997. Necessary studies were conducted for the system infrastructure and applications could be questioned via the Social Assistance and Solidarity Foundation and Social Assistance Information System.

Income tests have been performed via the Social Assistance Information System by the Social Assistance and Solidarity Foundation since 01.01.2012, as ordered by the Regulation on Rules and Principles for Income Identifying, Registering and Monitoring under the UHI which was issued in November 2011.

Assets and incomes of applicants, which are recorded in central data bases, are inspected in the system. In addition to the information collected from the system, social assistance and inspection officers also visit the applying households for household surveys.

Foundation Boards of Trustees identify monthly average incomes of households by using the outcomes obtained from the system inspections and household visits. In line with the decisions made by the Foundation Boards of Trustees, the SSI perform necessary procedures for individuals relevant to UHI registration, notification and premium collection. Afterward, the SSI decides whether premiums would be paid by the government depending on monthly income of individuals. The amounts of premiums that will not be covered by the government are notified to individuals for payment.

Table 32. Data Used for Identifying Premium Affordability of Individuals Interviewed for Income Tests (2013)

Income Codes	Monthly Income per Capita	Income Intervals*	Status of Premium Payment
G0	Below 1/3 of gross minimum wage	0 TRY- 340,50 TRY	To be paid by the government.
G1	1/3 of gross minimum wage to minimum wage	340,50 TRY – 1.021,50 TRY	To be paid by the individual. Amount of premiums: 340,50x12%=40,86 TRY
G2	Gross minimum wage to 2- fold minimum wage	1.021,50 TRY – 2.043 TRY	To be paid by the individual. Amount of premiums: 1.021,50x12%=122,58 TRY
G3	Above 2-fold gross minimum wage	2.043 TRY and above	To be paid by the individual. Amount of premiums: 2.043x12%=245,16 TRY

*Premiums were calculated by the rate of minimum wage in July-December 2013.

Source: SSI

As a result of the Household Income Tests performed by the the Social Assistance and Solidarity Foundation from 01.01.2012 to 31.12.2012, 14,8 million applicants were interviewed and 11,357 million citizens were covered by social security. 11.357.306 citizens were interviewed and assessed in scope of the Household Income Tests as of 31.12.2012. Today, social security premiums are paid by the government for total 7.558.821 citizens who can not afford social security premiums (income level G0). The tests found out that 3.798.485 citizens can afford social security premiums (income level G1, G2 and G3) and these people were covered by social security on condition that they paid for premiums depending on their income.

In 2006, an electronic control and payment management system was established for procedures related to health insurance funds (also including the Green Card) via MEDULA, under the SSI. Accordingly, all public and private health care facilities contracting with the SSI are required to use the MEDULA system. Submission of requests from all health insurance funds were standardized upon establishment of the MEDULA system which also achieved to set up a single payer system under the UHI. The MEDULA system and other reforming efforts in 2003-2013 period put an end to fragmentation and duplication in purchasing and provision functions, and created uniform institutional and accountability relationships between purchasers and providers.

The first change in this direction was taken in 2005, when SSK gave up its provision function to the Ministry of Health. Transfer of the Green Card program to the SSI was planned under the Social Security and UHI Law. Following devolution of the SSK-affiliated health care facilities to the MoH in February 2005, social security agencies withdrew from health service provision.

Payment of Medical Expenses of Traffic Victims: In this period, another important step taken in the field of health financing was that medical expenses occurring from injuries in road traffic accidents be paid by the Social Security Institution.

Payment of medical expenses and grievances related to treatment process caused by traffic accident injuries became a big suffering for individuals in Turkey. For this reason, a Guarantee Fund was established by the Regulation on Road Traffic Funds Dated 03.05.1997. The Fund was in charge of meeting treatment expenses of traffic accident victims. However, treatment and payment procedures were not managed properly and not only patients but also health care facilities were adversely affected. The Revolving Funds Administration for Traffic Services was founded under the MoH in 1999 so that both payment/collection and treatment procedures could be better monitored and regulated. The Administration collected the bills of treatment issued in the MoH-affiliated health care facilities from the Guarantee Fund. However, the Fund turned out to be inadequate later in terms of functioning and timeliness, leading to the aboslihment of the Fund and its replacement by the Regulation on Road Traffic Insurance that was issued in the Official Gazette Dated 03 July 2002 and No. 24804.

Increased number of accidents and patients under treatment, deepening damnification of patients, many parties' getting involved in procedures relevant to the payment of hospital bills, untimely and improper functioning of the system all contributed to the necessity to set up a new system. So, the Government resolved that all medical expenses of traffic accident victims be paid by the Social Security Institution and enacted the Amending Law No.6111 which was issued in the Official Gazette Dated 25.02.2011 and No. 27857. Accordingly, costs of medical treatment at university hospitals, private hospitals and Ministry of Health hospitals for traffic accident victims would be paid by the Social Security Institution. In addition, the accounts of the Revolving Funds Administration for Traffic Services would be closed down in 6 months.

Treatment costs were paid by transferring 15% of the premiums previously collected by insurance companies and co-pays collected by the guarantee fund to the SSI. So, gaps in payment to health care facilities were removed and payment schedules and procedures were standardized in the context of a single reimbursement agency. Apart from all these, the Regulation on Collection of Medical Bills Relevant to Traffic Acidents was issued in the Official Gazette Dated 27.08.2011 and No. 28038, bringing a detailed and comprehensive explaination to the functioning of this new and dynamic system.

Council for Economic Coordination for Health: Establishment of the Council for Economic Coordination for Health, through which all decisions that could create economic impacts in health financing were taken, proved to be another significant reform in health financing in 2003-2013 period. The council, which makes decisicons on health and social security in the name of the government, is headed by the Deputy Prime Minister in charge of the Undersecretariat of Treasury and other members are the Minister of Health, the Minister of Finance, the Minister of Labor and Social Security, and the Minister of Development. The council convenes regularly, discusses health-related events, especially those pertaining to financing of the health care system, and takes measures, if necessary. Also respective bureaucrats and other officers join the council sessions and give briefings.

Health Expenditures Monitoring and Evaluation Committee: As per the Measure No. 10 stating that "measures will be taken in order to ensure effective and efficient use of public resources", the Health Expenditures Monitoring and Evaluation Committee was established in 2009, under the Council for Economic Coordination for Health, for systematic monitoring and evaluation of health expenditures, and rapid identification of financial risks that are likely to occur. The Protocol on Establishment of Health Expenditures Monitoring and Evaluation Committee was signed on 8 October 2009 by relevant parties which are the Undersecretariat of State Planning Organization (SPO)*, Undersecretariat of Treasury, Ministry of Finance, Ministry of Health, Ministry of Labor and Social Security, the SSI and TurkStat. The committee is comprised of 4 members (2 permanent delegates and 2 substitute members) from each of these institutions and keeps records during all meetings and sessions. The committee is primarily charged with managing and presenting data on health expenditures, debriefing decision-makers by submitting reports that contain accurate information and objective analyses, and making recommendations for necessary strategies. So, the committee analyzes the changes in and progress of health expenditures and decision-makers design new policies, if necessary.

To sum up, global budgeting, which helps to identify the MoH share in public spending for health, has been one of the most prominent reforms achieved in the field of health financing since 2006.

* Undersecretariat of State Planning Organization was restructured and renamed as the Ministry of Development in 2011.

Global Budget: The period of transition to global budgeting and its stages should be known well so that the structural changes made in health financing in Turkey are fully understood.

In pre-2006 period, the public health care facilities in Turkey, which were affiliated with the MoH and approximately one thousand in number, had to submit service bills to the reimbursement agencies in line with the Budget Execution Directive (the official price list for health care services announced by the MoF before the SSI became entitled) in order to collect their receivables. However, it was quite a complex, costly and dysfunctional method for billing and collection in many aspects. The reimbursement agencies had difficulty in paying for their debts which created a financial bottleneck for the MoH. The problem was discussed in details in the negotiations which were held on 27 December 2005 for the budget 2006 and it was concluded that the method was not sustainable for the MoH anymore.

On 27 December 2005, the Paragraph "c" was inserted to the Article 31 of the Law on Central Government Budget for 2006 No. 5437 which stated that "for individuals who are covered by the Presidency of Social Insurance Organization and General Directorate of BAG-KUR, and subject to the Law Dated 18.6.1992 and No.3816, all of the service bills, which were issued by the MoH health care facilities and remained unpaid as of 31.12.2005, will be cancelled by this Law and the Ministry of Finance is entitled to perform necessary procedures". Following the enactment of this Law, receivables of the MoH health care facilities from the SSK, BAG-KUR and the Green Card System, which amounted to 3,5 billion TRY and could not be collected as of 2005 and before, were cancelled. The concealment, for which the consent of the MoH was not taken prior to its execution, inspired the MoH to a new method of collection.

In the meanwhile, the MoH had more difficulties in ensuring financial sustainability for its affiliated health care facilities following the enforcement of this rule. Concurrently with this problem, some media published news alleging that the national health care system collapsed, patients were in trouble at hospitals, hospitals became bankrupt and insolvent and did not manage to provide medicines and medical supplies for patients.

Upon the objections by the MoH to the Government, the date of cancelment was changed to 31.12.2004 by the Law Dated 07 March 2006 and No. 5471 and the MoH receivables from the reimbursement agencies were cancelled for 2004 and before. However, the MoH adopted global budgeting later with the aim of finding a permanent solution to these problems and ensuring financial sustainability of health expenditures without prejudice to service quality and patient satisfaction with health care services.

Global budget, which is determined by the Council for Economic Coordination for Health at the end of long and comprehensive efforts, refers to the amount of progressive payment to be received in return for services which will be provided during a fiscal year that is the cap and target for spending by taking the expenditures of MoH-affiliated institutions and agencies into account. Capping total amount of money to be spent for health care services, global budget aims at keeping health spending under control.

Prior to the Global Budget: Service financing was based on billing. People covered by a social security scheme could visit primary care facilities with their health certificates and a medical visit form or a patient referral paper. Green Card holders, on the other hand, were expected to visit primary health care facilities with their Green Cards. People with no social security coverage had to pay for their treatment costs out of their pockets in order to receive primary care services.

As a result of the consultations performed in the primary health care facilities, each of the consultation request forms displayed the consultations and tests performed, patient referral forms and health certificates used to be photocopied and kept in the health care facilities while the originals used to be submitted to the provincial health directorates on a monthly basis. The provincial health directorates used to classify these papers, which were submitted by the primary health care facilities, individually and by reimbursement agencies, and used to make out invoices per person and by reimbursement agencies, accordingly. The provincial health directorates used to keep two separate files: one including the original invoices made out by the reimbursement agencies and the other including just the photocopies. In addition, these invoices and their attachments used to be mailed to the reimbursement agencies. Procedures were even more complex in secondary and tertiary health care facilities. Each of the consultation request forms displaying the consultations and tests, patient referral forms and health certificates used to be photocopied and kept in the health care facilities while the originals used to be submitted to the reimbursement agencies in the accompany of the hospital bills. The bills submitted to the reimbursement agencies were examined (by thousands of employees mostly selected from the health care personnel) and - if deemed to have been properly issued - reimbursement was made in line with the capacity of the budget. Yet, some of the bills were not issued properly and therefore some health care facilities could receive full reimbursement while some others could not receive even the half.

Apart from this, the reimbursement agencies were required to keep the records of these papers for long years which resulted in construction and even rental huge warehouses. Even legal amendments were required from times to times in order to dispose extremely large amount of records and papers that could not be stored any more. Finally, Global Budgeting reduced both costs and red-tapism in health care sector.

Global Budgeting: The implementation of Global Budgeting was launched by the Protocol on Global Budgeting signed between the MoF, the MoH and the MoLSS (SSI). The protocol specifies the total amount of allocation for the MoH, the reimbursement agency, and the date and amount of reimbursement to be made in return for treatment services provided for people, who are covered by the SSI, and others whose treatment costs are paid from the General Budget (the TGNA, Constitutional Court and judicial cases). In scope of Global Budgeting, the SSI and the MoH sign a "Lump Sum Service Procurement Contract" in compliance with the Paragraph 8 of the Article 73 of the Law on Social Insurance and Universal Health Insurance No. 5510. Pertaining to the amount of receivables surpassing the Global Budget, a cabinet decree is issued on yearly basis in order to cancel the surpassing amounts. Collection of public receivables amounting to 14,168 billion TRY (as of the prices in 2013) was cancelled by the reimbursement policies and global budgeting between 2004 and 2013. Since there was no increase in the Medical Enforcement Declaration (SUT) prices, deferral prices decreased by years in 2005. As the billing amount was nearly equal to global budget amount, no deferrals occurred.

Table 33. Costs of Cancelled Receivables of the MoH, (2004-2013), (million TRY/USD)

Years	TRY	As of 2013 Prices, TRY	USD	PPP USD
2004	269	551	189	332
2005	1.220	2.308	910	1.468
2006	481	831	336	569
2007	1.264	2.008	971	1.462
2008	1.472	2.117	1.139	1.654
2009	1.501	2.031	970	1.652
2010	1.753	2.184	1.168	1.863
2011	1.492	1.746	893	1.512
2012	365	392	203	346
2013	0	0	0	0
Total	**9.817**	**14.168**	**6.781**	**10.859**

Source: Ministry of Health

Stages of Global Budget Implementation: Global budgeting, which was first implemented in 2006, was finalized having passed through 3 stages so far:

Ist Stage: Global budgeting was first implemented in June 2006 and the amount of annual disbursement was identified. While disbursement was capped with the pre-identified global budget, both hospitals and primary care facilities affiliated with the MoH maintained billing for services at this stage.

IInd Stage: The second stage of Global Budgeting was launched by exempting primary health care facilities from billing, as ordered by the Article 4 of the Law Dated 08.03.2007 and No. 5597, and the Additional Article 2 to the Law No. 5502. Accordingly, service procurement contracts were signed with the SSI for the SSI insurees (including those covered by the SSK, BAG-KUR and ES scheme), and with the Ministry of Finance for the Green Card holders and other civil servants. So, all health care services provided by primary health care providers were offered free-of charge regardless of people being covered by the social security. Not only medical consultations but also issuance of health reports (required for certain licenses including driving license and marriage procedures), blood type determination and blood sugar measurements etc. were provided free of charge in the primary care level which is among the major steps taken towards the reforming of the Turkish Health Care System. With this implementation, access to primary care services were faciliateted and bureaucratic requirements were abolished. In addition to creating positive impacts on people, also bureaucratic procedures and paperwork were diminished among public agencies and organizations.

As a result, the MoH put an end to the long and complex bureaucratic procedures starting with the health centers and continuing through the reimbursement agencies such as photocopies, documents, referral papers, health certificates and bills etc. Besides, the implementation yielded some other benefits that could not be foreseen in the pre-implementation period. For instance, people who could not afford some medical tests prior to marriage procedures took such tests free of charge and preferred civil marriage.

IIIrd Stage: The third stage of Global Budgeting was launched by abolishment of the system requiring sending bills to SSI, in the MoH-affiliated hospitals and oral and dental care centers. Accordingly, service costs at hospitals are calculated on the MEDULA system electronically. The MoH hospitals and oral and dental care facilities are not expected to submit bills or other payment papers to the SSI any more, as in the MoH primary health care facilities.

Global Budgeting facilitated procedures and work flows not only for individuals but also for reimbursement agencies and the MoH – the service provider. It allowed public agencies and organizations to plan their future in terms of financing. Implementing the Global Budget, impressive cost-cuts were achieved (due to the improved cash flow, particularly) and reimbursement procedures were significantly accelerated. With the Global Budgeting, the share for the Undersecretariat of Treasury, which was 15% before, was reduced to 1% in 2009 and later re-identified as 3% in 2010 and again 1% in 2011.

On the other hand, the relation between the SSI and other service providers such as university hospitals and private facilities is rather based on a traditional purchasing model. Accordingly, the SSI signs contracts with each university and private hospital in order to purchase health care services that are included in the benefit package.

Chapter Five

Health Expenditures by Service Providers (2002-2013)

Health Expenditures by Service Providers (2002-2013)

Table 34. Development of Health Expenditures by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH-affiliated Health Care Facilities *	TRY	5.536	7.546	9.528	10.462	14.372	16.862	19.328	20.884	23.905	26.976	32.673	37.755	5,8
	%	29,5	31,1	31,7	29,6	32,6	33,1	33,5	36,1	38,8	39,3	44,0	44,7	
University Health Facilities	TRY	1.578	2.033	2.526	2.804	3.408	4.113	4.848	5.100	5.920	6.690	6.612	7.469	3,7
	%	8,4	8,4	8,4	7,9	7,7	8,1	8,4	8,8	9,6	9,8	8,9	8,9	
Private Health Care Facilities	TRY	3.214	4.152	4.793	6.547	8.468	11.034	12.242	9.460	9.898	12.006	14.396	15.903	3,9
	%	17,1	17,1	16,0	18,5	19,2	21,7	21,2	16,3	16,0	17,5	19,4	18,8	
Private Pharmacies	TRY	6.955	8.610	9.993	11.413	13.553	14.654	16.454	19.405	18.790	19.662	17.677	20.042	1,9
	%	37,0	35,5	33,3	32,3	30,8	28,8	28,5	33,5	30,5	28,7	23,8	23,7	
Other	TRY	1.491	1.938	3.180	4.133	4.268	4.242	4.868	3.061	3.165	3.274	2.831	3.221	1,2
	%	7,9	8,0	10,6	11,7	9,7	8,3	8,4	5,3	5,1	4,8	3,8	3,8	
Total	**TRY**	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

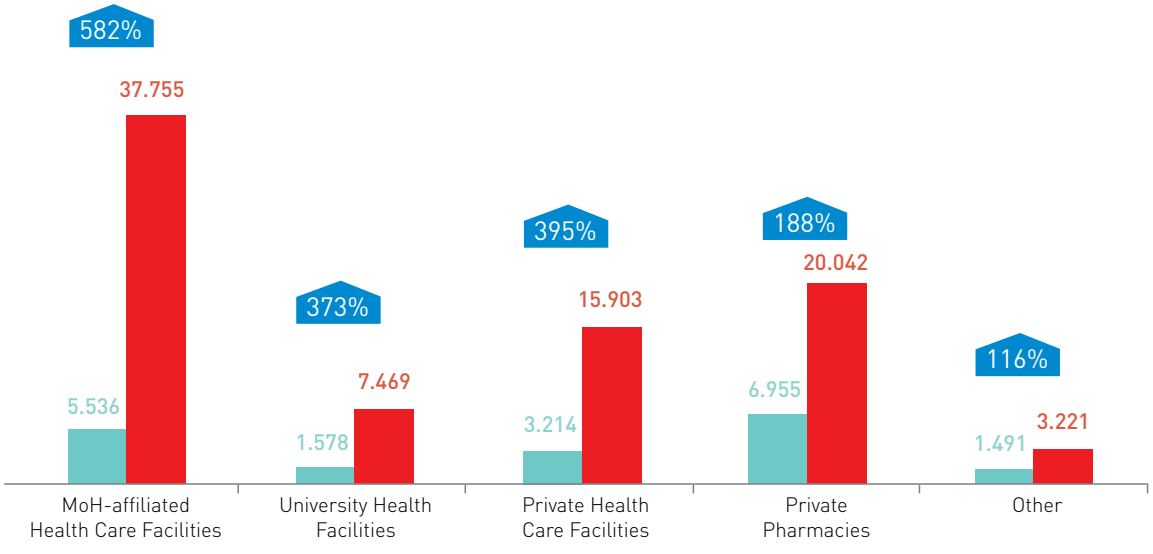
* Expenditures of SSK facilities were included

Source: Ministry of Health, Ministry of Development, TurkStat, SSI

When we analyze development of health expenditures by service providers in last eleven years, we can see significant changes compared to 2002. For example, the share of the private pharmacies in health expenditure declined from 37,0% to 23,7% while the share of the university health facilities increased from 8,4% to 8,9% and MoH's share (including SSK health facilities) went up from 29,5% to 44,7%. Private health care facilities' share rose from 17,1% to 18,8%. The share of other health expenditures declined from 7,9% to 3,8%.

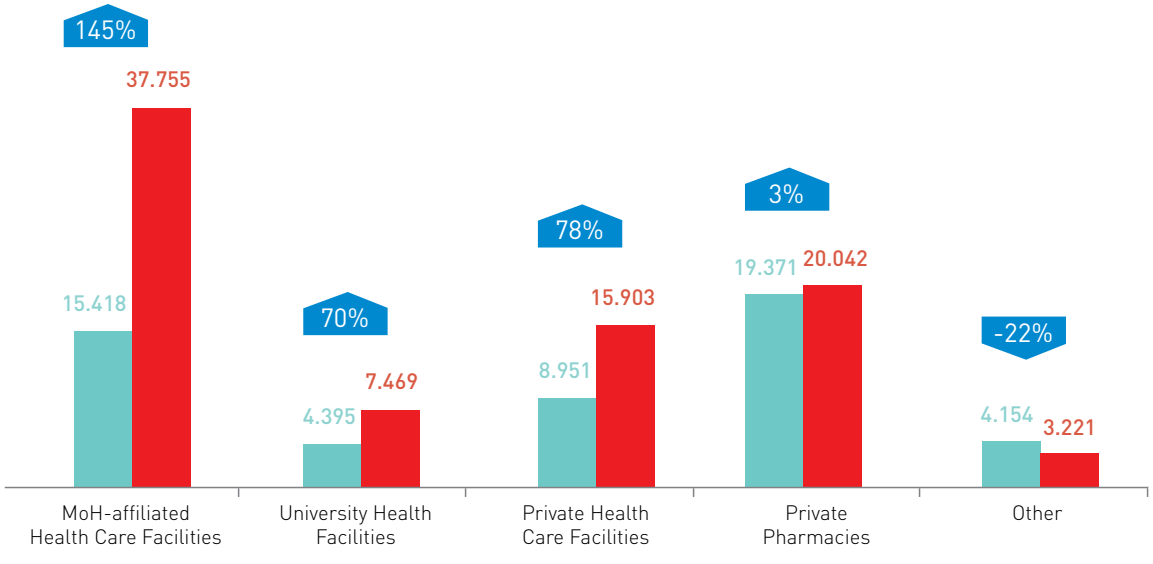
In 2002-2013, the most significant increase, in real terms, in health expenditures by service providers was observed in health care facilities under MoH. The expenditure occurred in health care facilities affiliated to the MoH increased in real terms by 145% thanks to these: the developments achieved in the service provision in terms of quality and quantity with the help of Turkey Health Transformation Program, performance-based supplementary payment, complete transfer of SSK health care facilities to the MoH, implementation of the global budget, improvements achieved in 112 health care services and implementation of family medicine system. While the health expenditure occurred in university health facilities increased by 70% and private health institutions by 78% in real terms, the expenditure occurred in private pharmacies had an increase of only 3% in real terms.

Graphic 21. Development of Health Expenditures by Service Providers, (2002-2013), (million TRY)



Source: Ministry of Health, Ministry of Development, TurkStat and SSI

Graphic 22. Development of Health Expenditures by Service Providers, (2002-2013), (As of 2013 Prices, million TRY)



Source: Ministry of Health, Ministry of Development, TurkStat and SSI

Table 35. Development of Health Expenditure by the Source of Financing and Service Providers (Detailed), (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security Agencies	1.817	2.998	4.083	3.521	5.442	6.399	7.204	7.307	8.118	10.160	15.784	18.436	9,1
Central Government Budget	3.250	3.957	4.717	6.223	8.055	9.415	11.012	12.324	13.574	15.040	14.967	16.607	4,1
Local Governments Budget	128	173	175	160	248	322	312	230	226	223	268	332	1,6
Private Sector	340	419	553	558	626	726	801	1.023	1.986	1.553	1.654	2.379	6,0
MoH Health Care Facilities *	**5.536**	**7.546**	**9.528**	**10.462**	**14.372**	**16.862**	**19.328**	**20.884**	**23.905**	**26.976**	**32.673**	**37.755**	**5,8**
Social Security Agencies	620	827	1.079	1.083	1.325	1.523	2.223	2.529	3.376	3.964	4.927	5.680	8,2
Central Government Budget	687	834	1.074	1.210	1.448	1.704	1.747	1.788	1.590	2.189	1.097	1.102	0,6
Local Governments Budget	102	131	131	131	214	283	275	181	164	152	189	231	1,3
Private Sector	170	242	242	380	421	602	603	602	790	384	398	455	1,7
University Health Care Facilities	**1.578**	**2.033**	**2.526**	**2.804**	**3.408**	**4.113**	**4.848**	**5.100**	**5.920**	**6.690**	**6.612**	**7.469**	**3,7**
Social Security Agencies	396	538	743	1.021	1.723	2.345	4.327	4.506	4.959	5.948	6.633	7.148	17,0
Central Government Budget	192	236	271	269	341	408	552	779	205	70	68	46	-0,8
Local Governments Budget	51	65	65	65	107	142	138	90	82	76	94	116	1,3
Private Sector	2.575	3.313	3.713	5.191	6.298	8.140	7.226	4.085	4.652	5.912	7.600	8.593	2,3
Private Health Care Facilities	**3.214**	**4.152**	**4.793**	**6.547**	**8.468**	**11.034**	**12.242**	**9.460**	**9.898**	**12.006**	**14.396**	**15.903**	**3,9**
Social Security Agencies	4.300	5.615	6.399	7.001	8.372	8.858	10.717	13.161	13.547	14.144	13.446	14.765	2,4
Central Government Budget	1.140	1.277	1.520	1.728	1.845	2.328	2.515	2.919	1.800	1.759	356	669	-0,4
Local Governments Budget	38	57	64	74	61	30	46	43	4	8	9	8	-0,8
Private Sector	1.477	1.661	2.011	2.610	3.275	3.439	3.176	3.282	3.439	3.751	3.866	4.600	2,1
Retail Medicine Expenditures	**6.955**	**8.610**	**9.993**	**11.413**	**13.553**	**14.654**	**16.454**	**19.405**	**18.790**	**19.662**	**17.677**	**20.042**	**1,9**
Social Security Agencies	498	685	926	1.373	805	572	876	773	695	720	839	964	0,9
Central Government Budget	14	13	77	90	78	111	123	136	39	28	5	0	-1,0
Local Governments Budget	37	57	64	37	53	91	94	122	102	98	102	122	2,3
Private Sector	943	1.183	2.113	2.633	3.332	3.468	3.775	2.030	2.329	2.427	1.885	2.135	1,3
Other Current Expenditures	**1.491**	**1.938**	**3.180**	**4.133**	**4.268**	**4.242**	**4.868**	**3.061**	**3.165**	**3.274**	**2.831**	**3.221**	**1,2**
Sum Total of Social Security Agencies	**7.631**	**10.662**	**13.231**	**14.000**	**17.667**	**19.697**	**25.346**	**28.277**	**30.695**	**34.937**	**41.630**	**46.993**	**5,2**
Sum Total of Central Government Budget	**5.283**	**6.317**	**7.659**	**9.520**	**11.766**	**13.966**	**15.948**	**17.946**	**17.209**	**19.086**	**16.493**	**18.425**	**2,5**
Sum Total of Local Governments Budget	**356**	**482**	**500**	**467**	**683**	**867**	**865**	**667**	**577**	**557**	**662**	**810**	**1,3**
Sum Total of Private Sector	**5.504**	**6.817**	**8.632**	**11.372**	**13.953**	**16.374**	**15.580**	**11.021**	**13.196**	**14.028**	**15.404**	**18.162**	**2,3**
Total Health Expenditure	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

*Expenditures of SSK facilities included.

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

A. Health Expenditures for the Ministry of Health

As has been mentioned previously, one of the most remarkable developments of the period 2002-2013 was the withdrawal of SSK from the service provision leaving it to the Ministry of Health, which is the most specialized organization in the health sector. This is considered as one of the most striking steps carrying the reforms for the success in this period. SSK owned 10% of the hospitals (120 hospitals), 17,6% of hospital beds (28.979 patient beds), and had 35% of hospital visits (43 million), 25% of inpatients (1.363.000), 34,7% of surgical operations (554.000). In addition to these, 11 oral and dental health centers, 261 pharmacies and approximately 200 dispensaries were under SSK. Nearly 33 million members of SSK had to get the health service largely from these health facilities of SSK and had a limited access to other public health facilities in Turkey.

The withdrawal of SSK from the delivery of health was not a quick process; thus, it became a painful period due to the internally and externally insuperable impediments. So many crucial steps were taken to help this process till the transfer of SSK was completely made and on 19th of February, 2005, all the public health institutions except from university and municipality hospitals and hospitals under Ministry of Defense were transferred to Ministry of Health. So with this transfer of SSK hospitals to the MoH, the service provision and health financing were separated from each other.

Table 36. Health Expenditure for the Health Care Facilities Affiliated to the Ministry of Health (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	5.536	7.546	9.528	10.462	14.372	16.862	19.328	20.884	23.905	26.976	32.673	37.755	5,8
As of 2013 Prices, TRY	15.418	16.777	19.506	19.800	24.817	26.772	27.786	28.257	29.791	31.576	35.121	37.755	1,4
USD	3.676	5.054	6.699	7.803	10.042	12.956	14.949	13.500	15.933	16.153	18.228	19.857	4,4
PPP USD	9.070	9.790	11.759	12.595	16.979	19.495	21.715	22.984	25.416	27.333	31.034	34.379	2,8
Share of Health Expenditure (%)	29,5	31,1	31,7	29,6	32,6	33,1	33,5	36,1	38,8	39,3	44,0	44,7	
Share of GDP (%)	1,6	1,7	1,7	1,6	1,9	2,0	2,0	2,2	2,2	2,1	2,3	2,4	

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

Between the years 2002 and 2013, MoH's share in health expenditure, which was 29,5% in 2002, climbed to 44,7% in 2013. Expenditures of health providers under Ministry of Health in 2013 increased 5,8-fold by comparison with the expenditures in 2002. The share of the expenditures for the health facilities affiliated to MoH rose from 1,6% to 2,4% of the GDP.

Table 37. Health Expenditures for the Health Care Facilities Affiliated to the Ministry of Health (Detailed) (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security Agencies	TRY	1.817	2.998	4.083	3.521	5.442	6.399	7.204	7.307	8.118	10.160	15.784	18.436	9,1
	%	32,8	39,7	42,9	33,7	37,9	38,0	37,3	35,0	34,0	37,7	48,3	48,8	
Central Government Budget	TRY	3.250	3.957	4.717	6.223	8.055	9.415	11.012	12.324	13.574	15.040	14.967	16.607	4,1
	%	58,7	52,4	49,5	59,5	56,0	55,8	57,0	59,0	56,8	55,8	45,8	44,0	
Local Governments and Other Public Institutions Budget	TRY	128	173	175	160	248	322	312	230	226	223	268	332	1,6
	%	2,3	2,3	1,8	1,5	1,7	1,9	1,6	1,1	0,9	0,8	0,8	0,9	
Private Sector	TRY	340	419	553	558	626	726	801	1.023	1.986	1.553	1.654	2.379	6,0
	%	6,1	5,5	5,8	5,3	4,4	4,3	4,1	4,9	8,3	5,8	5,1	6,3	
Total	**TRY**	**5.536**	**7.546**	**9.528**	**10.462**	**14.372**	**16.862**	**19.328**	**20.884**	**23.905**	**26.976**	**32.673**	**37.755**	**5,8**

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

During this period, while the share of social security agencies in MoH's financing rose from 32,8% to 48,8%, the share of central government agencies dipped from 58,7% to 44%, and share of local governments and other public agencies slumped from 2,3 to 0,9% but the share of private health expenditures increased from 6,1% to 6,3%.

Ministry of Health has been the only organization responsible for planning and supervising the health care services and also for public health and 112 emergency care services and it has always been the largest service provider in the delivery of the hospital services as well as the oral and dental health services.

When we look at the developments in hospital management services, MoH, the largest health provider in 2002, has been enhancing its active role for its mission. For example, while the Ministry of Health owned 47% of the hospital beds in 2002, this rate was increased to 60% in 2013. Likewise, MoH had 53% of the hospital visits in 2002, this rate climbed to 73% in 2013.

The Ministry of Health took all the public health facilities over, except for the university hospitals, municipality hospitals, and the hospitals of The Ministry of National Defence. Undoubtedly, the most crucial factor of this transfer process was the health care facilities of SSK. In 2005, the Ministry of Health took over 146 hospitals, 212 dispensaries, 11 oral and dental health centers, 2 specialty hospitals all of which had been owned by SSK before. This transfer has been one of the key reforms implemented in the early stages of Turkey's Health Transformation Program. This transfer in 2005 helped SSK relinquishing its control over the service provision function and focus on purchasing only. The main objective of this reform was to harmonize the management and disbursement mechanisms of all the public hospitals and separate the health service delivery from health financing.

With many innovations introduced in management field in MoH hospitals, the infrastructures that would be needed later in many other fields were also prepared for the Public Hospitals Union model which was enacted late 2011.

Major management practices launched by MoH via Health Transformation Program in Turkey are:

1. Launching the Uniform Accounting System: Since 2004, uniform accounting system has been used in revolving fund institutions (hospitals, oral and dental health centers, health directorates for primary health care facilities, hygiene centers) under MoH in accordance with international accounting standards. This system has been designed on accrual based accounting. With this system, significant progresses have been made in terms of appropriate and timely use of the income of the revolving fund institutions and available sources. There was a need for administrative, accurate and reliable information systems necessary to establish and develop as well as the legislative arrangements to ensure the financial sustainability of the revolving fund institutions affiliated to the Ministry of Health. In this respect, setting up and operating a uniform accounting system has been a key step. Uniform Accounting System has enabled both central users, managers of the institutions, relevant personnel and accounting units to see the electronic momentary follow-up of financial situation of institutions. With the system, the electronic follow-up of debts and receivables of the institutions under MoH were settled and the workload on the accounting units was reduced. Via uniform accounting system, a system, which conducts the financial work and transactions of the revolving fund institutions under the MoH, and analyzing and reviewing the situation of institutions, determining their financial risks and putting forward recovery proposals by reporting the determinations found out, was developed.

2. Implementation of Performance-Based Supplementary Payment System: In 2002, before the Health Transformation Program in Turkey, a very limited financial benefit from the revenues raised by the services of revolving fund institutions was paid to the personnel who also contributed to those services. As this kind of supplementary payment was not in direct relationship with the health service production; efficiency of the health services and recording it never worked. Theoretically it was possible to make supplementary payment up to 100% of basic salary but even this number was not paid. In 2002, average supplementary payment for specialist physicians was 1.115 TRY as of 2013 figures; this was around 345 TRY for other health care personnel like midwives or nurses in 2013 figures. However, with supplementary payment system implemented in 2003, this basis of a 100% of the basic salary was changed into 150% and 800% for the office hours taking the different profession groups and working conditions into consideration. It is possible for these bases to increase - from 150% to 180% and 800% to 1,040% with the practices after office hours. In 2013, average supplementary payment for specialist physicians was increased nearly by 5 folds to 5.116 TRY in real terms compared to 2002 and for other health personnel, there was nearly 3-fold increase in real terms by an average of 947 TRY when compared to 2002 figures. Supplementary payment system has been used in order to motivate the health personnel, to make them work more efficiently, to promote quality service delivery and to make measurable service descriptions and it has been quite successful so far. With the performance-based supplementary payment system introduced by the Health Transformation Program in Turkey, a system, in which time and sources could be used more efficiently by drawing similarities between the work and the gain, was created. The first concern revealed by this system was making the services of the institutions more measurable and the second was to make these measurable services assessed and then share them with the service producing personnel.

Active working hours were voluntarily extended in most institutions after this system. Most specialist physicians closed down their private offices and preferred full-time practice at hospitals. While the rate of the specialist physicians working full-time basis in public hospitals was 11% in the early 2003, the percentage (even before the law pertaining to full-time work) came close to 90% thanks to the commitments mentioned above. Thus, the efficiency of physicians, already few in number, was increased in public hospitals. This system proved to be a key element strengthening the motivation when meeting demand for services. Taking leaks in the system registry under control, providing the supplies at a lower cost, and reducing the dissipation of health service resources contributed to the performance-based supplementary payment system enormously. The system led to a routine registration system. While only 20% of the hospitals had automation systems in 2003, it was 100% in 2013. Waiting times to see a physician were reduced considerably; the allotted time for the patient care was increased. Number of referrals to an upper level of health care facilities was brought down to a reasonable level. Income-expenditure balances of health care facilities got monitored more precisely and the fight against "informal payments to health service providers" became easier.

3. Extending Service Procurement Processes: One of the most significant developments of the period from 2002 to 2013 was "the service procurements" implemented commonly in the institutions under the Ministry of Health. Service procurements were largely for especially medical services such as laboratory and imaging services and also for supporting services like cleaning, security, catering, and information technologies. Through these procurements; patient satisfaction was increased and the service quality of the care was improved, the need for personnel was met and service provision continuity was ensured, modern technologies were introduced to the hospitals, costs of the fixed investment were reduced, competitiveness with other health institutions was enhanced, services were provided in a more economical way, service costs were reduced after having been checked, financial risks were shared with the suppliers, the employment of qualified personnel became more easier and finally, management flexibility was created. This process evolved into a new employment model, particularly for supporting services. For example, while the number of the service procurement for the support services in MoH was around 11 thousand in 2002, this number was increased to 130 thousand in 2013.

4. Expanding the Authority of the Institution Managers: Institution managers were given more autonomy and flexibility regarding budget management, purchasing and investment decisions especially in accordance with financial opportunities. The right to spend up on the basis of their own budget enabled the managers to meet the needs of the institution quickly without notifying the central government. These practices provided managers great opportunities to improve the quality of the health care services and satisfaction of the citizens.

5. Dissemination of the Health Information System in All Institutions: National Health Information System (NHIS), which is one of the key components in Health Transformation Program, was started and national standards for health information system were set in this period. Thus, an effective information system infrastructure was established. The infrastructure needed for information technologies was formed in all hospitals. Even, this infrastructure allows the transmission of the medical images as it has fast backbone network all across Turkey. On the other hand, via this system, it has become possible to record manpower, movables, immovables, and the administrative and financial data of the institutions and organizations that provide health services. Through the dissemination of health information system: data standardization was achieved, support systems for data analysis and decision making were created, data flow between e-health stakeholders was accelerated, electronic personal health records were created, resource-saving was maintained and efficiency was created.

6. More Attention to Quality and Productivity in Hospitals: One of the main objectives of the Health Transformation Program in Turkey is to ensure the continuous quality improvement in health care services. In 2005, the service quality dimension was integrated into performance-based supplementary payment system quality introduced in 2003. Thus, a comprehensive assessment system was put into practice based upon the access to health services, service infrastructure, process assessment, measurement of patient satisfaction and the degree of the objectives that had been set earlier. After the international practices had been revised, the quality criteria list consisting of 150 items was made in 2007. With a revision in 2008, this list was re-designed both structurally and methodologically and evolved into a new set called "Service Quality Standards", which consists of 354 standards and 900 sub-components. In 2009, for the private hospitals and university hospitals, "Service Quality Standards for Private Hospitals", with 388 standards and about 1.450 sub-components, was prepared and published.

Manuals published with Service Quality Standards have become a pathfinder for the health providers and functions as timeline for the on-site assessments. Through this system set for the quality, service quality was enhanced and high quality of service delivery was tried to be ensured for all health providers equally, employee and patient safety was increased.

7. Ensuring Budgetary Discipline in the Revolving Fund Institutions: Budget program, designed parallel to the uniform accounting system, allows institutions to create their own budgets with revenue and expenditure estimates for every fiscal year. Monitoring the budget realizations in the year, revenues and expenditures of the institutions were brought under control. Investment budgets were arranged according to the institutions' financial structures and inappropriate spending were prevented. The balance between the budget and other implemented systems was ensured considerably and spendings were arranged according to the revenues thus, financial structure was sustained.

8. Implementation of the Global Budget: Another important step in the field of health financing was to determine the share which MoH received from health expenditures via global budget implemented in 2006. As a result of a long and comprehensive study determined as a result of long and comprehensive studies by the economic coordination committee for health, global budget generally refers to the amount to be obtained for the services provided in a financial year prospectively, in other terms; it refers to the spending limit and spending target. With the help of global budget, many procedures causing costs and bureaucracy ended. With this implementation, costs resulting from paper work, storing and mailing expenses were reduced and loss of time for personnel dealing with invoices and inspection was prevented. Global budged provided cash flow for the revolving fund institutions affiliated with the MoH, and payments were made on a regular basis, thanks to these developments the costs incurred by the sellers were reduced significantly.

Global budget also provided relief for the institutions financially. Accruals determined by the global budget were not payments having been made only according to the invoicing anymore. Instead, parameters such as the personnel burden of institutions, the size of the service area and the number of inpatients and outpatients were used in plans for the accruals.

These parameters were;

Outpatient income: in the institutions where the outpatient income is too high in the share of total income, a certain amount of this income is taken into consideration as the outpatient costs are lower.

Inpatient income: almost all of the inpatient income is taken into account as the inpatient costs are high.

Extra burden of personnel for the institution: This parameter is applied in order to diminish the difference between institutions due to payments for personnel expenditures from the revolving fund institutions.

Closed area expenses: This parameter is applied in order to ensure balance between institutions in terms of expenses for closed areas (due to electricity, rent, heating, etc).

Building maintenance expenditures: This parameter is followed in order to ensure balance between institutions in terms of expenses resulting from building maintenance expenditures.

Bundle procurement: This parameter is used to foster the institutions appointed for bundle procurement.

Commitment in terms of procurement: It is used in order to encourage institutions carrying out procurement procedures for other institutions as well.

B1 Type 112 Emergency Health Care Services Integrated Station: Since the B1 type integrated 112 Emergency Health Care Services stations cause an extra expenditure, this parameter is applied to encourage the institutions which they integrated with.

Diagnosis Related Groups: this parameter is applied according to the Diagnosis Related Groups (DRG) developed by MoH in December, 2010.

Stock Record Order: a reduction from the accrual by 1% is envisaged where there is an irregular stock record by the institutions.

Compliance with Hospital Roles: It is applied in order to ensure the compliance with the hospital rules brought by the General Directorate of Health Services.

9. Performance Practices for Managers: While performing their tasks, managers employed in the public hospitals should take some managerial -priority issues into consideration. These managerial - priority issues can be listed as:

- The institutions should have a sustainable financial structure,
- Institutions should make debt payments on time,
- Financial benefits of institution's personnel must be protected,
- A structure -in compliance with the quality standards generally accepted for the services provided- must be created and sustained,
- Strategic objectives set by the Ministry must be fulfilled.

In order to measure and evaluate managerial priorities, "manager performance" was introduced in March, 2010. According to this implementation, managers like head physician, deputy head physician, hospital manager, hospital deputy manager and head nurse were held accountable for the institution performance according to the performance criteria set before.

First "manager performance implementation" was started by measuring the financial criteria. These financial criteria measured two main criteria; the level of indebtedness and the duration of the debt. The average of these two performance criteria revealed the coefficient of the manager performance for each relevant manager after the type of the hospital, the manager's position in the institution and manager's service hours were taken into account. The coefficient of the manager performance that was identified separately for each manager was multiplied by the manager's supplementary payment.

Those managers who became accountable for their performance with this implementation promoted awareness for the efficient and effective use of sources. In addition to financial indicators, managerial indicators were also added into the manager performance and the managers' area of responsibility was expanded so these indicators were measured taking these changes into account.

10. Central Control of the Financial Management: one of the most important factors of the successful implementation of Turkey Health Transformation Program was the success achieved in financial management. During this period, it can be seen that the MoH-affiliated institutions were managed unprofessionally before the Health Transformation Program.

Main financial implementations managed by Presidency of Strategy Development under the MoH are;

10.1. Financial Management Operation:

- Determining the Number of Personnel to Be Assigned for Personnel-Based Service Procurements by Dynamic and Realistic Criteria, and Preventing Unnecessary Recruitment:

With the regulation made by Presidency of Strategy Development, a more dynamic system was built that could be modified in parallel with income, service provision, patient potential, the size of the facility and the number of current contracted and permanent personnel in order to be able to determine the number of workers who would be assigned under the scope of service procurement for the MoH-affiliated institutions. With this regulation, some limitations that wouldn't affect the performance and service provision of the institution were introduced to determine the number employees. A web-based program called "Determination and Follow-up of Employee Number" was developed and put into use for the institutions in order to estimate the number of the employees, who would work via service procurements, in a reliable way and also in accordance with the new criteria, and to track these estimations on provincial or Ministerial basis.

Institutions determine the number of employees according to their performances and the criteria they own via this program semiannually. These data can be instantly controlled and followed up by the MoH, Provincial Health Directorates and institutions. In addition, this system also allows users to access information about the number of personnel in terms of service procurement, educational background of such personnel and their salaries instantly. While the number of the employees assigned under the scope of service procurements for MoH institutions was increasing by 15.000 annually before this regulation, the increase in the number of employees was reduced to 1.500 after the regulation.

- Limitation for the Profit Ratio to be allocated to Contractors for Personnel-Based Service Procurements:

Even though the profit ratio for personnel-based service procurements could be up to 20% depending on the quality of the work in accordance with the provisions of implementing Regulation on Service Procurement Tenders published by the Public Procurement Agency, for personnel-based service procurements made by the institutions, maximum profit ratio to be allocated to contractors was firstly limited to 8% and then it was reduced to 5% thanks to the regulations implemented by presidency of strategy development under MoH between 2009 and 2010. These regulations made significant contributions to institutions under MoH financially. The average profit ratio, which was 7,53% before the regulations in 2009, it was reduced to 4,61% in 2010, 3,05% in 2011, 2,33% in 2012 and 2,18% in 2013.

- Standardization of Wages for Employees Hired in the Scope of Service Procurement:

With the regulation made by the Presidency of Strategy Development, necessary regulations were made in order to envisage an equal wage for employees hired for service procurement tenders based on personnel employment in accordance with the quality of the service, educational background and the certificates they had. With these regulations, an equilibrium wage was formed for the personnel hired for service procurement made by MoH-affiliated institutions.

- Determination of the Time of Payment and Regulation of the Payment Processes:

One of the most important factors while meeting the needs and efficient use of resources appropriately is that the suppliers should be informed about time of payment made by the administration and these payments should be made without any delay. With the regulations made by the Presidency of Strategy Development, matters such as "time of payment shall be stated in bidding documents" and "the time of payment should not exceed 90 days maximum" in accordance with income realization and cash flow of institution were cleared up. Institutions with a good financial status were enabled to determine an earlier payment time and forwarding payment papers to the relevant accountancies forthwith in order to avoid delays during inspection, admission and accrual processes was maintained. Thus, in order to ensure that health care needs could be met by health institutions and the satisfaction level could be increased to the maximum level stock implementations based on the provision of high quality products, low stock level and low cost were made.

10.2. Stock Management Operations:

- Implementations of Management System for Resources of Supply (MSRS):

MSRS is a web-based information management system configured to ensure efficient use and up to date follow-up of movables (medicine, medical devices, consumables and office equipment) owned by the institutions in the central and provincial organizations under the MoH. There are several modular structures for the use and the follow-up of the movables within MSRS. With this model, a combined resource management system was established consisting of an Inventory Information System, Storage (Depot) Information System, Durable Mobile Information System, Transportation Means Information System, Medical Devices Information System, Firm Information and Health Care Centers Supply Procedures.

With this system administrated actively by the Presidency of Strategy Development since 2008; several books, documents and tables required to by the financial legislation started to be prepared electronically. Additionally, potential errors and risks were reduced to a minimum level by automating record and reporting systems with regard to accountability of works and procedures to be carried out by the institutions.

Prior to MSRS, as in the other public administrations, all kinds of records and transaction of the movables of the institutions under the MoH were followed-up by movables officers through hard copy record. In this respect, financial data such as properties, consumption and stock data of an institution could be obtained only at the year-end closure. Additionally in order to investigate the properties and supply procurements of an institution or to find out which units received the items purchased before, the relevant books and registrations had to be examined by authorities after the long-term inspections and the information obtained from these books was subject to an extra estimation process, too. After the implementation of MSRS, all records started to be kept electronically and most of the books, papers and tables were removed from the use. Thus, records and reports of accountability started to be prepared electronically.

MSRS implementations have enabled its users to follow-up an institution's medicine and medical supplies stock, fuel oil consumption, stationary supplies, available spare part stock, and data about from whom, when and through what method these movables are purchased via detailed and consolidated reports through web.

- Maximum Stock Amount (MSA) Implementation:

In order to maintain continuous provision of health care services, institutions are supposed to keep their stock at a certain level. Stock level above the needed affects the financial sustainability of the institution negatively.

After the Health Transformation Program had held the health facilities obliges to provide all the medicine and medical consumables in order to ensure satisfaction for patients and their relatives, institutions began to increase their medicine and medical consumables stocks considerably.

In order to maintain a sustainable financial structure, new regulations were brought to stock management by the Presidency of Strategy Development. Within this context, in order to minimize risks such as expiration and deterioration as well as provision and stock costs, institutions were allowed to stock up only 3-months-needs after "Maximum Stock Amount Implementation" was started in order to supply medicine and medical consumables.

By means of the maximum stock amount implementation, that acceptance of goods were maintained in a way not to exceed 3 months' time in accordance with the needs and maturity periods were shortened by controlling the payment requirements. Before Maximum Stock Amount Implementation, stock levels tended to increase more than 20% annually. With this implementation launched in May, 2009, stock increases were stopped and the stock levels, which were 1 billion TRY in MoH-affiliated institutions before, were decreased to 635 million TRY at the end of the year 2013 all over Turkey.

- Overstock and Surplus Processes:

Need for medicine and medical consumables plays a significant role in service production expenditures and this affects the financial structures of institutions negatively as well as on provision costs negatively. For the surplus medical supplies or medicines stocked for over 3 months' needs listed in institutions' inventories or for the consumables that will never be used for some reasons or the ones with the risks such as expiry, being old-fashioned and deterioration; Presidency of Strategy Development developed "Excess Stock Portables Module" and "Surplus Portable Module" in order to transfer these medical supplies and medicines to the relevant institutions at no cost or with a charge. "Checking MSRS" before the call for tenders became compulsory in order to meet the need from the supplies included in the excess stock or surplus modules rather than supplying them from the market.

Institutions are required to determine their annual needs after checking the data of medicine and medical consumables registered in MSRS and maximum stock amount implementation transfers the products above three month of need into the excess stock module automatically and submit it to information of other hospitals. For example, if a hospital's need for an A item is 1.000 count, this hospital can only have 250 count of this item at most in accordance with the maximum stock amount implementation. If the hospital purchases 300 count of item B, 50 counts will be automatically transferred into excess stock module and submitted to information of other hospitals. Between the years 2009-2013, the excess stock supply transferred within the MoH institutions has value of 342 million TRY.

Goods and materials that were provided for service production but turned out to be extra for a reason are described as surpluses. In order support the efficient use of resources, the products included in Surplus Portable Module are transferred free-of-charge. Between the years 2009-2013, the surplus supply transferred within the institutions under the MoH was valued at 190 million TRY.

- Requirement of MSRS Inquiry Prior to the Call for Tenders:

One of the modules to be inquired in MSRS is "Supply Procurement Questioning Module". By means of this module, administrations are enabled to access to information about the purchase such as "of whom, what, from whom, when and how much" purchase was realized and also to finalize tenders through better data on approximate cost estimations accordingly. As a result, apart from its economic procurement function, MSRS questioning has been used as a significant means in transferring excessive public resources to other institutions in need and also decreasing stock levels.

- Stock Analyses:

The main purpose of stock and procurement analyses is to supply medicine and medical consumables required by service provision with economic procurement methods. Under the light of the information obtained through MSRS procurement method, procurement processes and stocks have been analyzed on a regular basis by the Presidency of Strategy Development. In the light of these analyses, necessary regulations and measures have been taken into consideration.

- Building Provincial Stock Coordination Teams and Creating Provincial Stock Pools:

As a continuation of to the implementations applied in the field of stock management, each province has been qualified as "Provincial Stock Pool" by the Presidency of Strategy Department and "Stock Coordination Teams" have been formed in every province in order to render stock management efficient in the provincial level and to keep supply transfers under coordination at institutional level. Stock coordination teams work on reviewing stock practices at institutional level, controlling annual needs, to prevent procurement of products which are already included in the provincial stock pool and creating awareness for administrations by analyzing procurement practices. Institutions are required to meet their need from the provincial stock pool primarily before trying to purchase their needs under the control of stock coordination unit.

- Establishment of Commissions for Determination of Needs:

In order to control appropriateness of demands for procurement of medical consumables, medicine and similar product purchases and to control amounts of demands, Presidency of Strategy Development has established "Commissions for Determination of Needs" for the institutions. This commission ensures identifying institutions' needs effectively, economically and efficiently, by trying to avoid unnecessary bureaucracy. This commission decides on;

- Whether a product to be provided after an agreement via supply procurement could be reimbursed as well as the amount to be purchased and also their maximum prices,

- The minimum price that could be obtained for a certain product taking the payment by reimbursement institutions into consideration in accordance with the quality and the scope of the service to be purchased, whether it is possible to meet the need at a lower price by investigating alternative products,

- Whether there is a possible method (donation, transfer from other institutions, renting, procurement) for the provision of the alternative supply or service needed, functioning of such commissions as a control media in order to maintain financial sustainability of institutions was ensured.

10.3. Purchasing Operations Management:

In order to provide the needs of health care institutions in an effective, economic and efficient way new methods under the scope of public procurement legislation have been put into effect by the Presidency of Strategy Development.

- Enabling Public Hospitals to Exchange Goods and Services with Each Other:

Relevant legislation was made by Presidency of Strategy Development in order to ensure the transfer of surplus stock and movables that are not used by MoH-affiliated institutions to other institutions that are in need as free-of-charge or at a value to be determined later. With this legislation, surplus of resources of the MoH hospitals, university hospitals and other public hospitals with this regulation have been brought into active use.

- Meeting the Needs of Small-Scaled Hospitals by Large-Scaled Hospitals:

In the second half of 2009, Presidency of Strategy Development set up the rule stating that the needs of small-scaled hospitals with a limited procurement capacity are to be met by large-scaled hospitals. Thus, procurement procedures of institution were facilitated and inventory costs were decreased and number of the hospitals purchasing medicine and medical supply was reduced from 835 to 312. A purchase of 171.2 million TRY of medicine and medical supply was met by larger institutions on behalf of small sized ones in between the years 2010-2013.

- Bundle Procurement through a Bundle Contract:

Legislation on bundle contracts was put into effect in order to ensure that procurement of services and goods needed by health service providers is carried out through a bundle agreement. Bundle contracts have proved to be an important method, contributing efficient stock management of institutions and enable procurement of needs immediately from predetermined suppliers. Additionally, through a bundle contract period (this period might be up to four years), it is not necessary to call for tender for each procurement, and candidates are not required to submit their papers again and again to prove their compatibility.

MoH started providing needs via bundle contract method. Bundle contracts were made mandatory in order to meet the needs for medicine and medical devices on a provincial basis via a circular issued by the MoH in 2009 and efforts were made to ensure such procurements to be handled by Provincial Health Directorates or Central Procurement Units that are established in hospitals with a capacity to regenerate procurements within the province concerned.

After bundle contracts became mandatory, information meetings about the legislation on bundle contracts were held for the personnel employed in central procurement units established in 81 provinces and also for representatives from the sector with the contributions of Public Procurement Agency experts. In 2011, the aim was to enhance the use of the bundle contract to meet the needs of institutions by means of legislative arrangements promoting the participation of candidates into bundle contracts and saving institutions from the problems resulting from the legislation of the time. While the ratio of bundle contract was 11,3% in the total purchase In 2010, this number was decreased to 8,6% in 2013.

- Meeting the Needs of Laboratory Service Providers through Bundle Procurements:

So as to provide laboratory needs in an economic and efficient way, following the regulation made by Presidency of Strategy Development in 2010, Provincial Health Directorates were obliged to use bundle procurement for providing laboratory supplies of 629 institutions with an insufficient procurement capacity and low budget. This practice continued in 2011 as well. Laboratory supplies of 629 institutions were provided through bundle procurement.

Via the regulations initiated in 2009 and 2010;

- The costs of provision and stocking were decreased
- The establishment of common terms of references was ensured
- Procurement capacity of the institutions was increased
- The number of competing tender offers were increased.
- The number of the tenders was reduced (the number of the tenders, which was 21.660 in 2009, was reduced to 18.787 in 2010, in 2011 to 18.052, in 2012 to 16.410 and in 2013 to 10.732.

- Facilitating the Provision of Needs for Research and Development:

Under the scope of paragraph (f) of the Article 3 of Public Procurement Law No. 4734, all the procedures and methods were defined by MoH Presidency of Strategy Development for all kinds of service procurements linked to the research and development activities to be carried out in the field of health by the MoH institutions. The research and development services to be carried out in the field of health care can be purchased from the sector through bargaining or direct provision method based on the principles defined by the MoH and directly from public institutions and universities based on the principles of the relevant protocol. In return for the services obtained from public institutions and universities carrying out the research and development activities needed, MoH allocated 3 million TRY financing for each service thus contributed to improvement of research and development activities in Turkey.

10.4. Managing Institutions by Financial Risk Management Principles:

During this period, over 1.000 institutions under the MoH were managed by Presidency of Strategy Development, taking the financial risk management principles into consideration and also financial analyses were made for the financially high risk bearing hospitals and their economic condition was healed.

- Financial Risk Management of Institutions:

The main objective of the regulations implemented under the scope of the Health Transformation Program Turkey is to sustain accessible, adequate and high quality health care services as a basis for citizen satisfaction and financial protection. This is achieved in MoH-affiliated institutions with effective and efficient use of resources. For this purpose, revolving fund institutions are assessed over their financial data and their "Financial Risk Analysis" is made and their risk situation is followed through five different grading systems on a daily basis.

MoH Presidency of Strategy Department examined the financial structure of the companies and institutions with a total debt burden equal to twice their monthly service production revenue or more are assessed as "1st-rank risk" accordingly.

- Financial Analysis Reports and Financial Action Plans:

The institutions followed-up by MoH Presidency of Strategy Development in terms of their risk analysis through financial tables were determined before they constituted a high risk level and financial analysis meetings were held with the managers of such institutions. During these meetings, institutions'' service production performances and revenue & expense realizations were reviewed and analyzed comparatively with the data coming from other institutions with the same role. In order to maintain a more effective and efficient use of resources and eliminate potential financial risks and maintain the financial sustainability "Financial Analysis Reports" and "Financial Action Plans (FAP)" both of which are specific to each institutions were prepared after these meetings held. Also, the items included in the analysis reports and action plans were followed-up along with the periodical realizations and consultation meetings were held with the institution body concerned when it was necessary.

- Financial Management Meetings:

Under the scope of financial condition assessments, MoH Presidency of Strategy Development has held regular "Financial Management Information Meetings" for hospital managers every year. Within this scope, training and information meetings about the new regulations which were implemented due to the changes in financial legislation were organized for the institution managers. Presidency of Strategy Development tried to make a difference with the use of in terms of revenue and expenditure balance in order to maintain financial sustainability of institutions during these meetings. In these meetings, In order to maintain "Income and Expenditures Equilibrium", a basic principle especially for the financial sustainability of the institutions, financial tables and implementation results were used to increase precision.

Moreover, to be able to stir up a more active financial management and observe the regulations implemented earlier, training and information meetings were continued regularly for managers in provincial health directorates once every three months.

- Establishment of an Internal Control System:

Under the scope of the Public Financial Management and Control Law No. 5018, the central organization of the Ministry of Health was equipped with an effective internal control system based on the Integrated Control Frame (COSO) model in accordance with the international standards and EU implementations. In accordance with this model, studies with regard to the establishment of the Internal Control System in the Directorate of Strategy Development were started as a first step in 2009 in order to ensure the effectiveness of services, increase the efficiency, and substantiate the eligibility of the administrative and financial reports for with the law and regulations in effect.

In the second step, under the scope of Public Internal Control Standards prepared by the Ministry of Finance, Internal Control Standards Harmonization Action Plan was put into effect in the Ministry of Health on 30.06.2009.

11. Field Coordination System and Enforcing Monitoring and Evaluation Effectively:

Based on on-site assessment of implementations, Ministry of Health has shown ultimate attention to see its employees' services on-site. For this, "Field Coordination System" began in January, 2006. The field coordination system has become a worldwide exemplary proactive monitoring and evaluation system. Ministry of Health has assessed the reforms on-site and gave provincial and central administrators recommendations for solutions of the problems encountered.

In 2006-2013, Ministry of Health analyzed 81 provinces on-site repeatedly without making any exception. In several provinces, more than one evaluation were carried out and the problems of these provinces were discussed with local administrators, tasks to find solutions were shared. Health administrators from other provinces were assigned to the field trips in other provinces thus they were given a chance both to assess other institutions and to compare their own institutions. Therefore provincial assessment studies were also appraised as in-service training opportunities.

12. Establishment of the Association of Public Hospitals:

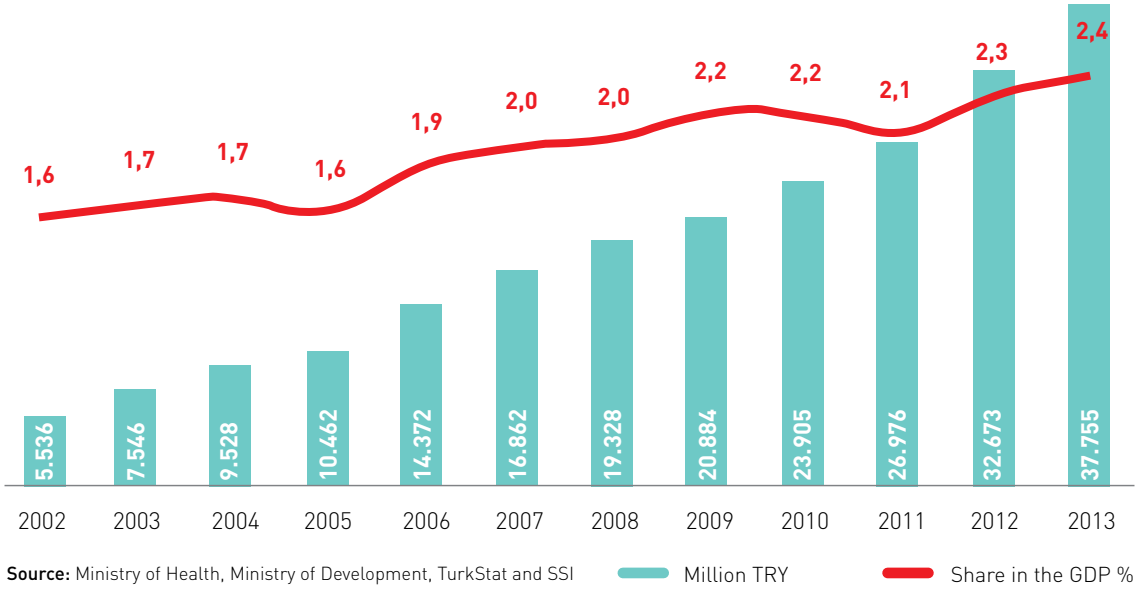
The Association of Public Hospitals was established in late 2012 with the aim of ensuring effective, quality and efficient management and functioning of the hospitals affiliated with the Turkish Public Hospitals Agency which resulted in the formulation of a professional management system in which managers within the provincial units and affiliated hospitals are employed on contract basis and is eligible for inspection and accountability.

Table 38. Financing of the Ministry of Health (2002-2013), (million TRY)

Years	GDP	Ministry of Health					
		Social Security Agencies	Central Government	Local Governments	Private	Total	Share in the GDP (%)
2002	350.476	1.817	3.250	128	340	5.536	1,6
2003	454.781	2.998	3.957	173	419	7.546	1,7
2004	559.033	4.083	4.717	175	553	9.528	1,7
2005	648.932	3.521	6.223	160	558	10.462	1,6
2006	758.391	5.442	8.055	248	626	14.372	1,9
2007	843.178	6.399	9.415	322	726	16.862	2,0
2008	950.534	7.204	11.012	312	801	19.328	2,0
2009	952.559	7.307	12.324	230	1.023	20.884	2,2
2010	1.098.799	8.118	13.574	226	1.986	23.905	2,2
2011	1.297.713	10.160	15.040	223	1.553	26.976	2,1
2012	1.416.798	15.784	14.967	268	1.654	32.673	2,3
2013	1.565.181	18.436	16.607	332	2.379	37.755	2,4
Total	**10.896.376**	**91.270**	**119.140**	**2.799**	**12.618**	**225.826**	**2,1**

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

Graphic 23. Expenditure for the Health Facilities Affiliated with the MoH and Its Share in the GDP (2002-2013)



Source: Ministry of Health, Ministry of Development, TurkStat and SSI — Million TRY — Share in the GDP %

Through 2002-2013 period, there was a steady increase in financing of the Ministry of Health. While the share of MoH's financing in GDP was 1,6% in 2002, this share increased to 2,4% in 2013.

Besides owning the largest hospital network, MoH is the only public administration responsible for public health service delivery. The year 2013 brought many important developments in public health field as well as in other fields. There were 21.175 family medicine units, 177 tuberculosis control centers, 183 mother and child care and family planning centers and 5.594 health houses operating actively under the Ministry of Health in 2013.

There were significant changes in public health service delivery by Ministry of Health in 2002-2013 period. One of the most important of these changes was that the enforcement "Law on Family Medicine Pilot Implementation" No.5258 was put into practice on December 9, 2004. This legal arrangement, making significant changes especially in the provision of primary health care services, enabled family physicians to participate actively in management by bringing the principle "one examination room for each physician". To be able to enhance the physical conditions and improve the working environment, necessary budgetary items were prepared. It took more than 5 years for the family medicine system - started as a pilot implementation-to spread all over the country.

Table 39. Calendar of Transition to Family Practice

Name of the Province	Date of the Transition
DUZCE	15.09.2005
ESKISEHIR	17.07.2006
BOLU	16.10.2006
EDIRNE	01.12.2006
ADIYAMAN	25.12.2006
DENIZLI	25.12.2006
GUMUSHANE	29.12.2006
ELAZIG	04.01.2007
ISPARTA	18.01.2007
SAMSUN	01.03.2007
IZMIR	14.05.2007
SINOP	15.08.2007
BARTIN	01.11.2007
AMASYA	03.12.2007
BAYBURT	02.01.2008
CORUM	02.01.2008
MANISA	02.01.2008
OSMANIYE	14.01.2008
KARAMAN	15.01.2008
KARABUK	01.02.2008
ADANA	21.05.2008
BURDUR	14.07.2008
KIRIKKALE	18.08.2008
CANKIRI	15.10.2008
TUNCELI	15.10.2008
YALOVA	15.10.2008
BILECIK	10.11.2008
KASTAMONU	10.11.2008

Name of the Province	Date of the Transition
ERZURUM	21.11.2008
KIRSEHIR	21.11.2008
KAYSERI	15.12.2008
RIZE	05.01.2009
TRABZON	05.01.2009
USAK	13.07.2009
BURSA	01.10.2009
KUTAHYA	04.01.2010
NEVSEHIR	04.01.2010
SAKARYA	04.01.2010
ARTVIN	18.01.2010
ERZINCAN	18.01.2010
IGDIR	12.04.2010
KILIS	12.04.2010
NIGDE	10.05.2010
GIRESUN	14.06.2010
KIRKLARELI	14.06.2010
KONYA	14.06.2010
BINGOL	05.07.2010
MERSIN	05.07.2010
YOZGAT	05.07.2010
CANAKKALE	12.07.2010
MALATYA	12.07.2010
AKSARAY	12.07.2010
ANKARA	15.07.2010
TOKAT	09.08.2010
ARDAHAN	09.08.2010
BATMAN	09.08.2010

Name of the Province	Date of the Transition
TEKIRDAG	09.08.2010
KARS	09.08.2010
ORDU	13.09.2010
BITLIS	13.09.2010
ZONGULDAK	13.09.2010
MUS	13.09.2010
SIVAS	20.09.2010
AGRI	11.10.2010
AFYONKARAHISAR	11.10.2010
BALIKESIR	11.10.2010
VAN	18.10.2010
HAKKARI	18.10.2010
ISTANBUL	30.10.2010
SIIRT	09.11.2010
MARDIN	15.11.2010
DIYARBAKIR	15.11.2010
KOCAELI	15.11.2010
SIRNAK	06.12.2010
SANLIURFA	13.12.2010
ANTALYA	13.12.2010
GAZIANTEP	13.12.2010
HATAY	13.12.2010
KAHRAMANMARAS	13.12.2010
MUGLA	13.12.2010
AYDIN	13.12.2010

Source: Public Health Institute

In October, 2008, a referral chain system was developed as a pilot project in provinces (Bayburt, Isparta, Gumushane, Denizli) where family medicine was being practiced. With a communiqué published by SSI in 2009, it was announced that chain referral practice would be implemented in all provinces where family medicine was being practice at that time. But after a short period, this mandatory referral system mentioned above was abandoned because it was hard to apply the system with the physicians who were already few in number. Instead of it, another referral system was built, creating the co-payments for applications in secondary and tertiary health care services. As of 13.12.2010, Family Medicine System was implemented completely in Turkey.

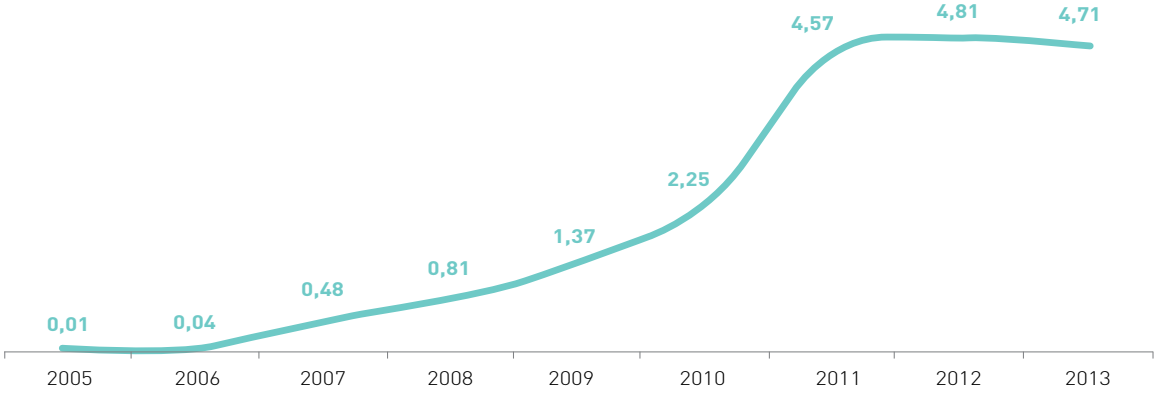
Table 40. Expenditures on Family Medicine (2005-2013), (million TRY/USD)

	2005	2006	2007	2008	2009	2010	2011	2012	2013
TRY	2	19	242	466	792	1.388	3.138	3.570	3.973
As of 2013 Prices, TRY	3	33	384	669	1.072	1.730	3.673	3.838	3.973
USD	1	13	186	360	512	925	1.879	1.992	2.090
PPP USD	2	23	280	523	872	1.476	3.180	3.391	3.618
Share of Health Expenditure (%)	0,01	0,04	0,48	0,81	1,37	2,25	4,57	4,81	4,71
Share of the GDP	0,00	0,00	0,03	0,05	0,08	0,13	0,24	0,25	0,25
Number of the Provinces in Family Medicine System	1	7	14	31	35	81			

Source: Ministry of Health, TurkStat

Though the family physician per population was 1.200 in average in the countries that had family medicine system, the family physician per population in Turkey was 3.621 by the year 2013. Shortage of family physicians made it impossible to implement mandatory referral chain system in advance. Also, community health centers were established in provinces which were family medicine system. These centers provide an integrated preventive health care services and diagnostic, curative and rehabilitation services. They are also responsible for preventive care services such as vaccination campaigns, reproductive health and child health services.

Graphic 24. Share of Family Medicine Spending in Health Expenditures, (2005-2013), (%)



Source: Ministry of Health, TurkStat

The share of the family medicine in health expenditure reached 4,71% after all the provinces started family medicine system. Another field that Ministry of Health is responsible for is the provision of 112 emergency care services. 2002-2013 period brought many important changes in the provision of 112 emergency care services. In 2008 air ambulances and in 2010 helicopter ambulances went into service. The number of the ground ambulances which was 618 in 2002 was increased to 3.357 in 2013. Also 17 helicopter ambulances, 4 air ambulances, 296 snow-pallet ambulances and 4 sea ambulances were already providing service, all of which weren't in service in 2002.

Ministry of Health made great strides in oral and dental health services in 2002-2013. While there were 8 oral and dental health centers in 2002, it was 127 in 2013 and also the number of the applications to these centers rose from 5 million to 37.8 million.

B. Expenditure on University Health Care Facilities

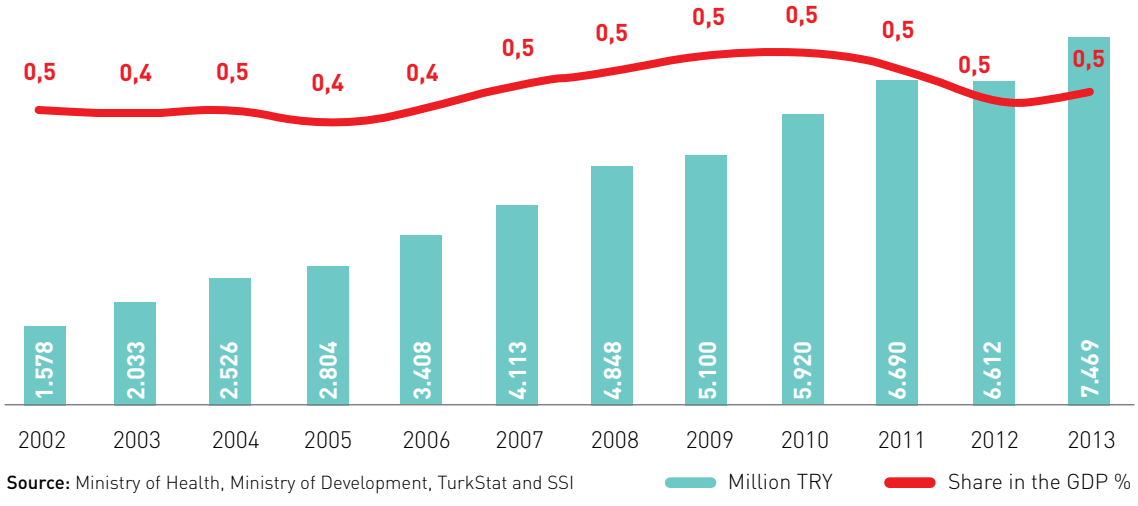
Table 41. Expenditures on University Health Care Facilities (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	1.578	2.033	2.526	2.804	3.408	4.113	4.848	5.100	5.920	6.690	6.612	7.469	3,7
As of 2013 Prices, TRY	4.395	4.521	5.172	5.307	5.885	6.530	6.970	6.900	7.378	7.830	7.107	7.469	0,7
USD	1.048	1.362	1.776	2.091	2.381	3.160	3.750	3.297	3.946	4.006	3.689	3.928	2,7
PPP USD	2.586	2.638	3.118	3.376	4.026	4.755	5.447	5.612	6.294	6.778	6.280	6.801	1,6
Share of Health Expenditure (%)	8,4	8,4	8,4	7,9	7,7	8,1	8,4	8,8	9,6	9,8	8,9	8,9	
Share of the GDP (%)	0,5	0,4	0,5	0,4	0,4	0,5	0,5	0,5	0,5	0,5	0,5	0,5	

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

In 2002, there wasn't a significant change in the share of university health care facilities (8,4%) in health expenditures. In 2013, with a slight increase of only 0,5%, it increased to 8,9%.

Graphic 25. Health Expenditure on University Health Care Facilities and the Share in the GDP (2002-2013)



Source: Ministry of Health, Ministry of Development, TurkStat and SSI

The share of health expenditure on university health care facilities in the GDP remained unchanged (0,5%).

Table 42. Funding Sources of University Health Care Facilities, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security Agencies	TRY	620	827	1.079	1.083	1.325	1.523	2.223	2.529	3.376	3.964	4.927	5.680	8,2
	%	39,3	40,7	42,7	38,6	38,9	37,0	45,9	49,6	57,0	59,3	74,5	76,0	
Central Government's Budget	TRY	687	834	1.074	1.210	1.448	1.704	1.747	1.788	1.590	2.189	1.097	1.102	0,6
	%	43,5	41,0	42,5	43,1	42,5	41,4	36,0	35,1	26,9	32,7	16,6	14,8	
Local Governments Budget	TRY	102	131	131	131	214	283	275	181	164	152	189	231	1,3
	%	6,5	6,4	5,2	4,7	6,3	6,9	5,7	3,5	2,8	2,3	2,9	3,1	
Private Sector	TRY	170	242	242	380	421	602	603	602	790	384	398	455	1,7
	%	10,8	11,9	9,6	13,6	12,4	14,6	12,4	11,8	13,3	5,7	6,0	6,1	
Total	**TRY**	**1.578**	**2.033**	**2.526**	**2.804**	**3.408**	**4.113**	**4.848**	**5.100**	**5.920**	**6.690**	**6.612**	**7.469**	**3,7**

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

During this period, there weren't any significant changes in the funding sources of university health care facilities. While the share of social security agencies in university health facilities financing rose from 39,3% to 76%, the share of the central government agencies dropped from 43,5% to 14,8%, the share of local governments and other public institutions went from 6,5% down to 3,1% and the share of private health care expenditures fell from 10,8% to %6,1.

The number of the university hospitals, which was 50 in 2002, was increased to 69 by the year 2013. And the number of the patient beds, which was 26 thousand in 2002, increased to 36 thousand. The number of the applications to the university health facilities, which was 8,8 million in 2002, increased to 30 million in 2013.

C. Expenditure on Private Health Care Facilities

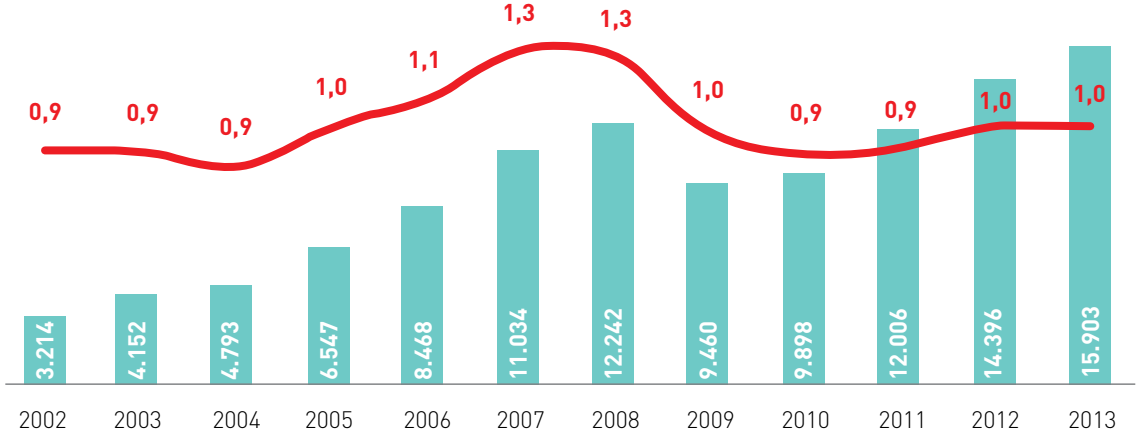
Table 43. Expenditure on Private Health Care Facilities (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	3.214	4.152	4.793	6.547	8.468	11.034	12.242	9.460	9.898	12.006	14.396	15.903	3,9
As of 2013 Prices, TRY	8.951	9.232	9.813	12.390	14.623	17.519	17.599	12.800	12.335	14.053	15.475	15.903	0,8
USD	2.134	2.781	3.370	4.883	5.917	8.478	9.468	6.115	6.597	7.189	8.031	8.364	2,9
PPP USD	5.266	5.387	5.915	7.882	10.004	12.757	13.754	10.412	10.524	12.165	13.674	14.481	1,8
Share of the Health Expenditure (%)	17,1	17,1	16,0	18,5	19,2	21,7	21,2	16,3	16,0	17,5	19,4	18,8	
Share of the GDP (%)	0,9	0,9	0,9	1,0	1,1	1,3	1,3	1,0	0,9	0,9	1,0	1,0	

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

The share of private health care facilities in health expenditures increased to 18,8 in 2013, which was 17,1% in 2002. When compared to 2002, health spending on private health facilities increased 3,9-fold in 2013.

Graphic 26. Expenditure on Private Health Care Facilities and Share in the GDP (2002-2013)



Source: Ministry of Health, Ministry of Development, TurkStat and SSI

MillionTRY

Share in the (GDP) (%)

Health spending on private health care services as a share of GDP increased from 0,9% to 1%.

Table 44. Financing Sources of Private Health Facilities (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security Agencies	TRY	396	538	743	1.021	1.723	2.345	4.327	4.506	4.959	5.948	6.633	7.148	17,0
	%	12,3	13,0	15,5	15,6	20,3	21,2	35,3	47,6	50,1	49,5	46,1	44,9	
Central Government's Budget	TRY	192	236	271	269	341	408	552	779	205	70	68	46	-0,8
	%	6,0	5,7	5,7	4,1	4,0	3,7	4,5	8,2	2,1	0,6	0,5	0,3	
Local Governments Budget	TRY	51	65	65	65	107	142	138	90	82	76	94	116	1,3
	%	1,6	1,6	1,4	1,0	1,3	1,3	1,1	1,0	0,8	0,6	0,7	0,7	
Private Sector	TRY	2.575	3.313	3.713	5.191	6.298	8.140	7.226	4.085	4.652	5.912	7.600	8.593	2,3
	%	80,1	79,8	77,5	79,3	74,4	73,8	59,0	43,2	47,0	49,2	52,8	54,0	
Total	**TRY**	**3.214**	**4.152**	**4.793**	**6.547**	**8.468**	**11.034**	**12.242**	**9.460**	**9.898**	**12.006**	**14.396**	**15.903**	**3,9**

Source: Ministry of Health, Ministry of Development, TurkStat and SSI

While only 20% of the private health care facilities' financing was covered by public resources in 2002, this ratio was close to 46% in 2013. In this period, the share of the social security agencies in funding private health care facilities rose from 12,3% to 44.9% while the share of central government agencies and local governments and also other public institutions decreased. In parallel with the expanding service procurement of public institutions by means of the private sector, ease of access to health services, and other achievements, the share of the private health expenditure in financing private health care facilities which was around 80% in 2002 decreased to 54% in 2013.

In this period, reimbursement institutions started to get service procurement more from private hospitals, policlinics, medical centers and foundation hospitals. The number of the physical consultation to private health care providers which was 14 million in 2002 increased to 101 million in 2013. The number of the private practices (reaching tens of thousands) was substantially reduced in 2013. While there were 12.387 patient beds in 271 private hospitals in 2002, this number was increased to 37.983 in 550 private hospitals in 2013.

Together with the adopted policies, public health care provision had serious drawbacks since the fast-growing private health sector started to transfer the rare and most preferred physicians in public health institutions by paying them higher wages. In February, 2008, in order to control the excess growth of the private sector, Ministry of Health, which tries to achieve health service delivery all across Turkey brought licensing and planning rules for growing areas in the sector including staff in the private sector. Moreover, in order to ensure better financial protection for citizens, the rule that the extra bills charged to citizens by private healthcare providers shall not exceed 30% the prices defined in the Medical Enforcement Declaration (SUT), was implemented in June 2008. The percentage in this rule was increased into 70% by cabinet decision in January, 2010. Cap for the additional fees charged by the private hospitals was increased from 70% to 90% in March, 2012 and finally in October 2013 it was increased to 200%.

D. Expenditures Occurred in Private Pharmacies

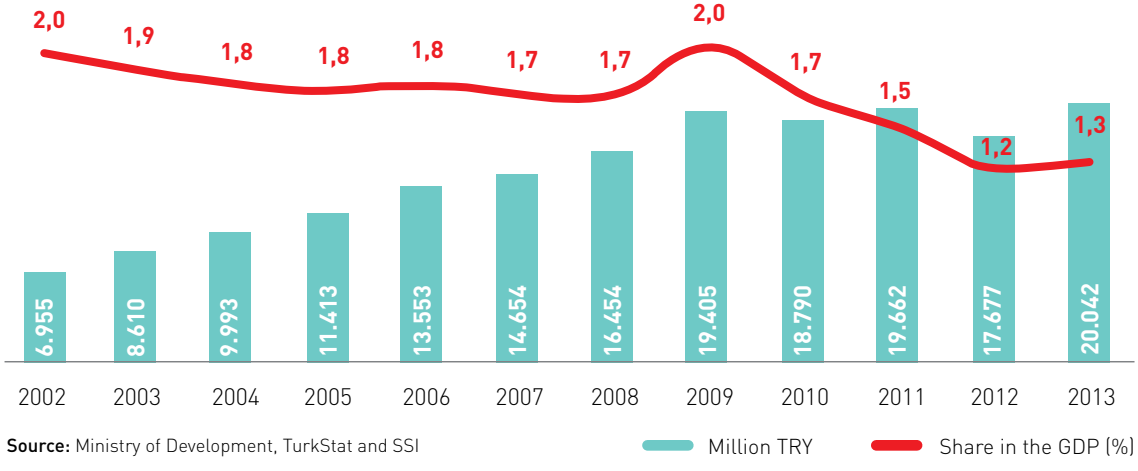
Table 45. Expenditures Occurred in Private Pharmacies (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	6.955	8.610	9.993	11.413	13.553	14.654	16.454	19.405	18.790	19.662	17.677	20.042	1,9
As of 2013 Prices, TRY	19.371	19.143	20.459	21.599	23.402	23.267	23.654	26.256	23.418	23.015	19.002	20.042	0,0
USD	4.619	5.767	7.026	8.512	9.470	11.260	12.726	12.544	12.524	11.774	9.862	10.541	1,3
PPP USD	11.395	11.170	12.333	13.740	16.011	16.943	18.486	21.356	19.979	19.923	16.790	18.250	0,6
Share of the Health Expenditures (%)	37,0	35,5	33,3	32,3	30,8	28,8	28,5	33,5	30,5	28,7	23,8	23,7	
Share of the GDP (%)	2,0	1,9	1,8	1,8	1,8	1,7	1,7	2,0	1,7	1,5	1,2	1,3	

Source: Ministry of Development, TurkStat and SSI

When we look at the development of health financing by health service providers in 2002-2013 period, the first of the worrying issues is the drop in the share of pharmaceutical expenditure in health expenditures. While 37% of health spending was pharmaceutical expenditures occurred in private pharmacies in 2002, this percentage decreased to 23,7% in 2013.

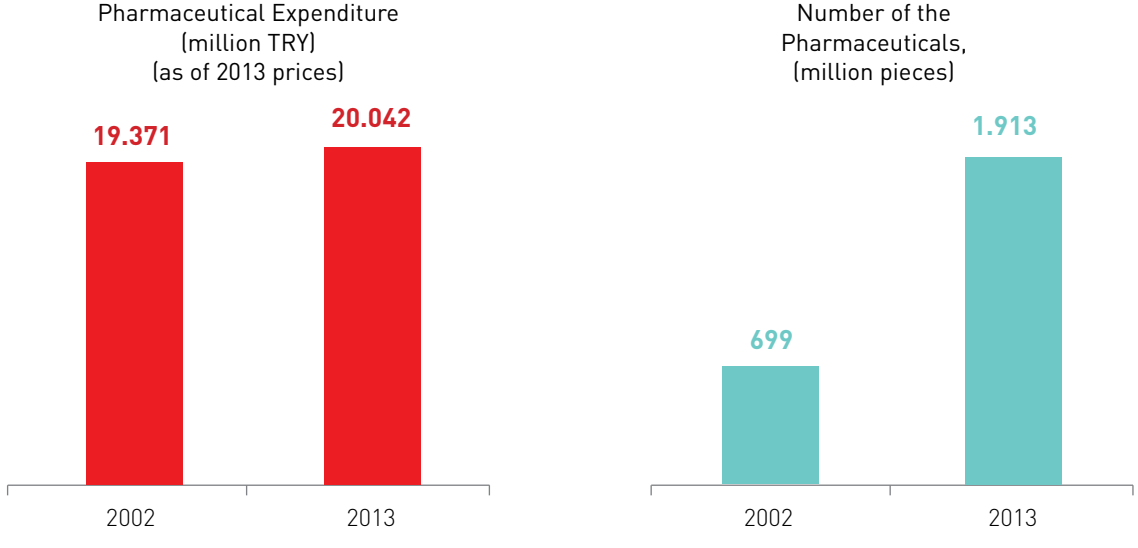
Graphic 27. Pharmaceutical Expenditures Occurred in Private Pharmacies and the Share in GDP (2002-2013)



Source: Ministry of Development, TurkStat and SSI

While expenditure on retail pharmaceuticals as a share of GDP was 2% in 2002, it fell to1,3% in 2013.

Graphic 28. Pharmaceutical Expenditure/Change in the Number of the Boxes (2002, 2013)



Source: Ministry of Development, Turkish Pharmaceuticals and Medical Devices Agency, TurkStat and SSI

During this period highly successful pharmaceutical price policies were followed on behalf of public finance. For example, in 2002, 19.371 billion TRY was paid for 699 million boxes of pharmaceuticals as of 2013 prices yet for 1.913 billion boxes, 20.042 billion TRY was paid in 2013. In other terms, while there was a 174% increase in the number of the boxes in eleven-year period, expenditure on pharmaceuticals increased just 3% in real terms. In 2002 the average price for a box of medicine was 27,7 TRY as of 2013 prices, this cost was reduced by approximately 60% to 10,5 TRY in 2013.

With the succession of pharmaceutical expenditure constituting an aggregate amount in health expenditure and revolutionary decisions, the share of pharmaceutical expenditure in health expenditures was considerably decreased.

The most significant ones of these revolutionary decisions are that;

The VAT was reduced from 18% to 8% for blood and blood products in June, 2003 and for the pharmaceuticals in March, 2004. As a result of these developments, a discount of 25% & 30% in average pharmaceutical prices was made. With the decree on pricing of pharmaceuticals enacted in April, 2004, "reference price monitoring" system was adopted based on cheapest five EU countries (France, Spain, Italy, Portugal, Greece) by making reductions ranging from 1% to 80% in the prices of 950 pharmaceuticals instead of cost-based system, which is vulnerable to be misused.

In December 2004, pharmaceutical expenses of beneficiaries started to be paid by the government. In February, 2005 SSK insurees were given right to get their medicines from private pharmacies. In January, 2009 in order to maintain the sustainability and predictability in the pharmaceutical expenditures, the global budget was prepared for 2010-2012 period. In 2002-2013 period, pharmaceutical prices were lowered many times by the decree on pricing of pharmaceuticals and other regulations.

Table 46. Funding Source for Pharmaceuticals Supplied from Private Pharmacies (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security Agencies	TRY	4.300	5.615	6.399	7.001	8.372	8.858	10.717	13.161	13.547	14.144	13.446	14.765	2,4
	%	61,8	65,2	64,0	61,3	61,8	60,4	65,1	67,8	72,1	71,9	76,1	73,7	
Central Government Budget	TRY	1.140	1.277	1.520	1.728	1.845	2.328	2.515	2.919	1.800	1.759	356	669	-0,4
	%	16,4	14,8	15,2	15,1	13,6	15,9	15,3	15,0	9,6	8,9	2,0	3,3	
Local Government Budget	TRY	38	57	64	74	61	30	46	43	4	8	9	8	-0,8
	%	0,5	0,7	0,6	0,6	0,4	0,2	0,3	0,2	0,0	0,0	0,1	0,0	
Private Sector	TRY	1.477	1.661	2.011	2.610	3.275	3.439	3.176	3.282	3.439	3.751	3.866	4.600	2,1
	%	21,2	19,3	20,1	22,9	24,2	23,5	19,3	16,9	18,3	19,1	21,9	23,0	
Total	**TRY**	**6.955**	**8.610**	**9.993**	**11.413**	**13.553**	**14.654**	**16.454**	**19.405**	**18.790**	**19.662**	**17.677**	**20.042**	**1,9**

Source: Ministry of Development, TurkStat and SSI

The share of the social security agencies in financing pharmaceutical expenditures rose from 61,8% to 73,7%, while the there were dramatic falls in the share of central government and local governments and other public institutions. However, the private sector's share rose from 21,2% to 23% in this period. The share of the expenditure on retail pharmaceuticals which was 2% in the GDP in 2002 fell to 1,3% in 2013.

E. Health Expenditure on Other Health Care Services

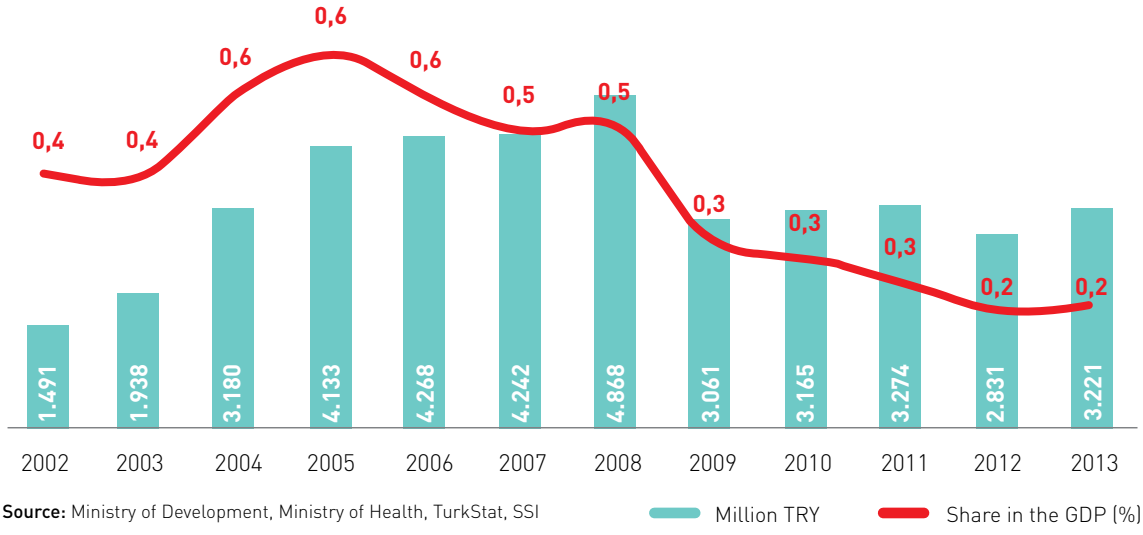
Table 47. Funding Sources for Other Health Care Services (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	1.491	1.938	3.180	4.133	4.268	4.242	4.868	3.061	3.165	3.274	2.831	3.221	1,2
As of 2013 Prices, TRY	4.154	4.308	6.511	7.821	7.370	6.735	6.998	4.142	3.945	3.832	3.043	3.221	-0,2
USD	990	1.298	2.236	3.082	2.982	3.259	3.765	1.979	2.110	1.960	1.579	1.694	0,7
PPP USD	2.444	2.514	3.925	4.975	5.042	4.904	5.469	3.369	3.365	3.317	2.688	2.933	0,2
Share of the Health Expenditures (%)	7,9	8,0	10,6	11,7	9,7	8,3	8,4	5,3	5,1	4,8	3,8	3,8	
Share of the GDP (%)	0,4	0,4	0,6	0,6	0,6	0,5	0,5	0,3	0,3	0,3	0,2	0,2	

Source: Ministry of Development, Ministry of Health, TurkStat and SSI

Thanks to the improvements in hospital services and easy access to medicine and medical supplies, expenditures for other health services had a small share in health expenditure in 2002-2013 period. The share of these expenditures, which was 7,9% in 2002, fell to 3,8%.

Graphic 29. Expenditures on Other Health Care Services and Share in the GDP (2002-2013)



Source: Ministry of Development, Ministry of Health, TurkStat, SSI

The share of the expenditure on other health care services in the GDP decreased from 0,4% to 0,2%

Table 48. Funding Source of Other Health Care Services, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Social Security Agencies	TRY	498	685	926	1.373	805	572	876	773	695	720	839	964	0,9
	%	33,4	35,3	29,1	33,2	18,9	13,5	18,0	25,3	22,0	22,0	29,6	29,9	
Central Government Budget	TRY	14	13	77	90	78	111	123	136	39	28	5	0	-1,0
	%	0,9	0,7	2,4	2,2	1,8	2,6	2,5	4,4	1,2	0,9	0,2	0,0	
Local Government Budget	TRY	37	57	64	37	53	91	94	122	102	98	102	122	2,3
	%	2,5	2,9	2,0	0,9	1,2	2,1	1,9	4,0	3,2	3,0	3,6	3,8	
Private Sector	TRY	943	1.183	2.113	2.633	3.332	3.468	3.775	2.030	2.329	2.427	1.885	2.135	1,3
	%	63,2	61,1	66,4	63,7	78,1	81,8	77,6	66,3	73,6	74,1	66,6	66,3	
Total	**TRY**	**1.491**	**1.938**	**3.180**	**4.133**	**4.268**	**4.242**	**4.868**	**3.061**	**3.165**	**3.274**	**2.831**	**3.221**	**1,2**

Source: Ministry of Development, Ministry of Health, TurkStat and SSI

During this period, while there was a decrease in the share of social security agencies, central government and the share of local governments and other public institutions and also private sectors increased in financing the other health care expenditures.

Chapter Six

Health Expenditures by Functions (2002-2013)

Health Expenditures by Functions (2002-2013)

Table 49. Health Expenditures by Functions, (2002-2013), (million TRY)

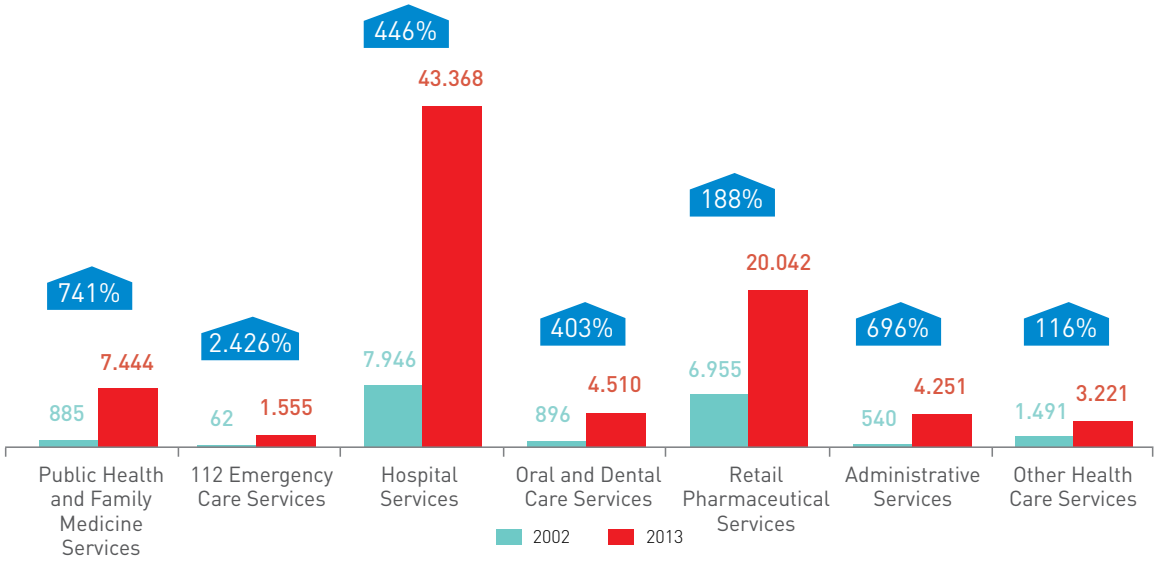
		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Public Health and Family Medicine Services	TRY	885	1.162	1.600	1.953	2.389	2.635	3.095	3.840	4.346	5.127	6.286	7.444	7,4
	%	4,7	4,8	5,3	5,5	5,4	5,2	5,4	6,6	7,0	7,5	8,5	8,8	
112 Emergency Care Services *	TRY	62	124	169	220	357	479	641	801	1.055	1.268	1.503	1.555	24,3
	%	0,3	0,5	0,6	0,6	0,8	0,9	1,1	1,4	1,7	1,8	2,0	1,8	
Hospital Services	TRY	7.946	10.782	12.874	14.634	19.890	24.688	28.119	25.551	28.629	32.831	38.417	43.368	4,5
	%	42,3	44,4	42,9	41,4	45,1	48,5	48,7	44,1	46,4	47,9	51,8	51,4	
Oral and Dental Care Services	TRY	896	940	1.281	1.955	2.218	2.549	2.614	3.078	3.320	3.961	4.366	4.510	4,0
	%	4,8	3,9	4,3	5,5	5,0	5,0	4,5	5,3	5,4	5,8	5,9	5,3	
Pharmaceutical Expenditures	TRY	6.955	8.610	9.993	11.413	13.553	14.654	16.454	19.405	18.790	19.662	17.677	20.042	1,9
	%	37,0	35,5	33,3	32,3	30,8	28,8	28,5	33,5	30,5	28,7	23,8	23,7	
Administrative Services	TRY	540	723	923	1.052	1.393	1.657	1.949	2.174	2.372	2.484	3.109	4.251	6,9
	%	2,9	3,0	3,1	3,0	3,2	3,3	3,4	3,8	3,8	3,6	4,2	5,0	
Other Health Care Services	TRY	1.491	1.938	3.180	4.133	4.268	4.242	4.868	3.061	3.165	3.274	2.831	3.221	1,2
	%	7,9	8,0	10,6	11,7	9,7	8,3	8,4	5,3	5,1	4,8	3,8	3,8	
Total	**TRY**	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

***** Emergency care services are included in primary care services according to the international standards. However, they are analyzed in a separate category in these books since such categorization is deemed to better suit the Turkish Health Care System and the current organization chart of the MoH.

Source: Ministry of Development, Ministry of Health, TurkStat, SSI and Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet,, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof.Dr. H.Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

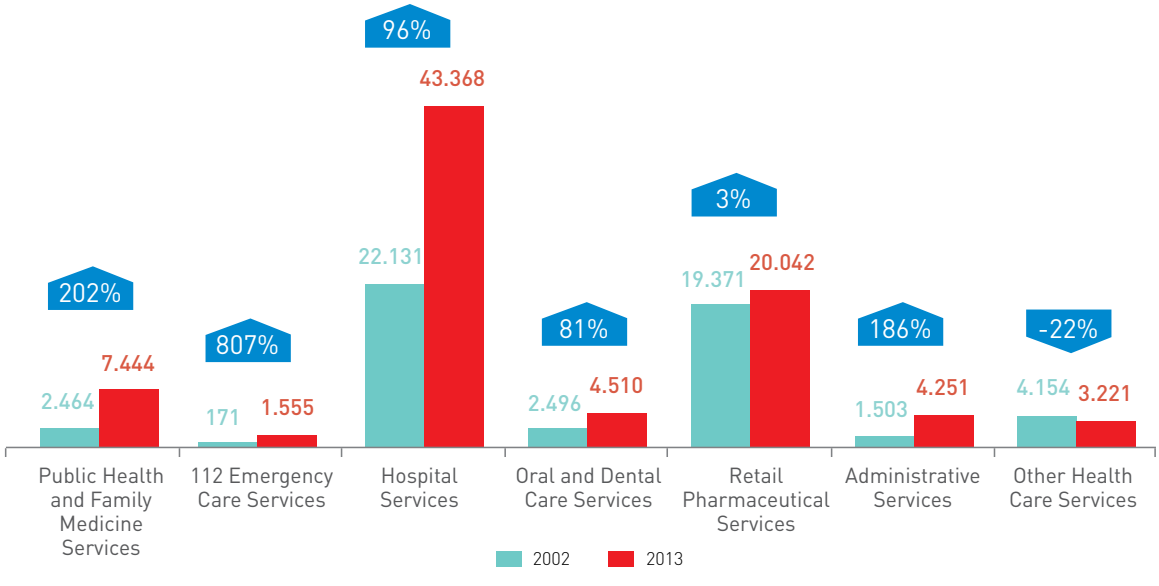
When health expenditures are analyzed by functions between 2002 and 2013, it could be asserted that the share of public health and family medicine services increased from 4,7% in 2002 to 8,8% in 2013 and the share of other services had similar increases: an increase from 0,3% to 1,8% for 112 emergency care services; an increase from 42,3% to 51,4% for hospital services; an increase from 4,8% to 5,3% for oral and dental care services; and an increase from 2,9% to 5,0% for administrative services. The share of retail pharmaceutical expenditures, on the other hand, decreased from 37% in 2002 to 23,7% in 2013 while the share of other health care services decreased from 7,9% in 2002 to 3,8% in 2013.

Graphic 30. Health Expenditures by Functions, (2002, 2013), (million TRY)



Source: Ministry of Development, Ministry of Health TurkStat, SSI and Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof. Dr. H.Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

Graphic 31. Health Expenditures by Functions, (2002, 2013), (As of 2013 Prices, million TRY)



Source: Ministry of Development, Ministry of Health TurkStat, SSI and Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof.Dr. H.Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

Table 50. Health Expenditures by Functions (Detailed), (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Public Health and Family Medicine Services (MoH)	**885**	**1.162**	**1.600**	**1.953**	**2.389**	**2.635**	**3.095**	**3.840**	**4.346**	**5.127**	**6.286**	**7.444**	**7,4**
112 Emergency Care Services (MoH)	**62**	**124**	**169**	**220**	**357**	**479**	**641**	**801**	**1.055**	**1.268**	**1.503**	**1.555**	**24,3**
MoH	4.022	5.534	6.792	7.066	10.039	11.806	13.461	13.682	15.603	17.089	20.503	23.213	4,8
Universities	1.472	1.897	2.351	2.601	3.167	3.821	4.509	4.738	5.490	6.189	6.069	6.831	3,6
Private Sector	2.452	3.351	3.731	4.967	6.685	9.061	10.150	7.131	7.536	9.554	11.846	13.323	4,4
Hospital Services	**7.946**	**10.782**	**12.874**	**14.634**	**19.890**	**24.688**	**28.119**	**25.551**	**28.629**	**32.831**	**38.417**	**43.368**	**4,5**
MoH	190	211	298	479	590	785	802	984	1.181	1.698	2.001	2.096	10,0
University	17	21	33	46	49	60	67	75	97	124	171	217	11,6
Private Sector	689	707	950	1.431	1.579	1.705	1.746	2.019	2.042	2.139	2.194	2.197	2,2
Oral and Dental Care Services	**896**	**940**	**1.281**	**1.955**	**2.218**	**2.549**	**2.614**	**3.078**	**3.320**	**3.961**	**4.366**	**4.510**	**4,0**
Retail Pharmaceutical Services	**6.955**	**8.610**	**9.993**	**11.413**	**13.553**	**14.654**	**16.454**	**19.405**	**18.790**	**19.662**	**17.677**	**20.042**	**1,9**
MoH	378	515	669	744	997	1.157	1.330	1.577	1.720	1.794	2.381	3.447	8,1
University	89	114	142	158	192	232	273	287	333	377	372	420	3,7
Private Sector	73	94	112	150	204	268	346	310	319	313	356	383	4,3
Administrative Services	**540**	**723**	**923**	**1.052**	**1.393**	**1.657**	**1.949**	**2.174**	**2.372**	**2.484**	**3.109**	**4.251**	**6,9**
Other Health Care Services	**1.491**	**1.938**	**3.180**	**4.133**	**4.268**	**4.242**	**4.868**	**3.061**	**3.165**	**3.274**	**2.831**	**3.221**	**1,2**
Total	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

Source: Ministry of Development, Ministry of Health TurkStat, SSI and Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof.Dr. H.Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

Public health and family medicine services increased by 7,4 folds while 112 emergency care services increased by 24,3 folds, hospital services by 4,5 folds, oral and dental care services by 4 folds, retail pharmaceutical services by 1,9 folds, managerial services by 6,9 folds and other health care services by 1,2 folds in 2013 compared to the rates in 2002.

A. Expenditures on Public Health Care and Family Medicine Services

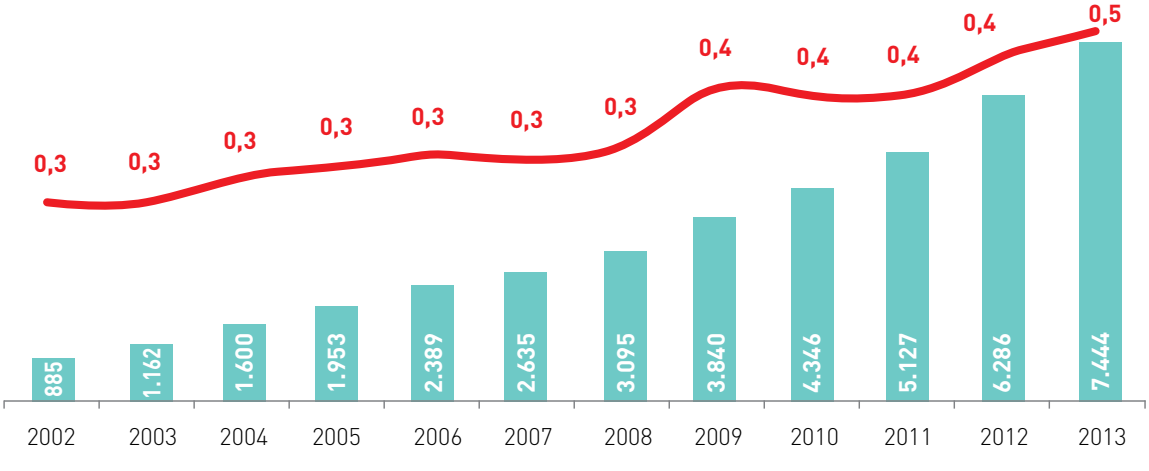
Table 51. Expenditures on Public Health Care and Family Medicine Services, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	885	1.162	1.600	1.953	2.389	2.635	3.095	3.840	4.346	5.127	6.286	7.444	7,4
As of 2013 Prices, TRY	2.464	2.584	3.275	3.696	4.125	4.184	4.449	5.196	5.416	6.001	6.757	7.444	2,0
USD	587	778	1.125	1.457	1.669	2.025	2.393	2.482	2.896	3.070	3.507	3.915	5,7
PPP USD	1.449	1.508	1.974	2.351	2.822	3.047	3.477	4.226	4.621	5.195	5.970	6.779	3,7
Share of Health Expenditures (%)	4,7	4,8	5,3	5,5	5,4	5,2	5,4	6,6	7,0	7,5	8,5	8,8	
Share of GDP (%)	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,4	0,4	0,4	0,4	0,5	

Source: Ministry of Development and Ministry of Health

Revolutionary steps were taken in public health in the period between 2002 and 2013. The share of public health and family medicine funds in health spending increased from 4,7% to 8,8%. Expenditures on public health and family medicine increased by 7,4 folds in 2013, when compared to 2002.

Graphic 32. Expenditures on Public Health Care and Family Medicine Services and Share of GDP, (2002-2013)



Source: Ministry of Development and Ministry of Health

Spending on public health care and family medicine services as a share of GDP increased from 0,3% to 0,5%.

In 2013, very significant changes occurred and very significant achievements were made in public health as in other fields of health care. For instance, infant mortality rate dropped from 31,5/1000 to 7,8/1000 while maternal mortality ratio dropped from 64/100000 to 15,9/100000.

Special attention was given to immunization services in 2002-2013 period and impressive results were obtained in vaccine-preventable diseases. In April 2003, national immunization days were organized in framework of the national immunization campaign against rubella, mumps and meningitis vaccines were incorporated into the "Expanded Immunization Program" (EIP) which was launched by the MoH in January 2006. Effective and regular immunization program in Turkey, which started with adoption of the law on compulsory vaccination against smallpox dated 1930, became systematic only in 1963, thanks to the socialization and expansion of health care services in Turkey. Afterwards, the national immunization rate for children – as of 2002 - was reported 78% and even less than 50% in some of the Southeastern Anatolian provinces, in spite of the intense efforts for long years. The Health Transformation Program (HTP), however, achieved a quantum leap; the national immunization rate mounted to 97% in 2010 and this high level of success was maintained in the following years.

Table 52. Expenditures on Immunization Services*, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	9	8	6	21	51	76	79	391	329	223	670	267	27,8
As of 2013 Prices, TRY	26	17	12	40	88	121	114	529	411	261	721	267	9,3
USD	6	5	4	16	35	59	61	253	220	134	374	141	21,8
PPP USD	15	10	7	25	60	88	89	430	350	226	637	243	15,0
Share of Health Expenditures (%)	0,05	0,03	0,02	0,06	0,12	0,15	0,14	0,68	0,53	0,33	0,90	0,32	

*Ministry of Health spending on vaccines.

Source: Ministry of Health

Note: Ministry of Health spending on vaccines is mostly accredited purchasing, that is first a letter of credit is opened for necessary vaccines and the spending does not seem to be a spending item in the budget for this reason. The letters of credits are set off upon delivery of vaccines and become a spending item in the budget only then. The study is based on the date when vaccine spending turned into a spending item in the budget. Therefore, the spending on vaccines may have a floating rate by years.

Expenditures on immunization services as a share of health spending, which was only 5/1000 in 2002, increased to 32/1000 in 2013.

While the routine vaccination scheme contained five antigens in 1960 in Turkey, the number of antigens could be raised to only seven in 2002, pointing out to the fact that vaccination was performed against 7 diseases (diphtheria, pertussis, tetanus, polio, measles, hepatitis-B and tuberculosis) before the Health Transformation Program. Then, immunization coverage was expanded and shots were given for Haemophilus influenza type B (Hib), rubella, mumps in all health care facilities beginning from 2006. In addition, DaBT-IPA-Hib vaccines (diphtheria, acellular pertussis, tetanus, inactive polio virus and Hib vaccine) have been provided in the form of prefilled single syringes since early 2008 which serves as a means for immunization against 5 diseases at once and enhances cost-effectiveness by using fewer syringes while expanding the immunization coverage. Although 7 antigens were given to infants up to 1 year of age in 15 shots in the past, 11 antigens are given in 12 shots today. The latest innovation in the vaccination schedule in 2010 was the introduction of quadrivalent combined vaccine (including acellular pertussis vaccine) for the first grades of primary schools with the aim of preventing acellular pertussis cases of higher prevalence during the primary school ages. Immunization against conjugated pneumococcus started with 7-component shots and then shots contained 13-components. Labeling, packaging, filling and formulation stages of the vaccine were gradually nationalized thanks to the approach of technology transfer which was adopted by some special provisions included in the vaccine supply contracts.

Table 53. Immunization Services, (2002, 2013)

	2002	2013
List of Routine Childhood Vaccines in Turkey	BCG Dyptheria Pertussis Tetanus Oral Polio Vaccine Measles Hepatitis-B Vaccine **(7 antigens)**	BCG Dyptheria Acellular Pertussis Tetanus Polio Haemophilus Influenza Type B (Pentavalent Combination Vaccine) Measles Rubella Mumps (Trivalent Combination Vaccine) Hepatitis B Conjugated Pneumococcal Vaccine Hepatitis A Chicken Pox Vaccine **(13 antigens)**

Source: Public Health Institute of Turkey

In 2002-2013 period, intensive efforts gave fruitful results in the field of communicable diseases such as malaria, tetanus and TB. Great success was achieved in the field of malaria control. Revising the "Malaria Elimination Program of Turkey" in 2003, the fight against malaria was speeded up. "HIV/AIDS Prevention and Support Program of Turkey" (HPSP) was put into implementation in July 2005. Pertaining to the TB patients with no social security coverage, it was decided that diagnostic, curative, follow-up and preventive services would be provided free of charge for uninsured TB patients and their close contacts. "Early Warning and Response System" (EWRS) was set up in January 2010 and field epidemiology trainings started in April 2012 in order for communicable diseases to be monitored by the surveillance system.

Maternal and child health care turned out to be another issue of higher priority in 2002-2013 period. Conditional cash transfer was introduced in March 2004 in order to promote health service utilization for 6 percent - slice of the population, which suffers from deprivation most (including the pregnant and children) and monetary aid in cash was given on condition that the 6% population took necessary medical tests and check-ups. In April 2004, the "Iron-like Turkey Project" started and health care facilities started to give free Vitamin D support to individuals in May 2004. Infant Death Certificates were issued and "Infant Mortality Follow-up Program" started to monitor and evaluate both routine services and special programs. "Conscious Mothers & Healthy Babies Project" was developed in December 2004 and baby-friendly hospitals were increased in number.

In May 2005, the MoH undertook the responsibility for Newborn Hearing Screening Program and made efforts to establish Newborn Hearing Screening Units in all provinces. In December 2006, screenings were introduced for congenital hyperthyroidism which is vital to neurological development of children. Neonatal Screening Program was launched in order to screen all newborns in Turkey for phenylketonuria and congenital hypothyroidism. The "Regulation on Newborn Hearing Screening Units" was issued in January 2007 and biotinidase deficiency was included in the list of diseases screened under the Neonatal Screeing Program in October 2008. So, the number of diseases, which are screened via heel lance procedure, was increased to 3.

In December 2004, the Law on Pilot Implementation of Family Medicine came into effect. The Family Medicine System, which has so far achieved a number of significant changes in delivery of primary health care services, set up a rule that a seperate consultation room would be allocated for each of the practitioners performing in the Family Health Centers and ensured effective business management for practitioners, in this way. Community Health Centers were opened up in September 2005.

In December 2004, Cancer Screening & Training Centers, which offer charge-free services, were opened up in all of 81 provinces in Turkey. In September 2005, uninsured individuals were provided access to free mammograms and Pap smear tests in these centers. In November 2006, the MoH organized the "WHO European Ministerial Conference on Counteracting Obesity". In January 2008, smoking was banned in open and closed public areas in Turkey and the Law on Prevention and Control of Hazards of Tobacco Products was adopted. Beginning from January 2011, free smoking cessation medications were disseminated for 250 thousand patients.

In June 2007, primary health care services were made free of charge for all individuals even if they were not covered by an insurance scheme.

"Community-Based Mental Health Care Model" was piloted in Bolu province in May 2008. In January 2009, bedridden patients were provided with high-quality, effective and easy-to-access health care services at home settings following the implementation of Home Care Services which avoided unnecessary occupation of hospital beds and contributed to cutting health care costs. In May 2011, Child Monitoring Centers (CIMs) were established for child protection and effective fight against child abuse.

B. Expenditures on 112 Emergency Care Services

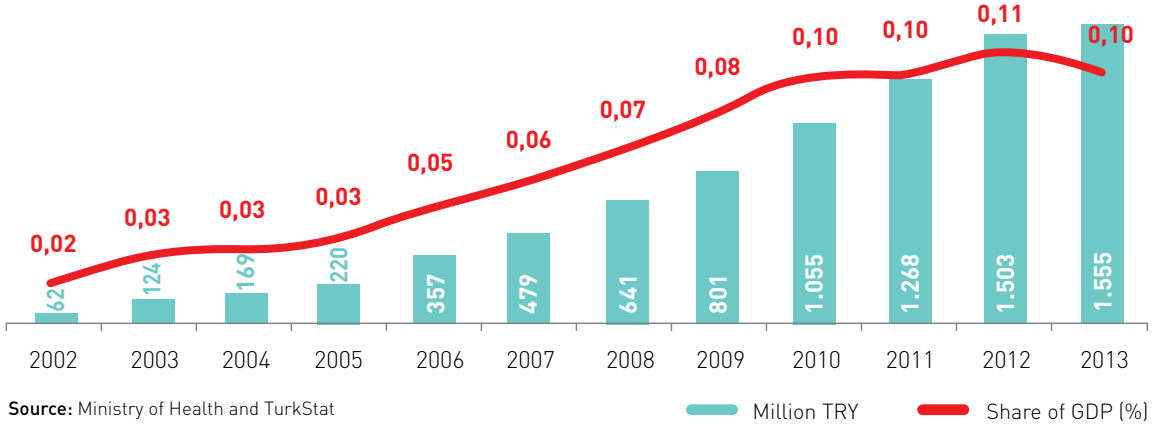
Table 54. Expenditures on 112 Emergency Care Services, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	62	124	169	220	357	479	641	801	1.055	1.268	1.503	1.555	24,3
As of 2013 Prices, TRY	171	276	345	416	617	760	922	1.084	1.315	1.484	1.616	1.555	8,1
USD	41	83	119	164	250	368	496	518	703	759	839	818	19,0
PPP USD	101	161	208	265	422	553	720	882	1.121	1.285	1.428	1.416	13,0
Share of Health Expenditures (%)	0,3	0,5	0,6	0,6	0,8	0,9	1,1	1,4	1,7	1,8	2,0	1,8	
Share of GDP (%)	0,02	0,03	0,03	0,03	0,05	0,06	0,07	0,08	0,10	0,10	0,11	0,10	

Source: Ministry of Health and TurkStat

Expenditures on 112 emergency care services as a share of health expenditures mounted from 0,3% in 2002 to 1,8% in 2013. So, expenditures on 112 emergency care services, which indicated a major progress, increased by 24,3 in nominal terms and by 8,1 in real terms.

Graphic 33. Expenditures on 112 Emergency Care Services and Share of GDP, (2002-2013)



Source: Ministry of Health and TurkStat

Expenditures on 112 emergency care services as a share of GDP increased from 0,02% to 0,10%.

Table 55. Developments in Provision of 112 Emergency Care Services, (2002, 2013)

	2002	2013
Snow Palette Ambulances	0	296
Snowtrack Ambulances	0	20
4-Strecther Ambulances	0	64
Intensive Care and Obesity Ambulances	0	86
Marine Ambulances	0	4
Motorized Ambulances	0	52
Fully-Equipped Ambulances	618	3.357
Number of 112 Stations	481	2.072
Helicopter Ambulances	0	17
Air Ambulances	0	4
Rural Population Accessing Services (%)	20	100
Number of Patient Transports by Air Ambulances	-	1.631
Number of Patient Transports by Helicopter Ambulances	-	2.407
Number of Patient Transports by Marine Ambulances	-	1.324
Number of Case Transports	382.907	3.665.368

Source: Ministry of Health

In addition to the improvements made to the infrastructure of 112 emergency care network, also services access was facilitated for individuals and measures were taken for financial protection. As of 2013, all Turkish citizens had access to free ambulance services – including air ambulances – regardless of social security coverage. In this regard, the 112 emergency care network in Turkey has been one of the most admirable examples in the world.

Besides, the provincial health directorates set up the Disaster Medical Assistance Teams in 2005 with the aim of providing effective health care services in cases of disasters. In addition to the Disaster Medical Assistance Teams, the National Medical Rescue Teams (UMKEs) were set up in all of 81 provinces across the country. UMKE, which saved a number of lives in the Van Earthquake for instance, did not only carry out rescue operations in Turkey but also joined the rescue operations in Indonesia, Iran and Haiti.

C. Expenditures on Hospital Services

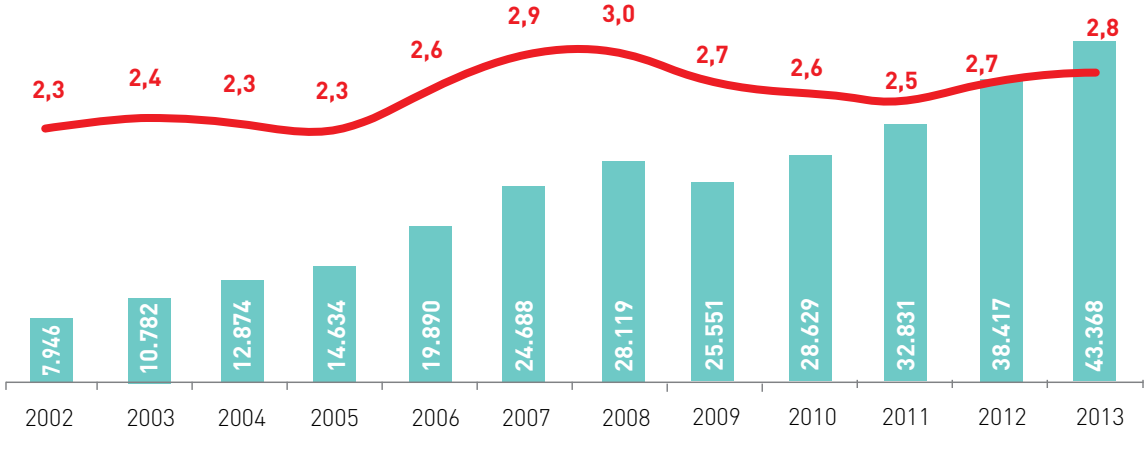
Table 56. Expenditures on Hospital Services, (2002 - 2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	7.946	10.782	12.874	14.634	19.890	24.688	28.119	25.551	28.629	32.831	38.417	43.368	4,5
As of 2013 Prices, TRY	22.131	23.973	26.358	27.694	34.346	39.199	40.424	34.571	35.679	38.429	41.296	43.368	1,0
USD	5.277	7.222	9.052	10.914	13.899	18.969	21.749	16.516	19.081	19.660	21.432	22.810	3,3
PPP USD	13.019	13.988	15.889	17.617	23.498	28.544	31.592	28.120	30.439	33.266	36.490	39.490	2,0
Share of Health Expenditures (%)	42,3	44,4	42,9	41,4	45,1	48,5	48,7	44,1	46,4	47,9	51,8	51,4	
Share of GDP (%)	2,3	2,4	2,3	2,3	2,6	2,9	3,0	2,7	2,6	2,5	2,7	2,8	

Source: Ministry of Health, Ministry of Development, TurkStat, SSI and Universities

The expenditures on hospital services as a share of health expenditures mounted from 42,3% in 2002 to 51,4% in 2013. So, expenditures on hospital services increased by 4,5 folds in nominal terms and by 1 fold in real terms.

Graphic 34. Expenditures on Hospital Services and Share of GDP, (2002-2013)



Source: Ministry of Health, Ministry of Development, TurkStat, SSI and Universities

Million TRY Share of GDP (%)

Expenditures on hospital services as a share of the GDP in 2002 mounted from 2,3% to 2,8% in 2013.

Composition of hospital services was significantly changed in Turkey in 2013. The SSK, which had been a major provider of health care services until 2013, withdrew from the health care sector while the MoH role in health service provision became even stronger. In 2013, the MoH hospitals were reported to constitute 56% of all hospitals in Turkey and be in charge of 60% of total bed capacity, 73% of total hospital visits, 57% of total inpatient treatments and 52% of total surgical operations.

Between 2002 and 2013, impressive developments occurred also in hospital services of Turkey. In this period, a number of steps were taken with the aim of improving both service access and service quality in health care sector such as providing individuals with access to private health care facilities, increasing private health care facilities in number and reducing the share of private practices by implementing the performance-based supplementary payment system in public hospitals.

Table 57. Hospital Data of Turkey, (2013)

Sectors	Hospitals		Beds		Visits		Inpatients		Surgical Operations	
	Number	%	Number	%	Number	%	Number	%	Number	%
Ministry of Health	854	56	121.269	60	277.485.135	73	7.023.313	57	2.414.538	52
University	69	5	36.056	18	29.985.697	8	1.630.464	13	715.889	15
Private	550	36	37.983	19	66.734.767	18	3.632.396	29	1.551.303	33
Other*	44	3	6.723	3	4.606.644	1	87.384	1	2.507	0
Total	**1.517**	**100**	**202.031**	**100**	**378.812.243**	**100**	**12.373.557**	**100**	**4.684.237**	**100**

* MoD hospitals included.

Source: Ministry of Health

Provision of hospital services was also promoted in 2002-2013. Pertaining to access to health care services, mechanisms were introduced in January 2003 so that the system of patients being held in hospitals as pawns due to non-payment of fees was abrogated.

In December 2004, the coverage of the Green Card System was widened retrospectively for poor people who got sick within 90 days after they had applied for but not received the Green Card benefits yet and free medical treatments were provided for the newborns and adults who needed emergency care and treatment. In scope of the afore-mentioned arrangement, the costs of outpatient visits and related outpatient diagnostic, medical dressing, tooth extracting, prosthetic, opticianry and pharmaceutical services were met by the government for the Green Card holders.

In February 2005, all public health care facilities, except for those affiliated with the Ministry of Defense, metropolitan municipalities (located in Istanbul, Ankara and Izmir provinces) and universities, were devolved to the MoH. Provision of health care services was separated from financing of health care services by the devolution of the SSK hospitals to the MoH, as well.

In June 2008, unconditional admission of emergency patients and charge-free provision of emergency care services were made mandatory for all health care facilities regardless of health insurance or affordability of patients. In October 2008, private hospitals were prohibited from charging patients co-payment for burn treatment, cancer treatment, neonatal care, organ transplants, congenital anomalies, dialysis and cardiovascular surgery.

In February 2010, the "Central Hospital Appointment System" was introduced for the MoH hospitals and oral and dental care facilities. In October 2010, the Green Card holders were provided charge-free emergency and intensive care services in private hospitals.

Improving the quality of health care services was considered as a priority in this period, too. For this purpose, patient rooms in the MoH hospitals were re-designed as double occupancy rooms and patient room design shifted from ward to quality single-room or shared accommodation offering built-in bathroom, television and refrigerator in February 2003. In October 2003, legal arrangements were made for patient rights and patient rights units were set up at hospitals. In September 2004, patients were granted the right to choose their physicians in order to raise competitiveness among health service providers in the public sector. The MoH hospitals were the first health care facilities which implemented this approach in Turkey. In March 2005, the scope of the "Performance-based Supplementary Payment System" implemented in the MoH facilities was expanded to include the organizational and quality criteria as well as others. In May 2005, it was ruled that an examination room was to be allocated for each physician in the MoH-affiliated hospitals. In July 2005, the Assisted Reproductive Treatment Centers Regulation was enacted.

In April 2007, regional blood centers were established for safe and easy supply of blood and blood products. In February 2008, the "Directive on National Organ and Tissue Transplantation Coordination System" was issued in order to identify rules and principles for organ and tissue transplantation procedures, centers and personnel. In January 2011, the MoH established the "National Organ Transplantation Waiting System" in order to optimize organ transplantation with respect to patient eligibility, timing and prevention of abuses and/or speculations.

As for cost-effectiveness and financial sustainability of health care services of other higher priority fields, benefit packages were put into use in June 2006 for inpatients and outpatients in the MoH hospitals, university hospitals and private hospitals having contracts with the SSI. The SSI-contracted hospitals were required to provide pharmaceutical and medical products for inpatients. Co-payment was introduced for outpatient treatments and medical and dental practices - except for primary health service providers and Family Medicine private practices —beginning from 1 October 2008.

In parallel to these improvements enhancing the capacity of hospitals was considered to be significant, too. In February 2009, arrangements were made so that the MoH-affiliated facilities, which are subject to the Law No. 4734, could purchase goods and services from each other via intra-governmental procurement procedures for diagnostic and curative purposes. In January 2010, the MoH and university facilities signed a protocol for cooperation and common use of goods and services.

The Association of Public Hospitals, on the other hand, was opened up in 2012.

D. Expenditures on Oral and Dental Care Services

Table 58. Expenditures on Oral and Dental Care Services, (2002-2013), (million TRY/USD)

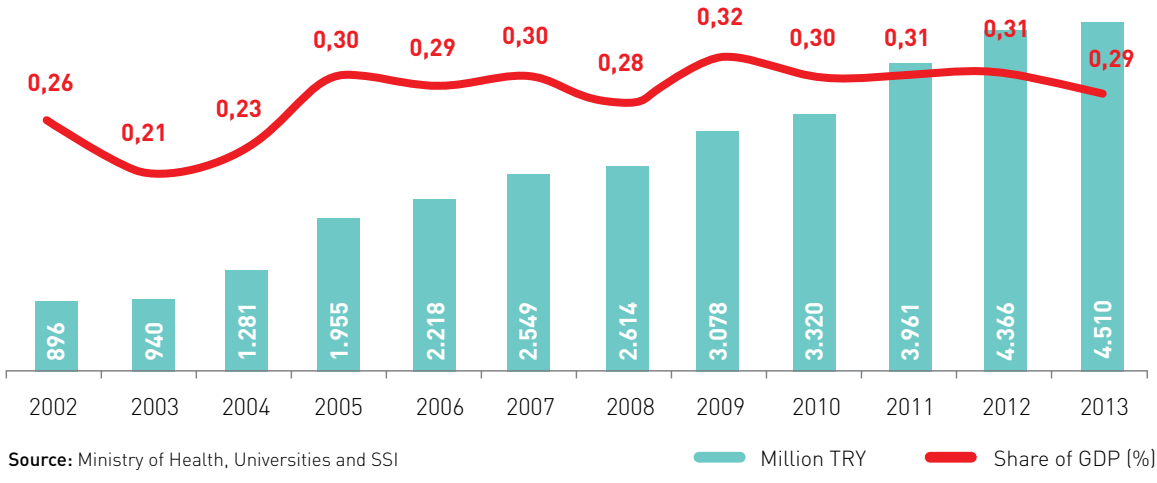
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	896	940	1.281	1.955	2.218	2.549	2.614	3.078	3.320	3.961	4.366	4.510	4,0
As of 2013 Prices, TRY	2.496	2.089	2.622	3.700	3.831	4.048	3.758	4.165	4.138	4.636	4.693	4.510	0,8
USD	595	629	900	1.458	1.550	1.959	2.022	1.990	2.213	2.372	2.436	2.372	3,0
PPP USD	1.468	1.219	1.581	2.354	2.621	2.947	2.937	3.388	3.530	4.013	4.147	4.107	1,8
Share of Health Expenditures (%)	4,8	3,9	4,3	5,5	5,0	5,0	4,5	5,3	5,4	5,8	5,9	5,3	
Share of GDP (%)	0,26	0,21	0,23	0,30	0,29	0,30	0,28	0,32	0,30	0,31	0,31	0,29	

Source: Ministry of Health, Universities and SSI

Expenditures on oral and dental care services as a share of health expenditures mounted from 4,8% in 2002 to 5,3% in 2013, pointing out to an increase by 4 folds in nominal and by 0,8 folds in real terms. In this period, access to oral and dental care services were facilitated and related services were offered in all of 81 provinces. Oral and dental care services also became available in scope of home care services.

It could be asserted that substantial increases occurred in the number of oral and dental care centers, supply of dentists and actively used dental treatment units when compared to 2002.

Graphic 35. Expenditures on Oral and Dental Care Services and Share of GDP, (2002-2013)



Source: Ministry of Health, Universities and SSI

Expenditures on oral and dental care services as a share of the GDP mounted from 0,26% in 2002 to 0,29% in 2013.

In scope of the "Oral and Dental Care Center (ODHCC) in Every Province Campaign", which the MoH started in 2005, the 81st and latest ODHCC was established in Sirnak province on 06 November 2008. In October 2010, the Green Card holders were provided free dental treatments such as root canal therapy and dental filling.

E. Expenditures on Retail Pharmaceutical Services

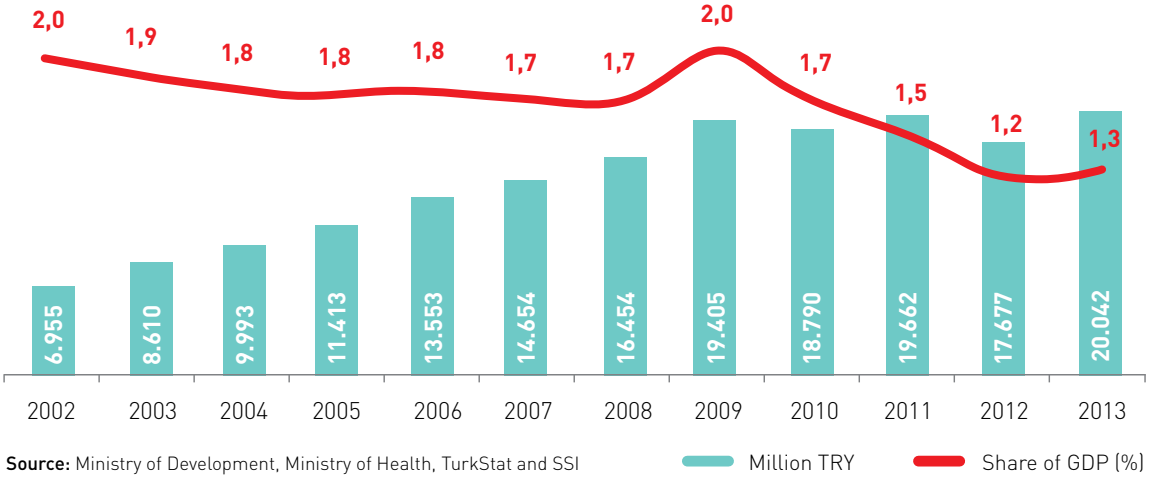
Table 59. Expenditures on Retail Pharmaceutical Services, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	6.955	8.610	9.993	11.413	13.553	14.654	16.454	19.405	18.790	19.662	17.677	20.042	1,9
As of 2013 Prices, TRY	19.371	19.143	20.459	21.599	23.402	23.267	23.654	26.256	23.418	23.015	19.002	20.042	0,0
USD	4.619	5.767	7.026	8.512	9.470	11.260	12.726	12.544	12.524	11.774	9.862	10.541	1,3
PPP USD	11.395	11.170	12.333	13.740	16.011	16.943	18.486	21.356	19.978	19.923	16.790	18.250	0,6
Share of Health Expenditures (%)	37,0	35,5	33,3	32,3	30,8	28,8	28,5	33,5	30,5	28,7	23,8	23,7	
Share of GDP (%)	2,0	1,9	1,8	1,8	1,8	1,7	1,7	2,0	1,7	1,5	1,2	1,3	

Source: Ministry of Development, Ministry of Health, TurkStat and SSI

Analyzing the evolution of health expenditures by service providers between 2002 and 2013, one could suggest that reduction in pharmaceutical expenditures as a share of health expenditures is quite outstanding. Expenditures on retail pharmaceutical services as a share of health expenditures dropped from 37% in 2002 to 23,7% in 2013. While pharmaceutical expenditures increased by 1,9 folds in nominal terms, no significant increase was noted in real terms.

Graphic 36. Expenditures on Retail Pharmaceutical Services and Share of GDP, (2002-2013)



Source: Ministry of Development, Ministry of Health, TurkStat and SSI

Expenditures on retail pharmaceutical services as a share of the GDP decreased from 2% in 2002 to 1,3% in 2013.

In 2002, some noteworthy decisions about pharmaceutical expenditures, which constituted the largest spending item in health care services, came one after another. These decisions could be discussed in three sub-topics as: decisions regulating pharmaceuticals and pharmacy sector, decisions reducing costs in pharmaceutical expenditures and decisions enhancing access to medicinal products.

Decisions regulating the pharmaceuticals and pharmacy sector:

By the MoF Circular Dated February 2004, the "Reimbursement Commission" was set up for reimbursement decisions and the "Regulation on Licensing Medicinal Products for Human Use" was issued in January 2005. In June 2006, patients diagnosed with chronic conditions such as blood pressure, diabetes and cholesterol etc. were allowed to take their medicines in 3-month dosages for two years after they received a bill of health and prescription for only once. In August 2007, coordination of the "Reimbursement Commission", which was regulated by the MoF, was devolved to the SSI. In February 2008, clips were removed from product boxes and replaced by a new descriptor called "square code". After November 2011, patients who received a bill of health were not allowed for re-prescribing 15 days before the maturity date of the bill while the re-prescribing period was 7 days before. In April 2013, in the framework of the European Union standards and good clinical practices, the "Regulation on Clinical Researches and Studies" was issued, identifying the rules and principles for conducting scientific studies on humans and protecting the rights of volunteer human subjects.

Decisions reducing costs in pharmaceutical expenditures:

The VAT rate on blood and blood components was reduced from 18% to 8% in June 2003 and the VAT rate on medicinal products was reduced from 18% to 8% in March 2004, resulting in about 25% to 30% cuts in pharmaceutical prices. Beginning from April 2004, the pharmaceutical pricing system shifted from the explicit cost-based system, which is susceptive to abuses, to the reference price system, which is grounded on the cheapest product-based price in selected EU countries, and 1% to 80% cost cuts were achieved in 950 individual medicinal products, as a result. In February 2005, about 10% price cuts were made in medicinal products by a protocol signed with the Turkish Pharmacists' Association. By the Law No. 5335, which was issued in the Official Gazette in April 2005, 20% co-payment was collected from the Green Card beneficiaries for pharmaceuticals. Beginning from 10 November 2011, pertaining to the reimbursement for the costs of equivalent pharmaceuticals, the ceiling price was brought down from 15% to 10% of the cheapest medicinal product. In March 2012, co-payment was charged for also prescriptions written out by family physicians. In addition, 3 TRY co-payment was charged for prescription drugs - either 3 boxes of the same drug or 3 separate items of drugs - while an extra 1 TRY was charged for every other drug prescribed additionally. In May 2013, the "National Action Plan for Rational Drug Use 2014-2017" was developed in order to ensure coordination and collaboration for rational drug use-supporting activities and behavioral changes in correspondents. Using the Prescribing Information System (PIS), feedback has been given to physicians since November 2013 about the prescriptions they have written out.

Decisions enhancing access to medicinal products:

In December 2004, pharmaceutical expenditures for the Green Card beneficiaries were covered by the government. After the devolution of the SSK hospitals to the MoH, the SSK pharmacies were closed down and the SSK insurees were allowed to take their medicines from private pharmacies in February 2005. In June 2007, it was decided that medicinal products would be provided for inpatients by hospitals. In September 2009, mobile pharmacies were opened up in order to facilitate access to medicines for people who lived in rural areas with no pharmacies nearby.

F. Expenditures on Health Care Management

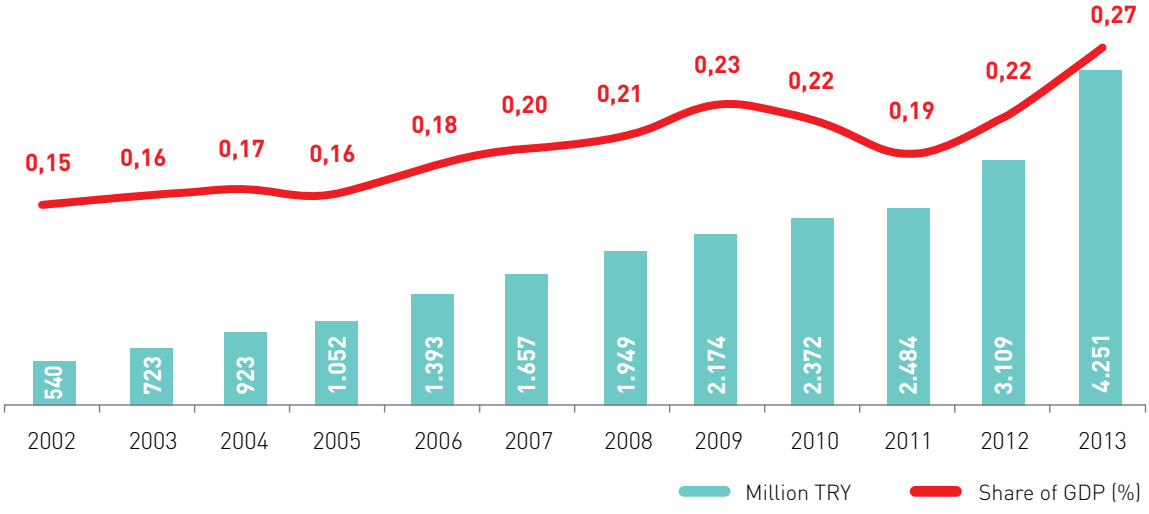
Table 60. Expenditures on Health Care Management, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	540	723	923	1.052	1.393	1.657	1.949	2.174	2.372	2.484	3.109	4.251	6,9
As of 2013 Prices, TRY	1.503	1.608	1.890	1.990	2.405	2.631	2.802	2.942	2.957	2.907	3.342	4.251	1,8
USD	358	485	649	784	973	1.273	1.507	1.405	1.581	1.487	1.734	2.236	5,2
PPP USD	884	939	1.140	1.266	1.646	1.916	2.190	2.393	2.522	2.516	2.953	3.870	3,4
Share of Health Expenditures (%)	2,9	3,0	3,1	3,0	3,2	3,3	3,4	3,8	3,8	3,6	4,2	5,0	
Share of GDP (%)	0,15	0,16	0,17	0,16	0,18	0,20	0,21	0,23	0,22	0,19	0,22	0,27	

Source: Ministry of Health and Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof.Dr. H.Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

Expenditures on health care management as a share of health expenditures increased from 2,9% in 2002 to 5% in 2013, referring to an increase by 6,9 folds in nominal terms and an increase by 1,8 folds in real terms.

Graphic 37. Expenditures on Health Care Management and Share of GDP, (2002-2013)



Source: Ministry of Health and Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004, Ankara, 2007

Expenditures on administrative services as a share of the GDP mounted from 0,15% in 2002 to 0,27% in 2013.

In this period, competencies and capabilities of managers, who performed in the MoH hospitals particularly, were enhanced. The Association of Public Hospitals, which was established in November 2012, paved the way for an impressive transformation in this regard.

G. Expenditures on Other Health Care Services

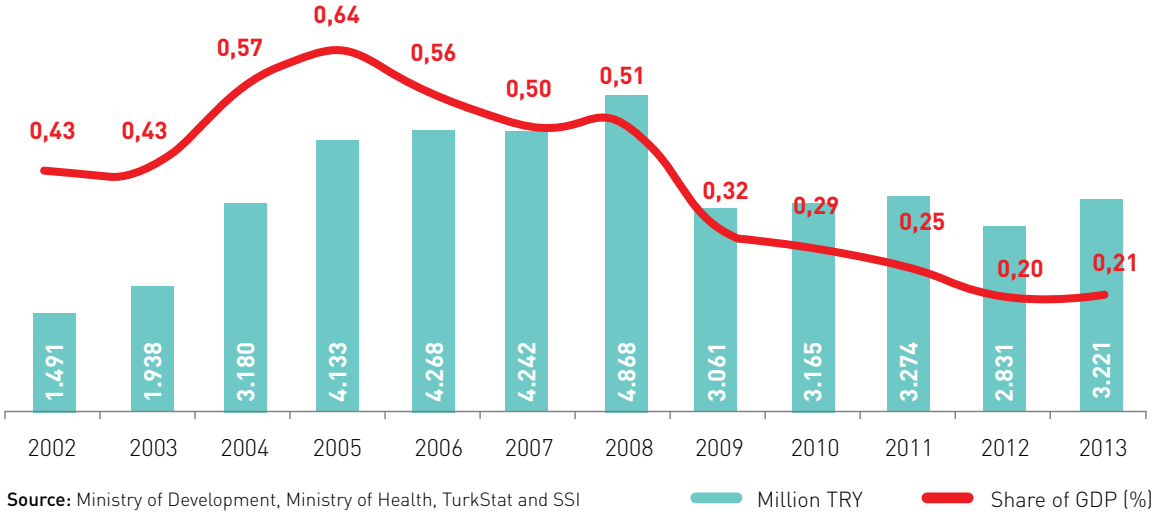
Table 61. Expenditures on Other Health Care Services, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	1.491	1.938	3.180	4.133	4.268	4.242	4.868	3.061	3.165	3.274	2.831	3.221	1,2
As of 2013 Prices, TRY	4.154	4.308	6.511	7.821	7.370	6.735	6.998	4.142	3.945	3.832	3.043	3.221	-0,2
USD	990	1.298	2.236	3.082	2.982	3.259	3.765	1.979	2.110	1.960	1.579	1.694	0,7
PPP USD	2.444	2.514	3.925	4.975	5.042	4.904	5.469	3.369	3.365	3.317	2.688	2.933	0,2
Share of Health Expenditures (%)	7,9	8,0	10,6	11,7	9,7	8,3	8,4	5,3	5,1	4,8	3,8	3,8	
Share of GDP (%)	0,43	0,43	0,57	0,64	0,56	0,50	0,51	0,32	0,29	0,25	0,20	0,21	

Source: Ministry of Development, Ministry of Health, TurkStat and SSI

Expenditures on other health care services as a share of health expenditures dropped from 7,9% in 2002 to 3,8% in 2013, pointing out to an increase by 120% in nominal terms and a decrease by 20% in real terms.

Graphic 38. Expenditures on Other Health Care Services and Share of GDP, (2002-2013)



Source: Ministry of Development, Ministry of Health, TurkStat and SSI

Expenditures on other health care services as a share of the GDP dropped from 0,43% in 2002 to 0,21% in 2013.

In June 2007, the SSI-contracted hospitals were required to provide medicinal and medical products for inpatients. Accordingly, all needs of inpatients for medical and medicinal products, who were admitted to the MoH hospitals particularly, were met by the hospitals and the service costs, which were paid by the SSI just because the hospitals did not, were deducted from the MoH global budget, later. So, expenditures of hospitals and the MoH hospitals particularly increased while the SSI disbursements – except for hospitals and pharmacies – decreased to a significant extent. Service quality was also improved and out-of-pocket payments were reduced, even if reimbursement was provided for individuals by reimbursement agencies.

Apart from all these, the implementation also contributed to savings in total public expenditures on health because hospitals paid less for collective procurement of goods and services which the SSI used to purchase at retail prices before. In October 2010, medical devices and equipment prescribed for outpatient treatment were paid on behalf of the Green Card insurees on condition that unit price did not exceed the rates identified by the SSI.

Chapter Seven

Health Expenditures by Spending Items (2002-2013)

Health Expenditures by Spending Items (2002-2013)

Health expenditures by spending items have been analyzed in two main categories as current health expenditures and investment expenditures.

Table 62. Health Expenditures by Spending Items (2002-2013), (million TRY)

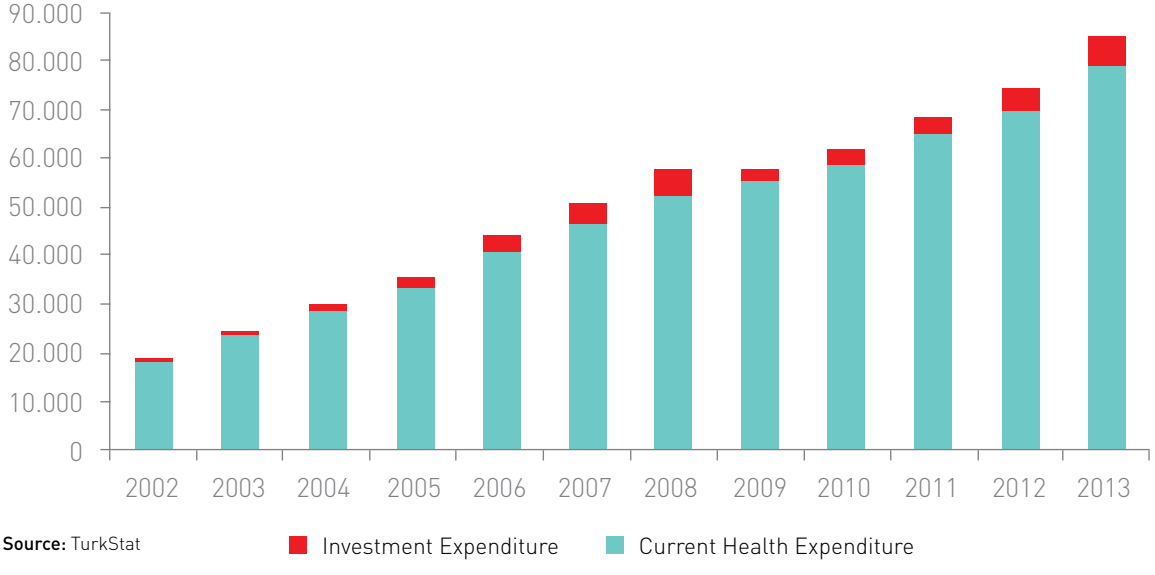
		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Current Health Expenditures	TRY	18.331	23.676	28.616	33.292	40.949	46.495	52.320	55.295	58.624	65.371	70.288	79.702	3,3
	%	97,6	97,5	95,3	94,2	92,9	91,3	90,6	95,5	95,0	95,3	94,7	94,4	
Investment Expenditures	TRY	443	603	1.405	2.067	3.120	4.409	5.420	2.616	3.054	3.236	3.901	4.688	9,6
	%	2,4	2,5	4,7	5,8	7,1	8,7	9,4	4,5	5,0	4,7	5,3	5,6	
Total	TRY	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

Source: TurkStat

When compared to 2002, health expenditures increased by 3,5-fold, current health expenditure and investment expenditures increased by 3,3-fold and 9,6-fold, respectively. In addition to the improvements in current health expenditures and health investments, remarkable developments occurred in both public sector and private sector.

During this period, the share of the current health expenditures decreased in health expenditures yet the share of the investment expenditures increased. In 2002, the share of the investment expenditures which was 2,4% in health expenditures reached 9,4% in 2008 when health investment by the private sector peaked and then in 2013 this share was observed as 5,6%.

Graphic 39. Health Expenditures by Spending Items (2002-2013), (million TRY)



Source: TurkStat

Table 63. Health Expenditures by Spending Items (Detailed) (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Staffing	TRY	4.446	6.485	7.878	8.729	11.318	14.081	15.540	15.386	16.554	21.008	25.449	29.579	5,7
	%	23,7	26,7	26,2	24,7	25,7	27,7	26,9	26,6	26,8	30,6	34,3	35,1	
Service Procurement	TRY	921	1.236	1.532	2.057	2.939	3.770	3.809	4.308	5.181	5.364	6.399	7.021	6,6
	%	4,9	5,1	5,1	5,8	6,7	7,4	6,6	7,4	8,4	7,8	8,6	8,3	
Pharmaceuticals	TRY	7.290	9.003	10.384	11.918	14.271	15.546	17.673	21.122	20.612	21.334	19.941	21.885	2,0
	%	38,8	37,1	34,6	33,7	32,4	30,5	30,6	36,5	33,4	31,1	26,9	25,9	
Medical Supplies and Equipment	TRY	1.555	1.938	2.333	2.723	2.423	2.712	3.014	3.209	3.476	3.812	4.647	5.500	2,5
	%	8,3	8,0	7,8	7,7	5,5	5,3	5,2	5,5	5,6	5,6	6,3	6,5	
Medical Diagnostic Tests (Lab and Imaging)	TRY	340	484	585	700	830	1.212	1.845	2.086	2.422	2.681	3.056	3.339	8,8
	%	1,8	2,0	1,9	2,0	1,9	2,4	3,2	3,6	3,9	3,9	4,1	4,0	
Administration	TRY	540	723	923	1.052	1.393	1.657	1.949	2.174	2.372	2.484	3.109	4.251	6,9
	%	2,9	3,0	3,1	3,0	3,2	3,3	3,4	3,8	3,8	3,6	4,2	5,0	
Liabilities	TRY	404	477	1.123	1.277	1.919	934	888	960	1.437	1.269	1.243	1.390	2,4
	%	2,2	2,0	3,7	3,6	4,4	1,8	1,5	1,7	2,3	1,8	1,7	1,6	
Other Current	TRY	1.844	2.080	1.603	2.077	2.440	3.096	5.457	3.830	4.165	4.959	4.534	4.528	1,5
	%	9,8	8,6	5,3	5,9	5,5	6,1	9,5	6,6	6,8	7,2	6,1	5,4	
Unclassified Expenses	TRY	992	1.251	2.254	2.759	3.415	3.488	2.144	2.222	2.405	2.462	1.910	2.209	1,2
	%	5,3	5,2	7,5	7,8	7,7	6,9	3,7	3,8	3,9	3,6	2,6	2,6	
Total Current Health Expenditures	TRY	18.331	23.676	28.616	33.292	40.949	46.495	52.320	55.295	58.624	65.371	70.288	79.702	3,3
	%	97,6	97,5	95,3	94,2	92,9	91,3	90,6	95,5	95,0	95,3	94,7	94,4	
Construction	TRY	233	348	697	957	1.544	2.078	2.159	1.321	1.628	1.544	1.779	2.499	9,7
	%	1,2	1,4	2,3	2,7	3,5	4,1	3,7	2,3	2,6	2,3	2,4	3,0	
Machinery-Equipment	TRY	148	184	529	659	997	1.318	897	830	835	887	1.127	1.134	6,7
	%	0,8	0,8	1,8	1,9	2,3	2,6	1,6	1,4	1,4	1,3	1,5	1,3	
Repair and Maintenance	TRY	46	54	150	407	436	700	391	285	421	546	712	786	16,2
	%	0,2	0,2	0,5	1,2	1,0	1,4	0,7	0,5	0,7	0,8	1,0	0,9	
Ambulance	TRY	6	8	11	19	34	45	57	49	51	88	95	39	5,0
	%	0,0	0,0	0,0	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,0	
Other	TRY	10	10	18	25	109	268	1.916	132	120	170	189	230	22,4
	%	0,1	0,0	0,1	0,1	0,2	0,5	3,3	0,2	0,2	0,2	0,3	0,3	
Investment Expenditures	TRY	443	603	1.405	2.067	3.120	4.409	5.420	2.616	3.054	3.236	3.901	4.688	9,6
	%	2,4	2,5	4,7	5,8	7,1	8,7	9,4	4,5	5,0	4,7	5,3	5,6	
Total	**TRY**	**18.774**	**24.279**	**30.021**	**35.359**	**44.069**	**50.904**	**57.740**	**57.911**	**61.678**	**68.607**	**74.189**	**84.390**	**3,5**

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

A. Current Health Expenditures

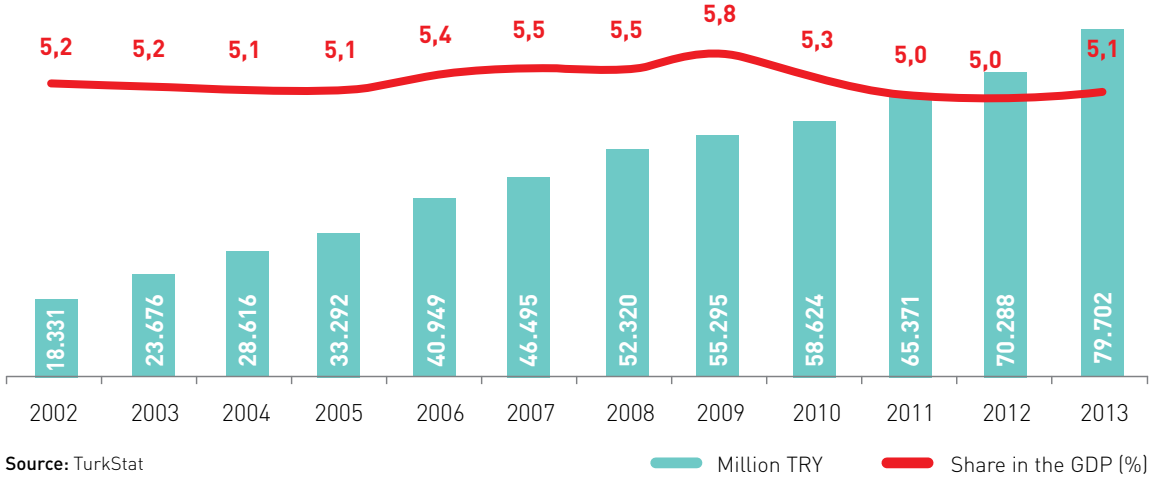
Table 64. Current Health Expenditures, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	18.331	23.676	28.616	33.292	40.949	46.495	52.320	55.295	58.624	65.371	70.288	79.702	3,3
As of 2013 Prices, TRY	51.056	52.639	58.585	63.005	70.709	73.823	75.215	74.815	73.060	76.518	75.554	79.702	0,6
USD	12.173	15.857	20.119	24.830	28.613	35.724	40.467	35.743	39.073	39.145	39.212	41.919	2,4
PPP USD	30.035	30.715	35.316	40.080	48.376	53.757	58.782	60.854	62.331	66.237	66.761	72.575	1,4
Share of the Health Expenditures (%)	97,6	97,5	95,3	94,2	92,9	91,3	90,6	95,5	95,0	95,3	94,7	94,4	
Share of the GDP (%)	5,2	5,2	5,1	5,1	5,4	5,5	5,5	5,8	5,3	5,0	5,0	5,1	

Source: TurkStat

When compared to 2002, current health expenditure increased by 335% in nominal and 56% in real terms in 2013.

Graphic 40. Current Health Expenditures and Share in the GDP, (2002-2013)



Source: TurkStat

Table 65. Development of Current Health Expenditures by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	5.227	7.138	8.884	9.259	12.765	14.856	17.445	19.041	21.615	24.729	30.130	34.600	5,6
	%	28,5	30,1	31,0	27,8	31,2	32,0	33,3	34,4	36,9	37,8	42,9	43,4	
University Health Care Facilities	TRY	1.446	1.839	2.300	2.576	3.140	3.751	4.453	4.629	5.519	6.177	6.100	6.891	3,8
	%	7,9	7,8	8,0	7,7	7,7	8,1	8,5	8,4	9,4	9,4	8,7	8,6	
Private Health Care Facilities	TRY	3.214	4.152	4.259	5.913	7.270	9.174	10.948	9.223	9.600	11.622	13.632	14.997	3,7
	%	17,5	17,5	14,9	17,8	17,8	19,7	20,9	16,7	16,4	17,8	19,4	18,8	
Private Pharmacies	TRY	6.955	8.610	9.993	11.413	13.553	14.654	16.454	19.405	18.790	19.662	17.677	20.042	1,9
	%	37,9	36,4	34,9	34,3	33,1	31,5	31,4	35,1	32,1	30,1	25,1	25,1	
Other	TRY	1.490	1.936	3.180	4.132	4.220	4.060	3.020	2.995	3.100	3.182	2.749	3.173	1,1
	%	8,1	8,2	11,1	12,4	10,3	8,7	5,8	5,4	5,3	4,9	3,9	4,0	
Total	**TRY**	**18.331**	**23.676**	**28.616**	**33.292**	**40.949**	**46.495**	**52.320**	**55.295**	**58.624**	**65.371**	**70.288**	**79.702**	**3,3**

Source: Ministry of Health, Ministry of Development, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When the development of current health expenditure is analyzed in terms of service providers between 2002-2013, it is clear that the most important development has occurred in the MoH-affiliated health care facilities with a 562% increase.

While there was an increase of 377% in university health care facilities and 367% in private sector health care facilities, pharmaceutical expenditures showed a slight increase.

Table 66. . Development of Current Health Expenditures by Spending Items (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Staffing	TRY	4.446	6.485	7.878	8.729	11.318	14.081	15.540	15.386	16.554	21.008	25.449	29.579	5,7
	%	24,3	27,4	27,5	26,2	27,6	30,3	29,7	27,8	28,2	32,1	36,2	37,1	
Service Procurement	TRY	921	1.236	1.532	2.057	2.939	3.770	3.809	4.308	5.181	5.364	6.399	7.021	6,6
	%	5,0	5,2	5,4	6,2	7,2	8,1	7,3	7,8	8,8	8,2	9,1	8,8	
Pharmaceutical	TRY	7.290	9.003	10.384	11.918	14.271	15.546	17.673	21.122	20.612	21.334	19.941	21.885	2,0
	%	39,8	38,0	36,3	35,8	34,9	33,4	33,8	38,2	35,2	32,6	28,4	27,5	
Medical Supplies and Equipment	TRY	1.555	1.938	2.333	2.723	2.423	2.712	3.014	3.209	3.476	3.812	4.647	5.500	2,5
	%	8,5	8,2	8,2	8,2	5,9	5,8	5,8	5,8	5,9	5,8	6,6	6,9	
Medical Diagnostic Tests (Lab and Imaging)	TRY	340	484	585	700	830	1.212	1.845	2.086	2.422	2.681	3.056	3.339	8,8
	%	1,9	2,0	2,0	2,1	2,0	2,6	3,5	3,8	4,1	4,1	4,3	4,2	
Administration	TRY	540	723	923	1.052	1.393	1.657	1.949	2.174	2.372	2.484	3.109	4.251	6,9
	%	2,9	3,1	3,2	3,2	3,4	3,6	3,7	3,9	4,0	3,8	4,4	5,3	
Liabilities	TRY	404	477	1.123	1.277	1.919	934	888	960	1.437	1.269	1.243	1.390	2,4
	%	2,2	2,0	3,9	3,8	4,7	2,0	1,7	1,7	2,5	1,9	1,8	1,7	
Other Current	TRY	1.844	2.080	1.603	2.077	2.440	3.096	5.457	3.830	4.165	4.959	4.534	4.528	1,5
	%	10,1	8,8	5,6	6,2	6,0	6,7	10,4	6,9	7,1	7,6	6,5	5,7	
Unclassified Expenses	TRY	992	1.251	2.254	2.759	3.415	3.488	2.144	2.222	2.405	2.462	1.910	2.209	1,2
	%	5,4	5,3	7,9	8,3	8,3	7,5	4,1	4,0	4,1	3,8	2,7	2,8	
Total	**TRY**	**18.331**	**23.676**	**28.616**	**33.292**	**40.949**	**46.495**	**52.320**	**55.295**	**58.624**	**65.371**	**70.288**	**79.702**	**3,3**

Source: Ministry of Health, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH, SAHIN, Assoc. Prof. Ismet,, AKAR, Asst. Prof. Cetin, State University Hospital Cost-Analysis Report 2004

When the development of current health expenditure is analyzed in terms of qualifications between 2002-2013 period, it is seen that the most major increase took place in expenditures for medical diagnostic tests by a 882% increase. The increases are also seen in administration and service procurement expenditures with 688% and 663% respectively.

A.1. Expenditures for Staffing

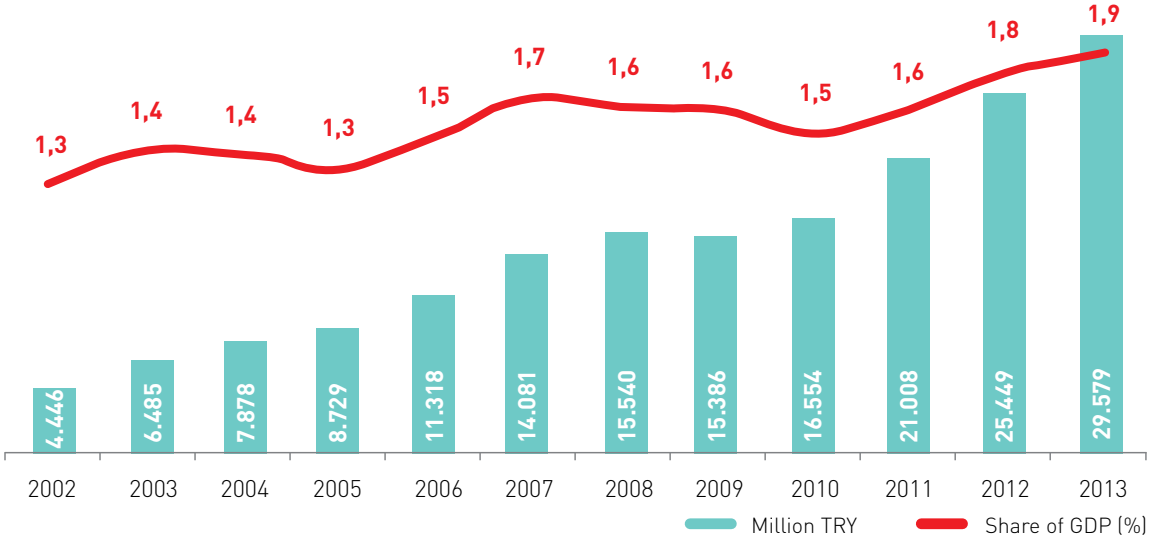
Table 67. Expenditures for Staffing, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	4.446	6.485	7.878	8.729	11.318	14.081	15.540	15.386	16.554	21.008	25.449	29.579	5,7
As of 2013 Prices, TRY	12.382	14.417	16.129	16.520	19.543	22.356	22.341	20.817	20.631	24.590	27.356	29.579	1,4
USD	2.952	4.343	5.539	6.510	7.908	10.819	12.020	9.945	11.034	12.579	14.198	15.557	4,3
PPP USD	7.284	8.413	9.723	10.509	13.371	16.279	17.460	16.932	17.601	21.286	24.173	26.934	2,7
Share of the Health Expenditures (%)	23,7	26,7	26,2	24,7	25,7	27,7	26,9	26,6	26,8	30,6	34,3	35,1	
Share of the GDP (%)	1,3	1,4	1,4	1,3	1,5	1,7	1,6	1,6	1,5	1,6	1,8	1,9	

Source: Ministry of Health, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

While the proportion of the expenditures for staffing in the health expenditures was 23,7% in 2002, it increased to 35,1% in 2013. In 2013, staffing costs increased 5,7-fold in nominal terms and 1,4-fold in real terms when compared to 2002.

Graphic 41. Expenditures for Staffing and Share of GDP (2002-2013)



Source: Ministry of Health, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

The share of the expenditures for the employees working in the health sectors, which was 1,3% in the GDP in 2002, increased to 1,9% in 2013.

Staffing costs constitute the most significant spending item in health expenditure in Turkey as well as in every country. Health care personnel are the key component of health service delivery. In 2002 - 2013 period, efforts were made to increase the staff in quantity and quality. Arrangements in motivating and enhancing performance of the health care personnel, already few in number, were made as well.

The first implementation as a result of this motive was the performance-based supplementary payment system, started in health care facilities under MoH in April, 2003. Due to the performance-based supplementary payment practices, the number of the physicians' private practices that was 90% in 2002 decreased to 7% in the late 2010. A regulation on full time working for health care personnel came into force in January, 2010. With this regulation, pay for shifts was increased and payment cap for 80 hours monthly was increased to 130 hours. Staff (other than health care personnel that could get pay for shifts) were also added into the list and this situation brought the pay for personnel in the oral and dental health centers and 112 emergency care services staff with it. Physicians were given some amount of their performance-based supplementary payment in advance, and SSI premiums were deducted from this money in order to create another retirement pension for them. Also, Compulsory Liability Insurance of Medical Malpractice was implemented for physicians in cases when the half of the premiums is paid by the employer.

Table 68. Supplementary Pensions for Physicians by Revolving Fund Deductions

Title	Current Pension	5-Year Premium Payment		10-Year Premium Payment		15-Year Premium Payment	
		Supplementary Pay	Total Salary	Supplementary Pay	Total Salary	Supplementary Pay	Total Salary
Faculty Member-1/4	2.002	317	2.319	670	2.672	1053	3.055
Specialist-1/4	2.002	259	2.261	547	2.549	860	2.862
Practitioner-1/4	2.002	139	2.141	294	2.296	462	2.464

Title	Current Pension	20-Year Premium Payment		25-Year Premium Payment		30-Year Premium Payment	
		Supplementary Pay	Total Salary	Supplementary Pay	Total Salary	Supplementary Pay	Total Salary
Faculty Member-1/4	2.002	1.469	3.471	1.920	3.922	2.423	4.425
Specialist-1/4	2.002	1.200	3.202	1.569	3.571	1.980	3.982
Practitioner-1/4	2.002	645	2.647	843	2.845	1.064	3.066

Source: Ministry of Health

Note: Identified according to the basic salary coefficient of July 1, 2013

In May, 2012, Board of Arbitration for Public Officers made some arrangements for the personal rights and benefits of health professionals.

According to these arrangements,

- Contracted health care personnel in inpatient treatment facilities are provided with free meals.
- The personnel also serving as an ambulance driver is given an extra performance score of 10 from the revolving fund payments (emergency health technicians, emergency health technologists, community health technician).
- Compensation, defined as an additional spending item paid for all employees apart from their basic salaries, is also paid to health care personnel in cash together with their own salaries every month with no contingencies. Tough the personnel doesn't contribute to the revolving fund with reasons such as annual leave or sick leave, it was agreed that they will still receive this amount in cash.
- Supplementary payment cap for non-physician personnel working in 112 emergency health care services was increased from 150% to 200%.
- Health personnel's shift pay on religious holidays started to be paid with a 20% increment.
- That net amount of fixed supplementary payment for physicians from the revolving fund cannot be less than net amount of fixed supplementary payment was decreed on amending article to Decree Law No. 375.
- Supplementary pays for the substitute deputy health directors, branch office managers, hospital managers or deputy hospital managers are calculated over the basic salary of the substituted position.
- Health personnel get paid a total amount for a fiscal year as a part of their financial rights. And other personnel receive supplementary payment which is not subject to the income tax. Due to the fact that tax cuts are deducted from the supplementary payments of the health personnel and it was decreed that if the supplementary payment of the health personnel is less than the amount to be paid for a fiscal year, income gap between health and other personnel resulting from this procedure shall be retrieved from revolving fund budget with the Statutory Decree No.375.
- Health personnel such as civil servant, nurse, and midwife, health officer working as movable record and control officers were allowed to get cash indemnity (indemnity for cashier's responsibility).

Prior to 2003, there was a prevailing opinion that there was sufficient human resource yet its distribution was unequal. Because of this misguided opinion, necessary arrangements to increase the number of the health personnel weren't made for a long time. Initiatives were started to increase the number of the health personnel in Turkey, which ranked lowest in the WHO European Region average in terms of the number of physician and nurse per a hundred thousand people. To increase the number of the physicians, new medical faculties were established, also student additional placement quotas were created for the existing medical faculties, and similar approaches were followed to increase the number of the other health care personnel.

With the new regulations brought by Ministry of Health, health care personnel started to be assigned to health care facilities and regions deprived of health care personnel for decades after the new employment methods. Also in July 2003, contracted health care personnel were assigned in rural and less developed regions with higher financial rights compared to other personnel of equivalent position. Despite these incentives, adequate staffing was not ensured thus obligation of public services was re-imposed in June 2005.

During the period 2002-2012 with the Health Transformation Program-Turkey, a fair system ensuring objectivity and equity in personnel appointment and transfer proceedings was set up to maintain a balanced distribution of the health care personnel among the regions, to achieve manpower planning. In order to prevent nepotism in personnel appointment and ensure a more balanced distribution of healthcare personnel to all the MoH-affiliated healthcare facilities, Regulation on Appointment and Transfer was implemented in 2005. Through these implementations, the ratio between the province with the highest population per specialist physician and with the least population was 1/14 in December 2002, however this ratio was decreased to 1/5 in December 2013. The said ratio for the general practitioners decreased from 1/9 to 1/2,6 and for dentist from 1/8,5 to 1/5,9 and for nurses and midwives this ratio was reduced from 1/8 to 1/3,4.

In April 2011, terms of references were established for the health occupations that were not defined earlier. In February 2011, within the scope of the Law on Full Time Medical Practice, faculty members working in university health care facilities would no longer ask for extra fee for their private examination services therefore 448 million TRY was transferred to universities from the budget just for the year 2011 in order to prevent faculty members' financial loss.

In April 2009, government employees working in inpatient treatment institutions were allowed to have free meals that of patients.

With a 94% percent increase, the number of the health care personnel -378 thousand in 2002- was increased to 735 thousand in 2013 (including service procurement).

Table 69. Number of the Health Care Personnel in Turkey, (2002-2013)

Health Care Personnel	2002	2013
Specialist	45.457	73.886
General Practitioner	30.900	38.572
Medical Resident	15.592	21.317
Dentist	16.371	22.295
Pharmacist	22.289	27.012
Nurse	72.393	139.544
Midwife	41.479	53.427
Other Health Care Personnel	50.106	134.488
Other Personnel	72.543	96.253
Total Number of Health Care Personnel	**367.130**	**606.794**

Source: Ministry of Health

Note: Service procurement is not included.

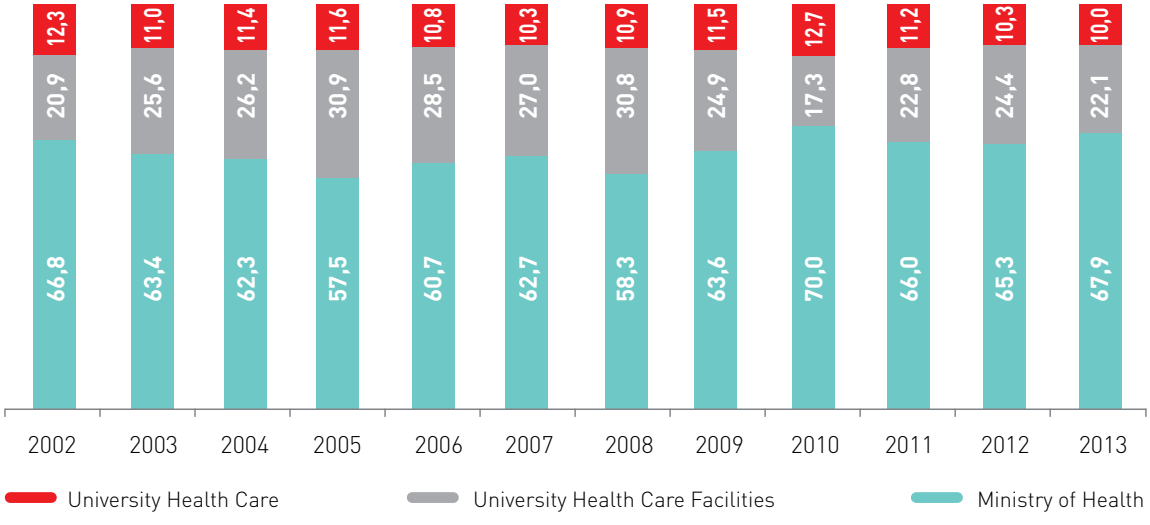
Table 70. Development of Staffing Expenditures by Service Providers (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	2.972	4.114	4.910	5.023	6.870	8.828	9.057	9.787	11.591	13.859	16.627	20.069	5,8
	%	66,8	63,4	62,3	57,5	60,7	62,7	58,3	63,6	70,0	66,0	65,3	67,9	
University Health Care Facilities	TRY	547	712	902	1.013	1.217	1.453	1.695	1.769	2.107	2.354	2.615	2.967	4,4
	%	12,3	11,0	11,4	11,6	10,8	10,3	10,9	11,5	12,7	11,2	10,3	10,0	
Private Health Care Facilities	TRY	928	1.658	2.067	2.693	3.231	3.799	4.788	3.829	2.856	4.795	6.207	6.542	6,1
	%	20,9	25,6	26,2	30,9	28,5	27,0	30,8	24,9	17,3	22,8	24,4	22,1	
Total	**TRY**	**4.446**	**6.485**	**7.878**	**8.729**	**11.318**	**14.081**	**15.540**	**15.386**	**16.554**	**21.008**	**25.449**	**29.579**	**5,7**

Source: Ministry of Health, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When we look at the change in personnel expenditures by the service providers in 2013 by comparing to 2002, we see that the most significant increase is in the private health care facilities with a rise of 610%. This is followed by MoH health care personnel expenditures with a rise of 580% then expenditures of university health care facilities with a rise of 440%.

Graphic 42. Development of Staffing Costs by Service Providers, (2002-2013)



Source: Ministry of Health, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

While the 66,8% of the personnel expenditures occured in health care facilities under the MoH in 2002, this ratio increased to 67,9% in 2013. The share of private sector increased from 20,9% to 22,1% yet the share of university health care facilities decreased from 12,3% to 10%.

A.2. Expenditures on Service Procurement

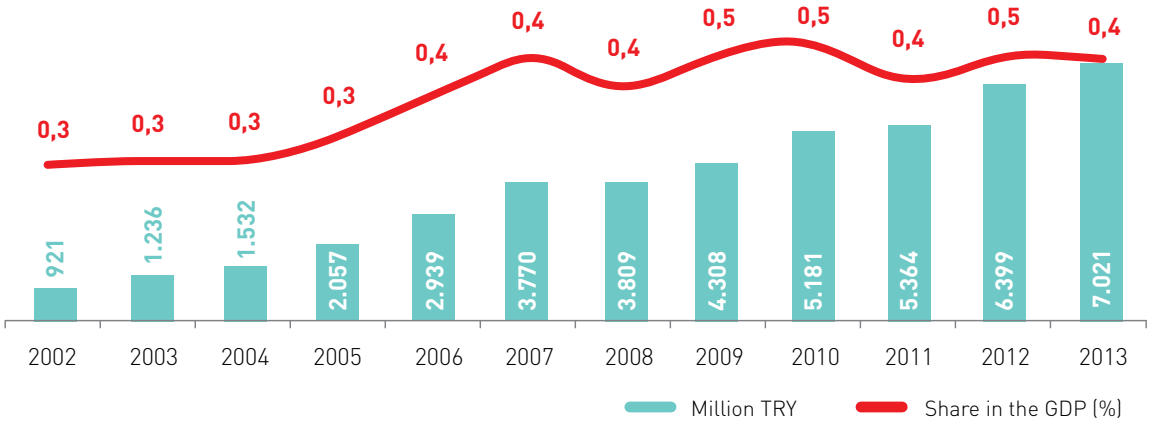
Table 71. Expenditures on Service Procurement,(2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	921	1.236	1.532	2.057	2.939	3.770	3.809	4.308	5.181	5.364	6.399	7.021	6,6
As of 2013 Prices, TRY	2.564	2.747	3.137	3.892	5.075	5.986	5.475	5.828	6.457	6.278	6.878	7.021	1,7
USD	611	828	1.077	1.534	2.054	2.896	2.946	2.784	3.453	3.212	3.570	3.693	5,0
PPP USD	1.508	1.603	1.891	2.476	3.472	4.359	4.279	4.741	5.509	5.435	6.078	6.393	3,2
Share of the Health Expenditures (%)	4,9	5,1	5,1	5,8	6,7	7,4	6,6	7,4	8,4	7,8	8,6	8,3	
Share of the GDP (%)	0,3	0,3	0,3	0,3	0,4	0,4	0,4	0,5	0,5	0,4	0,5	0,4	

Source: Ministry of Health, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When compared to 2002, expenditures for service procurement increased 663% in nominal and 170% in real terms in 2013.

Graphic 43. Expenditures on Service Procurement and Share in the GDP (2002-2013)



Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

Expenditures on service procurement as a share of GDP, which was 0,3% in 2002, increased to 0,4% in 2013.

During period, expenditures on service procurement had a far-reaching effect on accessing to health care services and improving the quality of the services. This must be discussed in two distinct fields. First of them was the improvements in the field of support services such as housekeeping, information processing, security, etc., the second was the developments in the service procurement for medical diagnostic tests such as the radiology-imaging and lab services.

With the improvements in the procurement of support services, almost a new employment model formed in the field of health. For example, while there were around 11 thousand people working in the MoH by service procurement in 2002, this number nearly increased to 130 thousand in 2013.

The second important field where the level of service procurement was high for health services was medical diagnostic tests such as the radiology-imaging and lab services. These procurements were mostly for radiology-imaging services such as MRI, CT devices etc., and for lab services such as microbiology, biochemistry, hematology. With the help of implementations, time for patients' wait lists was shortened; satisfaction level in health care services was increased.

Table 72. Development of Expenditures on Service Procurement by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	290	419	582	833	1.373	1.849	2.065	2.402	2.536	2.805	3.259	3.775	12,0
	%	31,5	33,9	38,0	40,5	46,7	49,0	54,2	55,8	48,9	52,3	50,9	53,8	
University Health Care Facilities	TRY	174	228	271	295	366	403	593	621	720	967	943	931	4,3
	%	18,9	18,4	17,7	14,3	12,4	10,7	15,6	14,4	13,9	18,0	14,7	13,3	
Private Health Care Facilities	TRY	456	589	680	928	1.201	1.518	1.150	1.285	1.925	1.592	2.197	2.314	4,1
	%	49,5	47,6	44,4	45,1	40,9	40,3	30,2	29,8	37,2	29,7	34,3	33,0	
Total	**TRY**	**921**	**1.236**	**1.532**	**2.057**	**2.939**	**3.770**	**3.809**	**4.308**	**5.181**	**5.364**	**6.399**	**7.021**	**6,6**

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

In 2002, while 31,5% of the expenditures on service procurement occurred in health care facilities under MoH, this percentage raised to 53,8% in 2013. On the other hand, the share of the private sector and university health care facilities decreased.

A.3. Expenditures on Pharmaceuticals

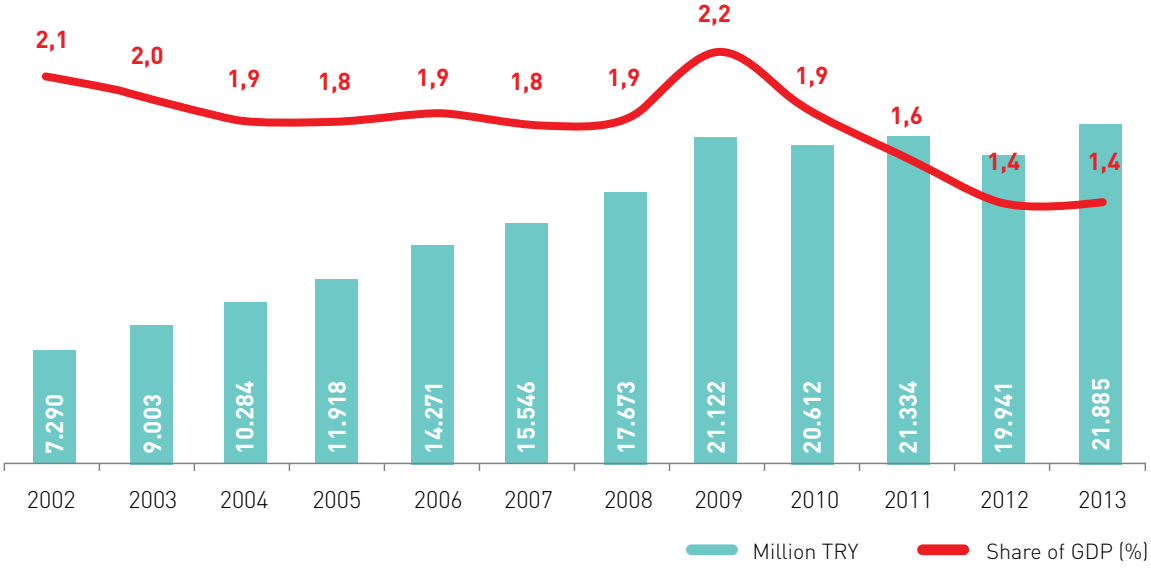
Table 73. Expenditures on Pharmaceuticals (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	7.290	9.003	10.384	11.918	14.271	15.546	17.673	21.122	20.592	21.334	19.941	21.885	2,0
As of 2013 Prices, TRY	20.304	20.016	21.259	22.555	24.643	24.683	25.406	28.578	25.663	24.972	21.435	21.885	0,1
USD	4.841	6.030	7.301	8.889	9.972	11.945	13.669	13.653	13.725	12.775	11.125	11.510	1,4
PPP USD	11.944	11.679	12.815	14.348	16.860	17.974	19.856	23.245	21.894	21.616	18.940	19.928	0,7
Share of the Health Expenditures (%)	38,8	37,1	34,6	33,7	32,4	30,5	30,6	36,5	33,4	31,1	26,9	25,9	
Share of the GDP (%)	2,1	2,0	1,9	1,8	1,9	1,8	1,9	2,2	1,9	1,6	1,4	1,4	

Source: Ministry of Health, Ministry of Development, SSI, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When compared to the year 2002, there was an increase of 200% in nominal terms and of 8% in real terms in pharmaceutical expenditures (including costs for inpatients' medicines and for vaccines) in 2013. The share of pharmaceutical expenditures in health expenditures was 38,8% in 2002, this percentage was reduced to 25,9% in 2013.

Graphic 44. Pharmaceutical Expenditures and Share in the GDP (2002-2013)



Source: Ministry of Health, Ministry of Development, SSI, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

Pharmaceutical expenditures as a share of GDP, which was 2,1% in 2002, dropped to 1,4% in 2013.

Table 74. Development of Pharmaceutical Expenditures by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	220	244	225	300	429	435	639	1.084	1.014	925	1.434	1.102	4,0
	%	3,0	2,7	2,2	2,5	3,0	2,8	3,6	5,1	4,9	4,3	7,2	5,0	
University Health Care Facilities	TRY	79	103	122	133	165	161	299	313	363	413	402	322	3,1
	%	1,1	1,1	1,2	1,1	1,2	1,0	1,7	1,5	1,8	1,9	2,0	1,5	
Private Health Care Facilities	TRY	37	47	44	73	124	295	281	319	444	334	428	419	10,4
	%	0,5	0,5	0,4	0,6	0,9	1,9	1,6	1,5	2,2	1,6	2,1	1,9	
Private Pharmacies	TRY	6.955	8.610	9.993	11.413	13.553	14.654	16.454	19.405	18.790	19.662	17.677	20.042	1,9
	%	95,4	95,6	96,2	95,8	95,0	94,3	93,1	91,9	91,2	92,2	88,6	91,6	
Total	**TRY**	**7.290**	**9.003**	**10.384**	**11.918**	**14.271**	**15.546**	**17.673**	**21.122**	**20.612**	**21.334**	**19.941**	**21.885**	**2,0**

Source: Ministry of Health, Ministry of Development, SSI, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

While 95,4% of the pharmaceutical expenditures in 2002 (including costs for inpatients' medicines and for vaccines) consisted of the expenditures on pharmaceuticals obtained from private pharmacies, this ratio was reduced to 91,6% in 2013. There are two important underlying reasons for this decrease in the pharmaceutical expenditures. First, with the citizen-centered health service delivery policies, the ratio of the coverage for inpatients' pharmaceuticals by hospitals has been considerably increased as compared to 2002. Second, share of vaccine expenditures, financed by the Ministry of Health, was considerably increased.

Table 75. MoH Expenditures on Pharmaceuticals and Vaccines, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Pharmaceutical Expenditures	TRY	211	236	219	279	379	359	560	693	685	702	763	835	3,0
	%	95,8	96,8	97,5	93,0	88,2	82,5	87,6	63,9	67,5	75,9	53,2	75,7	
Vaccine Expenditures	TRY	9	8	6	21	51	76	79	391	329	223	670	267	27,8
	%	4,2	3,2	2,5	7,0	11,8	17,5	12,4	36,1	32,5	24,1	46,8	24,3	
Total	TRY	**220**	**244**	**225**	**300**	**429**	**435**	**639**	**1.084**	**1.014**	**925**	**1.434**	**1.102**	**4,0**

Source: Ministry of Health

Pharmaceutical expenditures for inpatients constituted 95%, vaccine expenditures for public health services constituted 4,2% and 112 emergency care services constituted 0,8% of the MoH's pharmaceutical expenditures in 2002. The percentage of the vaccine costs increased 24,3% by years in 2013.

A.4. Expenditures on Medical Equipment and Supplies

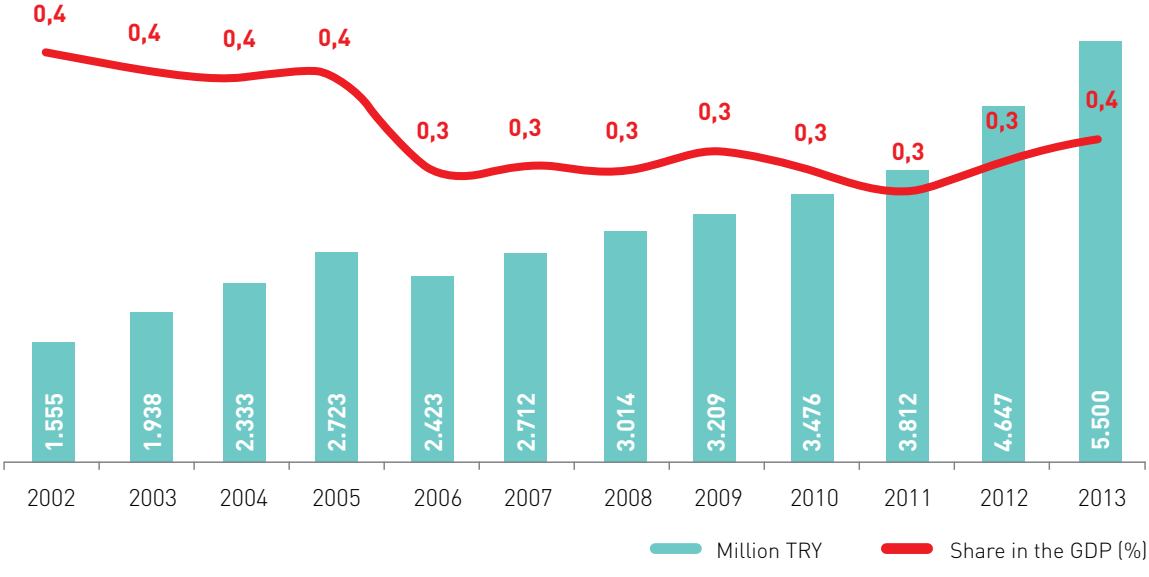
Table 76. Expenditures on Medical Equipment and Supplies (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	1.555	1.938	2.333	2.723	2.423	2.712	3.014	3.209	3.476	3.812	4.647	5.500	2,5
As of 2013 Prices, TRY	4.331	4.309	4.776	5.153	4.184	4.305	4.333	4.341	4.332	4.462	4.995	5.500	0,3
USD	1.033	1.298	1.640	2.031	1.693	2.083	2.331	2.074	2.317	2.282	2.592	2.893	1,8
PPP USD	2.548	2.514	2.879	3.278	2.863	3.135	3.387	3.531	3.696	3.862	4.414	5.008	1,0
Share of the Health Expenditures (%)	8,3	8,0	7,8	7,7	5,5	5,3	5,2	5,5	5,6	5,6	6,3	6,5	
Share of the GDP (%)	0,4	0,4	0,4	0,4	0,3	0,3	0,3	0,3	0,3	0,3	0,3	0,4	

Source: Ministry of Health, TurkStat, SSI, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

As compared to 2002, expenditures on medical equipment and supplies increased by 250% in nominal terms and only 30% in real terms in 2013. The share of expenditures on medical equipment and supplies in health expenditures, which was 8,3% in 2002 , was reduced to 6,5% in 2013.

Graphic 45. Expenditures on Medical Equipment and Supplies and Share in the GDP, (2002-2013)



Source: Ministry of Health, TurkStat, SSI, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

The share of the expenditure on medical equipment and supplies in the GDP, which was 0,4% in 2002, remained stable in 2013.

Table 77. Development of Expenditures on Medical Equipment and Supplies by Service Providers, (2002-2013), (million TRY/USD)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH	TRY	637	774	873	760	711	712	954	1.136	1.136	1.389	1.794	2.154	2,4
	%	41,0	39,9	37,4	27,9	29,3	26,3	31,7	35,4	32,7	36,4	38,6	39,2	
University Health Care Facilities	TRY	142	185	220	240	298	314	494	518	600	682	666	833	4,9
	%	9,1	9,6	9,4	8,8	12,3	11,6	16,4	16,1	17,3	17,9	14,3	15,1	
Private Health Care Facilities	TRY	384	453	529	681	864	1.343	1.078	1.138	1.375	1.365	1.729	1.970	4,1
	%	24,7	23,4	22,7	25,0	35,7	49,5	35,8	35,5	39,6	35,8	37,2	35,8	
Other	TRY	392	526	710	1.042	550	343	488	417	365	376	459	543	0,4
	%	25,2	27,1	30,4	38,3	22,7	12,6	16,2	13,0	10,5	9,9	9,9	9,9	
Total	**TRY**	**1.555**	**1.938**	**2.333**	**2.723**	**2.423**	**2.712**	**3.014**	**3.209**	**3.476**	**3.812**	**4.647**	**5.500**	**2,5**

Source: Ministry of Health, TurkStat, SSI, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

While 25,2% of expenditures for medical equipment and supplies (including medical equipment and supplies for inpatients) was made for retail procurement in 2002, this percentage was reduced to 9,9% in 2013. The underlying cause of this decrease was the rule implemented consequent to citizen-centered health service delivery policies stating that inpatients' pharmaceuticals shall be covered by hospitals. With this rule, the medical equipment needs of the citizens started to be met by relevant hospitals largely thus citizens had a great relief while accessing to health and also costs were reduced in bundle procurements executed by hospitals.

A.5. Expenditures on Medical Diagnostic Tests

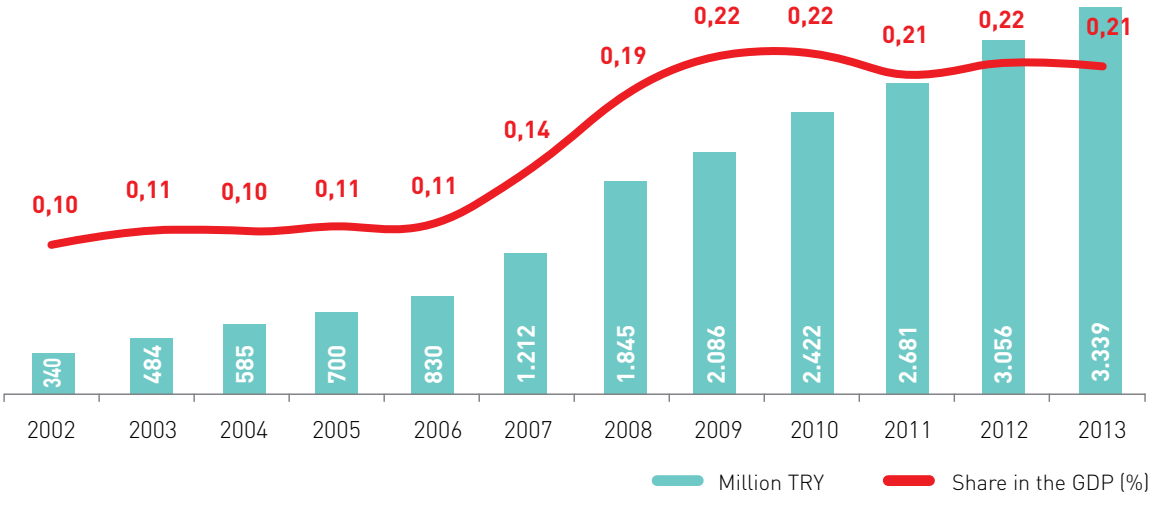
Table 78. Expenditures on Medical Diagnostic Tests (Lab and Imaging) (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	340	484	585	700	830	1.212	1.845	2.086	2.422	2.681	3.056	3.339	8,8
As of 2013 Prices, TRY	947	1.075	1.197	1.325	1.433	1.925	2.652	2.822	3.018	3.138	3.285	3.339	2,5
USD	226	324	411	522	580	931	1.427	1.348	1.614	1.605	1.705	1.756	6,8
PPP USD	557	627	722	843	981	1.402	2.073	2.295	2.575	2.716	2.903	3.041	4,5
Share of the Health Expenditures (%)	1,8	2,0	1,9	2,0	1,9	2,4	3,2	3,6	3,9	3,9	4,1	4,0	
Share of the GDP (%)	0,10	0,11	0,10	0,11	0,11	0,14	0,19	0,22	0,22	0,21	0,22	0,21	

Source: Ministry of Health, TurkStat, SSI, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When compared to 2002, expenditures on medical diagnostic tests increased by 880% in nominal terms and 250% in real terms in 2013. The share of these expenditures rose to 4% in 2013 in health expenditures, which was 1,8% in 2002.

Graphic 46. Expenditures on Medical Diagnostic Tests and Share in the GDP, (2002-2013)



Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

Expenditures on medical diagnostic tests as a share of GDP, which was 0,10% in 2002, increased to 0,21% in 2013.

Table 79. Development of Expenditures on Medical Diagnostic Tests by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	141	198	223	200	328	507	802	1.066	1.231	1.507	1.764	1.950	12,9
	%	41,4	41,0	38,2	28,6	39,5	41,8	43,4	51,1	50,8	56,2	57,7	58,4	
University Health Care Facilities	TRY	67	87	104	113	140	218	400	419	485	552	538	598	7,9
	%	19,7	18,1	17,8	16,2	16,9	17,9	21,7	20,1	20,0	20,6	17,6	17,9	
Private Health Care Facilities	TRY	26	39	42	55	107	258	256	244	376	277	374	370	13,1
	%	7,7	8,1	7,2	7,9	12,9	21,3	13,9	11,7	15,5	10,3	12,2	11,1	
Other	TRY	106	159	216	331	255	229	388	357	330	345	380	421	3,0
	%	31,2	32,8	36,9	47,3	30,7	18,9	21,0	17,1	13,6	12,9	12,4	12,6	
Total	**TRY**	**340**	**484**	**585**	**700**	**830**	**1.212**	**1.845**	**2.086**	**2.422**	**2.681**	**3.056**	**3.339**	**8,8**

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

It is clearly seen that in 2002, 31,2% of medical diagnostic tests, supposed to be made mainly in hospitals, were made in private health care facilities like private labs. With the rule implemented consequent to citizen-centered health service delivery policies stating that inpatients' pharmaceuticals shall be covered by hospitals thus this percentage was reduced to 12,6% in 2013. With this rule, access to health was facilitated, out of pocket expenses and costs occurred by bundle procurements were reduced.

A.6. Expenditures on Health Care Management

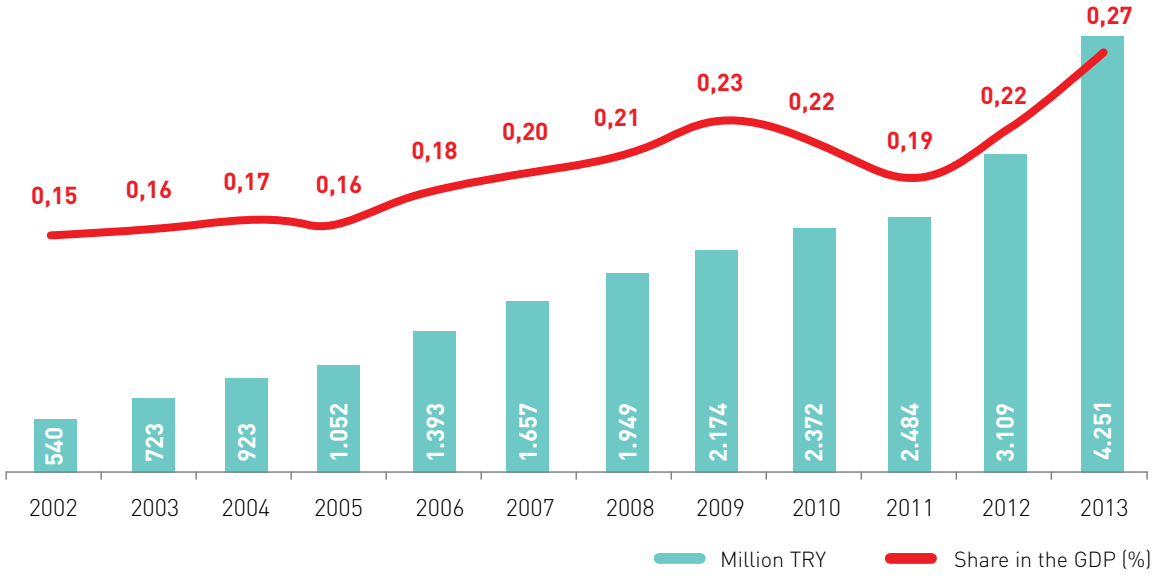
Table 80. Expenditures on Health Care Management, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	540	723	923	1.052	1.393	1.657	1.949	2.174	2.372	2.484	3.109	4.251	6,9
As of 2013 Prices, TRY	1.503	1.608	1.890	1.990	2.405	2.631	2.802	2.942	2.957	2.907	3.342	4.251	1,8
USD	358	485	649	784	973	1.273	1.507	1.405	1.581	1.487	1.734	2.236	5,2
PPP USD	884	939	1.140	1.266	1.646	1.916	2.190	2.393	2.522	2.516	2.953	3.870	3,4
Share of the Health Expenditures (%)	2,9	3,0	3,1	3,0	3,2	3,3	3,4	3,8	3,8	3,6	4,2	5,0	
Share of the GDP (%)	0,15	0,16	0,17	0,16	0,18	0,20	0,21	0,23	0,22	0,19	0,22	0,27	

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet,, AKAR, Asst. Prof. Dr. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

Expenditures on health care management increased by 690% in nominal terms and 180% in real terms in 2013 as compared to 2002. While the share of management expenditures in health expenditures was 2,9% in 2002, this percentage climbed by 5% in 2013.

Graphic 47. Expenditures on Health Care Management and Share in the GDP, (2002-2013)



Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet,, AKAR, Asst. Prof. Dr. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

In 2013, the share of health care management expenditures in the GDP went up to 0,27%, which was 0,15% in 2002.

When we look at the development of expenditures on health care management in 2002-2013 period, the most noticeable issue is that the authorities of the managers were increased and much more importance was placed on management services. Over a 10.000 personnel including managers, management trainees and experts have been trained via online education by MoH since 2007. In March 2010, "Manager Performance Implementation" was put into service for hospital mangers in Ministry of Health hospitals. In November 2012, with the Decree Law No. 663, the central and provincial organizations of the MoH were restructured and "Public Hospital Unions" was carried into effect all across Turkey as of November 2, 2012. With this implementation, whole managers in hospitals and their affiliated unions started to be employed as contracted.

Table 81. Development of Expenditures on Health Care Management by Service Providers , (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	378	515	669	744	997	1.157	1.330	1.577	1.720	1.794	2.381	3.447	8,1
	%	70,0	71,1	72,5	70,8	71,5	69,8	68,2	72,5	72,5	72,2	76,6	81,1	
University Health Care Facilities	TRY	89	114	142	158	192	232	273	287	333	377	372	420	3,7
	%	16,5	15,8	15,4	15,0	13,8	14,0	14,0	13,2	14,0	15,2	12,0	9,9	
Private Health Care Facilities	TRY	73	94	112	150	204	268	346	310	319	313	356	383	4,3
	%	13,5	13,0	12,1	14,2	14,7	16,2	17,8	14,3	13,5	12,6	11,4	9,0	
Total	**TRY**	**540**	**723**	**923**	**1.052**	**1.393**	**1.657**	**1.949**	**2.174**	**2.372**	**2.484**	**3.109**	**4.251**	**6,9**

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group, SAHIN, Assoc. Prof. Ismet,, AKAR, Asst. Prof. Dr. Cetin, State University Hospital Cost-Analysis Report 2004, BUYUKMIRZA, Prof. Dr. H. Kamil, Project on Setting up Cost Accounting Systems within Revolving Fund Enterprises under MoH

While the 70% of management expenditures occurred in MoH-affiliated health care facilities in 2002, this percentage increased to 81,1% in 2013. On the other hand, the shares of private sector and university health care facilities decreased.

A.7. Liabilities

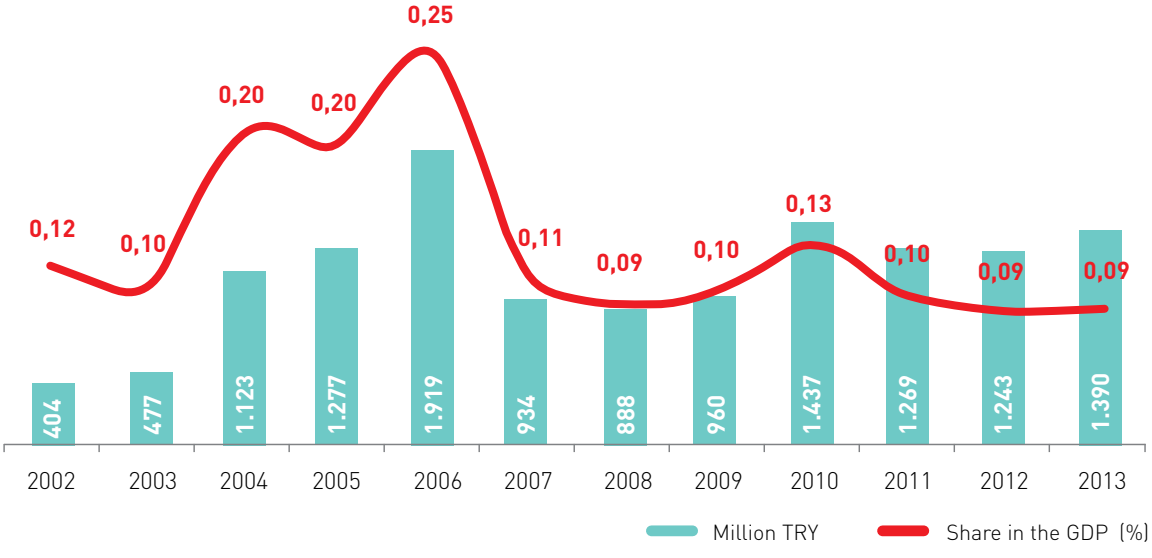
Table 82. Liabilities and Expenditures, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	404	477	1.123	1.277	1.919	934	888	960	1.437	1.269	1.243	1.390	2,4
As of 2013 Prices, TRY	1.126	1.061	2.300	2.417	3.314	1.482	1.277	1.299	1.791	1.485	1.336	1.390	0,2
USD	268	320	790	953	1.341	717	687	621	958	760	693	731	1,7
PPP USD	662	619	1.387	1.538	2.267	1.079	998	1.056	1.528	1.286	1.181	1.266	0,9
Share of the Health Expenditures (%)	2,2	2,0	3,7	3,6	4,4	1,8	1,5	1,7	2,3	1,8	1,7	1,6	
Share of the GDP (%)	0,12	0,10	0,20	0,20	0,25	0,11	0,09	0,10	0,13	0,10	0,09	0,09	

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When compared to 2002, expenses upon liabilities increased by 240% in real terms and only 20% in nominal terms in 2013. While the share of expenditures incurred by liabilities in health expenditures was 2,2% in 2002, it was decreased to 1,6% in 2013.

Graphic 48. Liabilities and Expenditures and Share in the GDP, (2002-2013)



Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

Its share in the GDP, which was 0,12% in 2002, dropped to 0,09% in 2013.

Table 83. Development of Liabilities and Expenditures by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	187	193	787	901	1.450	339	449	506	834	867	691	979	4,2
	%	46,2	40,6	70,1	70,5	75,6	36,3	50,6	52,7	58,1	68,3	55,6	70,4	
University Health Care Facilities	TRY	194	253	301	328	406	491	420	352	510	348	339	386	1,0
	%	47,9	53,0	26,8	25,6	21,2	52,6	47,2	36,6	35,5	27,4	27,3	27,7	
Private Health Care Facilities	TRY	24	31	36	49	63	104	19	103	93	54	213	26	0,1
	%	5,9	6,5	3,2	3,8	3,3	11,1	2,2	10,7	6,5	4,3	17,2	1,8	
Total	**TRY**	**404**	**477**	**1.123**	**1.277**	**1.919**	**934**	**888**	**960**	**1.437**	**1.269**	**1.243**	**1.390**	**2,4**

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

In 2002, while 46,2% of the expenditures for liabilities were realized in health care facilities under Ministry of health, this percentage went up to 70,4% in 2013. On the other hand, the share of private sector and the university health care facilities declined.

A.8. Other Current Health Expenditures

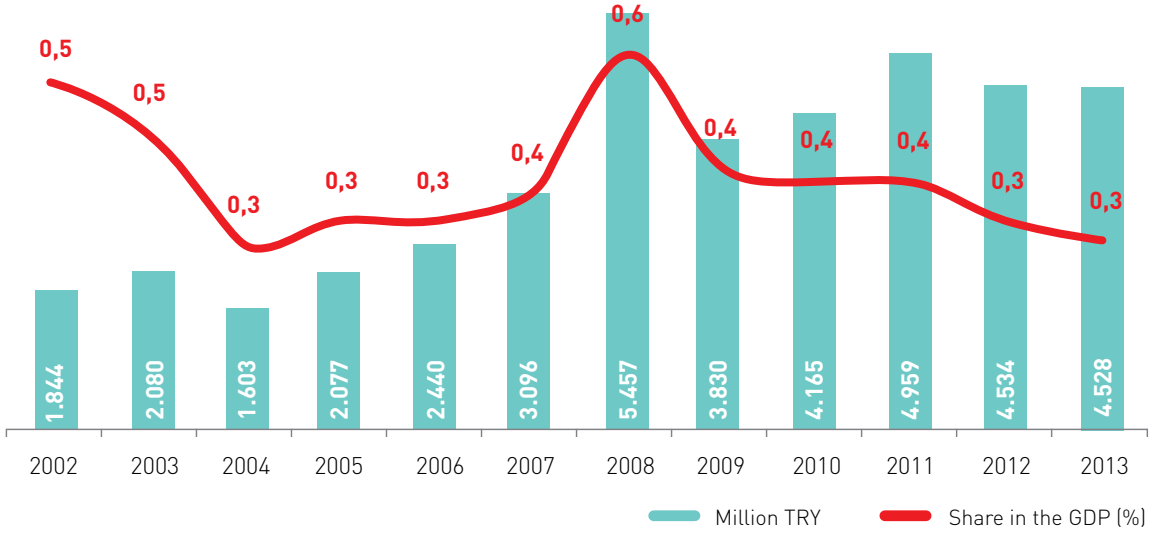
Table 84. Other Current Health Expenditures, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	1.844	2.080	1.603	2.077	2.440	3.096	5.457	3.830	4.165	4.959	4.534	4.528	1,5
As of 2013 Prices, TRY	5.136	4.623	3.281	3.931	4.214	4.916	7.845	5.182	5.191	5.805	4.874	4.528	-0,1
USD	1.225	1.393	1.127	1.549	1.705	2.379	4.221	2.476	2.776	2.970	2.529	2.382	0,9
PPP USD	3.021	2.698	1.978	2.501	2.883	3.580	6.131	4.215	4.429	5.025	4.306	4.123	0,4
Share of the Health Expenditures (%)	9,8	8,6	5,3	5,9	5,5	6,1	9,5	6,6	6,8	7,2	6,1	5,4	
Share of the GDP (%)	0,5	0,5	0,3	0,3	0,3	0,4	0,6	0,4	0,4	0,4	0,3	0,3	

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

In 2013, the share of other current health expenditures increased by 150% in nominal terms and decreased by 10% when compared to 2002. Its share in the health expenditure decreased to 5,4% in 2013, which was 9,8% in 2002.

Graphic 49. Other Current Health Expenditures and Share in the GDP, (2002-2013)



Source: Ministry of Health, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

The share of other current health expenditures in the GDP, which was 0,5% in 2002, dropped to 0,3% in 2013.

Table 85. Development of Other Current Health Expenditures by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	402	681	615	497	608	1.029	2.148	1.484	1.554	1.583	2.182	1.122	1,8
	%	21,8	32,8	38,4	23,9	24,9	33,2	39,4	38,7	37,3	31,9	48,1	24,8	
University Health Care Facilities	TRY	155	158	238	296	358	479	280	351	402	485	224	434	1,8
	%	8,4	7,6	14,9	14,3	14,7	15,5	5,1	9,2	9,6	9,8	5,0	9,6	
Private Health Care Facilities	TRY	1.287	1.241	750	1.284	1.475	1.588	3.029	1.995	2.210	2.892	2.128	2.972	1,3
	%	69,8	59,7	46,8	61,8	60,4	51,3	55,5	52,1	53,0	58,3	46,9	65,6	
Total	**TRY**	**1.844**	**2.080**	**1.603**	**2.077**	**2.440**	**3.096**	**5.457**	**3.830**	**4.165**	**4.959**	**4.534**	**4.528**	**1,5**

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

In 2002, while 21,8% of the expenditures for other health expenditures were realized in health care facilities under Ministry of Health, this percentage went up to 24,8% in 2013. On the other hand, the share of private sector decreased, yet, the share of the university health care facilities increased.

A.9. Unclassified Current Expenditures

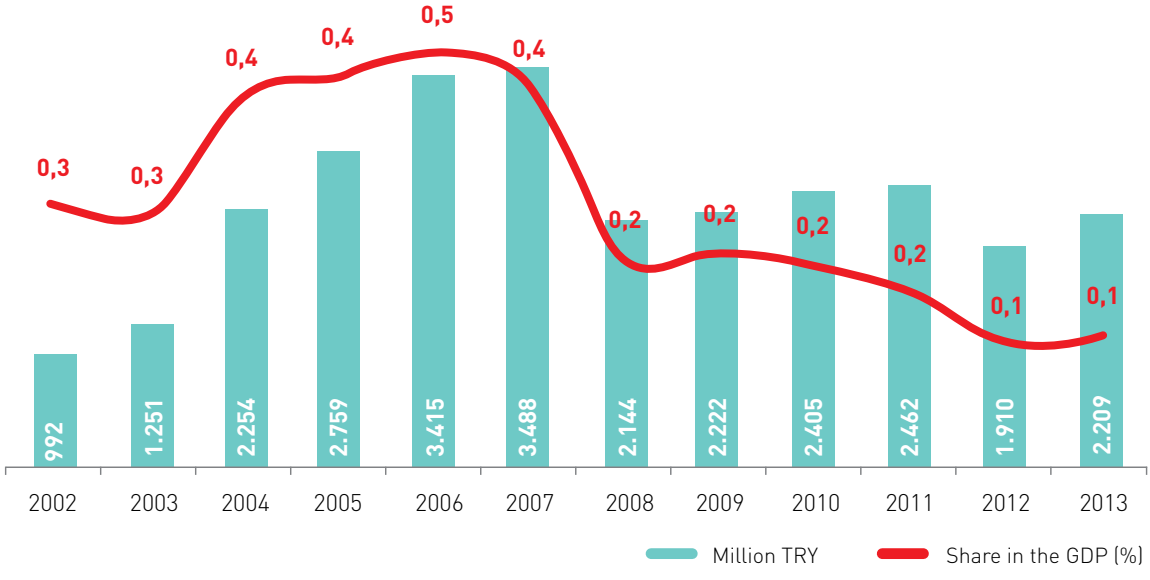
Table 86. Unclassified Current Expenditures, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	992	1.251	2.254	2.759	3.415	3.488	2.144	2.222	2.405	2.462	1.910	2.209	1,2
As of 2013 Prices, TRY	2.763	2.782	4.615	5.221	5.897	5.539	3.083	3.007	2.997	2.882	2.053	2.209	-0,2
USD	659	838	1.585	2.058	2.386	2.680	1.659	1.436	1.603	1.474	1.065	1.162	0,8
PPP USD	1.625	1.624	2.782	3.321	4.034	4.033	2.409	2.445	2.557	2.494	1.814	2.011	0,2
Share of the Health Expenditures (%)	5,3	5,2	7,5	7,8	7,7	6,9	3,7	3,8	3,9	3,6	2,6	2,6	
Share of the GDP (%)	0,3	0,3	0,4	0,4	0,5	0,4	0,2	0,2	0,2	0,2	0,1	0,1	

Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

Compared to 2002, the unclassified current health expenditures increased 120% in nominal terms and decreased 20% in real terms in 2013. While its share in health expenditures was 5,3% in 2002, it was decreased to 2,6% in 2013.

Graphic 50. Unclassified Current Expenditures and Share in the GDP, (2002-2013)



Source: Ministry of Health, TurkStat, Universities, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

Unclassified current health expenditures as a share of GDP decreased from 0,3% to 0,1%.

B. Expenditures for Health Investments

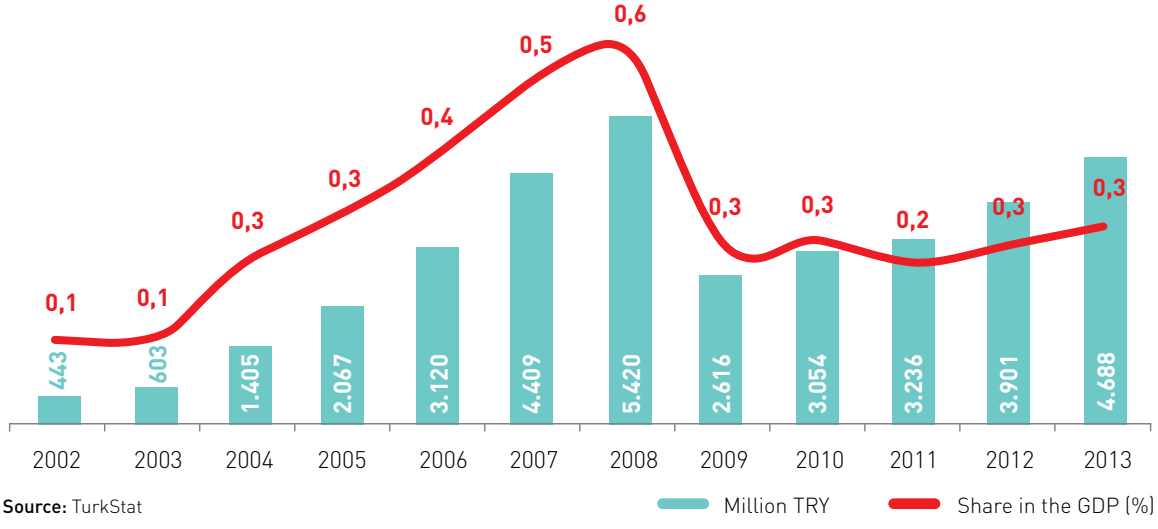
Table 87. Expenditures for Health Investments, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	443	603	1.405	2.067	3.120	4.409	5.420	2.616	3.054	3.236	3.901	4.688	9,6
As of 2013 Prices, TRY	1.234	1.341	2.876	3.912	5.388	7.000	7.792	3.540	3.806	3.788	4.193	4.688	2,8
USD	294	404	988	1.542	2.180	3.388	4.192	1.691	2.036	1.938	2.176	2.466	7,4
PPP USD	726	782	1.734	2.488	3.686	5.098	6.089	2.879	3.247	3.279	3.705	4.269	4,9
Share of the Health Expenditures (%)	2,4	2,5	4,7	5,8	7,1	8,7	9,4	4,5	5,0	4,7	5,3	5,6	
Share of the GDP (%)	0,1	0,1	0,3	0,3	0,4	0,5	0,6	0,3	0,3	0,2	0,3	0,3	

Source: TurkStat

Compared to the year 2002, expenditures for health investments increased by 960% in nominal terms and by about 280% in real terms in 2013. The share of health investments in health expenditures increased by about one-fold, it rose from 2,4% to 5,6%.

Graphic 51. Expenditures for Health Investments and Share in the GDP, (2002-2013)



Source: TurkStat

The share of health investments in the GDP, which was 0,1% in 2002, increased to 0,3% in 2013.

Table 88. Development of Expenditures for Health Investments by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	309	408	644	1.204	1.607	2.005	1.883	1.843	2.290	2.247	2.543	3.155	9,2
	%	69,8	67,6	45,8	58,2	51,5	45,5	34,7	70,4	75,0	69,4	65,2	67,3	
University Health Care Facilities	TRY	132	194	226	229	267	362	395	470	401	513	512	578	3,4
	%	29,9	32,1	16,1	11,1	8,6	8,2	7,3	18,0	13,1	15,9	13,1	12,3	
Private Sector Health Care Facilities	TRY	0	0	534	634	1.198	1.860	1.294	237	298	384	764	907	-
	%	0,0	0,0	38,0	30,7	38,4	42,2	23,9	9,1	9,8	11,9	19,6	19,3	
Other *	TRY	2	1	1	1	48	181	1.848	66	65	92	82	48	30,8
	%	0,3	0,2	0,0	0,0	1,5	4,1	34,1	2,5	2,1	2,8	2,1	1,0	
Total	**TRY**	**443**	**603**	**1.405**	**2.067**	**3.120**	**4.409**	**5.420**	**2.616**	**3.054**	**3.236**	**3.901**	**4.688**	**9,6**
	%	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	

Source: Ministry of Health, Universities, TurkStat

* Amount of the investments whose service provider cannot be determined. 904,4 million TRY of it, which was 1.848 million TRY as of 2008, is considered to be expropriation cost of the Ministry of Health.

As for the change in the expenditures for health investments by service providers to compare 2002 to 2013, it is clear that the most significant increase was in the investment expenditures occurred in private health care facilities. Private health care institutions – which didn't have any health investments in 2002- had a share of 19,3% in total health investment in 2013.

Table 89. Development of Expenditures for Health Investments by Spending Items, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Construction	TRY	233	348	697	957	1.544	2.078	2.159	1.321	1.628	1.544	1.779	2.499	9,7
	%	52,7	57,7	49,6	46,3	49,5	47,1	39,8	50,5	53,3	47,7	45,6	53,3	
Machinery-Equipment	TRY	148	184	529	659	997	1.318	897	830	835	887	1.127	1.134	6,7
	%	33,3	30,5	37,7	31,9	32,0	29,9	16,5	31,7	27,3	27,4	28,9	24,2	
Repair-Maintenance	TRY	46	54	150	407	436	700	391	285	421	546	712	786	16,2
	%	10,3	8,9	10,6	19,7	14,0	15,9	7,2	10,9	13,8	16,9	18,3	16,8	
Ambulance	TRY	6	8	11	19	34	45	57	49	51	88	95	39	5,0
	%	1,5	1,4	0,8	0,9	1,1	1,0	1,0	1,9	1,7	2,7	2,4	0,8	
Other	TRY	10	9	18	25	109	268	1.916	132	120	170	189	230	22,4
	%	2,2	1,5	1,3	1,2	3,5	6,1	35,3	5,1	3,9	5,3	4,8	4,9	
Total	**TRY**	**443**	**603**	**1.405**	**2.067**	**3.120**	**4.409**	**5.420**	**2.616**	**3.054**	**3.236**	**3.901**	**4.688**	**9,6**

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

When the expenditures for health investments by spending items are analyzed, comparing 2002 to 2013, it can be seen that the share of maintenance-repair increased and machinery-equipment's share increased in 2013.

B.1. Expenditures for Health Care Facilities

Table 90. Expenditures for Construction of Health Care Facilities, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	233	348	697	957	1.544	2.078	2.159	1.321	1.628	1.544	1.779	2.499	9,7
As of 2013 Prices, TRY	650	773	1.428	1.812	2.666	3.299	3.104	1.787	2.028	1.808	1.912	2.499	2,8
USD	155	233	490	714	1.079	1.597	1.670	854	1.085	925	993	1.314	7,5
PPP USD	382	451	861	1.152	1.824	2.402	2.426	1.453	1.730	1.565	1.690	2.276	5,0
Share of the Health Expenditures (%)	1,2	1,4	2,3	2,7	3,5	4,1	3,7	2,3	2,6	2,3	2,4	3,0	
Share of the GDP (%)	0,07	0,08	0,12	0,15	0,20	0,25	0,23	0,14	0,15	0,12	0,13	0,16	

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

When compared to 2002, construction investments in 2013 increased by 971% in nominal and 284% in real terms. Its share in 2002, which was 1,2%, increased to 3% in 2013.

Table 91. Development of Expenditures for Construction of Health Care Facilities by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	166	249	315	541	788	941	1.114	900	1.196	1.020	1.116	1.679	9,1
	%	71,1	71,6	45,2	56,5	51,0	45,3	51,6	68,2	73,5	66,1	62,7	67,2	
University Health Care Facilities	TRY	67	99	115	120	148	213	251	296	271	330	299	328	3,9
	%	28,9	28,4	16,5	12,5	9,6	10,3	11,6	22,4	16,6	21,4	16,8	13,1	
Private Health Care Facilities	TRY	0	0	267	296	608	923	794	125	160	194	365	492	-
	%	0,0	0,0	38,3	30,9	39,4	44,4	36,8	9,5	9,9	12,6	20,5	19,7	
Total	**TRY**	**233**	**348**	**697**	**957**	**1.544**	**2.078**	**2.159**	**1.321**	**1.628**	**1.544**	**1.779**	**2.499**	**9,7**

Source: Ministry of Health, Universities, TurkStat, Consolidated Financial Charts and Independent Audit Report of Acibadem Healthcare Group

When the change in construction investments by service providers between 2002- 2013 is analyzed, it is seen that private health care institutions have had a noticeable increase.

During this period, all the health investments were revised thoroughly; a detailed health inventory was created and scheduled by the Ministry of Health. These investments were evaluated in terms of fire and earthquake risk and functionality. These investment planning and priority of investment procedures were carried out at the level of districts, provinces and regions by on-site examinations together with the local administrators. Projects were re-arranged in accordance with the priority and importance level so as to utilize a more rational use of investment budgets. In February 2003, the ward system at hospitals was abandoned and "qualified room system" was set up, these rooms have an inbuilt toilet, bathroom, TV and refrigerator for maximum two people.

Construction of Health Care Facilities by the Ministry of Health via TOKI (Housing Development Administration of Turkey);

One of the crucial steps taken in the construction of health facilities is the protocol signed between the Ministry of Health and TOKI. The purpose of this protocol is to generate additional resources for the health facilities needed by the MoH without using the capital budget and to transfer the MoH-owned lands to TOKI in return for the construction of these facilities. TOKI has tried to meet the construction costs, making the use of the lands it has taken over. Ministry of Finance has become the other party authorized in handing over the lands owned by MoH.

Construction of health care facilities by the Ministry of Health via TOKI dates back to a protocol signed in 2006. It was envisaged that construction costs of health care facilities by the Ministry of Health via TOKI would be met only by transferring the MoH-owned lands to TOKI. In the scope of protocol, projecting the construction of hospitals by TOKI in exchange for the land, hospitals were built and handed over to Ministry of Health. The cost of these hospitals' construction was met by signing over the public land owned by the MoH to TOKI.

Protocol signed with Prime Ministry Housing Development Administration of Turkey (TOKI) enabled building health facilities just in exchange for MoH-owned property. This protocol did not allow the Ministry of Health to allocate funds to TOKI from the MoH budget. Though it was envisaged in the protocol that in case construction costs were not met via land costs, they could be appropriated in cash, it was impossible in terms of financial legislation. However, Ministry of Health was planning to have its construction works completed both by paying from the capital budget and by transferring its lands to TOKI. For this purpose, with the Regulation in 2007 on Statutory Decree on Organization and Duties of the Ministry of Health No. 181, it was agreed that the construction cost of the health facilities built by TOKI would be met by the appropriations allocated to the relevant budget parts to pay this cost or it could be met by revolving fund incomes through the transfer of the property or in cash form in compliance with the forms to be determined in future protocols and an additional protocol was signed with TOKI accordingly.

Also, with the same Regulation, Department of Construction and Maintenance was set up for the construction and maintenance works in the MoH and Department of Public-Private Partnership was opened in order to conduct projects to be done via public-private partnerships and these two were departmentalized away from the Presidency of Strategy Development.

Statutory Decree on Organization and Duties of Ministry of Health No. 181, which sought the construction of health care facilities via TOKI, was amended as Article 48 of the Statutory Decree on Organization and Duties of Ministry of Health and Affiliated Institutions No. 663 in November 2011. In the Statutory Decree No. 663, Ministry of Health and The Affiliated Institutions are held authorized to have the health facilities built by TOKI in line with the protocol rules to be set further.

A new protocol was signed between TOKI and Ministry of Health on 19.02.2008 subsequent to the legal regulation which authorized MoH to make payments from the capital budget as well as to transfer its own lands to TOKI in return for the health care facilities. This protocol revoked additional protocols signed in 2006 and before that. In this protocol, it was agreed that the construction cost of the health facilities built would be met by the appropriations allocated to the relevant budget parts to pay this cost or by revolving fund incomes and advance payments could be made so as to appropriate later in time and subsequent to the in-kind and in-cash appropriations, remaining debt shall be paid to TOKI in five (5) years.

Due to the increase in the extent of the business and new demands, the 2008-protocol was repealed by the protocol dated 24.11.2009. This new protocol changed the terms of payment as "the thirty percent (30%) of the TOKI-construction costs shall be met by the appropriation of the transferred immovables, the remaining debt shall be pain in seven (7) years with the effect from the date of the renewed protocol". On 25th of November, 2010, an additional protocol to the aforesaid protocol was signed stating that the plans and procedures for the expropriation of the immovables in the site lodged which were put out to tender by TOKI should be conducted by TOKI and corresponding payments should be met by the Ministry of Health.

Due to the new demands emerged through the time, the protocol was changed once again in 2013 by having sumbitted a payment plan to TOKI for its operations completed and to be completed. In addition to this, it was ensured that tender process of listed hospitals would be completed in 2013 and they might be purchased from TOKI as for the public housing purposes, if needed, moreover, their cost could be met by the transfer of the immovables, mentioned before.

At first, in protocols allowing payments from MoH's budget for TOKI, it was envisaged that payments to be made to TOKI would be advance payments. However, any provision regarding liquidation of these advance payments is not concluded in Regulation on Expenditure Documents of Central Government hence due to the hesitations caused by this situation, advance payments for TOKI was paid off for a long time including the year 2008. Doubts resulting from this issue were resolved after the provision regarding liquidation of advance payments was added in Regulation on Expenditure Documents of Central Government at the end of 2013 so advance payments have been paid off. Thus, the issue of counting advance payments as budget expenditure is left to 2013. Taken into account by Health Expenditure Monitoring and Evaluation Commission and TurkStat, this issue was reflected in the health expenditures. That is, advance payments made to TOKI by the MoH are included in health expenditures study of TurkStat and in its investment items, as well.

Table 92. Payments to TOKI by the Ministry of Health, (2008-2013)

Years	General Budget Advance Payments	Revolving Fund Advance Payments	Total	As Budget Cost
2008		63.000.000	63.000.000	
2009	225.615.000		225.615.000	
2010	586.098.975		586.098.975	
2011	273.606.763		273.606.763	
2012	696.239.095		696.239.095	
2013	1.179.408.102	75.000.000	1.254.408.102	2.531.606.473
TOTAL	**2.960.967.935**	**138.000.000**	**3.098.967.935**	**2.531.606.473**

Source: Ministry of Health

Table 93. Completed Health Care Facilities Constructed by TOKI for the MoH, (2008-2013)

Years	Number of Hospitals	Bed Capacity	Indoor Space m^2	Project Cost (TRY)
2008	1	400	82.000	72.622.723
2009	5	421	65.285	66.075.123
2010	11	2.936	488.859	457.521.228
2011	14	2.996	493.589	509.881.610
2012	17	2.586	480.928	534.402.484
2013	24	3.565	575.824	634.025.740
TOTAL	**72**	**12.904**	**2.186.485**	**2.274.528.908**

Source: Ministry of Health

In the period 2008-2013, 72 hospital projects with a bed capacity of 12.904 contracted out to TOKI by the MoH came into health care delivery service. As of the end of 2013, 191 hospital projects with a bed capacity of 18.652 and a cost of 3.630.599.868 TRY have been carried out by TOKI. In addition to this, preparations for putting out 48 hospital projects with a bed capacity of 7.227 and a cost of 1.627.315.683 TRY to tenders were started by TOKI. Additionally, the MoH is planning to offer TOKI to carry out the construction of 45 hospitals with a bed capacity of 7.450 and a project cost of 1.764.011.905 TRY.

Building Health Care Facilities by Public Private Partnership;

Another method used in this period in order to carry out health investments is Public-Private Partnership.

Enforced in 2005, the legal regulation on building health care facilities by public-private partnership has the following underlying reasons: immovables earmarked by the Treasury are allocated to persons specified in the tender for the purpose of building health care facilities, contractors build the health facilities on these immovables according to the specifications set by the Ministry of Health, they lease these health care facilities to the Ministry of Health for a period set in their contracts and transfer the ownership of the immovable property to the Ministry of Health without charge at the end of this period.

Public-Private Partnership model is a method consisted of the following steps:

- Immovable earmarked by the Treasury are allocated to persons specified in the tender for the purpose of building health care facilities,

- Contractors build the health facilities on these immovable according to the specifications set by the Ministry of Health, and if stated in their contracts, they provide tangible goods and render the services.

- Completed health facilities are handed over to the Ministry of Health and leasing price determined in the contract within the prescribed time to the contractors by the MoH. Contract can produce an income by running commercial activities in the places other than the spaces specified in the contract and places where health care services are provided. It is, also, possible to allow the contractors to run the service procurement.

- All the maintenance and renovations specified in the contract are done by the contractor.

- The ownership of the immovable property is transferred to the Ministry of Health at the end of the period, specified in the contract.

The most significant feature of this method is to have the public land, on which health facilities cannot be completed due to lack of public financing entirely, built with non-public sources by assigning it to the contractor. In other words, any public source is not used from the capital budget for the period until the investment is made and the facilities are taken over for the public use, so needed health facilities are built just by paying their lease price.

Even though the leasing period is set as 49 years, it is generally 25 years in practice.

In 2005, Public-Private Partnership has acquired a legal infrastructure with an amending article to Health Services Fundamental Law No. 3359 under the scope of construction of health care facilities. Later in 2006, with decision issued by the cabinet the "The Regulation on the Construction of Health Facilities in return for Lease and the Renovation of Health Facilities in return for Management of Non-Medical Services and Areas" was prepared.

In 2007, with the Law No. 5683, Department of Public-Private Partnership was set up to conduct project implementations and procedures via this method in the name of Ministry of Health. The said department was integrated with the Department of Construction and Maintenance and was renamed as General Directorate of Health Investments with the Law on the Organization of the Ministry of Health, in 2011.

In order to speed up the procedures via Public-Private Partnership, the "Law on the Construction and Renovation of Facilities and the Procurement of Services via Public-Private Partnerships by the Ministry of Health and the Amendment of Laws and Statutory Decree Laws" was adopted in 2013.

By the end of 2013, 17 project contracts via public-private partnership method were signed by the Ministry of Health. Apart from these projects, feasibility studies of 41 projects continue. By the time the investments planned through public-private method are realized, 50.000 new beds will have been put into service.

During this period, remarkable progress has been recorded. For example, in 2003-2013 period, closed area of the health care facilities only built by Ministry of Health reached up to 7 million m2. In the last eleven years, we have built and commissioned 2.243 health facilities in total, 650 of which are the hospitals and 1.593 of which are primary health care institutions, to public. We have completed constructions waiting for a rebound for years and 40 thousand qualified patient beds have been put into service.

The share of both constructed health care facilities and the number of the qualified patient bed in total beds increased from 6% to 37% during this period. This was a period in which private health care facilities had a significant share in health care system and crucial health investments were made.

B.2. Expenditures for Health Care Hardware

Table 94. Expenditures on Machinery and Equipment, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	148	184	529	659	997	1.318	897	830	835	887	1.127	1.134	6,7
As of 2013 Prices, TRY	411	409	1.083	1.248	1.722	2.093	1.289	1.123	1.040	1.038	1.211	1.134	1,8
USD	98	123	372	492	697	1.013	694	536	556	531	628	596	5,1
PPP USD	242	239	653	794	1.178	1.524	1.008	913	888	899	1.070	1.032	3,3
Share of the Health Expenditures (%)	0,8	0,8	1,8	1,9	2,3	2,6	1,6	1,4	1,4	1,3	1,5	1,3	
Share of the GDP (%)	0,04	0,04	0,09	0,10	0,13	0,16	0,09	0,09	0,08	0,07	0,08	0,07	

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

Compared to 2002, machinery-equipment investments increased by about 670% nominally and 180% in real terms in 2013. The share of machinery-equipment investments in health expenditures was increased from 0,8% to 1,3% in 2013.

Table 95. Development of Expenditures on Machinery and Equipment by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	101	115	246	377	525	632	468	631	666	662	748	750	6,5
	%	68,1	62,5	46,5	57,2	52,6	48,0	52,1	76,1	79,8	74,6	66,4	66,1	
University Health Care Facilities	TRY	47	69	80	78	80	100	99	120	84	113	148	161	2,4
	%	31,9	37,5	15,2	11,9	8,0	7,6	11,1	14,4	10,1	12,8	13,1	14,2	
Private Health Care Facilities	TRY	0	0	203	204	393	586	330	78	85	111	231	223	-
	%	0,0	0,0	38,3	30,9	39,4	44,4	36,8	9,5	10,1	12,6	20,5	19,7	
Total	**TRY**	**148**	**184**	**529**	**659**	**997**	**1.318**	**897**	**830**	**835**	**887**	**1.127**	**1.134**	**6,7**

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

When the change in machinery-equipment investments by service providers between 2002-2013 is analyzed, it is observed that while there wasn't any expenditures by private health care institutions for the year 2002, expenditure valued 223 million TRY was realized by them in 2013. Expenditures for machinery-equipment investments increased by 6,5 folds in the Ministry of Health and 2,4 folds in the university health care facilities.

B.3. Expenditures for Repair and Maintenance

Table 96. Expenditures for Repair and Maintenance, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	46	54	150	407	436	700	391	285	421	546	712	786	16,2
As of 2013 Prices, TRY	127	120	306	770	754	1.111	563	385	525	640	765	786	5,2
USD	30	36	105	303	305	538	303	184	281	327	397	414	12,6
PPP USD	75	70	185	490	516	809	440	313	448	554	676	716	8,6
Share of the Health Expenditures (%)	0,2	0,2	0,5	1,2	1,0	1,4	0,7	0,5	0,7	0,8	1,0	0,9	
Share of the GDP (%)	0,01	0,01	0,03	0,06	0,06	0,08	0,04	0,03	0,04	0,04	0,05	0,05	

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

Repair and maintenance expenditures increased by about 16-fold in nominal terms and 5,2-fold in real terms in 2013 as compared to 2002. The share of repair and maintenance expenditures in 2002 increased from 0,2% to 0,9% in 2013.

Table 97. Development of Expenditures for Repair by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	31	32	66	256	231	350	211	206	336	411	514	559	17,3
	%	66,9	58,8	44,4	63,0	53,0	50,0	53,9	72,5	79,8	75,3	72,1	71,0	
University Health Care Facilities	TRY	15	22	26	25	33	39	37	51	42	66	53	73	3,8
	%	33,1	41,2	17,3	6,1	7,6	5,6	9,3	18,1	10,1	12,1	7,4	9,3	
Private Health Care Facilities	TRY	0	0	57	126	172	311	144	27	43	69	146	155	-
	%	0,0	0,0	38,3	30,9	39,4	44,4	36,8	9,5	10,1	12,6	20,5	19,7	
Total	**TRY**	**46**	**54**	**150**	**407**	**436**	**700**	**391**	**285**	**421**	**546**	**712**	**786**	**16,2**

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

When the repair expenditures by service providers between 2002- 2013 is analyzed, it is seen that while there wasn't any expenditures by private health care institutions for the year 2002, expenditure valued 155 million TRY was realized by them in 2013. The increase in repair expenditures was 17,3-fold in MoH health care facilities and 3,8 in university health care facilities.

B.4. Expenditures for Ambulance Procurement

Table 98. Expenditures for Ambulance Procurement, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	6	8	11	19	34	45	57	49	51	88	95	39	5,0
As of 2013 Prices, TRY	18	19	22	35	59	72	82	66	63	103	102	39	1,2
USD	4	6	7	14	24	35	44	31	34	53	53	20	3,8
PPP USD	11	11	13	23	40	52	64	53	54	89	90	35	2,3
Share of the Health Expenditures (%)	0,0	0,0	0,0	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,1	0,0	
Share of the GDP (%)	0,04	0,04	0,09	0,10	0,13	0,16	0,09	0,09	0,08	0,07	0,08	0,07	

Source: Ministry of Health

Expenditures for ambulance procurement increased by about 5 folds in nominal terms and over 1,2 folds in real terms in 2013 as compared to 2002.

Table 99. Expenditures for Ambulance Procurement by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Ministry of Health	TRY	6	8	10	17	30	42	53	43	46	86	89	37	4,7
	%	100,0	100,0	95,8	93,2	89,5	92,9	93,4	88,1	90,0	97,5	94,4	95,0	
University Health Care Facilities	TRY	0,0	0,0	0,1	0,1	0,3	0,0	0,1	0,2	0,4	0,4	0,0	0,6	-
	%	0,0	0,0	1,4	0,4	0,8	0,0	0,2	0,5	0,7	0,4	0,0	1,5	
Private Health Care Facilities	TRY	0	0	0	1	3	3	4	6	5	2	5	1	-
	%	0,0	0,0	2,8	6,4	9,7	7,1	6,4	11,4	9,3	2,0	5,6	3,5	
Total	**TRY**	**6**	**8**	**11**	**19**	**34**	**45**	**57**	**49**	**51**	**88**	**95**	**39**	**5,0**

Source: Ministry of Health

When the expenditure for ambulance procurement by its service providers is analyzed, it is seen that an increase of 4,7-fold was realized in the Ministry of Health in 2013 when compared to 2002. 95% of the ambulance procurement for the 112 emergency care services in 2013 is owned by the Ministry of Health. Since 2007, MoH has provided sea ambulance services, and air ambulance services since 2008. As these services have been provided through service procurement method, the expenditures made in this scope are included in current health expenditures.

B.5. Other Expenditures for Health Investments

Table 100. Other Expenditures for Health Investments, (2002-2013), (million TRY/USD)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
TRY	10	10	18	25	109	268	1.916	132	120	170	189	230	22,4
As of 2013 Prices, TRY	27	21	38	47	187	425	2.754	179	149	199	203	230	7,4
USD	7	6	13	19	76	206	1.482	86	80	102	105	121	17,6
PPP USD	16	12	23	30	128	310	2.153	146	127	173	179	209	12,0
Share of the Health Expenditures (%)	0,1	0,0	0,1	0,1	0,2	0,5	3,3	0,2	0,2	0,2	0,3	0,3	
Share of the GDP (%)	0,01	0,01	0,03	0,06	0,06	0,08	0,04	0,03	0,04	0,04	0,05	0,05	

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

Expenditures for other health investments increased by about 22,4 folds in nominal terms and over 7,4 folds in real terms in 2013 as compared to 2002. The share of expenditures for other health investments was 0,3% in 2013.

Table 101. Development of Other Investment Expenditures by Service Providers, (2002-2013), (million TRY)

		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
MoH	TRY	5	4	6	12	32	40	38	62	46	67	76	131	23,0
	%	55,6	42,8	35,0	48,2	29,6	15,0	2,0	47,0	38,3	39,6	40,4	56,8	
University Health Care Facilities	TRY	3	4	5	5	7	10	8	3	3	3	13	16	4,7
	%	28,9	43,6	25,5	21,9	6,1	3,6	0,4	2,3	2,2	1,7	6,9	7,0	
Private Sector Health Care Facilities	TRY	0,0	0,0	7	7	22	37	23	1	6	8	18	35	-
	%	0,0	0,0	36,5	26,8	20,3	13,7	1,2	1,0	4,9	4,9	9,4	15,2	
Other	TRY	2	1	1	1	48	181	1.848	66	65	92	82	48	30,8
	%	0,2	0,1	0,0	0,0	0,4	0,7	1,0	0,5	0,5	0,5	0,4	0,2	
Total	**TRY**	**10**	**10**	**18**	**25**	**109**	**268**	**1.916**	**132**	**120**	**170**	**189**	**230**	**22,4**

Source: Ministry of Health, Ministry of Finance, Universities, TurkStat

When we examine the other investment expenditures by service providers, comparing to the year 2002, we can see that in 2013, an expenditure of 35 TRY million was realized by private sector health care facilities whereas any expenditure was not realized by them in 2002.

Chapter Eight

Analysis Of Health Expenditures (2002-2013)

Analysis of Health Expenditures (2002-2013)

Health expenditures as a share of GDP are regarded as one of the crucial indicators for measuring sustatinability of health expenditures.

A. Comparison of Health Expenditures and the GDP

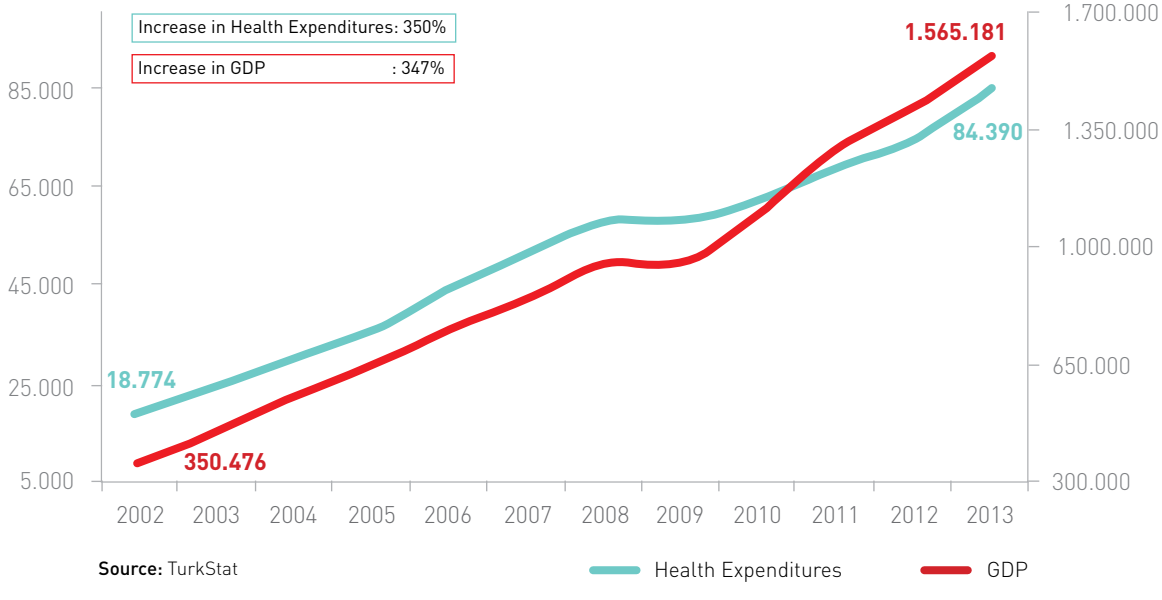
Table 102. Health Expenditures and Share in GDP in GDP, (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Health Expenditures	18.774	24.279	30.021	35.359	44.069	50.904	57.740	57.911	61.678	68.607	74.189	84.390	3,5
GDP	350.476	454.781	559.033	648.932	758.391	843.178	950.534	952.559	1.098.799	1.297.713	1.416.798	1.565.181	3,5
Health Expenditures as a Share of GDP (%)	5,4	5,3	5,4	5,4	5,8	6,0	6,1	6,1	5,6	5,3	5,2	5,4	

Source: TurkStat

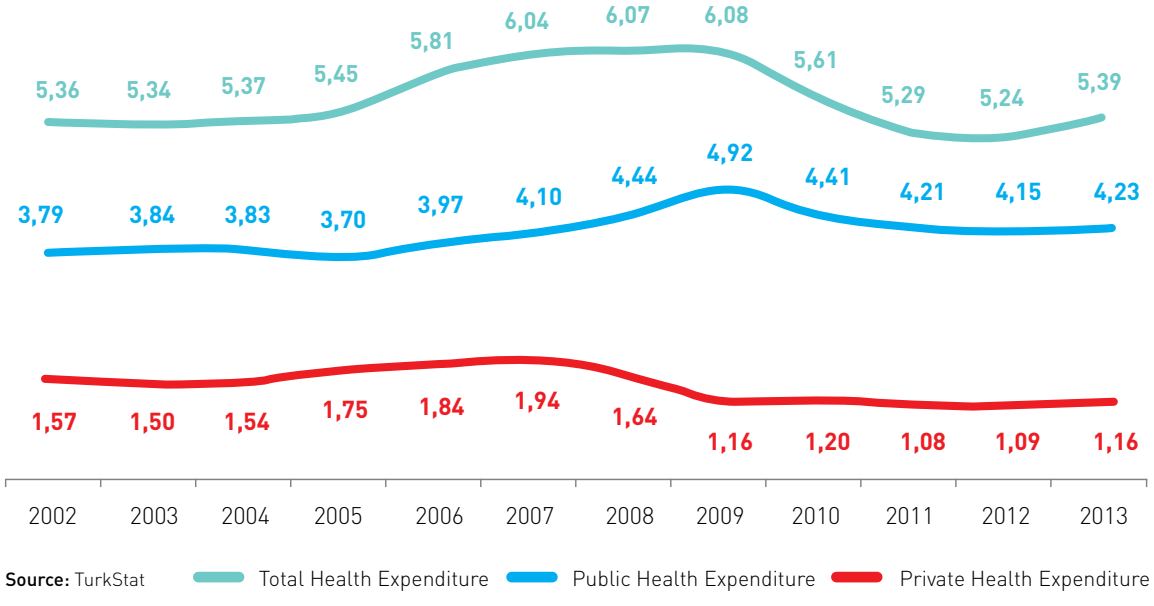
During 2002-2013 period in which Health Transformation Program in Turkey was implemented, the increase in the GDP realized in line with the increase in health expenditures. During this period, the increase in GDP expenditure was 347% and the increase in health expenditures was 350%.

Graphic 52. Comparison of Increase in Health Expenditures and in GDP, (2002-2013), (million TRY)



Source: TurkStat

Graphic 53. Health Expenditures as a Share of GDP (2002-2013), (%)



Source: TurkStat

B. Comparison of Non-Interest Public Expenditures and Public Health Expenditures

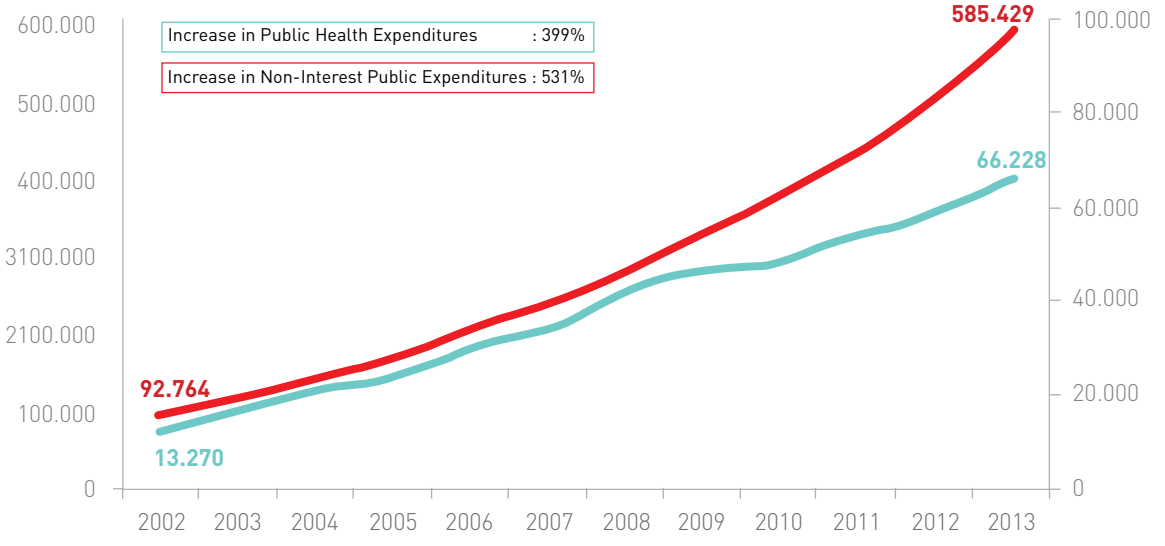
Table 103. Non-Interest Public Expenditures and Public Health Expenditures, (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Public Health Expenditures	13.270	17.462	21.389	23.987	30.116	34.530	42.159	46.890	48.482	54.580	58.785	66.228	4,0
Non-Interest Public Expenditures	92.764	118.963	140.953	167.536	206.875	235.683	277.195	327.381	373.009	433.459	500.443	585.429	5,3
Public Health Expenditures as of 2013 Prices	36.959	38.824	43.790	45.395	52.004	54.825	60.608	63.443	60.421	63.886	63.190	66.228	0,8
Non-Interest Public Expenditures as of 2013 Prices	258.369	264.492	288.571	317.060	357.226	374.205	398.496	442.954	464.868	507.368	537.941	585.429	1,3
Public Health Expenditures as a Share of Non-Interest Public Expenditures %	14	15	15	14	15	15	15	14	13	13	12	11	

Source: Ministry of Development, TurkStat

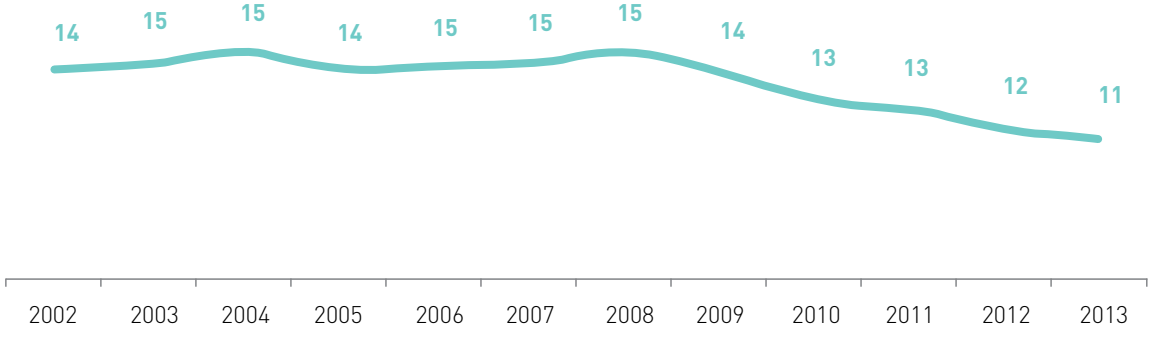
During 2002-2013 period in which Health Transformation Program in Turkey was implemented, the increase in the non-interest public expenditures was bigger than the increase in public health expenditures. During this period, the increase in non-interest public expenditures was 531% and it was 399% in public health expenditures.

Graphic 54. Comparison of Non-Interest Public Expenditures and Public Health Expenditures, (2002-2013), (million TRY)



Source: Ministry of Development, TurkStat

Graphic 55. Public Health Expenditures as a Share of Non-Interest Public Expenditures, (2002-2013), (%)



Source: Ministry of Development, TurkStat

While public health expenditures as a share of non-interest public expenditures were 14% in 2002, this figure decreased to 11% in 2013.

C. Comparison of Tax Revenues and Public Health Expenditures

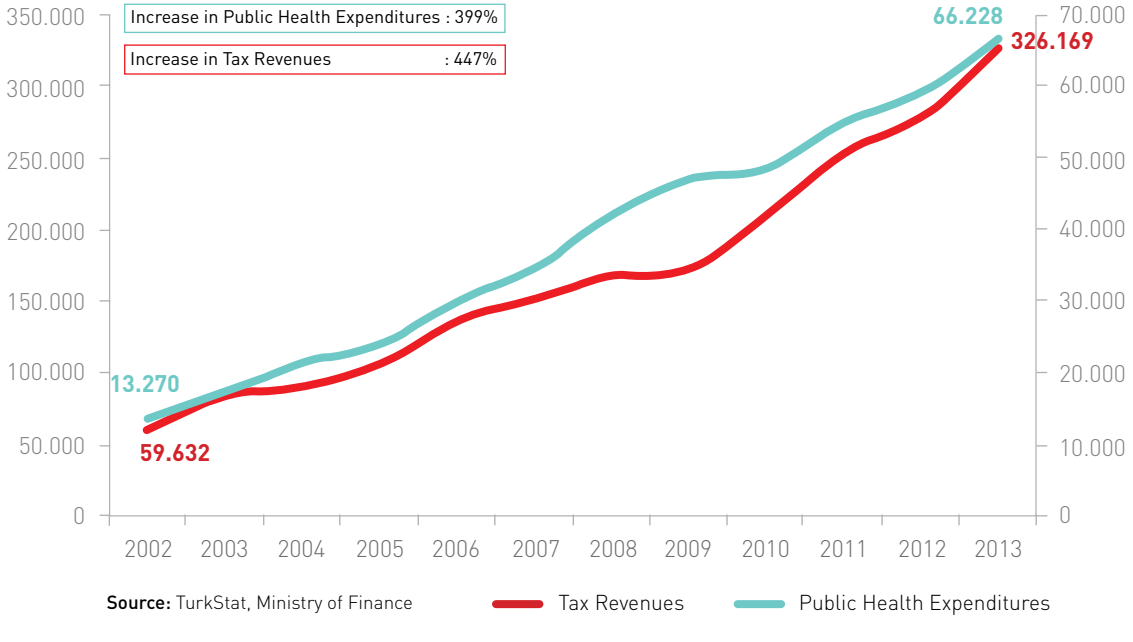
Table 104. Tax Revenues and Public Health Expenditures, (2002-2013), (million TRY)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Increase in 2002-2013 (Folds)
Public Health Expenditures	13.270	17.462	21.389	23.987	30.116	34.530	42.159	46.890	48.482	54.580	58.785	66.228	4,0
Tax Revenues	59.632	84.316	90.077	106.929	137.480	152.835	168.109	172.440	210.560	253.809	278.781	326.169	4,5
Public Health Expenditures as of 2013 Prices	36.959	38.824	43.790	45.395	52.004	54.825	60.608	63.443	60.421	63.886	63.190	66.228	0,8
Tax Revenues as of 2013 Prices	166.088	187.461	184.413	202.363	237.397	242.663	241.674	233.316	262.414	297.086	299.670	326.169	1,0
Public Health Expenditures as a Share of Tax Revenues (%)	22	21	24	22	22	23	25	27	23	22	21	20	

Source: TurkStat, Ministry of Finance

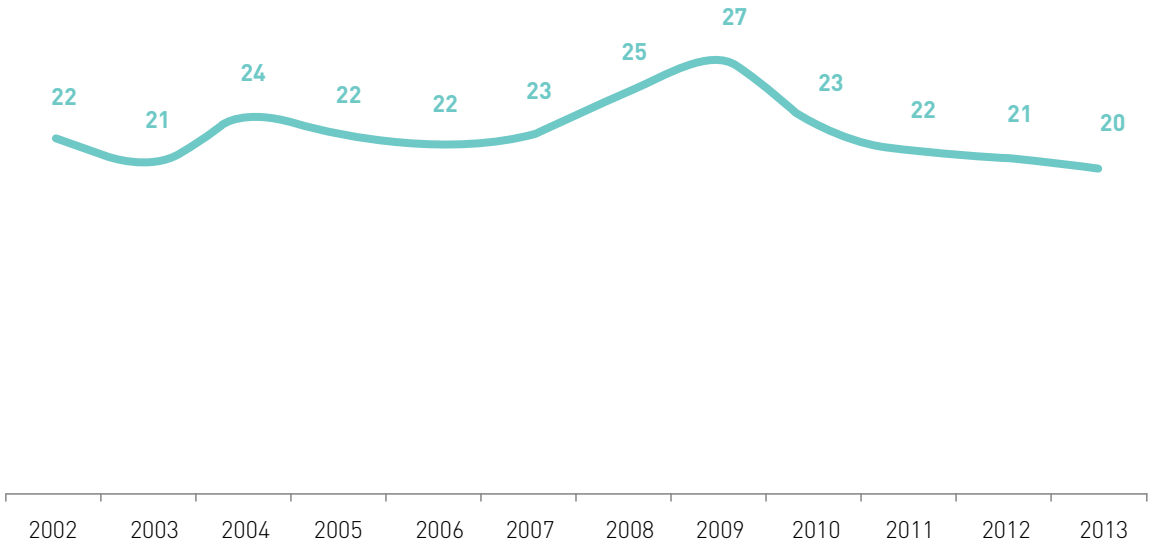
The increase in tax revenues was realized in line with the increase in public health expenditures. During this period, while the increase in tax revenues was 447%, it was 399% for health expenditures. Considering developments in health care in 2002-2013 period, this is a positive situation in terms of financial sustainability.

Graphic 56. Comparison of Tax Revenues and Public Health Expenditures, (2002-2013), (million TRY)



Source: TurkStat, Ministry of Finance

Graphic 57. Public Health Expenditures as a Share of Tax Revenues, (2002-2013), (%)



Source: TurkStat, Ministry of Finance

D. Cumulative Total of Health Expenditures for 2003-2013 Period

Table 105. Cumulative Total of Health Expenditures (2003-2013), (million TRY/USD)

	Nominal	As of 2013 Prices	USD	PPP USD	%	Share in the GDP (%)
Public Health Expenditure	444.608	612.613	287.740	475.392	75,5	4,2
Private Health Care Expenditure	144.539	209.336	95.962	157.649	24,5	1,4
Total	**589.146**	**821.949**	**383.702**	**633.041**	**100,0**	**5,6**

Source: TurkStat

Pertaining to the GDP produced in 11-year period in Turkey between 2003 and 2013, 5,6% of GDP was used in financing health expenditures, 4,2% of it was for public health expenditures and 1,4% of it was for private health care expenditures. For health care services in this eleven-year period- through which Health Transformation Program was implemented- resource fund amounting to 821.9 million TRY was spent from the fund, as of 2013 prices.

Table 106. Total Health Expenditures by Service Providers (2003-2013), (million TRY/USD)

	Nominal	As of 2013 Prices	USD	PPP USD	%	Share in the GDP(%)
MoH Health Care Facilities	220.291	297.958	141.174	233.479	37,4	2,1
University Health Care Facilities	51.522	71.067	33.385	55.125	8,7	0,5
Private Health Care Facilities	108.899	151.741	71.194	116.954	18,5	1,0
Private Pharmacies	170.254	243.256	112.005	184.980	28,9	1,6
Other Health Expenditures	38.181	57.927	25.945	42.504	6,5	0,4
Total	**589.146**	**821.949**	**383.702**	**633.041**	**100,0**	**5,6**

Source: Ministry of Health, Ministry of Development, TurkStat, SSI

However, when we look at the assessment of service providers during the Health Transformation Program in Turkey 2003-2013, it is seen that pertaining to the GDP produced in 11-year period in Turkey, 2,1% of the GDP was spent for health care facilities under MoH, 1,6% for private pharmacies for retail medicine supply, 1% for private health care institutions, 0,5% for university health care facilities and 0,4% for other health care expenditures.

E. Cumulative Total of Health Investments for 2003-2013 Period

Table 107. Total Health Expenditures by Service Providers (2003-2013), (million TRY/USD)

	Nominal	As of 2013 Prices	USD	PPP USD	%	Share in the Total Healh Expenditure (%)
MoH Health Care Facilities	19.829	27.036	12.885	21.134	57,4	3,4
University Health Care Facilities	4.147	5.796	2.698	4.460	12,0	0,7
Other	2.433	3.447	1.816	2.702	7,0	0,4
Public Health Care Facilities	26.409	32.831	15.583	25.594	76,5	4,5
Private Health Care Facilities	8.111	12.046	5.601	8.961	23,5	1,4
Total	**34.519**	**48.324**	**23.000**	**37.257**	**100,0**	**5,9**

Source: Ministry of Health, Ministry of Development, TurkStat

5,9% of total health expenditure made during the Health Transformation Program in Turkey, 2003-2013 was for health investments. 57,4% of these investment expenditures was spent by the MoH, 12% for the investments made by university health care facilities, 7% was for other public health investments and around 23,5% was for the investments made by private health care facilities. For health investments made in this 11-year period, resource funds amounting to 48,3 million TRY were spent from the fund as of 2013 prices.

Chapter Nine

Assessment and Conclusion

Assessment and Conclusion

Thanks to the Health Transformation Program (HTP), which was implemented in Turkey from 2002 to 2013, the Turkish health care system went through an impressive reforming process in a number of aspects varying from health system financing and approach towards health service delivery to public expectations, staff attitudes, resource allocation and financial sustainability. The HTP achieved a true significant transformation in Turkey and the achievements of the HTP are presented in the following outline of topics and subtopics.

A. Developments Empowering Managerial Capacity for Health Care

- The MoH incentivized full-time medical practice in public sector via the "Performance-based Supplementary Payment System".
- "Managerial Performance" was introduced for the managers in the MoH hospitals.
- The MoH launched the "Health-Net" application.
- Nationwide distribution of the health care personnel was balanced by compulsory medical service.
- Medical staffing and appointment processes and procedures became transparent and equitable.
- The MoH delegated its authority to the provincial organization units in many fields.
- The MoH provided online health management courses.
- "Ministry of Health Call Center (SABIM)" was established to open up a communication channel with people.
- Policies were designed and implemented for preventing workplace violence for health care.
- The MoH was re-structured by the Decree Law No. 663.
- In scope of the Decree Law No. 663, domestic industry was incentivized for high-technology investments and technology transfers and offsets, free health zones and international health service units were facilitated.

B. Developments in Health Service Delivery

Developments in health service delivery in Turkey could be assessed in terms of 5 fundamental functions related to health care services.

B.1 Developments in Public Health Care and Family Medicine Services

- Fund allocation was expanded for public health care services.
- Public health care services were empowered by transition to the "Family Medicine System".
- Free-of-charge ambulatory health care services were extended to all rural areas across the country.
- Cancer screening and training centers (KETEMs), which offer free-of-charge services, were established in all provinces.
- The most clinically advanced vaccines in the world were included in the national immunization program.
- Public health care services were provided completely free of charge.
- New regulations were made for consumption of tobacco and tobacco products. "Smoke-Free Air Zone" settings were created.
- Modern screening programs were designed and implemented for child health care, accompanied by the "Guest Mother Project" and "Conditional Cash Transfer".
- "Community-based Mental Health Care" model was adopted in order to provide follow-up and curative services for people diagnosed with severe mental disorders.
- Comprehensive programs were designed and implemented in order to prevent ill health and premature deaths due to chronic conditions.
- Programs were introduced in order to promote healthy eating and active living behaviors in addition to creating urban environments that integrate physical activity into everyday routines.
- Programs for multi-sectoral health responsibility were introduced.
- Maternal and child health care services became widespread and strengthened.
- "Home Care Services" were launched.

B.2 Developments in 112 Emergency Care Services

- 112 emergency care services were provided without charge.
- 112 emergency care network was equipped with land, air and marine ambulances, and service access and utilization was facilitated in every corner of the country.
- Europe's largest National Medical Rescue Team (UMKE) was established.

B.3 Developments in Hospital Services

- Mechanisms were introduced so that the system of patients being held in hospitals as pawns due to non-payment of fees was abrogated.
- It was ruled that an examination room was to be allocated for each physician in the MoH-affiliated hospitals and patients were granted the right to choose physician.
- Patient room design shifted from ward to quality accommodation offering built-in bathroom, television and refrigerator at hospitals.
- High-technology medical devices used in contemporary medicine were put into service for the Turkish people concurrently with developed countries.
- Hospital capacities were increased for intensive care, burn and newborn treatment services.
- Public hospitals were merged under one roof.
- Hospitals provided charge-free medicinal and medical products for inpatients.
- Service access and utilization was facilitated for safe blood and blood products.
- Emergency and intensive care units provided charge-free services in all public and private health care facilities.
- Private hospitals were prohibited from charging patients co-payment for burn treatment, cancer treatment, neonatal care, organ transplants, treatment of congenital anomalies, dialysis services and cardiovascular surgeries.
- "National Organ Transplantation Waiting System" was developed.
- "Patient Rights Units" were established for patient claims in all MoH hospitals.
- Efficiency was improved in all health care facilities through service procurement method.
- National screening campaigns became widespread for newborns.
- "Law on Full-Time Medical Practice for University and Ministry of Health Personnel" was adopted, freeing patients from unwilling visits to private practice offices.
- All MoH hospitals adopted full automation.
- "Central Hospital Appointment System" (MHRS) was introduced.

B.4 Developments in Oral and Dental Care Services

- At least one oral and dental care center (ODCC) was opened up in every province. The number of oral and dental care centers increased from 14 in 2002 to 127 in 2013, and the number of dental hospitals increased from 1 in 2002 to 5 in 2013.
- Dentist supply had more than 1-fold increase.
- Service provision capacity was boosted by patient-oriented approaches and service access was facilitated.

B.5 Developments in Access to Medicinal Products, Medical Equipment and Supplies

- SSK beneficiaries and the Green Card holders were provided access to private pharmacies such as other individuals.
- Pharmaceutical prices were brought down to the most affordable levels in the European market.
- A single reimbursement commission was established for medicinal products.
- Mobile pharmacies were opened up.
- "Pharmaceutical Track and Trace System" (PTTS) was set up which traces medicinal products through all stages from manufacturing to sale.
- Strategies were designed and implemented for Rational Use of Medicines.
- Prescribing information inserted in drug packages was simplified in order to facilitate understanding.
- The VAT on medicinal products was reduced to 8%.
- Discounts were made for pharmaceutical procurement of the SSI.
- The "Regulation on Licensing Medicinal Products" was harmonized with that of the EU.
- It was ruled that the price of a generic medicinal product, the original of which is also available in the market, could not cost more than 60% of the original product price.
- Pertaining to the reimbursement for the costs of prescribed equivalent pharmaceutical products, the ceiling price was brought down to 10% of the cheapest pharmaceutical product.
- The VAT rate on pharmaceutical raw materials was reduced to 8%.
- Hospitals were required to provide medical supplies and equipment for inpatients.

C. Developments in Health Indicators

Though being classified as an upper-middle income country by the WHO, Turkey reached up to a level that is comparable to the upper income countries, as a result of the health reforms realized between 2002 and 2013. Pertaining to life expectancy at birth, which is regarded the most significant indicator of health in the international arena, Turkey (having 76,9 years) has almost moved from the category of upper-middle income countries to the upper income countries (79 years).

Table 108. International Indicators Used to Assess Health Care Services, (2013)

	Turkey	WHO Regions (2013 or the most recent year available)		
		European Region	Upper-Middle Income Group	World
Life Expectancy at Birth (years)	76,9	76,0	74,0	70,0
Infant Mortality Rate (per 1000 live births)	7,8	10,0	16,0	35,0
Under-5 Mortality Rate (per 1000 live births)	10,3	12,0	20,0	48,0
Maternal Mortality Ratio (per 100.000 live births)	15,9	17,0	57,0	210,0
Proportion of Out-of-Pocket Health Expenditure to Total Health Expenditure, (%)	16,8	26,6	32,2	17,9
Satisfaction with Health Care Services in General (%)	74,7	63,0	-	-

Source: Ministry of Health, TurkStat, World Health Statistics 2013-2014, OECD Health Data and World Bank Database

The Turkey Health Transformation Program (HTP) facilitated access to health care services. The number of physician visits per capita mounted from 3,1 in 2002 to 8,2 in 2013.

- WHO regards life expectancy at birth as the most significant indicator of health. While a WHO report which was published in 1998 projected life expectancy at birth for Turkey to become about 75* years by 2025, Turkey already achieved this level in 2009.

- The afore-mentioned WHO report in 1998 projected infant mortality rate for Turkey to become 16/1000 by 2025. However, infant mortality rate for Turkey, which was 31,5/1000 in 2002, was reported 7,8/1000 in 2013.

- Maternal mortality ratio, which was 64/100.000 in 2002, reduced to 15,9/100.000 in 2013. Maternal mortality ratio is 57/100.000 in upper-middle income countries.

- The world's most advanced vaccines were included in the national immunization program and the immunization rates were increased. While the immunization rate was 93% in the WHO Region for Europe in 2002, Turkey had a rate of 78% and while the WHO Region for Europe achieved 95% rate in 2012, Turkey achieved 98% rate in 2013.

* Turkey reached this level in 2009 according to the WHO data whereas reached earlier - in 2006 - according to the TurkStat data.

Table 109. Some Health Indicators, (2002, 2013)

Indicator	2002	2013
Life Expectancy at Birth	72,5	76,9
Infant Mortality Rate (per 1000 live births)	31,5	7,8
Under-5 Mortality Rate (per 1000 live births)	40,0	10,3
Maternal Mortality Ratio (per 100.000 live births)	64,0	15,9
Proportion of Out-of-Pocket Health Expenditure to Total Health Expenditure (%)	19,8	16,8
Proportion of Households Bearing Catastrophic Expenditures for Health (%)	0,81	0,22
Satisfaction with Health Care Services in General (%)	39,5*	74,7
Number of Beds per 10.000 Population	24,8	26,4
Number of Physicians per 100.000 Population	138	174
Number of Midwives- Nurses per 100.000 Population	171	252
Number of Midwives - Nurses per Physician	2,44	1,44

* Data refer to the year 2003.

Source: Ministry of Health, TurkStat and OECD Health Data

D. Developments in Economic Indicators

D.1. Developments in Economic Indicators of Health Care

Turkey achieved a quantum leap in economic health indicators between 2002 and 2013, as in basic health indicators.

Table 110. International Economic Indicators of Health Care, (2013)

Indicator	Turkey	OECD Average	WHO Regions (2011 or the most recent year available)		
			European Region	Upper-Middle Income Group	World
Proportion of Public Health Expenditures to the GDP (%)	4,2	6,7	-	-	-
Proportion of Total Health Expenditures to the GDP (%)	5,4	9,3	9,0	5,8	9,1
Public Health Expenditure per Capita (USD)	458	-	1.782	226	613
Total Health Expenditure per Capita (USD)	584	-	2.370	408	1.007
Public Health Expenditure per Capita (PPP USD)	793	2.548	2.168	330	619
Total Health Expenditure per Capita (PPP USD)	1.010	3.484	2.886	586	1.053
Per Capita GDP (USD)	10.824	37.804	29.439	6.962	10.358

Source: Ministry of Health, TurkStat, World Bank, World Health Statistics 2013 and OECD Health Data

- The proportion of out-of-pocket expenditures on health to total health expenditures dropped from 19,8% in 2002 to 16,8% in 2013.
- Turkey Health Transformation Program (HTP) increased efficiency and ensured financial sustainability for the health care system. While the increase in non-interest public spending in general was 531% in 2002-2013 period, the increase was reported 399% in public spending in the same period.

Table 111. Economic Indicators of Health Care, (2002, 2013)

Indicator	2002	2013
Proportion of Public Health Expenditures to the GDP (%)	3,8	4,2
Proportion of Total Health Expenditures to the GDP (%)	5,4	5,4
Public Health Expenditure per Capita, as of 2013 prices, (TRY)	560	871
Total Health Expenditure per Capita, as of 2013 prices, (TRY)	792	1.110
Public Health Expenditure per Capita (USD)	134	458
Total Health Expenditure per Capita (USD)	189	584
Public Health Expenditure per Capita (PPP USD)	329	793
Total Health Expenditure per Capita (PPP USD)	466	1.010

Source: TurkStat

D.2. Developments in Other Economic Indicators

Table 112. Economic Indicators, (2002, 2013), (As of 2013 Prices, million TRY)

Indicator	2002	2013
Gross Domestic Product (GDP)	976.152	1.565.181
Per Capita GDP (TRY)	14.790	20.580
Central Government Budget	333.122	407.890
MoH Share in Central Government Budget	9.053	16.607
Total Public Fund Allocation for the MoH*	14.471	35.376
Public Health Expenditures	36.959	66.228
Total Health Expenditures	52.290	84.390
Non-Interest Public Expenditures (except for Health Expenditures)	221.410	519.201
Tax Revenues	166.088	326.169

* Includes the MoH and affiliated facilities' share in the central government budget, reimbursements for service costs and contributions from local governments to the MoH.

Source: Ministry of Development, Ministry of Finance, TurkStat and Health Statistics Yearbook

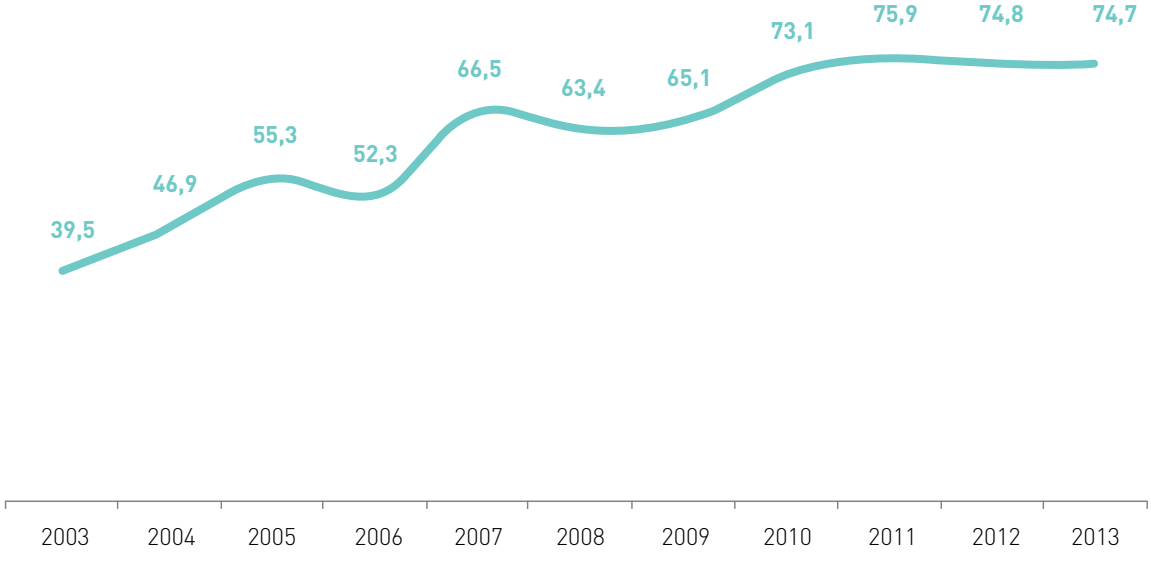
E. Developments in Health Financing

- Private hospital services were provided for individuals through the health insurance system.
- Emergency and intensive care services were provided free-of-charge in all hospitals.
- Poor citizens gained full access to public health care services.
- "Reference Pricing System" was put into use for medicinal products.
- Business management principles were applied to the MoH hospitals for better management.
- Harmonization and coordination was promoted among health financing departments and units by establishment of the Council for Economic Coordination for Health.
- "Global Budgeting" model was adopted to finance health care services.
- All individuals under the age of 18 and all students were covered by the UHI.
- Minimum period for premium payment, which is required for the SSK insurees and Green Card beneficiaries to receive health care services, was reduced to 30 days.
- Global budgeting was also introduced for medicinal products.
- According to the Catastrophic Health Expenditures Report published by the TurkStat, the proportion of households with catastrophic health expenditures dropped from 0,81% in 2002 to 0,22% in 2013.

F. Developments in Satisfaction with Health Care Services

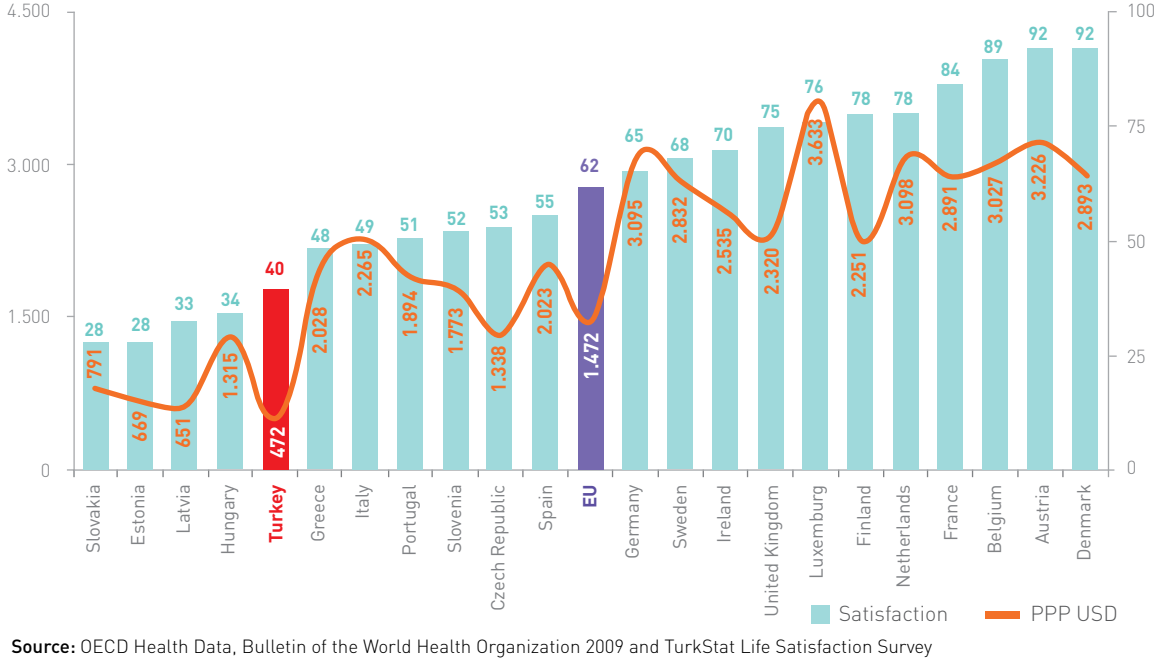
Public satisfaction with health care services outstandingly increased thanks to the citizen-oriented policies implemented between 2002 and 2013.

Graphic 58. Satisfaction with Health Care Services, (2003-2013), (%)



Source: TurkStat Life Satisfaction Survey

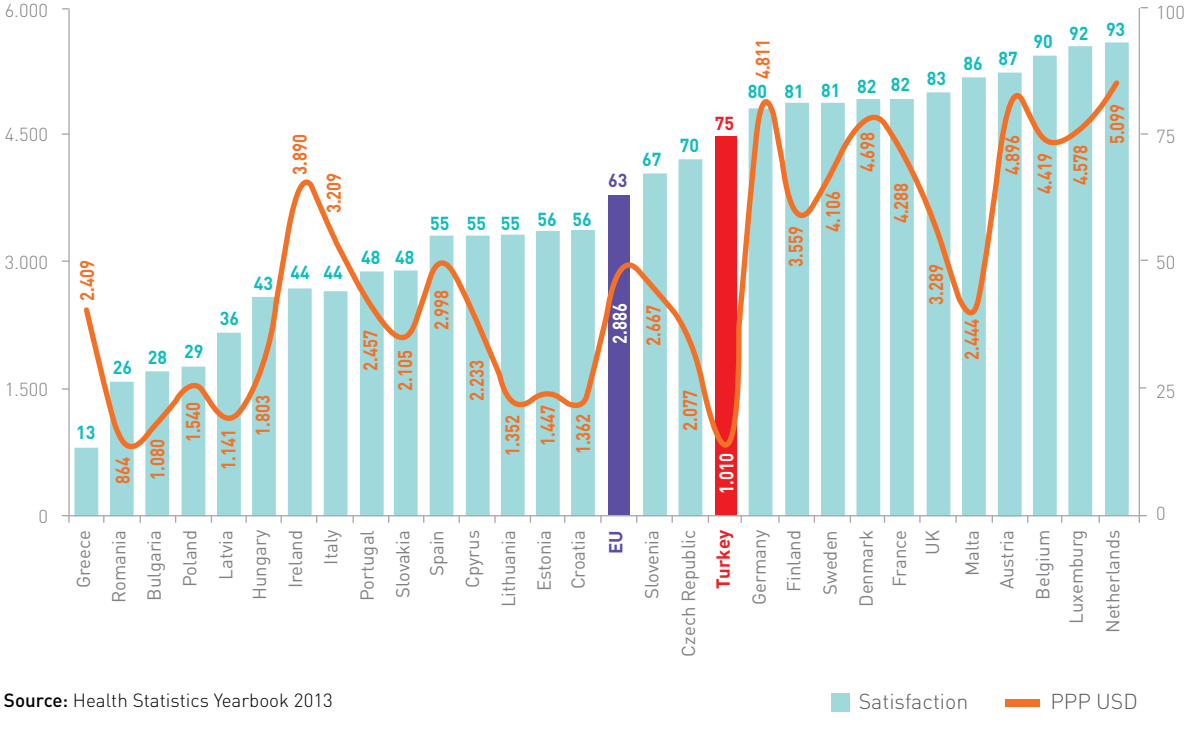
Graphic 59. Satisfaction with Health Care Services (%) and Health Expenditure per Capita (PPP USD), (2003)



Source: OECD Health Data, Bulletin of the World Health Organization 2009 and TurkStat Life Satisfaction Survey

In 2003, health spending per capita was 472 USD by the purchasing power parity (PPP) and satisfaction with health care services was 39,5%. In 2013, however, the spending reached up to 1.010 USD while satisfaction with health care services increased to 74,7%.

Graphic 60. Satisfaction with Health Care Services (%) and Health Expenditure per Capita (PPP USD), (2013)



Source: Health Statistics Yearbook 2013

While satisfaction with health care services was 62% in the European Union in 2003, it was estimated 39,5% in Turkey. Yet, the satisfaction ratio in Turkey reached up to 74,7% in 2013 while it remained 63% in the EU in the same year.

While public satisfaction with health care services in Bulgaria, which is similar to Turkey in terms of health spending patterns (1.080 PPP USD), is 1/3-folds in comparison to Turkey (pointing out to 28% satisfaction in Bulgaria), health spending in the Czech Republic (amounting to 2.077 PPP USD), which is similar to Turkey in terms of satisfaction ratio (referring to 70% satisfaction), is more than two times higher than the spending in Turkey.

Annex

Developments in Health Care System (2003-2013, Detailed)

Developments in 2003

January

- By the MoH Circular Dated 26.11.2002 and No.119, mechanisms were introduced so that the system of patients being held in hospitals as pawns due to non-payment of fees was abrogated.

- By the Official Letter Dated 11.12.2002 and No. 26807 of the MoH General Directorate of Curative Services, the MoH directors were entitled to announce tenders without sticking to a limit and to approve all tenders amounting up to 2 million TRY for the procurements from the Revolving Fund Budget in 2003.

- By the Cabinet Decision issued in the Official Gazette Dated 29 January 2003 and No.25008, it was resolved that 20% discount would be made in 2012 for reimbursement of the unpaid costs of primary care consultation, diagnostic and curative services which were offered to the personnel covered by other social security schemes than those specified in the Law No. 506.

March

- Charge-free ambulatory health care services were extended to all rural areas across the country.

April

- Immunization days were organized in scope of the national measles immunization campaign.

- Beginning from 01.04.2003, the "Performance-based Supplementary Payment System" was piloted in 10 inpatient health care facilities affiliated with the MoH so that health care services were enhanced and quality and efficient health service delivery was ensured. Afterwards, the performance-based supplementary payment system was generalized in all primary health care facilities.

- "Turkey Malaria Elimination Program" was revised and the fight with malaria was strengthened.

- Government employees were provided access to private health care facilities as of 17 April 2003.

- By the Cabinet Decision No. 2003/5557, the VAT rate on blood products and components used for human and animal health, formulas used for human nutrition, anti-serums used for human and animal health, immunoglobulins and vaccines was reduced from 18% to 1%.

June

- The VAT rate on blood products was increased from 1% to 8%.

Developments in 2003

July

- Insurees were provided access to both SSK and public hospitals in 6 provinces by the "MoH-SSK Protocol for Common Use of Their Health Care Facilities" beginning from 1 July 2003.

- A new employment model on contractual basis peculiar to the Ministry of Health was put into force which targeted improved service delivery in rural and under-developed areas.

- "Ministry of Health Call Center (SABIM)" was established to open up a communication channel with people and "Patient Rights Units" were established for patient receivables.

- Pertaining to the appointment of non-civil servants to government posts for the first time, the Ministry of Health became entitled to appoint dentists and pharmacists through lottery and without an examination by the Law Dated 10 July 2003 and No. 4924 which allowed the MoH to bypass prior approval from the Ministry of Finance.

August

- A protocol was signed between the MoH and SSK and came into effect on 6 August 2003 which provided the SSK insurees with access to the MoH health care facilities.

- By the Cabinet Decision issued in the Official Gazette Dated 06 August 2003 and No. 25191, health checks for detainees under investigation and prosecution were offered free of charge in public health care facilities.

October

- By the Cabinet Decision issued in the Official Gazette Dated 23 October 2003 and No. 25268, highway and Bosporus Bridges' tolls were abolished for the MoH ambulances.

- Legal arrangements were adopted for patient rights and hospitals started to set up patient rights units.

Developments in 2004

January

- SSK insurees' access to both SSK and public hospitals ordered by the "MoH-SSK Protocol for Common Use of Their Health Care Facilities" was generalized as of 1 January 2004.

- The "Performance-based Supplementary Payment System" was generalized in all MoH facilities beginning from 1 January 2004.

- By the Cabinet Decision issued in the Official Gazette Dated 02 January 2004 and No. 25334, public health care services were provided free of charge for foreign national patients who were ascertained as the victims of human trafficking and who could not afford health care services.

- Accounts of the Ministry of Health and its affiliated facilities were kept in compliance with principles of the uniform accounting system through the software which was developed specifically for this purpose.

- By the Cabinet Decision issued in the Official Gazette Dated 30 January 2004 and No. 25448 and as ordered by the Law No. 506 and the Law No. 2925; insurees, insurees receiving unemployment benefits and their dependents were provided 30% discount in consultation fees in case of referrals from the MoH primary health care facilities to the MoH secondary and tertiary health care facilities and 20% discount in all inpatient and outpatient diagnostic and medical tests in case of treatments given by the SSK and the MoH secondary and tertiary health care facilities, from 1.7.2003 to 31.12.2003.

February

- Reimbursement commission was established by a Circular issued by the Ministry of Finance (MoF).

- Resolution on Pricing of Medicinal Products for Human Use was issued in the Official Gazette Dated 14 February 2004 and No. 25373.

March

- Conditional cash transfer started. The poorest and the most deprived 6% of the population (pregnant women and children) received cash assistance on condition that they underwent necessary medical examinations

- By the Cabinet Decision Dated 2004/8301, the VAT rate was reduced from 18% to 8% for medicinal products beginning from 1 March 2004.

Developments in 2004

April

- High schools for health professions, which had been affiliated with the Ministry of Health, were devolved to the Ministry of Education.
- "Iron-Like Turkey Project" started.
- Beginning from 14 April 2004, the Pharmaceutical Pricing System shifted from the explicit cost-based system, which is susceptive to abuses, to the reference price system, which is grounded on the cheapest product-based price in selected EU countries, and 1% to 80% cost cuts were achieved in 950 individual medicinal products.
- The change in exchange rates were reflected on pharmaceutical prices and pharmaceutical costs were reduced by 20% as of 14 April 2004.

May

- "Prevention of Vitamin D Deficiency and Bone Health Protection Project" was launched and free Vitamin D support was provided for infants in health care facilities.
- With the aim of guiding studies and researches on child health and monitoring delivery of routine services and management of special programs, Infant Mortality Notification/Register Form was developed and the "Infant Mortality Monitoring Program" was launched.
- By the Cabinet Decision issued in the Official Gazette Dated 15 May 2004 and No. 25463, disabled individuals, who were not covered by health insurance and were required to undergo medical examination in order to receive disability and unemployment benefits, were provided free health care services through the Turkish Labor Agency.

June

- By the Cabinet Decision issued in the Official Gazette Dated 12 June 2004 and No. 25490, 112 emergency care services were provided free of charge for individuals who did not have social security insurance.
- "Opticianry Law" was issued in the Official Gazette Dated 22 June 2004 and No. 5193.

July

- By the Law Dated 14 July 2004 and No. 5220, it was ordered that the MoH-owned real estates could be sold out by the MoF upon the MoH's agreement and the sales revenues would be transferred to the MoH budget.

Developments in 2004

August

- Pharmaceutical prices were increased by 8,7% following the increase in the exchange rates as of 2 August 2004.

December

- "Conscious Mother and Healthy Babies Project" was developed and the baby-friendly hospitals were increased in number.

- Free cancer screening and training centers were established in 81 provinces.

- By the Amending Regulation Dated 22 December 2004, which widened the coverage of the Green Card System retrospectively for poor people who got sick within 90 days after they had applied for but not received the Green Card benefits yet, free medical treatments were provided for the newborns and the adults who needed emergency care and treatment.

- By the Amending Regulation Dated 22 December 2004, inpatient treatment costs under the Green Card System and related costs of consultation, diagnostic, medical dressing, tooth extracting, dental prosthetic, opticianry and pharmaceutical services were met by the government.

- "Law on Family Medicine Pilot Implementation" No. 5258 came into effect on 09.12.2004.

Developments in 2005

January

- 18% VAT rate was abolished for treatment costs by the budget directive, beginning from 1 January 2005.
- "Regulation on Licensing Medicinal Products for Human Use" was issued.

February

- About 10% price cuts were made in medicinal products by a protocol signed among the MoF, MoLSS and Turkish Pharmacists' Association, beginning from 10 February 2005.
- The SSK pharmacies were closed down and the SSK insurees were allowed to take their medicines from private pharmacies.
- All public health care facilities except for those affiliated with the Ministry of Defense and universities were devolved to the MoH on 19 February 2005. Separation of health service delivery from health service financing was completed when the SSK hospitals were devolved to the MoH, finally.
- By the Cabinet Decision Dated 22 February 2005 and No. 25735, the BAG-KUR insurees under the Law No. 2926 and their dependents were provided free preventive care services in the MoH primary health care facilities, primary care consultation charges were determined by the Budget Implementation Directive and discount rates were applied for diagnostic services and medical tests etc., as ordered by the Decision. Also, 20% discount rate was applied on the Budget Implementation Directive prices for all diagnostic services and/or medical tests given to the BAG-KUR insurees and their dependents in the MoH secondary and tertiary care hospitals (except for oncology, chest diseases and physical therapy and rehabilitation hospitals) from 1.5.2003 to 31.12.2003.

March

- Pharmaceutical bioequivalence approach was adopted for the ES (Emekli Sandigi/Government Employees' Retirement Fund) scheme. Accordingly, disbursement was allowed up to 30% of the most inexpensive bioequivalent medicinal product as of 1 March 2005.
- The scope of the "Performance-based Supplementary Payment System" implemented in the MoH facilities was expanded to include the organizational and quality criteria as well as others.
- "Cosmetics Law" was issued in the Official Gazette Dated 24 March 2005 and No. 5324.

Developments in 2005

April

- Significant amendments were made to the Regulation on Management of Inpatient Treatment Facilities on 1 April 2005. Accordingly, every clinician specialist was required to offer polyclinic services and patients were granted the right to choose their physicians. It was ruled that patient rooms would be designed as double occupancy rooms and patient room design shifted from ward to quality single-room or shared accommodation offering built-in bathroom, television and refrigerator. Establishment of patient rights units and commissions was made mandatory in health care facilities.

- 20% co-payment was collected from the Green Card beneficiaries for medicinal products by the Law issued in the Official Gazette Dated 27 April 2005 and No. 5335.

- Law on Revolving Funds No. 209 was amended by the Law issued in the Official Gazette Dated 27 April 2005 and No. 2598. Accordingly, health care institutions generating revolving funds were allowed to undertake prospective payments and borrowing in order to procure through service contracts or lease continuous services and high-cost and high-technology medical devices.

May

- By the "Regulation on Amendment to the Regulation on Management of Inpatient Treatment Facilities" issued in the Official Gazette Dated 5 May 2005 and No. 25806, set up of an individual examining room for each clinician became a must in all MoH hospitals.

- By the Cabinet Decision issued in the Official Gazette Dated 5 May 2005 and No. 25806, city or suburban ambulance patient transfers via 112 Emergency Care Service network was made free of charge for all people.

- Charged with the responsibility for implementing the newborn hearing screening program, the MoH started working on establishment of hearing screening units for newborns in all provinces.

June

- The price ceiling for generic medicinal products produced from domestic raw materials, which was up to 80% of the originals before, was brought down to 70% as of 13 June 2005.

- Compulsory medical service, which was abolished in 2003, was re-introduced for physicians by the Amending Law Dated 21 June 2005 and No. 5371.

- By the Amending Law Dated 21 June 2005 and No. 5371, emergency medical technicians (having associate and high school degrees) were entitled to perform interventions for patients in emergency cases.

Developments in 2005

July

- "Assisted Reproductive Treatment Centers Regulation" was enacted.
- "HIV/AIDS Prevention and Support Program" (HPSP) was introduced.
- The article, which envisaged amendment to the Health Care Services Fundamental Law for the Public-Private Partnership (PPP) model in health sector investments, was adopted in the TGNA.
- Beginning from July 2005, pharmaceutical prices were reduced by 8,8% following the decrease in the exchange rates. The coverage of the bioequivalent pharmaceutical products was expanded and the bioequivalent medicinal product groups were increased from 77 to 333 in number.
- By the Regulation Dated 1 July 2005 and No. 5378, the MoH was authorized to issue the certificate of establishment and manage other procedures for enterprises to be opened with the aim of producing auxiliary medical equipment and accessories to be use for health care services.

September

- Family Medicine System was piloted in Duzce province on 15 September 2005. Accordingly, a separate examination room was allocated for each of the physicians practicing family medicine centers and the effectiveness of family physicians in management were enhanced. Necessary funds were generated to improve physical conditions and work setting.
- By the Cabinet Decision Dated 2 September 2005 and No. 25924, free mammograms and Pap smear tests were provided for uninsured people in cancer screening and training centers.
- Population Health Centers were set up.

December

- Paragraph C of the Article 31 of the Law on Central Government Budget 2006 Dated 27 December 2005 and No. 5437 states that "All treatment service bills, which were issued by the MoH health care facilities for those covered by the Social Insurance Organization (SSK), General Directorate of BAG-KUR and the Law Dated 18/6/1992 and No. 3816 and were not paid by 31/12/2005, shall be cancelled by the effective date of this Law. The Ministry of Finance is authorized to perform relevant regulatory procedures". So, the receivables of public hospitals from the SSI and Green Card insurees for 2005 and before, which amounted to approximately 3,5 billion TRY were cancelled.

Developments in 2006

January

- Public Financial Management and Control Law No. 5018 was passed and Strategy Development Presidencies were established in order to ensure effective and efficient use of public resources and to achieve financial discipline, accountability and financial transparency in financing of public services.

- A positive list of pharmaceuticals was compiled for common use by all institutions as of 1 January 2006.

- The effective date of the protocol, which was signed among the MoF, MoLSS and Turkish Pharmacists' Association and made about 10% price cuts in medicinal products in the previous year, was extended for a year's time beginning from 1 January 2006.

- The budget implementation directive, which came into effect as of 1 January 2006, did not allow increases in average treatment prices compared to the previous year.

- "Expanded Immunization Program" (EIP) was introduced and covered rubella, mumps and meningitis vaccines.

- By the health-related provisions of the Law No. 5510, the scope and financing of health care services was unified and singularized for all citizens. Accordingly, government subsidies were created for the persons who cannot afford health insurance premiums and co-payment was introduced for outpatient treatments.

February

- By the Cabinet Law issued in the Official Gazette Dated 8 February 2006 and No. 26074, it was decided to provide free-of-charge diagnostic, curative, follow-up and preventive care services for tuberculosis patients and their close house contacts.

March

- The Ministry of Health was authorized to raise the share of revenues to be transferred from the MoH revolving fund institutions to the MoH central organization from 2% to 4% so that the MoH primary and preventive health care services were promoted and inter-regional developmental gaps were diminished.

- By the Law Dated 07 March 2006 and No. 5471, the effective date of cancellment for the MoH receivables which was ruled by the Budget Law Dated 2006 was changed from 31.12.2005 to 31.12.2004 and the receivables for 2004 and before were cancelled. In addition, the MoH was authorized to fund or loan the revolving fund institutions which were in a weak financial position from the revolving fund institutions which were in a strong financial position.

- Amendments were made to the "Regulation on Inpatient Treatment Facilities" on 17 March 2006.

Developments in 2006

April

- "National Immunization Days for Tetanus" were organized in scope of the "Tetanus Elimination Program".

May

- "Social Security Institution (SSI) Law No. 5502" came into effect and the existing social security agencies (SSK, BAG-KUR and ES) were unified.
- The price ceiling for bioequivalent pharmaceutical groups, which was up to 30% of the originals until May 15, 2006, was brought down to 22% thereafter.

June

- Delivery of health care services, which had variations by service providers, were standardized by the Social Insurance and the Social Security Institution Law issued in the Official Gazette Dated 16 June 2006 and No. 5510 and mandatory national Universal Health Insurance scheme was established.
- Global budgeting was introduced for the MoH revolving fund institutions.
- "Directly Observed Therapy" (DOT) was rolled out for tuberculosis patients across the country.

July

- "Family Medicine System" was introduced in Eskisehir province.
- The number of medicinal products in the positive list was reduced and case payment was started for outpatient treatment services as of 1 July 2006.
- Pharmaceutical prices were increased by 5% following the increase in the exchange rates.

August

- Pharmaceutical prices were increased by 5% following the increase in the exchange rates.

September

- A pharmaceutical expenditure tracking system was set up in the SSI and the "MEDULA" system was put into implementation.
- Pharmaceutical prices were increased by 5% following the increase in the exchange rates.

Developments in 2006

October

- "Family Medicine System" was introduced in Bolu province.

- The Council of State granted a motion for stay of execution of the case payment system which came into effect in July 2006.

November

- WHO European Ministerial Conference on Counteracting Obesity was held in our country on November 15-17, 2006 and the "European Charter on Counteracting Obesity" was signed by Recep AKDAG, the Minister of Health of Turkey. In parallel to the Charter, the "Healthy Diet and Active Life Program of Turkey" was developed by the MoH General Directorate of Primary Health Care Services.

December

- "Family Medicine System" was introduced in Edirne, Adiyaman, Denizli and Gumushane provinces.

- National screening programs were newborn congenital hypothyroidism which has a vital importance for neurologic development of children.

- Following the Marmara Earthquake in 1999 and with the aim of satisfying the need for a professional medical rescue team in Turkey, the "National Medical Rescue Teams" (UMKEs) were set up in 2004 under the General Directorate of Primary Health Care Services of the MoH Department of Healthcare Organization in Disasters. The provincial organization was structured as disaster health care units within provincial health directorates in 2005 and the National Medical Rescue Teams (UMKEs) were set up in all of 81 provinces by late 2006.

- By the MoH General Directorate of Mother and Child Health/Family Planning Circular Dated 19 December 2006 and No. 2006/130, the national "Neonatal Screening Program" was launched to screen newborns for phenylketonuria and congenital hypothyroidism.

Developments in 2007

January

- The effective date of the Law on Social Insurance and Universal Health Insurance No. 5510 was determined as 1 July 2007 by the Central Government Budget Law 2007.

- By the MoH General Directorate of Mother and Child Health/Family Planning Circular Dated 31 January 2007 and No. 2007/5, the Directive on Newborn Hearing Screening Units was issued.

- The MoH share for the Treasury, which was allocated from the MoH revenues collected from the MoH revolving fund institutions, was reduced from 15% to 1%.

- "Family Medicine System" was introduced in Elazig and Isparta provinces.

March

- Snow palette ambulances and 4 marine ambulances were put into service.

- "Family Medicine System" was introduced in Samsun province.

- By the Regulation Dated 28 March 2007 and No. 5614, physicians who were under compulsory medical service were allowed to practice as contracted family physicians in the provinces of compulsory medical service.

April

- By the Law on Blood and Blood Products Dated 11 April 2004 and No. 5624, regional blood centers were established for safe and easy supply of blood and blood products.

- By the MoH Strategy Development Presidency Circular Dated 4 April 2007 and No. 2007/25, necessary arrangements were made for collective procurement procedures of the MoH facilities. Accordingly, the provincial health directors were allowed to announce and approve tenders for collective procurements and sign relevant contracts without upper limits pertaining to the procurement of goods and services (such as medical devices, medical supplies and equipment, medicinal products and stationery items etc.) on condition that payments were made from the revolving funds of the individual institutions.

- By the Cabinet Decision Dated 27 April 2007 and No. 2007/12013, it was ruled that the MoH primary health care services would be provided free of charge for uninsured people in case that the social security agencies provided primary health care services from the MoH through direct service procurement method, resulting in free-of-charge provision of primary health care services for all people in the country. In addition, the receivables of the MoH facilities from the social security agencies in 2007, which went beyond the limit of the protocol, were cancelled by the same Decision.

Developments in 2007

May

- "Family Medicine System" was introduced in Izmir province.
- By the Law No. 5655 which was issued in the Official Gazette Dated 20 May 2007, the effective date of the Law on Social Insurance and Universal Health Insurance No. 5510 was changed to 1 January 2008.
- By the Implementation Directive on Medical Treatment Subsidy issued in the Official Gazette Dated 25 May 2007 (Repeated Edition), price stability in 2006 was substantially maintained in 2008 and the positive list was continued.

June

- By the Additional Article of the Law Dated 03.06.2007 and No. 5683 to the Decree Law on the Organization and Duties of the Ministry of Health No.181, it was ruled that health care facilities could be constructed by the Housing Development Administration of Turkey (TOKI) following a protocol signed between the MoH and TOKI.

July

- A new 1-year protocol was signed between the SSI and TEB (Turkish Pharmacists' Association) and cuts in pharmaceutical prices were continued.
- By the Cabinet Decision Dated 9 July 2007 and No. 2007/12377, it was ruled that all services, which were provided by the MoH primary health care facilities and not included in the scope of the contract, would be free of charge for people covered by social security and all services would be free of charge for people not covered by social security on condition that the social security agencies provided primary health care services from the MoH through direct service procurement method.

August

- "Family Medicine System" was introduced in Sinop province.

September

- By the Resolution on Pricing of Medicinal Products for Human Use issued in the Official Gazette Dated 22 September 2007, price evaluation commission was convened and determined the basis exchange rate for medicinal products to be prescribed in the upcoming period, resulting in 7,77% decrease in pharmaceutical prices.

Developments in 2007

November

- "Family Medicine System" was introduced in Bartin province.

December

- Full automation system was introduced in all MoH hospitals.
- "Family Medicine System" was introduced in Amasya province.
- "Health Promotion Program" started.
- Payments to the MoH hospitals from the global budget were based on the objective criteria such as the hospital performance and structural characteristics.
- The MoH hospitals were closely monitored for the MoH-identified financial risks. Financial analyses were made for risky hospitals and special action plans were developed so that such hospitals improved their financial status.

Developments in 2008

January

- By the MoH Strategy Development Presidency Circular Dated 02 January 2008 and No. 2008/1, arrangements were made in order for intra-governmental procurement of goods and services by the MoH facilities.

- The Law on Prevention and Control of Hazards of Tobacco Products was amended by the Law Dated 3/1/2008 and No. 5727 and accordingly, tobacco use was prohibited in the following places:

    - Indoor areas of public workplaces;

    - Indoor areas of buildings that are privately owned by legal entities and used for educational, health, commercial, social, cultural, sports or entertainment purposes, including hallways with room for more than one person (except private houses);

    - In intercity, railway, sea and air mass transportation vehicles, including private taxis; the indoor and outdoor areas accepted as part of the premises of: preschool educational institutions, primary and secondary schools, including private establishments preparing students for various examinations, and cultural and social service buildings;

    - Restaurants owned by legal persons and entertainment establishments such as cafes, cafeterias and bars.

- "Family Medicine System" was introduced in Corum, Manisa, Bayburt, Osmaniye and Karaman provinces.

- By the Ministry of Finance Approval Dated 31.01.2008, the share of the university hospitals' revolving funds which were allocated for the Undersecretariat of Treasury was reduced from 15% to 5% beginning after 01.01.2008.

Developments in 2008

February

- With the aim of ensuring balanced, efficient and qualified provision of health care services without wasting resources and creating an idle capacity, the "Regulation on Private Outpatient Diagnostic and Curative Facilities" was issued pertaining to the structuring, establishment and closure of private outpatient health care facilities, respective licensing procedures, control and inspection, and other issues. The licensing procedures were renewed by the Regulation.

- Amending the "Resolution on Packaging and Labeling of Medicinal Products for Human Use", clips were removed from product boxes and replaced by "square codes".

- General Directorate of Pharmaceuticals and Pharmacy issued the "Guideline on the Readability of the Labelling and Package Leaflet of Medicinal Products for Human Use" on 26 February 2008 in order to minimize misuse of medicinal products.

- "Family Medicine System" was introduced in Karabuk province.

- By the Cabinet Decision Dated 18 February 2008 and No. 2008/13284, the receivables of the MoH facilities from the social security agencies in 2008, which went beyond the limit of the protocol, were cancelled.

- Pentavalent vaccines were incorporated into the routine immunization program by the MoH General Directorate of Primary Health Care Services Circular Dated 25 February 2008 and No. 2008/14.

- By an Additional Article to the Law No. 5683 and Decree Law No.181, a protocol was signed between the MoH and TOKI on 19.02.2008 pertaining to the construction of health care facilities by TOKI. Accordingly, 30% of the cost of construction jobs by TOKI would be paid from the alienated land prices while the remaining cost would be paid in installments in 7-plan-year periods.

April

- "Guest Mother Project" was launched aiming to provide safe deliveries in health care facilities for pregnant women who live in geographically hard-to-reach areas.

Developments in 2008

May

- "Community-based Mental Health Services Model" was piloted in Bolu province.

- "Directive on National Organ and Tissue Transplantation Coordination System" was issued in order to identify rules and principles for organ and tissue transplantation procedures, centers and personnel.

- "Family Medicine System" was introduced in Adana province.

June

- By the Prime Ministry Circular No. 2008/13, which was issued in the Official Gazette Dated 26.06.2008 and No. 26918, unconditional admission of emergency patients and free-of-charge provision of emergency care services were made mandatory for all health care facilities regardless of health insurance or affordability of patients.

- By the Cabinet Decision No. 2008/13728 , which was issued in the Official Gazette Dated 4 June 2008, it was ruled that private health service providers could charge an extra fee up to 30% above the price paid by SSI for procedures other than hotel services and exceptional health care services.

- By the Law No. 5766 which was issued in the Official Gazette (Repeated Edition) Dated 06 June 2008 and No. 26898, municipalities were required to pay for the bills of health care services provided for their personnel by university and MoH hospitals, however, it was ruled that the remaining receivables of university and MoH hospitals could be cancelled due to the non-affordability of municipalities on condition that the municipalities paid 75% of the bills before the date of 31.3.2008.

- 4% share, which the MoH collected from the provinces implementing the "Family Medicine System" as a contribution to the MoH central organization fund, was abolished by the MoH Regulation Dated 13 June 2008.

- Pertaining to health care services provided by university hospitals (except for foundation hospitals) for government employees and the Green Card holders, it was ruled that 85% of the debts, which arouse from the health service bills and could not be collected from the service users (before the date of 31.3.2008), would be collected from the Ministry of Finance and the remaining would be cancelled.

Developments in 2008

July

- "Family Medicine System" was introduced in Burdur province.

- Pharmaceutical prices were increased by 8% on 28 July 2008.

August

- "Family Medicine System" was introduced in Kirikkale province.

- By the Amended Article to the Law on Social Insurance and Universal Health Insurance No. 5797 issued in the Official Gazette Dated 19 August 2008, it was ruled that the health expenditures for the Green Card holders and general-budget facility personnel would have been completely devolved to the SSI in 3 years' time.

- A directive was issued on 8 August 2008 on working rules and principles of the disbursement commission which was established by the Article 72 and the Amended Sub-Clause 2 of the Clause (f) of the Article 63 of the Law on Social Insurance and Universal Health Insurance No. 5510. Accordingly, the commission was headed by the General Director of Universal Health Insurance and comprised of 7 members minimum: 3 department directors from the General Directorate of Universal Health Insurance and the General Directorate of Pharmaceuticals and Pharmacy, 2 department directors from the MoF and MoH and minimum 2 department directors from the Ministry of Development and Undersecretariat of Treasury. The directive was replaced by a new directive by the Social Security Institution on 16 April 2012.

Developments in 2008

October

- Medical Enforcement Declaration of the Social Security Institution, which was issued in the Official Gazette (Repeated Edition) Dated 25 May 2007 and came into effect on 15 June 2007, remained in force until 1 October 2008 and treatment fees were not increased in that period.

- Medical Enforcement Declaration of the Social Security Institution, which was issued in the Official Gazette (Repeated Edition) Dated 29 September 2008, came into effect on 1 October 2008. Treatment fees were kept mostly stable and prices were increased for only risky surgical operations which were classified as the Group A and the fees of which were below their costs. Besides, the Directive introduced co-payment for outpatient health care services (except for primary care level), piloted chain of referral system in four provinces implementing the "Family Medicine System" (Bayburt, Isparta, Gumushane, Denizli) and announced that chain of referral would be rolled out in all provinces implementing the Family Medicine System in 2009. Pertaining to deliveries, the fee for Caesarean Section (CS) was reduced and the fee for normal delivery was increased in order to promote normal deliveries. In addition, the fees for physical therapy, FAKO surgeries and outpatient consultations in private hospitals were reduced and some control measures were put into use for electronic monitoring.

- Helicopter ambulances were used for the first time in Ankara province on 28 October 2008.

- The Law on Social Insurance and Universal Health Insurance No. 5510 came into effect on 1 October 2008. SSK, BAG-KUR and ES Laws were abolished and their beneficiaries gathered under the UHI which unified these three separate social security agencies. All individuals under the age of 18 and all students were covered by the UHI.

- Co-payment was introduced for outpatient medical and private dental practices except for primary health service providers and Family Medicine private practices beginning after 1 October 2008. 3 TRY co-payment was charged for secondary health service providers while 4 TRY was charged for training and research hospitals, 6 TRY for university hospitals and 10 TRY for private health service providers.

- Private hospitals were prohibited from charging patients co-payment for burn treatment, cancer treatment, neonatal care, organ transplants, congenital anomalies, dialysis and cardiovascular surgery.

- By the Article 67 of the Law No. 5510, all health care services were provided free of charge for all people – no matter if they had insurance or not – in case of epidemics, job accidents and occupational diseases.

- All insurees were provided with the opportunity to receive medical treatment abroad pertaining to the cases that could not be treated in Turkey. As for the SSK and BAG-KUR insurees, the minimum period for premium payment, which was required to receive health care benefits, was reduced from 120 days to 30 days.

- Scope of the Neonatal Screening Program was expanded by incorporating Biotinidase Deficiency in October 2008. So, routine heel lance procedures were performed for 3 diseases.

- "Biotinidase Deficiency Screening Program" was launched.

- "Family Medicine System" was introduced in Cankiri, Tunceli and Yalova provinces.

Developments in 2008

November

- "Family Medicine System" was introduced in Bilecik, Kastamonu, Erzurum, Kirsehir and Kayseri provinces.

- In scope of the "Oral and Dental Care Center (ODHCC) in Every Province Campaign", which started in 2005, the latest and 81st ODHCC was established in Sirnak province by the Ministerial Approval Dated 06.11.2008 and No. 41873.

- Pneumococcal conjugate vaccine was put into use in November 2008.

- By the SSI Medical Enforcement Declaration (SUT) issued in the Official Gazette (Repeated Edition) Dated 29 September 2009 and No. 27012, chain of referral became mandatory in Bayburt, Isparta, and Gumushane and Denizli provinces beginning from 1 November 2009. Also, it was ruled that chain of referral would be applied in all provinces under the Family Medicine System after 1 January 2009, as ordered by the SUT provisions. For this purpose, mandatory chain of referral was abolished in 4 piloting provinces by the amending SUT provisions issued in the Official Gazette Dated 17 January 2009 and No. 27113 and the implementation was postponed to the date of 1 July 2009. After that, mandatory chain of referral was delayed indefinitely in provinces under the Family Medicine System by the SSI General Directorate of Health Insurance Dated 30 June 2009 and No. 2009/85.

- Material Resources Management System (MRMS) became mandatory for stock monitoring and control in all MoH facilities on 25 November 2008, resulting in easy monitoring of medical device, equipment and medicinal product procurements by hospitals in terms of prices and quantities.

December

- By the Amendments to the Law No. 5812 and Law No. 4734 issued in the Official Gazette Dated 5 December 2008 and No. 27075, health care facilities which were subject to these respective laws were exempted from the Public Procurement Law for intra-governmental procurement of goods and services for diagnostic and curative purposes.

- By the Amending Clause "f" of the Article 22 of the Law No. 4734 Dated 5 December 2008, direct procurement method was allowed in order to ease provision of patient-specific medical supplies and test and diagnostic kits such as medicinal products, vaccines, serums, anti-serums, blood and blood products which are not economical for long-term stocks due to limited shelf life or which could be used in cases of emergency, and orthoses and prostheses which are tailored for individual patients.

Developments in 2009

January

- The MoH and SSI adopted service procurement contracts for health service payments. Billing procedures such as dispatch of invoices or substitutive documents to the SSI was cancelled for the MoH primary, secondary and tertiary health care providers.

- "Family Medicine System" was introduced in Rize and Trabzon provinces.

- Pharmaceutical industry agreed on global budgeting for 2010-2012 in order to ensure sustainability and predictability in pharmaceutical spending (the pharmaceutical global budget was determined as follows: 14.600 million TRY for 2010, 15.562 million TRY for 2011 and 16.669 million TRY for 2012).

February

- "Regulation on Intra-Governmental Procurements of Goods and Service by Facilities and Entities under the Public Procurement Law No. 4734 for Diagnostic and Curative Purposes" was issued in the Official Gazette Dated 7.2.2009 and No. 27134. Accordingly, the rules and principles were identified pertaining to intra-governmental procurement of goods and services by and among facilities and entities providing health care services.

- By the Article 97 of the Law on Social Insurance and Universal Health Insurance No. 5510 amended by the Law No. 5838 which was issued in the Official Gazette (Repeated Edition) Dated 28 June 2009 and No. 27155, arrangements were made for bill due dates and it was resolved that total costs of bills could be paid in advance to service providers within 60 days after billing.

- After a 6-month preliminary work, "Social Assistance Information System" (SOYBIS) was put into service as an e-state application by the General Directorate of Social Assistance and Solidarity in February 2009 in order to ensure inter-organizational data exchange so that personal and financial data of social aid applicants could be obtained/checked and duplicated aid could be avoided.

Developments in 2009

March

- By the Strategy Development Presidency Circular Dated 27 March 2009 and No. 2009/23, price query and average cost estimates were required for the MoH through the "Material Resources Management System" (MRMS). Maximum Stock Implementation was started and the stock levels were limited to 4 months maximum. So, stock levels were considerably reduced.

- "Surplus Movable Property Module" and "Excess Movable Property Module" were developed for disinvestment and avoiding wastage of materials with close expiry dates, resulting in significant savings in costs.

April

- The Council of State granted a motion for stay of execution of the consultation copayment on 3 April 2009.

- By the Amending Regulation on Civil Servants Food and Clothing Allowances issued in the Official Gazette Dated 28 April 2009 and No. 27213, civil servants employed in inpatient health care facilities were provided free access to cafeterias.

May

- By the Strategy Development Presidency Circular Dated 12 May 2009 and No. 2009/32, staffing and pricing standards were set for the contracted personnel. Accordingly, new criteria were developed for determining the supply of the personnel whom could be employed in the MoH facilities on contract basis which complied with the new health service delivery model designed in scope of the Turkey Health Transformation Program and depended on revenues, service provision, patient capacity, physical setting and supply of the permanent and/or contracted personnel. Similarly, contracted personnel wages were increased above the subsistence wage, standardized for all facilities and the profit margin, which could be paid for service procurements for staffing, was reduced from 20% to 8%. The profit margin was re-identified as 5% by the Circular Dated 4 June 2010 and No. 2010/43 later.

Developments in 2009

June

- By the Article 14 of the Law Dated 25 June 2009 and No. 5917 and the Provisional Article 14 of the Law No. 209, it was ruled that the remaining 50% part of the hospital bills, which were issued for uninsured patients by the MoH and university hospitals before the date of 1.1.2009, would be cancelled with their subsidiary receivables on condition that the main 50% part of the bills were paid by the liable parties or were paid in installments within six months after the issuance of such bills. Accordingly, the bills would be directly cancelled if the unpaid bills cost less than 100 TRY.

July

- "Family Medicine System" was introduced in Usak province.

- By the Strategy Development Presidency Circular Dated 23 July 2009 and No. 2009/45, Provincial Stock Pools" were established for the MoH facilities and "Stock Coordination Teams" and "Central Procurement Units" were set up in provinces. All stocks in provinces were incorporated into the provincial stock pools which avoided duplicate purchase for surplus goods and improved savings. Purchasing power of small-scaled hospitals was limited and their needs were met by large-scaled hospitals. As a result of these regulations, the number of hospitals, which were authorized to procure medicinal products and medical supplies & equipment, decreased from 835 to 312.

- It was ruled that medicinal products and medical supplies & equipment would be procured at the provincial level via framework contracts.

August

- Pertaining to the reimbursement for the costs of equivalent pharmaceuticals, the ceiling price was brought down from 22% to 15% of the cheapest medicinal product which had the the same active ingredient and could be prescribed for the same indication.

- Red tape reduction and administrative simplification efforts were launched by the Circular Dated 28.08.2009 and No. 50.

September

- By the "Protocol on On-Site Supply of Medicinal Products for People Living in Rural Areas without Pharmacies" signed between the MoH and the Turkish Pharmacists' Association on 18 September 2009, mobile pharmacies were opened up in order to facilitate access to pharmaceuticals for people who lived in rural areas without pharmacies.

October

- As of 01.10.2009, copayments were charged as: 2 TRY for outpatient health care services, medical and private dental practices in provinces implementing the "Family Medicine System", 8 TRY for public secondary health care facilities, 8 TRY for training and research hospitals and 15 TRY for private health service providers. Accordingly, patients would not be charged 2 TRY copayment for primary care and family medicine consultations and 3 TRY deduction would be made in copayment for other health care services if no medicine was not prescribed or prescriptions were not used.

- As per the Measure No. 10 in the Program 2009 which stated that "measures will be taken in order to ensure effective and efficient use of public resources", it was envisaged to set up the "Commission of Health Expenditure Monitoring and Evaluation" was established for systematic monitoring and evaluation of health spending and developing strategies required to ensure quality-cost efficiency in health care services. The Protocol on Establishment of the Commission of Health Expenditure Monitoring and Evaluation was signed by relevant parties (the SPO, Undersecretariat of Treasury, MoF, MoH and MoLSS Undersecretaries, and the SSI and TurkStat Directors) on 8 October 2009. Total 4 delegates (2 full members and 2 associate members) joined the commission from these institutions. The commission was charged with collecting, managing and submitting data on health spending, informing decision-makers about health policies by drafting reports offering accurate information and objective analyses, and making suggestions for developing proper strategies.

- "Family Medicine System" was introduced in Bursa province.

December

- By the Amending Resolution on Pricing of Medicinal Products for Human Use issued in the Official Gazette Dated 3 December 2009 and No. 27421 (Repeated Edition), the following decisions were made in order to achieve targets relevant to global budgeting beginning from 4 December 2009:

  - The manufacturer's price for original medicinal products the generics of which were also available in the market was brought down from 100% to 66% of the reference price.

  - 100% of the manufacturer's price was still taken as basis for original medicinal products or products without generics in the market; however, the public discount applied by the SSI was increased from 11% to 23%.

  - While 80% of the reference price was taken as basis in pricing generic pharmaceuticals in the past, the threshold was brought down to 66%.

  - While pricing for old pharmaceuticals with more than 20-year market availability was not based on reference prices before, the reference price system was introduced for such products and set up as 100% of the manufacturer's price.

  - Both medicinal product prices and profit margins of warehouses and pharmacies were reduced.

- By the Cabinet Decision issued in the Official Gazette (Repeated Edition) Dated 8 December 2009 and No. 27426, it was decided that contracted health service providers, which were classified by the SSI criteria (such as the standard of service quality, patient rights, patient and employee safety, hospital service quintile index, hospital capacity, personnel rights, liabilities and etc.) including foundation hospitals other than those managed by the government, could charge an extra fee up to 70% of the service costs identified by the Health Service Pricing Commission.

- By the Cabinet Decision Dated 17 December 2009 and No. 2009/15712, it was decided that the receivables of the MoH health care facilities from the social security agencies, which went beyond the limit of the protocol in 2009, were cancelled.

- "Pharmaceutical Track and Trace System" (PTTS) was piloted.

Developments in 2010

January

- By the SSI Directive on Rating Private Hospitals and Extra Billing, private hospitals were classified and co-payments amounting 30% to 70% were identified by different classes.

- Health service payments for government employees and their dependents were devolved to the SSI.

- "Law on Full-Time Medical Practice for University and Ministry of Health Personnel" was adopted. Pre-transition period was 1 years' time for universities and 6 months for other health care facilities.

- Pays for hour shifts were increased for the health care personnel, from 80 hours maximum to 130 hours maximum per month. The coverage of the shift system was extended for non-health care personnel and shift pays were offered in oral and dental care facilities and in 112 emergency care service network, too.

- As for physician salaries, partial advance payments were made to physicians from their performance-based bonuses (which were treated as regular earnings) and the SSI premium payments were deducted from these partial advance payments which paved the way for an additional pension for physicians.

- By the Amending Article to the Law Dated 21 January 2010 and No. 5947, "Medical Malpractice Liability Insurance" was introduced in order to guarantee the right of compensation against physicians in cases of medical malpractice.

- The MoH and university facilities signed a protocol for cooperation and common use of facilities in accordance with the Amending Law Dated 21 January 2010 and No. 5947.

- By the Amending Law Dated 21 January 2010 and No. 5947, legal arrangements were made for devolution of the Turkish Red Crescent (KIZILAY) hospitals and medical centers (which were licensed and running as of 1/5/2009) to the Ministry of Health within 6 months after the protocol was signed. Accordingly, 3 hospitals and 26 medical centers were devolved to the MoH.

Developments in 2010

January

- The Amending Law Dated 21 January 2010 and No.5947 ruled that faculty members, having their personnel rights still reserved by their universities, could be temporarily assigned in other public institutions and organizations upon request from public institutions and organizations, consent of faculty members, permission of university executive boards and approval of university presidents. In such cases, monthly salaries, subsidiary payments and other benefits would be maintained by universities. However, the faculty members except for the Higher Education Council, Inter-University Board and Forensic Sciences Institute personnel would not be paid from revolving funds.

- The Amending Law Dated 21 January 2010 and No. 5947 ruled that public health care personnel, if necessary, could be temporarily assigned in medical and dental schools and health research centers upon request from such organizations and consent of the personnel. Accordingly, temporary assignment would be allowed for certain cases and/or duties, on certain days and/or at certain times. For those, who were temporarily assigned for a certain case and/or duty, an extra payment, which would not exceed the ceiling rates, would be made from the host organization's revolving fund in addition to the regular bonus payment that the personnel received for the permanent assignment.

- By the Amending Law Dated 21 January 2010 and No. 5947, supplementary payment ceilings were re-identified for medical and dental school personnel and supplementary payment was introduced for time-off work, too. Besides, supplementary payment ceilings were re-identified for university directors, as well.

- Total 377 million TRY financial support was given to 22 university hospitals: 209 million TRY in 2010 and 168 million TRY in 2011.

- Preliminary efforts were made to set up an "Early Warning and Response System" (EWRS) for monitoring communicable diseases.

- Undersecretariat of Treasury's share from the revenues of university health care facilities' and hospitals' revolving funds reduced from 5% to 3% while the its share from the MoH revenues was increased from 1% to 3%.

- "Family Medicine System" was introduced in Sakarya, Kutahya, Nevsehir, Artvin and Erzincan provinces.

Developments in 2010

February

- By the MoH Directive on Methods and Principles of Home Care Services, bedridden patients were provided with quality, effective, accessible and safe health care services at home settings which avoided unnecessary occupation of hospital beds and unnecessarily increased costs.

- "Central Hospital Appointment System" was piloted in Erzurum and Kayseri provinces on 23 February 2010 in order to facilitate medical and/or dental visits for patients in the MoH hospitals and oral and dental care facilities.

- With the aim of promoting primary and preventive health care services and diminishing inter-regional development gaps, the Minister of Health was authorized to raise the share of revenues to be transferred from the MoH revolving fund health care facilities and hospitals to the MoH central organization from 4% to 6%.

March

- "Managerial Performance" was introduced for the managers in the MoH hospitals

April

- After helicopter ambulances, ambulance aircrafts were integrated into the air ambulance network for distant patient transfers.

- "Family Medicine System" was introduced in Kilis and Igdir provinces.

May

- By the MoH Strategy Development Presidency Circular Dated 28 May 2010 and No. 2010/37, "Commissions for Determination of Needs" were established in order to control appropriateness of demands for procurement of medical supplies, equipment and medicinal products etc.

- "Family Medicine System" was introduced in Nigde province.

Developments in 2010

June

- "Family Medicine System" was introduced in Ordu, Kırklareli, Giresun and Konya provinces.

- By the MoH Strategy Development Presidency Circular Dated 04 June 2010 and No. 2010/43, the profit margin, which could be paid for service procurements for staffing, was reduced from 8% to 5%.

- By the Cabinet Decision Dated 9 June 2010 and No. 2010/948, pain killer medications such as morphine, which would be given to cancer patients, were provided by the MoH free of charge for primary, secondary and tertiary health care facilities.

July

- By the Income Tax Law Dated 23 July 2010 and No. 6009 and the Article 9 of the Amending Law on Some Laws and Regulations, total 377 million TRY financial support was given to the university hospitals at financial risk: 209 million TRY in 2010 and 168 million TRY in 2011.

- By the Regulation Dated 31 July 2010 and No. 27658, the MoH was entitled to meet the needs of its R&D centers without being subject to the Public Procurement Law.

- "Family Medicine System" was introduced in Canakkale, Malatya, Mersin, Bingol, Ankara and Aksaray provinces.

August

- "Family Medicine System" was introduced in Yozgat, Tokat, Ardahan and Batman provinces.

- By the MoH Regulation Dated 2 August 2010 pertaining to the Law on Full-Time Medical Practice for University and Ministry of Health Personnel No. 5947 and the Additional Article to the Law No. 209, partial advance payments were made to physicians from their performance-based bonuses (which were treated as regular earnings) and the SSI premium payments were deducted from these partial advance payments which paved the way for an additional pension for physicians.

- Accordingly, chief clinical officers and their deputies in the MoH health care facilities would be given supplementary payment from revolving funds amounting to 410% of the highest civil servant salary (including additional indicator coefficient) per month, specialist physicians and specialist dentists would be given supplementary payment amounting to 335% of the highest civil servant salary and general practitioners and dentists would be given supplementary payment amounting to 180% of the highest civil servant salary per month. These supplementary payments would not be based on the personnel's extra contribution to the organization but would be regulated by certain provisions. The amount of supplementary payment in the scope of this Law would be deducted from the bonus payment to be given for the same month in scope of the Article 5. Besides, if the supplementary payment regulated by this Law was higher than the bonus payment to be given under the Article 5, the price gap would not be returned and no other additional payment would be given by the Additional Article 3 of the Law No. 375 for those who received payment in scope of this law.

- By the MoH Regulation Dated 6 August 2010, the provincial health directorates were required to perform collective procurements in order to effectively and efficiently meet demands and needs of laboratories which were 629 in number.

- Amendments were made to the Circular on Admission of Emergency Cases to Hospitals, Emergency Patient Transfers and Payments for Emergency Care Services No. 2008/13, which was issued in the Official Gazette Dated 10 August 2010 and No. 27668, and the Prime Ministry Circular No. 2010/16 was issued in order to clarify some points relevant to the management of emergency care services.

September

- "Family Medicine System" was introduced in Hakkari, Siirt, Bitlis, Tekirdag, Zonguldak and Mus provinces.

October

- By the Regulation on Government Funding for Treatment Costs of Individuals Unable to Pay for Health Care Services and Amendment to the Regulation on the Green Card System issued in the Official Gazette Dated 13 October 2010 and No. 27728;

  - Green Card holders were provided free dental treatments such as root canal therapy and dental filling.

  - Green Card holders were provided free emergency and intensive care services in private hospitals.

  - Medical devices and equipment prescribed for outpatient treatment were paid on behalf of the Green Card insurees on condition that unit price did not exceed the rates identified by the SSI.

- By the MoH Official Letter Dated 11 October 2010 and No. 41128, quadrivalent combined vaccine including acellular pertussis vaccine was incorporated into the immunization scheme for the first grades of primary schools in order to prevent the cases of acellular pertussis which are common in primary school age.

- "Family Medicine System" was introduced in Kars, Agri, Afyonkarahisar, Sirnak, Mardin, Balikesir, Van and Istanbul provinces.

- By the MoH Regulation Dated 12 October 2010, measures were taken so that the procedures of payment to sellers were fulfilled in 90 days maximum, the procedures of examination and control were fulfilled in 10 work days maximum and the procedures of payment order were fulfilled in 10 work days maximum following examination and control. Besides, it was suggested to set up a "Procurement Monitoring Commission" and to develop "Payment Processes Monitoring Chart" in order to ensure regularity of payments.

- By the MoH Regulation Dated 13 October 2010, arrangements were made pertaining to transfer, sale and retirement of assets and movables.

Developments in 2010

November

- By the Cabinet Decision Dated 2 November 2010 and No. 27747, cancer patients, regardless of social security coverage, were provided charge-free access and use of Morphine Sulphate (MS) Contin tablets, Morphine Sulphate (MS) Immediate Release tablets and capsules and Elixirs (Roxanol) which were used for pain management in the MoH primary, secondary and tertiary health care facilities.

- "Family Medicine System" was introduced in Sivas and Kahramanmaras provinces.

December

- Hatay, Gaziantep, Sanliurfa, Diyarbakir, Aydin, Mugla, Kocaeli and Antalya provinces. So, the Family Medicine system became widespread in the country as of 13.12.2010.

- According to the protocol Dated 18 December 2010 which was signed by pharmaceutical companies aiming to meet targets relevant to global budgeting, an additional 9.5% discount was made in the prices of original medicinal products with no generics or original medicinal products without generics of market availability (except for the medicinal product groups not included in the Resolution on Pricing of Medicinal Products for Human Use).

- By the Cabinet Decision Dated 20 December 2010 and No.2010/1178., it was decided that the receivables of the MoH health care facilities from the social security agencies would be cancelled in 2010.

Developments in 2011

January

- In line with the MoH General Directorate of Curative Services Circular Dated 24 January 2001 and No. 2011/4, the MoH established the "National Organ Transplantation Waiting System" in order to optimize organ transplantation with respect to timing and preventing abuses and/or speculations.

- The MoH share for the Treasury, which was allocated from the MoH hospitals' and university hospitals' revenues collected from the revolving funds, was reduced from 3% to 1%.

- "Prevention and Control Program for Cardiovascular Diseases in Turkey" was put into implementation.

February

- In the framework of the Law on Full-Time Medical Practice for University and Ministry of Health Personnel, an additional fund of 448 million TRY was allocated for the medical school faculty members for once only in 2011 with the aim of avoiding financial bottlenecks that were likely to occur from the prohibition of extra-billing for private consultations at university hospitals beginning from February 2011.

- By the Cabinet Decision No. 2011/1333 issued in the Official Gazette Dated 13 February 2011 and No. 27845, the medicines to be used for smoking cessation treatments were provided free of charge in the MoH primary, secondary and tertiary health care facilities regardless of social security coverage of patients.

- Pertaining to the legislation identifying the rules and principles for common use of health care facilities by and cooperation between the MoH and universities, the Regulation on Supplementary Payment for Personnel from Revolving Funds was issued in the Official Gazette Dated 18 February 2011 and No. 27850. Accordingly, a city governor and a university president could sign a protocol for this purpose upon consent of the MoH and Higher Education Council (YOK) and common use of health care facilities would start in latest 6 months following the signature of the protocol the effective date of which could not be less than 4 years and 2-year extension would start automatically if one of the parties did not notify the other party for termination of the protocol 6 months before the date of termination. In this context, health care facilities which are affiliated with the MoH and 13 universities across the country (Ahi Evran University in Kirsehir province, Marmara and Istanbul Medeniyet University in Istanbul province, Ordu University in Ordu province, Sakarya University in Sakarya province, Rize University in Rize province, Yildirim Beyazit University in Ankara province, Izmir Katip Celebi University in Izmir province, Mugla University in Mugla province, Erzincan University in Erzincan province, Adiyaman University in Adiyaman province, Dumlupinar University in Kutahya province and Hitit University in Corum province) have been used commonly.

- Prescribing information inserted in drug packages was simplified in order to facilitate understanding.

- By the Law No. 6111 issued in the Official Gazette Dated 25.02.2011, the Government resolved that all medical expenses of traffic accident victims be paid by the Social Security Institution regardless of social security availability. Accordingly, costs of medical treatment at university hospitals, private hospitals and Ministry of Health hospitals for traffic accident victims would be paid by the Social Security Institution. In addition, the accounts of the Revolving Funds Administration for Traffic Services would be closed down in 6 months.

Developments in 2011

March

- By the MoH Regulation Dated 21.03.2011, the Ministry of Health was authorized to raise the share of revenues to be collected from the MoH secondary and tertiary health care facilities from 4% to 6%.

April

- The MoH revenue items were expanded by property and right lease contracts as specified in the Article 70 of the Income Tax Law, medical specialty certificates, licensing and examination procedures, default interests and interest yields.

- By an Additional Article to the Law on Social Security Institution No. 5502, it was decided that all bills, prescriptions and attached papers be destroyed at the end of the 5th financial year after date of issue, except for the ones which are still under inspection.

- By the Amending Law Dated 26 April 2011 and No. 6225, job descriptions were made for health professions which had not been described before such as clinical psychologist, physiotherapist, audiologist, dietitian, speech and language therapist, podologist, health physicist, anesthesia technologist/technician, medical labarotory and pathology lab technician, medical imaging technician/technologist, oral and dental care technician, dental prosthesis technician, medical prosthesis and orthoses technician/technologist, operating room technician, forensic medicine technician, audiometric technician, dialysis technician, physiotherapy technician, perfusionist, radiation therapy technician, pharmacy technician, occupational therapy technologist (ergotherapist), occupational therapy technician (ergotheraphy technician), electroneurophysiology technologist and mammography technician.

- By the Amending Articles 6 and 7 to the Law No. 6225 issued in the Official Gazette Dated 26 April 2011 and No.27916, rental incomes to be obtained by the MoH facilities in scope of the Article 70 of the Income Tax Law No. 193 were exempted from the Corporate Income Tax and excluded from the Valued Added Tax.

- By the Amending Law No. 5302 to the Law No. 6225 issued in the Official Gazette Dated 26 April 2011 and No. 27916, it was ruled that "the appropriations, which are warranted to the Special Provincial Administrations for a specific project but may not be properly used by the end of the relevant fiscal year, may be re-allocated for the same Special Provincial Administration but for a different project or for another Special Provincial Administration or the Mass Housing Administration by the approval of the authorized Minister". So, the cash funds remaining idle in the special provincial administrations were utilized more effectively.

Developments in 2011

April

By the Law No. 6225 issued in the Official Gazette Dated 26 April 2011 and No. 27916 and the Amending Provisional Article to the Law No. 209;

- It was ruled that "the costs of health care service, which remained unpaid as of the effective date of this Law, would be cancelled with their subsidiary receivables for uninsured persons who were not capable to pay for hospital bills and lost their lives while being treated in the MoH and other public health care facilities (except for the foundation universities)". So, debts of the persons, who lost their lives in public hospitals when they were not covered by any social security scheme and not capable of paying for hospital services during treatment, were cancelled.

- It was ruled that "pertaining to the costs of health care services, which were provided by the MoH facilities for real persons who could not benefit from social security aids for any reasons at the time of service provision and which remained unpaid as of 31.12.2010, the remaining 50% of the bills would be cancelled with their subsidiary receivables on condition that the first 50% part of the bills were paid in 1 years' time by liable parties by single payment or in installments. If the unpaid bills cost 250 TYR or less, the bills would be directly cancelled and if the half of the unpaid bills cost less than 250 TRY, then the total cost would be cancelled and the residue would be collected". So, the MoH receivables from persons were cancelled providing that the persons paid half of their bills in 1 years' time by 31 December 2010. Besides, the receivables, which cost less than 250 TRY, were directly cancelled.

- It was ruled that "the hospital bills of the patients who were transferred to Turkey from the Northern Cyprus Turkish Republic, which remained unpaid as of 31.12.2010, would be cancelled". So, the MoH receivables from the patients transferred from the Northern Cyprus Turkish Republic were cancelled as of 31 December 2012.

May

- "Child Monitoring Centers" (CIM) were established in order to prevent child abuse and perform proper and effective interventions in cases of child abuse.

Developments in 2011

June

- By the MoH Regulation on 6 June 2011, new arrangements were put into use in order to prevent abuses in government institutions' procurements from the State Supply Office.

- By the Cabinet Decision Dated 7 June 2011 and No. 2011/2002, it was ruled that debts of the persons would be cancelled who lost their lives in public hospitals when they were not covered by any social security scheme and not capable of paying for hospital services while being treated.

- By a 10-year protocol signed between the MoH and MoF on 15 June 2011, the MoH became entitled to rent commercial revenue-generating properties (such as cafeterias, canteens and parking lots etc.) in the MoH hospitals and the family medicine centers out to the third parties. According to the protocol, the MoH would make payment to the MoF from its annual rental incomes in 4 installments and would also allocate an extra 30% share for the MoF if rental income was higher. The rental income to be obtained from the family medicine centers were also considered when identifying the annual rate.

August

- By the Amending Regulation on Civil Servants Food and Clothing Allowances issued in the Official Gazette Dated 20 August 2011 and No. 28031, the 112 Emergency Care Personnel were provided charge-free meal service during work hours.

- Regulation on Collection of Medical Bills Relevant to Traffic Acidents was issued in the Official Gazette Dated 27.08.2011 and No. 28038.

September

- The MoH General Directorate of Health Researches launched the "Distance Learning Certificate Program in Healthcare Management" for the MoH managers in both central and provincial organization on 26 September 2011.

- By the Amending Regulation on Outpatient Curative and Diagnostic Care Facilities issued in the Official Gazette Dated 28.9.2011 and No. 28068, physician transfers from public to private sector health care facilities was regulated for appropriate physician turnover.

- "National Mental Health Action Plan" was announced for 2011-2023.

Developments in 2011

October

- By the Decree Law Dated 11 October 2011 and No. 663, the MoH abolished the requirement of obtaining the Republic of Turkey citizenship for performing medical practice in Turkey and officially allowed foreign workforce of non-Turkish doctors and nurses.

- By the MoH Regulation Dated 19 October 2011, new arrangements were made and a program was developed for Identification of Estimate Costs for Procurement of Medical Devices and Medical Services.

November

- By the Amendment to the SSI Medical Enforcement Declaration (SUT) issued in the Official Gazette Dated 5.11.2011, copayment was increased by 5 TRY for inpatient medical and oral and dental care visits for the same medical/oral-dental specialty branch in another health care facility within 10 days after the first, except for primary care consultations, chronic diseases and emergency cases. The increased copayment amounting to 5 TRY would be charged from salaries and pensions for active employees, pensioners and their dependents while it would be charged from the persons themselves during their visits to pharmacies.

- Beginning from 5 November 2011;

    - Manufacturer's price for original medicinal products the generics of which were also available in the market was brought down from 66% to 60% of the reference price.

    - Public discount, which applied by 32,5% for all medicinal products, was increased by 7,5% and reached to 40%.

    - Public discount base rate was increased to 41% for original medicinal products with no generics or without generics available in the market.

    - While 66% of the manufacturer's reference price was taken as basis in pricing generic medicines in the past, the threshold was brought down to 60%.

    - While pricing for old medicinal products with more than 20-year market availability was based on 100% of the reference prices before, the threshold was brought down to 80%.

- Beginning from 5 November 2011, patients who received a bill of health were not allowed for re-prescribing 15 days before the maturity date of the bill while the re-prescribing period was 7 days before.

- Beginning from 10 November 2011, pertaining to the reimbursement for the costs of equivalent pharmaceuticals, the ceiling price was brought down from 15% to 10% of the cost of the cheapest medicinal product.

- The organizational structure of the Ministry of Health was redesigned and the MoH organization was restructured as the Ministry of Health, Turkish Public Hospitals Agency, Public Health Institute of Turkey, Pharmaceuticals and Medical Devices Agency of Turkey and the General Directorate of Health for Borders and Coastal Areas of Turkey.

- By the Circular Dated 11.11.2011 and No. 2011/59, advertising and promotional activities of private health care facilities were regulated.

Developments in 2011

December

- By the Amendment to the SSI Medical Enforcement Declaration (SUT) issued in the Official Gazette Dated 17 December 2011 and No. 28145, it was ruled that stock losses of pharmaceutical warehouses, which might occur from additional public discounts, would be refunded to warehouses by companies and to pharmacies by warehouses, and notifications of pharmacies to the Pharmaceutical Track and Trace System would be taken as basis for relevant procedures.

- By the Amendment to the SSI Medical Enforcement Declaration (SUT) issued in the Official Gazette Dated 31.12.2011, the number of patients per physician per day was limited to 60 in private health care facilities. Also, it was ruled that the upper limit of daily consultations would be set for private health care facilities by multiplying work hours of physicians with the coefficient 6, except for emergency care visits.

Developments in 2012

January

- By the Cabinet Decision Dated 02 January 2012 and No. 2012/2688, it was decided that the receivables of the MoH health care facilities from social security agencies, which were beyond the limits of agreement, would be cancelled in 2012.

- By the Amendment to the SSI Medical Enforcement Declaration (SUT) issued in the Official Gazette Dated 21 January 2012, copayment was charged for outpatient care visits to emergency care departments by the rules of triage.

- "Green Card Program" was covered by the UHI.

- Chief clinical officers and their deputies were titled as clinical instructors.

February

- By the Regulation on Organ and Tissue Transplantation Services issued in the Official Gazette Dated 01.02.2012 and No. 28191, eligibility criteria were established for and composite tissue transplantations.

March

- By the Article 68 of the Law No. 5510 which was amended by the Law Dated 1.03.2012 and No. 6283, copayment was charged for also prescriptions written out by family physicians. In addition, 3 TRY copayment was charged for prescription drugs - either 3 boxes of the same drug or 3 separate drugs - while an extra 1 TRY was charged for every other drug prescribed additionally.

- Beginning from 24 March 2012, the VAT rate on imported pharmaceutical raw materials, which were used for pharmaceutical medicinal production, was reduced to 8%.

- By the Cabinet Decision issued in the Official Gazette Dated 17 March 2012 and No. 2012/2939, the upper limit of extra-billing, which is allowed in private hospitals, was increased from 70% to 90%.

- The final value of the SSK-owned real estates, which were devolved to the MoH, was estimated 3.240.000.000 TRY. The MoH paid to the SSK in installments for the expropriated real estates as follows: 901,5 million TRY was paid to the SSK in June 2008, 739,4 million TRY was paid in March 2009, 150,4 million TRY was paid in December 2010 and 54,3 million TRY was paid in December 2011. So, total 1 billion and 845 million TRY was paid as the cost of expropriation and the residue was paid by the MoD as the Undersecretariat of Treasury's grant to the SSI.

April

- "Field Epidemiology Training Program" started.

May

- By the Board of Arbitration Decision Dated 29.05.2012, some improvements were made to the personnel rights of health care employees.

- Accordingly;

    - Contracted personnel employed in inpatient health care facilities were provided free access to cafeterias.

    - Additional 10 points of performance score was given to the personnel who were permanently employed as ambulance drivers in addition to their main positions (such as emergency care technicians, emergency care technologists and community health technicians etc.).

    - Balancing payment was given every month, in cash and with no prerequisite. Also, it was ruled that the personnel would receive balancing payment even if no contribution was made to revolving funds for reasons such as paid leave or bill of health etc.

    - Supplementary payment ceiling was increased from 120% to 200% for non-physician personnel employed in 112 Emergency Care.

    - By the Additional Article 33 of the Law on Civil Servants No. 657, pays for hour shifts during religious holidays were increased by 20% for health care personnel.

    - By the Clause 1 of the Additional Article 3 of the Law No. 209, it was ruled that, beginning from the date of 1.7.2012, the net fixed monthly supplementary payment, which would be given to physicians from revolving fund as ordered by the Additional Article 3 of the Law No. 209, would not be less than the amount specified by position or job description in scope of the Additional Article 9 of the Decree Law No. 375.

    - Supplementary payments given to the acting deputy provincial health directors, branch directors, hospital managers and deputy hospital managers were based on the tax bases for personnel cadres deputized.

    - It was ruled that gaps would be paid from revolving funds, if total sum of payments given for financial rights in a fiscal year's time was less than the amount of payments required by the Decree Law No. 375.

    - Of officers, nurses, midwives, health officers and etc., the personnel, who were assigned as record management and control officers for movable properties were given pay raises in return for their financial responsibilities.

    - The Circular Dated 14.05.2012 and No. 2012/23, the "White Code Policy" was put into implementation in order to prevent violence against health care personnel.

Developments in 2012

June

- By the Cabinet Decision Dated 28 June 2012 and No. 2012/3304, the MoH handed out 2 million charge-free pedometers by means of family physicians in order to fight against obesity.

July

- By the new paragraphs added to the to the Article 73 of the Law No. 5510 by the Law No. 6353 issued in the Official Gazette Dated 12/07/2012 and No. 28351, civil servants, soldiers and non-commissioned officers, temporary or voluntary village guards, students and civilians whom were granted invalidity pension due to the events within the scope of the Anti-Terrorism Law No. 3713, and persons, who were disabled on active duty and/or war and could not live their daily lives without external support even if they were not covered by the Law No. 3713, were unlimitedly provided with charge-free orthotic and prosthetic products and rehabilitative equipment by the SSI.

- By the Amending Law Dated 4 July 2012 and No. 6354, the MoH-affiliated training and research hospitals were allowed to recruit contracted clinical instructors.

- By the Amending Law Dated 4 July 2012 and No.6353, the 6th grade Turkish medical students in medical schools (including Gulhane Military Medical Academy (GMMA)) were paid monthly intern salaries from university budgets in return for the medical practices they performed under the supervision of faculty members during the internship program for 12 months. The intern salary was calculated by multiplying the indicator coefficient 4.350 with the monthly indicator coefficient for government employees.

- Shifts were scheduled for family physicians except for their routine work hours. So, family physicians started to receive shift payments.

August

- By the MoH Circular Dated 1 August 2012 and No. 2012/23, the costs of the services amounting to 1.466.000.000 TRY, which exceeded the MoH global budget 2011, TRY were cancelled.

Developments in 2012

October

- By the Prime Ministry Circular No. 2012/20 issued in the Official Gazette Dated 4 October 2012 and No. 24831, the CIM Management and Coordination Council was established with the participation of delegates from the Ministry of Justice, Ministry of Family and Social Policies, Ministry of Interior, Ministry of Education, Presidency of Religious Affairs and Forensic Sciences Institute (deputy undersecretaries from the ministries and vice-presidents from other organizations) with the aim of taking necessary measures and ensuring inter-organizational cooperation for effective management of the Child Monitoring Centers (CIM).

- By the MoH Approval Dated 5 October 2012 and No.547, the Directive on Efficiency Assessment of Association of Public Hospitals was put into effect.

November

- The central and provincial organization of the Ministry of Health was re-structured as ordered by the Decree Law No. 663. Accordingly, health directorates were established in districts in addition to those already existing in provinces. Within the provincial organizational structure of the Public Health Institute of Turkey and Turkish Public Hospitals Agency, public health directorates and general secretariats were established in provinces. The project for the "Association of Public Hospitals" was realized on 2 November 2012. Accordingly, all personnel in the general secretariats and directors performing at hospitals and oral and dental care centers were employed on contract basis.

December

- It was decided that the spending on early screenings for cancer (breast, cervical and colon cancers) would be met from the MoH global budget. In this context, 152 million TRY fund was added up to the global budget 2013.

Developments in 2013

January

- "Regulation on the Implementation of Family Medicine System", which addresses strengthening primary health care services and regulates working rules and principles for the Family Medicine staff, was issued in the Official Gazette Dated 25.01.2013 and No. 28539.

- Energy Saving in Health (SEVER) Project started in order to ensure more effective management of power supply and energy resources in health care facilities in addition to reducing energy costs.

February

- "Regulation on Supplementary Payment for the Personnel Employed in Health Care Facilities Affiliated with the Turkish Public Hospitals Agency" was issued.

March

- "Law on Construction and Renewal of Health Care Facilities under the Ministry of Health and Procurement of Service via Public-Partnership Model" came into effect after having been issued in the Official Gazette.

- Studies and researches were launched in order to adapt the EU Guidelines on Good Distribution Practice to Turkey.

- "Learning Hospital Project", which aims at raising morale and motivation of hospital staff and patients/ affiliates going through a long-term treatment process in health care facilities, was designed in cooperation with the General Directorate of Life Long Learning of the Ministry of Education (MoE) and piloted in 13 provinces and 15 health care facilities.

Developments in 2013

April

- In the framework of the European Union standards and good clinical practices, the "Regulation on Clinical Researches and Studies" was issued in the Official Gazette Dated 13 April 2013, identifying the rules and principles for conducting scientific studies on humans and protecting the rights of volunteer human subjects.

- The Regulation on Manufacturing Plants of Medicinal Products for Human was issued in the Official Gazette Dated 27 April 2013.

May

- Fund allocation for clothing support given to 112 Emergency Care personnel was raised.

- "National Action Plan for Rational Drug Use 2014-2017" was developed in order to ensure coordination and collaboration for rational drug use-supporting activities and behavioral changes in correspondents.

- Legal amendments were made to the effective laws allowing academic members to receive bonus payments, which are proportional with their titles and will be paid in return for the extra services they offer after work hours, as agreed by the SSI and regulated by the university executive boards.

June

- Actions were taken in order to develop software programs for the Medical Device Tracking System and the Cosmetics Tracking System, and a protocol was signed with TUBITAK for that purpose.

Developments in 2013

July

- The MoH signed a cooperation protocol with TUCRIN in order to establish a data base for clinical researches.
- "Directive on Health Care Services to be Offered in scope of Health Tourism and Protecting the Health of Tourists" came into effect on 23.07.2013.
- 10th Development Plan for 2014-2018 was announced and health-related targets were declared.
- 10th Development Plan introduced two Priority Transformation Programs to the health care sector.

1- Structural Transformation Program for Health Industry

- Meeting 20% demand for medical devices and supplies via domestic production
- Meeting 60% demand for medicines via domestic production

2- Health Tourism Promotion Program

- Building 100.000-bed capacity for thermal tourism
- Offering service to 1.500.000 foreign tourists (600.000 of whom visiting Turkey for treatment purpose) in scope of thermal tourism
- Having 3 billion USD revenue generated by thermal tourism
- Taking part in the first 5 global destinations in medical tourism
- Providing curative services for 750.000 foreign patients
- Having 5,6 billion USD generated by medical tourism
- Building 10.000-bed capacity in senior tourism
- Having 150.000 foreign tourists in scope of senior tourism
- Having 750 million USD generated by senior tourism

Developments in 2013

August

- "Regulation on Advertising and Promotional Activities of Medicinal Products for Human Use" was issued in the Official Gazette Dated 26.08.2013 and No. 28037.

- In coordination with the Ministry of Health and Ministry of Environment and Urbanization, the "Project for Public-Private Collaboration for Energy Efficiency" was launched so as to serve as a good example for other public facilities, too.

October

- By the Cabinet Decision No. 2009/15627, which was issued in the Official Gazette Dated 12.10.2013 and No. 28793, the ceiling rate for extra billing at private hospitals was increased from 90% to 200%.

November

- By the Ministry Approval Dated 15.11.2013, a guideline was published on the statements used by cosmetic companies for advertisement and sale.

- Using the Prescribing Information System (PIS), feedback has been given to physicians since November 2013 about the prescriptions they have written out.

December

- Service Provision Standards and On-Site Evaluation Criteria were developed for patient care and hotel services for health care.

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