THE PROGRESS SO FAR

Turkey Health Transformation Program

November 2002 - June 2007

Prof. Dr. Recep AKDAĞ

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Foreword

My fellow citizens,
We put into effect what we have promised in the Government Program and Urgent Action Plan so far in order to provide effective, fair, accessible and quality health services for our public. We put Health Transformation Program into practice and we continue our services in this field along the line.

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

We, as the government, always cared about and gave priority to the trust that our public have towards the State in the most vulnerable area of health as well as receiving services without being writhed and troubled. Thus, we wanted all our citizens to have a State to be proud with when having their children, spouses and parents treated and a State of which they can experience the compassion.

Since we execute the Health Transformation Program in a serious, determined and careful manner, all of the citizens are able to receive their medication and health services without any discrimination, as equal and honorable citizens, from all the health institutions they wish. Our hospitals are more modernized and this modernization process is still continuing.

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

While making effort in order to ensure mothers give birth to healthy babies and individuals assured of their parents' health, we bravely conducted new regulations which will please every member of the health staff within our existing means.

It is our most important objective to enhance our efforts within other sectors with health services, when building a healthy society. Because we know that our nation deserves the best of all services and we continue on our way by saying "human first".

I would like to congratulate everyone who put effort into the implementation of Health Transformation Program and present my gratitude on behalf of my nation.

With all my respect…

Recep Tayyip ERDOĞAN
Prime Minister

Preface

As you know, for four years we have been realizing an important transition with the Health Transformation Program. The main goal of our efforts is to make the Turkish health system compatible with the vision of 21st century and to provide our people with a high quality health service which they deserve.

As the 58th and 59th Government of the Republic, we set out believing we had the power to present the citizens a humanly, equal and modern healthcare service. We strengthened this belief with the evaluation of all the efforts that have been taken in the field of health since the foundation of our Republic.

We developed our Health Transformation Program, which is a Turkey Model focusing on human, by analyzing and evaluating the health systems of a lot of developed countries' health systems on site; we combined it with our inheritance. We put all the components of this model into effect with the power we gain from our nation, the instruction of our Prime Minister, the determination of our Government and the support of Turkish Grand National Assembly.

While planning the program and preparing its infrastructure, we had to start the implementation of the transformation program on the other side. Thus, we have continued our studies without forgetting the fact that the health services cannot be delayed for a moment.

We accomplished important achievements and we still continue.

Today we experience the contributions and the most important outcomes of this program. And we strongly believe that we will accomplish better results in the future.

At the end of this productive process, when we look retrospectively, the accomplishments of our government can be perceived clearly. We, of course, do not assume that this is enough. We have a lot to do, to serve and to work up a sweat.

What matters for us is to please our people in the field of health just as in other fields and to have their blessings. We believe that Turkish Republic has the dynamics and power to achieve these goals.

On this occasion, we would like to express our gratitude to everyone – physicians, nurses, midwives, technicians, officers, drivers, etc.- who altruistically made efforts for public health through understanding the essence of Health Transformation well.

In this study, you will find the 5 year story of the Health Transformation Program. With this study, we wanted to share the distance we covered as the Ministry of Health in the field of health.

We enjoy the service provided and the positive results in the very vital area of health and we leave it to our people's discretion.

Prof. Dr. Recep AKDAĞ

Minister of Health

Introduction

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

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

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

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

Health Transformation Program which is being executed within this scope is the supplementary part of the national policy. Health services are gaining a dynamic base which will be able to cover the rapidly changing and transforming health priorities.

With this study, we present with examples what we achieved through the Health Transformation Program which we have been implementing as a unique model to Turkey starting from contemporary health policies. Our aim is to continue our way with the feedback we will take from all the related parties and stakeholders in Health.

PART 1

Our Health Policies

From Past to the Present

Our Health Policies from Past to the Present

Besides the continuity of the Seljuk – Ottoman medical tradition, a cultural unity stands out when the organization of the health services are considered. While this structure was developing since the foundation of our young Republic, a western oriented path was mostly followed for the organization of the state including all of its institutions and the establishment of service policies. Within this process, health policies demonstrated basic preference changes related with the trends in the world.

Health Policies between the Years 1920-1923

The Ministry of Health of Turkey was established by the Law No: 3 and dated 3/5/1920. The first Minister of Health was Dr. Adnan Adıvar. An opportunity of regular recording did not exist in this period. The focus was mostly on removing the damages of the war and developing of legislation.

Health Policies between the Years 1923-1946

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

In this period the following Laws were adopted:
- Law No: 1219 on the Practice of Medicine and its Branches (1928)
- Law No: 1593 on General Hygiene (1930)
- Law on the Officers and the Organization of the Ministry of Health and Social Aid dated 1936, which is still in effect.

Health policies were determined with these four principles:
1- Central execution of the planning, programming and administration of the health services,
2- Determination of the preventive medicine under central administration and of the curative medicine under local administration,
3- In order to meet health manpower demand, improving the attraction of Medical Schools, establishing dormitories for medical school students, establishing compulsory duty for the graduates,
4- Initiation of control programs for communicable diseases such as malaria, syphilis, trachoma, tuberculosis and leprosy.

Under the light of these principles;
- The health services have been conducted with "single purpose service in a wide area/ vertical organization" model
- "Preventive medicine" concept has been developed through legal regulations, the local administrations have been promoted to open hospitals, offices of government doctor have been established.
- Diagnosis and treatment centers have been established in district centers beginning from the places with high population (150 district centers in 1924 and in 20 district centers in 1936), physicians were banned to work independently.
- As a guide for the cities, Ankara, Diyarbakır, Erzurum, Sivas Numune Hospitals were opened in 1924; Haydarpaşa Hospital was opened in 1936; Trabzon Hospital was opened in 1946 and Adana Numune Hospital was opened in 1970.

Health Policies between the Years 1946 - 1960

Behçet Uz started the National Health Policy studies in 1946 and established a policy aiming at increasing the number of hospital beds. Uz's objective was the presentation of the preventive and curative healthcare services together by establishing 10-bed health centers for a population of 40.000.

Health centers were established in order to provide integrated health services based on population in this period. Hospital services were transferred from the local administrations to the Ministry of Health.

The Emergency Law on Malaria Control was adopted (1945). Labor Insurance Administration (Social Insurance Institution) was established (1946). Mother and Child health services were initiated (1952). Beginning

from 1952, health institutions and hospitals for insured workers were started to be opened. Minister Uz's health plan developed in the framework of population based organization, integration of the curative and preventive services, and implementation of the inpatient health services under the Ministry of Health; medical specialization was brought forward.

Health Policies between the Years 1960-1980

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

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

"Multi dimensional service in narrow area" approach was adopted alternative to the "single dimensional service in wide area".

However a draft law on general health insurance was prepared, it could not be forwarded to the Council of Ministers. In the 2nd Five Year Development Plan in 1969, the initiation of the general health insurance was anticipated again. Draft Law on General Health Insurance was forwarded to the Parliament in 1971 but it was not adopted. In 1974, the draft which was presented to the Parliament was not discussed.

In 1978, the Law on the Principles of Health Personnel's Full Time Working was adopted. The doctors in public sector were prohibited from establishing private doctor's offices. This Law was repealed with the Law on the Amends and Working Principles of the Health Personnel in 1980 and the freedom of establishing doctor's offices was initiated again.

Health Policies between the Years 1980 – 2002

The 1982 Constitution includes provisions both regarding the citizens having social security rights and the responsibility of the State for realization of these rights. According to the 60th article of the Constitution, everyone has the right to social security and the State shall

take the necessary measurements and establish the necessary organization to provide this security. Additionally according to the 56th Article of the Constitution "To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the State shall regulate central planning and functioning of the health services. The State shall fulfill this task by utilizing and supervising the healthcare and social institutions, in both the public and private sectors". Besides, the article includes the provision "In order to establish widespread health services general health insurance may be introduced by law."

"Basic Law on Health Services" was adopted in 1987. However because the necessary regulation for the execution of this Law was not made and some of its articles were repealed by the Constitutional Court, the Law was not put into effect and remained as a body of wishes.

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

The first and the second National Conference on Health were held and the theoretical studies on health reform gained acceleration. Green card practice was started in 1992 with the Law no. 3816 for the low income citizens who are not covered by social security. The effort was aiming at including the needy part of the society in the health insurance even limitedly.

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

General health insurance was presented to the Parliament by the Council of Ministers under the name "the Law on Personal Health Insurance System and the Establishment and Operation of the Health Insurance Institution" in 1998 but it did not become a law. A Draft Law on the "Health Fund" was presented for the opinion of the ministries however it was not concluded either.

The main components of the Health Reform which was conducted in 1990's were:
1- Establishment of a general health insurance by gathering the social security institutions under one umbrella,
2- Development of the primary health services in the framework of family medicine,
3- Transformation of the hospitals into autonomous health facilities,
4- Providing a structure to the Ministry of Health which plans and supervises the health services prioritizing preventive health services.

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

Health Policies after 2003: Turkey Health Transformation Program

Right after the elections on 3 November 2002, the basic objectives to be conducted under "Health for Everyone" title were determined in the Rapid Action Plan which was declared on 16 November 2002.

The key objectives are:
1- Administrative and functional restructuring of the Ministry of Health ,
2- Covering all the citizens by the general health insurance,
3- Gathering the health institutions under one umbrella,
4- Providing the hospitals with an autonomous structure on the administrative and financial aspect,
5- Starting the implementation of family medicine,
6- Giving special importance to mother and child healthcare,
7- Generalizing the preventive medicine,
8- Promoting the private sector to make investment in the field of health,
9- Transforming the authorities to the lower echelons in all the public institutions,
10- Eradicating the lack of health personnel in the areas which have priority in development,
11- Realizing the e-transformation in the field of health.

Right after the determination of the Urgent Action Plan, the Health Transformation Program was prepared and declared to the public by the Ministry of Health. The Health Transformation Program aimed at transforming in the framework of 8 themes:

1- Ministry of Health as the planner and auditor,
2- General health insurance gathering everyone under single umbrella,
3- Widespread, easily and friendly accessible health service
a) Strengthened primary health services and family medicine,
b) Efficient and graduated referral chain,
c) Health facilities having administrative and financial autonomy,
4- Manpower in the field of health which has adequate information, skills and high motivation,
5- Education and science institutions to support the system,
6- Quality and accreditation for qualified and efficient health services,
7- Institutional structuring in rational management of medicine and supplies,
8- Access to effective information in decision process.

The period between the years 2003-2007 has witnessed important changes. The program which was prepared and publicized at the beginning of 2003 was inspired by our recent experiences, health reform studies and the successful examples in the world.

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

In the last few years that the Health Transformation Program have been put into effect, Turkey has witnessed a period in which the health policy changes was discussed by the public opinion and the implementations are noticed by the service receivers as well as the service providers.

The matters subject to public displeasure have changed. Now, the patient safety is being discussed rather than access to health services. The agony of the patients waiting in medicine queue replaced with the amount of the medicine used in the media agenda.

Now the main issues are the scope of the social security and general health insurance instead of the pledged patients because of poorness. The emergency patient referral problem replaced with the demands for intensive care beds.

Instead of discussing the problem of low vaccination rate, addition of new vaccines to the vaccination calendar began to be discussed about and even implemented.

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

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

PART 2

A New Era in Health

A New Era in Health

1. Mentality Change towards Human-Centered Service Perception

Our needs in the field of health cannot be delayed. Unfortunately this fact has not been taken into consideration. **We started the way with an approach focused on service, putting aside the institutional concerns and priorities.**

We placed "human centered" approach at the top of the Health Transformation Program. We are aware that the health services are not the mercy of the State but delivery of people's rights.

> We have set off with the conception that places human in the centre of service, fling aside all institutional concerns and priorities.

We left the days behind that the patients were pledged and price demanded for ambulance services. We are experiencing a period in which we can provide "112 Emergency" service not only in cities but also in the villages; a period that we can provide service to our citizens in their homes by the mobile services in rural areas and a period that we can provide service for the patients who need dialysis through driving them from home.

We eradicated all of the difficulties obstructing our citizens from accessing health services. Now, our people can consult to any hospital they wish; they can take their medicine from the pharmacies without being returned empty handed because of the lack of medicine and they do not wait for their queues for hours.

Currently, family medicine practice that we initiated in Duzce one and a half years ago is being executed in 11 provinces. Nine million citizens are benefiting from this practice and can choose their doctors.

We follow the pregnant women and babies delicately. We have significant accomplishments regarding health personnel attendance in deliveries and having vaccinations completed.

We have established one of the greatest medical rescue teams in Europe with 2400 specially trained health personnel ready to act in emergencies in 81 provinces.

A significant decrease in the number of the communicable diseases such as malaria, typhoid fever and measles is recorded.

Today, every hospital in our country includes a "Patient Rights" unit. We can choose our own doctors in more than the half of our hospitals. Our hospitals are well equipped in terms of medical devices and equipments. We provided 19.000 new hospital beds. In the new hospital projects, we place bathrooms and toilets in the patient rooms and we place one or two beds in the rooms. We doubled the bed capacity of intensive care.

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

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

We eradicated the imbalance in Health, through giving priority to places with inadequate equipment and health personnel country-wide. We employed nearly 100.000 new health personnel in public sector.

A New Era in Health

2. Widespread and Equal Health Insurance: General Health Insurance

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

Efforts were made in order to provide the harmonization between the existing social security institutions until the legal and institutional infrastructure of the general health insurance is formed. Reimbursement commission was established including the representatives from the Social Security Institution, Occupational Pension Fund, Ministry of Finance, State Planning Organization and the Treasury. Thus, different reimbursement mechanisms conducted by different social security institutions were eradicated and a joint model and strategy were built.

In the direction of the principle of equity, Health Transformation Program has aimed to develop a social insurance model in which citizens will contribute in proportion of their paying abilities and will receive health service as much as they need.

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

Radical changes were completed for providing unity between service provision and target groups of healthcare service providers. The citizens under the public insurance were provided the opportunity to access service from the private health institutions also. Thus, the service presentation forms of the private hospitals were harmonized. On the other side, the discrimination between state hospitals and Social Security

Institution hospitals was eradicated and thus unity was provided between public hospitals' operation models.

An infrastructure providing the usage of a joint medicine database by all the social security institutions was developed. This infrastructure enabled the central audit of medicine. Similarly, joint databases were developed for the controlling of progress and services based on a single system.

The coverage of the green card implementation widened and provided to be more realistic and effective. Thus, the citizens with low income were covered by a health insurance which is not different from the Social Security Institution, Social Security Institution for Artisans and Self-employed, and the Government Employees' Retirement Fund.

The first step of the social security reform was taken with the Law No: 5502 and all the security institutions were restructured and gathered under the Social Security Institution. With the Law No: 5510, it was aimed to eradicate the inequalities in the accession to health services through defining the rights and responsibilities, besides covering all the population by the social security. A strong structure was designed to conduct surveillance, produce policy based on information and centralize public purchasing power on Health. However this structure is delayed until the beginning of 2008 because the Constitutional Court repealed some of the articles.

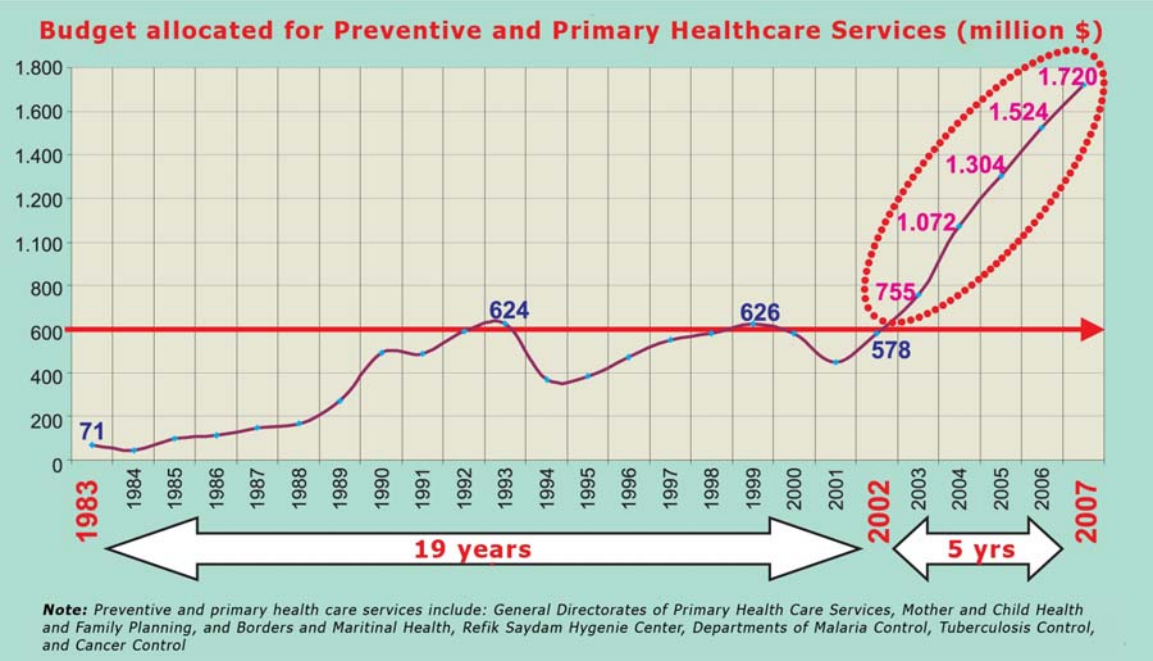
Meanwhile, the Communiqué on Social Security Institution published by the Social Security Institution started a new era that enabled citizens to access health services equally and easily. This equalized the citizens, who were under the coverage of different social securities, in front of healthcare services. Additionally, beginning from January 2007, no payment will be required from the citizens for primary healthcare even though they do not have social security. The steps taken within this area will be completed when the Law no.5510 comes into effect.

A New Era in Health

3. Campaign for Preventive and Primary Healthcare Services

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

Preventive and primary health care services are safeguarded.

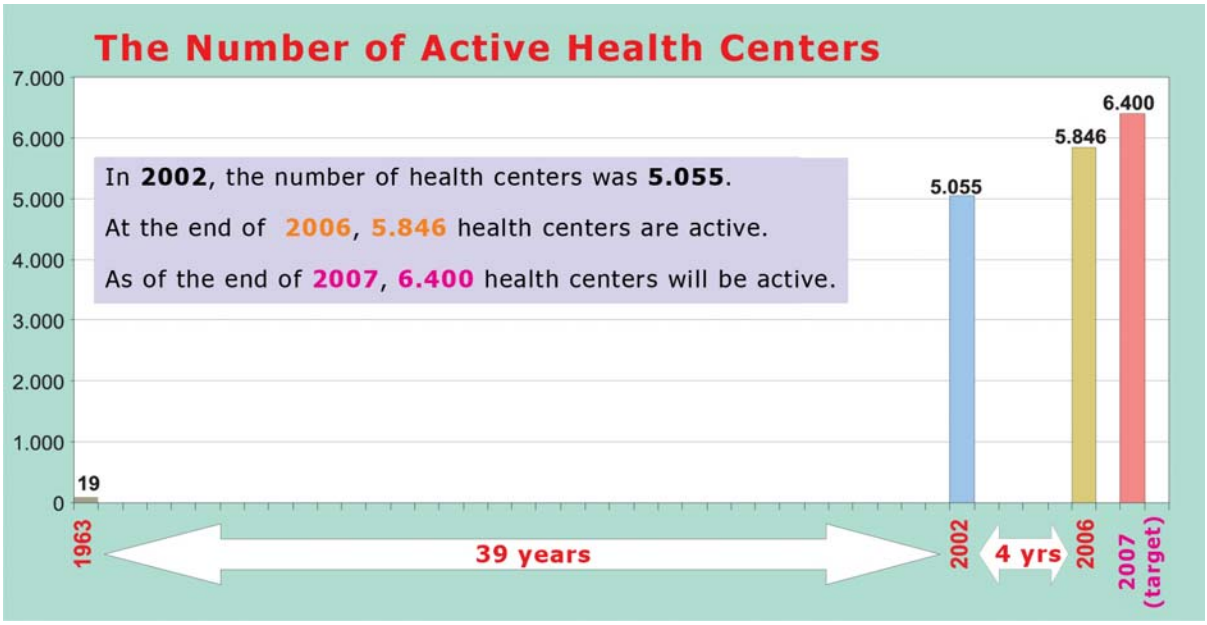


A campaign was held in this period and the budget of the preventive healthcare services which was 876 million YTL reached up to 2 billion and 511 million YTL in 2007.

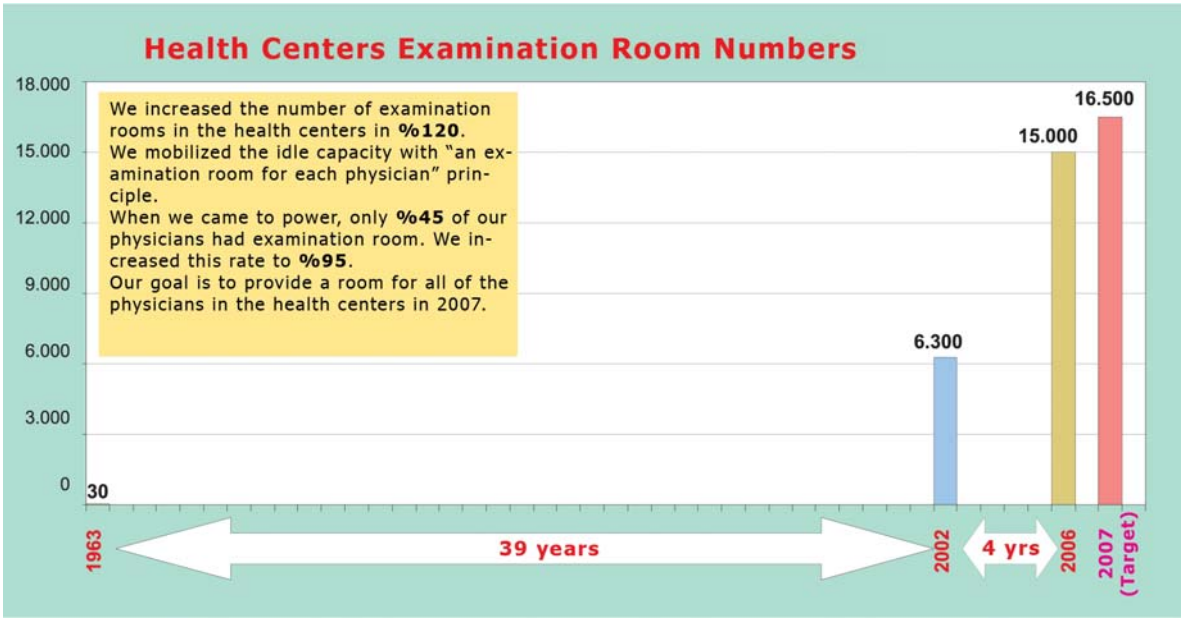
a) A New Face and New Tasks for Health Centers

Health Transformation Program strengthened the health centre network which was provided by the socialization policy it also put the local administrations in action as well as the Ministry resources. "A room for each physician" principle was turned into a campaign. The one-to-one communication between the public and physicians was promoted and simplified. Additionally, primary healthcare institutions strengthened with circulating capital and the diagnosis equipments were generalized. The personnel have been provided additional payment based on performance which became an economic and personal motivation source.

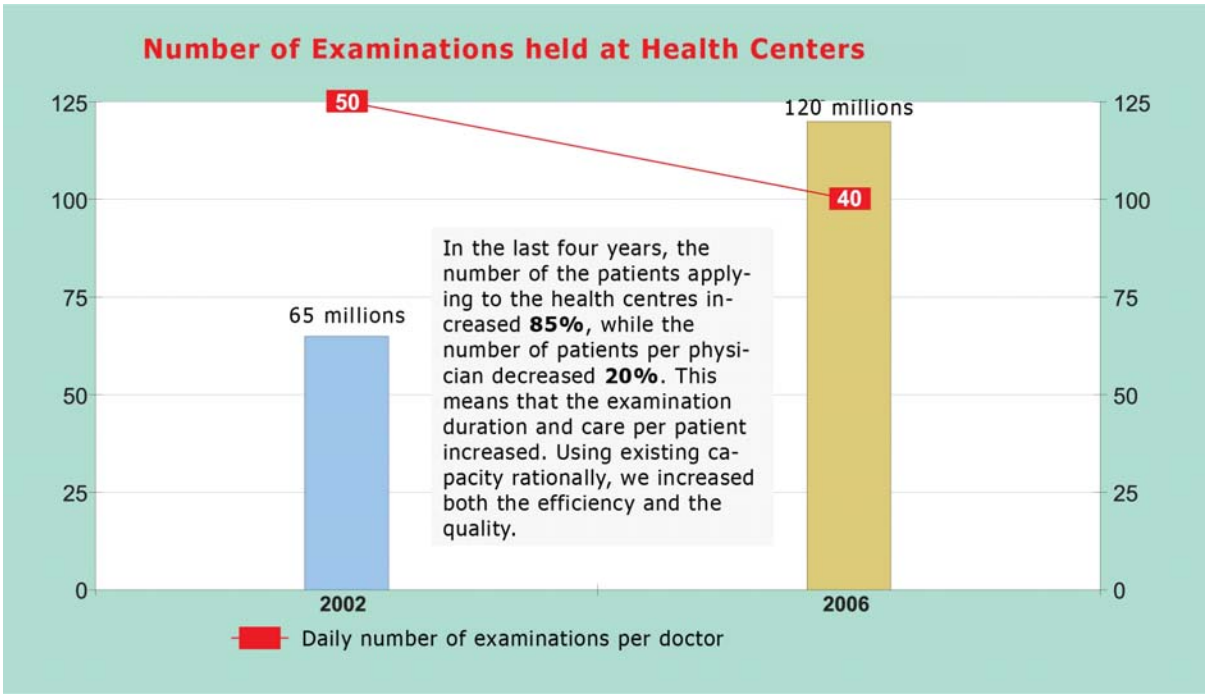
While the number of health centers with physicians was 5.055 in 2002, it reached up to 5.846 in 2006. By the end of 2007, 6.400 health centers with physicians in total will be active together with the family healthcare centers and population healthcare centers within the provinces that family medicine is being practiced.



With "room for each physician" principle, the number of the examination rooms was raised from 6.300 to 15.000.

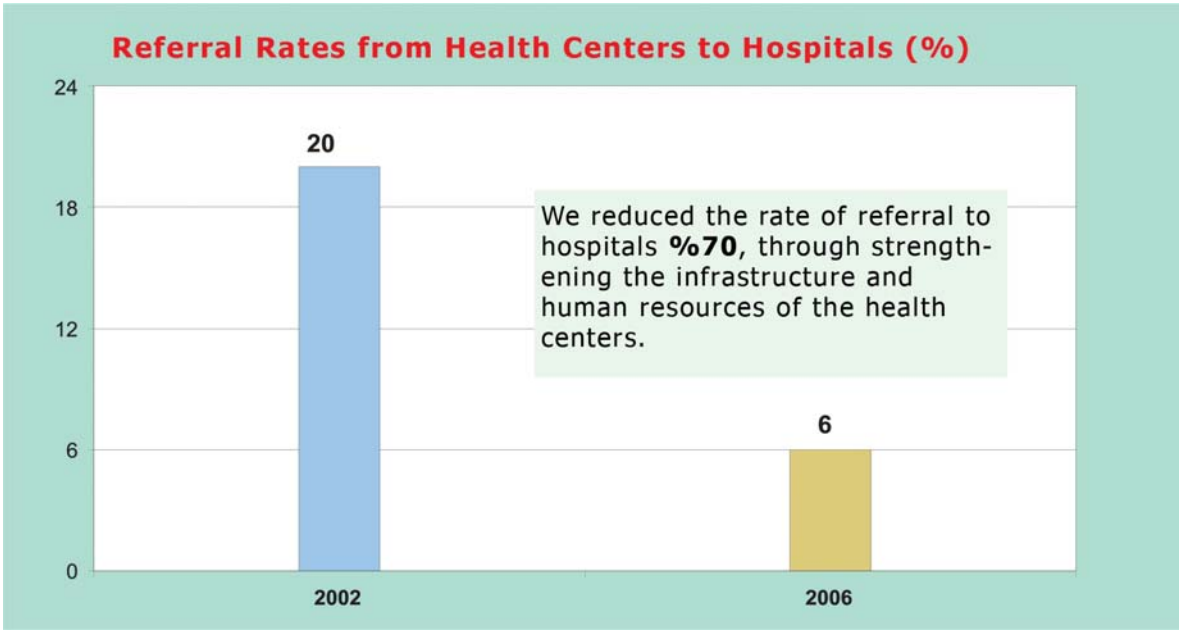


Though the number of the patients consulting to the health centers increased in 85%, the number of patients per physician decreased in 20%. This means that the examination duration and care per patient increased. This improved the satisfaction of patients and physicians at health centers which are the first contact point of health services.



Note: SSK Dispensaries are included in the number for 2002

The rate of referral from health centers to hospitals decreased with a rate of 1/3. The problems that can be solved on the first level of the system were solved through increasing care and equipment. Human resources were saved through preventing unnecessary occupation of the system's upper levels.



We had 1.572 health posts in 2002. By the end of 2006, 4.107 health posts were active. Our final target on the number of active health posts is 5.950. We are planning to achieve this objective by the end of 2007.

The rate of mobile service delivery which was %10, reached up to %80.

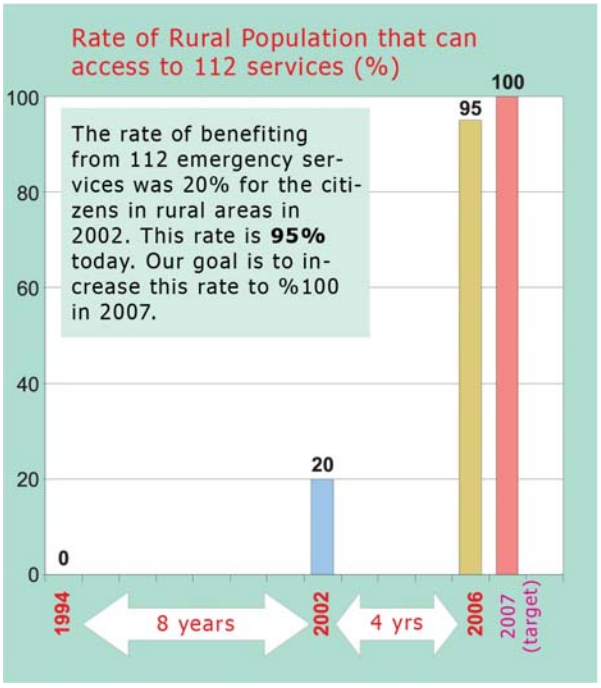
We developed the mobile health care services in order to reach the remotest places in the rural area.
Health personnel we employed in specific centers provide periodic village visits on dates announced in advance, primarily for the follow ups of infants, pregnant and chronical disease patients.
We will have generalized mobile health care services nationwide in 2007.

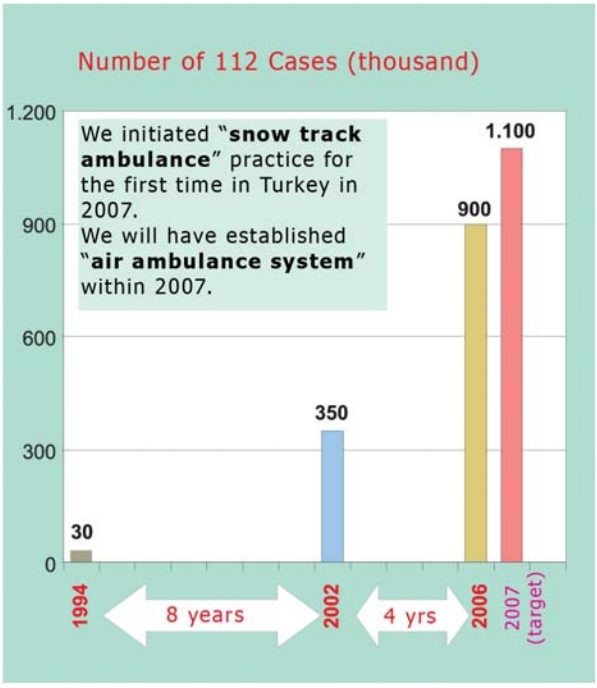
b) Emergency Healthcare Services Gained Speed

Emergency healthcare service is an important public health issue. In the 10th anniversary of the establishment of 112 Emergency Services, there exist Command Control Centers in all the provinces all over the country to reach the place of incident, to carry out the first intervention and to provide the transportation to a health institution as soon as possible in cases of urgent disease and injuries.

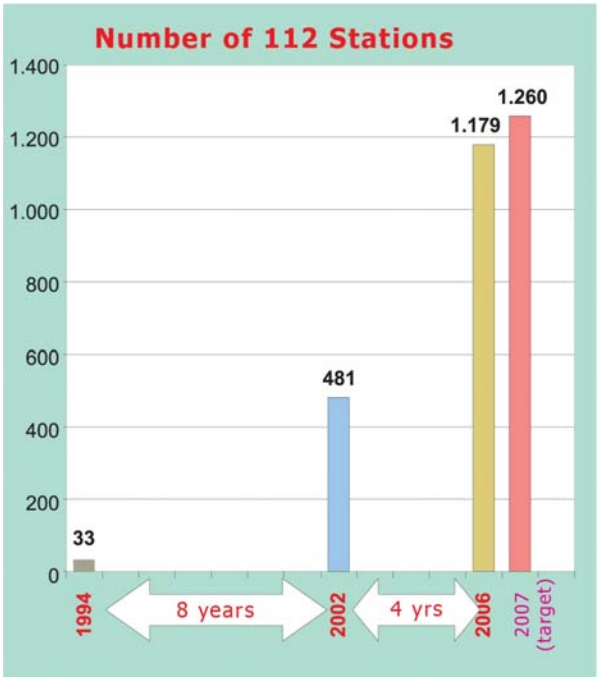
First stop on the road to health: 112 Health Station

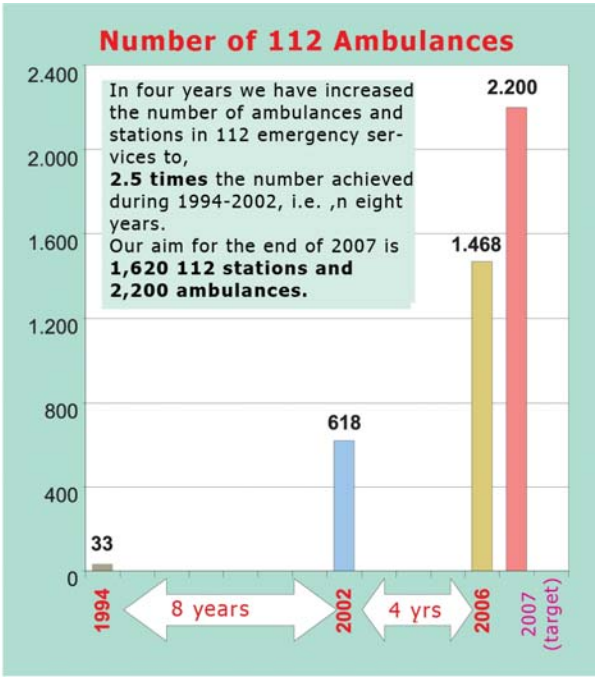
In the last 4 years, our capacity to transport emergency patients has been improved more than double. 90% of the cases are being reached in the first ten minutes now. The number of the fully equipped ambulances was 618 in 2003. This number is 1468 today. The number of the stations was 481 in 2003. This number is 1179 today.





In 2002 number of the people benefited from the 112 emergency services was 350 thousand. This number reached up to 900 thousand in 2006. The rate of benefiting from emergency services was 20% for the citizens in rural areas. This rate is 95% today.





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

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

The biggest Medical Rescue Team in Europe

The implementation of the Healthcare Organization in Disasters Project was started for the possible disasters, primarily for earthquakes, that may happen. Adequately trained and equipped personnel provided in order to ensure medical services within the shortest possible time and shortest and safest patient transportation in the disasters. The fact that 95% of Turkey is within the earthquake line shows the importance of specializing and being well prepared.

Basic and complementary training provided for 2.400 health personnel from the National Medical Rescue Teams (UMKE) within the scope of the project under the control of the Ministry. The scope of the training program is given below:
* General Overview of Disasters, * Disaster Epidemiology,
* Terms of Reference of the Medical Team and Legal Dimensions,
* Circulation, * Basic and Advanced Life Support, * Alternative Splints,
* Crush Syndrome, * Disaster Psychology, * Stress Management,
* Prevention from the NBC Attacks,
* Strategic Team and Conflict Management,
* Fixation, Identification, Packaging of the Patient/Injured,
* Stretcher Placement and Transportation,
* Wreckage Study,
* Psychological Support and Intervention to Shock,
* International Signs and Signaling system, * Communication,
* Disaster Management- Crisis Management, * Basic Approach to Accidents,
* Procurement.

These teams which are trained in a way to enable them to work in the sites abroad, performed their duty in the earthquakes in Iran, Pakistan and Indonesia as well as the tsunami disaster in Indonesia which we are proud of today.

SUCCESS STORY

THE BIGGEST MEDICAL RESCUE TEAM IN EUROPE

We established the "Department of Healthcare Organization in Disasters" in 2004 with the aim of keeping the mortality and the number of the injuries at the lowest level possible by providing medical rescue services in the shortest time by adequately equipped and trained voluntary teams during possible disasters (earthquakes first of all) that may happen, as well as providing the safest and fastest patient transportation and the emergency treatment units and services and the required professional administration organization.

We provided basic training for 2.400 personnel performing duty on a voluntary basis in the National Medical Rescue Teams that are established in 81 provinces.

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

Some of the studies that the National Medical Rescue Teams participated in since its establishment are:

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

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

d) Social Movement and Awareness for Chronical Diseases

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

Important improvements were achieved regarding the formation of the National Cardiac Health Program, National Mental Health Program and National Diabetes Policy with the participation of the scientists and the representatives of NGOs.

Note to history: Cancer Screening and training centers

National Advisory Committee on Cancer was established with the aim of policy and strategy development in the planning of Turkey's cancer control program. "Cancer Screening and Training Centers" were opened in 49 provinces in the last four years. Citizens with no ability to pay can benefit from services at these centers free of charge.

e) Effective Fight with Communicable Diseases

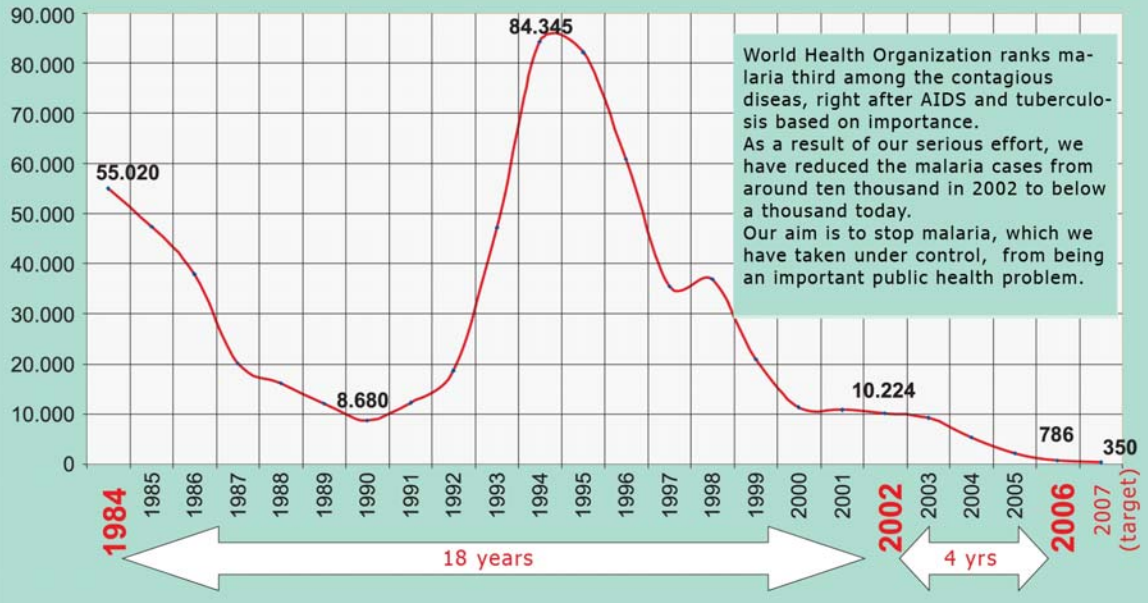
Giving a few examples about the studies that the Ministry has been conducting regarding the communicable diseases and the outcomes of these studies will be enough. A great achievement was made in the field of malaria control. The number of malaria cases was over 10.000 in 2002. In 2006, number of malaria cases was 786.

The name of the victory in "Malaria Control": Strong mind and stability

As a result of the effective activities, the number of the leishmaniasis cases which was approximately 5.000 in 2004, descended to 1.800.

The number of dysentery – typhoid fever cases which was approximately 52.000 in 2002, descended to 12.000 in 2006.

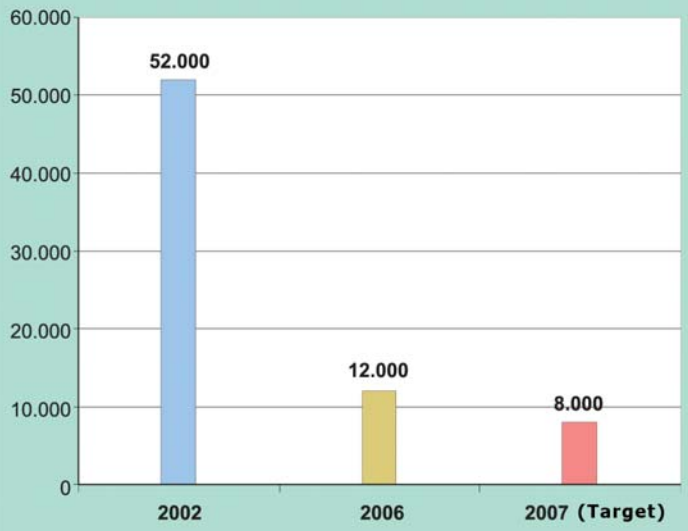
Number of Malaria Cases



World Health Organization ranks malaria third among the contagious diseas, right after AIDS and tuberculosis based on importance.
As a result of our serious effort, we have reduced the malaria cases from around ten thousand in 2002 to below a thousand today.
Our aim is to stop malaria, which we have taken under control, from being an important public health problem.

Note: Department of Malaria Control was established in 1983.

Number of Dysentery-Typhoid Fever Cases



Important public health issues, dysentery and typhoid fever were succeededly taken under control with the cooperation of municipalities.

The number of dysentery and typhoid fever decreased as %80 percent in the results of our serious activities.

Our goal is to prevent dysentery and typhoid fever from being public health issues.

SUCCESS STORY

New Solutions for the Old Problem:
TO FORGET ABOUT MALARIA FOR GOOD

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

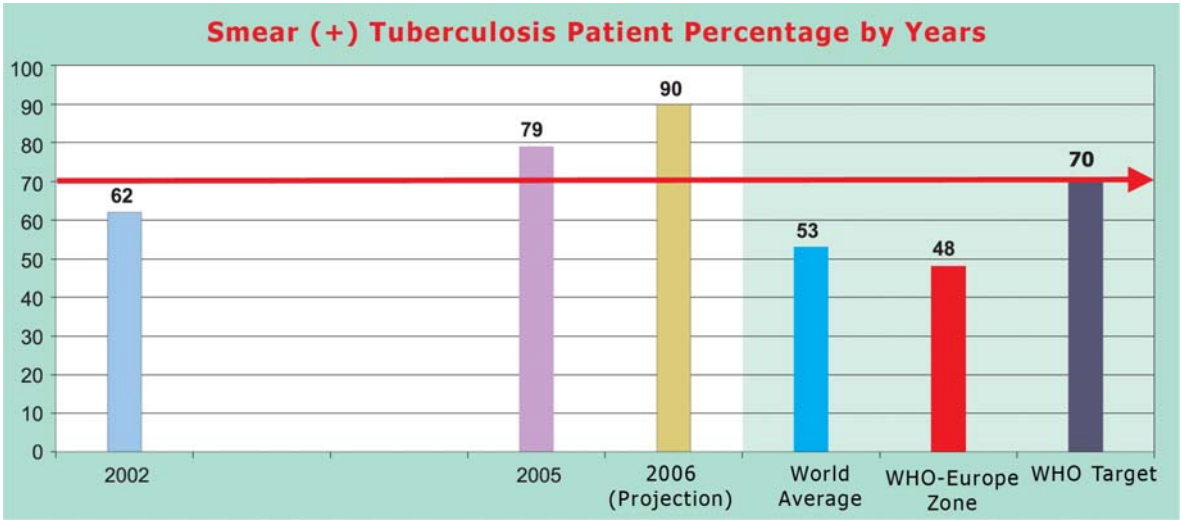
Insecticide groups which have been used for years for the purpose of vector control were changed and more effective drugs were provided. Intensive working programs were prepared for vector control and the control of these programs conducted regularly. Coordination was provided in malaria-intensive provinces. Joint studies and information share were developed. Surveillance studies were carried out in order to find malaria cases. Establishment of the mobile teams was considered important with the aim of strengthening surveillance treatment services.

One-to-one treatment of the patients with malaria diagnosis was performed. Temporary workers were assigned during the malaria season from the areas with no malaria or a low level of the disease.

The number of the malaria cases was 10.224 in 2002. With our effective fight with the disease, the number of malaria cases descended to 786 by the end of 2006.

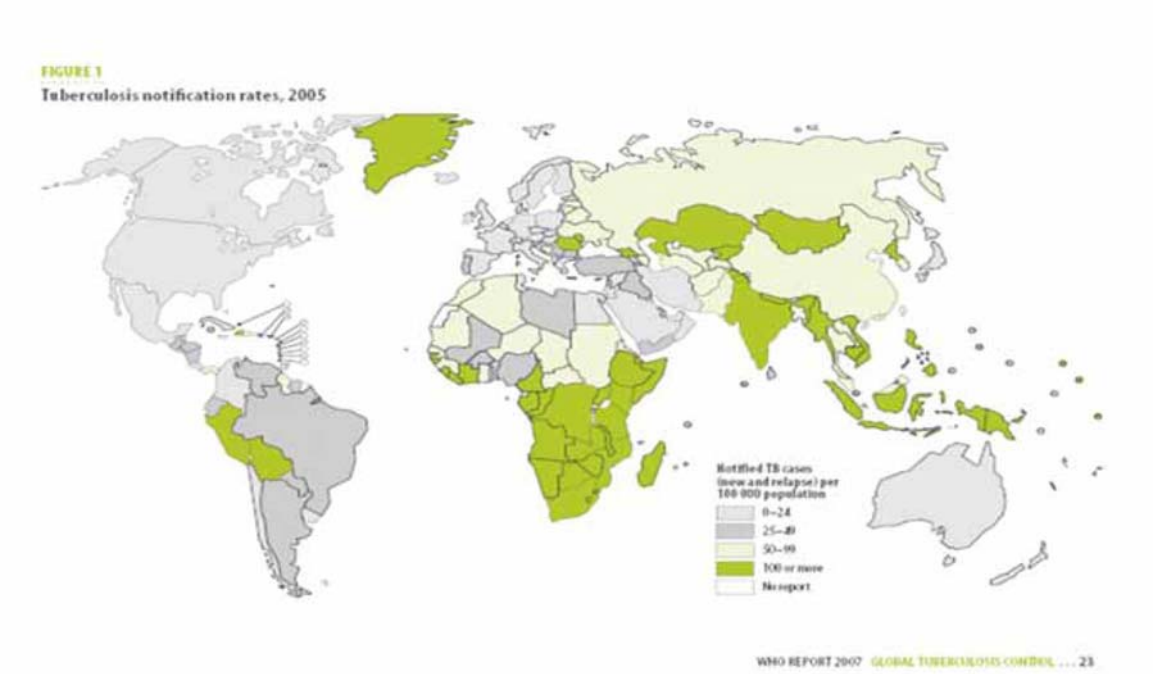
In the fight with tuberculosis, smear method is very important for keeping the record of the certain cases and cases communicating microbes. According to the WHO's 2007 Global Report on Tuberculosis, 62% of the patients with tuberculosis were reached with the smear (+) method in 2002. This rate reached up to 79% in 2007. Thus, 70% rate determined as minimum for the countries by the WHO was exceeded.

Since tuberculosis requires long term treatment, cooperation and control of the patient is important.



In the fight with tuberculosis, smear method is very important for keeping the record of the certain cases and cases communicating microbes.
According to the WHO's 2007 Global Report on Tuberculosis, 62% of the patients with tuberculosis were reached with the smear (+) method in 2002. This rate reached up to 79% in 2005. WHO chose 70% rate as the minimum for countries.

The practice of "Direct Observed Therapy-DOTS" started in 2003 for the fight with tuberculosis. Now, the treatment of the patients with tuberculosis is being conducted with this practice.



WHO groups countries into 5 categories based on malaria determined by the number of cases per 1000.000 population

Our country is in the second best group of "25-49" cases per 100.000 population.

DOTS is the medicament of the tuberculosis patients directly by the physician until the treatment is concluded. We provided nationwide generalization of this practice in 2006.

The number of the notified measles cases was 7.804 in 2002. This number descended to 34 in 2006 as a result of the measles elimination program.

SUCCESS STORY

A dream coming true:
MEASLES IS ALMOST ERADICATED

The WHO's target "Eradicating Measles" within the scope of measles control is nearly being accomplished in Turkey. We are still dedicated in the aim of stopping the domestic virus circulation in Turkey by the end of 2010.

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

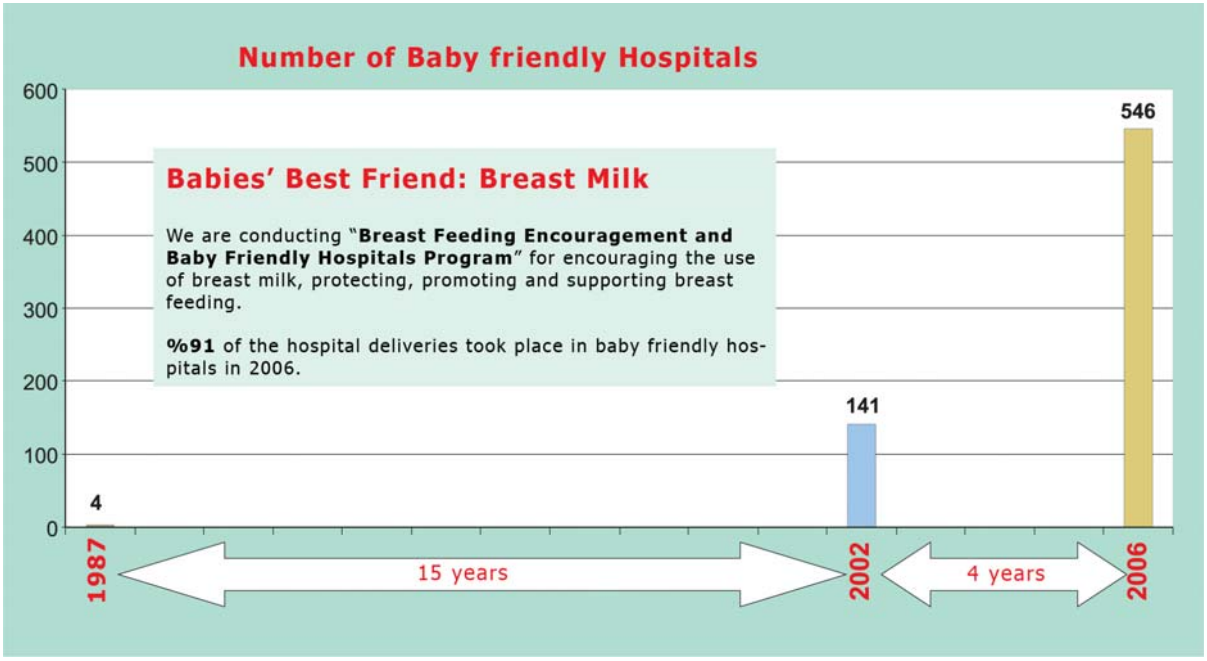
18.217.000 children were vaccinated within the framework of the campaign. The vaccination rate was 97%. **The campaign has the widest target group when the Republic history and Europe concerned.**

The number of the measles cases was 30.509 in 2001. In 2006 this number descended to 34. A dream coming true: close to zero…

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

f) Mother and Child Health

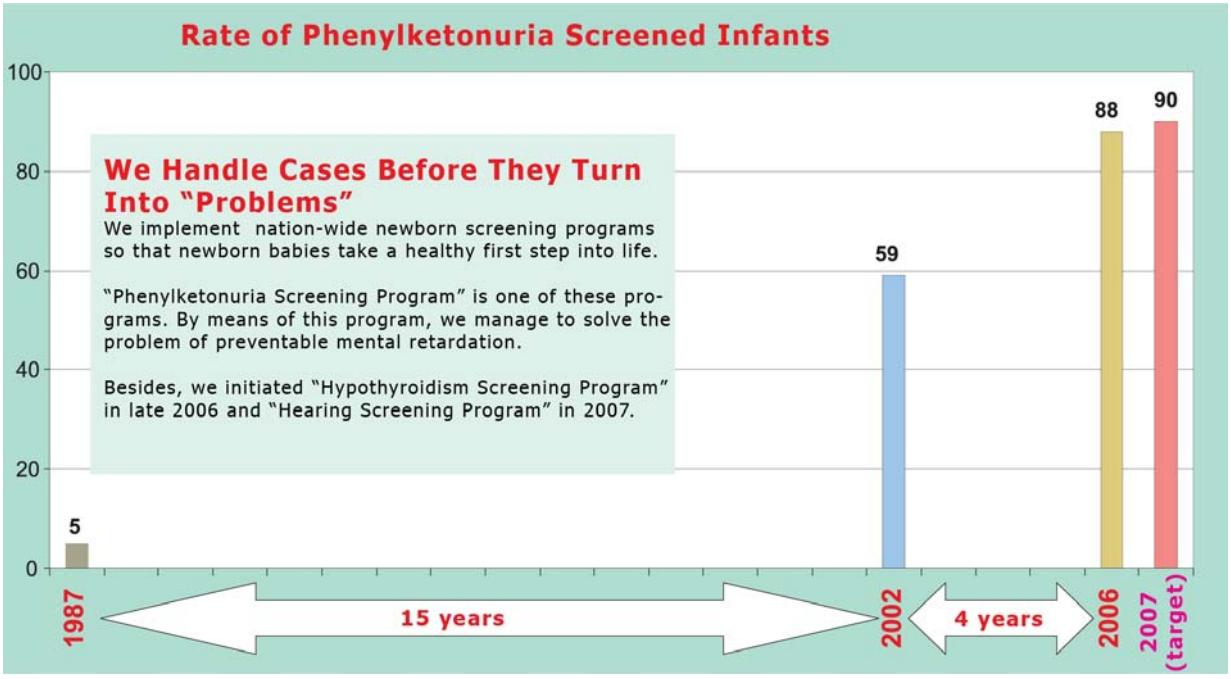
The number of the "Baby Friendly Hospitals" aiming at the improvement of baby health, reached up to 546 in 2006 when it was 141 in 2002.



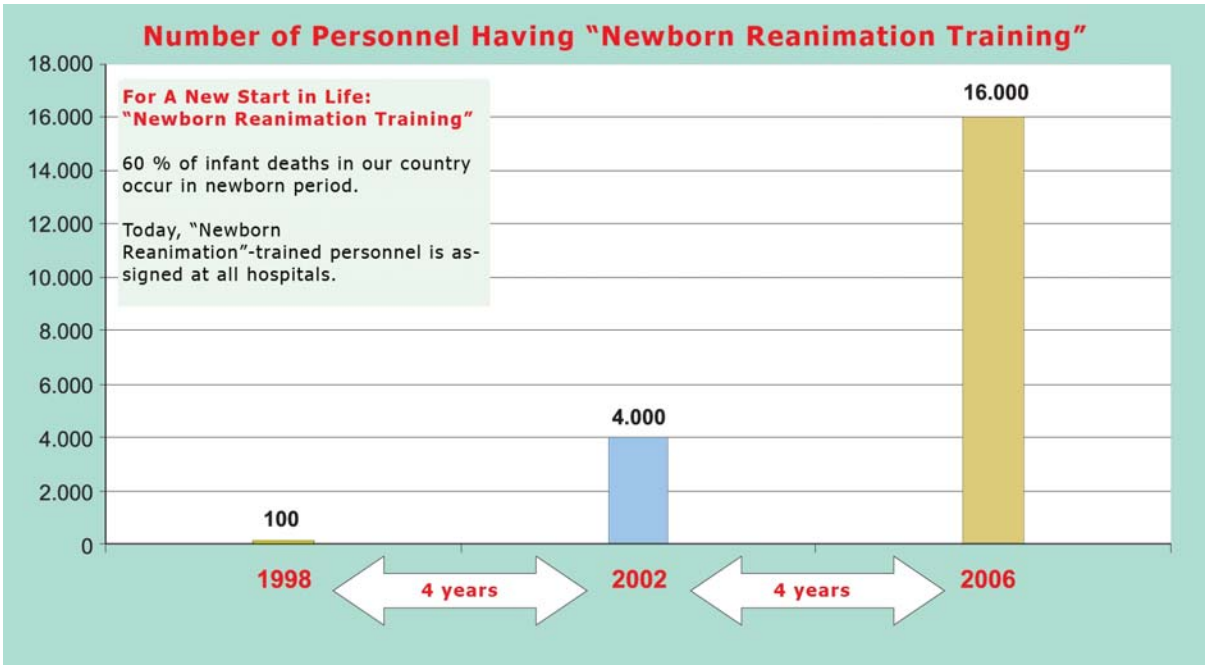
We started giving free of charge iron support to the pregnant to protect the babies and the pregnant from anemia. Each year, 1 million pregnant women benefit from this service. Vitamin D is being provided free of charge to ensure bone development of the babies.

New-born screening program has gained acceleration to provide a healthy beginning for the babies. Phenylketonuria is a disease that can be prevented easily when detected, however if it is not detected, the results are irreparable. 88% of the target group for Phenylketonuria disease scanning was reached. Congenital hypothyroid screening, as vital as Phenylketonuria, began widespreadly. Newborn Hearing Screening Units are completed in 39 institutions under the Ministry, including 26 provincial hospitals in total, screenings have been initiated. Approximately 158.000 infants received hearing screenings.

Low cost, high efficacy: Iron like Turkey



16.000 health personnel have been trained since the beginning of the newborn reanimation programme. Today, trained personnel are available in all delivery units



People who constitute the poorest 6 % of entire population were refused by hospitals not so long ago but today they are granted monthly allowance amounting to 17 YTL on condition that they continue health checks for pregnants and children. Also, pregnants are granted monetary aid amounting to 55 YTL when they like to give birth at public hospitals.

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SUCCESS STORY

IRON-LIKE TURKEY
Iron Support for the Pregnant and the Babies

According to the data from the WHO, it is predicted that approximately 30% of the world's population and more than half of the pregnant women have anaemia. More than 1/3 of the women have anaemia in the world.

According to the researches, approximately **50% of the 0-5 age group children, 30% of the school age children and 30% of the nursing women** had anaemia in Turkey.

Because the development of human is very fast in specially the first 18 months, nourishment of the babies and infants effect their later mental, physical and social development. Anaemia causes insufficient development, lack of attention lack of resistance to infections and inadequate linguistic development

We started the "Iron-Like Turkey Programme" in order to provide consciousness for the society on anaemia, ensure the nursery of the babies for the first six months with breast milk, continuation of the nursery until the age 2 together with the proper additional food, ensuring iron support between 4-12 months for all the babies and iron treatment for the 13-24 months babies with anaemia. **We provided iron support for 2.639.804 babies from the beginning of the programme to the end of 2006.** We enlarged the scope with the Iron Support for the Pregnant Programme. **We provided 1.368.569 boxes of iron preparation in one year by the end of 2006.**

"Research on iron deficiency" was conducted by the participation of our Ministry and Hacettepe University Medical School Social Paediatrics Department in March-April 2007. **According to the preliminary results, 7.6% of the 0-2 age group has anaemia. The progress we have made for healthier and cognitively developed babies is clearer with these results.**

1.600.000 people have made use of these incentives since March 2004.

Healthy Mothers, Healthy Generations

"Conscious Mother, Healthy Baby Programme" was started with the aim of reaching all the mothers who give birth at in-patient health facilities. One of the objectives of this programme is to provide consciousness for mothers on the issues related with their and their babies' health before they leave the hospitals. Mothers are given basic information on baby care and health right after delivery, and "Guidelines for Conscious Mothers and Healthy Babies", as well. So, we have managed to reach almost 2 million mothers so far.

SUCCESS STORY

ALMOST…
Mothers will live motherhood…
We reach the European average on prevention of maternal mortality

Access to health care services during pregnancy, in delivery and post-delivery period, benefiting from health care services, training of women, gender equality and social conditions are related with maternal mortality. With this feature, **the level of maternal mortality** is used as a **multi dimensional indicator of development**. Maternal mortality includes women's deaths which occur in pregnancy and delivery, and in 42 days following the delivery, as well.

According to calculations made by the WHO, 529.000 mothers die in every year. 99% of the maternal mortality is reported in developing countries. World average for maternal mortality is 400/100,000. African average is 870/100,000, Asian (excluding Japan) is 380/100,000 and European is 24/100,000. Data and information on maternity mortality was limited in Turkey until recently. The rates which reflected the existing situation were provided by the population censuses. In 1997 – 1998, maternal mortality was found to be 49,2/100,000 at 615 delivery hospitals located in 53 provinces in Turkey.

National Survey on Maternal Mortality was conducted between the dates 1 January 2005 – 31 May 2006 in order to find out the maternal mortality rate of Turkey. Results were publicized at a meeting held on 8 December 2006.

SUCCESS STORY

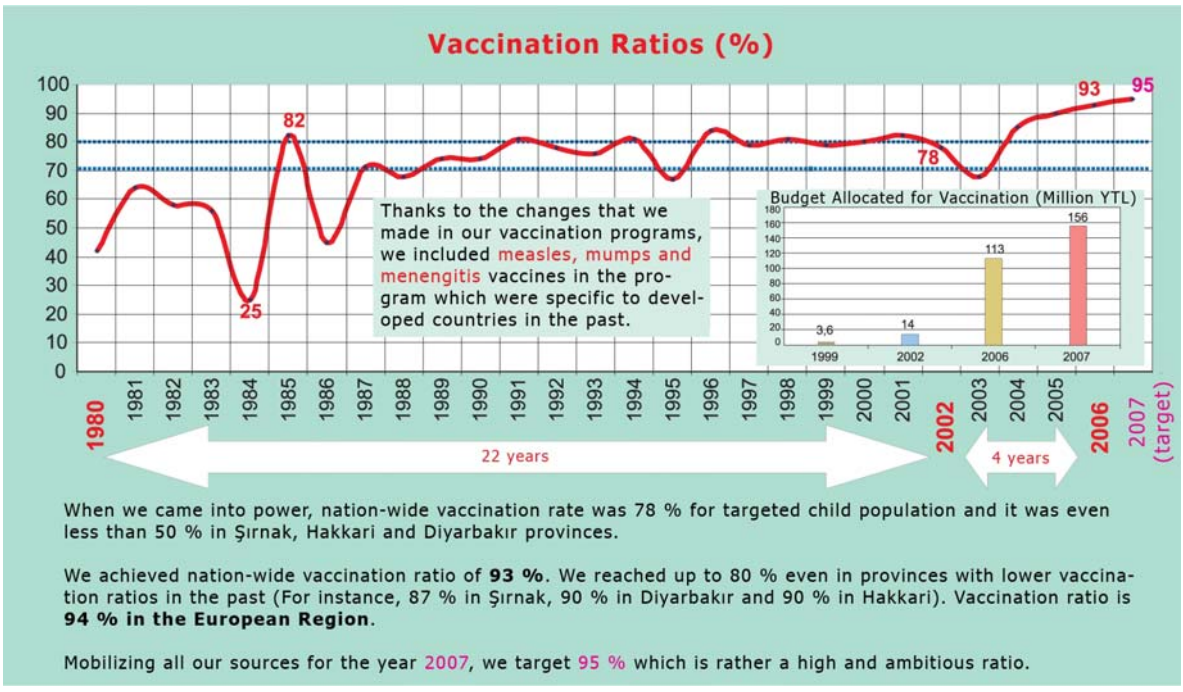
The afore-mentioned survey is the single study of scientific competence in the Country's history. The survey pointed out that the mortality rate for 2005-2006 was 25.5/100,000. Turkey accessed to the real and actual numbers in this issue for the first time and introduced its achievement in maternal mortality rate which is very close to Europe's.

Our target is to reduce the maternal mortality rate under 20% in 100.000 by the late 2010.

g) Immunization Programs

In 2002, the vaccination rate was 78 % for targeted children group. This rate was even below 50% in Şırnak, Hakkari and Diyarbakır provinces. In 2006, vaccination rate was noted 93 % in general. We accomplished a rate over 80% in regions even with the lowest vaccination rates. The budget for the year 2002 was 14.000.000 YTL. In 2007, the budget reached up to 156.000.000 YTL. Besides, rubella, mumps and meningitis vaccinations, which did not exist in the standard vaccination program formerly, were included in the program.

Our children are our future and we save our future



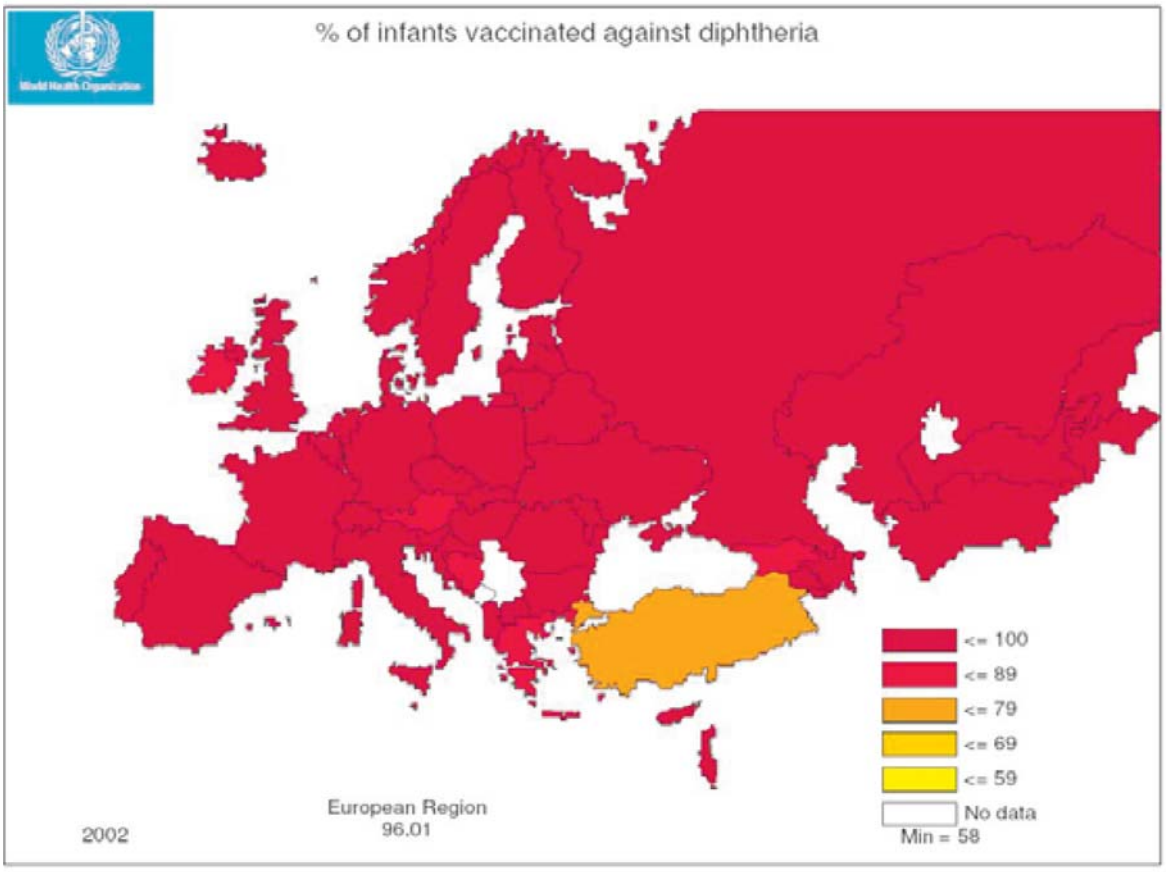
When we came into power, nation-wide vaccination rate was 78 % for targeted child population and it was even less than 50 % in Şırnak, Hakkari and Diyarbakır provinces.

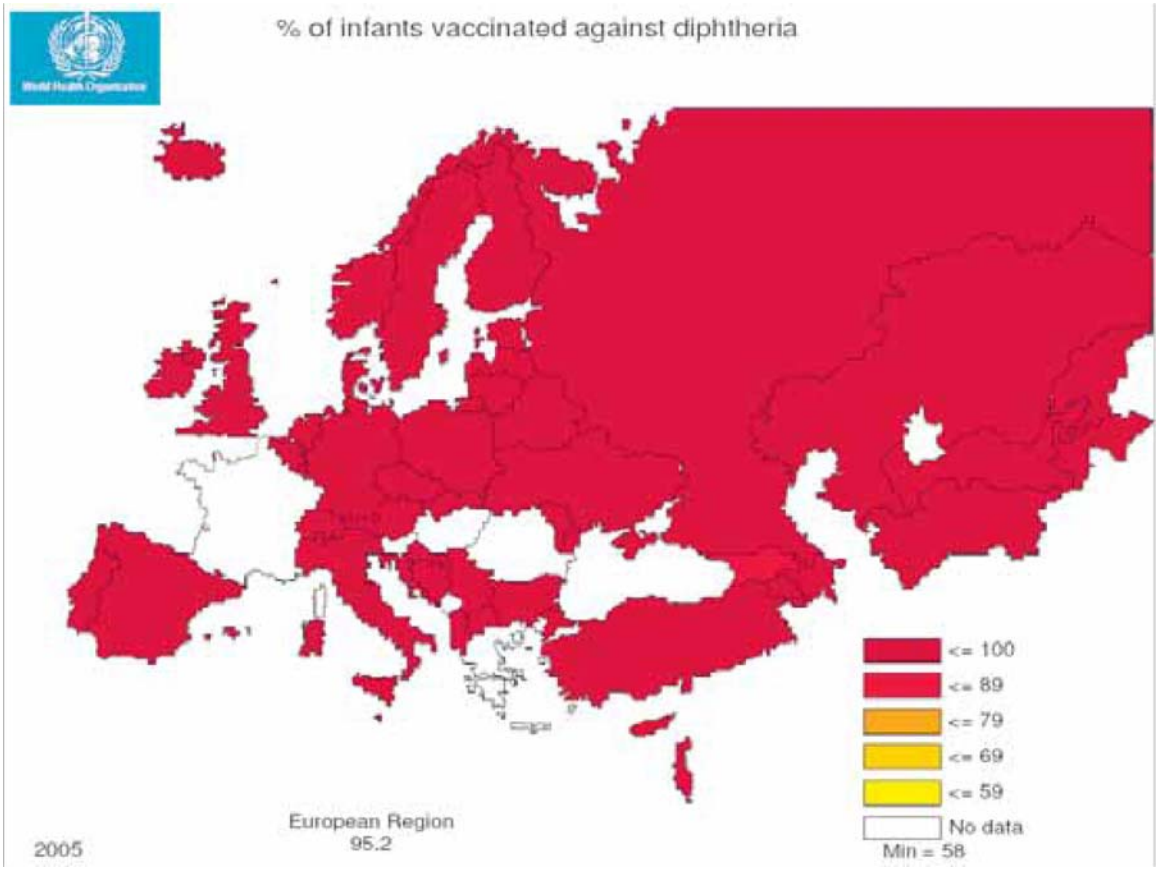
We achieved nation-wide vaccination ratio of **93 %**. We reached up to 80 % even in provinces with lower vaccination ratios in the past (For instance, 87 % in Şırnak, 90 % in Diyarbakır and 90 % in Hakkari). Vaccination ratio is **94 % in the European Region**.

Mobilizing all our sources for the year 2007, we target 95 % which is rather a high and ambitious ratio.

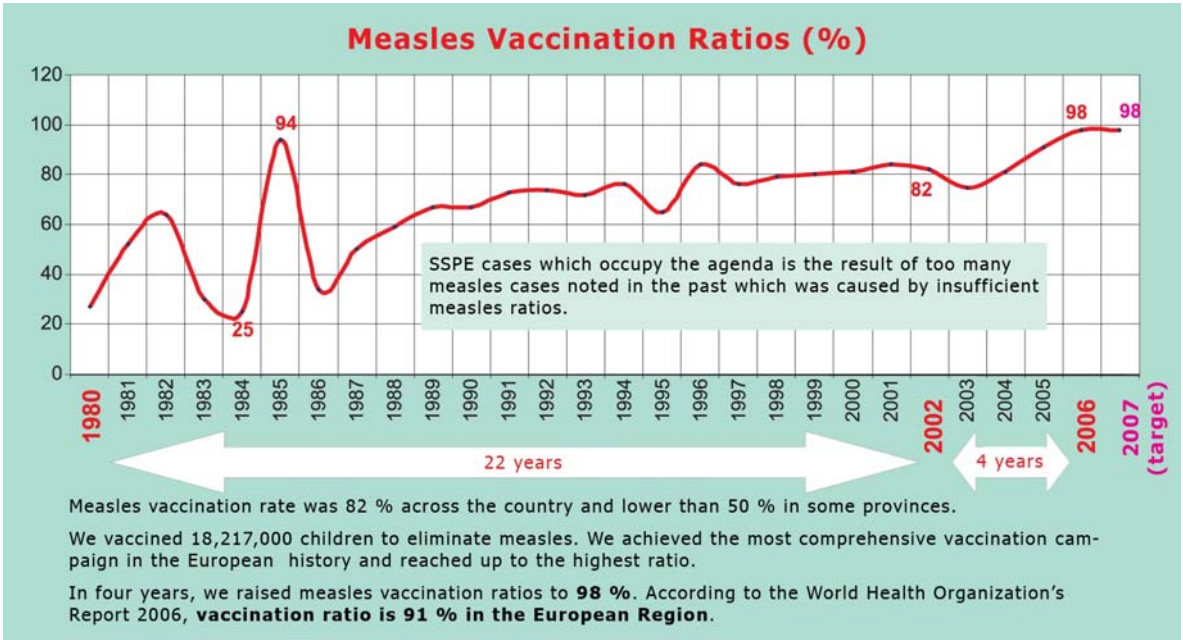
In 2003-2004 period, 18,217,000 children were vaccinated under a big vaccination campaign in order to eradicate measles in the country. The vaccination rate was 97 %. The campaign, with respect to the scope of its target group, is the most comprehensive one not only in Turkey but also in Europe.

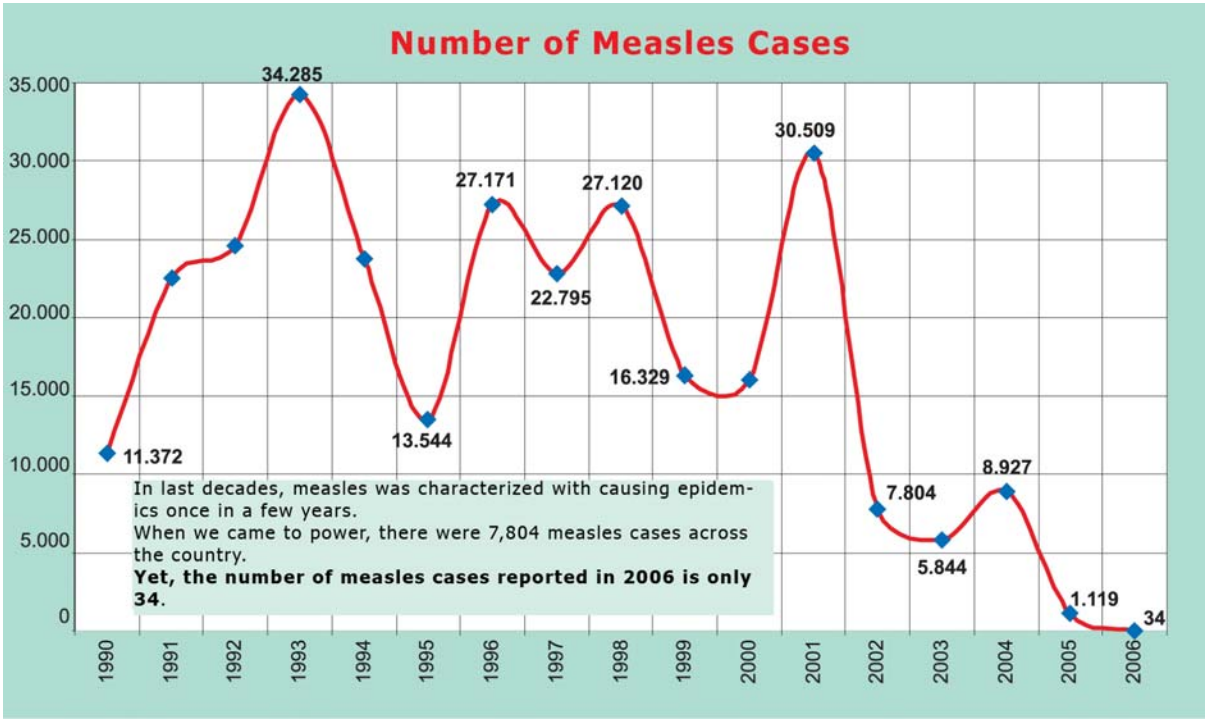
Our children are vaccinated, we have right to be proud of this success.





These studies proved to be successful soon. In 2002, 7804 measles cases were reported and it was diminished to 34 in 2006.

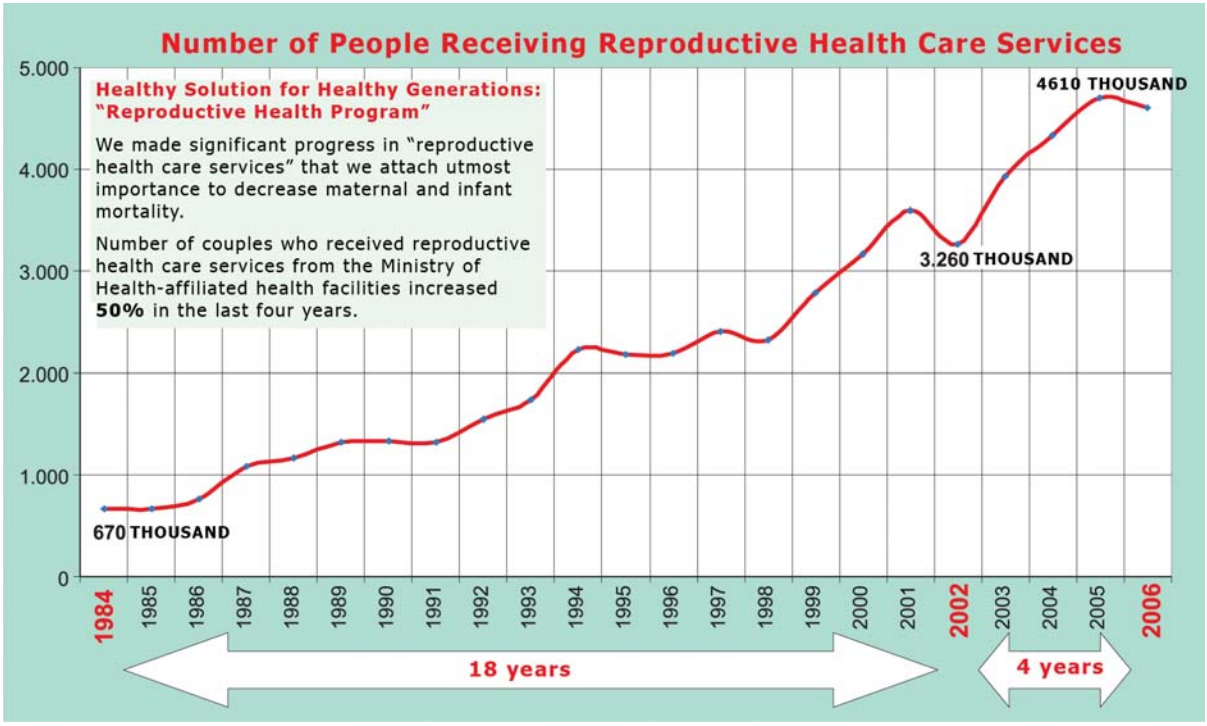




h) Sexual and Reproductive Health Program

Turkish Sexual and Reproductive Health Program is implemented in cooperation with the European Union in order to increase the utilization and accessibility of services in the field of sexual and reproductive health, improve service quality to support the MoH-conducted studies and to strengthen the collaboration with the NGOs. In 2002, 3,260,000 couples received sexual and reproductive health care services from the MoH-affiliated facilities. In 2006, the number of couples reached up to 4,610,000.

Ministry of Health and Turkish Armed Forces initiated collaborative work in educating men on sexual health and family planning. In this respect, trainer's training was given to 3,150 military health care personnel so that they give Reproductive Health and Family Planning Counseling Services and Trainings to military men and noncommissioned officers under Turkish Armed Forces. So, these personnel started to give reproductive health trainings in all platoons and troops. Since April 2004, more than 1 million military men have received training. We aim to train everybody who conducts military service this way. So, every year 500,000 young men will have been trained on reproductive health when are released from military service and set off to go back home.


Number of People Receiving Reproductive Health Care Services
Healthy Solution for Healthy Generations: "Reproductive Health Program"
We made significant progress in "reproductive health care services" that we attach utmost importance to decrease maternal and infant mortality.
Number of couples who received reproductive health care services from the Ministry of Health-affiliated health facilities increased 50% in the last four years.
5.000
4.000
3.000
2.000
1.000
0
670 THOUSAND
3.260 THOUSAND
4610 THOUSAND
1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006
18 years
4 years

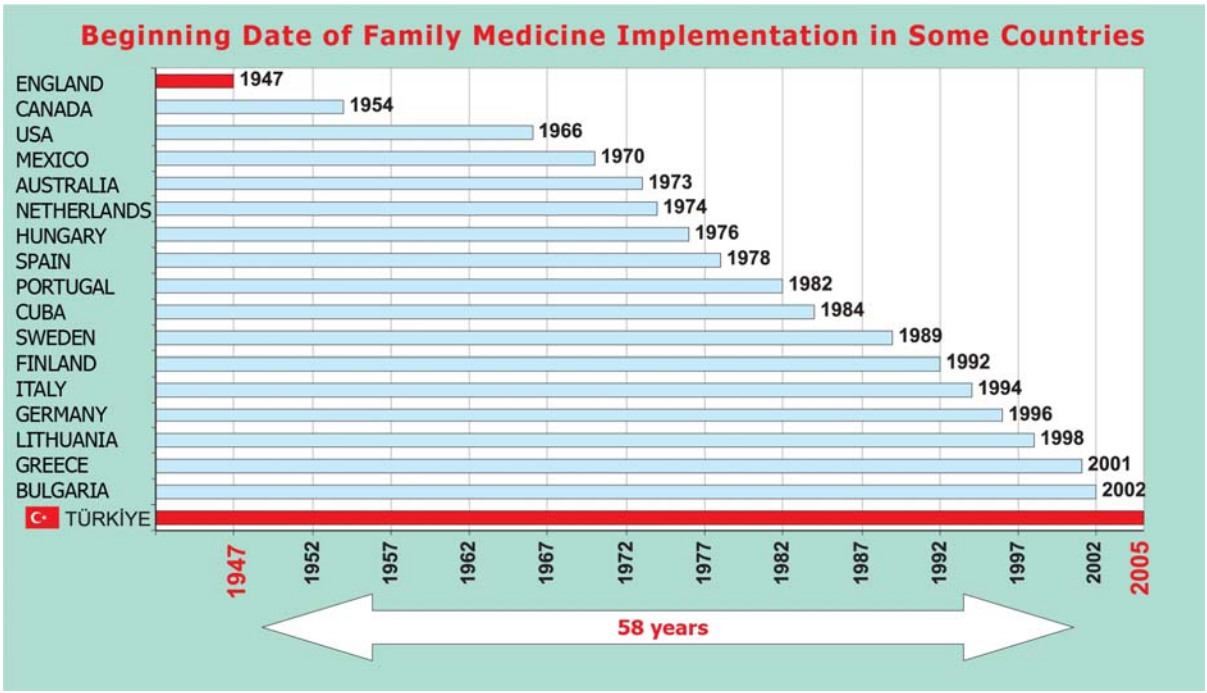

Our Priorities In Reproductive Health Program
Sexually Transmitted Diseaseses
Infant Mortality
Sexually Transmitted Diseaseses
Safe Sex for Youth
Maternal Deaths in
Rural Areas
Infant Mortality
Pregnancies at Early
Ages
Maternal Deaths
Undesired Pregnancies
Pregnancies at Early
Ages
Infant Mortality
Sexually Transmitted Diseaseses
Infant Mortality

A New Era in Health

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

The Transformation in Health Program is human centered. This principle means that the system will take into consideration human being firstly when planning and providing services. Thinking that health is produced within a family first, individual health is dealt within the concept of "family health". We know that sharing responsibilities and single approach to individuals in primary health care services will increase the rate of success. Preventive services for individuals and primary diagnosis and curative services have enabled more close relationships between family members and the family physician thus the role of primary health care personnel has been identified better.

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



Central Role In Health Care System: Family Medicine

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

The family practitioner is close to residences of families and is easy to access. The family practitioner knows the society for which s/he provides services and evaluates patients' family, environment and employment relations. Family practitioners evaluate patients' situation as a whole taking into consideration the risks, health conditions, psycho-social environment and current other acute or chronic health problems.

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

According to Prof. Dr. Nusret Fişek "Preventive care services, out-patient and home care services should be integrated. (…) Contemporary family medicine system is the most simple example of this integrated model. Contemporary family physicians examine children periodically and vaccinate them. They also examine elder people and pregnant women and give advice, if necessary. They train family members on domestic and personal hygiene. They treat family members who get ill and refer them to a specialist, if necessary."

In order to create an effective chain of referral, it is a pre-requisition that people have the right to receive primary care services from professionals whom they prefer. This pre-condition is highly related with the issue of strengthening primary health care services and the quality of services provided by family physicians. In this respect, family physicians, as coordinators of the health care system, should prevent false referrals, disorders and unnecessary health expenditures.

Family medicine, in this respect, prevents waste, unnecessary expenditures, excessive workload, long waiting lists and patients' suffering.

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

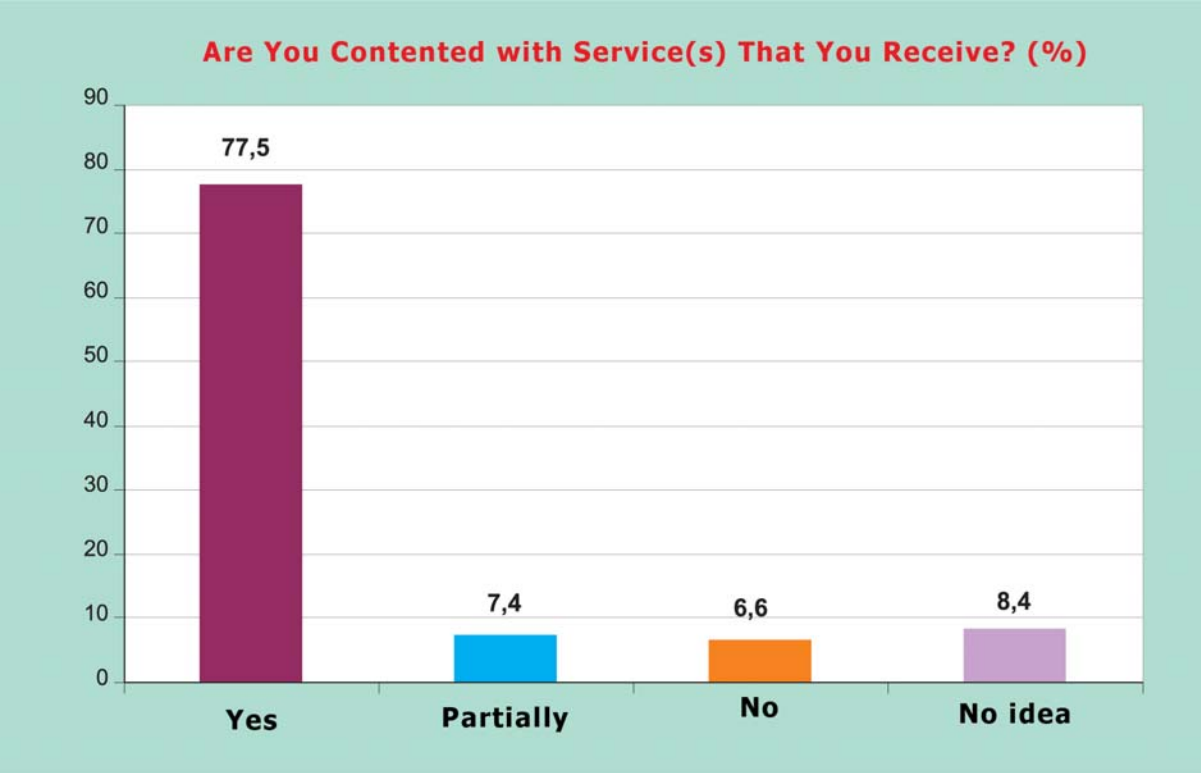
Community Health Centers were founded in order to provide more effective and productive health services by gathering primary care under a single roof except for preventive, diagnostic, curative and rehabilitation services. These centers give free-of-charge logistic support to vaccination campaigns, mother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

Turkish Grand National Assembly enacted the Law on Pilot Implementation For Family Medicine in November 2004. Pilot implementation was first initiated in Düzce. Eskişehir, Gümüşhane, Edirne, Bolu, Adıyaman, Elazığ, Denizli, Isparta, Samsun and İzmir provinces were added to the list, then. So, a total of nine million people were brought under the coverage of family medicine.

Family medicine practices, preliminary results of which are so encouraging and successful, puts primary care services at the top of the public agenda, makes primary care attractive and thus facilitates easy and widespread provision of these services. Success of the system will reduce the number of patients visiting hospitals and alleviate excessive workload at hospitals. At the same, physicians who are employed in primary care will re-gain the professional respect that they already deserve. For now, the practice is supported by in-service training programs. However, the system envisages to train family physicians in long-run for well

functioning of the system. So, people will have more trust in the reliability of primary care services.

In a survey which was conducted under family medicine studies in Düzce, people were asked to what extent they were contented with family medicine services given so far and answers figured out rather high level of satisfaction.



Source: Family Medicine Survey in Düzce (ANAR)

A New Era in Health

5. Change of Mentality in Hospital Care Services

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

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

The principle of uniting all hospitals under single roof aims to use all sources for the sake of public. In this period, SSK hospitals were transferred to state hospitals, obstacles on the accessibility of the patients to health care access were eliminated and discrimination was stopped among people. Hospitals which suffered from unbalanced workload in the past were opened to all patients regardless of whether they were covered by the SSK, ES or Green Card. Today, all hospitals do give health care services to all people in a balanced way and with no discrimination.

Most people, who had difficulty in access to health care services formerly, have already had the opportunity to make use of these services whenever they need**. Unifying SSK and state hospitals did not only create different alternatives for people but also granted SSK beneficiaries the right to utilize health care services which they could not utilize in the past although they paid premiums and thus were covered by the insurance system.**

Single base and single roof in health

b) On-site management at hospitals:

In order to alter the awkward organization of state hospitals, private sector services were purchased primarily for imaging services and others, as well. So, rapid change was started in functioning of services at hospitals. Thus, the queues for medical tests and diagnosis were shortened. Differences in management models were removed by unifying

all hospitals under the Ministry of Health's shelter. Hospital autonomization, flexible management, right to use domestic sources and performance-based additional payment to personnel from revolving funds helped hospitals turn into patient-oriented and health services providing structures.

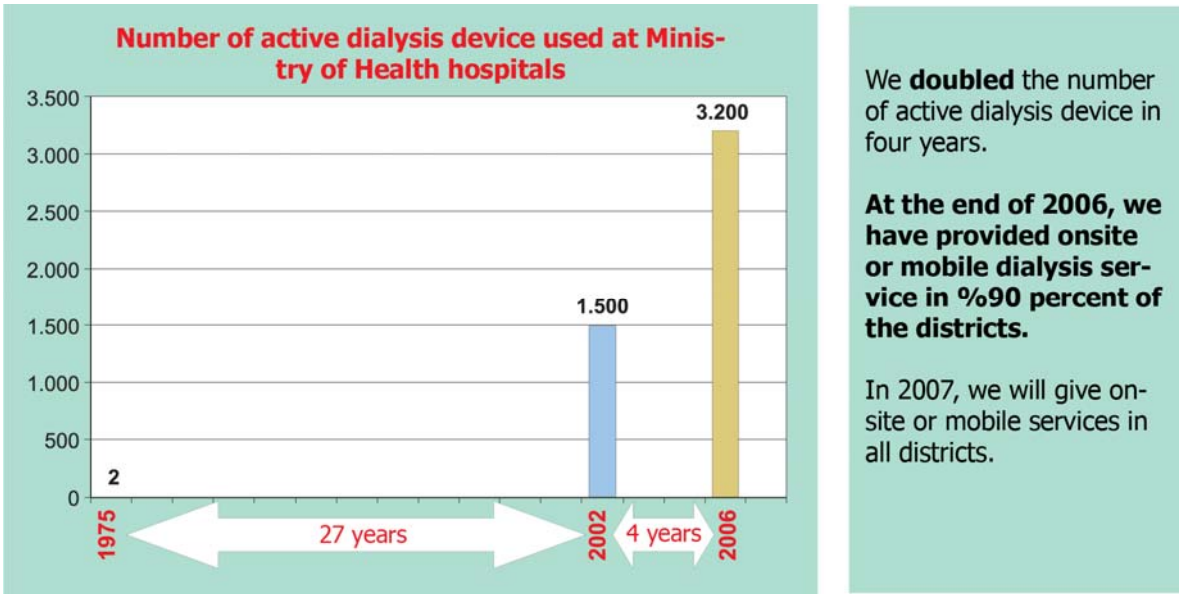
Hospitals in Turkey, which receive more autonomy every other day and which are already managed on-site, are becoming autonomous public facilities. In the last 4 years, most of the hospitals built their own data processing infrastructure and kept their services under record. More than 20,000 contracted personnel are employed at hospitals and their salaries are paid by the revolving funds.

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

c) Re-organization in hospital services

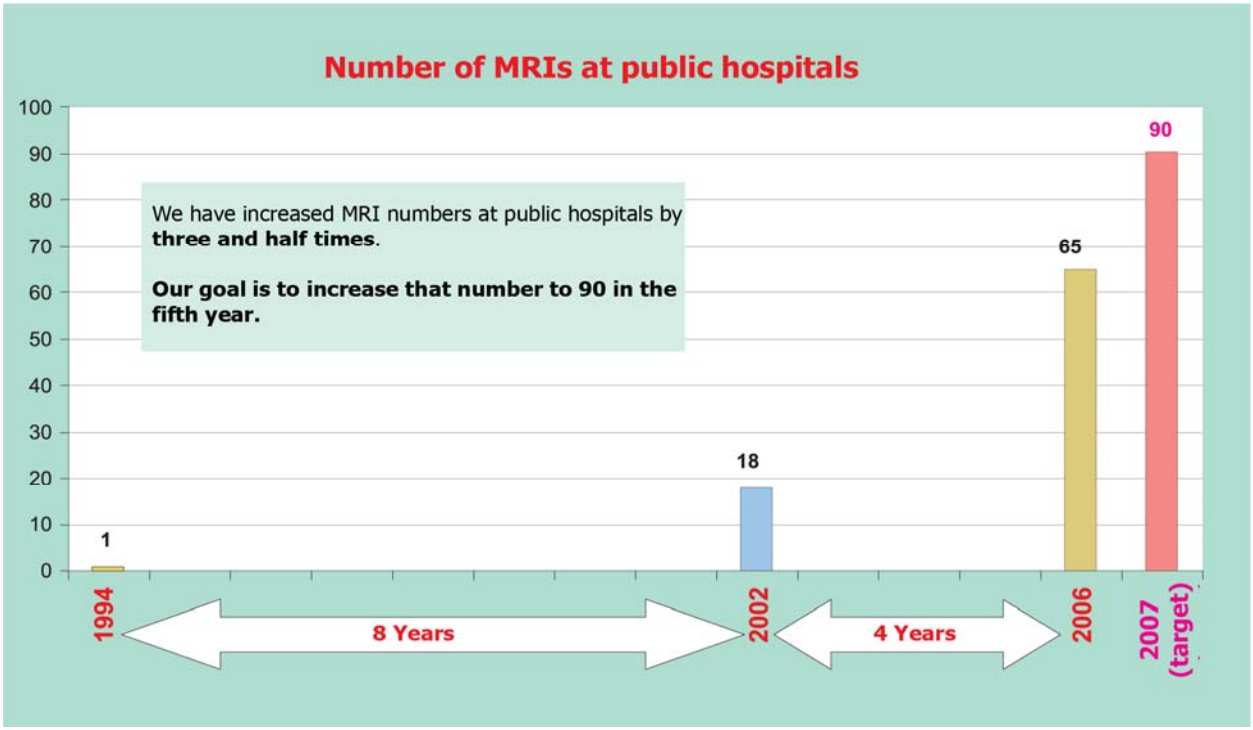
State hospitals were equipped with medical devices.

The number of dialysis machines at state hospitals was 1,500 in 2002 and the number was increased to 3,200 in 2006.

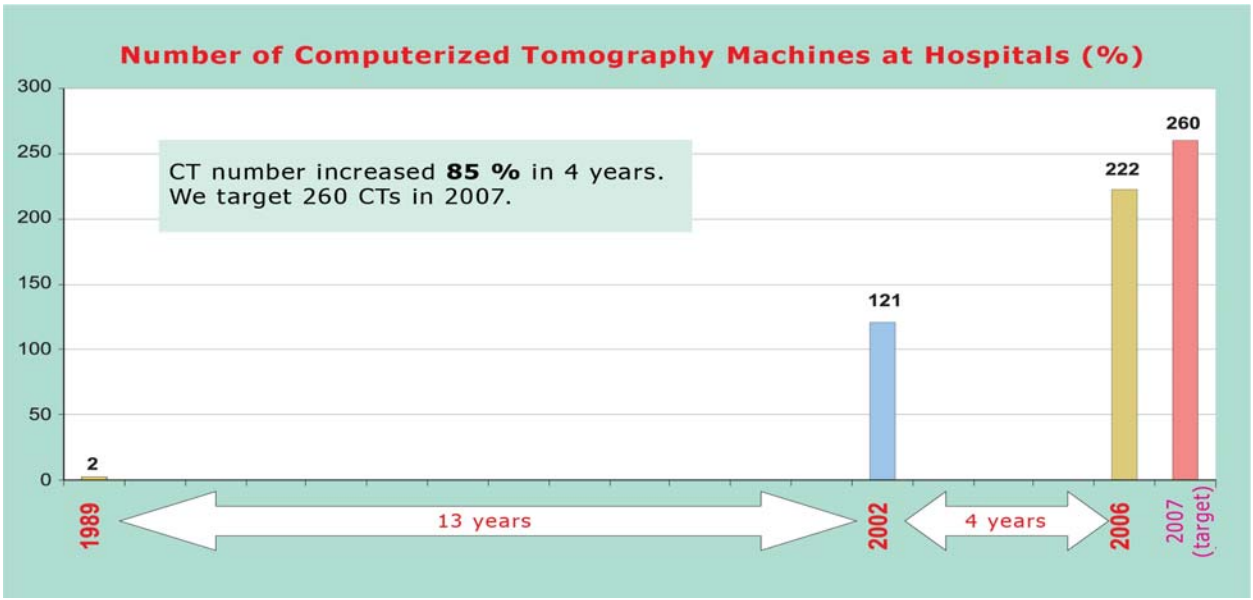


Note: The number for 2002 includes SSK institutions

The services provided in state hospital were supplied through the cooperation of state and private sector. In 2002, there were only 18 MRI devices in all public hospitals. This number was increased to 75 in 2007 and the number of computer based tomography devices was increased to 222 from 121.



Note: The number for 2002 includes SSK hospitals



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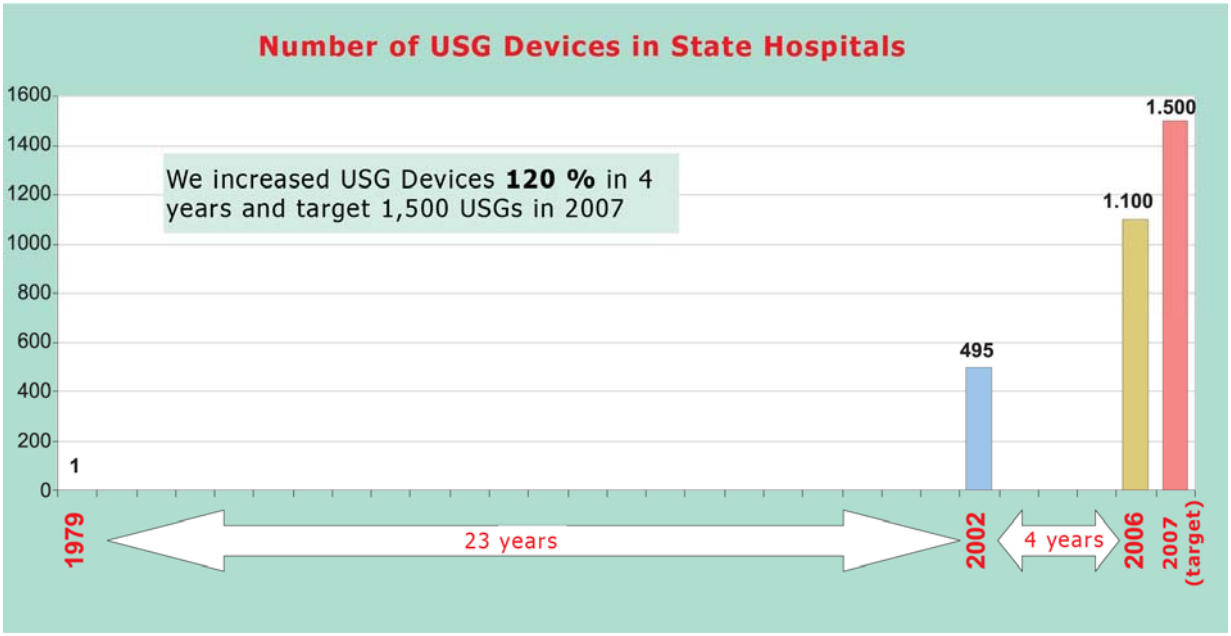
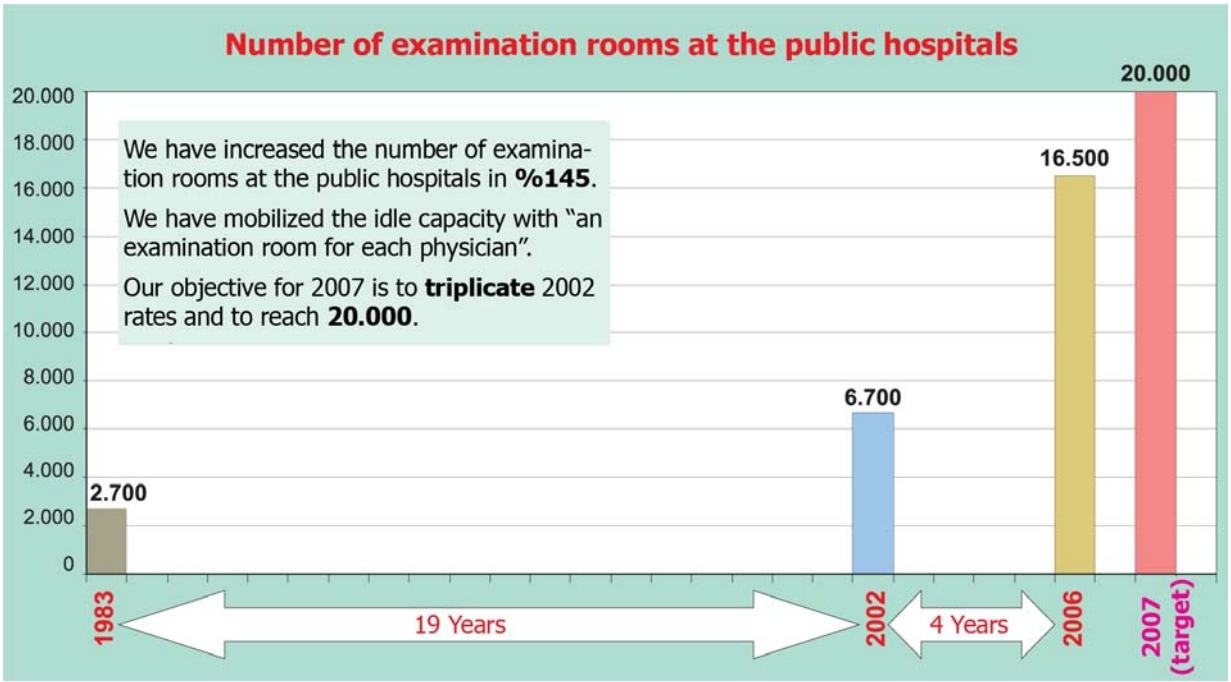


Note: The number for 2002 includes SSK hospitals

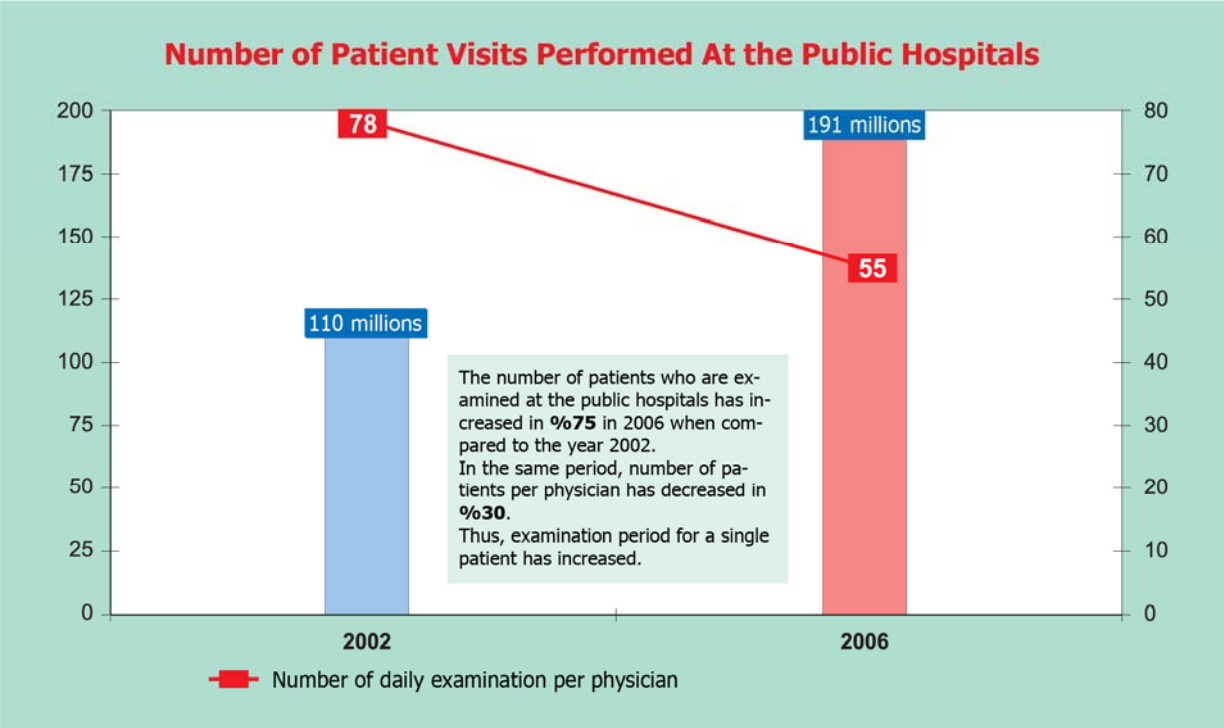
In 2002, only 20 % of state hospitals had electronic information systems and this rate increased to 100 % in 2006. By late 2002, the number of examination rooms was 6,500 which was later increased to 16,500 in 2006 (an increase of 145 %).



Note: SSK hospitals are included in the numbers

Idle facilities were activated in order to provide every physician with a room. In parallel to this, 110 million patients were examined at state hospitals (including SSK hospitals) in 2002. In 2006, this number was noted as 191 million patients, which refers to an increase of 75 %. In the same period, the number of patients per physician was decreased 30% and examination time spent per patient increased in parallel.

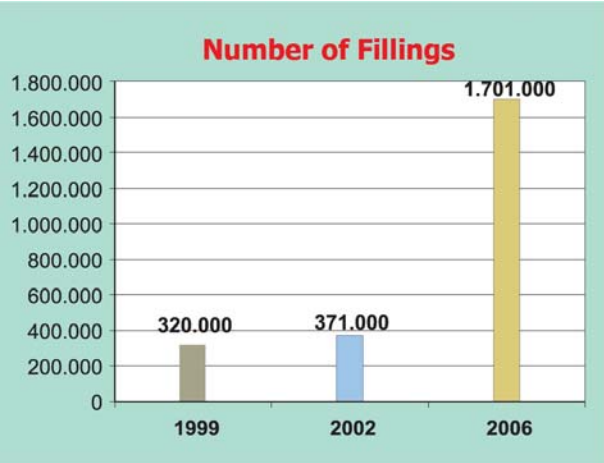
From hospital doors to examination rooms



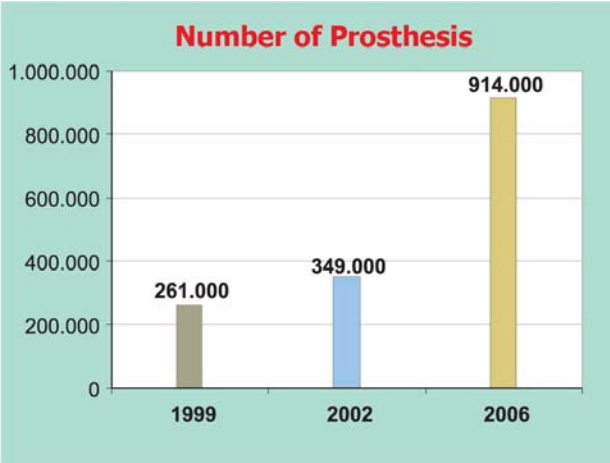
Note: The number for 2002 includes SSK hospitals

Public oral-dental health care services

When compared with the 2002 figures, the number people receiving dental care services was increased, too. Tooth filling was increased 4.5 times and prostheses 2.5 times.



Note: The numbers for 1990 and 2002 include SSK hospitals



Note: The numbers for 1990 and 2002 include SSK hospitals

When compared to 2002, the number of filled teeth increased 4,5 and prothesis increased 2,5 times at public hospitals in 2006.

We target a health care system in which patients' rights are not violated, patients are informed at all stages of treatment, their consent is taken, confidentiality is respected and patients are given all kinds of curative services without discrimination. As required by the relevant legislation, "Patient Rights Units" have been activated. "The right to choose physician" was put into practice at 11 hospitals in 2004 and it is being implemented at 400 hospitals, now.

Now, Both Patients and Their Families Have Rights!

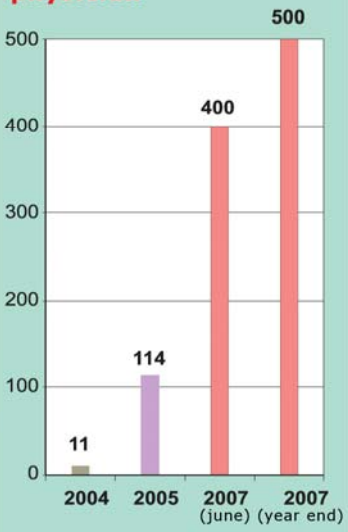
People could submit their wishes and complaints orally or in writing to patients rights units which we founded at hospitals. Their complaints are handled carefully and necessary corrections are made.

We have activated "Patient's Right Unit" at all state hospitals in Turkey.

You Have the Right To Choose Your Physician

In September 2004, we put into effect the "Right to Choose Physician", which is one of the basic patients' rights.
We started this implementation in **400** hospitals.
We target 500 for the late 2007.

Hospitals which give the right to choose physician



You Are Not Alone! You Can Directly Reach the MoH by Calling "184 SABIM"

We receive and solve your problems on the phone immediately or latest within 24 hours.

For your problems which can not be solved in 24 hours:

We give you a registration number. Then, we give directive to our health managers. They solve your problem and brief you when you call back.

We solve 90 % of problems within the first 24 hours.

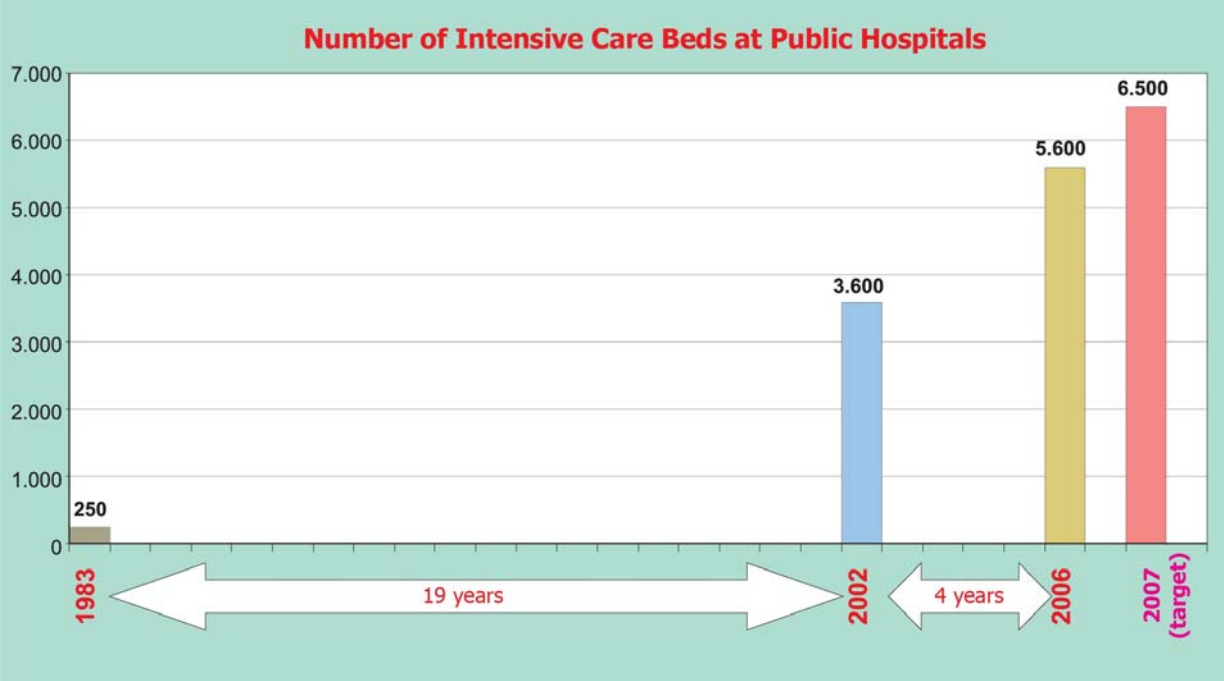
We handle and conclude **1 million** applications made to SABIM.

We are pleased to serve you 7/24 with our 52 call center operators.

Intensive care units are being re-animated.

In the last 4,5 years, 903 health facilities were opened. 301 of these are hospitals and side buildings. The number of patient beds was increased to 19,000. 80 % of the patient rooms built in this period have independent bathrooms and toilettes. Remaining 20 % consist of the projects which were started before but not revised technically. The number of such rooms was increased from 10,000 to 22,000, which refers to a share that increased from 9 % to 18 %.

In 2002, the number of intensive care beds was 3,600 and it was increased to 5,600 by 2006.



Note 1: The numbers include SSK hospitals
Note 2: General Directorate of Curative Services was founded in 1982

c) Private Hospitals Serve Everybody

Health Transformation Program envisages to include all sectoral sources in our country in the system and thus to ensure harmonization and enhance productivity. Hospital unification under single roof was a concrete step which was taken to this end. Other step will be to include private sector investments in the system in order for patients to benefit from these facilities as enabled by their own insurance schemes. Now, all sources (both private and public) in the country are open to public use without discrimination. Public hospitals became qualified enough to

compete with those in private sector and service quality increased, too. In this context, private health care facilities now serve to those who are covered by public insurance. So, the excessive workload which was mostly undertaken by public sector in the past, is shared with private health care facilities and people are provided with qualified health care services that they deserve.

Besides, registered work was facilitated in private sector. Private sector is supervised more carefully, today. In addition to all these, private health sector gained impetus this way. Increasing number of investments are made in this sector day by day.

A New Era in Health

6. Performance-Based Additional Payment

In the past, hospital personnel used to take a very little share from the revenue of hospital services given to people. For this reason, the issue of health services efficiency, registration or return of service cost did not concern most personnel except for few managers since personnel was not able to receive any share from hospital income, which led to increase in unregistered procedures at hospitals.

In previous implementation, institutions with a high level of revolving fund could offer their personnel an extra payment that could reach up to 100 % of their salaries. The new implementation, on the other hand, offers an extra payment varying from 150 % to 800 % depending on different professions and work styles.

Health Transformation Program states that performance indicators will be developed and performance-based payment systems will be established. The new implementation, in this context, has brought some changes in many respects. First, a system was set up by bringing the work and monetary contribution in parallel which would ensure more productive use of time and potential. It is fair that service producers have a share as much as they produce. We observed that such an implementation motivated the personnel and thus efficiency was increased. The very first benefit of this system is that the services provided in hospitals became measurable. The second benefit is the reflection of these services upon service providers**. In training hospitals, scientific studies, publications and assistant training were also accepted as performance indicators as well as the services given to patients.** Thus, assistant's trainings and scientific studies were encouraged.

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

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

As a result of the performance-based revolving fund payments, personnel extended work hours by their own will which means that operating rooms are kept open for a longer time. Most specialists closed their private offices and began to give all their energy to hospitals, which has helped a lot to overcome the patient overload in hospitals. In 2003, the share of full-time practitioners 11 %, which was increased to 60 % through these policies later. Thus, physicians work in a more productive way though they are still inadequate in number.

When we came to power, only **2,200** specialists were working full-time.

As a result of "**Performance-Based Additional Payment**" system, there are **14,800** full-time clinicans in public sector, now.

- Payment-per-performance refers to payment depending on the services given and we use it as an incentive instrument which facilitates service supply and productivity.
- It is an important instrument which increases motivation in meeting service demand.
- Prevention of illicit work, inexpensive provision of supplies and decrease in waste subsidize performance-based payment system to a large extent.
- The system also paved the way for a regular registration system. 20 % of hospitals were automated in the past whereas 100 % of them are automated now.
- Outstanding decrease is noted in waiting lists.
- Referrals to upper-level facilities are on an acceptable level, now.
- Income-expenditure balance of health enterprises are followed carefully.
- Today, we are much more capable of fighting with illegal payment to health care personnel.

Performance measurement has been an important instrument that encourages personnel motivation. **Registration procedures, acquisition of materials at low prices and avoiding wastes support the performance-based payment system in question. This practice has also facilitated a regular registration system. In the past, only 20 % of hospitals had electronic database system whereas it is available at 100 % hospitals, now. Thanks to this system, waiting hours are shorter at hospitals and income-expenditure balance at health care facilities is better followed.**

Health Transformation Program targets constant development. We realized performance-based payment system which is peculiar to us. We also included quality assurance in the system and put into effect the legislations on Institutional Performance and Quality Improvement. Thus, hospital evaluation system was established which facilitated the assessment of access to health care services, infrastructure and

procedures, measurement of patient's satisfaction and analysis of the achieved goals. Thus, additional payment made to personnel depends on both quantity and quality of services produced.

SUCCESS STORY

PERFORMANCE MANAGEMENT IN HEALTH

We began to implement the policy mentioned above in 10 pilot areas in 2003. the relevant amendments and changes were carried out in accordance with the feedback returned from these places. This policy was put in effect in all health institutions linked to the Ministry in 2004. In one year's time, an integrated inspection model was formed through institutional performance and quality development methods.

We altered the definition of "quality" in public health via performance based extra payment system. While quality used be defined according to service provider, it is now also defined in accordance with the demanders. Patient oriented approach in public health has changed many things in quality understanding.

Through this policy, services provided have been registered, the shortcomings of the system have been prevented and physicians began to prefer public hospitals to their private offices.

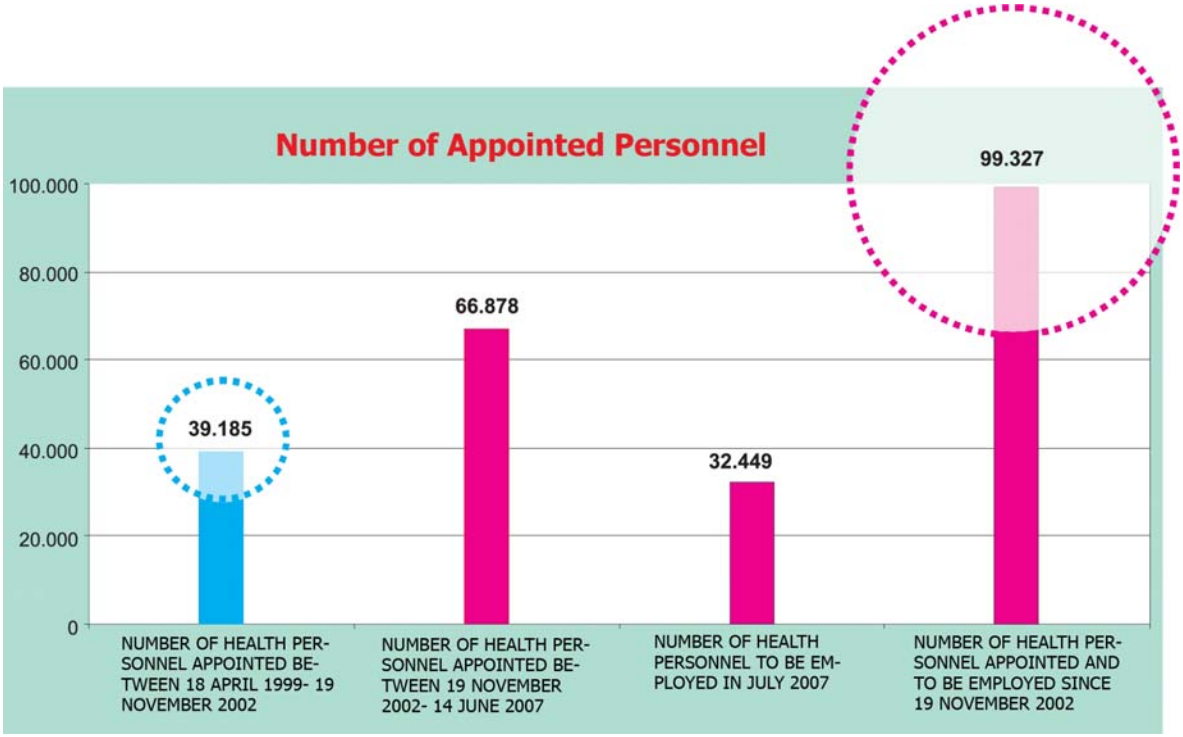
This policy increased both patient and personnel content as it both encouraged performance based payment and patient satisfaction.

A New Era in Health

7. Human Sources Management in Health

a) Quantum Leap In Health Human Resources

66,000 new health personnel were appointed during the last 4 years. In July 2007, this number will reach to 100,000. 16,000 contracted personnel are assigned in deprived places which had no personnel in the past. In this way, the gap between the best and worst rates were diminished (for specialists: from 1/14 to ¼; for practitioners: from 1/9 to 1/2,5; and for nurses and midwives: from 1/8 to 1/5). In the next few years, distribution of health care personnel will be more equal and fair.

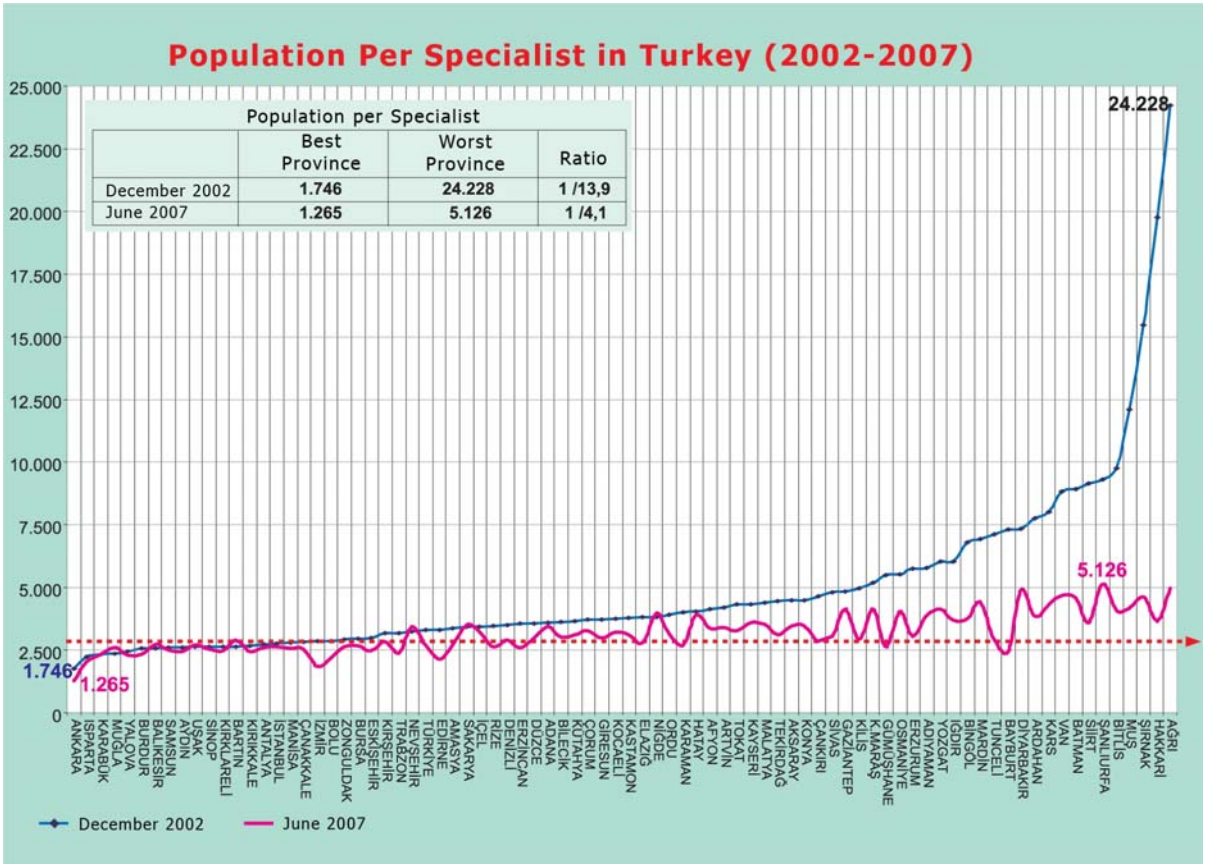


b) Transparency in Personnel Appointment

It is known that personnel distribution is one of the most important problems in our country. One of the priorities of the Health Transformation Program is to alleviate regional differences in personnel

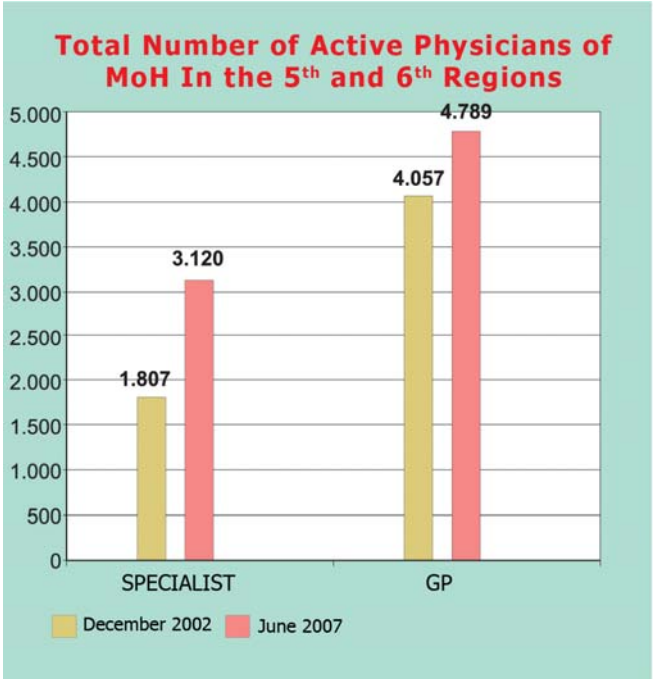
distribution, to plan human resources in accordance with the titles in personnel employment and to assign people objectively and equally.

The number of physicians is inadequate in our country.



In order to encourage personnel to work in priority development regions, the law no: 4924 was adopted. So, personnel in such regions were granted further employee rights. Thanks to this policy, more than 7,000 new health personnel were assigned in the East and Southeast Regions.

We do not redeprive our regions that are already deprived.



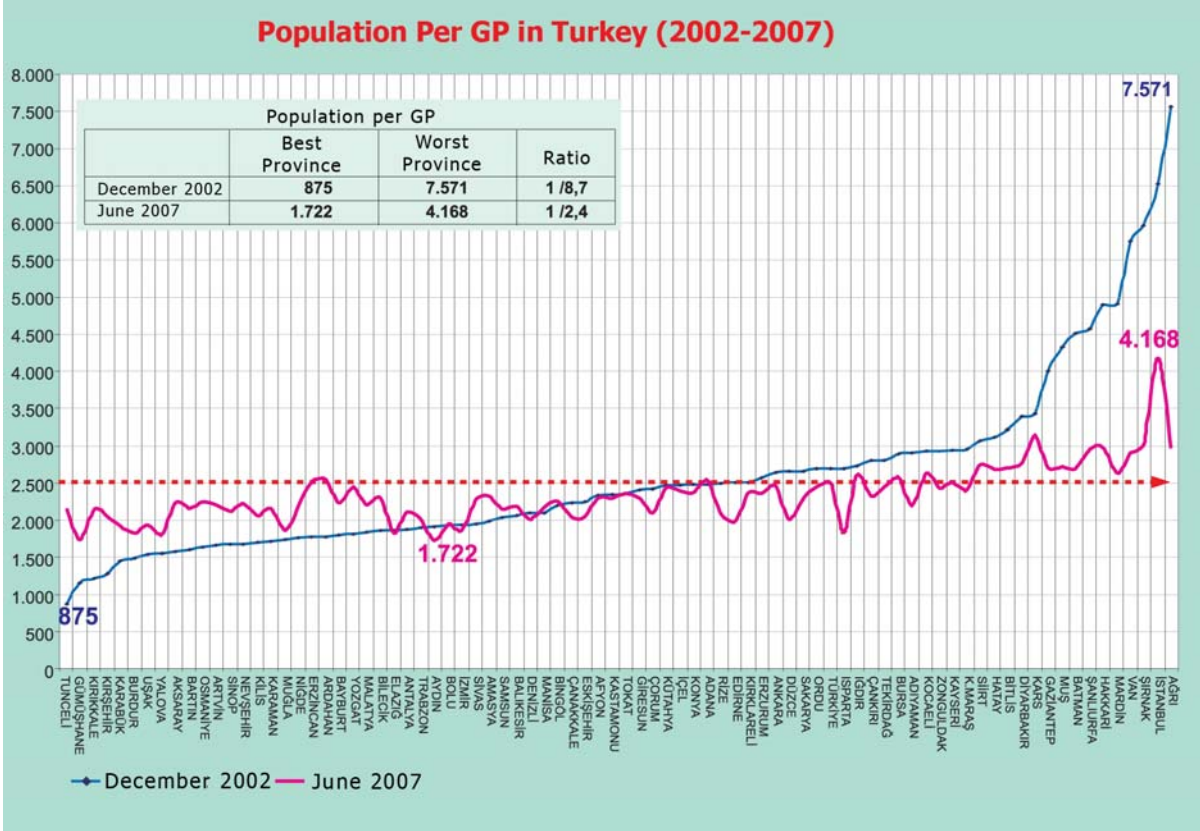
Physicians are not adequate in number and it is difficult to employ them in the less developed regions since most of them like to work in metropols.

Taking health for all policy as the basis, we put into effect the subsidized compulsory service for physicians since we do not have adequate number of physicians.

Considering former implementations of compulsory service, we made a fair and sustainable arrangement and identified separate work periods and higher payment policies in accordance with deprivation areas.

We increased the number of specialists to 3,120, which was only 1,807 in the 5th and 6th regions when we came to power, and we target 4,606 specialists, as well. We also increased the number of GPs to 4,789, which was only 4,057 in the past and we target 6,160 GPs, similarly.

Note: The numbers 2002 include SSK institutions



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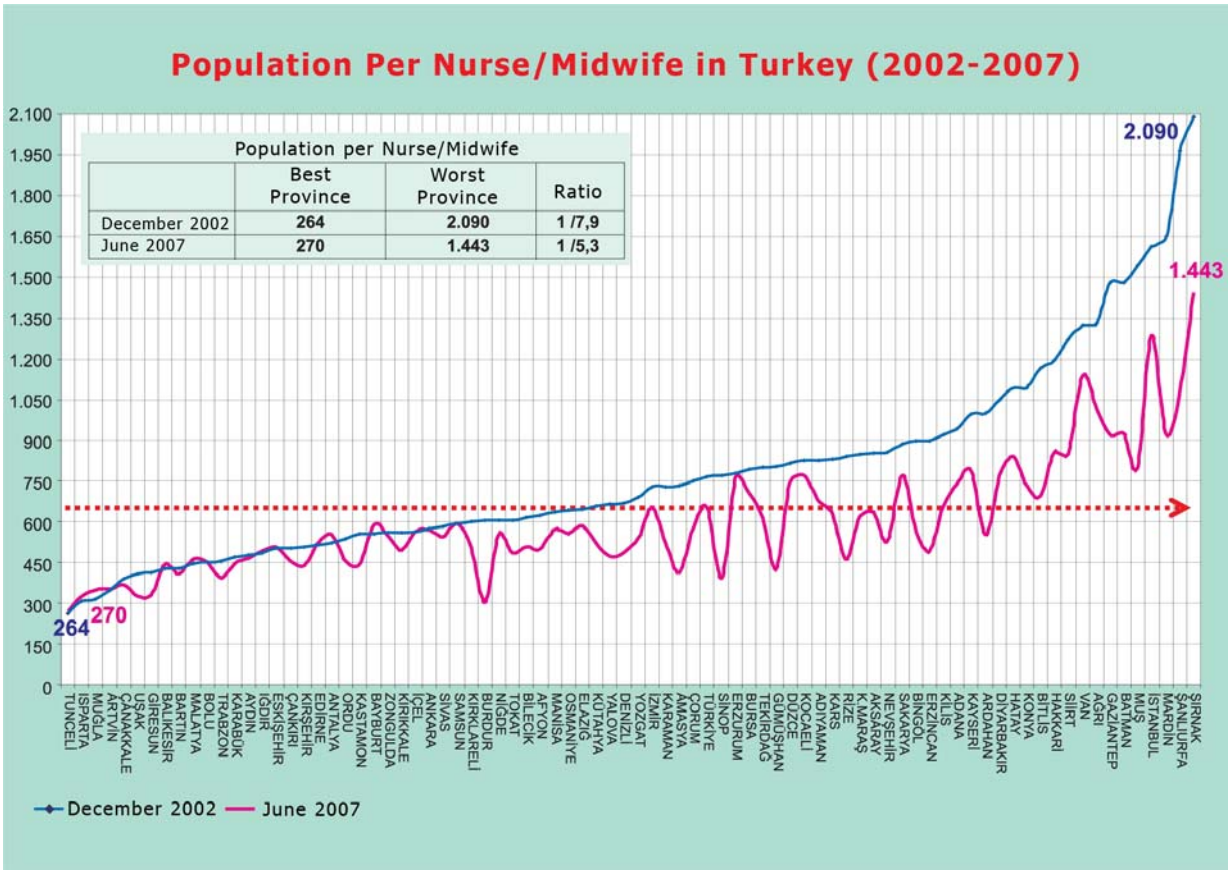


With positive effects of performance-based additional payment system, a lot of physicians closed their own private offices. Along with these, some others asked to be assigned in places in urgent need of personnel.

In order to prevent favoritism and nepotism in personnel appointment, Directive on Appoinment nd Transfer was prepared so that health care personnel are distributed to all the MoH-affiliated health care facilities in a balanced way. In first appointment, specialists, general practitioners, dentists and pharmacists are appointed by a computer-based lottery and other personnel is appointed by a central examination conducted in

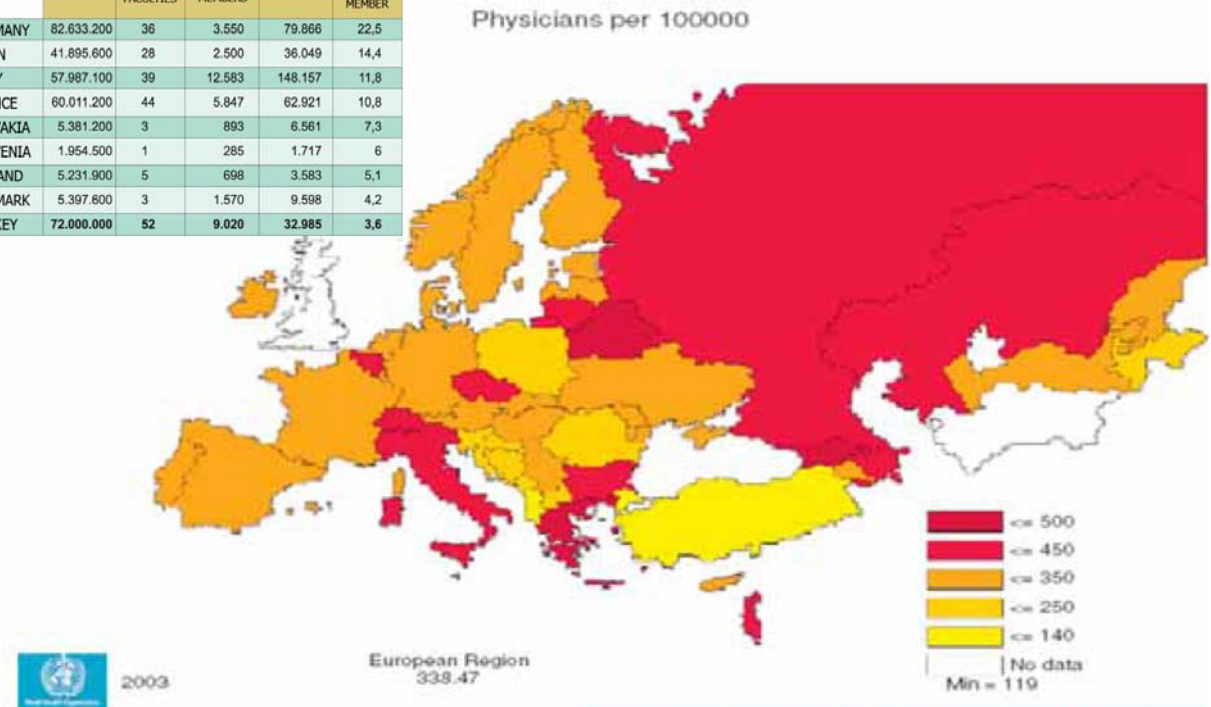
accordance with general provisions. In the new implementation, personnel appointment and transfer proceedings are based on the "service points" that depend on work places and periods. A more strict supervision system was set up for excuses. **Service points-based and computerized lottery prevented favoritism and nepotism pressures on politicians and bureaucrats as well as some unjust interventions**. Thus, a marked success is achieved in the balanced distribution of health personell all over the country.

d) Health Personnel Training

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

Primarily, a kind of mobilization process has been initiated in order to train current directors. On one hand, regional training meetings are held on technical issues. On the other hand, School of Public Health gives systematic health management trainings on the web.

	COUNTRY POPULATION	NUMBER OF FACULTIES	NUMBER OF FACULTY MEMBERS	NUMBER OF STUDENTS	NUMBER OF STUDENTS PER FACULTY MEMBER
GERMANY	82.633.200	36	3.550	79.866	22,5
SPAIN	41.895.600	28	2.500	36.049	14,4
ITALY	57.987.100	39	12.583	148.157	11,8
FRANCE	60.011.200	44	5.847	62.921	10,8
SLOVAKIA	5.381.200	3	893	6.561	7,3
SLOVENIA	1.954.500	1	285	1.717	6
FINLAND	5.231.900	5	698	3.583	5,1
DENMARK	5.397.600	3	1.570	9.598	4,2
TURKEY	**72.000.000**	**52**	**9.020**	**32.985**	**3,6**

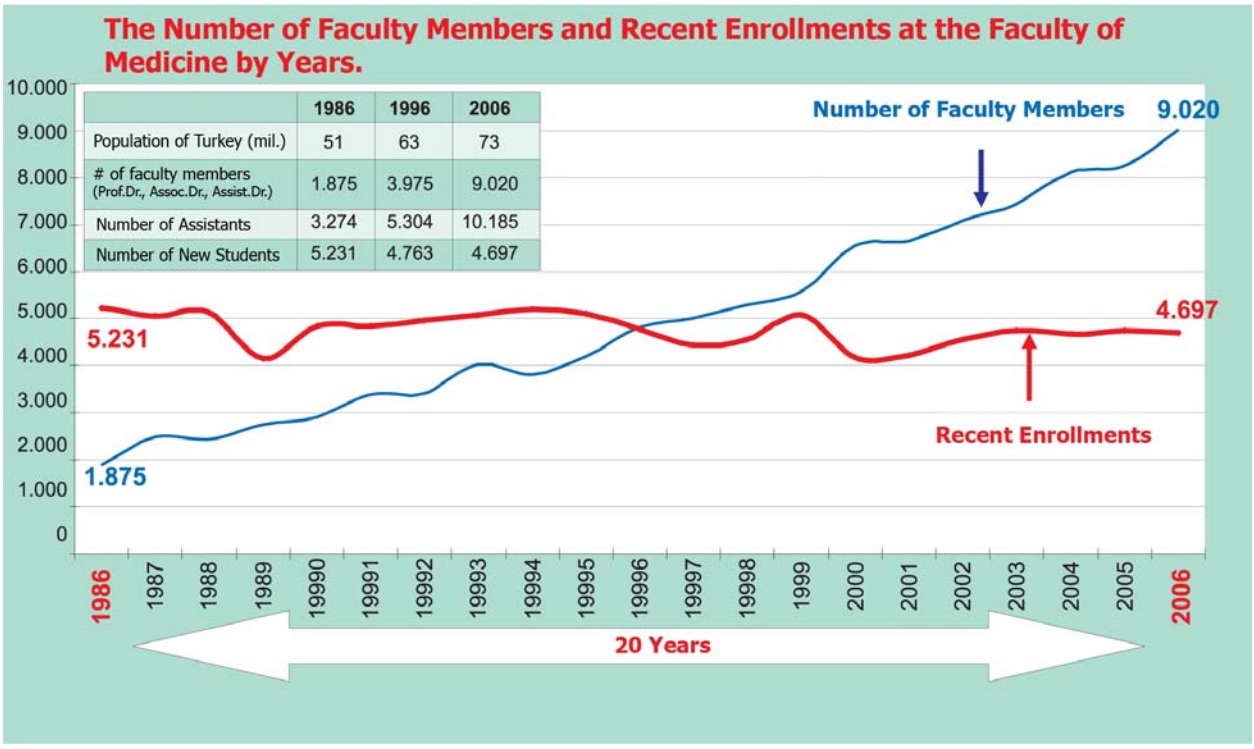


Turkey's need for doctors should be considered and student capacities of existing medical schools should be increased without reducing the quality of medical education. New medical schools should be opened.

The nursery-training program has been university-based and reached to international standards. The law on nursery was executed and this law is thought to help nursery services turn into a scientific discipline in patient care

It is important to raise the number of nurses and physicians without making concessions from the quality. Turkey is at the lowest level in the WHO European region with the number of physician per hundred thousand people. The situation for nurses is not different, either.

Increasing the number of nurses and physicians is inevitable because of the current needs and the increasing demands. However, the quality of the training of these people should be observed as well. The number of instructors in medical faculties is enough to meet this need. The Higher Education Council (YÖK) should fulfill this need as soon as possible in the following years.



A New Era in Health

8. Quality and Accreditation in Health Care Services

The Quality Coordination Unit of the Ministry of Health has been founded in order to organize the quality management and to unite the activities carried out in the field of health accreditation with an aim of providing more effective and efficient health services by the Ministry of Health. After the foundation of this unit the Performance Management and Quality
Indicators Development Deparment has been formed.

Thus, a need, which was not paid attention before, was taken into the agenda and a study was initiated. The Ministry of Health played a pioneer role in quality assessment studies that are mostly handled by private facilities in the sector.

The quality studies in public hospitals were accelerated and the Directive on Institutional Performance and Quality Development was put into effect. Thus, an inspection system was developed for hospitals in order to provide services, enable access to these services and to measure satisfaction level of patients and patient relatives. The current hospitals are measured and evaluated in accordance with this directive and the points they have gained are updated in every inspection period.

Excellence in services, quality in health care

When autonomous public hospital associations are founded, the process of inspection of hospitals and their grading will be carried out in accordance with the quality studies developed today.

A New Era in Health

9. National Medicine Policy

a) Reduction in Medicine Prices

Health Transformation Program indicated that increases in medicine prices were not evidence-based in the past. The Ministry of Health is responsible to determine the relevant norms and standards about medicine and pharmaceutical services. It is also competent and obliged to carry out inspections in this field and to encourage logical medicine consumption in cooperation with other relevant institutions and organizations.

As for medicine pricing, the program clearly emphasized the need for developing a method which all parties would agree on. **"The Decision on Pricing of Medical Products for Human Use" of 2004 removed the disturbance and negative aspects and rendered the issue of pricing medicine transparent. Thus the prices have been cheapened significantly. Now the prices of medicine are at the lowest level in Europe. Discounts ranging from 1 % to 80 % have been done in approximately a thousand products.**

In order to relief the workload of the Ministry of Finance, a Reimbursement Commission has been established under the directorate of the Ministry of Health. This commission has enabled "The Single Reimbursement System). With the consortium of the imbursement institutions, the prescribed bioequalent medical products will be reimbursed on condition that their price is within certain limits**.**

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

The VAT rates for medicine have been reduced to 8 % from % 18 leading to another decline in medicine prices. The negotiation of medicine prices by the public insurance institutions as the sole buyer and the resulting reduction further decreased the cost of the medicine prices to the public.

In the Price Decision of 1984,

Prices were determined according the cost accounts declared by firms. However, cost of imported medicine could not be inspected practically and expenditures and profit rates also used to be added to the prices. The prices of imported medicine used to rise in accordance with the rise of the foreign exchange. However the prices would not fall down when the foreign exchange fell.

With the new decision of our government on 6 February 2004 we initiated reference price system, transparency, measurable and objective principles and reasonable profit rates. We included the re-payment institutions in the decision making process. We eliminated the inspection on "Barriers in Trade" carried out by the EU Commission.

Determination of Prices in accordance with the reference price system:

* We identified 5 countries in which the prices of medicine are the lowest (for the year 2006 Italy, Spain, France, Portuguese and Greece).
* We determine the highest price of medicine based on the lowest price in these five countries (reference price).
* We determine the prices of medicine in accordance with the International, Medicine Statistics data. When we need extra information we demand an approved document from the relevant country and behave in cooperation with embassies.
* Thus discounts ranging from 1 % to 80 % have been done in approximately a thousand products.

The annual public saving achieved thanks to the reference price system is 900 million $

b) Pharmacies are open to everybody

People now do not encounter any difficulties in accessing medicine (especially people ensured by SSK and the Green Card).

Amount of Consumed Medicine in Turkey (million box/year)

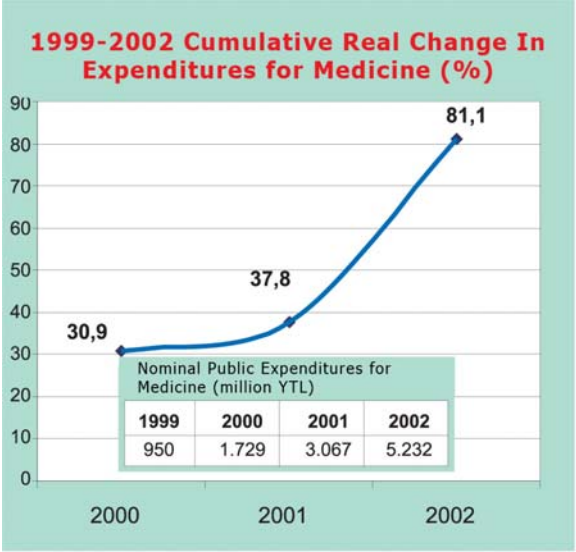
	2000	2001	2002	2003	2004	2005	2006
Original	66	73	76	86	98	147	168
Generic	548	543	555	613	682	966	999
Other	90	77	67	70	76	99	105
Total	764	693	699	769	856	1212	1272

We provided SSK and Green Card beneficiaries with access to medicines in private pharmacies. **We managed to save medicine with our medicine policies and spent these savings to provide our people with easy access to medicine.**

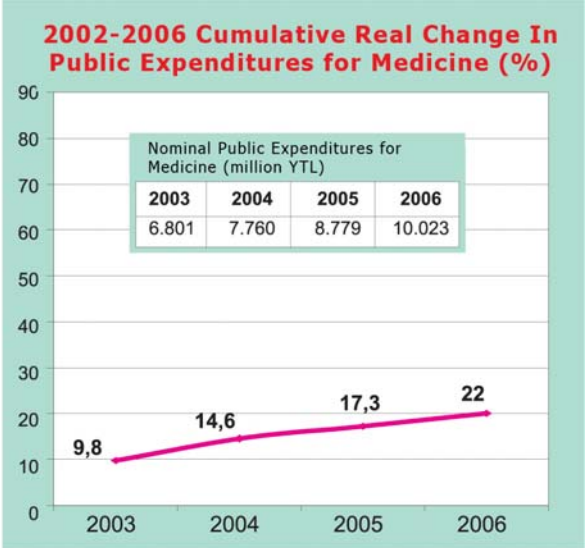
Because we immediately reflected the advantages we gained through medicine prices to public benefit. The decrease rates in prices of medicine can be easily observed.

People ensured by the SSK used to obtain their medicine from a limited number of specific pharmacies. Therefore they would not prefer these places. Now they are also free to obtain their medicine from any pharmacy. People ensured by the Green Card have had advantages as well. Now they are also in the out-patient treatment system; hence they are free to obtain their medicine from any pharmacy.

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



The real increase in public expenditures for medicine has been 81.1% in 3 years between 1999 and 2002



The real increase in public expenditures for medicine has been only 22% in 4 years between 2002 and 2006

A New Era in Health

10. Health Information System

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

From data collecting
To data processing...

Creating health information systems depends on integration of data obtained from different institutions and rendering these data usable in decision making processes.

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

The Core Sources Management System (CKYS) has been completed hence the intern surveillance of personnel, material and financial sources are being carried out more successfully. Additionally, Tender Information System of the Ministry of Health (SBİBS), Green Card Information System (YKBS), Medical Devices and Supplies Registration System (TCMKS) and Physicians Information Bank (DBB) has been prepared. Family Medicine Information System (AHBS) has also been implemented. Through this way patient records in the primary health care system began to be kept electronically in the pilot provinces. The relevant infrastructure studies to include all health systems and all actors of the health system are being continued.

A New Era in Health

11. Rational Investments

Time to make rational investments in health

A detailed health inventory has been created for the first time in the history of Republic and all the health investments so far have been reviewed. Public health investments have been re-planned. The financial, medical and technical analyses of investments have been re-evaluated. These planning procedures have been carried out on-site at the level of district, province and region together with the local administrators. The projects have been re-arranged in accordance with the priority and importance level and investment budgets began to be utilized more logically.

We conducted "Turkish Health Inventory" study, which was the first study in this field in Turkey.
We re-evaluated financial, medical and technical analysis of investments.
We made planning through on-site inspections and in collaboration with local administrators on district, provincial and regional level.
We classified projects with regards to priority and significance.
So, we made rational use of budget which was allocated for investments.

Health Investments Concluded In November 2002-June 2007				
Hospital	Hospital Side Bldg.s	Health Center	Other	Total
152	149	528	74	**903**

The Amount Spent For Health Investment, Maintenance And Medical Hardware Between The Years 2003-2007 (Million NTL)			
General Budget	Revolving Funds	Province	Total
2850	1661	325	**4836**

We spent **4 billion 836 million NTL** in the last 4 and a half years (**2 billion 172 million NTL for investment, 829 million NTL for maintenance and 1 billion 835 million NTL for medical devices**. These prices belong to 2007.)

We opened **903** health facilities, of which **301** are hospitals and side buildings.

Between 1999 and 2002 **5000** beds were opened. However between 2003 and 2007 **19.000** new beds were opened to service.

In 2007 we will add 3.700 more.

In the last four years, we doubled the number of patient rooms with enclosed bathroom and toilette.

	December 2002	June 2007	Increase (%)
Number of patient rooms with enclosed bathroom and toilette	6,850	14,252	%108
Total number of patient rooms	32,432	41,851	%29
Number of patient beds	107,307	125,411	%17
Number of beds with bathroom and toilette	10,100	22,088	119%
The rate of patient rooms with private bathroom and toilette to the total number of patient bed (%)	%9	%18	

Note: The numbers for 202 includes SSK hospitals.

We prepared the relevant legislation to enable investments with public and private cooperation for new health facilities and revision of some old ones.

A New Era in Health

12. Evaluation of Provinces: 81 Provinces

A significant attention was paid in order to evaluate the practices carried out on-site and monitored strictly. With this aim the most field studies have been carried out in this period

We analyzed and evaluated all health indicators in 81 provinces and MoH health care facilities on site

We made final evaluation of provinces in collaboration with local administrators, local politicians, deputies, local and central bureucrats and field coordinators.

Under Health Transformation Project, field coordinators conduct regular on-site follow-up and evaluation of health data in all provinces.

The amount of distance the Minister and the field coordinators covered is 450.000 km during these studies.
Touring around the world 11 times…

All of the 81 provinces were visited without missing any. The problems of provinces were examined with the local administrators and duties were shared in order to solve these problems. Local health directors also visited other provinces in order to have an opinion about other places. Thus provincial evaluation functioned also as an in-service training program. Seeing the satisfaction of our citizens as a result of these efforts is a source of pride for us.

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

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

Share of Experience
Thanks to such studies, health managers took the opportunity to Exchange their knowledge and experience. We paved the way for good practices across the country.

Broadening Perspective
We enabled our managers to look at cases from different perspectives than they had. We facilitated all parties and actırs to comprehend Ministerial policies within the framework of Health Transformation Program.

Standardization
We created "common vision" for agencies of similar structures so that they develop common language to adopt similar approaches.

Communication and Consultation
We created communication and consultation atmopshere in order for health managers across the country to come together, meet and consult each other to solve problems.

A New Era in Health

13. Dynamic and Healthy Foreign Affairs

There are 52 cooperation conventions with 44 countries. 13 of these conventions were signed in the last 4 years.

Turkish Ministry of Health headed the 56th European Regional Committee Meeting in Bucharest which hosted committees (consisting of health ministers and senior officials) from 53 World Health Organization Region for Europe member countries. Ministers' Conference for the Struggle Against Obesity of the World Health Organization was carried out in İstanbul.

In 2006 Deputy Under Secretary Prof. Dr. Sabahattin Aydın was elected as the member of the WHO Executive Board in 2006. Aydın is the 4th Turkish scientist on duty since 1948.

Medical supplies, medicines and medical personnel were sent to countries such as TRNC, Kyrgyzstan, Sudan, North Ossetia, Iraq, Indonesia, Georgia, Afghanistan, Bulgaria, Pakistan, Iran, Philistine, Lebanon, Kosovo, Algeria, Romania which were exposed to natural disasters such as earthquake, flood, tsunami and others.

In 2003-2006 period, 276 health personnel from 13 countries and on different levels were trained, as well.

A New Era in Health

14. Re-Structuring the Ministry of Health

The Health in Transition Program provides a vision that develops policies for the Ministry of health; develops, monitors and screens standards; enables effective use of national resources dedicated for Health; and provides guidance for above mentioned points. In parallel to that vision, it offers reformation of Institutions under the Ministry in line with principles of decentralization, and envisages an institutional framework that is capable of planning. In this way, the Ministry will be able to fulfill its mission of being the sole authority of planning for Health sector, as indicated in Turkish Constitution. This component of the program aims to realize effective and participatory administration, which is an important principle of modern public administration.

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

Despite these points mentioned above, drastic legislative changes for reformation of the Ministry could not yet be made. Nevertheless, preparations are already completed and a significant accumulation of experience is achieved. The process will continue when those legislative changes are put into effect.

PART 3

Still, we have a lot to do

Still, we have a lot to do

We aim to respond to 112 Health emergency calls in 10 Minutes in cities; and in 30 minutes in rural areas. We will carry on raising the number of ambulances and stations and renewing our ambulances with the most up-to-date technologies. In addition to ground vehicles, we will purchase naval and air vehicles.

Family Medicine will reach every part of our country. In consequence a new period will begin that enables us to choose the physician we want. Besides, we will be able to closely follow patient record sheets, and our hospitals will be able to develop an integrated healthcare system and a convenient referral chain. We will also be able to implement appointment - based healthcare services and be able to choose the doctor we want in hospitals. Family practitioners will fully provide individual protective healthcare services and mobile healthcare services. We will also closely follow family medicine implementation through “Public Health Centers”.

In this way, mother-child health care services that we attribute special importance will even develop more. We will carefully monitor health status of all mothers and pregnant women. We will strengthen our reproductive health programs especially in vulnerable regions.

We will intensify efforts aimed at protection of child health. We will manage to decrease infant mortality rate below the level of 20/1000, and mother mortality rate under the level of 20/100000. We will strengthen our program aimed at preventing children from malnutrition. We will raise children vaccination rate above the level of 95%. We will not only implement vaccination calendar of developed countries but also we will manage to implement most recent vaccination technologies and methods on our children.

We will show utmost care to protect young people from accidents and violence, from use of drugs, alcohol and tobacco.

We will ensure easy reach to healthcare services for disadvantaged groups, especially for the disabled. We will continue to sustain efforts to develop home care services.

We will give utmost importance to the health of the elderly and we will continue our effort for them to take an active role in social life .

We will decisively continue to implement our program on development of mental health.

In order to crown our success in protection from communicable diseases, we aim to eradicate measles, minimize Hepatitis B carriers and to hold mumps and whooping-cough incidence under the level of 1/100000; malaria 5/100000, and to decrease number of deaths emanating from tuberculosis, infant pneumonia and diarrhea .

In parallel to world developments, non-communicable diseases and deaths emanating from those will be among the top priorities of our agenda. We will develop national programs to combat against cardio-vascular diseases, cancer, diabetes, chronic respiratory diseases, paralysis, and kidney failure.

We will also combat seven main risks that are: Tobacco use, alcohol use, insufficient consumption of vegetables and fruits, insufficient physical activity, overweight, high blood pressure and high cholesterol. We aim to adapt our people to the healthy life programs.

We will intensify our efforts to protect from environmental pollution, to ensure continuous reach to sufficient and quality drinking water, to make living sphere healthier and to protect from accidents.

We will develop our national medical rescue teams in quality and quantity. We will prepare a 3500 people volunteers group to be used in the case of natural disasters.

We have added public-private partnership model to our methods of financing health investments. In addition, we have started with TOKİ, to build health facilities. We aim to give an end to the necessity of going

Istanbul, Ankara or Izmir for our patients by focusing on alternative health regions. We will build health campuses to regional centers. We will increase the number of hospitals with good facilities such as wide polyclinic and emergency area, rooms having bathroom and toilets and adequate intensive care units.

As regards all services in the sector, from public health programs to individual patient care, we will measure efficiency of strategies with health results and indicators. We will continue to show the effects of the quality of healthcare services and development of human rights on patient satisfaction.

We will ensure sustainability of healthcare financing, and thus, its comprehensiveness.

We will develop Turkish Health Information System (e-health) and provide an integrated health information system by bringing universities, social security institutions and private firms together.

We will initiate pilot implementation for "appointment and call centre system" which will provide the basis for appointment based system.

We will develop our cooperation with the Red Crescent. Our citizens will easily reach blood and blood products due to our increased cooperation with the Red Crescent.

It is obligatory to remedy the problems deriving from insufficient number of health personnel, and all relevant stakeholders should sustain efforts to solve the problem.

School of Public Health, which has become a respected and popular agency through its research and development studies mainly on health care system, health economics, health management and others will be transformed into Turkish Health Institute. We are also determined to establish a new structure for pharmaceuticals and medical equipment management and to establish an independent Medicine and Medical Devices Agency. We will continue our efforts aimed at making curative health services qualified and economic within the framework of rational drug use policy.

We will reform Ministry of Health and empower local authorities.

We will vitalize hospital unions in public sector and empower them with decentralized authority. We will encourage private sector to invest in health sector.

We will create opportunities for private and public sector, NGOs and international organizations to contribute to the reformation process in health sector.

We will have achieved most of the "Health Transformation Program" goals by 2013, that is equal, just, quality, contemporary and sustainable health care services for all!

2023 Vision:

In 2023, we aim to have a country where people are fully aware of health issues. Our health care system will be able to respond to this conscious demand.
We aim to have a perfect primary health care system in which "evidence-based medicine" is performed in case of disease or illness and patient rights are fully respected.

Maternal mortality will have been decreased to less than 10/100000 and infant mortality to less than 10/1000.

The community will have become conscious regarding what needs to be done to stay healthy and get rid of harmful addictions such as tobacco and alcohol.

We need to develop our capacity of human resources to reach our goals. Turkish universities should also immediately and accurately identify their goals for the year 2023. We should keep in mind that educating a general practitioner takes 6-7 and a specialist takes 12-13 years. Any moment of delay will mean loss of our goals set for 2023. On the other hand, our universities, with regards to the number of academicians, are capable of helping us to achieve our goals in educating physicians.

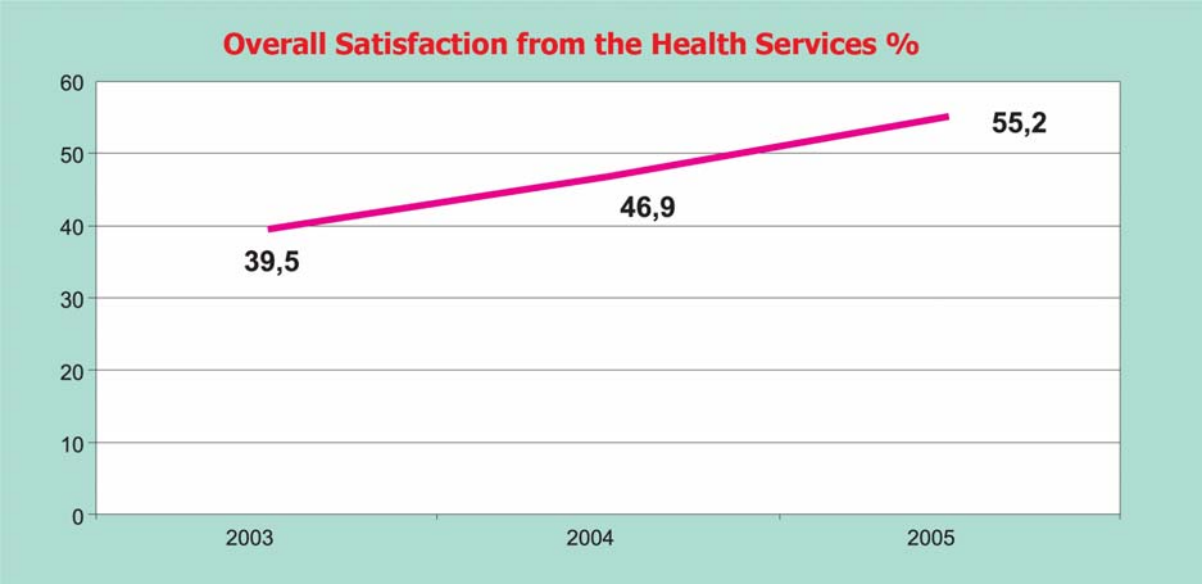
We regard development of human resources as a top priority issue for the year 2023.

We believe that Turkey is capable of realizing "Healthy Turkey 2023" goal.

Last Words

We do not strive to discover what is already discovered,
And we proceed carefully
With our own knowledge and experience,
And with lessons learned from our and others' mistakes.

We started rapid change and transformation,
Since we have a long way to take.
What we all need are people:
hardworking, good-willed, determined and long term people.
Whom we already have
And so will we succeed.



Source: TURKSTAT

Nothing is the same as 5 years ago;
and all will be better 5 years later.

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