

# Eurohealth

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## Health care and pharmaceutical policies in Turkey after 2003

Nebibe Varol and Omer Saka

*Summary: The health care system in Turkey has been going through a series of crucial reforms in recent years. The most tangible steps in this reform process were launched after the Justice and Development Party (AKP) emerged as the ruling party in the elections of 2002. The EU accession and harmonisation process has also provided additional momentum for implementation of change in the health care system. This article assesses the extent to which actions to date are consistent with the objectives of the reform programme launched in 2003.*

*Keywords: Health System Reform, Pharmaceutical Policy, Turkey*

The health care system in Turkey has been going through a series of crucial reforms in recent years. The most tangible steps in this reform process were launched after the Justice and Development Party (AKP) emerged as the ruling party in the elections of 2002. The EU accession and harmoni-

sation process has also provided additional momentum for implementation of change in the health care system. Thus one of the first political decisions the AKP took was to launch the Health Transformation Programme\* (HTP) in 2003.

The overarching objectives of the transformation programme were firstly to reduce inequalities in access to health care within the country and secondly to narrow the gap in the utilisation and quality of health services observed in Turkey compared with other middle-income, as well as EU, countries.<sup>1</sup> The specific objec-

*Nebibe Varol is reading for a PhD, LSE Health, London School of Economics and Political Science and Omer Saka is Health Economist, Division of Health and Social Care Research, King's College, London. Email: n.varol@lse.ac.uk*

\* Also known as Health Transition Project



**Box 1: Stated objectives of the 2003 Health Transformation Programme**

Restructure the Ministry of Health to facilitate more effective stewardship and policy making

Establish a universal health insurance fund to ensure equity and access to health services

Reorganise health care provision so as to separate service delivery from financing in order to achieve a more efficient resource allocation

Introduce family medicine to integrate and streamline the delivery of primary care with inpatient care

Ensure financial and administrative autonomy for all hospitals to improve technical efficiency and strengthen management

Set up a fully computerised health and social care information system

Encourage the private sector to invest in the health care sector

Improve maternal and child health

Eliminate shortages of health personnel in areas earmarked as being priorities for development

tives of the HTP are outlined in Box 1.<sup>2</sup> The article assesses the extent to which actions to date are consistent with these stated objectives.

**Restructuring of the MoH for effective stewardship**

The main components of the reform agenda include restructuring of the Ministry of Health (MoH) to encourage decentralisation, establish monitoring and evaluation capacity and ensure the quality of health care services. The MoH has transferred responsibility to the provincial authorities on the opening and closure of pharmacies, as well as for the monitoring of marketing and consumption of pharmaceuticals. In addition, decisions regarding extra working hours and transfer of health personnel between provinces, and the career progression of health personnel according to performance criteria are also now to be taken at the provincial level. As yet however, the necessary legislative changes have not been completed.

In a related aspect of reform, the Directive on Institutional Performance and Quality Development has been issued and a Quality Coordination Unit established under the MoH as the responsible authority for quality management in hospitals and other institutions that provide health care. The performance of hospitals is now evaluated through inspections undertaken in accordance with this directive.<sup>3</sup>

**Establishment of a Universal Health Insurance Fund**

Another element of reform has been to support the establishment of a universal health insurance fund through the consolidation of different health insurance schemes\* under one umbrella to ensure equity of access to services. The most important recent developments in Turkish social policy have been the enactment, despite much heated debate, of both a Social Security and General Health Insurance Law and Social Security Institution Law in 2006.<sup>4</sup> The new system embraces all social groups, including individuals not formally employed, and aims to facilitate universal access to health care services. Different reimbursement mechanisms employed by different social security institutions have been replaced by one model following enactment of the General Health Insurance Scheme (GHIS) by the Turkish Parliament in 2006.

Since January 2007, no payment is required for primary health care services, even if an individual is not covered by a social security scheme. Rejections, due to different insurance or payment processes, have been eradicated for emergency admissions in all health care institutions.<sup>4</sup> Individuals below the age of eighteen are

covered by the health insurance scheme free of charge. Considering the extent of child poverty in Turkey (according to the Turkish Statistical Institute approximately 5.7 million children under the age of fifteen were living in poverty in 2004), this provision is extremely significant in the context of the Turkish health care system.<sup>5</sup>

The Green Card Scheme, which helps cover health care costs for those living below a state determined poverty line, was extended in 2005 to cover all health care expenditure (previously outpatient care and prescriptions had been excluded) which facilitated the access of the poorest segments of the society to health care. Currently Green Card holders are fully covered, with the exception of a 20% co-payment for prescriptions. Access to medicines for SSK and Green Card beneficiaries has been improved by granting them the right to obtain medicines from all private pharmacies instead of the limited number of specified pharmacies that had provided this service in the past. Similarly, private hospitals can now be reimbursed for health care services provided to individuals covered by the public insurance scheme.

**Reorganisation of health care service delivery**

Reform measures have included the adoption of family medicine for the provision of outpatient or primary health care services, the integration and harmonisation of MoH and SSK hospitals, as well as the further development of services for the prevention and control of non-communicable diseases and the introduction of more effective maternal and child health interventions.

In November 2004, Parliament approved legislation to pilot a new family practitioner scheme. Implementation initially began in Düzce province, with the aim of extending the scheme to the whole country by 2008. Currently nine million people can avail themselves of the family practitioner scheme, which has been rolled out to the provinces of Eskişehir, Gümüşhane, Edirne, Bolu, Adıyaman, Elazığ, Denizli, Isparta, Samsun and İzmir. The introduction of the scheme has also been accompanied by a decrease in the number of patients presenting to secondary and tertiary care facilities. While the number of

\* Social Insurance Organisation (SSK), the Government Employees Retirement Fund (GERF), the Social Insurance Agency of Merchants, Craftsmen and the Self-Employed (Bag-Kur) and Green Card Scheme.



contacts with primary care have increased by 37% from 1.7 to 2.3 million, referrals to hospital from primary care have also decreased.<sup>6</sup> In addition, community health centres have also been established to further increase access to effective primary care services and monitor family practitioners. They also provide logistical free support for vaccination campaigns, as well as mother and child care and family planning services.

We have noted that all SSK and other public hospitals, previously not under the control of the MoH have now been transferred to the MoH. Thus the MoH is now the principal actor in health care provision followed by the university teaching hospitals. Another welcome improvement in legislation governing health care provision now permits state hospitals to use their own revenues to purchase selected services from private providers. This has resulted in a better use of already established but underutilised private hospital capacity. The relative workloads of the public and private health care facilities have also improved since private health care facilities now provide service to individuals covered by public insurance. More responsive management structures have also evolved as a result of the increased autonomy of public hospitals. One example of such managerial innovation that we can point to is the establishment of data processing infrastructures in most hospitals in recent years.

#### *Performance-based additional payment to personnel from revolving funds*

As part of the HTP objectives, performance indicators were developed and performance-based payment systems were established. Performance-based revolving fund payments which link the revenue of hospitals to the hospital personnel payment schemes have resulted in the voluntary extension of working hours by hospital personnel. Financial incentives have driven most specialists to close their private offices and start working only in hospitals, which in turn has relieved patient overload in hospitals. Such policies have increased the proportion of practitioners working full time in the hospital system from 11% in 2003 to 60% in 2007. The effectiveness of patient registration systems have also increased due to the introduction of the performance-based system. Currently all hospitals have established electronic database systems: before the reform process only 20% of hospitals had this capability.

#### **Building a health information system**

The Health Transformation Programme emphasised the need for better quality information to make sound health system policies and administrative decisions. The creation of health information systems requires both the integration of data obtained from different institutions and its packaging in a format amenable to use in decision making processes.

Institutions involved in providing health services, as well as data banks of physicians, international disease classifications, medicine and medical product codes have all been identified and/or harmonised. A system for the surveillance of personnel, material and financial sources (The Core Sources Management System) has been completed. A Family Medicine Information System has been implemented to store electronic patient record data in the provinces where the new primary health care system has already been rolled out. Moreover, in October 2007 all public hospitals adopted the Medula System, which will enable the creation of a health database to be used for health care data analysis.<sup>7</sup> This is an integrated information system for the electronic collection of billing information from health care providers and payments to health care services by the Social Security Institution.\* Efforts to determine further infrastructural needs related to the inclusion of all relevant actors in the health system are ongoing.

#### **National pharmaceutical policy and efforts to establish evidence-based policies**

Turkey has been criticised not only for its lack of transparency in pricing and reimbursement decisions, but also a lack of communication with the pharmaceutical industry.<sup>8</sup> The price of pharmaceuticals used to be determined based on a cost-plus approach until 2004. Concerns regarding the rising share of pharmaceutical expenditures in total health care expenditures and pressure to contain public expenditure have resulted in revisions of pricing policy. The MoH Decree on Pricing of Medicinal Products for Human Use issued on 6 February 2004 introduced external reference pricing as the main price setting criterion. The price of new drugs will be set to the lowest price in a basket of reference countries (currently France, Italy, Greece, Spain and Portugal). The reference price system has also improved

transparency: reference groups are formed based on similar dosage, same active ingredient and same indication. Reimbursement levels are set at the lowest price in a reference group plus 22%.<sup>9</sup>

Pharmaceutical prices have been pushed down due to a combination of discounts effectively applied to approximately one thousand products, a reduction in value added tax from 18% to 8% for pharmaceuticals, and the increase in the negotiating power of the public insurance scheme as the sole buyer in the market. Turkey has had a unified reimbursement system since 2003 with a common positive list for all social security funds. Reimbursement is based on rules set out in the Budget Implementation Guidelines (BIG). The Reimbursement Commission, established in 2004, is the key body in the preparation of BIG reimbursement decisions and the inclusion of products on the positive list. The inclusion/exclusion criteria for the list are still not clear; budget impact has so far been the most influential criteria. A significant number of over the counter (OTC) products were excluded from the list after 2004; however, there are still a significant number of reimbursed OTC products which implies that, coupled with a better use of generics, they can generate additional savings.<sup>8</sup>

Legislation enacted by the Social Security Institution in 2007 stipulates the submission of an economic evaluation for all new pharmaceuticals requesting reimbursement. The main challenge of this development is the inadequacy of epidemiological and health care data in Turkey, as well as a limited capacity in skills needed to build and evaluate pharmacoeconomic models. Health economics 'know-how' in Turkey needs to be developed both in the private and the public sector. A database also needs to be created to provide access to information on the epidemiology of diseases, current treatment practices, the efficacy of treatment options and health care costs.<sup>10</sup>

#### *Data exclusivity*

New data exclusivity principles were introduced in 2005 as one of the steps on the path to eventual membership of the European Union. Data exclusivity applies for a period of six years following the first registration date within the EU Customs Union area and is valid provided that it is limited to the patent term. As part of EU

\* The authority responsible for the social security provisions in Turkey.



accession, this data exclusivity period might be extended to the 8+2+1 principle for alignment with the EU.<sup>11</sup>

#### *Tackling counterfeit drugs and a Track and Trace System*

Counterfeit drugs have remained a problematic issue in Turkey.<sup>7</sup> A new Drug Track and Trace System (ITS-Ilac Takip Sistemi) has been implemented in Turkey to reduce the amount of counterfeit drugs in circulation. Tracking of individual drug packages has been mandatory since February 2008. According to the new regulations a Datamatrix barcode including information about the product code, serial number, order number, production date and expiry date must now be printed on drug packages, in addition to the already existing barcode requirements.<sup>12</sup>

#### **Future outlook**

The Health Transformation Programme and the EU accession process have been the major driving forces of health care reform since the beginning of the new millennium. Efforts have been focused on creating a purchaser-provider split, extending coverage to the whole population based on social insurance principles and organising primary care through family practitioners and autonomous hospitals.<sup>1</sup> There have been considerable changes in pricing and reimbursement policies to improve the objectivity and transparency of decisions. Pharmacoeconomic evaluations have been introduced as a new criterion in the reimbursement process. The need for sound information, robust data collection and the development of human capacity for health economic evaluation stand out as major hurdles to be overcome in the quest for sound evidence-based policy making.

What are the next steps in the reform process? A number of key developments can be identified in the latest programme for government published in September 2007.<sup>13</sup> These include the transformation of the Refik Saydam Hygiene Centre (The School of Public Health) which carries out research on health care systems, health economics and health management into the Turkish National Institute of Health.

An independent 'National Pharmaceutical and Medical Equipment Agency' will also be established. This agency will develop and audit the necessary guidelines for the production (including ingredients), import

and export of pharmaceutical products, cosmetics and medical devices. It will be charged with ensuring safety, effectiveness, quality and compliance with standards in providing access to these products.

The family practitioner scheme will be extended to the whole country in cooperation with Ministry of Finance, Social Security Institution, and local administrations. In this context, valuable experience with the current family practitioner practices will be drawn upon to enact the necessary legislation for the implementation of a nationwide scheme.<sup>14</sup> The governmental health programme also affirms a commitment to strengthen efforts to promote maternal and child health and build national programmes to combat non-communicable diseases.

Finally, public hospital unions/associations will be formed to increase the quality and efficiency of hospital services. Hospital unions will be empowered through the decentralisation of authority. Private sector investments in health will be encouraged and all hospitals will be privatised gradually following pilot studies. Health Accreditation Systems will also be devised to increase the quality of care by setting international standards for health services and personnel.

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