Leadership for Health Transformation Program in Turkey

Universal Health Coverage
Not a Dream

Prof. Dr. Recep AKDAĞ
Nay Pyi Taw, Myanmar
July, 2015

"...after 30 years of slow progress, since 2003 Turkey has been able to design and implement wide-ranging health system reforms to achieve universal health coverage that substantially reduced inequalities in health financing, health service access, and outcomes."
PRESENTATION FLOW

• Ethics
• Final Goals
• Health Policy Cycle and
  Context & Diagnosis
  Policy Development & Political decision
  Implementation
  Access & Efficiency
  Monitoring & Evaluation
• Sustainability

ETHICAL APPROACH: HEALTH AS A RIGHT

Ethical Principles for the HTP

• Human beings come first
• Health is one of the most important and fundamental human right

“Universal Health Coverage (UHC): Access for all to appropriate, promotive, preventive, curative and rehabilitative health care at an affordable cost in case of need.” *

* WHO
FINAL (PERFORMANCE) GOALS

• Health Status (HS)
• Public Satisfaction (PS)
• Financial Protection (FP)
• Sustainability (S)

HS: LIFE EXPECTANCY AT BIRTH

In 1998, WHO estimated life expectancy in Turkey to reach 75 years in 2025

(WHO Estimation, 1998)

We achieved a life expectancy of 75 years in 2009

(World Health Statistics, 2011)
**HS: MATERNAL MORTALITY RATIO (PER 100,000 LIVE BIRTHS)**

Maternal Mortality Ratio, 2010

- Upper Income Level: 14
- Turkey: 15.5
- WHO European Region: 20
- Upper-Middle Income: 53
- World: 210

Change (2000-2010)

- Upper Income Level: 7.7
- Turkey: 76.9
- WHO European Region: 31.0
- Upper-Middle Income: 30.3
- World: 34.4


**PS: SATISFACTION FROM PUBLIC SERVICES**

Satisfaction Rate in Public Services (%)

Reference: TURKSTAT, 2012
**PS: PATIENT SATISFACTION AND PER CAPITA HEALTH EXPENDITURES**

Patient Satisfaction (%)

References: OECD Health Data, EU Social Climate Report 2011; Turkish Statistical Institute, Life Satisfaction Survey 2011

**FP: CATASTROPHIC & IMPOVERISHING HEALTH EXPENDITURES**

Reference: TURKSTAT
Getting Health Reform Right: M. Roberts et al, 2004 (quoted with modification)

HEALTH POLICY CYCLE

- CONTEXT
- RECEPTIVITY

Openness   Responsiveness

HEALTH POLICY: TRANFORMATIONAL LEADERSHIP & TEAM WORK

Political Decision

Policy Development: A TEAM

Minister

Delivery: B TEAM

Monitoring/Evaluation

Education Pool: Learning Organization

Minister
A Team
Public
NGOs
Delivery Team
Field Coordinators
Field Managers
Health Staff

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HEALTH POLICY: HOW TO OBTAIN PUBLIC SUPPORT?

- Sincere and honest intention & approach
- Public will feel your intention and respond accordingly

- **Lesson to Learn:** Public support is the most important tool for any government which wants to take a reform initiative.

POLICY DEVELOPMENT: BEFORE HEALTH TRANSFORMATION PROGRAM (HTP)

**An Underachieving Health System**

<table>
<thead>
<tr>
<th>Finance</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Gaps in coverage (65%)</td>
<td>- Lack of efficiency and access of services</td>
</tr>
<tr>
<td>- Inequitable benefit packages (5 different)</td>
<td>- Gaps between east/west &amp; rural/urban</td>
</tr>
<tr>
<td>- High catastrophic expenditures</td>
<td>- Poor health status</td>
</tr>
</tbody>
</table>
POLICY DEVELOPMENT: WHAT I KEEP IN MY POCKET!

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POLICY DEVELOPMENT: TWO-PRONGED APPROACH

November 2002

Year 1

URGENT ACTION PLAN

November 2002

STRATEGIC PLANNING AND ACTION PLAN

Month 3

CONTINUOUS EVALUATION WITH A TIMETABLE

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POLICY DEVELOPMENT: DECISIVENESS FAST!

First day in the office
28.11.2002
NO HOSTAGES IN THE HOSPITALS!

POLICY DEVELOPMENT: COMPREHENSIVE STRATEGY

Social Determinants

Government Budget
Public Insurance (Single-Payer)
Single Benefit Package

Finance

Provision

Emergency Transport (Public)
Primary Care (Public)
Hospital (Public/Private)
Regulation by MoH (With delegation)

Implementation in Unison
Equity
Sustainability
IMPLEMENTATION: UNIVERSAL HEALTH INSURANCE SYSTEM

Government

MoH Hospitals
University Hospitals
Private Hospitals
Pharmacies

Service Providers

Premiums & Co-payments

Premiums of the poor

State Contribution & Deficit Financing

Social Security Institution

Payment

Invoice

Citizens

Free of charge

MoH Emergency Transport
Primary Health Care

• Patient Rights
• Financial Protection
• Access to Services
  – Emergency Transport and Care
  – Primary Healthcare
  – Secondary & Tertiary Care
IMPLEMENTATION: PATIENT RIGHTS

**Barrier**

- Lack of effective mechanisms for patient rights

**Intervention**

- Regulations for patient rights
- Patient rights units in all public hospitals
- Hotline, 7/24, for patient needs

IMPLEMENTATION: HEALTH INSURANCE CHARACTERISTICS

<table>
<thead>
<tr>
<th>Universal</th>
<th>Covers everyone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive</td>
<td>All needed care (generous benefit package)</td>
</tr>
<tr>
<td>Contribution based</td>
<td>Bismarckian model, single payer</td>
</tr>
<tr>
<td>Compulsory</td>
<td>Enforced by law</td>
</tr>
<tr>
<td>Authoritative body</td>
<td>Social Security Institution (SSI)</td>
</tr>
</tbody>
</table>

Without adequate public funding and government stewardship, health insurance mechanisms pose a threat rather than an opportunity to the objectives of equity and universal access to health care.

Health Insurance in low-income countries,
Joint NGO Briefing Paper, May 2008
IMPLEMENTATION: UNIVERSAL HEALTH INSURANCE COVERAGE

<table>
<thead>
<tr>
<th>Health Insurance Coverage</th>
<th>Number of people (million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holders of Compulsory Insurance</td>
<td>19.9</td>
</tr>
<tr>
<td>Pensioners</td>
<td>10.9</td>
</tr>
<tr>
<td>Dependents</td>
<td>33.0</td>
</tr>
<tr>
<td>Subsidized Persons (The poor)</td>
<td>9.0</td>
</tr>
<tr>
<td>Persons Subject to pay according to Means Testing</td>
<td>3.6</td>
</tr>
<tr>
<td>(Non-Working Group)</td>
<td></td>
</tr>
<tr>
<td>Other Public Coverage out of UHI</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Total Population</strong></td>
<td><strong>77.6</strong></td>
</tr>
</tbody>
</table>

IMPLEMENTATION: CONTRIBUTIONS

<table>
<thead>
<tr>
<th>Liable (Premium Rate 12.5%)</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>5%</td>
</tr>
<tr>
<td>Employer</td>
<td>7,5%</td>
</tr>
<tr>
<td>Self-Employed</td>
<td>12,5%</td>
</tr>
<tr>
<td>Individuals subject to only UHI</td>
<td>12%</td>
</tr>
<tr>
<td>MoF Contribution</td>
<td>¼ of Premiums collected annually</td>
</tr>
</tbody>
</table>

- The premiums of the most vulnerable groups such as individuals with lack of financial self-support, children under the age of 18 and heimatlos are paid by the government.
IMPLEMENTATION: CO-SHARING

<table>
<thead>
<tr>
<th>Services</th>
<th>Co - Payment</th>
<th>No Co - Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>10%-20% for outpatients</td>
<td>Chronic diseases and inpatient treatments</td>
</tr>
<tr>
<td>Orthesis/ Prosthesis</td>
<td>10%-20% (cap of 75% of gross minimum wage)</td>
<td>Those have vital importance</td>
</tr>
<tr>
<td>Outpatient visits at</td>
<td>(Public 2 - Private 5 $</td>
<td>Chronic illnesses and occupational diseases</td>
</tr>
<tr>
<td>hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency transport</td>
<td>None</td>
<td>All services</td>
</tr>
<tr>
<td>(including air amb.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>None</td>
<td>All services</td>
</tr>
</tbody>
</table>

IMPLEMENTATION: BENEFIT PACKAGE EXCLUSIONS

- Any kind of health care services for aesthetic purposes
- Health care services not permitted or licensed by MoH
- Some of very new treatment modalities
- Chronic sickness of foreign country citizens presenting with the diseases prior to their qualification for public health insurance
IMPLEMENTATION: EXTRA CHARGES IN PRIVATE HOSPITALS

- Private hospitals have the right to ask patients for additional charges up to 90% of the price list (2012)
  - Additional fee varies between 50% and 90% of the bill paid by SSI, based on the classification of private hospitals

- Exemptions are emergency treatment, intensive care and high-cost treatments

IMPLEMENTATION: PUBLIC & PRIVATE BALANCE

“Laissez-Faire”? 

27

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28

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• Consider country resources as a whole
  ▫ Keep public-private health care balance

• Ensure regulatory effectiveness
### IMPLEMENTATION: EMERGENCY TRANSPORT

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insufficient workforce and vehicles</td>
<td>• Free of charge service for all cases</td>
</tr>
<tr>
<td></td>
<td>• Access time</td>
</tr>
<tr>
<td></td>
<td>Urban: 0-10 min. : 94%</td>
</tr>
<tr>
<td></td>
<td>Rural: 0-30 min. : 96%</td>
</tr>
<tr>
<td>• 350,000 cases / year 2002</td>
<td>• 3,230,000 cases / year 2012</td>
</tr>
</tbody>
</table>

### IMPLEMENTATION: PRIMARY HEALTHCARE

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inadequate primary care health services</td>
<td>2005 Establishment of Family Medicine 2010</td>
</tr>
</tbody>
</table>

**Coverage for all individuals free of charge**

- Citizens’ right to choose their physicians
- Contract based per capita payment for health staff
- Extra payment for working in disadvantaged areas
- Different coefficients for different service needs
- Incentives and disincentives for efficiency
MONITORING: PRIMARY HEALTHCARE

Per capita based payments and disincentives

- Improved accountability and efficient preventive health care

- Access from 1 to 3 visits/person/year
- First point of contact from 37% to 48%
- Satisfaction from 75% in 2001 to 89% in 2011

MONITORING: INTERMEDIATE PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate preventive health services</td>
<td>Comprehensive and widespread services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother and Child Health</th>
<th>1994</th>
<th>2002</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal Care (%)</td>
<td>63</td>
<td>70</td>
<td>97</td>
</tr>
<tr>
<td>Rate of Delivery at Hospital (%)</td>
<td>64</td>
<td>69</td>
<td>97</td>
</tr>
<tr>
<td>Follow-up Rate for Infants (%)</td>
<td>60</td>
<td>62</td>
<td>99</td>
</tr>
<tr>
<td>Immunization Rate (%)</td>
<td>81</td>
<td>78</td>
<td>97</td>
</tr>
<tr>
<td>Routine Vaccines of Childhood (antigen numbers)</td>
<td>6</td>
<td>7</td>
<td>13</td>
</tr>
</tbody>
</table>
MONITORING: PRIMARY HEALTHCARE

Unfinished agenda

• Better monitoring & assessment
• More number of family physicians: 2000 people per physician
  – Accelerated family medicine training (distant/ part time)
  – New curricula fitted with emerging situations
• More incentives:
  – Non-communicable diseases management
  – Promotion of healthy life style
  – Better clinical quality practice

IMPLEMENTATION: HEALTH PROMOTION

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate health promotion</td>
<td>Health promotion</td>
</tr>
<tr>
<td></td>
<td>– Tobacco: Comprehensive approach (M-POWER)</td>
</tr>
<tr>
<td></td>
<td>– The world leader for fighting against tobacco</td>
</tr>
<tr>
<td></td>
<td>– Obesity and inactivity</td>
</tr>
</tbody>
</table>

http://apps.who.int/iris/bitstream/10665/85380/1/9789241505871_eng.pdf
IMPLEMENTATION: HOSPITAL SERVICES

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inefficient hospital services</td>
<td>• We brought public hospitals together under the administration of MoH and allocated them into semi-autonomous groups.</td>
</tr>
<tr>
<td></td>
<td>• We initiated performance based management.</td>
</tr>
</tbody>
</table>

Central patient appointment system  Home care services

“you are not alone at home”

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Former MoH

EFFICIENCY: HANDLING BUDGET GAP

Decreased health needs
- Promotion of healthy life styles
- Adequate prevention
- Increased health literacy

Increased budget
Increased efficiency
Cost containment
- Cutting services?
- Cutting purchasing prices?

✓ Drug Reference System
✓ Service Procurement
✓ Performance Based Payment
✓ Full-time Policy

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**EFFICIENCY: HUMAN RESOURCES ALLOCATION**

Addressing human resources inequity in distribution

- Obligatory service (300-500 days)
- Contract based recruitment
- Performance based payment
- No more dual practice
- New relocation rules
- Increased seats in med schools
- Central human resources planning

**EFFICIENCY: WHY DID WE ADOPT A FULL-TIME POLICY?**

Dual Working

- Citizen
- Hospital
- Victim
- Inefficiency

Full-Time Working

- Citizen
- Hospital
- Access
- Equity
- High Quality
- Efficiency
- High Quality
EFFICIENCY: INCREASED PRODUCTIVITY

Number of visits to physician / year

- Primary Healthcare Center
- Hospital
- Total

Consultation time per visit (min)

2 times
4.5
9.5

EFFICIENCY: CHANGE IN PUBLIC PHARMACEUTICAL EXPENDITURE (%)

Rate of increase in number of pillboxes

- 1994-2002
- 2002-2012

<table>
<thead>
<tr>
<th>Number of Pillboxes (million)</th>
<th>1994</th>
<th>2002</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>539</td>
<td>699</td>
<td>1.769</td>
</tr>
</tbody>
</table>

Rate of increase in drugs expenditures

- 1994-2002
- 2002-2012

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>6.244</td>
<td>14.624</td>
<td>14.484</td>
</tr>
</tbody>
</table>
EFFICIENCY: PUBLIC HEALTH EXPENDITURES BY SERVICE PROVIDER (USD)

- Ministry of Health
- University Hospitals
- Private Hospitals And Health Institutions
- Pharmaceutical Expenditures
- Other Health Expenditures

EFFICIENCY: STRENGTHENED PUBLIC SERVICES

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Weak infrastructure</td>
<td>• Investment in medical equipment and technology</td>
</tr>
<tr>
<td>• Service procurement</td>
<td>• Outsourcing</td>
</tr>
</tbody>
</table>

Computed Tomography

<table>
<thead>
<tr>
<th>Year</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>121</td>
</tr>
<tr>
<td>2012</td>
<td>448</td>
</tr>
</tbody>
</table>

MRI

<table>
<thead>
<tr>
<th>Year</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>18</td>
</tr>
<tr>
<td>2012</td>
<td>310</td>
</tr>
</tbody>
</table>
EFFICIENCY: SERVICE PROCUREMENT

Radiologic imaging prices (as of 2011 prices in Turkish Lira)

MONITORING AND EVALUATION

- Evaluation on site: meetings with ‘Field Coordinators’, governors, mayors and community managers
- Face to face informal conversations
- Meetings with:
  - Public
  - Health staff
  - Political party members
  - Professional associations

345 site visits in 81 provinces (2002-2011)
Presence on the Ground

After family medicine system was set up, there was a push by MoF and SSI for a referral system:

- Referral program piloted in 4 provinces, did not work
- On the ground evaluation: **Health Minister’s disguise**

### S: PUBLIC VS PRIVATE HEALTH EXPENDITURES

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Other Private</th>
<th>Out-of-Pocket</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>12.5 billion $</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>2012</td>
<td>42.6 billion $</td>
<td>77%</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Legend:
- Public
- Other Private
- Out-of-Pocket
- Total
S: TOTAL HEALTH EXPENDITURES IN RELATION TO GDP (USD)

References: Social Security Institution, Ministry of Finance

S: PUBLIC HEALTH EXPENDITURES IN RELATION TO GDP (USD)

<table>
<thead>
<tr>
<th>Year</th>
<th>2002</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Expenditure on Health</td>
<td>9,004</td>
<td>34,332</td>
</tr>
<tr>
<td>GDP</td>
<td>232,745</td>
<td>800,397</td>
</tr>
<tr>
<td>Public Health Expenditure in GDP</td>
<td>3.9%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
S: FISCAL SUSTAINABILITY

- Health service needs mostly met
- Economic growth continuing
- Pharmaceutical prices under control
- Service procurement become widespread
- New hospital investments by PPP initiated
- Preventive health strengthened
- Health promotion started
- Clinical quality studies started

S: RISKS

- Weak protection of individual rights against the system
- Difficulties for adapting to new conditions
- Low health literacy
- Unhealthy lifestyle

**Obesity & Inactivity**

- Tobacco
- Alcohol

*Success can make you blind.*
WHO, Successful Health System Reforms: The Case of Turkey

“It is possible to achieve major improvements in health system performance in a relatively short period of time under the right conditions.”

May, 2012