An Overview on Child Health Care in Turkey

Fugen Cullu, MD,[1,2] and Mehmet Vural, MD[2,3]

The general health status of the Turkish people has improved significantly in recent years. Improvements in the health status of the child population followed the introduction of health reforms, such as the Health Transformation Program. Presently, Turkey is undergoing further important changes concerning its medical system. The changes introduced during 2005-2015 have provided almost complete health insurance coverage and increased accessibility to primary health care givers. However, health providers realize that there are ongoing inefficiencies and deficiencies in both the health care system and health education. There is a need for continuous improvement; challenges lie ahead for improving services beyond primary care. The main criticism of previous health care reforms has come mainly from professionals in the health care sector because of their privileged position as inside observers being able to analyze pros and cons of the system. Quality and sustainability of future reform programs will rely not only on the economic support of the public health and health care sector, but also on the high standards of service pathways and satisfaction of both patients and providers of care by multifactorial quality assurance and continuous quality improvement analyses of basic elements of health care. *(J Pediatr 2016;177S:S213-6)*.

Turkey covers 779 452 km^2 at the cross-roads between Europe, Asia, and the Middle East, making it one of the largest countries in Europe and the Middle East. Over the years, Turkey has grown to become the 17th largest economy in the world with a gross domestic product (GDP) of US $799.54 billion in 2014 in less than a decade. The per capita income in the country showed a significant 3-fold increase, exceeding US $10 500 in 2015. Turkey is a member of the Organization for Economic Cooperation and Development and the Group of Twenty, the international forum for the governments and central bank governors of the 20 major world economies, and an increasingly important donor to the bilateral Official Development Assistance.

According to the World Bank data,[1] the consumption of the bottom 40% of the population increased during 2002-2012 at approximately the same rate as the national average. During the last 20 years, extreme poverty fell from 13% to 4.5%, and moderate poverty fell from 44% to 21%. Access to health care, schooling, and other public services has improved also for the poor. Even after the beginning of the global financial crisis in 2008, 6.3 million jobs have been created in Turkey, and unemployment was kept at approximately 10%. However, beginning in 2012, the economic growth seen in the previous decade has decreased, and after growing 4.2% in 2013, the economy decreased to 2.9% in 2014.[1]

Turkey has benefited significantly from cooperating with the European Union (EU) through both exports and imports and access to foreign investments in Turkey. Moreover, the negotiations with EU, which began in 1999, have been a pillar of strength for reforms in Turkey during recent years, including a beneficial impact on the health care system and its reorganization. Unfortunately, these processes have slowed down in recent years, thus, leading to a number of political obstacles for adapting the health care system to international standards.

Health Care System

The health status of people in Turkey has improved significantly in recent years. Improvements in the health status of the population followed the introduction of health reforms, such as the Health Transformation Program (HTP). Turkey is now undergoing another phase of a major health sector reform. Changes were introduced within the framework of governmental health reform and the new legislation restructuring the Ministry of Health (MoH), including the reorganization of its internal units and external collaborations. Among the main aims of such restructuring is strengthening the stewardship function of the MoH and enhancing its role in health system policy development, planning, and supervision of program implementation, monitoring, and evaluation.[2]

EU	European Union
GDP	Gross domestic product
HTP	Health Transformation Program
MoH	Ministry of Health
NIP	National Immunization Program
SSI	Social Security Institution

From the [1]Pediatric Gastroenterology, Hepatology and Nutrition Units, Cerrahpaşa Medical Faculty, Istanbul University of Istanbul, Istanbul, Turkey; [2]Turkish Paediatric Association, Istanbul, Turkey; and [3]Neonatology Unit, Cerrahpaşa Medical Faculty, University of Istanbul, Istanbul, Turkey

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The programs promoted by MoH put specific emphasis on preventive health care services. In particular, HTP aims at strengthening primary health care services through the use of a family medicine system. At the end of 2010, in accordance to the Family Medicine Program, each individual was assigned to a specific doctor. MoH also established community health centers, which provide free-of-charge logistical support to family physicians for priority services, such as vaccination campaigns, maternal and child health, and family planning services. Both family health centers and community health centers are under the supervision of provincial health directorates (81 provinces), which are responsible for planning and providing health services at the provincial level under the supervision and responsibility of the MoH. A system called performance-based supplementary payment for family physicians and key hospital personnel was implemented to reward productivity. The provision of high impact health services at the primary level is ensured for family physicians. The efforts of MoH were directed also at replacing a fragmentary financing and service delivery system with a more centralized control of the financial and organizational structure.[2]

The MoH is the main provider of health care services. The Social Security Institution (SSI) has the monopoly in the health care sector. SSI is the only buyer on the purchasing side of health care services, which are first financed by employers and employees who pay for accessing the SSI services, and second, by government contributions in cases of budget deficits. The health services delivery system, as well as investments in infrastructure, equipment and supplies, and training programs of health care personnel, expanded during recent years, reflecting a general positive economic growth. However, the health budget in Turkey is still low compared with the average expenditure of EU countries. In 2000, health expenditure per capita was US $457 (GDP per capita US $3500) and increased to US $981 in 2012 (GDP per capita US $10 500). However, although the GDP per capita has seen a 3-fold increase during this 12-year period, health expenditure per capita did not increase proportionally. In addition, the proportion of total health expenditure to GDP showed only a slight increase. It was 5.4% in 2002, rising to 6.1% in 2008. The public health expenditure was 14.7% of noninterest public expenditures in 2002, increasing modestly to 15.2% in 2008. The total number of personnel working in the MoH system rose from 294 587 in 2002 to 460 966 in 2012.[3]

Child Health Care Services

Turkey is presently undergoing important changes concerning its medical system. The pediatric primary health care system has changed recently from mixed- to a general practitioner-based system.[4,5] In 2015, the number of pediatricians per person in Turkey was 6.1/100 000, and in the EU it was 14.1/100 000. In 2015, the total number of licensed pediatricians in Turkey was 4025, of whom 513 worked in universities, 1694 in state hospitals, and 1818 in private practice. Approximately 500 residents are admitted yearly to the residency programs.

Regarding health care facilities, the number of hospitals increased 50%, and the number of beds 25%, but the population increased only 5%. Although there has been an increase, the number of beds per thousand people is approximately 26, whereas it is 51 in the EU. During the last 10 years, important changes also occurred in reference to the investments into the private health care sector, which expanded its services offered to the adult and youth population, as the share of private clinics increased from 7% to 10%. The difficulty of an effective quality control makes this one of the weakest points of the new health care system in Turkey. In fact, generalized quality and safety in the health care sector have rapidly risen over the recent decade; however, satisfactory control and effective quality assurance or continuous quality improvement procedures[6,7] have not yet been transformed sufficiently from theory into practice to improve the quality of care further in all medical settings throughout the country. Therefore, evaluation of quality of care in hospitals, identification of problems or shortcomings in the delivery of care, designing activities to overcome these deficiencies, and follow-up monitoring are needed to ensure effectiveness of corrective steps.[8]

With the amelioration of the health coverage, the Turkish population also experienced between 2003 and 2010, an increased number of consultations per person. For instance, during this period, the average number of consultations was 8.2 per person and year, and the share of pregnant women having 4 antenatal care visits increased from 54% to 82%. This increase was so high that it even surpassed many other European countries. However, although the overall number of consultations increased, Turkey still has an insufficient number of doctors (174 doctors/100 000 people) compared with EU (325 doctors/100 000 people). The result of this shortage is that doctors are able to spend only a few minutes with their patients during consultation. As an unwanted consequence, the number of consultations rose together with the request of inadequate complementary examinations, whereas the time dedicated to the single visit diminished. There is an ongoing lack of health care provision in rural areas because most hospitals and doctors are located in the cities and towns.

To cover the deficiency in the number of physicians, the Turkish educational system adapted itself by increasing the number of medical faculties from 40 in 2000 to 74 in 2014. The number of medical school students increased to almost 10 000. This raises many questions about the quality of education provided by overcrowded universities and by newly appointed teachers in recently opened medical faculties. Education quality assurance programs are needed urgently.[9]

After graduating from medical school, all young doctors must work 2 years for the state in remote public health settings. Those doctors who want to specialize in a particular field of medicine, such as pediatrics, must work for an additional 2 years in medical settings appointed by the MoH.