

CHAPTER 9. ENHANCING POLICIES FOR SOCIAL COHESION

9.1 *Ensuring sustained and inclusive growth is an important challenge for Turkey in view of the existing important social and regional gaps and the potential for the EU accession process to create “winners”, but also some “losers”.* Although reform is underway to define a more systematic approach to start closing the existing gaps, an integrated strategy will need to be formulated with a strong dimension on policies for social cohesion. The capacity of the social security system to contribute/strengthen social cohesion is impaired by several factors: it does not cover the entire population; it lacks financial stability, with the largest share of funds going to pensions; the presence of a large informal sector; and administrative and management problems which have adverse effects on the effectiveness in the delivery of services. This chapter provides analytical underpinnings in the key areas of social inclusion and health care, with emphasis on policies to improve efficiency and ensure financial sustainability.

9.1. SOCIAL INCLUSION

9.2 *A wide range of policies and programs can have an important positive impact upon social inclusion and cohesion.* Notable amongst these are basic and secondary education policies (discussed in the recent World Bank report on education) which extend high quality education at an affordable price to the entire citizenry. Tertiary education is more complex because of its higher unit costs, and more limited coverage. UHI, as discussed already, if implemented correctly, will be a powerful tool of social cohesion. However, a number of other measures are necessary. The key ones are highlighted below.

9.3 *Poverty monitoring:* Maintain the excellent work on poverty monitoring under the State Institute of Statistics (DIE) based upon annual household income and consumption expenditure surveys (HICES). Strengthen the poverty mapping function.

9.4 *Conditional cash transfer (CCT):* Maintain and strengthen the CCT which is targeted towards the poorest 6 percent of children (with the benefit paid to the mothers) which helps families to maintain the poorest children in school and obtain adequate preventive health services. This program is already reaching 2.0 million children and is administered by the General Directorate of Social Assistance and Solidarity (SYDGM)

through its 931 associated foundations throughout the country. The proxy means test for this program was updated in 2005 according to the 2003 HICES. The proxy means test for CCT will be systematically updated based upon the latest HICES, and in this manner strengthened so that it can be used for the determination of eligibility for other government programs (such as UHI premia paid for by the state) by adjusting the cut-off point accordingly.

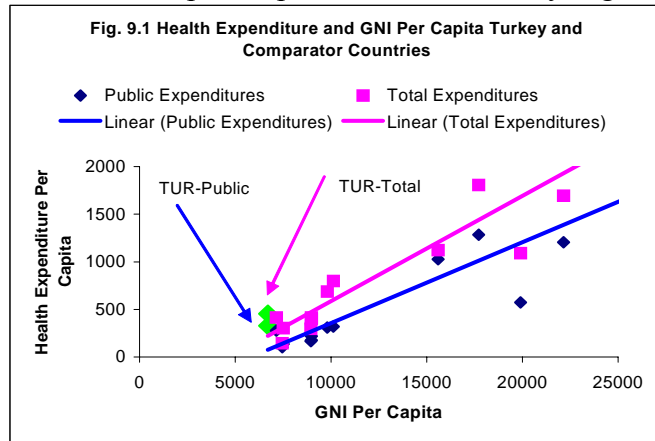
9.5 ***Social Services:*** A wide range of agencies including municipalities, the Social Services & Child Protection Organization (SHCEK) and the SYDGM are providing social services. Unfortunately there is no integrating framework, and both problems of duplication and inadequate service provision apply, although the related agencies are doing their best to coordinate. There is a need to develop an integrated social policy under one lead ministry, improve the monitoring and evaluation of social services, and then expand cost-effective services to underserved population groups, although it would be very appropriate for the SYDGM to remain as an executive agency making payments and providing services but not under the direct control of the policy-making ministry..

9.6 ***Youth policy:*** With youth aged under 25 accounting for 50 percent of the total population, youth are a particularly important population group to target as they represent nothing less than the future social and human capital of the country. It is urgent to give more attention to the issues of youth empowerment and inclusion, together with specific programs to overcome barriers to youth employment (youth unemployment is 2.5 times the national average). Inter alia, this process would be enhanced through the development of a national youth policy and providing significantly more resources to youth programs.

9.7 ***Gender:*** Whilst Turkey has made good progress in addressing some gender inequities, and both primary and secondary school enrollment rates are converging for the two genders, there is still more to be done in terms of promoting and supporting female employment, reducing the pay gap and in general integrating women as full equal partners in society.

9.2. MANAGING THE HEALTH CARE SYSTEM

9.8 *Health care expenditures and outcomes are unevenly distributed.* Turkey spends around 6.7 percent of its Gross National Income (GNI) on health, of which public expenditures account for about 70 percent.⁹⁷ Per capita expenditure is relatively higher than in countries with similar income levels (Figure 9.1), while the health system fails to reach the poor and vulnerable sections of society. Expenditures favor Turkey's Central and Mediterranean regions over other parts of the country and East and Southeast Turkey receiving less than the proportionate share of spending given their population. The distribution of health benefits to different income quintiles shows a significant bias towards the top two quintiles, who consume about 52 percent more health care per capita relative to the bottom two quintiles.



9.9 *There is ample room for improving health care outcomes and for efficiency gains in public expenditure.* Despite spending levels on the high end of comparators, Turkey faces an unacceptably high burden of ill health and ranks far behind most middle-income countries in terms of the health status of its people. The reasons for such low outcomes are many and varied. There are gaps in nutrition, housing, access to clean water and satisfactory sanitation, and education, especially of girls and women – all of which are widely recognized to be powerful determinants of good health – that adversely affect health status. On the financing side, besides the fact that there are multiple problems with mobilization of resources, the available resources are not allocated efficiently and equitably. A significant proportion of the population has little or no financial protection, and despite support from special funds and programs like the Social Assistance Fund and

⁹⁷ Public expenditures on health consist of expenditures incurred by the Ministry of Health, General Directorate of Coastal Health Services, Universities, Social Solidarity Fund, other Ministries and agencies, local governments, state enterprises, civil servants, and social security institutions: Sosyal Sigortalar Kurumu (SSK), Emekli Sandigi and Bagkur. Private expenditures on health consist of out-of-pocket treatment and pharmaceutical expenditures incurred by individuals and households, and by companies and individuals contributing to private insurance schemes. Social health insurance – offered by SSK, BagKur and Emekli Sandigi – accounts for almost 66 percent of all public expenditures on health, equivalent to about 12,875 trillion liras in 2004, with the balance (6,582 trillion liras in 2004) coming from the central government budget. A little over 53 percent of all public expenditures on health take place on care provided by hospitals, followed by 30 percent on the provision of pharmaceuticals and medical goods and 8.5 percent on outpatient care. Source: World Bank calculations, based on MOF/MOH/MOLSS data, reorganized and presented in the NHA2000 format

the Green Card, in practice the disadvantaged groups are not targeted effectively. In addition, there are multiple payers for same or similar services, and the institution of revolving funds – which allow health providers to accept user charges and account for them outside the budgetary flow of funds – introduces a variety of perverse incentives for providers and further constrains access to health services for consumers. Public provision of health is characterized by poor incentives for managers and providers alike, leaving them open and vulnerable to alternative sources of income to augment their meager salaries. Like financing, the delivery of health care is also fragmented, and there is little continuity in the different levels of care. Clinical effectiveness of existing medical interventions and treatment protocols is not always tested and attention to quality and effectiveness of care is uneven. The private sector is growing, but its full potential is not fully realized and their role and responsibilities not adequately defined.

9.10 *Systemic and comprehensive reforms in the health sector are being undertaken.*

Key elements of the proposed reforms that aim at improving equity and access to health services are the introduction of universal health insurance and the creation of a health insurance fund that would integrate all functions and premium collections related to health in the existing insurance agencies such as SSK (Sosyal Sigortalar Kurumu), BagKur and Emekli Sandigi. The health insurance fund would combine all financial flows of fund in the health sector, including budgetary support to MOH (except for public health care activities), financial outlays for the existing Green Card program, and health expenditures of civil servants. Based on the principles of solidarity and risk pooling, all citizens of the country are proposed to be covered under universal health insurance, with the state making premium contributions on behalf of the indigent and others unable to do so on their own behalf.

9.11 *Providing adequate financial protection for health care to the entire population is a key challenge.*

The present system of insurance leaves many without any coverage and with inadequate coverage for many who are nominally covered. Additionally, there are many who enjoy multiple sources of coverage, either by design or by circumstances. There is also little doubt that the different health insurances being offered through SSK, Bagkur and Emekli Sandigi, and the coverage provided to civil servants and welfare programs like the Green Card should – in the interest of efficiency, risk-pooling and consolidation of financing – be combined into one compulsory universal health insurance system.

9.12 *Unless it is accompanied by cost-reduction and efficiency enhancing measures, the introduction of UHI could lead to higher levels of public expenditure on health in the short run and jeopardize the fiscal sustainability of the system.*

Public expenditure may increase not only because the state will have to bear the health insurance expenditures of those hitherto uninsured, but also due to the induction impact on account of changes in utilization of health services by the already insured as they adjust to new boundaries of coverage, and the utilization patterns of the newly insured. In order for the system to be fiscally sustainable, therefore, the introduction of universal health insurance

needs to be accompanied by system-wide efficiency changes that will contain health costs and compensate for the additional expenditures associated with extending financial protection to all segments of the population. The proposed introduction of universal health insurance has already triggered a number of reform measures in the health sector in Turkey, and the emphasis at this point needs to be not only on sustaining this momentum and extending it to other areas not included so far, but increasingly on ensuring that the desired access and efficiency outcomes are achieved without any increase in public expenditures on health. The more important of these focus areas are elaborated below.

(a) Consolidating hospitals and improving efficiency

9.13 ***While some gains in efficiency can be brought about simply by consolidating and reducing the number of hospital beds in many provinces, further gains will come about only by improving efficiency in the use of hospital resources and overall management and accountability.*** A large number of hospitals continue to be underutilized, and huge variations still exist in hospital occupancy rates among provinces. Many MOH hospitals are too small in size to allow for efficient operation and provision of care, and have significantly lower utilization rates compared to SSK and University hospitals. In addition, hospital managers enjoy very limited administrative and financial autonomy, and have very few incentives to adopt efficiency-enhancing measures. The proposed introduction of universal health insurance provides a good opportunity to further strengthen the gains from the merger of MOH and SSK hospitals under MOH ownership and management. However, the separation of provision and financing provides an opportunity to introduce innovative methods in management of health facilities, which can be achieved by granting financial and administrative autonomy to public hospitals. The introduction of hospital autonomy will require appropriate legislation that will allow for public assets to be managed outside the direct purview of the government, and related laws and regulation would need to be amended in order to facilitate the transformation of MOH and SSK facilities to autonomous bodies.

(b) Strengthening delivery of health services

9.14 ***The introduction of universal health insurance also provides an opportunity to initiate measures to improve delivery of health services.*** This process has also started with the piloting of the family medicine system, which is aimed at shifting the emphasis from treatment of the sick to health promotion and prevention of illness. The family medicine system will bring the physician and family members into closer and more personal contact, enabling the physician to play an important role in the family's health and prevention of illness. Under the family medicine system, simple and routine diagnostic services and consultations could be provided under a single-window and

common illnesses could be treated across a broad spectrum of medicine domains, including internal medicine, gynecology and pediatrics. Family medicine places special emphasis on continuity of care and on quality of health services, and integrates preventive health services with basic health services and provides the full package under one window. The family medicine system has the potential for the strengthening of the patient referral system as well.

(c) Reforms in provider payment mechanisms

9.15 ***Changes in provider payment systems and incentives for physicians to provide quality care at lowest costs are required.*** Some of these changes are already being planned, and a system of paying family physicians on the basis of capitation is being worked out.⁹⁸ Physicians participating in this scheme bear most risks of treating a patient, and therefore are likely to be conservative in the amount of health care they provide. Such a system would need to be extended to cover all outpatient care as family medicine is scaled up from the Duzce pilot.

9.16 ***Prospective payment mechanisms introduced at the hospital level would provide incentives to hospitals to contain costs.*** Prospective payment mechanisms rely on the fact that services associated with a particular treatment are reasonably predictable and can be bundled into a group to which a monetary value can be attached. The hospital then gets reimbursed according to a pre-fixed rate per bundle. Such payment mechanisms do not encourage excessive use, since the hospital can conceivably make a profit (or a surplus) by being careful about inputs and hospital lengths of stay. One of the most widely-known prospective payment systems is the Diagnosis Related Group (DRG), developed to classify treatments according to the resource costs of its treatment. To be certain, a DRG-based system by itself will not necessarily promote efficient use of resources. Hospital care providers and managers need the flexibility and tools to actively manage their resources and redirect their use, which will ensure that cost-savings in treatment of one case are passed through the entire system.

(d) Containing outpatient care provided by hospitals

9.17 ***A rules-based approach would be needed to contain costs.*** A large number of outpatient services in Turkey are provided in hospitals, accounting for almost 43 percent of total costs of outpatient services. Outpatient services provided in hospitals cost significantly more than outpatient services provided in outpatient clinics, and it is imperative that the introduction of universal health insurance and family medicine be

⁹⁸ Physicians paid on the basis of a capitation fee per enrollee receive a fixed amount per enrollee regardless of the type and extent of treatment sought.

accompanied by a significant reduction in number of outpatient visits in hospitals that are paid out of the health insurance fund. This can be managed by establishing clear and transparent rules restricting reimbursement by the health fund of outpatient treatment carried out in hospitals.

(e) *Managing pharmaceutical costs*

9.18 ***Containing expenditures on drugs is a key challenge.*** Drugs are perhaps the single largest cost driver in almost all healthcare systems, and have been the most dynamically growing element in overall costs of healthcare services in recent years. According to new data released by OECD, spending on pharmaceuticals across OECD countries has increased by an average of 32 percent in real terms since 1998, reaching more than US \$450 billion in 2003. Growth in drug spending has outpaced total health expenditure in most OECD countries, and Turkey is no exception. Expenditure on pharmaceutical products constitutes a significant proportion of total expenditures on health in Turkey, accounting for almost half of all SSK, Emekli Sandigi and Bagkur spending on health. While pharmaceutical prices have increased broadly in line with inflation, there has been a much larger change in consumption levels, including subtle changes in consumption in favor of newer and more expensive drugs.⁹⁹

9.19 ***One of the reasons why Turkey spends a huge amount on drugs and pharmaceutical products is that most of the insured population is insensitive to pharmaceutical prices.*** Out-of-pocket payments for medicines constituting between 10 and 20 percent of total medicine bill of the insured.¹⁰⁰ In addition to price controls, managing consumption of pharmaceuticals is critical in order to contain expenditures on drugs. Many countries have successfully adopted demand-side measures of controlling consumption, and cost-sharing has proved to be the most effective such measure.¹⁰¹ The consumption of pharmaceutical products among the insured is actually not low by international standards, and there is a strong scope for cost containment if indiscriminate consumption can be curbed.

⁹⁹ Between the years 2000 and 2001, for example, the proportion of drugs consumed priced at half million TL or less decreased slightly from 34 percent to 30 percent, while the proportion of drugs consumed priced at 2 million TL or more increased from 34 percent to 47 percent.

¹⁰⁰ Indeed, the high percentage of pharmaceutical expenditures in terms of overall health expenditures is as much a reflection of low overall expenditures on health as it is of high expenditures on drugs.

¹⁰¹ In the Netherlands, for example, the introduction of co-payments on prescribed pharmaceuticals (a fixed amount per prescription) led to substantial decrease in the total number of prescriptions. In Germany, drug cost-containment measures take the form of cost-sharing, prescription limitations, reference prices and the pharmaceutical spending cap that makes physicians' associations liable for any overspending with no upper limit. These measures led to substantive decreases in pharmaceutical expenditures for social health insurance, mainly attributable to price reductions, changes in physicians' prescribing behavior resulting in a reduced number of prescriptions by 11.2 percent and increased prescriptions for generics. The French government imposes a fine on pharmaceutical companies if pharmaceutical expenditures surpass budget ceilings either due to price or quantity increases.

9.20 ***Reforms should be phased in with appropriate sequencing.*** While all of the above measures are critical to ensure improvements in access, equity and efficiency, it is critical that utmost attention is paid to the sequencing of the above reforms so that the process is seamless and does not lose effectiveness and credibility in the process of its implementation.