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OECD Reviews of Health Systems
Turkey
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Executive Summary

The health status of the Turkish population has improved significantly over the past few decades, accompanying improvements in the scale and functioning of the health-care system. Impressive progress has been made in expanding financial protection to the population through expansions in the breadth and depth of health insurance coverage combined with service delivery reforms to improve equity in access to health services. Health expenditures have also increased in the past decades commensurate with income increases. Nonetheless, health policy in Turkey faces important challenges in further improving the health status of the population and enhancing the efficiency of the system.

This *Review of the Turkish Health System* starts out by providing an overview of the salient features of the system prior to the implementation of the government's Health Transformation Programme (HTP) in 2003. Next, it outlines the major reforms implemented under the HTP. It then evaluates system performance against the main aims of health policy, namely access and equity, health improvement, responsiveness to consumers, value for money and fiscal sustainability. It assesses the recent reforms, including the transition to Universal Health Insurance coverage, and their potential impacts. Finally, the review outlines areas where additional policies may be needed to strengthen the system.

The Turkish health-care system is in transition towards the health systems of most other OECD countries

The Turkish health system is in transition. As a part of the government's Health Transformation Programme, institutional and organisational reforms are underway that aim at eliminating fragmentation and duplication in the health financing and delivery systems and assuring universal access to health insurance and health services.

Prior to 2003, the Turkish health system was characterised by the presence of several different public agencies funding and providing health care, some vertically integrated and others relying on contractual relationships. They served different parts of the population leaving significant gaps in coverage. Social security institutions covered salaried workers in the formal sector, as well as the self-employed and active and retired civil servants. A government-financed programme covered the low-income uninsured (the Green Card programme). Informal-sector workers account for about 25% of the population and only some of these were covered as dependents. Although the majority of the population was covered through one of the health insurance schemes, including the Green Card, and although all citizens were eligible for free primary and emergency hospital care, there were serious problems on the delivery side, which meant that even insured persons did not have

adequate access to timely health services. The Ministry of Health (MoH) operated a very large network of preventive and primary health-care centres and hospitals, while one of the social security agencies managed its own network of facilities. There also existed private facilities, many of which were not effectively regulated.

There were regional and urban-rural disparities in utilisation of health services, and accessing health services in rural areas was significantly harder and more expensive. Allocative efficiency of health services was poor, with the majority of health expenditures allocated for more costly inpatient and outpatient hospital-based services instead of preventive and primary health-care services. Demand for preventive and primary health-care services among the population was very low, partially driven by the low perceived quality of care in primary health-care facilities and the public sector more generally. The majority of outpatient visits occurred therefore in hospital settings. Despite the establishment of a four-tiered integrated health services delivery system, the referral system did not work and patients routinely by-passed primary health care to seek services at higher levels of care.

The government's Health Transformation Programme (HTP), which has as its objective to make the health system more effective by improving governance, efficiency, user and provider satisfaction and long-term fiscal sustainability has been under implementation since 2003. Key elements of the HTP include: *i)* establishing the MoH as a planning and supervising authority; *ii)* implementing Universal Health Insurance (UHI) uniting all citizens of Turkey under a single Social Security Institute (SSI); *iii)* expanding the delivery of health care and making it more easily accessible and friendly; *iv)* improving the motivation of health personnel and equipping them with enhanced knowledge and skills *v)* setting up educational and scientific institutions to support the system; *vi)* securing quality and accreditation systems to encourage effective and quality health-care services; *vii)* implementing rational drug use and management of medical materials and devices, and *viii)* providing access to effective information for decision making, through the establishment of an effective Health Information System.

The implementation of the HTP since 2003 has resulted in significant changes in the health system. The majority of public hospitals in Turkey, including those previously managed by a social security institute, are now integrated under one umbrella (the MoH), thereby resulting, in principle, in the separation of the purchaser of health services from the provider. As a result of the reforms, the various social security institutions are now integrated under one institution, the SSI, and share common beneficiary databases, claims and utilisation management systems. The benefits package across the various health insurance schemes is unified and provider payment mechanisms are shifting away from atomised, retrospective, fee-for-service systems towards prospective payment systems incorporating pay-for-performance. With the implementation of the "Social Security and Universal Health Insurance Law", in October 2008, a single-payer system has been established for public patients in Turkey. An integrated primary health-care system (based on the model of family medicine) is under implementation in 23 out of 81 provinces of Turkey, and public hospitals have been given more autonomy over resource allocation while simultaneously being expected to operate under a more rigorous MoH accountability framework.

Despite major improvements in health status, consumer satisfaction and financial protection, the system still needs to improve performance

Health status in Turkey has been improving rapidly in recent decades and in some respects has been converging with OECD averages. Nevertheless, average life expectancy in Turkey remains lower than in any other OECD country and infant mortality remains higher. Despite recent improvements under the HTP, Turkish health status appears to be slightly below the level that might be expected when comparisons are made between Turkey and other upper middle-income countries inside and outside OECD.

While many factors are responsible for the improvements in health status in Turkey, it seems likely that a significant part is due to higher and more effective spending on health care. While both total spending on health care and public spending on health care do not appear to be excessive, judging by spending levels in other *OECD* countries, when Turkey is compared to other *upper middle-income* countries, its overall health spending is not excessive but public spending on health, however measured, is at or above the average level in comparable countries. In the first three years following the introduction of the HTP in 2003, although health expenditures rose rapidly, increases in both total and public spending on health care seem to have remained affordable because economic growth in Turkey was also rapid.

A long succession of improvements in effective health insurance coverage in Turkey, culminating with the passage of legislation introducing UHI in 2008, has improved both financial protection for the poor against high health expenditures, and equity in access to health care across the population. In previous years, the lack of health insurance coverage, and inadequacies in benefits for some of the more disadvantaged groups in the population, are likely to have played an important contributory role in determining the comparatively low levels for certain health indicators in Turkey. The presence of the "inverse care law" (access to care inversely related to need for care) in Turkey can be illustrated with regional data which suggest that in 2007 the density of physicians was inversely associated with infant mortality across Turkish regions, in spite of the fact that under the HTP, there has been a significant increase in medical staffing in the south and east of Turkey where the need is greatest.

On health sector inputs, the nurse/physician ratio in Turkey is one of the lowest in the OECD, raising questions regarding appropriate skill mix. Only about 30% of physicians were practicing as general practitioners, which is likely to have contributed to reported weaknesses in primary care. Remuneration of physicians and other staff improved significantly with the introduction of performance-related pay in 2004, and has also increased for GPs choosing to become family practitioners. Nevertheless, in 2005, remuneration of salaried GPs in government health centres was still relatively low in comparison with other OECD countries but remuneration of salaried specialists looked relatively high. The relative remuneration of nurses seemed to be in line with that in a number of other OECD countries. Pharmaceutical consumption has been increasing in volume, especially in 2005 when coverage was improved for Green Card and *Sosyal Sigortalar Kurumu* (SSK) scheme members. Various price reductions for drugs have been achieved in recent years which suggest that value for money has risen. However, there are

remaining concerns with the rationality and cost-effectiveness of drug consumption in Turkey.

Since the introduction of performance-related pay, there seem to have been large increases in the volume of activity and in physician productivity, judging by reported consultations per physician. However, despite progress towards the introduction of a family practitioner system in Turkey, the consultation mix remained weighted towards hospital attendances compared with some other OECD countries. Average length of stay in hospital was shorter than the OECD average in 2005, although this may reflect Turkey's demographics. There are few data available on the technical quality of medical care in Turkey. However, there have been major improvements in vaccination rates for children. Measles was almost eliminated in Turkey in 2007. Data on the responsiveness of the system and on satisfaction with care suggest that there were long waits for, and low patient satisfaction with, both health centres and hospital care prior to the introduction of the HTP. Following its introduction, there were reports of shorter waiting times and of steeply rising overall satisfaction with the quality of both primary health care and health care in public hospitals. Turkish patients seem to be particularly pleased with their new family practitioner services.

While the ambitious health reform programme offers new opportunities, challenges remain

The Health Transformation Programme in many ways reflects "good practice" in the development and implementation of a major health sector reform including the introduction of UHI. Strong government commitment and leadership along with major financing reforms have been complemented by carefully planned service delivery reforms. While it is too early to evaluate the impacts of the HTP on all aspects of health status, financial protection, and consumer satisfaction, the preliminary indications from the available data suggest important progress in all three areas. Turkey is closing the performance gap with other OECD countries and, on a number of measures including overall costs, performs well relative to other comparable upper middle-income countries. Indeed, there may be much that other countries can learn from the recent health reforms in Turkey, especially in the use of performance-related pay to raise staff productivity.

Nevertheless, some old challenges remain and some new ones have been created. The most important remaining challenge facing the health system in 2008 is how to improve health status further – to bring it up to the average level in other upper middle-income countries and to continue these improvements in an affordable manner in light of the demographic, epidemiological and nutrition transitions. A related challenge is how to do this while maintaining the sustainability of public spending on health. Because of the design of the new health system, there appears to be a high risk of cost-containment crises in the years to come, potentially exacerbated by downturns in the rate of future economic growth. What is needed to meet this challenge, is policies which will: *i)* allow control to be maintained over the rate of growth of health expenditure; *ii)* encourage further improvements in efficiency; and *iii)* continue progress towards equity in access and assuring continued high levels of financial protection. Another challenge will be to raise sufficient revenues to assure the financial solvency of UHI.

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Control should be maintained over the rate of growth of health expenditure

Turkey has a good history of cost-containment in health care, but the new health system – which can no longer rely on limiting access to services – has a potential to grow more rapidly. Hence, it will be desirable, in the future, to maintain a hard cap on total public spending on health by the SSI, to allow the government to maintain control over total public spending on health including payments to private providers. This cap should embrace all public spending on primary health care and on hospitals, including private hospitals. It will imply control either of volumes of health care or of prices – or of some mix of both – and will require active purchasing by the SSI and appropriate evolution of the performance management system.

In addition, when family practitioner services are extended to the whole country, it will be desirable to implement co-payments for visits to hospital outpatient departments without a referral from a family practitioner and to re-instate the family practitioner reimbursement penalty for excessive referrals. Such copayments should also be implemented for inappropriate self-referrals to higher level hospitals. Another important way to contain costs will be to pursue further reductions in pharmaceutical prices and further rationalisation in the consumption of drugs – which account for some one-third of health spending.

In the medium to longer term, after necessary expansion of physician numbers has been completed, it will be important to reduce once more, and to subsequently control, the number of graduates entering the medical profession. There is evidence that health spending is positively associated with doctor numbers in health systems like that of Turkey.

Further improvements in efficiency will be needed

To encourage improvements in efficiency, which can aid cost containment as well as improve value for money, the authorities should press on with completion of Stage 2 of the Health Transformation Programme during the next five years. In primary care, they should continue to roll out the new family practitioner services and continue to develop community preventive services alongside them. Although additional family practitioners may add to cost pressures in the short term, they should help to improve efficiency in the medium to longer term by reducing the load on hospital outpatient departments.

In secondary care, it will be important to complete the transfer of purchasing of services to the SSI, when its management capacity is appropriate to the task, and when the DRG and bundled-outpatient payment reforms are sufficiently advanced. At the same time, it will be desirable to reform the performance management system in hospitals to ensure that it is consistent with other payment reforms and that it rewards efficiency and unit cost savings as well as volume and quality. It will also be desirable to persist with the policies which give hospitals more autonomy – provided that they display the management capacity to handle it.

More generally, it will be important to invest in: better information and information technology (IT); health technology assessment; and the size and skills of the nursing workforce. Judging by experience in other OECD countries, there seems to be ample scope for nurses to play a bigger role in support of doctors in Turkey. There are some important gaps in the measurement of the quality of care and in the ability to monitor and project health expenditure changes and to evaluate changes in technology.

Further progress towards equity in access is required

There is potential to raise average health status in Turkey by making further improvements in equity of access to health care, particularly in the geographical dimension. The new health system will help to improve equity of access because money will follow the patient. However, action will be needed on the supply side to strengthen the capacity of the system in the East of the country and in Istanbul. Such action could be guided by appropriate "needs" adjustments in the Diagnosis-related Groups (DRGs) and outpatient bundled payment rates, the development of weighted capitation approaches for regional, public spending on health care and by stronger financial incentives to attract professional health workers to underserved areas.

There is a need to increase revenue raising

It will be important for the SSI to pursue ways to increase registration of the population for health insurance purposes and to collect contributions. However, given the policies of the authorities to reduce the informal sector in Turkey, it will be desirable to keep the share of public spending on health which is raised from contributions under review – because contributions raise the "tax wedge" on labour and thereby encourage informality. It may be easier to raise general revenues if informality declines. There are clearly possibilities for revenue enhancements both through improved tax administration and through reforms in the existing taxes.

It will be important to address wider public health issues

It is unlikely that better health care, alone, will enable Turkey to match similar countries in health status. There is strong evidence that other, non-medical determinants – such as educational attainment, smoking, diet and physical activity – play a big part in determining health status. Hence, stronger cross-sectoral policies, involving several ministries apart from the MoH are needed in Turkey.

Further difficult decisions lie ahead

The challenges discussed above suggest that there will be a big role for continuing stewardship by the MoH. There is a need to oversee completion of the HTP. There will be a continuing need for steering of the public primary and secondary providers, even if they become more autonomous. And there is a need for the MoH to take the lead in co-ordinating action on the wider public health agenda, involving other key Ministries in the Turkish Government. It would be desirable for the MoH, the SSI, Treasury, the Ministry of Finance and the State Planning Office to continually monitor spending and revenues and to confer, to assure sustainability and value for money.

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Summary of key suggestions

- Maintain a hard cap on *total* public spending on health care by the SSI.
- Implement co-payments for visits to hospital outpatient departments without a referral.
- Pursue further reductions in pharmaceutical prices and implement rational drug prescribing.
- Control entry to the medical profession in the medium to long term after the expansion in physician numbers needed currently.
- Continue with implementation of the HTP in the next five years.
  - ❖ Continue to roll out family practitioner services.
  - ❖ Continue to develop and co-ordinate community public health services alongside the family medicine services.
  - ❖ Complete transfer of purchasing of hospital and primary health-care services to the SSI when management capacity is appropriate..
  - ❖ Complete the DRG and bundled outpatient payment systems and develop new systems to transfer risk to providers based on managed care principles.
  - ❖ Reform the performance management system to support DRG payment and to put more emphasis on efficiency and cost-effectiveness.
  - ❖ Continue with granting more autonomy to hospitals with appropriate management capacity.
  - ❖ Invest in stronger IT systems and data for decision making.
  - ❖ Develop capacity to undertake health technology assessment and to evaluate and monitor health reforms.
  - ❖ Enhance the number and role of nurses in Turkey.
- Take action on the supply side to support the new health system in improving geographical equity in access – possibly informed by weighted capitation targets for regions.
- Increase registration and payment of contributions to UHI and carefully monitor solvency.
- Address wider public health issues across ministries.
- Continue to develop the stewardship capacity of the Ministry of Health.