

Chapter 4

Policy Challenges and Options for Further Reform

4.1. Introduction

This chapter assesses Turkey's reform efforts in the context of the global evidence base on "successful" health-care reforms. It considers some contextual issues which will face the Turkish health system in the future. It makes an assessment of the Health Transformation Programme (HTP) and the steps needed to complete its implementation over the next five years. It considers some of the opportunities and challenges facing the health system in the longer term, and it offers alternative projections of costs based on likely future scenarios of economic growth, demographic/epidemiology changes, and increases in service use and provision. It identifies several critical areas for future health policy choices in Turkey. Finally, Box 4.2 puts forward key suggestions for meeting these challenges.

4.2. The evidence base on successful health-care reforms

In assessing Turkey's reform efforts to date, it is instructive to contrast Turkey's processes and policies with the evidence base on "good practices" in large-scale health financing reforms. While the evidence base is far from complete,¹ several recent OECD and World Bank studies attempt to assess the common enabling factors for successful health reforms. This type of comparison is of interest as there are few low- and middle-income countries which have actually undertaken "big bang" health sector reforms and achieved universal coverage.² The World Bank's most recent study, "Good Practices in Health Financing: Lessons from Low- and Middle-Income Countries" identifies 15 "enabling" factors based on nine "good practice" cases. These factors are completely consistent with those in a previous Bank study which identified the key enabling factors in high-income countries.³

The enabling conditions for good-practice reforms are grouped into three broad categories: institutional and societal factors, policy factors, and implementation factors. Table 4.1 contains the 15 "enabling" factors.

Table 4.1. **Enabling conditions for health reforms**

Institutional and societal factors	Implementation factors
<ul style="list-style-type: none"> ● Strong and sustained economic growth ● Long-term political stability and sustained political commitment ● Strong institutional and policy environment ● High levels of population education 	<ul style="list-style-type: none"> ● Coverage changes accompanied by carefully sequenced health service delivery and provider payment reforms ● Good information systems and evidence-based decision-making ● Strong stakeholder support ● Efficiency gains and co-payments used as financing mechanisms ● Flexibility and mid-course corrections
Policy factors <ul style="list-style-type: none"> ● Commitment to equity and solidarity ● Health coverage and financing mandates ● Financial resources committed to health, including private financing ● Consolidation of risk pools ● Limits to decentralisation ● Primary care focus 	

Source: Gottret et al. (2008).

Most of these common enabling factors have been present in Turkey, and indeed have provided much of the impetus for the reform. Nevertheless, given the long-term nature of “big bang” universal coverage reforms, several of these factors are still very much germane, particularly the fiscal issues and service delivery changes such as the sequencing of service delivery reforms (*e.g.* increasing the overall physician and family practitioner supply), provider payment reforms, efficiency gains, use of copayments, and the need for strong and sustained economic growth. As discussed below, there are a number of unfinished items in the HTP and Social Security agendas which directly bear on these enabling conditions.

4.3. Contextual issues

Demographic and epidemiological prospects

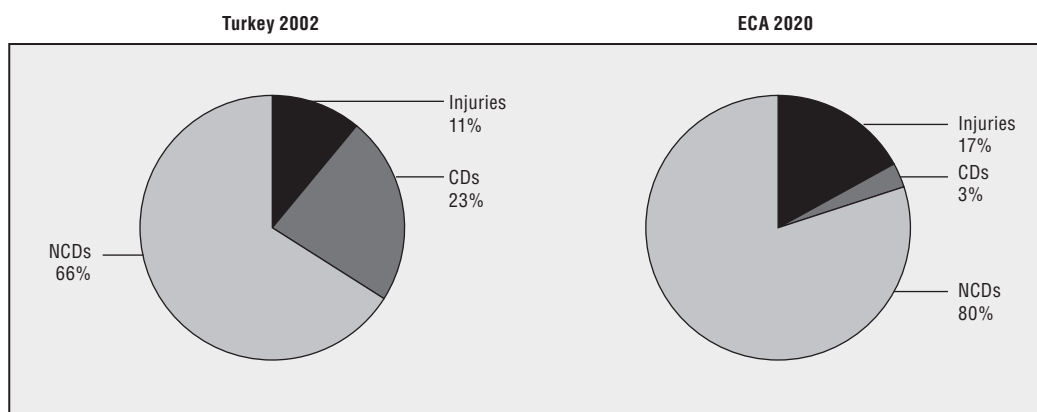
Turkey is facing demographic, epidemiological and nutrition transitions which will have major impacts on population health needs, as well as the ability of Turkey’s economy to finance those needs. From the point of view of the ability of the working-age population to support those needs, Turkey is facing more favourable demographic prospects than most other OECD countries over the next 25 years. According to medium-variant, UN population projections, the proportion of the population which is of working age (15-65) will increase from 66% in 2005 to 69% in 2030, meaning that there will be rising numbers of potential contributors to health insurance who are, on average (compared with children and the elderly), relatively low users of health services. Nonetheless, the key question of whether such “population momentum” will be a demographic “benefit” or “curse” is heavily dependent on the country’s ability to employ productively and tax this growing segment of its population.

However, while the proportion of the population in the “productive” age ranges is increasing in Turkey, and while the elderly proportion will remain below the 14% of population level found in most other OECD countries in 2005, the proportion of the population which is over 65 will double from over 5% to nearly 11%, placing increasing cost pressures on the health system. There will also be implications for long-term care services – which are outside the scope of this report, but will need to be addressed, perhaps in a separate comprehensive report. The crude death rate, the determinant of an important part of the demand for health care, will increase only modestly in Turkey over the same period, from about 6 per 1 000 population to about 7. The fertility rate, another determinant of part of the demand for health care, is expected to continue to decline, resulting in fewer people in the younger dependent age ranges.

These changing demographics will have important impacts on the underlying burden of disease faced by individuals and the health system. As a result the burden of disease in Turkey will shift significantly away from the 2000 burden (Ministry of Health, 2004), shown here, to one much more in line with that of Europe and central Asia in 2020, as projected by the WHO (Figure 4.1).

Thus, Turkey’s health system and health financing will be much more driven by the need to treat non-communicable diseases (NCDs), where effective health promotion and prevention policies are needed. Similarly, the health system’s physical infrastructure and human resources will need to adjust as Turkey’s disease profile shifts towards that of other upper-income countries. Basic public health policy will also need to deal with difficult cross-sectoral issues such as nutrition, as the burden of disease from over-nutrition and its

Figure 4.1. **The burden of diseases in Turkey, 2002, and in the Europe and central Asia region of the World Bank, 2020**



Note: CDs = communicable diseases; ECA = Europe and central Asia; NCDs = non-communicable diseases.

Source: WHO and Ministry of Health, School of Public Health (2004).

deleterious effects comes to exceed that of malnutrition, which, despite significant progress, is still a problem in parts of Turkey (Akdağ, 2008). Clearly this is an area that also requires careful co-ordination in terms of both medical and consumer education. Turkey's high road accident rate and other economic and social causes of injuries will also need to be contained as this area accounts for an increasing and expensive part of the future disease burden. Handling this dual burden of disease and transition to a non-communicable disease and injury-driven burden of illness is an important public health, delivery system, and health financing challenge.⁴

Macroeconomic prospects

Demographic changes, while important, are unlikely to be as important as other drivers of the demand for health care in Turkey. A recent OECD analysis of rising real public spending on health care across all OECD countries between 1981 and 2002 (OECD, 2006b), indicated that the average increase of public spending on health had been 3.6% per annum. About two-thirds of this annual increase could be attributed to rising GDP per capita, assuming an income elasticity of 1. Over a quarter of the increase could be attributed to a combination of changing medical technology and the so-called "relative price effect", *i.e.*, the tendency for the price of health care to rise more rapidly than general inflation through time because productivity in the health sector tends to rise more slowly than productivity in the economy as a whole. Less than 10% of the annual increase could be attributed to demographic change. Given good prospects for economic growth in Turkey and openness to technological change in health care, it seems likely that Turkey will face similar demand pressures to those in other OECD countries in future years. Over the past decade, only one OECD country (the Czech Republic) has kept health expenditure growth below GDP growth. In fact from 1990-2006, the nominal elasticity of health spending relative to GDP was only 1.07% for Turkey, compared to 1.29% on average for all OECD countries. In other words, over this period, health spending increased annually 7% faster than GDP in Turkey, but 29% faster for all OECD countries. Despite Turkey's greater success in keeping spending increases in line with GDP growth in the recent past, as Turkey completes its transition to universal coverage and continues to substantially expand its delivery capacity, it is likely to face these increased cost pressures endemic to the more mature OECD health systems.

The future macroeconomic picture for Turkey is positive, but there are potential pitfalls that could derail the economy (International Monetary Fund, 2008). The OECD has projected forward an economic growth rate averaging about 5% per year until 2010, which, preliminary projections from the World Bank suggest, is likely to be sustained over the next 25 years. The Turkish Government has projected forward a significantly higher growth rate of over 6% to 2035. These different growth scenarios are used in the actuarial analysis below for attempting to assess the costs and sustainability of Universal Health Insurance coverage.

An important and related question is whether there will be “fiscal space” in the budget for additional government spending on health. That depends not only on the future economic growth rate, but also on borrowing, grants, seignorage policies, and the efficiency of public spending across and within sectors (Heller, 2005). Currently, as shown in Chapter 3 and Annex 3.A1, Turkey spends a large share of its public budget on health, indeed a much higher share than other comparable low- and middle-income countries. Will efficiency gains in health and other public programmes and future growth allow the budget to expand sufficiently to absorb the increased costs from UHI, technology growth, relative price changes, the demographic, epidemiological, and nutrition transitions, and other government priorities, without endangering the future fiscal sustainability of the Turkish economy? Can the government improve its relatively low revenue collection efforts?⁵ How will Turkey balance competing demands from other critical sectors with increased health expenditure pressures?⁶ Will the non-contributors’ share of UHI financing coming from general revenues, remain at the initially proposed notional share of 25% of UHI costs or will it impose an ever-increasing burden on the general government budget as suggested by the policy simulations discussed below? The actuarial analysis below provides some stark early warnings of the need to assure a UHI implementation trajectory firmly grounded in effective expenditure containment policies.

4.4. Assessment of the Health Transformation Programme to date

The assessments of the HTP which follow, are made against the background of the three main goals of health policy set out at the beginning of Chapter 3: i) maximising health outcomes and responsiveness to consumers; ii) minimising costs, subject to attainment of these outcomes; and iii) pursuing equity both in terms of financial protection against unpredictable catastrophic medical care costs, and in terms of access to health services. They are also based on the analysis in the preceding chapter.

In many ways, the content of the HTP appears to represent a “textbook” set of reforms for a health system of the type found in Turkey prior to 2003, building on the strengths of the system, yet targeting the weaknesses. That system (like those in many other middle-income and some OECD countries) displayed excessive fragmentation and incomplete health insurance coverage; focused on costly curative hospital-based care; had limited availability of new technologies; encouraged dual physician practice arrangements resulting in significant informal payments and out-of-pocket costs; had limited incentives for efficiency; contained serious inequities in access to care for the poor, near poor, and those in rural areas; and often provided poor-quality care. The HTP/UHI reforms represent a comprehensive blueprint to tackle the main weaknesses of the system.

They also seem to have been designed to build on the strengths of the system, such as the institution of a Green Card scheme for the poor in the previous decade, public specialist services of a reasonable underlying quality in many parts of Turkey, a vibrant private

sector, upward momentum in levels of health status in the population and a government and a Ministry of Health committed to providing access to quality services to the entire population, but especially to the poor and other underserved groups.

The steps taken to implement the HTP appear to have made significant improvements to the performance of the system. On the health insurance side, Green Card coverage was extended to include outpatient services and outpatient prescription drugs in 2005, and SSK enrolees were given access to all hospitals and to private pharmacies in 2004. These changes were associated with a 7.5% increase in Green Card enrolees and a nearly 33% increase in SSK enrolees between 2003 and 2007. They were also associated with sharp increases in both access to hospitals and per capita spending on pharmaceuticals for these groups. The latter was offset to some extent by reductions in pharmaceutical prices. As discussed in the previous chapter, the level of health spending overall, but particularly the public share, increased significantly over much of this period, while out-of-pocket payments for consumers fell. Fortunately, the Government of Turkey was able to accommodate these increases due to Turkey's strong economic growth over this period.

Indeed, both the SSI and the MoH have taken the view that by 2008, most Turkish citizens with significant needs for health care are enjoying reasonable access to services. That is because there are no eligibility barriers to primary care and to emergency hospital care. Moreover, partly because there has been adverse selection in enrolment into *Bağ-Kur* and the Green Card schemes, in addition to some casual or fraudulent use of insurance cards by non-eligibles, most of the population with significant needs has been accessing government-financed health services, even though "formal" enrolment information suggests uncovered groups to be between 10 to 15% of the population.

Meanwhile, the introduction of the performance management system in MoH facilities – which from February 2005 included the former SSK hospitals – together with improvements in consulting facilities, appear to have been associated with a rise in full-time working of specialists in the public sector and a significant rise in hospital activity. The most recent Ministry of Health information suggests that the number of full-time physicians in MoH facilities has increased from 11% in 2003 to 73% in 2008. Considerable outsourcing of support services has been developed in MoH hospitals, and many staff, especially nurses, are now on short-term contracts rather than on civil service appointments.

The new family practice system has been implemented in 23 provinces as of August 2008 and will cover 59 provinces by late 2009. Some 20% of the population had been assigned to family practitioners as their source for basic primary care, a level of coverage that MOH plans to increase to 50% by the first quarter of 2009. Several evaluations of pilot projects are underway, with some preliminary results available on certain outcomes. For example, patient satisfaction has increased in provinces that have implemented the family practice system. Visits to primary health-care facilities have increased by 27% in provinces with the new system compared with 23% in provinces without it. This has been accompanied by a 1% decrease in the number of visits to secondary care facilities in provinces with the family practice system, compared with a 16% increase in hospital visits in other provinces. Hospitals accounted for 58% of all visits before implementation of the family practice system compared with 41% after. Despite suspension of the referral-system penalties, provinces which are implementing family medicine had 51% of their visits in primary care and 49% in secondary care in 2008, and the Ministry of Health expects the primary care percentage to increase to 60% when the new copayment rules are put into

effect. Based on these preliminary evaluations, it appears that the system has shifted utilisation toward primary care and away from secondary care and increased patient satisfaction (Department of Family Medicine; Akdağ, 2008). The effects of the new system on outcomes await the results of the full scale evaluations now in progress. These changes were backed up on the supply side with improvements in the distribution of doctors across geographical areas in Turkey.

On the supply side, the changes outlined above appear to have represented improvements in capacity and productivity – although it is arguable that too much of the expansion of ambulatory services was in the “wrong” place – *i.e.* in hospital outpatient departments. In particular, consultations per physician rose steeply following the introduction of the performance management system and the shift towards full-time working. Thus, improvements in coverage were matched both by rising activity and by the equity-enhancing redistribution of capacity in primary and secondary care. Given that there was almost certainly unmet need in Turkey prior to the reforms, their effect is likely to have been improved access and equity, at least for the groups which had formerly faced barriers to access. Had the improvements in capacity and productivity not taken place, the rising demand for care might have been left unsatisfied because of constraints on human resources and on facilities.

In its early years, the HTP appears to have remained affordable: the increase in health expenditure has been in line with GDP growth. The costs of improvements in access and staff remuneration appear to have been offset, at least partially, by improvements in productivity and reductions in pharmaceutical prices. Public spending on health care rose on average by about 7% per annum between 2003 and 2006 having risen at 10% per annum between 1999 and 2004. The share of total health spending in GDP remained virtually constant between 2003 and 2006 due to strong economic growth whereas it had risen by nearly a percentage point between 1999 and 2003.

4.5. Completing the Health Transformation Programme, 2009-13

The Health Transformation Programme is far from complete in 2008 due to: controversy over the reforms in Parliament and the courts, leading to legislative delays; difficult policy choices, such as on extra billing by private providers and setting budget caps; and the inevitable lags involved in setting up incentive-payment schemes such as DRGs, increasing the capacity of SSI to pay the large numbers of new claims, and training new staff and retraining existing staff.

On the funding side, the parts of the Social Security Bill which dealt with UHI passed Parliament only in April 2008. The Green Card scheme has not yet been fully integrated into the SSI – although plans are in place to integrate it by 2009. Many Turkish citizens, above the level of income defined for Green Card eligibility, work in the informal sector and many do not appear to be registered for or contributing to health insurance. New procedures for means-testing by SSI for both Green Card eligibles and those formerly uninsured are not yet in place. Decisions about co-payment rates await secondary legislation following passage of the UHI bill, although it is envisaged that there will be higher co-payment rates for inappropriate self-referral behaviour including hospital out-patient consultations which are initiated without a referral from a family practitioner. Critical issues concerning the referral system are otherwise still in abeyance – awaiting completion of the Family Practitioner system (*i.e.*, according to the MoH this means 30 000 new family practice physicians trained

and in practice). Similarly, decisions about extra-billing ceilings in private hospitals await implementation of new draft rules limiting extra-billing to 30%. In addition, while the UHI Law states that SSI will implement global budgets with state health-care institutions (MoH and university), it is unclear how SSI will deal with private health-care facilities. This is critical since spending on private health-care facilities is the fastest-growing component of SSI expenditures, and is likely to generate a deficit for SSI in 2008.

On the delivery side, as discussed above, the family practitioner services have been rolled out in only 23 of Turkey's 81 provinces. Public hospitals have not yet achieved significant autonomy and the purchaser-provider split is not yet fully operational for MoH hospitals. Also, capacity constraints have increased among doctors and nurses, exacerbated by the increased demand from enhanced coverage and a buoyant private, health-care sector in some parts of Turkey. The government has announced that it is planning to increase medical school intake from about 4 500 students per annum to about 6 000 per annum. It has also published new planning regulations, early in 2008, setting standards for new private hospitals and outpatient diagnosis and treatment centres in order to rationalise joint public and private sector capacity.

The new payment system envisaged in the HTP – to have money follow patients according to DRGs – is not yet operational. The Ministry of Health is still deciding the budgets and monthly payments for MoH hospitals, including the revolving-fund revenues which flow from SSI to MoH hospitals. SSI funds are disbursed to MoH hospitals monthly, based on MoH decisions, rather than in accordance with bills submitted for services rendered. In addition, the ministry is still paying part of the salaries of hospital staff in public hospitals and the funds required for primary care and public health services, including the new family practitioner projects. The introduction of DRGs for hospital care is still at a design stage, albeit ready to be tested – with exploratory projects in 47 hospitals. Hospital performance standards have increased hospital activity; yet, the incentives in the performance-based supplementary payment system (see Box 2.1 above) need to be implemented in line with those in the proposed DRG system, and complement those implicit in the budget caps for public hospitals in order to improve, simultaneously, physician and institutional productivity, enhance allocative and technical efficiency, and assure macro efficiency by controlling overall costs by discouraging the provision of unnecessary services.

Finally, the changes in governance envisaged by the HTP are far from complete. The SSI has not yet acquired the capacity to process all claims adequately or to design and implement innovative incentive-based payment systems. The Ministry of Health is still deeply involved in budgeting for and providing primary and secondary services rather than assuming a steering/stewardship role.

Thus, there are still a large number of key policy decisions awaiting final specification and some of these will take many years (*e.g.* increasing the supply of physicians). These ultimately will determine the effectiveness, affordability and sustainability of UHI in improving health outcomes, financial protection, and consumer responsiveness for the Turkish population. The key implementation decision areas for completion of the HTP are discussed in what follows.

Financing, basic benefit package and purchasing

There are a large number of financing issues and policies contained in the HTP that either await implementation and/or further specificity in the near future. These include:

informal-sector enrolment and new targeting mechanisms for non-contributors; Green Card targeting; the scope of the government contribution to UHI, extensiveness of the basic benefit package (BBP); user fees and informal payments; the scope of extra billing by private providers; the role of the private sector in health financing; development, testing and implementation of incentive-based payment systems such as DRGs and bundled payments for outpatient care, and other potential risk-sharing arrangements; the role and scope of global expenditure caps; financing of medical education; and pharmaceutical policies. Each of these areas is discussed in turn.

Informal-sector workers

Informal-sector workers account for some 22% of employment and 25% of the workforce does not report income for tax purposes (OECD, 2008a, Chapter 2). Some will be young and healthy and may see few reasons to make contributions. This poses the greatest difficulty for both voluntary and mandatory insurance systems. Identifying such workers and then having them pay their premium contributions is a difficult problem that all countries face. Some countries like Thailand made the decision to cover them in the same way they cover the poor with no contributions required. Other countries provide strong incentives for them to enrol by eliminating all price subsidies at public facilities, thereby providing very strong negative financial incentives for them to voluntarily enrol and contribute. It appears that under the new UHI in Turkey, Turkish citizens will not be required to provide any proof of contributions to health insurance for access to primary care, but that non-contributors would indeed be liable for charges if they sought non-emergency hospital care. The SSI policy is to register non-contributors when they seek hospital care and to pursue the question of contributions, or alternatively, eligibility for the Green Card, thereafter. However, so long as informal-sector workers do not approach public hospitals they could remain unregistered. Other countries have dealt with this problem by a variety of demand-side, supply-side, and administrative arrangements. Demand-side arrangements include: providing premium subsidies; eliminating price subsidies at public facilities by setting charges to reflect the full costs of services; and, allowing private sector facilities to charge whatever they want. Supply-side subsidies and administrative arrangements include: having an attractive benefit package; enrolling individuals through unions, trade associations, and other community organisations; and improving confidence in the government's programmes by assuring good governance and eliminating corruption.⁷

Identifying and targeting the poor

Identifying and targeting the poor is another major administrative issue. From 2003-06, Green Card coverage increased from 25% of those in the lowest income decile to 54%. The community targeting scheme, where the centrally appointed District Officers (*Kaymakams*) have the authority to distribute the cards, appears to work quite well, as 83% of the benefits from the Green Card programme accrued to those in the bottom two deciles of the income distribution (Aran and Hentschel, forthcoming). Meanwhile, the proxy means test (PMT) system for targeting the conditional cash transfers has been found to be extremely well targeted—but to a much smaller, more narrow group of beneficiaries. Switching over from the existing Green Card to the PMT system would involve very considerable logistical difficulties, requiring *a*) a substantial re-training of existing Green Card staff; *b*) moving staff from one organisation (Green Cards at Ministry of Health) to another (PMT at the Social Solidarity Fund); as well as *c*) ensuring computerisation and

Internet connectivity (as the PMT relies on an internet database). Turkey should weigh carefully the costs and benefits of retaining the Green Card or moving to the PMT mechanism as a way to target UHI exemptions.

The scope of the government contribution to UHI

The scope of the government contribution to UHI should be kept under careful review. One of the main economic aims of the Turkish authorities is to increase formality in the Turkish workforce with a view to promoting growth and productivity. A contributory policy is to reduce the tax wedge on labour income which is high in Turkey and which discourages employment in the formal sector. This policy has been supported by the OECD's recent *Economic Survey of Turkey* (OECD, 2008b) and a separate analysis in the 2008 *Employment Outlook* (OECD, 2008a). Contributions to health insurance constitute part of that tax wedge. While the initial intention may have been to keep the general revenue share of the cost of UHI to about 25%, there exists an option to limit the growth rate of contributions, or even to lower them, by substituting additional general revenues for health insurance contributions. The authorities need to balance carefully the efficiency and equity impacts of these alternative tax/revenue sources.

Most OECD and developing countries fund their UHI programmes from combinations of general revenues and payroll-based taxes. Estonia is perhaps the only country in the world to fund its social health insurance system almost exclusively from payroll taxes. Many OECD countries fund their UHI programmes mainly by general revenues. Other OECD countries which have Bismarckian health-care systems, like that of Turkey, including France and Germany, have altered the balance of funding of their public systems from payroll-based health contributions towards general revenues – partly to reduce the tax burdens on employers and employees. That seems to be happening *de facto* in Turkey to some extent because of growing social security deficits which are funded from general revenues. Clearly, it would be desirable not to make any such switch a source of open-ended tax liability. Thus, there is a need to assure that future expenditure liabilities are both affordable and sustainable and do not become an unlimited contingent liability on the government budget. Two of the critical factors that will drive such a *de facto* shift are future growth in the wage base and health spending increases in excess of future wage growth. As shown below, spending efficiency will be a critical determinant of a potential major shift in the contribution base from individual contributions to general revenues. Further discussions of actuarial solvency and of capping expenditures can be found below.

The extensiveness of the basic benefit package (BBP)

The extensiveness of the BBP is also an important issue for the authorities. The BBP is the key instrument for determining the impacts that UHI will have on health outcomes, financial protection, and consumer responsiveness. While in and of itself not a contentious issue, the extensiveness of the UHI benefit package raises questions about the future affordability of the system. Extensive benefits are certainly a good thing from the point of view of consumer responsiveness and financial protection. In principle, if most services are covered including important preventive and primary care services, allocative efficiency and health outcomes should be enhanced, although it is important to keep in mind that the societal and individual benefits from such risk pooling mechanisms pertain to the financial protection they provide against unpredictable large medical care expenses, not small predictable ones. While many countries have extensive benefit packages, costs are

often limited by various combinations of budget caps, co-payments and supply-side constraints. In Turkey, with the government rapidly attempting to remove some of these constraints, at least in terms of physical infrastructure, equipment, and human resources, the basic benefit package may in some ways represent a blank cheque on future medical consumption. Moreover, as citizens (especially contributors) will view UHI as a contractual agreement between them and the government, the authorities will be under increasing pressure to provide extensive benefits irrespective of costs.

As discussed above, changes in medical technologies have been found to be an important cost-increasing factor in most OECD health systems. While it appears that Turkey has been relatively successful at keeping health expenditures in line with GDP during its implementation of the HTP through prudent purchasing, outsourcing, productivity enhancements, and rapid GDP growth, it will be a major challenge for Turkey to withstand future cost pressures, judging by the experiences of most OECD countries cited above and the medical technology literature as recently summarised in *Disease Control Priorities in Developing Countries* (Weatherall et al., 2006). With a virtually unlimited benefit package and increasing availability of services, the authorities may need to re-evaluate whether they can in effect afford such an open-ended package with few exclusions. Rules for covering new technologies would be an important element of future cost containment and inclusion of criteria concerning cost-effectiveness would be important first steps in limiting this potentially large future contingent liability.

User fees (formal and informal)

User fees (formal and informal) are one of the most contentious and politically charged issues facing all governments. User fees are a source of revenues and a mechanism to prevent inappropriate service use (e.g. deal with the moral hazard issue). While the new Social Security Law provides the authorities with the possibility to impose user fees of up to TRL 10 per consultation, detailed policies concerning the circumstances and fee levels have not yet been worked out (although certain SSI-listed chronic diseases would be exempt). Part of the issue relates to the recent shelving of the requirement for patients to follow the referral chain. Because of the perceived insufficient number of first-line primary care providers, the authorities have suspended financial penalties for by-passing the referral system and have suspended the referral target for family practitioners. Also the ability of individuals to self-refer to all hospitals results in routine cases being treated in more expensive specialty and teaching hospitals, causing wasted resources and inefficiency. Virtually all OECD countries have copayments on services that tend to be overused, and the global evidence base discussed above shows that many countries use copayments to finance major health coverage expansions.

An increase in copayments per outpatient consultation for non-poor enrollees, set at 5% of average resource use, would directly generate about 0.8% of total UHI financing needs, and would reduce total UHI spending by another 0.5%, resulting in a 1.3% reduction in overall SSI financing needs. A recent study showed that in 2002, some 25% of consumer out-of-pocket payments were informal payments to providers (Tatar et al., 2007). However, formal co-payment requirements, together with the significant increases in remuneration of physicians, should “crowd out” informal payments – patients will resist paying twice. In any event, the authorities should monitor this area to ensure that the high level and equitable distribution of financial protection in Turkey are not compromised.

Extra-billing

Extra-billing is another important issue which has major implications for UHI programme costs, total health-care costs, equity, and financial protection. Currently, extra-billing is allowed under certain narrow circumstances for university hospitals (amenities, being treated by the university faculty) and for private hospitals which under new rules resulting from the new Social Security Law will be able to charge up to an additional 30% of the SSI tariff plus extra charges for amenities. Part of the rationale is to create a level-playing field and allow private hospitals to recoup costs that are paid through the regular Ministry of Health budget as supply-side subsidies to MoH hospitals (*e.g.*, base salaries of staff, some capital costs, land costs, etc.).

However, extra-billing creates an unfair liability on patients and increases private/out-of-pocket patient payments and total health-care costs. The most satisfactory way to deal with the “level-playing field” issue would be to eliminate the supply-side subsidies to public institutions and ensure that the reimbursement levels approximate the full efficient production costs for all hospitals. However, this might have to await the gradual attrition by retirement and resignation of staff employed on civil-service terms and conditions at public hospitals. If the only reason for allowing extra-billing by private hospitals is to compensate for the subsidies to public hospitals, the fairest and most effective way to do that would be to include that extra payment as part of the reimbursements of the SSI since the insuree should receive the same level of insurance coverage whether he/she goes to a public or private hospital. If there is also an issue of better amenities, a set level of amenity standards covered by the base tariff should be established, and all hospitals should be allowed to extra-bill for additional well-defined amenities.

However, public coverage for extra billing of private hospitals to offset salary subsidies to public hospitals would have to be funded – perhaps by raising contribution rates. There is also an issue here of whether Green Card holders should have to make such payments, since they will receive the same benefits package as other insurees (which includes access to private health-care facilities) once they formally join UHI. Thus, on equity, financial protection, and overall cost grounds, the authorities need to consider carefully how they will implement this extra-billing policy and whether the extra-billing should be paid by the insured individuals or by SSI. Elimination of supply side subsidies to public institutions over time may be a more straightforward and efficient way to implement the purchaser-provider split and create a level playing field for the private sector.

The role of private financing

Currently private sector payments account for 28% of health expenditures in Turkey, according to *OECD Health Data*. The role of private financing (beyond the issues of copayments and extra-billing previously discussed) is an important, but often neglected issue. The question of the role of private voluntary health insurance (PVHI) is an important one. A major OECD study has analysed the different roles of private health insurance in OECD countries (Tapay and Colombo, 2004). Now that Turkey has universal coverage and an extensive set of benefits, there would appear to be a limited role for PVHI. That role might include providing complementary insurance to cover: higher standards of amenities than those offered in the basic benefit package; and additional services, such as care in very high-quality specialised private institutions without contracts with SSI. While the role of PVHI will be limited in such a system, good regulation is important both for industry survival and consumer protection. In addition, the authorities will need to consider

carefully whether, as in Canada and several other countries, private insurers should be forbidden to cover the copayments in the public system. International evidence shows that, where possible, consumers will buy private policies to fill in the gaps, particularly coinsurance in public programmes (*e.g.* some 80% of the French population purchases cover from *Mutuelles* to fill in the copayments in the French social health insurance system, while approximately the same per cent of Medicare beneficiaries make similar arrangements in the United States). Unfortunately, by filling in the publicly required copayments, additional costs are imposed on the public insurance system because beneficiaries then face no costs at the point of service and will tend to use more public services. As such coverage is not widespread at this time of transition to universal coverage, it is timely for the authorities to address regulatory policy with respect to PVHI.

Development and implementation of incentive-based payment mechanisms

The HTP contains provisions for the development and implementation of incentive-based payment mechanisms such as DRGs and other bundled-payment schemes. In addition, the performance bonus system utilises a Current Procedure Terminology (CPT)-coded, resource-based relative value scale (RBRVS). DRGs have been under development for some time, and are in the process of being evaluated in 47 hospitals (33 MoH, seven university and seven private). DRG hospital payment systems are widely used in OECD countries and have generally been found to promote efficient use of resources and quality. Nevertheless, DRGs are a fee-for-service payment mechanism, albeit a highly-bundled one, and it is desirable to monitor the cost and quality of the services purchased and to be ready to counter some of the inherent perverse incentives of DRGs, such as DRG creep (reporting of more intensive cases), split admissions, and additional admissions.

It is important that the significant development work done by Tepe-Teknoloji and Hacettepe University be pilot tested, refined, and then implemented by the SSI. Turkey should also consider reforming its largely fee-for-service based outpatient payment systems both to conform to the more innovative bundled prospective outpatient payment systems in use in OECD countries (*e.g.*, the new outpatient prospective-payment systems, modelled on the DRGs, such as the US Medicare programme's Ambulatory Payment Classification – APC – System) and to incorporate the risk-sharing arrangements inherent in most managed care plans. Significant efficiency gains can be achieved by giving service providers strong incentives to reduce unnecessary referrals to specialists, diagnostic tests, and admissions to hospitals. Selective contracting could be an important concomitant to such arrangements. This could be a much more effective way of controlling costs than making small reductions in payment levels for individual services. This would help Turkey address the recent Court challenges to its outpatient bundled payment system.

A related technical issue that needs to be explored with respect to Turkey's current payment mechanisms and the global budgets discussed below, is the need to ensure consistency in the incentives promoted by the performance-based supplementary payment-system in hospitals (Box 2.1, above) and by the DRG payment system for hospitals. For example do the relative weights in the CPT-coded RBRVS contain the same financial treatment incentives as do those in the DRGs and bundled outpatient payments? To what extent are these incentives contrary to those in a global budget cap? Do the payment mechanisms and global budgets promote the same sets of incentives across different types of services (inpatient *versus* outpatient) and providers (MoH, university, and

private)? At the moment, each of these different areas appears to be handled by different agencies in the health system, and the incentive aspects of these different mechanisms all interact.

In conformity with past IMF ceilings global caps have been an important element of the Turkish authorities' policies to control overall health-care costs. Such appear to have played an important role in maintaining the affordability of the HTP in its early years. However, they have only been applied to Ministry of Health hospitals. Article 73 of the new Social Security Law gives the government authority to apply caps to all state hospitals, including university hospitals. Without some global limit, particularly in the presence of a hospital performance bonus system that encourages additional service provision, health-care costs are likely to increase at unacceptably high levels. The topic of cost-containment in the longer term is addressed below. However, it will be important to address cost-containment in the near future, also. Consideration should be given not only to using Article 73 but also to establishing a cap for all SSI expenditures during Stage II of the implementation of the HTP, thereby bringing university and private hospitals as well as outpatient services under the scope of capping. A new World Bank publication "How to Do It: Manuals for Designing and Implementing a Health Care Provider Payment System" provides detailed policy and technical guidance on: implementing case-based payment systems and global budgets for hospitals; and associated contracting, and management information systems for purchasers and providers (Langenbrunner et al., forthcoming).

Financing of medical education

As discussed above, with the large proposed expansion in physician numbers, Turkey needs to have a clear policy on the financing of medical education. Medical education involves both direct costs (salaries of professors and residents and interns) as well as indirect costs (*e.g.* extra tests ordered as part of the educational function) and is also closely tied with the funding of medical research. University hospitals have several outputs: patient care, medical education, and research. There are scale and scope economies with respect to the simultaneous production of these outputs. Currently, several major university hospitals are on the verge of bankruptcy, partly because the revolving-fund payments and other pedagogical sources of financing from the Ministry of Education are insufficient to support medical education, and partly because freedom of choice of hospital by patients is resulting in large numbers of routine patients being treated unnecessarily in these more expensive teaching hospital settings.⁸ Also concerns have been expressed about the efficiency of teaching hospitals in Turkey. It may be desirable to address these issues, through a Presidential Commission or national task force with a view to developing clear policies consistent with the goals of expanding a well-trained and state-of-the-art health workforce, of ensuring that university hospitals perform their functions efficiently, and of providing sufficient funding to sustain their operation.

Pharmaceuticals

Pharmaceuticals account for about one-third of total health spending in Turkey. That suggests that any efficiency savings could make a major contribution towards financing of the second stage of the HTP. Under the HTP, Turkey has already taken major steps to reform its pharmaceutical policies. Reimbursement lists of different health insurance funds have been merged into a joint Social Security Institution (SSI) list. The 14 February 2004 decree on setting reference prices for pharmaceuticals based on the cheapest price in the

five EU countries of France, Italy, Spain, Portugal, and Greece, resulted in price reductions of up to 80% in more than 900 pharmaceutical products. Reductions in the VAT in the same year further reduced the costs of pharmaceuticals. Reimbursement decisions are taken by a central commission under SSI. This commission has started using its bargaining power to get lower prices from manufacturers in exchange for including a new drug into the reimbursement list. Generic drugs are reimbursed based on the cheapest option available with patients responsible for the price difference if they choose a more expensive drug. A new system to monitor physician's prescribing behaviour is being developed. Statutory rebates enforced at manufacturer and retail level are an attempt by SSI to "claw back" some of the informal volume rebates that are passed on from manufacturers to wholesalers and retailers in a market with limited shelf space and many equivalent products in the common generic categories. All this has led to a significant slowdown in pharmaceutical expenditure growth in the past two years.

Nevertheless, there is still a significant efficiency reserve in the pharmaceutical sector. Cost-effectiveness criteria are not consistently applied in reimbursement decisions, making the reimbursement list in parts look more generous than in some high-income countries like Germany or Sweden. For example, unlike Turkey, Germany has reimbursement ceilings that cover more than one molecule, when different drugs have been shown to have similar clinical effectiveness and safety. That can bring expensive "me-too" products under the same ceiling as cheaper, older products. Prices for newer generic drugs (those recently introduced after patent expiry) are relatively high compared with the prices found in more competitive markets. Most importantly, Turkish physicians are still ignoring rules of rational prescribing in qualitative and quantitative terms without being held accountable in any way, making physician training in rational drug use an important priority. While SSI has limited its exposure to some extent by introducing reimbursement ceilings for certain drugs, patients are exposed to increasing out-of-pocket payments as a result of financial incentives for providers being aligned in a way that favours prescription and dispensing of more expensive drugs (Çelik and Seiter, 2008).

Delivery system changes

As discussed above, countries which have undertaken successful financing reforms have simultaneously made carefully synchronised delivery system changes. The authorities realised the necessity of such accompanying changes early on, and the HTP was carefully designed to increase capacity and activity for needed increases in access, to improve quality, to enhance allocative and technical efficiency, and to promote an appropriate role for the private sector. Nevertheless, there remains a significant agenda to complete the provision of family practitioner (FP) services and the training of FPs throughout Turkey, to resolve the relationship between FPs and the (separate) local community health services, to increase the number of physicians and nurses and optimise their skill-mix, to implement hospital autonomy and to make best use of private providers within UHI. These issues are discussed in turn, below.

Family practitioners

Clearly, completing the development of the new family practice system throughout Turkey is a key element in the full realisation of the reforms and is essential for realising efficiency gains. As has been mentioned above, the new system had been implemented in 23 provinces as of October 2008. It is planned that the implementation will have been

launched in 59 provinces by the end of 2009 and, according to the MoH, will be generalised to all provinces in Turkey by 2010 – although the inclusion of Istanbul within this timetable will be a challenge because of a shortage of potential FPs in the Province. It can be anticipated that the consultation mix between FPs and hospital outpatient departments will continue to adjust in favour of the former as the FP system is rolled out. However, the full benefits of the FP system on the cost side are unlikely to be realised until the now-deferred referral system is re-established and appropriate copayment incentives are put in place. The authorities take the view, currently, that it will require not only full implementation of the FP system but also reduction of the average patient list from the current level of about 3 000 to about 2 000-2 500, before a mandatory referral system can be established. Indeed, the patient load for FPs seems to be excessive. According to March 2008 data, the number of daily medical examinations per physician is 44 on average (which means approximately 7.5 minutes per clinical examination).⁹ Appropriate utilisation could be improved by levying differential co-payments on hospital consultations, with and without a referral.

Future training of family practitioners

The Turkish authorities have identified a need for 25 000 to 30 000 new family practitioners to secure full implementation of the new FP service, which MoH estimates to take 40 000 to 45 000 FPs in total. The announced policy to increase medical school intake by 50%, will not have any impact on services delivered during the next five years because it takes at least six years to train new doctors in Turkey – and to train specialised FPs takes longer. The desired increases in capacity can partly be achieved by re-training of existing GPs. The MoH has implemented a new training programme which involves three stages. First-stage training takes ten days and focuses on adaptation. All FPs are obliged to receive this training. As of March 2007, approximately 11 430 practitioners out of about 25 000 in public service in Turkey had received this training. It is planned to give the second-stage training via distant-training methods. Training will consist of 40 modules and three of them will be given in practice. Depending on the performance of trainees, training as currently planned will take 12 months. This phase of training has not been launched yet. The third stage has not been specified yet. It is planned that the third-stage training be given on a part-time basis by the National Medical Residency Examination and be mainly clinically-based. The authorities may consider looking into other primary care training models in OECD countries to ensure that this module, combining internet-based and clinical training, is optimised.

On the incentive side, the current remuneration system provides strong financial incentives for physicians to train and practice as FPs. Total remuneration (salary, or capitation payments plus bonuses) for an FP is slightly higher than for a GP working in a hospital, and significantly higher than for a GP working in a health centre. Moreover, remuneration for FPs is typically higher in regions with shortages – as it should be in order to address geographic misdistributions – whereas for GPs in hospitals and health centres, it is not. This means that the structure of wages across facilities, modes of practice and geographic areas is conducive to encouraging medical graduates to take up training in family medicine.

Family practitioners and community health services

It is intended, under the HTP, that public-health specialists will continue to operate out of local community health centres while family doctors work out of family health

centres – although the two premises may sometimes be the same. The development of a division of labour between these two important sets of agents will be a necessary condition for the efficient promotion of public health locally. For example, Family Practitioners will be in a good position to inquire opportunistically about the smoking habits of their patients. Brief counselling of smokers by primary care physicians – to encourage the smokers to quit – has been shown to be successful for a minority of patients and to be highly cost-effective. However, many smokers will fail to quit after brief counselling by their physician, or will relapse after an interval. At that point, a referral of the patient to a smoking-cessation clinic organised by the community health centre may be appropriate.

Nurse/physician skill mix

It has been noted above that Turkey reports one of the lowest ratios of practising nurses to practising doctors in the OECD area: 1.4 compared with an OECD average of 3.1 in 2006. It is very questionable as to whether this is a cost-effective skill mix. Also, Turkey appears to have a nurse graduation rate, at 30.7 graduates per 1 000 nurses, which is well below the OECD average of 45.7 in 2005. Yet, with respect to nursing training, unlike physician training, there are currently no plans for any major scaling up. It takes far less time and cost to the public purse to train a nurse than to train a doctor. The authorities might like to consider expanding both the training rate and the clinical role of nurses with a view to scaling up service delivery quickly in a cost-effective manner. Additional nurses could be trained within the timescale envisaged for completing the HTP.

Hospital autonomy

There is a new law, which is still under consideration in Parliament, on hospital autonomy, the intent of which is to gradually give public hospitals more freedom to act efficiently. The draft law proposes the establishment of local Executive Boards to govern public hospitals. It specifies the composition of the Board (experienced civil servants with a range of relevant qualifications), payment of Board members, the powers of the Board (to include hiring and firing of staff, contracting-out of services, including medical services, and the right to sell immovable and movable assets). The granting of autonomy would have to be “earned” on the basis of an assessment of each hospital’s performance.

As has been mentioned in the previous chapter, managers in Ministry of Health hospitals are already exercising some new freedoms: to employ contract staff; to use the performance management system to reward staff for performance; and to contract out some services to the private sector, such as catering and cleaning. It has been suggested, in Chapter 3, that these changes have been associated both with higher remuneration of medical staff and gains in productivity. Considerable investments have also been made by the MoH in distance-education programmes that train hospital staff in management. But further efforts are necessary in this area.

Experience in other OECD countries suggests that further “earned” autonomy, as envisaged in the proposed law, is almost certainly necessary to allow public hospitals to compete effectively with private hospitals and to realise the full potential for efficiency gains inherent in the new purchaser/provider split for hospital services in Turkey. However, additional training of managers may well be required to secure the necessary level of management competence to support autonomy. Also, it will be important for adequate information and incentives to be in place – such as completion of the DRG-payment system and of the new contracting arrangements with the SSI. Appropriate hospital information

systems tailored to decentralised decision making are also required. Given that a new form of behaviour must be learned in public hospitals for autonomy to succeed, it is right to allow time for such behaviour not only to be learned but also to be demonstrated. That suggests that dual MoH/autonomy regimes may have to co-exist among public hospitals for some years to come.

The role of the private sector in health-care delivery

The role of the private sector in health-care delivery is a critical issue for access, efficiency, and the future sustainability of the system. Turkey, unlike many other countries, has attempted to create a level-playing field in the sense of allowing private providers to treat, and be reimbursed for, publicly-insured patients. It has also encouraged the contracting-out to the private sector of support services in public hospitals. This has resulted in considerable growth of the private health sector during the past five years.

Despite an espoused policy which is supportive of private sector delivery, the MoH has increased performance bonuses to the extent that some 70% of MoH physicians are now full-time and no longer work in the private sector. Where the new family practitioner system has been established, it has more or less driven out the private sector for primary care in some provinces (e.g. Eskişehir). Similarly, the enormous growth in technology in the public sector may in some cases be duplicating existing private sector capacity and is putting further survival pressure on private diagnostic centres. On the other hand, the MoH is increasingly concerned about losing highly trained sub-specialists, who are in short supply, to the private sector, whereby, under the current extra-billing policies and unconstrained patient self-referral, private sector facilities in these shortage areas can pay higher salaries – between 1.5 to 2 times the salary levels in the public sector.

Legislation has now been put into effect to rationalise combined public and private delivery capacity. Nevertheless, given the shortage of skilled medical personnel, especially physicians, the authorities' role toward the private sector appears at times to be somewhat conflicted. While the matrix of policies is generally well designed to promote a vibrant public and private sector collaboration and competition in the longer term, in the medium term, compromises may have to be made because of constraints on the rate at which public hospitals can be safely granted autonomy and constraints on the rate at which hospital employees on civil service terms and conditions will dwindle because of retirements and resignations. The government must carefully balance all these concerns. Getting the incentives right and maintaining a level playing field on the provider-payment side are key concomitants for maximising the efficiency of joint public-private sector delivery capacity.

Governance and administration

There are a number of major governance and administrative issues concerning the MoH itself and other relevant government agencies such as the Ministry of Education and SSI that still need to be addressed. Some of these issues result from the fact that the changes in health system roles envisaged in the HTP are still in their initial stages. The MoH has not progressed very far in moving away from its role as a financier and provider of services, and the impetus for the SSI to take over fully its designated role as the payer for UHI is being attenuated. The SSI needs to enhance its capacities both in terms of its operational claims payment functions and as a policy-making body concerned with issues such as provider-payment reforms and how best to forecast the solvency and sustainability of UHI.

As has been mentioned above, the relationships and roles among the MoH, the Ministry of Education, the SSI, and the medical professional groups also require more clarity, particularly in the light of the proposed major expansions in the health workforce and what appears to be lack of a clear policy on the funding of medical education and medical research.

The final section of this chapter turns to the long-term issues that will challenge the Turkish health system once the HTP/UHI reforms have been completed.

4.6. Longer term issues facing the Turkish health system

In the longer term, when all Turkish citizens have access to health insurance and the system is fully modernised, some old challenges will remain and some new ones are likely to emerge. OECD countries which have reached the milestone of UHI, find invariably that they are still left with challenges concerning the prevention of disease, the full realisation of equity in access to services, containment of public and overall costs, long-term fiscal sustainability and the maximisation of efficiency.

Public health challenges

Some of the public health challenges alluded to in Chapter 3, are likely to persist or, in some cases, to worsen. Recent measures to improve the average educational attainment of children, by extending the period of compulsory education, will only gradually work their way through the population. Ingrained habits such as smoking are likely to be resistant to rapid change. Technological and lifestyle changes which encourage unhealthy diets and reduction in physical activity in the population, which in turn trigger obesity and chronic diseases, are likely to continue.

That suggests that inter-sectoral, prevention policies (across ministries) will be important, not only for improving health status in Turkey but also for reducing pressure on health expenditure. For example, the evidence cited in Chapter 3 shows that educational status plays a very important role in determining health status. That suggests that the Ministry of Health has a joint interest with the Ministry of Education in promoting higher levels of education, and higher levels of effectiveness in educational spending in Turkey, especially among girls. There are potential health gains and potential future savings in health expenditure to be added to the economic and cultural benefits which can be attributed to additional educational attainment.

Intersectoral policies are also required to tackle Turkey's growing disease burdens associated with poor lifestyles.¹⁰ In the case of smoking, there is a wealth of experience in many countries of developing cost-effective, cross-sectoral policies to reduce tobacco smoking and ample evidence that policies based on that body of knowledge have been used successfully to reduce smoking rates in many countries, sometimes dramatically.

Geographical inequities in access to services

Experience in other OECD countries suggests that geographical inequities in access to preventive and curative health services across Turkey are likely to persist even after the introduction of Universal Health Insurance. That is partly because historical inequities in the geographical distribution of the human and physical resources required for health care can remain in place for many years after the introduction of UHI. Such inequities are often perpetuated by the preferences that health-care professionals have for working in

economically, physically and socially attractive areas as opposed to, say, poor, remote areas or depressed, industrial areas. Extra-billing and dual (public-private) practice rules may exacerbate access inequities for disadvantaged groups and reduce equity, particularly between wealthier and underserved areas. Physicians and other health professionals will be motivated when taking up practice not only by the clinical load that a job entails and by the net income they can earn (after allowing, for example, for local variations in the cost of living), but also by many other factors such as housing, the lifestyle they can enjoy out-of hours, the quality of the local schools (if they have children), and job opportunities for their partners and opportunities for professional enrichment.

Continued attention to the pursuit of geographical equity in access to health services in Turkey is desirable, given the country's size and geographical diversity. On the demand side, careful monitoring of the flows of funds will be required, as money fully begins to follow patients, particularly in underserved areas. If such flows, after reimbursement formulae adjustments for appropriate geographic needs factors, still result in serious inequities, then the authorities will need to consider either further adjustments to the reimbursement formulae and/or direct geographic subsidies. An important step in such policy formulation would be to develop targets for equitable public spending on health care across different regions in Turkey and to aim to bring public spending gradually into line with these targets. What level of public spending in each region would provide equal treatment for equal need for health care across Turkey? Several OECD countries with mainly tax-funded financing of health care have established weighted capitation targets for steering the allocation of public resources for health care across geographical areas and some have gradually brought spending into line with these benchmarks (see, for example, Department of Health, England, 2005). Appropriate targets are identified with the help of formulae which adjust the crude population in an area by weighting it, typically, by the age-structure of the population (for age-related need), by indicators such as age-standardised mortality and socio-economic status (for additional need) and by measures of unavoidable variations in the cost of providing care across geographical areas (to allow for geographical price and wage variations). The Ministry of Health could be charged with developing such targets for regional UHI health spending in Turkey and the SSI with bringing geographical spending gradually into line with such targets over a specified period *e.g.* 10 or 20 years.¹¹

On the supply side, an important step would be to develop further Turkey's policies for encouraging health-care professionals to practice in areas where there are shortages. It has already been noted above that considerable improvements in Turkey's geographical distribution of physicians have been achieved under the HTP, albeit judged against crude, rather than weighted, capitation benchmarks. The OECD has published a Working Paper on the supply of physician services which addresses the question of the geographical distribution of physicians (OECD, 2006b). It identified a number of policies that have been adopted with some success in OECD countries to improve the distribution. They include: increasing overall numbers of physicians (but it is possible to reach saturation in some areas without eliminating shortages in other areas); using educational initiatives (including placing medical schools in shortage areas, selecting students who have grown up in such areas, and modifying the curriculum to expose students to experience of practice in such areas); using educational funding initiatives (such as providing scholarships or loans for medical education conditional on graduates taking up practice in a shortage area for a number of years); regulatory policies (such as restricting entry to practice in surplus areas and making the granting of a licence conditional on taking up

practice in shortage areas); and financial policies (such as raising remuneration or providing additional practice grants for practitioners in shortage areas).

Clearly, the financial policies mentioned here should complement the wage and price elements of the demand-side funding policies, mentioned above. In Turkey's case, there appear to be shortages (at least of GPs and FPs) in the East of the country and in Istanbul. The former appears to be related to economic weakness. The latter may be related to economic strength – which affects the unavoidable cost of living in big cities, of accommodation and of setting up a practice. In both types of areas, for quite different reasons, it may be necessary to pay relatively more for physician services and to adjust relative public funding allocations accordingly, to eliminate shortages and to ensure that patients throughout Turkey obtain equitable access to health care. This will almost certainly have implications for differentiating DRG rates and bundled outpatient payments geographically in Turkey. Many countries differentiate DRGs for geographical reasons, including France which pays a supplement of 7% in Paris-Île de France and a supplement as high as 30% on the Island of Réunion, on grounds of cost differences.

Cost-containment, the appropriate level of public and total spending on health care and fiscal sustainability

The new Turkish health system with universal coverage, a generous benefit package, fee-for-service (or DRG) incentives, and an expanded physical and human health infrastructure will mirror other OECD countries in terms of having to deal with persistent cost-containment pressures. Moreover, the very extensive basic benefits package available to the entire population will not constrain population expectations. There will be few financial barriers to access – the price of services will be highly subsidised, even if appropriate co-payments are required. Over time, cost-increasing technological change will add not only to the effectiveness of services that can be offered to existing patients but will also extend the range of diseases and patients for whom effective medical care can be offered. All of this will mean high and rising expectations and demand. Meanwhile, on the supply side, growing numbers of physicians will find many new opportunities to prescribe improved drugs, order newly available diagnostic services, and to refer patients to higher levels of care. And the payment of hospitals by DRGs – a bundled form of fee-for-service – along with the potential for extra-billing for private hospitals will make hospital providers eager to expand services. Any rise in GDP will be double-edged. It will help to add to the fiscal capacity to fund higher public spending on health. But it will also raise patient expectations and, more subtly, help to generate an adverse relative price effect.

These characteristics of the new Turkish health system will make it important not only to build into the system cost-containment “brakes” for public and perhaps overall spending on health care but also to use them firmly and regularly. The main cost-containment “brakes” available to Turkish policy-makers include: “hard” global caps on all public spending on health care including SSI payments to private hospitals – to be applied, for example, by the Treasury to the health budget of the SSI; suitable levels of co-payments for patients accessing services; control on the number of physicians in Turkey once an “appropriate” level has been reached; and, of course, continual improvements in micro-economic efficiency – a topic dealt with in the next section. Policy-makers also need to consider additional tougher risk-sharing arrangements including policies such as penalising hospital physician groups for overrunning their prospectively agreed-upon hospital budgets (International Monetary Fund, 2007). As discussed above, despite Turkey's

apparent success in keeping expenditures more or less in line with its significant economic growth during the past five years (Akdağ, 2008), both the OECD experiences and global evidence, cited above, suggest that a mature modern health system with universal coverage of an extensive benefit package and with widespread availability of the latest technologies, the situation that Turkey is rapidly approaching, will face serious expenditure pressures. Box 4.1 provides some rather stark projections of the potential unsustainability of such a system unless a combination of strong cost-containment measures, both on the demand and supply sides is adopted.

Virtually all OECD countries (except the United States which is currently spending some USD 7 000 per person and over 16% of its GDP on health) cap public spending on health in one way or another. Sometimes this takes the form of specific caps as in Germany and certain Canadian provinces (International Monetary Fund, 2007) and in other cases excess expenditures are offset through continually declining fees, as in Japan. Turkey has experience with caps for public hospitals and, as has been mentioned above, needs to apply

Box 4.1. Actuarial analysis of alternative growth paths for health expenditure, 2008-33

Without cost-containment measures, efficient levels of health spending are not likely to be achieved under UHI. The following actuarial analysis, which has been carried out in conjunction with experts in SSI, Treasury and SPO (see Mays *et al.*, forthcoming), presents alternative “cost containment” and “non-cost containment” scenarios for total and public health spending in Turkey, 2008-33. The two scenarios presented here differ mainly because of alternative assumptions about the excess rate of growth of health expenditure over GDP resulting from varying degrees of cost containment. The cost containment scenario assumes that Turkey will continue to control health expenditure growth as it has done in the past – with the annual percentage growth in health expenditure exceeding the annual percentage growth of GDP by some 7% over the 25 year projection period. The non-cost-containment scenario assumes that Turkey will start to behave like other OECD countries which have largely achieved universal coverage, where the percentage growth in health expenditure exceeds the percentage growth in GDP by 29% per year. Both scenarios also take explicit account of population aging. Under the cost-containment scenario, health spending would only increase 1.09 percentage points a year faster than GDP. Under the non-cost-containment scenario, health spending would increase 2.41 percentage points per year faster than GDP. Table 4.2 illustrates the differential health expenditure and fiscal impacts of the two scenarios.

The differences are rather stark. With cost-containment measures, overall health spending would only increase by 1.5 percentage points from 5.9% of GDP in 2011 to 7.4% by 2033. SSI health spending as a share of GDP would increase by 0.9 percentage point from 3.6 to 4.5%. The general revenue contribution would increase from 1.2% of GDP to 2.1%, and the general revenue share of SSI would increase from 33% to 46%, a significant but perhaps not unsustainably large increase. Without cost-containment measures a different picture emerges: health spending would increase by 3.8 percentage points from 5.9% of GDP in the base year to 9.7% in 2033. SSI health spending as a share of GDP would increase by 2.4 percentage points from 3.6% to 6.0% of GDP. More problematically, the general revenue contribution would increase from 1.2% of GDP to 3.5% of GDP, and the general revenue share of all SSI revenues would increase from 33% to 60% (assuming fixed contribution rates and wages growing in line with GDP).

Box 4.1. Actuarial analysis of alternative growth paths for health expenditure, 2008-33 (cont.)

To put this in an affordability context, without cost containment would the authorities be able to reallocate over 2 percentage points of central government spending as a share of GDP from other areas of government spending to health care? As central government spending in Turkey is currently slightly more than 20% of GDP, would the authorities be able to reallocate 10% more of the budget to health with a consequent reduction of 10% for other critical public spending priorities such as infrastructure and education? Alternatively, would Turkey be able to increase its revenue to GDP ratio by an additional 2 percentage points (also, roughly, a 10% increase) per year to accommodate such potential future health expenditure increases? While these figures are rough, they do provide an indication of the importance of controlling health expenditures as a key concomitant of having UHI. The cost containment “brakes” which could bring about such control of health expenditures, have been discussed in the paragraph above this box.

Table 4.2. Alternative cost scenarios under UHI

	Total health expenditure as % of GDP	Public spending on health as % of GDP	SSI health spending as % of GDP	SSI general revenue share as % of GDP	SSI general revenue as a share of all SSI revenue
Cost-containment scenario					
2011	5.9	4.6	3.6	1.2	32.9
2033	7.4	5.7	4.5	2.1	46.3
Non-cost-containment scenario					
2011	5.9	4.6	3.6	1.2	33.4
2033	9.7	7.6	6.0	3.5	59.5

Source: Mays et al. (forthcoming).

them to public spending in private hospitals, also, particularly as some of the most recent spending information shows the largest increases coming from private hospital services.

Many OECD countries also manage the number of admissions to medical schools or to post-graduate medical training with a view – among other things – to controlling costs indirectly. Deciding on the “right” growth path for the number of physicians through time in Turkey will be an important and difficult decision. The HTP has highlighted the scarcity of physicians in Turkey, now at about 1.5 per 1 000. As has been mentioned above, the government has decided to raise the medical student intake from about 4 500 to about 6 000 per annum which is likely to raise the graduation rate per 1 000 physicians above that of any other country in the OECD area. An analysis of the age structure of the physician workforce indicates little expected attrition due to retirement in the next 20 years. Half of doctors are aged under 35. Hence, the existing rate of expansion in the physician workforce (see Chapter 3) will accelerate, other things being equal, from six years onwards.

Clearly, it is right to increase physician numbers when services are required to expand to meet unmet needs or to raise quality because of the implementation of policies such as UHI, and the establishment of family practitioner services. But at some stage, these requirements will be met and diminishing returns will set in. At that point, supplier-induced demand may become a problem rather than a blessing. Meanwhile, there is evidence that increasing physician density in health systems that pay by fee-for-service raises health expenditure, other things being equal (OECD, 2006c). Also, it may be

significant that in other OECD countries with Bismarckian health systems, there seems to be some correlation between doctor density and the health expenditure share of GDP.

In Turkey, if a significant share of new medical school graduates becomes family practitioners, much of the increased medical school enrolment will be absorbed to address shortages in family medicine, which will allow an effective referral system to be established. In that case, supplier-induced demand may be benign rather than perverse, particularly if coupled with effective referral and risk-sharing requirements. For this reason, it is crucial that the MoH ensures that capacity and incentives for specialising in family medicine are strong.

Productivity and microeconomic efficiency

Continuous productivity and efficiency improvements will be required if the new Turkish health system is to deliver improving quality of health care at an acceptable cost – especially an acceptable public cost. As mentioned above, gains in microeconomic efficiency can make a crucial contribution to finding the “appropriate” level of health spending. It seems certain that even if the main structural changes envisaged in the HTP are completed by 2013, a considerable agenda will remain for delivering the efficiency improvements envisaged in the programme.

Active purchasing by the SSI

As the dominant purchaser of health services in the new Turkish health system, the SSI will be in a strong position to shape both the quality and cost of health services. It will be important for the SSI to continue to acquire the management skills to exercise that function. SSI management capacity will be particularly important in relation to: processing and analysis of claims; undertaking of actuarial analyses and economic modelling; and developing, testing and implementing incentive-based payment systems.

Family practitioners

Although FPs may serve the whole population by 2013, the list sizes will still be around 3 000 at best. To allow an effective referral system to be established, it may require further expansion of FP numbers and a rise in the range and quality of services provided in family practice centres. At that point, it might be appropriate to introduce the tougher risk-sharing approaches which are characteristic of many managed-care arrangements in the United States. In addition to re-introducing negative incentives for family practitioners for excessive referrals, consideration might be given to allowing primary care physicians to share in savings from unnecessary prescribing, diagnostic tests and referrals. A further step would be to introduce hospital and pharmaceutical budget-holding for FPs.

Hospitals

Although the contracting system between the SSI and hospitals with payment by DRGs is likely to be in place by 2013, it is unlikely that all hospitals will have achieved autonomy by then. Those that have achieved autonomy may still be learning the skills and behaviour that will be required to operate successfully with more freedom in a more competitive environment. Many hospital staff may remain on civil-service contracts for some years to come. Given that the scope for market competition may remain limited in Turkey for some years to come, especially in areas where the population cannot support more than one hospital, it may be desirable to introduce benchmark or yardstick competition between hospitals.¹² That will be facilitated when the new DRG payment

system is in place – but it will also be desirable to develop better indicators of the clinical quality of care and of patient satisfaction. The authorities should also tackle the low hospital occupancy rates, through payment incentives, and effective planning.

Information technology

Some of the steps that Turkey is already taking to develop IT and eHealth Systems under the HTP have been described in Chapter 2, above. However, there is a significant need for Turkey to continue these efforts and to implement the needed information systems for its reforms at all levels including in hospitals and physician practices. Data for decision making and effective monitoring and evaluation are critical and often neglected concomitants of any serious reform effort. There is widespread agreement that IT offers great potential for enabling improvements in the efficiency of health-care delivery. Major areas for the application of IT include: storing, managing and sharing data (especially clinical records); informing and supporting clinical decision making; and delivering expert professional and clinical care remotely. A particular medium-term goal in many OECD countries is to establish a national electronic health record for each insured individual which can be accessed by health-care professionals on all occasions that care is sought. There are many commercial interests already eager to offer hardware and software in all three areas. In addition, several OECD governments have issued nation-wide strategies, set targets and established co-ordination bodies aimed at developing health information infrastructures for eHealth. For example, the UK launched the “National Programme for Information Technology in the National Health Service” in 2002 and Canada established “Health Infoway” in 2001 to foster and accelerate the development and adoption of electronic health information systems. More recently, in 2004, Australia established a National eHealth Transition Authority team, responsible for a new national health information strategy. The IT/ehealth agenda is moving at a different pace both across countries and within countries and according to different applications. Levels of national investments also vary widely across OECD countries. The United Kingdom has been reported to be spending over EUR 15 billion on computerising the National Health Service, while funding agreements between the Minister of Health and Canada Infoway amounted to CAD 1.6 billion by 2007. However, national programmes, strategies and investment approaches taken are only part of the picture. In a significant number of countries, local jurisdictions are carrying the highest burden. The result is the emergence of distinct “local” IT/ehealth agendas and strategies that reflect local priorities and constraints in some countries.

An extensive review of the literature on applications of IT in healthcare (Car *et al.*, 2008), has suggested that there is a vast gulf between the potential advantages associated with eHealth applications and the actual empirically demonstrable benefits. There is a lack of evaluation evidence and many of the studies which do show benefits tend to focus on integrated systems, such as Kaiser Permanente and the Veterans Health Administration in the United States (Garrido *et al.*, 2005; Evans *et al.*, 2006). Where experience has been disappointing, there is a “general consensus” that organisational issues and human factors are at the root of the problems (Car *et al.*, 2008). That is to say, the potential of technological solutions is often not realised because the applications have not been designed with sufficient understanding of the users, their interactions and their limitations.

A tentative interim conclusion is that many programmes are progressing more on the basis of potential cost-avoidance (*i.e.* on the prospects of not incurring future costs) and on the basis of anticipated improvements in the quality of care and patient safety, rather than

on the basis of reducing current costs (cost-savings). Many eHealth investments may prove to be cost-increasing rather than cost-saving – although the additional benefits may well outweigh the additional costs.¹³

Pharmaceutical consumption

Pharmaceutical expenditure accounts for some one third of total health expenditure in Turkey. Moreover, it is likely to grow faster than overall health expenditure (as observed in almost all OECD countries over the past 20 years); reasons are:

- Innovation (new, effective but very expensive drugs replacing older, cheaper treatments or addressing conditions that were untreatable so far).
- Improved access to health care, more physicians – leading to a higher rate of discovery of existing conditions such as diabetes and high blood pressure that require drug treatment.
- Growing incidence of chronic diseases, caused by lifestyle factors and aging populations and requiring long-term medication.

That suggests that efforts to improve the rationality of prescribing and to lower the price paid for drugs are particularly necessary. Suggestions for improving efficiency include: more extensive use of the pharmaceutical cost-management toolbox, with a focus on 1) creating competition in the generic drugs market (a role model is Germany, where the patient copayment is waived for the cheapest generics); 2) introduction of binding physician guidelines for rational use of medicines linked to a solid monitoring system, feedback and financial incentives; and 3) expert support for the Reimbursement Commission and increased transparency to ensure that assessment of the cost-effectiveness of drugs plays a major role in reimbursement decisions.

Health technology assessment

The last suggestion, above, for pharmaceuticals, can be generalised: Turkey needs to develop a capacity to deploy health technology assessments and cost-effectiveness evaluations in decisions about the funding and management of health care. It may not be necessary for Turkey, itself, to develop the capacity to undertake original clinical and cost-effectiveness studies across the whole range of health technologies. There is now a growing body of international literature on evidence-based medicine and on health technology assessments which is openly accessible everywhere. However, Turkey may need to develop its existing capacity to access that evidence and to adapt and interpret it to Turkish circumstances. The National Institute for Clinical Excellence (NICE) in the United Kingdom may be a useful model for Turkey to consider in making coverage decisions regarding new technologies (Miners *et al.*, 2005).

4.7. Conclusions and key suggestions for the future

This section draws out some conclusions from the report above and makes some key suggestions for the future (Box 4.2).

Preliminary indications are that the HTP has been successful

The Health Transformation Programme in many ways reflects “good practice” in the development and implementation of a major health sector reform including UHI coverage in an OECD country. Strong government commitment and leadership along with major

financing reforms aided by strong economic growth have been complemented by sequential delivery system 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 that there has been 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 in relation to other comparable upper middle-income countries. There may be much that other countries can learn from the recent health reforms in Turkey.

But there remain both old and new challenges in the Turkish health system

However, some old challenges remain and some new ones have been created. The most important remaining challenge which appears to face the health system in Turkey 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 will be how to do this while maintaining the sustainability of public spending on health. Because of the design of the new health system in Turkey, 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: allow control to be maintained over the rate of growth of health expenditure; encourage further improvements in efficiency; continue progress towards equity in access; and assure continued high levels of financial protection. Another challenge will be to raise sufficient revenues to assure the financial solvency of UHI.

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 and/or of prices 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. These measures should allow GP services to be withdrawn – or partially withdrawn – from hospital outpatient departments and will reduce the pressures on teaching 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. As has been indicated above, 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 the 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 IT; health technology assessment; and the size and skills of the nursing workforce. 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. Also, 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.

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 DRG 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 through both improved tax administration and 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.

Health system reform is a perpetual process. At this early stage in its implementation, Turkey appears to be one of the few middle-income countries to be implementing a “big bang” reform effectively. The HTP represents both an important improvement in Turkey’s social welfare system and a “good practice” example for other countries struggling with the

Box 4.2. 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 supply, 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 service
 - ❖ 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 with, 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 MoH

same issues. Yet the ultimate success of the program, including its sustainability, will very much depend on the difficult policy and implementation decisions that the Turkish authorities are still in the process of addressing. International experience suggests that the right choice of policies and their effective implementation will be required to ensure the financial sustainability of the health system in the long-term and continuing improvement in the health status and well-being of the Turkish people.

Notes

1. Few studies define what is meant by “successes”, contain rigorous evaluations, have enough details of the health system to be able to address the full range of complex health and key cross-sectoral interactions affecting outcomes, and many often lack critical underlying data on health outcomes, costs, and financial protection.
2. Gottret and Schieber (2006) and Gottret *et al.* (2008). An OECD perspective can be found in OECD (2004a) and OECD (2004b). The latter contains a chapter by Docteur and Oxley on “Health System Reform: Lessons from Experience”.
3. Gottret and Schieber (2006), Chapter 9, Gottret *et al.* (2008), Chapter 5.
4. The World Bank, in collaboration with the Government of Turkey, will be undertaking a major study on public health in Turkey in 2008/09.
5. Turkey’s revenue to GDP ratio is below the levels of other comparable upper middle income countries. See George Schieber, “Overview of Health Financing”, presentation made at the Senior Policy Seminar, Ankara, Turkey, 29 May 2008.
6. See International Monetary Fund (2008) and World Bank (2006a) for discussions of the overall expenditure and revenue situations in Turkey as well as the potential fiscal space pressure, in part engendered by increases in government spending on health.
7. Acknowledgement is due to William Hsiao, “Enrolling Informal Sector Workers and the Poor”, presentation made at the Senior Policy Seminar, Ankara, Turkey, 29 May 2008.
8. Certain policies that may differentially affect university hospital efficiency include: the ability of full-time university faculty to have private practices inside and outside the hospital, full freedom of choice of patients to self-refer to any level of hospital, the performance standards used in university hospitals; and current funding modalities for medical education and medical research.
9. Department of Family Medicine, May 2008. The number may be somewhat higher if services provided outside the office and preventive health-care services are also included.
10. In the case of what might be called more “modern” epidemics, such as the epidemic of obesity and its many adverse health consequences, including diabetes and cardio-vascular disease, there is not yet a good body of evidence on what interventions are cost-effective. The OECD is currently reviewing the economics of prevention, with a special focus on chronic diseases related to poor diets and lack of physical activity, and a report is planned for the end of 2008. Among other things, this will review evidence on the cost-effectiveness of interventions to tackle poor diets and lack of physical activity. It will also contain a review of policies in OECD countries on these issues.
11. A fairly long time horizon would be needed to avoid forcing losing areas to cut services in absolute terms, which would be politically very difficult to enforce, and to allow gaining areas to put additional resources to productive use, which may involve adjusting human and physical capacity. Indeed, Ministry of Health action on the supply-side may be needed to complement UHI policies on the demand side to bring spending into line with targets.
12. “Benchmark” or “yardstick” competition refers to a process in which, typically, a dominant purchaser enters into negotiation with providers about improving their contractual performance in terms of costs, volume or outcomes, on the basis of suitable performance indicators, or benchmarks, which are designed to be comparable across providers. Such indirect competition can be contrasted with direct, market competition, typically driven by many purchasers choosing between providers – although such market competition might also be informed by suitable performance indicators.
13. The OECD is carrying out a review of the application of IT in Health and will be publishing a report by the end of 2008.