Currency Equivalents
Exchange Rate Effective = September 1, 2001
Currency Unit = Turkish Lira (TL)
US$ 1 = TL 1,500,000

Government Fiscal Year
January 1-December 31

Weights and Measures
Metric System

Abbreviations and Acronyms

AIDS Acquired Immune Deficiency Syndrome
CPI Consumer Price Index
DHS Demographic and Health Survey
ECA Europe and Central Asia
EU European Union
GDP Gross Domestic product
HIV Human Immunodeficiency Virus
MDG Millennium Development Goals
MOH Ministry of Health
MOLSS Ministry of Labor and Social Security
OECD Organization for Economic Co-operation and Development
PPP Purchasing Power Parity
SPO State Planning Organization
SSK Sosyal Sigortalar Kurumu
STD Sexually Transmitted Diseases
TL Turkish Lira
UNFPA United Nations Population Fund
WHO World Health Organization

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Turkey: Reforming the Health Sector for Improved Access and Efficiency

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Structure of the report</td>
<td>3</td>
</tr>
<tr>
<td>3. Key findings</td>
<td>5</td>
</tr>
<tr>
<td>3.1 Health of the people</td>
<td>5</td>
</tr>
<tr>
<td>3.2 Utilization of health services</td>
<td>7</td>
</tr>
<tr>
<td>3.3 Supply of health care</td>
<td>10</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>13</td>
</tr>
<tr>
<td>Private Health Sector</td>
<td>16</td>
</tr>
<tr>
<td>Issues and Concerns</td>
<td>17</td>
</tr>
<tr>
<td>3.4 Human resources in the health sector</td>
<td>18</td>
</tr>
<tr>
<td>Physician Earnings</td>
<td>21</td>
</tr>
<tr>
<td>Issues and Concerns</td>
<td>21</td>
</tr>
<tr>
<td>3.5 Organization and management</td>
<td>22</td>
</tr>
<tr>
<td>Shared beliefs and values</td>
<td>22</td>
</tr>
<tr>
<td>3.6 Health financing</td>
<td>24</td>
</tr>
<tr>
<td>Structure of health financing</td>
<td>24</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>25</td>
</tr>
<tr>
<td>Social Security Institutions</td>
<td>26</td>
</tr>
<tr>
<td>The Green card program</td>
<td>27</td>
</tr>
<tr>
<td>Population Coverage</td>
<td>28</td>
</tr>
<tr>
<td>Distribution of public expenditures</td>
<td>29</td>
</tr>
<tr>
<td>3.7 Pharmaceutical consumption and production</td>
<td>31</td>
</tr>
<tr>
<td>Issues and concerns</td>
<td>33</td>
</tr>
<tr>
<td>3.8 Impact of economic shocks on the health sector</td>
<td>33</td>
</tr>
<tr>
<td>Economic Crisis and Demand for Health Services</td>
<td>35</td>
</tr>
<tr>
<td>Economic Crisis and Health Insurance</td>
<td>36</td>
</tr>
<tr>
<td>Issues and Concerns</td>
<td>37</td>
</tr>
<tr>
<td>3.9 Health-Related Millennium Development Goals</td>
<td>38</td>
</tr>
<tr>
<td>Antenatal Care</td>
<td>40</td>
</tr>
<tr>
<td>Delivery Care</td>
<td>40</td>
</tr>
<tr>
<td>4. Health reform strategy</td>
<td>43</td>
</tr>
<tr>
<td>4.1 Universal Coverage: The Case for Social Health Insurance</td>
<td>48</td>
</tr>
<tr>
<td>Private health insurance</td>
<td>50</td>
</tr>
<tr>
<td>Advantages of Private Insurance</td>
<td>51</td>
</tr>
<tr>
<td>Disadvantages of Private Insurance</td>
<td>52</td>
</tr>
</tbody>
</table>
Coverage Options under Private Health Insurance ............................................................ 54
Public versus Private Financing.......................................................................................... 55
Moving toward a single-payer universal social health insurance system ................................... 55
Cost containment .............................................................................................................. 58
4.2 Developing a package of essential services and targeting public spending................ 60
Developing a package of essential services ........................................................................ 61
Reaching essential services to the poor ............................................................................ 63
4.3 Reorganizing public hospitals and providing greater autonomy ............................... 64
4.4 Consolidating and redefining institutional responsibilities ......................................... 68
4.5 Strengthening delivery of primary care services ......................................................... 71
Epidemiological surveillance and data collection .............................................................. 72

5. Conclusion: An Action Plan for Implementation of the Health Sector Reforms ............... 73
References ......................................................................................................................... 81

List of Tables

Table 1 - Out-of-Pocket Payments on Health Care (by quintile), 2001 ............................... 9
Table 2 - MOH Health Centers and Health Posts Lacking Key Staff .............................. 12
Table 3 - Percentage of Primary Care Health Staffing Posts Filled ................................. 13
Table 4 - Distribution of Hospital Beds and Physicians by Provider, 2000 ...................... 13
Table 5 - Hospital Efficiency by Hospital Size (all hospital types), 2000 ......................... 14
Table 6 - Population Covered by Green Cards, 1992-2001 ............................................. 27
Table 7 - Population Coverage (Health Insurance and Green Card), 1999-2000 ............. 30
Table 8 - Per Capita and Total Consumption of Pharmaceutical Products, 1998-1999 ................................................................. 32
Table 9 - Health Sector Reforms - Objectives and Mechanisms ......................................... 45
Table 10 - Provider Payment mechanisms in EU Accession Countries ............................ 59
Table 11 - Key Health Reform Measures for Short and Medium-Term ......................... 73
Table 12 - Estimated One-time Costs of the Measures Proposed as Part of the Reform Package ................................................................. 77
List of Figures

Figure 1 - Maternal Mortality Ratios, Selected European Countries, 1998 ................ 5
Figure 2 - Percent That Sought Treatment Among Those That Reported Illness .......... 8
Figure 3 - Propensity to Seek Treatment (by region and location) ...................... 9
Figure 4 - Trends in Number of Health Personnel (1990-1999) .......................... 19
Figure 5 - Distribution of Health Personnel ................................................... 19
Figure 6 - Public Expenditures on Health, 1996-2002 (2001 prices) ..................... 25
Figure 7 - MOH Health Expenditures, 1996-2002 ......................................... 26
Figure 8 - Health Expenditures by Social Security Institutions (% of GNP) ............. 26
Figure 9 - Annual Health Expenditures and Income, 2001 (million TL) ............... 31
Figure 10 - Public Expenditures on Health, 1998-2001 (billion TL) ...................... 34
Figure 11 - Percent Population Seeking Treatment When Ill, 1999-2001 ............... 36
Figure 12 - Bagkur Health Expenditures .................................................... 37
Figure 13 - New Green Card Applications, 1998-2001 .................................... 37
Figure 14 - Use of Selected Health Services in Turkey: Poor-Rich Differences ....... 39
Figure 15 - Antenatal Care Visits .............................................................. 39
Figure 16 - Skilled Attendance at Delivery ................................................... 40
Figure 17 - Health System in Turkey (after reform) ....................................... 56

List of Boxes

Box 1 - Making Basic Health Accessible to All: The Case of Mexico .................. 47
Box 2 - Staffing Outlying Health Facilities in Indonesia .................................. 64
Box 3 - What is Autonomy? ................................................................. 66
Box 4 - Hospital Autonomy in Poland ....................................................... 67
Box 5 - Regulatory Constraints .................................................................. 69
EXECUTIVE SUMMARY

Despite considerable progress achieved in the recent past, Turkey continues to rank far behind most middle-income countries in terms of the health status of its people. Life expectancy is nearly ten years below the OECD average, and infant and maternal mortality rates are among the highest of middle-income countries. By most accounts, the health sector in Turkey is underperforming in achieving health outcomes, and if the current situation is any indication, substantial and sustained efforts will have to be made in the coming years if Turkey is to meet the health targets of the Millennium Development Goals by the year 2015.

The reasons for such low outcomes are varied. On the financing side, in addition to the fact that there are multiple problems with mobilization of resources, the available resources are not allocated efficiently and equitably. Public provision of health is characterized by poor incentives for managers and providers alike, leaving them open and vulnerable to alternative sources of income to augment their meager salaries. The delivery of health care is also fragmented, and the practice of integrated health services is rare. The potential of the private sector is not fully realized and its role and responsibilities are not adequately defined. Access to clean water, satisfactory sanitation and education – all known to be powerful determinants of good health – is uneven, and large populations in rural areas and in the Eastern regions of the country lack even the basic amenities. The present situation, therefore, is one in which reported health expenditures are low for a country at the level of economic development of Turkey, the poor do have erratic access to health services and the health status of the population is well below that of countries of comparable income.

Many efforts have been made in recent years to identify the root causes of the problems in the Turkish health-care system, but the assessments have frequently been inadequate and incomplete. This study makes a start at thinking about these issues, and takes stock of the current situation in the health sector in Turkey in an effort to identify and examine the key issues related to the various constituents of the health system. An evaluation at this juncture is meant to lay the foundations for the development of a medium-term health sector strategy and a prioritized action plan aimed at improving access to health services, enhancing equity in utilization, increasing cost-effectiveness, enhancing quality of care and improving health outcomes overall.

Detailed background studies were carried out to examine the trends in health status of Turkey’s population and evaluate the structure of production, finance, delivery and organization of the country’s health system. The key findings of these studies are:

- The health status of Turkey’s population is poor, both in absolute terms as well as in comparison with other countries at same levels of income; in particular, maternal and child mortality and morbidity rates are very high.
- There are huge locational and regional disparities in health outcomes across almost all indicators.
- Not all those who are ill are able to get treatment for their illness; in particular, the poor are significantly more likely to not get treatment when ill compared to the non-poor.
Knowledge of health conditions and treatments has a significant bearing on seeking care, and those with greater awareness of health conditions and treatments seek care more often compared to those with lower levels of awareness.

Health insurance is also a strong determinant of seeking care when ill, and those without any form of financial protection seek care less often when ill relative to those who have some form of financial protection.

The primary health care system is substantially underfunded and ineffective; in particular, most people circumvent public primary care facilities and either directly seek care at outpatient facilities of hospitals or, if they can afford it, from the private sector.

A large number of health centers are understaffed and many do not have even one physician; the situation is particularly grim in rural areas in general and in the Eastern and South Eastern Anatolia regions of the country.

Majority of general hospitals in Turkey are run inefficiently and are responsible for considerable waste of resources.

The large number of very small hospitals under the Ministry of Health is a major contributor to an inefficiently run hospital system; in particular, they suffer from a lack of manpower and outdated or ill-functioning equipment. As a result, people utilize larger facilities even if they are further away, and the bed-occupancy rates in the smaller hospitals are very low.

There are huge gaps in the distribution of health personnel among the provinces and regions; in particular, there is a concentration of physicians in the big cities and towns and rural areas are significantly understaffed.

Considerable imbalance exists between physicians in primary and specialty care in Turkey, and almost half of all physicians in patient care are specialists.

There is little or no coordination between the Ministries of Health and Labor who, between them, control most financing and provision of health care in Turkey; in particular, even though their activities overlap across most services and they have facilities in the same towns and cities, there is very little discussion and dialogue between them and almost no planning or collaboration at any level.
• Very little is spent on preventive care and on maternal and child health; in fact, allocations to preventive activities have fallen in real terms over the last five years.

<table>
<thead>
<tr>
<th>Distribution of Health Personnel</th>
</tr>
</thead>
<tbody>
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<td>Population per Health Personnel</td>
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- a) Physicians, Nurses, Midwives

• Large segments of the population do not have adequate health insurance or any other form of financial protection; in particular, over 50 provinces have 10 percent or more of their population not covered under any insurance or Green Card program.

• The distribution of public expenditures on health is not equitable; in particular, the richer regions spend more public money per person on health care compared with the poorer regions.

• Income inequality and inequity in health status and utilization constitute a formidable barrier to meeting the health-related Millennium Development Goals.

These findings suggest that in order to meet the ultimate objective of improving the health status of the people, fundamental and systemic changes would be required in the ways that health care is financed, delivered, organized and managed in Turkey. Piecemeal changes at the margin are unlikely to revitalize the health system, and nothing short of major restructuring and reorganization of the health system will work if the country’s population has to be given access to quality health services produced and delivered in an economically and institutionally sustainable environment. Any reform strategy aimed at addressing the health sector problems in Turkey thus has to essentially be shaped around at least five programmatic areas, that include (i) improvements in resource mobilization and allocation; (ii) enhanced access to health services; (iii) increase in demand and utilization of health services; (iv) improvements in efficiency in production and delivery of health services; and (v) improvements in clinical effectiveness of health services.
The key elements of the proposed health reform strategy are as follows:

**Compulsory universal social health insurance, with optional supplemental private insurance**
The different health insurances being offered through SSK, Bagkur and Emekli Sandigi, and the coverage provided to civil servants and welfare programs like the Green Card should be combined into one compulsory social health insurance system, or the Health Fund (HF). The establishment of the Health Fund – which should be founded as an autonomous legal umbrella organization, preferably under the Ministry of Labor and Social Security, the only government administrative body with experience in managing insurance – should be part of an overall reform of the social security system, so that SSK and Bagkur continue to function as social security institutions but transfer all health insurance premium collections to the Health Fund. Similarly, all active civil servants should become members of the Health Fund, with their parent departments paying the health insurance premiums directly on their behalf. Likewise, Emekli Sandigi should also transfer all health insurance premiums to the Health Fund, and the Green card program should be folded into the Health Fund, with the state paying premiums on behalf of those who cannot afford to pay themselves. The Health Fund should enjoy a high degree of autonomy and be professionally managed.

The services covered by the Health Fund should include routine physician visits, routine obstetrics and gynecological visits, well baby visits, immunizations, emergency room visits, general ward hospital stays, surgeries, ambulatory surgeries, chemotherapy and radiation therapy, deliveries, mental health and substance abuse, routine eye exams, hearing aids, laboratory services, X-rays, and prescription drugs (generics where available). Services not covered by the Health Fund – such as over-the-counter drugs, brand name prescription drugs where generics are available, frames, lenses and contact lens, cosmetic surgery unless required as rehabilitation, non-emergency use of emergency room, shared and single-room stays in hospitals, speech therapy for non-acute medical conditions, long-term rehabilitation, home health care, durable medical equipment, and home nursing – may be covered by optional supplemental private health insurance.

**Developing a package of essential services and targeting public spending**
Several factors other than health services, genetics and lifestyles affect health at the population level, and malnutrition, poor water supply, sanitation and personal hygiene, and tobacco use are among the major risk factors for population health. In order to reduce maternal and child mortality and morbidity, therefore, health care should be delivered as part of a package of essential services, which should include (i) evidence-based and cost-effective medical interventions based on such tested initiatives as WHO’s “Making Pregnancy Safer Initiative” and WHO/UNICEF’s “Integrated Management of Childhood Illness”; and (ii) a series of measures aimed at providing all-purpose health education, clean drinking water, basic household sanitation, timely immunizations, home care of pregnancy and home management of diarrhea.

In order to reach the package of essential services to the poor, incentive-compatible strategies should be devised so as to get medical personnel to work in areas where the poor live. These incentives may include extra remuneration, shorter duration of posting, posting in place of choice after serving in a shortage area, and admission to specialization programs. Another approach worth considering is that of cluster staffing, whereby physicians accept posting in a district or
sub-district location and, by rotation, attend to patients in nearby traditionally shortage areas. District and sub-district hospitals should supply transportation and support staff to facilitate the movement of physicians to these areas.

The role and effectiveness of paramedical staff in bringing the package of essential services to the poor and the vulnerable in underserved areas also needs to be examined. The key question in this context is whether the basic services that are likely to reduce maternal and child morbidity and mortality are such that paramedical personnel, without the direct supervision of physicians, can deliver them. This is an area that needs further research, but if it is found that a large number of services can, in fact, be delivered by nurses and other paramedical staff, then the obvious strategy would be to hire and train nurses locally in the underserved areas – so that they are less likely to feel the pressure of the location – and deliver the package of essential services for the reduction of maternal and child morbidity and mortality through them. Not only would this be a much less expensive proposition, it would also lead to higher utilization of health services because of the greater familiarity of the patients with the health care provider.

Reorganizing public hospitals and providing greater autonomy

In order to improve hospital efficiency, it is suggested that all hospitals, particularly MOH and SSK hospitals, be granted administrative and financial autonomy and autonomy in the procurement of necessary inputs to produce and manage health services. The autonomization of MOH and SSK hospitals should be done in a phased manner. In the first phase, the collective organization of hospitals will be given autonomy. All MOH hospitals should be consolidated under one quasi-public legal entity under the Ministry of Health, and this quasi-public legal entity should be made autonomous of the parent Ministry. Likewise, the health facilities of SSK should be separated from rest of SSK operations and consolidated under a separate quasi-public legal entity, and this quasi-public legal entity should be made autonomous of the parent Ministry of Labor and Social Security. Both autonomous organizations should have their own governing bodies, and in order to ensure coordination and collaboration, both ministries of Health and of Labor and Social Security should be represented at a senior level on both the governing bodies. In the first phase, the employees of MOHHC and SSKHC will retain their civil servant status.

In the second phase, individual facilities should be given autonomy on a selective basis. In order to become autonomous, the individual facilities would need to demonstrate their capacity and readiness for self-governance. All employees of the health facilities will become contract employees of the respective corporations in this phase, and have long-term open-ended contracts. The phased introduction of autonomy will allow time and opportunity for individual facilities to gather the required knowledge, experience and managerial acumen necessary for self-governance.

Consolidating and redefining institutional responsibilities

Both Ministry of Health and the Ministry of Labor and Social Security have critical roles to play in the health care system in the country, given their experience, their existing investments and their respective influence in the health sector. Yet, the present responsibilities and relationships – that result in much duplication and waste in the use of resources – are the least efficient of all possible configuration. In a sense, neither Ministry should really be in the direct business of producing and providing health care, a function that is so central to both in the present setup, for
both have other more critical functions to perform that are given relatively low priority at the moment. The relationship between the two Ministries needs to be completely overhauled so that they function as two arms of the same government, with the same shared values and beliefs, instead of the present adversarial stances that the two adopt.

As far as the Ministry of Health is concerned, its primary role and responsibility should be that of policy formulation and providing regulatory oversight. Other areas that the Ministry of Health in Turkey needs to focus on are quality control and consumer education. The Ministry of Health should develop the capacity to focus priority setting for the health sector, and on quality monitoring and regulation, accreditation of institutions and licensing of professionals, insurance regulation and oversight and leading public health functions and epidemiological surveillance. As far as the Ministry of Labor and Social Security is concerned, its primary role in the health sector should be that of providing oversight and guidance in the management and functioning of the universal health insurance system, considering that it is proposed to establish the Health Fund under the overall supervision of this Ministry.

**Strengthening delivery of primary care services**

In the existing setup in Turkey, primary care does not form the basis of a well-designed and performance-focused health care system, and is not organizationally situated to have power and control over other levels of care. Any reform in the delivery of primary care would have to start by improving the relative position of primary care providers in both the medical as well as the patient community. In other words, in delivering the essential package of services in Turkey, primary care professionals in Turkey would need to be given the necessary levers to steer patient treatment, either in home-care setting or in the hospital setting, so as to ensure integration of the different health service delivery sectors. One such way is by adopting the concept and practice of “family medicine”. Family medicine physicians provide health services for the whole family, treating common illnesses across such medicine domains as internal medicine, gynecology, pediatrics, prevention and health propagation. Patients are provided with diagnostic services, laboratory services, and consultations, so that almost all services are provided under a “single-window” system by one provider. Family medicine brings the physician and members of a family into closer and more personal contact, and the physician plays an important role in health education, prevention of diseases, and general betterment of health.

Timing and sequencing are critically important to allow the system to prepare itself to absorb the changes and to not overwhelm the implementation machinery. Therefore, a two-phase gradual implementation is suggested, with the first phase spread over three to five years and the second phase a further three to five years after completion of Phase I. Phase I is essentially the preparatory phase, to enable the finalization of all legal and institutional requirements. Phase II is the completion phase, during which the reform measures are actually implemented.
1. Introduction

Despite considerable progress achieved in the recent past, Turkey continues to rank far behind most middle-income countries in terms of the health status of its people. Life expectancy is nearly ten years below the OECD average, and infant and maternal mortality rates are among the highest of middle-income countries. Less than two-thirds of all mothers receive antenatal care and less than one-third receive the full dose of tetanus toxoid injections; on average, only 2 out of 5 child-births are attended by a physician, compared with over 90 percent in middle-income countries, and 2 out of 3 children do not receive full immunization. If the current situation is any indication, substantial and sustained efforts will have to be made in the coming years if Turkey is to meet the health targets of the Millennium Development Goals by the year 2015.\(^1\) By all accounts, the health sector in Turkey is under-performing in achieving health outcomes.

The reasons for such low outcomes are varied. As the World Bank’s Sector Strategy on Health, Population and Nutrition notes, nutrition, better housing, access to clean water and satisfactory sanitation, and improved education, especially of girls and women, are powerful determinants of good health, and there is potential for significant improvements in these areas in Turkey. In addition, effective health-related public policies and interventions also have a strong impact on health status. On the financing side, besides the fact that there are multiple problems with mobilization of resources, the available resources are not allocated efficiently and equitably. A significant proportion of the population has little or no financial protection, and despite support from special funds and programs like the Social Solidarity Fund and the Green Card, in practice the disadvantaged groups are not targeted effectively. In addition, there are multiple payers for same or similar services, and the institution of revolving funds – that allow health providers to accept user charges and account for them outside the budgetary flow of funds – introduces a variety of perverse incentives for providers and further constrains access to health services for consumers. Public provision of health is characterized by poor incentives for managers and providers alike, leaving them open and vulnerable to alternative sources of income to augment their meager salaries. The delivery of health care is also fragmented, and the practice of integrated health services is rare. The potential of the private sector is not fully realized and their role and responsibilities not adequately defined. Clinical effectiveness of existing medical interventions and treatment protocols is not tested, and attention to quality and effectiveness of care is very uneven. The present situation, therefore, is one in which reported health expenditures are low for a country at the level of economic development of Turkey, the health system fails to reach the poor and vulnerable sections of society and the health status of the population is well below that of countries of comparable income.

Many efforts have been made in the last decade to identify the root causes of the problems in the Turkish health-care system, but the assessments have frequently been mis-targeted, the solutions and remedies have been inadequate and most have remained unimplemented. A comprehensive reform agenda was planned in the early 1990s, with the government aiming at creating a national consensus using international expertise and improved data. This resulted in the preparation of the

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\(^1\) The Millennium Development Goals (MDGs) are a set of goals which were endorsed by 189 countries at the September 2000 UN Millennium General Assembly in New York. The goals aim to cut by half the proportion of people in extreme poverty worldwide by 2015, provide education, improve health, and preserve the environment. The MDGs comprise a total of 8 Goals, 18 targets and 48 indicators.
Health Sector Master Plan Study by the State Planning Organization (SPO) in 1990, and of the Draft Health Sector Reform by the Ministry of Health in 1992. The proposals included universal health insurance coverage, improved efficiency, and equal access to health care services, and sought to achieve these goals through reforms in financing, service delivery, and organizational structure. Almost a decade later, however, nothing has been implemented. The broad principles on which these proposals were based still remain relevant today, though most of the suggested reforms would need to be refined and updated to conform to the present reality of Turkey's economic and political situation.

In addition, the overall fiscal situation is under severe strain following the recent economic crisis. The February 2001 crisis was a result, among others, of the increasing difficulty of maintaining the exchange rate arrangement compounded by market perceptions of unraveling political commitment to many structural reforms. The loss of market confidence reflected in changes in the exchange rate and its effects on the real economy and the financial sector have clearly raised the risks to the fiscal framework. An assessment prepared by the World Bank and IMF in March 2001 estimated the net fiscal cost of the crisis between $31-39 billion, a figure that can grow rapidly if events provoke another crisis that spreads more widely to the rest of the economy. There is a large implicit liability in all this, with a significant potential for adverse effects on the already low levels of public spending on health.

It is clear that the challenges presented by the health sector are manifold, and piecemeal and ad-hoc measures would not be effective in bringing about the required changes in the system. Indeed, fundamental and systemic changes would have to be brought about in the ways that health care is financed, delivered, organized and managed in Turkey in order to meet the ultimate objective of improving health status of the people, and not only meet but surpass the health-related Millennium Development Goals. This would require significant improvements in resource mobilization, allocation and utilization, enhanced efficiency in production and delivery of health services, including primary and hospital care, and greater emphasis on clinical quality and patient access to health services. Against this background, the World Bank and Government of Turkey agreed to undertake an intensive review of all aspects of the health sector, and the present report is a product of this effort.

One objective of an evaluation at this juncture is to lay the foundations for the development of a medium-term health sector strategy and a prioritized action plan aimed at improving access to health services, enhancing equity in utilization, increasing cost-effectiveness, enhancing quality of care and improving health outcomes overall. In particular, the emphasis of this study is to develop viable medium-term options for enhancing the health services coverage of poor and vulnerable groups and examine which priorities and approaches are likely to be most pro-poor. The study also examines the appropriate role of the government in the provision of health services, and the institutional, managerial and administrative requirements for developing an efficient, sustainable and patient-responsive health system. In doing so, the study examines ways in which public spending can be oriented so as to maximize its effect on access, equity and efficiency in the health sector. An added objective of this study is to engage policy makers and major stakeholders in discussions and debates on health reforms and bring about a consensus among them not only on broad principles but also in terms of integrated and coordinated approach to implementing reform measures.
2. Structure of the report

This report is organized in two volumes. Volume I contains a discussion of health sector priorities and key recommendations for the development of a medium-term reform strategy for Turkey's health sector. The suggested strategy calls for major restructuring and reorganization of the health system in order to meet the desired objectives of universal access to quality health services produced and delivered in an economically and institutionally sustainable environment. The recommended course of action is based on the assessment that piecemeal changes at the margin are unlikely to revitalize the health system, particularly since its performance record in the recent past has been less than satisfactory. Volume 1 concludes with an implementation plan for the short and medium terms.

The reform strategy discussed in Volume I is based on the findings of the detailed background studies that were carried out to examine the trends in health status of Turkey’s population and evaluate the structure of production, finance, delivery and organization of the country’s health system. Volume 1 is designed to be a stand-alone report, and while it contains the essential messages and findings of each of the background papers, it is necessarily short on details. Volume 2 contains the full background reports and data annexes that form the basis of the suggested health system reform. Chapter 1 of Volume 2 describes the current situation in Turkey in terms of health status, key risk factors and trends in health indicators and contains discussions on reproductive health and fertility, morbidity and mortality among children, nutritional status of children, morbidity and mortality among adults, and smoking. Chapter 2 of Volume 2 inquires into the determinants of health care seeking behavior and choice of health care provider in Turkey. The decision to seek care is modeled jointly with the choice of provider in a nested decision-making framework, and price and income elasticities are computed for different providers and across different income groups. Chapter 3 of Volume 2 reviews the structure and organization of public and private health services, and describes the delivery structure of outpatient and inpatient care in both sectors. This chapter also contains a short account on patient rights and public policy in Turkey.

More so than other organizations, government organizations are complex systems comprised of interdependent external and internal subcomponents that are linked to each other through incentive processes that retain them within the bounded organizational system. Understanding these organizations requires an appreciation of the organization’s operating environment, the strategies used by the organization in dealing with its constituents and environment, the structural and systemic features within the organization, and the organization’s values and behaviors. Chapters 4 and 5 of Volume 2 fill precisely this gap. Specifically, Chapter 4 presents an overview of the numbers, types and distribution of health personnel in Turkey. It also contains discussions on worker productivity in the health sector, and describes the current system of medical education and training in Turkey. Chapter 5 is devoted to an understanding of the industrial organization of the existing institutions in the health care system in Turkey, and focuses on identifying and isolating the institutional characteristics that influence and shape the organization, including the organizational mission, work-culture and ethics, the structure of the inherent organizational motivations and incentives, and the strengths and short-comings in the organizational framework.
Moving from organization and management to financing of health care, Chapter 6 of Volume 2 examines health sector financing in Turkey, and includes detailed analysis of the structure of public financing of the health sector. A special emphasis in the health-financing chapter is on efficiency and equity in the context of public expenditures on health, and accordingly a detailed discussion of the Green card program is presented in the chapter. Other issues discussed in the chapter relate to population coverage and the linkages between health policies and public expenditures. A brief account of production and consumption of pharmaceutical products is presented in Chapter 7 of Volume 2 of the report.

Volatile growth, persistent high inflation, high real interest rates and continuing vulnerability to economic crisis have marked Turkey’s economic performance over the past decade. Despite frequent warnings, however, it was only toward the end of 1998 that the expansionary fiscal policies and rapid increases in public debt caught up with the existing inflationary pressures to significantly slow down the economy and drive growth rates into negative territories. Unable to turn around rapidly enough – and triggered by massive capital outflows – Turkey faced two serious economic crises in rapid succession, in November 2000 and again in February 2001, by the end of which the currency had depreciated by more than 100 percent, consumer price inflation rate was about 68 percent, and the economy had contracted by more than 8 percent. Across-the-board cuts following the recession have undoubtedly affected consumption and utilization of health services as well, even though real and visible effects on mortality and morbidity might not be readily apparent. Accordingly, Chapter 8 of Volume 2 is devoted to an analysis of the impact of the economic crises on health services demand, utilization and supply of health services.

Chapter 9 of Volume 2 contains an analysis of the health-related Millennium Development Goals. Using data from the Country Report on Socio-Economic Differences in Health, Nutrition and Population, December 2001, Demographic and Health Survey (DHS), 1993 and from Demographic and Health Survey (DHS), 1998 (for adolescent reproductive health), this chapter presents disaggregated health status and health services utilization data for reproductive health services, by asset or wealth quintiles. The main conclusion of this chapter is that income inequality and inequity in health status and utilization constitute a formidable barrier to the attainment of the health-related MDGs in Turkey, and the vicious circle of poverty and ill health would need to be broken before any rapid and sustained progress can be achieved in the MDG indicators.

Data and technical annexes, where applicable, are placed at the end of each chapter.
3. Key findings

3.1 Health of the people

Home to 67.85 million people, Turkey is among the 20 most populous countries in the world (SIS 1999). High fertility and growth rates of the past have resulted in a young population structure and 30 percent of the population is under the age of 15 and almost 11 percent under the age of 5 (2000). Over 17.8 million women are in the reproductive age group of 15-49 years.

There is little doubt that the health status of Turkey’s population is poor, both in absolute terms as well as in comparison with other countries at same levels of income. Of the many areas of concern, at least four demand immediate attention. First, maternal mortality rates are very high. Estimates of maternal mortality range from 52 deaths per 100,000 live births (1999) – as reported in a study undertaken by the Ministry of Health and Hacettepe University, with support from UNFPA and WHO, based on hospital-reported deaths – to 130 deaths per 100,000 live births for the period 1980-97, as reported in the 1998 Ministry of Health Statistics. Whichever figure is considered more accurate, including the most conservative one, maternal mortality in Turkey is the highest for all countries in the European region (Figure 1). While the main clinical causes of the high rates of maternal mortality are believed to be complications due to infections and toxemia, the fact that a quarter of all births take place at home and a third of pregnant women do not receive any antenatal care also contribute to increasing the risks associated with infections and toxemia. Whether this is a reflection of the inability of the health system in the country to provide access to antenatal care and delivery facilities or an indication of poor demand for health services as a result of certain socio-cultural perceptions and low levels of knowledge of health issues is moot; what is important is that maternal mortality rates are very high in Turkey whereas even many poor countries have succeeded in containing pregnancy and delivery-related fatalities.

A second area of concern is the high rates of infant mortality. Despite significant reduction in the last few decades – during which IMR has fallen from over 150 per 1,000 live births in 1970 to
under 40 per 1,000 live births in 1998 – infant mortality rates in Turkey remain higher than most other countries in Europe. Low weight of the child at birth, short birth intervals and lack of adequate care during pregnancy and delivery are some of the factors that can potentially explain the high rates in infant mortality. Low education levels of the mother are also positively correlated with higher infant mortality rates.

The countrywide infant mortality rate masks considerable variation across urban and rural Turkey and across regions. Infant and child mortality rates are lower than the national average in the urban areas and in Western and Southern regions, and almost 40 percent higher than the national average in the rural areas and in the Eastern region. While infant mortality declined in most regions in the last decade, regional disparities widened as the infant mortality rates increased in the Eastern region between 1988 and 1998, from 60 per 1,000 live births to 62 per 1,000 live births. Wide variations exist in infant mortality rates between the rich and the poor, and infant and child mortality rates are almost four times higher in the lowest income quintile relative to the richest income quintile.

A third area of concern relates to the huge locational and regional disparities in health outcomes across all indicators. By and large, rural areas are worse off on all counts compared to urban areas, and regions in Eastern Turkey are worse off on all counts compared to the national average and to the regions in Western Turkey. Besides the variations in infant and child mortality discussed earlier, wide variations also persist in the nutritional status of children, and both stunting and under-weight are almost twice as prevalent in rural than in urban areas (22 percent versus 12.6 percent for stunting and 11.9 versus 6.2 percent for under-weight in 1998). Regional differences also present, and three times as many children were stunted in the Eastern than in the Western region (30 percent versus 9.9 percent) in 1998, and the prevalence of under-weight children was four times higher in the Eastern region than in the Western region (17.1 percent versus 3.8 percent).

Some of the reasons for the observed variations are obvious, for there is a strong positive correlation between economic wealth and health, and few of the economically wealthy in Turkey live in rural areas or in Eastern provinces. The economically wealthy are also typically better educated and generally have a better awareness of health issues and treatment options, and to this extent have a higher demand for health care. The other probable demand-side reasons for such wide disparities are probably cultural and related to demand-seeking behavior. Supply-side issues are also important – as is borne out by the large number of under-staffed and under-equipped health facilities in some regions of Turkey – and it is here that the effectiveness of public expenditures on health needs to be considered.

The fourth area of concern relates to smoking, which is well documented to be a major risk factor for lung cancer, heart diseases and respiratory infections. The incidence of cigarette smoking is very high in Turkey, and a large number of men and women and even secondary and high school students smoke. Both the number of smokers and the number of cigarettes consumed has increased significantly over time, the latter increasing from 37,506 million pieces in 1970 to 115,500 million pieces in 2000, an increase of 207 percent overall and 34 percent in per capita cigarette consumption. Following the free import of foreign brand cigarettes into the country in 1986, there has been an increase in absolute and relative numbers of smokers, along with a shift in favor of the imported foreign cigarettes. During the 10-year period between 1990-99, Turkey
experienced the second highest growth rate in cigarette consumption in the world. The increase
for this period was 52 percent, second only to Pakistan (71 percent). Turkey’s per capita
consumption in 1999 (1,734 cigarettes per person per year) was above that of many other
countries in the European region and above the European average of 1,675 cigarettes per person
per year. In 1999, Turkey consumed 15 percent of total cigarettes smoked in the European and
Central Asia (ECA) region, and worldwide, Turkey accounted for 2.25 percent of total cigarette
consumption (World Bank).

Turkey is experiencing an epidemiological transition with the twin challenges of addressing
communicable and non-communicable diseases. In resolving the huge regional and income
disparities in health outcomes, especially for infant and child health, special efforts will need to
be undertaken to enhance immunization coverage, improve access to health services and change
attitudes and practices with regard to maternal, infant and child health. In addition, prevention
programs would need to address lifestyle choices and behaviors. HIV infection and AIDS are
still not documented as major health problems for Turkey, but no country – Turkey included – is
invulnerable to this threat, and early action is always advisable to control the spread before it
takes on epidemic proportions.

One of the challenges in conducting this analysis of health outcomes and epidemiological trends
in Turkey has been the availability and reliability of data. Some data are simply not collected,
and in many instances where it is, under-reporting and misclassification pose huge challenges. In
some cases, such as in the data on maternal mortality, huge variations exist depending on when,
how and by whom is the data collected. In other cases, such as in the data on adult mortality,
most of the available mortality data is based on hospital deaths and thus heavily weighted
towards non-communicable diseases. Incomplete and inadequate data cannot form the basis of
effective policy and action; on the contrary, it poses the definite risk of distorted emphasis and
attention. The importance of an effective and rigorous disease surveillance system and
information and data collection cannot be over-emphasized, and this is an area to which the
health system in Turkey needs to give immediate attention.

3.2 Utilization of health services

Knowledge of household demand for health care is useful in guiding the allocation of scarce
resources. The role of the government in the production, finance, delivery and management of
health services is more appropriately defined if the factors affecting the demand for health care
are known and understood. Additionally, decisions regarding facility design, scope of services,
intensity of services and location tend to be better informed if the patterns of utilization of health
services are known.

Two sets of data are used in order to understand the demand for health care in Turkey. The first
data set (400 households) pertains to the year 1999 and was commissioned by the Ministry of
Health and originally used in the research and analysis of user satisfaction with health services
provided in public and private facilities. The survey was conducted in six provinces, representing
five different regions, and covered Adiyaman in the Southeastern Anatolia Region, Bilecik in the
Marmara Region, Corum in the Black Sea Region, Eskisehir in the Central Anatolia Region, and
Malatya and Van in the Eastern Anatolia Region. The Aegean and the Mediterranean Region
were not represented in the sample. The second data set used in the analysis pertains to the year 2001 and was collected during a baseline survey commissioned by the World Bank as part of the Social Risk Mitigation Project. The survey covered 62 provinces in all the seven regions, and a total of about 4,000 households were interviewed.

An analysis of the 2001 data shows that about one-tenth of those sampled report an illness event or medical need during the recall period of the previous month. An additional three percent reported having an illness that required hospitalization during the last 6 months. Over seventy percent of those reporting an illness seek some form of medical treatment for the reported illness, and sick individuals with higher incomes are more likely to seek treatment compared to sick individuals with lower incomes (Figure 2). Among the poorest 40 percent, only 68 percent seek care, which is significantly different from the 77 percent of individuals in the top two quintiles.

![Figure 2: Percent that Sought Treatment Among Those that Reported Illness](chart.png)

The propensity to report an illness and seek treatment for the reported illness also varies by location and gender. The percentage of ill seeking care is the lowest in the Southeastern and Eastern Anatolia, and is generally lower for rural areas compared to the urban areas (Figure 3). Woman are more likely to report an illness, and marginally more likely to seek treatment for that illness. Individual with higher levels of education are more likely to seek treatment when ill compared to those lower levels of education, but the differences are not significant.

The mean payment for outpatient treatment was 38.4 million TL and the median payment for outpatient treatment was 10 million TL. Excluding those who did not have to pay for outpatient treatment the mean payment was 54.3 million TL. Similarly, excluding those who did not have to pay for hospitalization, the mean payment for inpatient care was 178 million TL. Out-of-pocket expenditures on health pose a greater burden on the poor compared to the rich. The poor spend disproportionately higher amounts on health care relative to the rich. As Table 1 shows, average out-of-pocket payments for visits to a health facility tend to be higher for those in the lower income quintile groups relative to those in the higher quintile group. With the exception of the third quintile group, out-of-pocket payments are generally higher in urban areas within each quintile group.
Knowledge of health conditions and treatments has a significant bearing on seeking care, and households more knowledgeable about health conditions and treatments are more likely to seek care compared to those who are less knowledgeable. Also, there is a very strong correlation between having health insurance and seeking treatment, irrespective of the kind of insurance, which also explains why the poor, who are less likely to be employed in the formal sector and are less likely to have health insurance compared to the rich, are less likely to seek care when ill.

Table 1: Out-of-Pocket Payments on Health Care (by quintile), 2001

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Location</th>
<th>Mean Cost of Last Visit to a Health Institution</th>
<th>Percent of Individuals in Group with Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quintile 1</td>
<td>Rural</td>
<td>42,300,000</td>
<td>43,100,000</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>43,400,000</td>
<td></td>
</tr>
<tr>
<td>Quintile 2</td>
<td>Rural</td>
<td>23,500,000</td>
<td>37,000,000</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>42,000,000</td>
<td></td>
</tr>
<tr>
<td>Quintile 3</td>
<td>Rural</td>
<td>55,200,000</td>
<td>40,800,000</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>37,000,000</td>
<td></td>
</tr>
<tr>
<td>Quintile 4</td>
<td>Rural</td>
<td>26,000,000</td>
<td>30,300,000</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>31,200,000</td>
<td></td>
</tr>
<tr>
<td>Quintile 5</td>
<td>Rural</td>
<td>27,900,000</td>
<td>38,600,000</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>40,600,000</td>
<td></td>
</tr>
</tbody>
</table>

Note: All costs are in TL. Payments are for outpatient visits only.
Note: Possession of Green Card insurance is not counted as possession of insurance for these calculations.
Lack of health insurance leads to delayed diagnoses and treatment, which then results in higher expenditures afterwards and potentially life-threatening complications. The uninsured are more likely to ignore the more subtle illnesses and symptoms, like hypertension and high cholesterol, and are less likely to receive common screening tests and preventive interventions. Despite the Green Card program and other similar facilities to which the otherwise uninsured can potentially have access, in all likelihood the vast majority of the uninsured simply go without health care until an illness becomes severe and intolerable.

The challenge for policy makers lies in ensuring that people have access to health care early before they get very ill, and that they have access to a full range of basic services. This is by no means an easy task, but the implications are too serious to ignore, for besides the obvious medical outcomes, many less tangible but equally important benefits come with health insurance. These include financial security and stability, peace of mind, alleviation of pain and suffering, disabilities avoided or delayed, and gain in life expectancy. For many in Turkey, these benefits remain out of reach.

3.3 Supply of health care

Health services in Turkey are supplied by a multitude of public and private providers. The three key public providers are the Ministry of Health, the Social Insurance Organization (SSK) and the Universities through University hospitals. Other public Ministries, (Defense, Transport, Education), and some state enterprises and municipalities also provide health services, but their capacity is quite limited. At the central level, the Ministry of Health (MOH) is the major government body responsible for sectoral policymaking, implementation of national health strategies and programs and provision of health services. At the provincial level, provincial health directorates, accountable to the provincial governors for administrative matters and to MOH for technical matters, administer health services provided by MOH.

Outpatient Care

MOH is the major provider of primary and secondary health care and essentially the only provider of preventive health services. MOH operates an extensive network of health facilities providing primary, secondary and specialized inpatient and outpatient care, which were established throughout the country on the basis of the 1963 law on socialization of health services. SSK operates a significant network of secondary in- and out-patient facilities and a more limited number of primary facilities servicing their members and their dependents. University hospitals provide in-and outpatient care. Outpatient services are also provided by state-owned facilities of the Ministries of Education, Health, Transport and the Municipalities. Public sector health facilities are complemented by a much smaller network of private facilities providing both inpatient and outpatient care.

The law provides for rural health posts to serve an average of 2,000-2,500 people and for three types of health centers. Current regulations provide for rural health posts to be staffed by a midwife who is to provide primary health care and family planning services, attend deliveries and make monthly visits to ascribed households. Rural health posts are attached to and supervised by a health center. Rural health centers are to serve a population of 5,000-10,000 and
have a staff of eight, including a physician, nurse, and health officer, two midwives and support staff. District health centers, expected to serve a population of 10,000 – 30,000, are to be staffed by a team of about 16 health professionals and five support staff, while provincial health centers are expected to serve 30,000 to 50,000 people and to be staffed by a team of 28 staff, including 22 health professionals and six support staff.

Following this model, the Ministry of Health has established almost 11,700 health posts and 5,700 health centers. This compares to fewer than 3,500 health centers and about 10,700 health posts one decade ago. For maternal and child care and for key preventive services, MOH also runs a number of vertical programs. To help implement these programs, particularly in urban areas, MOH also operates a series of specialized centers and dispensaries, including 291 maternal and child care centers, 270 tuberculosis control dispensaries and a small number of other specialized dispensaries. These dispensaries, with their specialized personnel, offer preventive and curative health services and training for health personnel from other primary care units. Within the framework of preventive care, health centers also deal with TB, malaria, and family planning and maternal and childcare.

MOH’s facilities are complemented by SSK’s more limited primary care network consisting of 219 health stations and 189 health dispensaries. SSK’s facilities are primarily located in industrial areas with a high concentration of SSK beneficiaries.

The relatively rapid expansion of MOH primary care facilities has resulted in a situation where funds available to cover staffing and operating costs have fallen short of what is needed to effectively operate all facilities. As a result, many health centers are understaffed and lack operating funds. Official statistics show that 665 health centers (12 percent) do not have a doctor and two thirds of all village health posts do not have a midwife (Table 2). In reality, the number of health centers without doctors is even higher as doctors who have been assigned to a rural health center sometimes refuse to work there and end up working at the district health center instead, where living and working conditions are better than in rural areas. Given that the midwife is the only medical staff assigned to village health posts, the lack of midwives at two thirds of health posts essentially means that the vast majority of rural health posts are not functional. This situation is further aggravated by the lack of adequate transportation for midwives and other medical staff in rural areas. About 270 health centers and 1,887 health posts are closed due to lack of staff and equipment.

Southeastern Anatolia and, to a somewhat lesser extent, the Eastern Anatolia regions have the lowest number of primary care medical staff per capita. Not surprisingly, these are also the regions with the lowest health indicators. The Marmara region, even when Istanbul is excluded, also has a low number of primary care medical staff per capita. However, given the level of economic development and the strong presence of alternative primary care providers (SSK, private), the high number of people which each MOH primary care staff is expected to serve in the Marmara region is of somewhat less concern than in the Southeastern and Eastern Anatolia. Lower disposable incomes and a higher share of people not covered by health insurance make it more difficult for the population in Eastern and Southeastern Anatolia to use alternative primary care such as private or SSK providers. In addition, the low rate of urbanization compared to other
regions makes it more difficult for the population in these regions to reach primary health care facilities in urban areas that are generally better staffed than those in rural areas.

Table 2: MOH Health Centers and Health Posts Lacking Key Staff

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Health Centers Without Doctors</th>
<th>Percent of all Health Centers</th>
<th>Number of Village Health Posts Without Midwives</th>
<th>Percent of Health Posts</th>
<th>Percent of Births Unattended by Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marmara</td>
<td>99</td>
<td>11</td>
<td>766</td>
<td>53</td>
<td>1.9</td>
</tr>
<tr>
<td>Agean</td>
<td>65</td>
<td>7</td>
<td>693</td>
<td>47</td>
<td>3.0</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>62</td>
<td>8</td>
<td>503</td>
<td>44</td>
<td>3.9</td>
</tr>
<tr>
<td>Central Anatolia</td>
<td>116</td>
<td>11</td>
<td>1179</td>
<td>73</td>
<td>4.1</td>
</tr>
<tr>
<td>Black Sea</td>
<td>144</td>
<td>13</td>
<td>2068</td>
<td>68</td>
<td>4.3</td>
</tr>
<tr>
<td>Eastern Anatolia</td>
<td>98</td>
<td>18</td>
<td>1575</td>
<td>85</td>
<td>19.8</td>
</tr>
<tr>
<td>Southeastern Anatolia</td>
<td>81</td>
<td>20</td>
<td>927</td>
<td>84</td>
<td>17.3</td>
</tr>
<tr>
<td>Turkey</td>
<td>665</td>
<td>12</td>
<td>7713</td>
<td>66</td>
<td>5.8</td>
</tr>
</tbody>
</table>

Source: MOH, General Directorate of Primary Health Care, Web Page

Rural areas are lacking significantly more in primary health care staff than urban areas (Table 3), because it is more difficult to find well-trained and experienced staff who are willing to serve in remote areas with the current incentive system. The lack of primary care staff in rural areas, particularly in Eastern and Southeastern Anatolia, is further aggravated by high staff turnover. MOH representatives estimate that staff turnover at primary care facilities is at least 35 percent per year. Harsher working conditions, coupled with a compensation system that fails to reflect the more difficult circumstances in rural areas make it extremely difficult to retain experienced staff, particularly doctors, in those provinces where the need for effective primary care is highest. The obligation for medical school graduates to serve as doctors at primary care facilities for one to two years upon graduation was cancelled, but reintroduced as of July 2002. This has made it even harder to staff rural facilities. To the extent that rural primary care facilities do have medical staff, these posts are generally filled with personnel with limited professional experience. Most doctors strive to obtain employment at a hospital where working conditions are better and where they can receive income supplements from revolving funds proceeds.

Almost 90% of the primary health care budget is used to pay staff salaries. This leaves extremely little to cover operating costs and make even minimal investments in new equipment. The shortage of operating funds has resulted in a situation where many primary care centers lack adequate medical supplies and are unable to stock up with sufficient drugs. Tight operating budgets furthermore severely limit medical personnel’s access to appropriate means of transport and thus prevent most of them from visiting rural areas and health posts assigned to them. Lack of funding has also resulted in a marked shortage of well functioning equipment in many health centers and posts, as no funds are available to repair or replace outdated equipment. Insufficient
operating funds and equipment, coupled with staff shortages in general and lack of well-experienced staff in particular, have had a negative bearing on the quality of primary care provided, particularly in areas outside the large urban centers.

Table 3: Percentage of Primary Care Health Staffing Posts Filled

<table>
<thead>
<tr>
<th>Region</th>
<th>Actual number of doctors as a percent of doctor allocations</th>
<th>Actual number of nurses as a percent of nurse allocations</th>
<th>Actual number of midwives as a percent of midwife allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marmara</td>
<td>62 URBAN 52 RURAL</td>
<td>71 URBAN 46 RURAL</td>
<td>59 URBAN 67 RURAL</td>
</tr>
<tr>
<td>Agean</td>
<td>91 URBAN 56 RURAL</td>
<td>80 URBAN 46 RURAL</td>
<td>84 URBAN 58 RURAL</td>
</tr>
<tr>
<td>Mediterranean</td>
<td>104 URBAN 60 RURAL</td>
<td>94 URBAN 46 RURAL</td>
<td>84 URBAN 53 RURAL</td>
</tr>
<tr>
<td>Central Anatolia</td>
<td>87 URBAN 56 RURAL</td>
<td>73 URBAN 34 RURAL</td>
<td>74 URBAN 44 RURAL</td>
</tr>
<tr>
<td>Black Sea</td>
<td>66 URBAN 43 RURAL</td>
<td>67 URBAN 29 RURAL</td>
<td>59 URBAN 34 RURAL</td>
</tr>
<tr>
<td>Eastern Anatolia</td>
<td>69 URBAN 53 RURAL</td>
<td>79 URBAN 43 RURAL</td>
<td>77 URBAN 54 RURAL</td>
</tr>
<tr>
<td>Southeastern Anatolia</td>
<td>65 URBAN 53 RURAL</td>
<td>72 URBAN 60 RURAL</td>
<td>61 URBAN 67 RURAL</td>
</tr>
<tr>
<td>Turkey</td>
<td>77 URBAN 54 RURAL</td>
<td>78 URBAN 42 RURAL</td>
<td>73 URBAN 53 RURAL</td>
</tr>
</tbody>
</table>

Source: MOH, General Directorate of Primary Health Care, Web Page

Inpatient services

The public sector accounts for ninety two percent of hospital capacity in Turkey. MOH, SSK and the Universities are the major public providers of in-patient hospital care. MOH hospitals account for about forty six percent of all hospital beds, while SSK accounts for eighteen percent, and university hospitals for about sixteen percent. Hospital bed capacity has increased by about twelve percent between 1995 and 2000, with the largest absolute increase occurring in MOH hospitals, followed by a very noteworthy increase in the capacity of private hospitals (Table 4).

Table 4: Distribution of Hospital Beds and Physicians by Provider, 2000

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of Hospitals</th>
<th>Number of Approved Beds</th>
<th>Number of Actual Beds</th>
<th>Number of GPs</th>
<th>Number of Specialists</th>
<th>Total Number of Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOH Hospitals</td>
<td>744</td>
<td>86,117</td>
<td>69,089</td>
<td>12,790</td>
<td>8,788</td>
<td>21,578</td>
</tr>
<tr>
<td>SSK Hospitals</td>
<td>118</td>
<td>27,900</td>
<td>27,245</td>
<td>4,865</td>
<td>2,531</td>
<td>7,396</td>
</tr>
<tr>
<td>University Hospitals</td>
<td>42</td>
<td>24,647</td>
<td>23,838</td>
<td>7,204</td>
<td>7,791</td>
<td>14,995</td>
</tr>
<tr>
<td>Ministry of Defense</td>
<td>42</td>
<td>15,900</td>
<td>15,900</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Other public hospitals</td>
<td>10</td>
<td>2,287</td>
<td>1,491</td>
<td>80</td>
<td>275</td>
<td>80</td>
</tr>
<tr>
<td>Municipal Hospitals</td>
<td>9</td>
<td>1,341</td>
<td>1,130</td>
<td>182</td>
<td>40</td>
<td>222</td>
</tr>
<tr>
<td>Foundation Hospitals</td>
<td>18</td>
<td>1,318</td>
<td>1,112</td>
<td>434</td>
<td>40</td>
<td>474</td>
</tr>
<tr>
<td>Private Hospitals</td>
<td>234</td>
<td>11,667</td>
<td>10,074</td>
<td>3,217</td>
<td>259</td>
<td>3,476</td>
</tr>
<tr>
<td>Minority and Foreign Hospitals</td>
<td>9</td>
<td>1,272</td>
<td>976</td>
<td>118</td>
<td>25</td>
<td>143</td>
</tr>
<tr>
<td>Total</td>
<td>1226</td>
<td>172,449</td>
<td>150,855</td>
<td>29,085</td>
<td>19,554</td>
<td>48,639</td>
</tr>
</tbody>
</table>

Source: MOH, General Directorate of Primary Health Care, Web Page
The size of hospitals in Turkey varies significantly and ranges from health center hospitals (saglik merkezi) with less than ten beds to hospitals with over 1,800 beds. There are a very large number of small hospitals. Overall, over half of all hospitals in Turkey have 50 or fewer beds, 124 hospitals have 10 or less beds and almost three hundred hospitals have between ten and thirty beds. At the other end of the distribution, there are thirty hospitals with between six hundred and one thousand beds and nine hospitals with more than one thousand beds. One quarter of all hospital beds are thus in hospitals with more than six hundred beds.

The distribution of admissions across providers is in relatively close concordance with their respective shares of hospital beds, with MOH hospitals accounting for over half of all hospital admissions, close to two thirds of all births and somewhat less than have of all surgeries. SSK hospitals account for about one-fifth of all beds but for one-quarter of all admissions, surgeries and births, and university hospitals account for only one-eighth of all admissions but one-fifth of all large surgeries. Foundation and private hospitals account for a disproportionate share of surgeries, particularly large ones, compared to their share of beds in the system.

Bed occupancy rates vary significantly across public providers. MOH hospitals post a significantly lower average rate than SSK and University hospitals. The latter have witnessed the most significant increase in bed occupancy rates over the past five years (from 61 percent in 1995 to 73 percent in 2000) despite the large increase in capacity. On the other hand, they have only recorded a minimal reduction in the average length of stay which remains significantly above that of most other hospitals, including foundation hospitals although the latter post higher surgery rates than university hospitals.

A look at hospital efficiency by hospital size confirms that the large number of small hospitals lead to significant inefficiency and thus ineffective use of scarce resources (Table 5).

<table>
<thead>
<tr>
<th>Beds</th>
<th>ALOS</th>
<th>Occupancy rate</th>
<th>Outpatients/physician</th>
<th>Inpatients/physician</th>
<th>Operations/physician</th>
<th>Beds/physician</th>
<th>Through put/bed</th>
<th>Deaths/1000 discharges</th>
<th>Bed turnover interval</th>
<th>No. of hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>2.6</td>
<td>17.4</td>
<td>2,969</td>
<td>75</td>
<td>28</td>
<td>2.8</td>
<td>27</td>
<td>3</td>
<td>57</td>
<td>293</td>
</tr>
<tr>
<td>30-50</td>
<td>3.7</td>
<td>32.5</td>
<td>2,518</td>
<td>107</td>
<td>33</td>
<td>2.8</td>
<td>37</td>
<td>6</td>
<td>32</td>
<td>163</td>
</tr>
<tr>
<td>50-99</td>
<td>4.7</td>
<td>35.1</td>
<td>3,249</td>
<td>145</td>
<td>38</td>
<td>3.8</td>
<td>38</td>
<td>7</td>
<td>28</td>
<td>266</td>
</tr>
<tr>
<td>100-199</td>
<td>6.1</td>
<td>55.0</td>
<td>3,040</td>
<td>154</td>
<td>44</td>
<td>3.3</td>
<td>47</td>
<td>10</td>
<td>8</td>
<td>176</td>
</tr>
<tr>
<td>200-400</td>
<td>7.5</td>
<td>61.7</td>
<td>2,917</td>
<td>131</td>
<td>38</td>
<td>3.7</td>
<td>36</td>
<td>15</td>
<td>5</td>
<td>99</td>
</tr>
<tr>
<td>400-600</td>
<td>9.7</td>
<td>73.4</td>
<td>2,212</td>
<td>113</td>
<td>38</td>
<td>2.9</td>
<td>40</td>
<td>20</td>
<td>4</td>
<td>43</td>
</tr>
<tr>
<td>600-1000</td>
<td>9.1</td>
<td>76.9</td>
<td>1,228</td>
<td>65</td>
<td>27</td>
<td>1.9</td>
<td>35</td>
<td>36</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>&gt;1000</td>
<td>10.3</td>
<td>76.9</td>
<td>757</td>
<td>52</td>
<td>24</td>
<td>2.0</td>
<td>26</td>
<td>36</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: MOH, Yatakli Tedavi Kurumları İstatistik Yılıği, 2000
More sophisticated analyses by Turkish researchers also confirm that the majority of general hospitals in Turkey are run inefficiently and are responsible for considerable waste of resources. Using a nonparametric method (Data Envelopment Analysis), these studies analyzed the efficiency with which general hospitals in Turkey used inputs such as hospital beds, doctors, nurses, allied health staff and some times also revolving funds expenditures, to produce output such as the number of outpatient visits, number of in-patient admissions and the number of surgical operations. Taking the hospital as decision making unit, one study found that only 54 out of 573 general hospitals could be considered as operating efficiently and that inefficient hospitals on average used twice as many beds, thirty percent more generalists and almost fifty percent more specialists than efficient hospitals. Even with these excess inputs, however, the inefficient hospitals accounted for about 13,000 less outpatient visits, 1,000 less inpatients and 2,000 less surgical operations than their efficient counterparts. Another study compared the efficiency with which provinces operate MOH general hospitals and found that 55 percent of provinces ran their hospitals inefficiently. According to this study, MOH general hospitals lacked 80,000 outpatient visits and over 4,600 discharged patients, while inefficient provinces collectively over-bedded by more than 6,700 beds and employed an excess of almost 1,100 doctors, over 5,000 nurses and over 8,100 allied health professionals to produce hospital based health care. The third and most recent study only looked at the efficiency of MOH’s provincial hospitals and found that 58 percent were run inefficiently.

Although Turkey has a relatively modest number of hospital beds relative to its population, the overall impression provided by the above data is one of a hospital system which is not under pressure from unmet demand, but which needs to resort to significant restructuring to increase its efficiency. The large number of very small hospitals under MOH control is a major contributor to an inefficiently run hospital system. They cannot be run efficiently because they are too small to benefit from economies of scale and scope. Most of them have very low occupancy rates, because they suffer from a lack of manpower and outdated or ill-functioning equipment, which results in low quality of service and leads people to utilize larger facilities even if they are further away.

Public hospitals in Turkey have limited financial and administrative autonomy. Managers have no power to hire or fire the staff working under their supervision. All health personnel for MOH and SSK hospitals are recruited and assigned to specific hospitals centrally (by MOH for MOH hospitals, by SSK’s General Directorate of Health Affairs for SSK hospitals), following requests put forth by the head physician. Public hospital managers also have limited financial autonomy. For MOH hospitals, budgets must be approved by MOH’s General Directorate of Curative Services and by MOF’s representative in MOH’s budget department. MOH’s Directorate of Curative Services must approve revolving fund budgets. Hospital managers have no authority to shift resources between expenditure categories; this applies to budgetary funds as well as revolving funds.

SSK hospital managers also have very limited financial autonomy. All expenditures need to be approved by SSK’s General Directorate of Health Affairs. Funds are generally only transferred

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2 Ersoy, K., Kavuncbasi S., Ozcan Y. and J M. Harris, “Technical Efficiencies of Turkish Hospitals DEA Approach”, in Journal of Medical Systems; Volume 21, number 2, April 1998, pp 67-74
to the SSK hospital for specific payments, although in some cases SSK’s General Directorate of Health Affairs grants the hospital director the authority to execute individual purchases and make specific payments within a given allocation without further central approval (e.g. for the purchase of some supplies and drugs). Allocation of SSK funds for investment purposes, such as the purchase of new equipment or renovation of facilities, often depends on the personal relation of the hospital director with SSK’s General Directorate of Health Affairs. Several SSK hospital managers interviewed during this review indicated that they would be significantly more successful in managing their hospital effectively and providing better services if their hospital had its own revolving fund, like MOH or University hospitals and if their facility received SSK funding on a fee for service basis rather than the current system where SSK facilities are essentially funded on an as needed basis.

Private Health Sector

Private outpatient services are provided in five different settings: (i) private physicians who work on a full time basis in private practice; (ii) public sector physicians who work part-time in private practice; (iii) private policlinics and medical centers; (iv) private services provided in public facilities, and (v) health services provided by so called occupational physicians engaged by private companies with 50 or more employees. Information on the number of private doctors and medical establishments is scant and of questionable reliability. MOH estimates that there are about 11,200 doctors (15 percent) who work on a private basis only, while somewhat below sixty percent of all public sector physicians also work part-time in private practice. Dentists who work full time in private practice are significantly more common and essentially all dentists who work in public facilities also practice in private. The relatively higher share of dentists working full time in private practice is at least partly driven by the limited number of dentist positions in the public sector.

Doctors working in MOH and university hospitals are allowed to see private out-patients in these facilities after 4 pm. Social insurance beneficiaries making appointments with specific doctors in public facilities after 4 pm pay an out-of-pocket surcharge, while basic treatment fees are covered by their insurance. Revenues from treatment of private patients in public hospitals are shared between the hospitals’ revolving fund and the treating physician. SSK physicians cannot see private patients at SSK facilities except from a recently initiated pilot in a limited number of SSK facilities. While such arrangements help public hospitals and physicians increase their revenues, they again pose a significant moral hazard problem, as doctors have little incentives to adequately treat patients before 4pm.

Non-public hospitals are grouped into four categories in Turkey: private hospitals (i.e. hospitals owned by Turkish citizens and established as a corporation), foundation hospitals, hospitals owned by ethnic minorities and hospitals owned by foreigners. Together they only account for about eight percent of Turkey’s hospital capacity. Private hospitals are the dominant group among non-public hospitals and account for 82 percent of non-public capacity. They have grown significantly during the 1990s, and their capacity almost doubled between 1995 and 2000. Foundation hospitals are significantly less dominant in terms of number and capacity (9 percent of non-public hospital capacity), although they have grown at a moderate rate over the 1990s. foreigners and ethnic minorities are the only provider type that has continuously reduced its
capacity over the past decade, as they have come under pressure from the rapidly growing private hospitals. Private hospitals are heavily concentrated in the three largest cities - only one third of private hospital capacity is outside Ankara, Istanbul and Izmir. Istanbul alone accounts for half of all private hospitals. On the other hand, there are only three private hospitals in Eastern Anatolia and seven in Southeastern Anatolia. In recent years, a significant number of private specialty hospitals (e.g. ophthalmology, orthopedics, physical therapy or micro-surgery) have been opened, particularly in Istanbul. Until the mid-1990s the expansion of private hospitals was facilitated by subsidized directed Government credits.

**Issues and Concerns**

The public health care system suffers from significant inefficiencies, while access to timely and quality health care is becoming increasingly unequal. The primary health care system is substantially underfunded and ineffective. A majority of people circumvent public primary care facilities and either directly seek care at outpatient facilities of hospitals or, if they can afford it, from the private sector. The absence of an effective and enforceable referral system further contributes towards excessive use of secondary level outpatient care. As a result, hospital outpatient facilities have become increasingly overloaded with cases that could easily be treated at the primary care level. This has lead to ineffective use of resources, as care at hospital outpatient clinics tends to be more costly than at primary care facilities.

The hospital sector continues to suffer from much inefficiency. Although some efficiency gains have been achieved during the 1990s, a large number of hospitals remain substantially underutilized. There are a large number of facilities that are too small to allow for efficient operation and effective provision of care. Many hospital managers lack the skills necessary to effectively carry out their job. In addition, hospital managers are not given any incentives to strive for efficiency improvements at the facilities that they manage. The absence of administrative and financial autonomy, coupled with a budgeting system that largely ignores the actual amount of services provided substantially prevents hospital managers from undertaking steps to achieve efficiency gains. Although this constraint has been recognized almost fifteen years ago and the legal basis was then set to turn public hospitals into autonomous units, nothing has been undertaken to move in this direction.

The existence of multiple public providers, who operate with little or no coordination, has led to significant duplication of efforts and inefficient use of resources. In most cities there are at least two and some times even more hospitals by public providers, namely MOH and SSK. In many areas these are complemented by University and some times private hospitals. The lack of coordination among providers often results in investment in equipment that remains underused, as there is not sufficient demand in smaller cities for multiple providers that offer the same range of services. In the absence of choice, providers face little competition and have few incentives to improve the timeliness and quality of their services. As a result, an increasing share of the population is opting for private health care. This in turn leads to growing inequities, as those who can not afford to do so are left with an ill performing public system.

Although health service provision is dominated by the public sector, the private sector has an increasingly strong presence. While exact data are not available, it is estimated that up to three quarters of the country’s doctors are involved in the provision of private health services at least on
a part time basis. Non-public hospitals have grown significantly over the past decade, although they still only account for about eight percent of hospital bed capacity and nine percent of in-patient admissions. The growing importance of the private sector is driven by increased demand for what people perceive as higher quality and more timely services. The mix of private and public service provision by doctors employed in public health institutions raises serious moral hazard problems. Doctors have few incentives to provide quality services at public facilities if they know that these compete for the same clients as they could treat privately.

The current system does not allow those who benefit from public health insurance under one of the social insurance or the green card schemes to freely chose between using public and private health services. With the exception of specialized services which can not be readily provided by public institutions and are thus contracted out to the private sector, private health services are only available to those who have the financial means to pay for them or who benefit from private insurance. There is, therefore, a danger that access to quality and timely health services will become increasingly inequitable.

Regulation and supervision of private health services is largely focused on physical standards, with little if any attention paid to the quality of actual service provision. Because of the specialized nature of health services, clients cannot be expected to have the knowledge necessary to judge the quality of services provided. There is therefore a need to strengthen the supervision of the quality of health services provided and to institute an officially recognized and mandatory accreditation system for physicians.

3.4 Human resources in the health sector

The health care industry is one of the largest employers in Turkey, and employs physicians, nurses, dentists, pharmacists, psychologists, health services administrators, therapists, lab and X-ray technicians, social workers, and other allied health workers. According to the MOH Health Statistics for the year 2000, there were a total of 81,988 physicians in Turkey in 1999 – equivalent to one physician for every 785 persons – of whom 36,854 were specialists and 45,134 were general practitioners. Between 1990 and 1999, there has been a 62 percent increase in the number of physicians, equivalent to a 48 percent increase in the number of specialists and 75 percent increase in the number of practitioners (Figure 4). In addition, there are 14,226 dentists (one for every 4,522 persons), 22,065 pharmacists (one for every 2,916 persons), 43,032 health officers (one for every 1,495 persons), 70,270 nurses (one for every 916 persons) and 41,271 midwives (one for every 1,559 persons). These numbers do not compare unfavorably with upper middle income countries like Mexico (625 persons per physician) and Brazil (769 persons per physician), and are better than Thailand (2,500 persons per physician) and Tunisia (1,428 persons per physician). The average for OECD countries as a whole is 370 persons per physician.

The distribution of health personnel as measured by the population to physician ratio also varies significantly across provinces, especially across rich and poor provinces of Turkey (Figure 5). The population to physician in the ten poorest provinces – Mus, Agri, Sirnak, Bitlis, Ardahan, Bingol, Van, Hakkari, Kars and Mardin – is, on average, 1,823 persons per doctor. Similarly, the population to nurse ratio in these provinces is 1,471, while the population to midwife ratio is 2,138. In comparison, the population to physician ratio in the ten richest provinces – Kocaeli, Bolu,
Yalova, Istanbul, Kırklareli, İzmir, Mugla, Ankara, Zonguldak and Eskişehir – is, on average, 413 persons per doctor, four times less than the poorest ten provinces. Ankara has the lowest population to doctor ratio (266), followed by İzmir (361) and Istanbul (430). Similarly, the population to nurse ratio in these provinces is 506, while the population to midwife ratio is 1,539, both significantly lower than the poorest ten provinces. As a result of lesser difference in the number of nurses across the two sets of provinces, the poorer provinces have more nurses per doctor (1.24) compared to the richest ten provinces (0.82).

**Figure 4: Trends in Number of Health Personnel (1990-1999)**

![Graph showing trends in number of health personnel](image)

There are great gaps in the distribution of health personnel among the provinces and regions. One of the basic assumptions that Turkish health personnel policy underlined in the 1970s and 1980s was that a great increase in the supply of health personnel would both solve problems of health personnel shortage and optimize or balance the geographic distribution of health personnel. Overall, while there are sufficient numbers of health personnel, rural and inner city areas continue to face a shortage of health personnel.

**Figure 5: Distribution of Health Personnel**

![Graph showing distribution of health personnel](image)

*Source: MOH, Health Statistics, Research, Planning and Coordination Council, 2000*
Physicians’ locational preferences are affected by factors such as opportunities for income generation, professional interaction, access to modern healthcare facilities and medical technology, continuing education and professional development, higher standards of living, recreational facilities, and quality of education for their family members. Problems that have contributed to the difficulties in recruiting physicians to rural areas include long working hours, frequently being on call, inadequate financial rewards, professional isolation, and limited access to high technology.

To develop policies to correct the maldistribution of health personnel, it is essential to know not only which geographic areas are underserved, but also the reasons for this problem and the types and amounts of resources necessary to address it. Possible policy actions include changes in the wage and salary system, tax incentives for private physicians accepting solo or group practice in rural areas, financial rewards and fringe benefits for those willing to serve in shortage areas, development and modernization in the capacity of health care organizations where health personnel work (e.g. telemedicine), provision of scientific assistance to the health personnel to enhance their professional knowledge and skills (e.g. distance education) and changes in the legal structure to motivate health workers.

In addition to the skewed geographic distribution of physicians, considerable imbalance exists between physicians in primary and specialty care in Turkey. The supply of primary care physicians dropped sharply after late 1980s, though the decline has moderated considerably since then, and today nearly 50 percent of all patient care physicians are specialists. The major driving forces behind the increasing number of specialists are the development of medical technology and better financial prospects. Rapid advances in medical technology have continuously expanded the diagnostic and therapeutic options at the disposal of physician specialists. Today most of the publicly funded hospitals with over 150-200 beds try to offer medical services in all major specialty fields and consequently employ specialists in those fields. Knowledgeable patients have started to turn to physicians in urban areas who provide them with the most up-to-date, sophisticated treatment. Specialists not only earn higher incomes, they also have more predictable work hours and enjoy higher prestige among their colleagues and from the public at large.

The imbalance between generalists and specialists has several undesirable consequences. Having too many specialists contributes to the high volume of intensive, expensive, and invasive medical services, and to rise in health care costs. Seeking care directly from specialists is often less effective than using primary care because the latter attempts to provide early intervention before complications develop. Higher levels of primary care professionals are associated with lower overall mortality and lower death rates due to diseases of the heart and cancer. Primary care physicians have been the major providers of care to the poor, and people living in underserved areas. The continual shortage of primary care physicians in medically underserved areas often exacerbates access to care, particularly for the underserved.

There is thus a need to achieve a better balance in the distribution of primary care physicians and specialists. Medical schools need to develop students' competencies in skills, values, and attitudes relevant to the practice of primary care. Their curricula need to be oriented toward issues of special concern to generalists such as outpatient experience, public health concepts,
disease prevention, and cultural, ethnic, and population-specific knowledge. They must also provide students with opportunities to work with the poor and the uninsured, and make such opportunities available in rural and other underserved areas.

**Physician Earnings**

Public sector salaries in Turkey at all levels of employment are set by the central government. There are no pay negotiations, and the government determines salaries unilaterally. Pay increases are subject to budgetary constraints and predicted inflation rates for the year. The Budget Law determines pay increases for the first half of the fiscal year; the Cabinet may determine increases for the second half of the year as part of the powers vested in it by the Budget Law.

In addition to the basic salary, incomes of health personnel from public sources may also include contributions from revolving funds, housing compensation, foreign language compensation, family support allowance, night duty payments, and other compensations. Incomes of health personnel also include any earnings from their private practices.

A large number of public sector physicians also work part-time in private practice; in fact, under Law 1219, doctors working in MOH and university hospitals are allowed to see private outpatients in these facilities after 4pm (health personnel working at university facilities are allowed to work privately part time at university hospitals after midday). Social insurance beneficiaries making appointments with specific doctors in public facilities after 4pm pay an out-of-pocket surcharge, while basic treatment fees are covered by their insurance. Revenues from treatment of private patients in public hospitals are shared between the hospitals’ revolving fund and the treating physician. SSK physicians cannot see private patients at SSK facilities except from a recently initiated pilot in a limited number of SSK facilities. While such arrangements help public hospitals and physicians increase their revenues, they also pose a significant moral hazard problem, as doctors have little incentives to adequately treat patients before 4pm. Reliable statistics of dual job-holding are not available, though some recent studies (Tokat, 2001) estimate that about 60 percent of all public physicians (i.e., over 44,000 doctors) also have private practices. Further, essentially all dentists who work in public facilities also have private practices.

Since salaries of doctors in the public sector are low, engagement in private practice allows public sector doctors to substantially increase their earnings. In effect, therefore, the possibility of private practice by public doctors helps the public sector keep the necessary number of doctors engaged despite low public sector wages. Tokat (2001) estimates that doctors working part-time in the public sector (and part-time in the private sector) earned 5 times more than those working full time in the public sector.

**Issues and Concerns**

There is no specific Human Resources Management Program in the health sector in Turkey. Even though the recruitment of health personnel (as in other civil servants) is based on seemingly-objective selection criteria, the appointment of the selected health personnel is carried out by the central administration of the Ministry of Health, and there is no deliberate process in place for the matching of the appointment with individual skills and comparative advantages. Other problems
include inappropriate distribution of health workers, low ratios of non-physician health workers to physicians, inadequate basic training of the health workers for service, insufficient numbers of teachers and academicians in the professional schools, inadequate supply of training materials, low professional status of non-physician professionals, inadequate salaries, promotions unrelated to performance, lack of incentives for working in rural areas and underserved areas, centralized health worker recruitment, inadequate staffing norms based on population and bed numbers rather than workload, outdated legislation on the responsibilities and authority of health personnel, absence of sufficient job descriptions, and inadequate coordination and monitoring of in-service training programs.

3.5 Organization and management

Management and administration in the public sector health care system in Turkey is characterized by an hierarchical organizational structure, with a single model for appointments and promotions within hospitals and other organizations. The legislation ensures permanent employment for all civil servants, and there is limited performance assessment and limited managerial and financial autonomy. Promotions tend to be seniority based, and there is limited formal acknowledgment of the management skills required in senior positions. The hierarchical system of administration in the government does not provide the appropriate incentives for organizations or for individuals, and at the same time, the accountability for results and outcomes is also limited. In the process, health outcomes and clinical quality of care receive minimal attention and emphasis.

The importance of management being held accountable for the areas over which they have responsibility cannot be overstated. Financial autonomy for managers is critical, for even though managers may not always be able to influence the size of their budget, they need to have the autonomy and authority within the budget allocated in order to achieve the results expected. Otherwise, a great deal of management energy is spent on attempting to influence relationships with those who hold various forms of financial power rather than manage health care issues and create teams that work to achieve the desired results.

In the present system, hospital directors and most health services directors are doctors. This is both a structural and a human resources capability issue. It is chance rather than design if the doctor (or the chief administrator and chief nurse) has the management capability to lead and manage the organization. With essentially a single model of health organizational management in Turkey, the current style of the physician-director is dominant, whether this is authoritarian, participatory, charismatic or laissez-faire. Recruitment procedures that actively seek management skills as the predominant focus are clearly an important step. Associated with this is planned and deliberate skill development in management for the senior levels of health decision-making (nurses, administrators and doctors). Management capability of senior staff is extremely important in providing leadership for achieving the specific vision or mission of an organization.

Shared beliefs and values

Organizations can usually be highly effective when key individual personal values are congruent with core organizational values, and when there is a congruence of values among the variety of
groups that comprise an organization. An assessment of shared beliefs and values in the context of the health system in Turkey has to be carried out at two levels: within the organization of each major player in the health system, and across the boundaries of these organizations. At the intra-organizational level, cultural behaviors that dominate are based on shared understanding and frustrations over legislative constraints, lack of delegated decision-making and financial autonomy, and the lack of ability to hire and fire staff. Whether it be the Ministry of Health or the Ministry of Labor and Social Security (MOLSS), hierarchical structures and the civil servant ethos dominates relationships and organizational behavior at all levels, including policy making at the senior levels and implementation at the field level. With the exception of minor differences on the margin, both Ministries are organized in much the same way, with the same kind of constraints imposed by law, practice and convention. To be sure, within these organizations and at individual levels, there exist common values of wanting high quality services that make a real difference for each individual patient and their families exist. There also exist individual and collective cases of using positive opportunities when they are available, for example, in developing team approaches and collaborative and collegial approaches to decision-making. However, these do not mark or personify either of the two organizations.

More interesting than the intra-organizational aspects in Turkey are the inter-organizational ones, for herein lie the differences that make the fragmentation of the health system a problem. As has been stated earlier as well, the co-existence of a variety of funding sources, budgetary and non-budgetary, has resulted in a multi-tier system of health care production, financing and delivery, that varies across several parameters, such as quality of health services, where and by whom health care is provided, and how much is paid for it and by whom. Outpatient care is provided by the Ministry of Health in health centers and posts, by SSK hospitals and clinics for its members, and by private providers, all at varying levels of quality and prices. Similarly, inpatient care is provided in Ministry of Health hospitals, free to Green Card holders and on the basis of established fee-schedules to others, in University hospitals at established fee-schedules, in SSK hospitals to its members and in private hospitals. The fragmentation of the health financing and delivery systems underscores the need for shared beliefs and values that dominate decision-making, policy formulation and implementation. It is in this context that it is necessary to examine the perceived roles and responsibilities of MOH and MOLSS.

Between them, MOH and MOLSS control most financing and provision of health care in Turkey, and yet their activities are not coordinated across any parameter. Besides preventive care, of which MOH is the sole provider, their activities overlap across all other services. They have facilities in the same towns and cities, conduct the same kind of procedures – though quality may vary, their personnel enjoy the same civil servant status, and they are both core governmental ministries. Yet, there is very little discussion and dialogue between them and almost no planning or collaboration at any level. Both Ministries have over time developed innovative approaches in such areas as management, administration, and delivery of hospital services, and yet there is little sharing, little exchange of ideas, and almost no comparison of efforts and outcomes.

At the same time, there is little or no competition between the two. Neither function on the principles of profit making, neither seeks each other’s patients, and neither competes for the same scarce human resources – because the human resources are not scarce. If at all there is any competition, it is for the scarce budgetary resources, for both get budgetary support for their
health-related activities in one way or the other – MOH more directly and obviously than the MOLSS.

This obvious absence of shared beliefs and values between the two organizations adversely affects, directly or indirectly, all aspects of health care. On the financing side, the fragmented nature of public expenditures on health makes it difficult to ascertain spending across different functions by different agents, which makes monitoring and regulation very challenging. Moreover, the fragmented nature of the budget increases the administrative costs, because the different funding sources entail different accounting conventions for the same activity. Further, the fragmentation of the budget compromises the importance of budget numbers, releases of funds, commitment of funds, and adequacy of budget as a basis for accountability. As far as the patient is concerned, the current system of responsibilities does not encourage integrated care for the patient, who then typically responds with less than adequate utilization of preventive health care. As far as general governance is concerned, it is difficult in the present system to track the flow of funds and the decision-making processes, and ensure accountability and transparency at all levels. The net overall result is inefficiency in the use of public resources, ineffectiveness of the production and delivery of health care and inadequate utilization of health services by the population.

3.6 Health financing

Structure of health financing

Turkey spent about 9,207,615 billion TL on health care in 2001, of which 7,604,855 billion TL (83 percent) came from public sources, and the remaining 1,602,760 billion TL (17 percent) came from private sources. Public expenditures on health consist of expenditures incurred by the Ministry of Health, General Directorate of Coastal Health Services, Universities, Social Solidarity Fund, other Ministries and agencies, local governments, state enterprises, civil servants, and social security institutions: Sosyal Sigortalar Kurumu (SSK), Emekli Sandigi and Bagkur. Private expenditures on health consist of out-of-pocket treatment and pharmaceutical expenditures incurred by individuals and households, and by companies and individuals contributing to private insurance schemes. Annually, Turkey spends about 135 million TL (US$112) per person on health (2001).

Total public expenditures on health (at 2001 prices) increased at an average annual rate of 11.1 percent between 1996 and 2001. Population grew at an average annual rate of 1.6 percent during this period, so that per capita health expenditures increased by 9.1 percent per annum during this period (Figure 6). Both total and per capita public spending on health increased in real terms between 1996 and 2000, but experienced a slight decline thereafter.

The composition of health expenditures by source changed significantly during 1996-2002. Measured at 2001 prices, the share of the consolidated budget in total public expenditures on health fell from one-half to one-third between 1996 and 2002, with the largest decline being recorded by MOH expenditures, the share of which fell from one-third of total public expenditures to one-fifth. At the same time, the share of social security institutions in total public expenditures increased from 37.9 percent to 53.4 percent during this period, reflecting the
growing importance of health insurance in financing health expenditures in the country. The share of revolving funds also increased from 4.5 percent to 7.7 percent between 1996 and 2002.

![Figure 6: Public Expenditures on Health, 1996-2002 (2001 prices)](image)

**Ministry of Health**

Health expenditures by MOH as a percentage of GNP have, by and large, remained unchanged during 1996-2001 (Figure 7). Excluding the revolving funds of MOH facilities, health expenditures by MOH increased from 0.78 percent of GNP in 1996 to 1.03 percent in 1999, and then fell to 0.94 percent of GNP in 2001. In terms of the share of the total consolidated budget, MOH expenditures on health fell from 2.95 percent in 1996 to 2.87 percent in 1999, declining thereafter to 2.19 percent in 2001. Including the contributions of the revolving funds of MOH facilities, the share of health expenditures as a percentage of total public expenditures on health by MOH fell from 39.6 percent in 1996 to 28.6 percent in 2001.

Overall, public expenditures on preventive care as a share of total expenditures on health have dropped from 12.1 percent in 1996 to 6.3 percent in 2001, while public expenditures on curative care have increased from 79.6 percent in 1996 to 89.1 percent in 2001. Maternal and child health activities receive less than three-fourth of one percent of public spending. It is therefore discouraging to note that despite the increasing trend in total public expenditures on health as a share of GNP in the last five years, there is no clear trend in MOH expenditure and allocations to preventive activities have, for most of the years under review, actually fallen relative to the previous year. The implication is that most of the increased spending has been on curative care programs outside the MOH budget. To be sure, the poor coverage for a country at the level of economic development of Turkey is a reflection of both the effectiveness of existing public expenditures and the volume of allocation made for this purpose. On both counts, public expenditures on health in Turkey need to pay much greater attention to preventive services.
Social Security Institutions

SSK, Bagkur and Emekli Sandigi comprise Turkey’s social security system, and cover more than 80 percent of the country’s population. The share of health expenditures of the social security institutions in GNP has more than doubled between 1996 and 2001, increasing from 0.96 percent in 1996 to 2.2 percent in 2001 (Figure 8).
The Green card program

The “Green Card” program was introduced as a mechanism to ensure targeted delivery of health services to the poor who have little or no capacity to pay for the services. Enacted under Law 3816 of 1992, it provides free health care services to its beneficiaries. The Green Card program is seen as a transitional solution until a general health insurance system is introduced.

Applications for Green Cards are finalized in the districts by the Councils of Provincial Administration. The Councils determine eligibility based on verification of applicant’s incomes, and make recommendations to the provincial Governor who then issues the Green Card. At present, approximately 11.3 million citizens benefit from this scheme (Table 6).

Table 6: Population Covered by Green Cards, 1992-2001

<table>
<thead>
<tr>
<th>Years</th>
<th>Green Card Applications</th>
<th>Green Cards Awarded</th>
<th>Total Population</th>
<th>Population Covered (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>910,873</td>
<td>365,509</td>
<td>58,179,932</td>
<td>0.6</td>
</tr>
<tr>
<td>1993</td>
<td>2,971,722</td>
<td>2,211,341</td>
<td>59,052,631</td>
<td>3.7</td>
</tr>
<tr>
<td>1994</td>
<td>4,469,935</td>
<td>3,671,452</td>
<td>59,938,421</td>
<td>6.1</td>
</tr>
<tr>
<td>1995</td>
<td>5,977,439</td>
<td>4,996,728</td>
<td>60,837,497</td>
<td>8.2</td>
</tr>
<tr>
<td>1996</td>
<td>6,948,328</td>
<td>5,713,066</td>
<td>61,564,398</td>
<td>9.3</td>
</tr>
<tr>
<td>1997</td>
<td>8,246,854</td>
<td>6,666,978</td>
<td>62,865,574</td>
<td>10.6</td>
</tr>
<tr>
<td>1998</td>
<td>9,592,807</td>
<td>7,760,443</td>
<td>64,166,750</td>
<td>12.1</td>
</tr>
<tr>
<td>1999</td>
<td>10,944,955</td>
<td>8,721,629</td>
<td>65,505,088</td>
<td>13.3</td>
</tr>
<tr>
<td>2000</td>
<td>12,555,783</td>
<td>10,125,706</td>
<td>67,844,903</td>
<td>14.9</td>
</tr>
<tr>
<td>2001</td>
<td>14,213,305</td>
<td>11,346,250</td>
<td>69,272,291</td>
<td>16.4</td>
</tr>
</tbody>
</table>

Since 1992 when the scheme was first initiated, a total of approximately 1.5 billion USD has been spent under the scheme. End-of-year expenditures have continuously exceeded revenues under the Green Card program, and large deviations have been observed between initial appropriations and year-end expenditures over the past few years.

Revolving Funds

The presence of revolving funds and other special funds in the resource pool of MOH and universities merits special discussion, not only because of their salience but also because of the way in which they interact with the regular budgetary sources of financing. Off-budget options of receiving and spending public funds are attractive for a variety of reasons. All budgetary agencies and provincial and municipal administrations are subject to the provisions of the General Accounting Law, the Public Tender Law, the Travel Allowance Law and the Civil Servants Law. The General Accounting Law, more popularly known as Code 1050, lays down individual and office responsibilities (articles 11, 13-15, 22), rules related to “visa” requirements of Ministry of Finance (article 64), and procedures for advance payments and credits related to purchases (article 83). The rules of procurement are laid down in the Public Tender Law, more popularly known as Code 2886, and covers all issues related to procedures and preparation of bidding and evaluation, settling of a contract, general provisions related to purchase, and a
variety of prohibitions. In addition to the Codes 1050 and 2886, expenditures under the consolidated budget are also subject to Travel Allowance Law 6245, and Civil Servants Law 657. All these codes and laws are rather restrictive in that they provide very limited flexibility in procurement procedures, payment mechanisms, compensation levels, etc. Moreover, the consolidated budget allocates funds according to line items, leaving very little scope for any subsequent changes.

Revolving Funds are not subject to any of the above restrictions. They have their own accounting regulations and procurement laws which are far less restrictive in the conditions they impose; in addition they allow for additional payments for personnel employed in these organizations. Procurement procedures of revolving funds attached to budgetary institutions and of special funds established under Code 3418 are determined by regulations issued by the Council of Ministers – number 18478 of 1984 (governing special funds) and number 18479 of 1984 (governing revolving funds). The procurement procedures for revolving funds are simpler compared to consolidated budgetary institutions, largely because of the absence of the “visa” system that is required in the budgetary process. In general, as long as the principles of openness and fairness are not compromised, the revolving funds can follow procurement procedures in quite the same way as practiced in the private sector.

Of the 727 hospitals owned and operated by the MOH, 536 hospitals, i.e., 73.7 percent of all hospitals, accounting for 96 percent of all hospital beds, have revolving funds. Some hospitals have more than one revolving fund, so that there are 562 revolving funds in MOH facilities. Of these, 440 revolving funds are in state general hospitals, 23 in children hospitals, 46 in Women and Children hospitals and 53 in other facilities. In addition, there are 43 revolving funds that operate in university hospitals.

*Population Coverage*

In the absence of reliable data, it is difficult to estimate exactly how much of the population is covered by health insurance and Green Card programs. The figures put out by the social security institutions have to be treated with caution, since they rely on estimates rather than on an actual headcount. Three major issues related to counting the insured are: (i) many persons are insured with more than one social security institution, and thus show up on multiple records; (ii) the number of “active” population indicates those registered under the program, not necessarily those whose status is current, in that they are regular in their contributions, a particularly serious problem for Bagkur; and (iii) the number of dependents is estimated, and not known with any certainty.

Excluding military personnel, and subject to reliability of the data, it appears that the health insurance and Green Card programs between them cover the entire population of Turkey (Table 7). SSK is the single-largest insurer, covering 46.54 percent of the country’s population. Bagkur covers a further 22.36 percent, followed by Emekli Sandigi (16.13 percent). The Green Card program provides coverage to 14.92 percent of the population. Coverage by private insurance funds is relatively insignificant (0.45 percent).

Adding up the population numbers reportedly insured by one or the other program, however, shows that in 15 provinces the number of insured exceed the population, reaffirming the point made earlier of duplication in insurance records. The highest reported extra coverage is in Zonguldak, Sinop,
Tekirdag, Denizli, Istanbul, Bursa, and Kocaeli. On the other hand, there are over 50 provinces with 10 percent or more of the population not covered under any insurance or Green Card program. Provinces with the highest proportion of the population not covered by any program include Sirnak (67 percent population not covered by any social security institution or by the Green Card program), Osmaniye (60 percent), Hakkari (52 percent), Urfa (52 percent), Agri (51 percent), Mus and Van (47 percent), Diyarbakir (45 percent), Igdir (43 percent), Ardahan (42 percent), Mardin, Maras and Kilis (41 percent). The figures provided in Table 7, therefore, overestimate and over-report population coverage.

Coverage by SSK is concentrated in urban and industrial provinces, with almost 50 percent of their beneficiaries coming from Istanbul, Izmir, Ankara and Bursa. SSK covers more than half of the population in twenty provinces, the highest of which is Zonguldak (98 percent population covered). On the other hand, SSK covers less than 10 percent of the population in 10 provinces, the lowest coverage in terms of numbers being in Ardahan (10,060) and in terms of share of population being in Agri (4.37 percent).

Similarly, almost 40 percent of Bagkur's beneficiaries come from 9 provinces, including Istanbul, Ankara, Izmir, Konya, Antalya, Bursa, Icel, Hatay and Adana. The highest Bagkur coverage areas in terms of the share of population covered are Sivas and Amasya (both over 40 percent), while the lowest are Sirnak, Urfa and Van (all under 10 percent of the population).

**Distribution of public expenditures**

One justification and rationale for public expenditures is that they contribute to improving the distribution of income, and many public subsidies are advocated on the grounds that they will reduce costs to the poor. Figure 9 depicts the relationship between regional average per capita public expenditures on health (plotted on the x-axis) and regional average per capita income (plotted on the y-axis) for 2001. If well targeted, the richer regions should receive lower public allocations for health care. However, the degree to which the allocation of public funds does this is suspect. An analysis of public spending on health and regional per capita incomes shows a positive correlation ($p = 0.31$) between the two, and – with the exception of Marmara region – the richer regions consistently spend more public money per person on health care compared with the poorer regions, and the pattern of allocation shows no particular connection with income.

Overtime, however, real per capita public expenditures on health (2001 prices) have increased markedly in the poorer regions compared to the richer ones. The most significant increase was recorded in low-income region of Eastern Anatolia, which saw an increase of over 90 percent between 1996 and 1999, compared to the high-income Marmara region, which recorded an increase of only 27 percent during this period.
<table>
<thead>
<tr>
<th>I. SSK</th>
<th>Population Covered</th>
<th>Percentage of Population Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
<td>2000</td>
</tr>
<tr>
<td>Active (1)</td>
<td>30,047,750</td>
<td>31,572,609</td>
</tr>
<tr>
<td>Passive (2)</td>
<td>5,429,045</td>
<td>5,692,101</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>3,148,826</td>
<td>3,339,327</td>
</tr>
<tr>
<td>Active/Passive (1/2)</td>
<td>21,469,879</td>
<td>22,541,181</td>
</tr>
<tr>
<td>Dependency Ratio ((2+3)/1)</td>
<td>1.72</td>
<td>1.70</td>
</tr>
<tr>
<td>II. Bagkur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active (1)</td>
<td>14,024,920</td>
<td>15,171,559</td>
</tr>
<tr>
<td>Passive (2)</td>
<td>3,064,609</td>
<td>3,298,694</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>1,179,817</td>
<td>1,277,444</td>
</tr>
<tr>
<td>Active/Passive (1/2)</td>
<td>9,780,494</td>
<td>10,595,421</td>
</tr>
<tr>
<td>Dependency Ratio ((2+3)/1)</td>
<td>2.60</td>
<td>2.58</td>
</tr>
<tr>
<td>III. Emekli Sandigi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active (1)</td>
<td>10,635,818</td>
<td>10,945,821</td>
</tr>
<tr>
<td>Passive (2)</td>
<td>2,118,000</td>
<td>2,163,698</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>1,289,127</td>
<td>1,349,151</td>
</tr>
<tr>
<td>Active/Passive (1/2)</td>
<td>7,228,691</td>
<td>7,432,972</td>
</tr>
<tr>
<td>Dependency Ratio ((2+3)/1)</td>
<td>1.64</td>
<td>1.60</td>
</tr>
<tr>
<td>IV. Private Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active (1)</td>
<td>332,870</td>
<td>306,766</td>
</tr>
<tr>
<td>Passive (2)</td>
<td>78,861</td>
<td>118,485</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>58,624</td>
<td>59,940</td>
</tr>
<tr>
<td>Active/Passive (1/2)</td>
<td>195,385</td>
<td>128,341</td>
</tr>
<tr>
<td>Dependency Ratio ((2+3)/1)</td>
<td>1.35</td>
<td>1.98</td>
</tr>
<tr>
<td>TOTAL (I-IV)</td>
<td>55,041,357</td>
<td>57,996,754</td>
</tr>
<tr>
<td>Active (1)</td>
<td>10,690,515</td>
<td>11,272,978</td>
</tr>
<tr>
<td>Passive (2)</td>
<td>5,676,394</td>
<td>6,025,862</td>
</tr>
<tr>
<td>Dependent (3)</td>
<td>38,674,448</td>
<td>40,697,914</td>
</tr>
<tr>
<td>Active/Passive (1/2)</td>
<td>3.22</td>
<td>1.59</td>
</tr>
<tr>
<td>V. Green cards</td>
<td>8,721,629</td>
<td>10,125,706</td>
</tr>
<tr>
<td>GRAND TOTAL (IV+V)</td>
<td>63,762,986</td>
<td>68,122,460</td>
</tr>
</tbody>
</table>
As far as prioritizing and targeting public expenditures on health, economic theory provides some guidance using public goods, merit goods and redistribution arguments. On this basis, preventive health activities, health education, health protection for the vulnerable, and health coverage for the poor, children and the elderly deserve priority in targeting and allocation of public funds in Turkey. In conjunction with health policy targets, this would mean significantly higher MOH budgetary allocations for preventive activities like mother and childcare, as well as increased health coverage for the poor and the vulnerable. The present level of allocation of funds is not sufficient to extend preventive services to the whole population; this is especially true for maternal and child health care, which gets less than 2 percent of the MOH budget. There is, therefore, a strong case for increasing government allocations for preventive activities and for increased health coverage for the poor and vulnerable, even if it implies reductions elsewhere. The effectiveness of public expenditures can be increased rather simply by spending more where the poor live — and increased MOH allocations for Eastern and South Eastern Anatolia and in the shanty areas on the outskirts of large cities, justified on grounds of both public goods argument as well as on the grounds of poverty alleviation, will improve targeting and effectiveness of public funds.

3.7 Pharmaceutical consumption and production

Expenditure on pharmaceutical products constitutes a significant proportion of total expenditures on health in Turkey. It is estimated that the expenditure on pharmaceutical products of SSK, Emekli Sandigi and Bagkur combined in 2001 was about 1,981,672 billion TL, equivalent to about 48.5% of total expenditure on health by these three institutions. Expenditure on pharmaceutical products accounts for between 55 and 60 percent of total expenditures on health incurred by Bagkur and Emekli Sandigi, and between 33 and 38 percent for SSK during the period 1998 to 2002. Civil servants spent a further 579,370 billion TL on pharmaceutical products, equivalent to 52% of total expenditures on health. Exact figures on pharmaceutical expenditures are not available for other consumers and for out-of-pocket payments on pharmaceutical products for the uninsured.
In terms of absolute value of pharmaceutical products consumed, however, as Table 8 shows, Turkey ranks fairly low compared to other countries in Europe.

Table 8: Per Capita and Total Consumption of Pharmaceutical Products, 1998-99

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Capita Consumption (US$)</th>
<th>Total Consumption (ex-factory prices, $ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>285 287</td>
<td>16,744 17029</td>
</tr>
<tr>
<td>Belgium</td>
<td>252 269</td>
<td>2,547 2,756</td>
</tr>
<tr>
<td>Switzerland</td>
<td>250 270</td>
<td>1,822 1,938</td>
</tr>
<tr>
<td>Germany</td>
<td>225 227</td>
<td>18,511 18,597</td>
</tr>
<tr>
<td>UK</td>
<td>211 213</td>
<td>12,388 12,680</td>
</tr>
<tr>
<td>Austria</td>
<td>205 220</td>
<td>1,659 1,776</td>
</tr>
<tr>
<td>Portugal</td>
<td>203 212</td>
<td>2,009 2,128</td>
</tr>
<tr>
<td>Italy</td>
<td>189 196</td>
<td>10,821 11,266</td>
</tr>
<tr>
<td>Denmark</td>
<td>184 163</td>
<td>977 867</td>
</tr>
<tr>
<td>Norway</td>
<td>171 197</td>
<td>754 880</td>
</tr>
<tr>
<td>Spain</td>
<td>167 177</td>
<td>6,598 7,069</td>
</tr>
<tr>
<td>Ireland</td>
<td>158 171</td>
<td>586 651</td>
</tr>
<tr>
<td>Netherlands</td>
<td>144 159</td>
<td>2,268 2,525</td>
</tr>
<tr>
<td>Greece</td>
<td>134 144</td>
<td>1,424 1,524</td>
</tr>
<tr>
<td>Turkey</td>
<td>35 38</td>
<td>2,220 2,519</td>
</tr>
</tbody>
</table>

Source: IMS, Turkey, 1998 and 1999

SSK hospitals procure their requirement of drugs for their patients through their own drugstores, which, in turn, procure directly from producers. Contracts with producers are negotiated each year. Emekli Sandigi does not have direct procurement procedures. Patients insured with Emekli Sandigi purchase drugs from the over 15,700 private drug stores with whom Emekli Sandigi has contracts, and make the copayment at the rate applicable to them. The drug stores bill Emekli Sandigi for the balance. Bagkur follows the same practice as Emekli Sandigi. Civil servants obtain medicines directly from contracted drug stores and make small copayments, leaving the drug stores to claim reimbursement from their parent departments.

Drug prices are set by the Ministry of Health under Law 1262 (Law of Pharmaceuticals), and are based on the producing firm’s cost-based price proposal and prices of existing equivalents at domestic market. The insurees of SSK, Emekli Sandigi and Bagkur pay 20% of the market price of drugs, and the balance is covered by the insurance. The copayment rate is 10% for retired persons.

While the price increases in pharmaceuticals have, on average, been close to general inflation levels, there has been a subtle change in the consumption of drugs in favor of more expensive ones. Between the years 2000 and 2001, the proportion of drugs consumed priced at half million
TL or less decreased slightly from 34% to 30%, while the proportion of drugs consumed priced at 2 million TL or more increased from 34% to 47%. As a result, expenditure on pharmaceutical products has increased, particularly among consumers insensitive to prices, as is borne out by the rising expenditures on drugs by the social security institutions.

**Issues and concerns**

Turkey spends a disproportionately high amount on drugs and pharmaceutical products. Indeed, the high percentage of pharmaceutical expenditures in terms of overall health expenditures is as much a reflection of low overall expenditures on health as it is of high expenditures on drugs. A very large proportion of the population is fairly insensitive to pharmaceutical prices, and those insured with any of the social security institutions or belonging to the category of civil servants pay only one-fifth of the drug price, while those retired pay only one-tenth. The consumption of pharmaceutical products among the insured is actually not low by international standards, and there is a strong scope for cost containment if indiscriminate consumption can be curbed.

Another aspect of high expenditures on pharmaceutical products is related to the supply-side of the equation. With the introduction of new drugs in the market, accompanied by aggressive marketing policies of the pharmaceutical companies, the distribution of drugs according to prices has moved toward higher price medicines, so much so that there has been an increase of almost 50% in the number of drugs costing 5 million or more, after adjusting for inflation, between 2000 and 2001. Thus, while the overall pharmaceutical price index has not moved out of line relative to the general consumer price index, the proportion of expensive medicines has gone up, as a result of which pharmaceutical expenditures have also gone up, especially among the insured.

Aggressive marketing policies of the pharmaceutical companies undoubtedly pose a big challenge to effective supply-side cost-containment measures. Anecdotes abound of a nexus between suppliers of pharmaceutical products and providers of health care, and even if only a few of them are factually correct, bringing down expenditures on pharmaceutical products will be an uphill battle.

**3.8 Impact of economic shocks on the health sector**

Whereas the economic crises delivered a severe blow to all sectors of the Turkish economy, adversely affecting agriculture, industry and tertiary services alike, the poverty and social impacts of the crises have been particularly marked, with high unemployment rates, rising prices and negative growth rates reducing household incomes and exposing more people to the risk of poverty. Across-the-board cuts have undoubtedly affected consumption and utilization of health services as well, even though real and visible effects on mortality and morbidity might not be readily apparent. Turkey’s situation is not unique in this respect: international experience shows that economic crisis has affected health outcomes and utilization in many countries. In Mexico, for example, as Cutler et al (2000) show, mortality rates were 5 to 7 percent higher in crisis years compared to other periods. Similarly, infant mortality rates were higher during crisis years in Latin America and the Caribbean (Musgrove, 1987). In a recent paper, Yang et al (2001) show that health care consumption among Korean households was adversely affected by economic crisis.
An economic crisis can affect utilization of health services and health outcomes in several different ways. Following the conceptual framework developed by Musgrove (1987), the effects of an economic crisis can be classified and evaluated in terms of “direct” and “indirect” effects. The direct effects consist of supply-side changes – following reduced government spending on health in the aftermath of an economic crisis – and demand-side changes – following increase in prices of health services (or the “price effect”) and reduced household incomes (or the “income effect”) as a result of the economic crisis. The indirect effects of an economic crisis on health services utilization and health outcomes stem from such factors as reduction in insurance premium revenues and the impact of currency devaluation on medical prices, and also adversely affect both supply and demand for health services. Layoffs in the formal sector reduce the potential pool of insured, reducing health insurance premium collections and transferring the burden of financing health services for the newly unemployed on to the already cash-strapped public options. At the same time, since prices of a large proportion of medical goods and pharmaceuticals are set in international markets, devaluation of the local currency can significantly increase the domestic prices of these goods and services for the end-user. For all these reasons, an economic crisis drives the health care market to new equilibrium levels lower than pre-crisis levels, in which utilization of health services is lower and prices are higher than before the crisis. Expectedly, since the poor have a lower tolerance for adverse shifts in prices and incomes, and because those with marginal incomes even in the pre-crisis times are more likely to be pushed into poverty following economic downturn, the adverse impacts of an economic crisis are likely to be felt more by the poor, the elderly, the handicapped and by those otherwise vulnerable compared to the better-off.

There is limited evidence of a reduction in the scope or size of supply of health services, either in the public or the private sector, in the sense that only a few private health facilities closed down following the crisis. Some contraction in public spending on health, however, did occur, and total public spending on health, which increased by 11.4 percent between 1998 and 1999, and by 4.7 percent between 1999 and 2000, fell by 1.24 percent between 2000 and 2001 (Figure 10).

Figure 10: Public Expenditures on Health, 1998-2001 (billion TL)
Economic Crisis and Demand for Health Services

User charges for health services provided in facilities belonging to MOH and universities are set on the basis of a schedule of prices agreed between the MOH and the Ministry of Finance, and are not subject to market conditions. To this extent, therefore, the economic crisis has had no effect on prices in facilities operated by the MOH and by the universities. The other major public sector provider of health services is SSK, which also provides health services free of charge at point of service, principally to those insured with SSK and Bagkur. Similarly, facilities run by the General Directorate of Health for Borders and Coasts, state enterprises and local authorities provided health services free of charge to those entitled to use them. In effect, therefore, the price effect of the economic crisis insofar as publicly provided health services are concerned has been negligible.

The prices of medicines are also set by the MOH, under Law 1262, and are based on the producing firm’s cost-based price proposal and prices of existing equivalents at domestic market. As a result of the control that the MOH exercises, price increases in pharmaceuticals, on average, have usually been very close to general inflation levels. For instance, in the period January 2001 to January 2002, the rate of change in the Consumer Price Index for medical and pharmaceutical products increased by 84.6 percent compared to the 73.2 percent increase in the overall Consumer Price Index for urban settlements. In general, therefore, the effect of the economic crisis on pharmaceutical prices has been insignificant.

The income effect of the economic crises was, however, not negligible. The economic crises of 2000 and 2001 completely wiped out all the income gains of the previous five years, and in real terms (2001 prices), annual per capita income fell from 2,965 million TL in 2000 to 2,615 million TL in 2001. The change in real incomes is most dramatic for the poorest group, whose incomes fell by 32 percent in contrast to the richest group, whose incomes fell by 26 percent. Everyone is worse off after the economic crises of 2000 and 2001, but the poorer are affected harder and the poorest the hardest.

Considering that the price effect of the economic crisis has been negligible, the income effect probably explains most of the changes in utilization of health services. Data on utilization is obtained from surveys carried out in 1999 and 2001. In 1999, of those reporting illnesses, 82 percent sought some form of medical treatment for the reported illness. Sick individuals with higher incomes were more likely to seek treatment compared to sick individuals with lower incomes, and this trend was consistent across all income quintiles. Among the poorest 20 percent, only 73 percent sought care, significantly different from the 87 percent of individuals in the top two quintiles. Following the economic crises in 2001, the percentage of those seeking some form of medical treatment when ill dropped to 72 percent. Among the poorest 20 percent, only 68 percent seek care in 2001 (Figure 11).

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5 Note that the 1999 and 2001 surveys are not comparable, for besides the relatively small size of the 1999 survey, it is not nationally representative while the 2001 survey is. Since there is no other recent survey, however, the results of the 1999 and 2001 surveys are used to obtain a qualitative feel of directional changes in this period.
Overall, the propensity to seek care fell irrespective of type of insurance. The largest drop was observed among those with no insurance, in which category the percentage of persons seeking care when ill fell from 72 percent in 1999 to 55 percent in 2001.

**Economic Crisis and Health Insurance**

Social insurance programs in Turkey are tied to an individual having a job in the formal sector. With the exception of Bagkur – a social insurance plan for the self-employed – the whole social security system is linked to holding a formal job. In such a system, there is a distinct risk that those without a connection to the formal market will be excluded from social security benefits, and there is no other insurance program that comprehensively targets the vulnerable groups.

Total employment in Turkey was 20.6 million in 2000, of which 35 percent were employed in agriculture, 18 percent in industry, 6.5 percent in construction and the remaining 40.5 percent in the services sector. According to the Household Labor Force Survey (HLFS) of year 2000, the number of unemployed people was estimated to be 1.45 million, or 6.6 percent of the total workforce, and a further 7 percent were underemployed.

The addition of over a million persons in the category of the unemployed places a huge strain on the social security system. As far as the health sector is concerned, this translates into reduced health insurance premium collections and a greater burden for the state welfare system to finance health care for the unemployed. In particular, persons losing employment in the formal sector would also be losing their health coverage as provided under SSK. In turn, the newly unemployed and under-employed, both with reduced incomes, would be unlikely to participate fully in the Bagkur program as well. The combined result of all this would be a greater pressure on the Green Card program on the one hand and reduced utilization of health services on the other.
An examination of the relevant data confirms these presumptions. The collection to assessment ratio for Bagkur for 2001 was only 37.4 percent for agricultural sector employees (under code 2926) and 63.2 percent for others (under code 1479). Health expenditures by Bagkur fell by about 20 percent between 2000 and 2001 (Figure 12) and the over 3.2 million new green card applications were filed in the years 2000 and 2001 (Figure 13).

Issues and Concerns

The current economic crisis has had an impact on almost all sectors of the Turkish economy and has adversely affected everyday life for most citizens in the country. The impact of the crisis on
health outcomes is not readily apparent or measurable at this point of time, but there is little doubt that the economic turbulence of the last eighteen months or so has adversely affected utilization of health services and possibly the quality of publicly provided health services. In addition, the increasing unemployment and underemployment following the crisis has had a negative impact on the health insurance system and has put an additional strain on the already cash-strapped public finance and delivery system.

One major concern is that these types of crises affect the poor more than the rich, and the severely poor more than the marginally poor. When utilization falls, one concern is whether it is the consumption of necessary health services by the poor that has decreased. In the absence of disaggregated utilization data by quintiles by type of service, it is difficult to ascertain the equity effects of the crisis; however, there are many indications that the crisis has left more people vulnerable to general under-consumption. Simulations using household data from 1994 to assess the impact of the crisis on welfare distribution suggest that families with many children and those with moderate levels of education are particularly vulnerable to economic downturns the kind that Turkey experienced. These simulations suggest in families with many children, single mothers, families with unemployed members, and the urban underemployed, utilization of health services is likely to be deferred till it becomes absolutely essential, increasing vulnerability to illnesses in the short-run and adversely affecting health outcomes in the long run.

Periods of economic crisis also provide opportunities for positive change, both by exposing the fault lines in the existing system as well as by presenting innovative options for addressing the problems. The economic crisis of Turkey and its impact on health services utilization points to the need of back-up insurance coverage for the unemployed, for at least some time period after cessation of the employment. In addition, the existing vacuum in coverage of the non-formal sector employees, the underemployed, the marginally poor and others who are unable to make insurance premium contributions needs to be covered in some suitable manner.

### 3.9 Health-Related Millennium Development Goals

The consensus and commitment among many countries and the international community to the achievement of the Millennium Development Goals (MDGs) implicitly recognizes the substantial positive repercussions the attainment of these goals would have on reduction of poverty and welfare gains for millions of households. Despite considerable progress in the recent past, meeting the health-related MDGs for 2015 will continue to pose a challenge for Turkey, where income inequality and inequity in health status and utilization constitute a formidable barrier. Demand-side restrictions emanating from income, cultural and opportunity barriers, and supply-side problems caused by uneven distribution of facilities and personnel lead to a vicious circle of poverty and ill health that would need to be broken before any rapid and sustained progress can be achieved in the MDG indicators.

Data from the Turkey Country Report on Socio-Economic Differences in Health, Nutrition and Population, December 2001, Demographic and Health Survey (DHS), 1993 and Demographic and Health Survey (DHS), 1998 permit an analysis of the relationship between health status and health services utilization data for reproductive health services, by asset or wealth quintiles. Although the data is old, the patterns most likely remain valid even today.
The differences in the proportion of clients using health services between the poor and the rich in Turkey are large for all services, but are the greatest for the use of safe motherhood services (Figure 14). The inter-quintile disparity ratios between the poorest (reference) and richest quintiles are 2 or more, which suggests that the rich utilize safe motherhood services at least twice as much as the poor. The biggest difference is in antenatal care (inter-quintile disparity ratio of 2.8), followed by deliveries attended by skilled medical personnel (2.3), contraceptive prevalence rate, or CPR (2.2) and immunization (2.0). Thus, the high averages of the use of child and safe motherhood health services (>60 percent, except CPR) mask the low levels of utilization by the poor.

Figure 14: Use of Selected Health Services in Turkey: Poor-Rich Differences

Figure 15: Antenatal Care Visits
Antenatal Care

Inequity in the use of antenatal care between each successive quintile is large even though the average for antenatal care use is 62.5 percent (Figure 15). More women in all quintiles report visiting a doctor for antenatal care (average 47.1 percent) compared to a nurse or trained midwife (15.4 percent). Women from the richest quintile are four times more likely to visit a doctor and 2.6 times less likely to visit a nurse for antenatal care compared to women in the poorest quintile. Inequity in the number of visits for antenatal care is also high. Women from the richest households are almost 3 times more likely to have at least one antenatal visit and about 3.6 times more likely to have two or more antenatal visits relative to women from the poorest households. On average, 62.5 percent women report at least one antenatal visit, while 54.4 percent report at least two visits.

Delivery Care

Inequity is large for skilled attendance at delivery (Figure 16). Only 11.6 percent of the poorest women have had deliveries attended to by a doctor compared with 72.3 percent of the richest women, indicative of a more than 6-fold increase across quintiles. Attendance by a nurse or trained midwife is less inequitable than the attendance by a doctor, even though levels decrease across quintiles. Overall, women in the poorest quintiles are more likely to have a nurse or midwife attend their deliveries, while women in the richest quintiles are more likely to have trained doctors attend their deliveries.

The presence of a skilled attendant considerably influences the levels of infant mortality, as is also brought out by the high Infant Mortality Rates (IMR) among those with low levels of skilled attendance at birth. IMR inequality almost mirrors the inequality in skilled attendance,
suggesting that the poorer women not only face higher mortality and morbidity risks, their infants are also at higher risk compared with infants born to wealthier women.

The majority of women (average 55.9 percent) deliver in a public facility, followed by deliveries at home (40 percent). About 72 percent of the poorest women deliver at home compared to only 8.2 percent of women in the wealthiest quintiles. The use of public facilities for deliveries increases with income, while only very few women in the richest quintile prefer private facilities.

Without a doubt, there is a strong association between income status on the one hand and health status and utilization of services on the other. A consistent observation across almost all indicators is that the poor have worse health status relative to the rich and are less likely to use health services. These results are not unexpected; however, the extent of disparities is glaring. Significant improvements will have to be brought about in ways that health services are delivered and targeted among the poor if Turkey is to achieve its MDG targets. Since inequality in health indicators is high, health objectives and targets will be reached more aggressively and more effectively if the poor are targeted first. Turkey will thus have to invest considerably in reaching health services to the poorest sections of society in order to reduce the high levels of maternal mortality and morbidity and child mortality.
4. Health reform strategy

The analyses in the previous section highlight the key problem areas in the health sector in Turkey. To recap:

- The health status of Turkey's population is poor, both in absolute terms as well as in comparison with other countries at same levels of income; in particular, maternal and child mortality rates are very high.
- There are huge locational and regional disparities in health outcomes across all indicators.
- Not all those who are ill are able to get treatment for their illness; in particular, the poor are significantly more likely to not get treatment when ill compared to the non-poor.
- Knowledge of health conditions and treatments has a significant bearing on seeking care, and those who are more knowledgeable about health conditions and treatments are more likely to seek care compared to those who are less knowledgeable.
- Health insurance is also a strong determinant of seeking care when ill, and those without any form of financial protection are far less likely to seek care when ill relative to those who do have some form of financial protection.
- The primary health care system is substantially underfunded and ineffective; in particular, most people circumvent public primary care facilities and either directly seek care at outpatient facilities of hospitals or, if they can afford it, from the private sector.
- A large number of health centers are understaffed and many do not have even one physician; the situation is particularly grim in rural areas in general and in the Eastern and South Eastern Anatolia regions of the country.
- Majority of general hospitals in Turkey are run inefficiently and are responsible for considerable waste of resources.
- The large number of very small hospitals under the Ministry of Health is a major contributor to an inefficiently run hospital system; in particular, they have very low occupancy rates and suffer from a lack of manpower and outdated or ill-functioning equipment, which results in low quality of service and leads people to utilize larger facilities even if they are further away.
- There are huge gaps in the distribution of health personnel among the provinces and regions; in particular, there is a concentration of physicians in the big cities and towns and rural areas are significantly understaffed.
- Considerable imbalance exists between physicians in primary and specialty care in Turkey, and almost half of all physicians in patient care are specialists.
- There is little or no coordination between the Ministries of Health and Labor who, between them, control most financing and provision of health care in Turkey; in particular, even though their activities overlap across most services and they have facilities in the same towns and cities, there is very little discussion and dialogue between them and almost no planning or collaboration at any level.
- Very little is spent on preventive care and on maternal and child health; in fact, despite the increasing trend in total public expenditures on health as a share of GNP in the last
five years, allocations to preventive activities have actually fallen in real terms over the years.

- Large segments of the population do not have adequate health insurance or any other form of financial protection; in particular, over 50 provinces have 10 percent or more of their population not covered under any insurance or Green Card program.
- The distribution of public expenditures on health is not equitable; in particular, the richer regions spend more public money per person on health care compared with the poorer regions.
- Income inequality and inequity in health status and utilization constitute a formidable barrier to meeting the health-related Millennium Development Goals.

The ultimate objective of health system reform is to improve health outcomes in an efficient, equitable, and sustainable manner. Reform interventions, however, do not necessarily impact health status directly, but rather through improvements in resource mobilization and allocation, equity and access, demand and utilization of health care, and efficiency and effectiveness of health care production and delivery. Any reform strategy aimed at addressing the health sector problems in Turkey thus has to essentially be shaped around at least five programmatic areas:

- Improvements in resource mobilization and allocation
- Enhanced access to health services
- Increase in demand and utilization of health services
- Improvements in efficiency in production and delivery of health services
- Improvements in clinical effectiveness of health services

While there can potentially be little debate around formulating the health sector strategy so as to meet the above broadly defined goals and objectives, a much greater scope for debate and discussion surrounds the wide variety of specific measures and actions that can be employed to achieve these objectives and goals. In the end, it is the practicality, effectiveness and sustainability of the mechanisms employed that will yield the best results, and much will depend on the political will and administrative capability to push forward the reform process on the basis of the chosen set of actions.

The strategy proposed for health sector reforms in Turkey in this document is based on the assessment that piecemeal changes at the margin are unlikely to revitalize the health system, and nothing short of major restructuring and reorganization of the health system will work if the desired objectives of universal access to quality health services produced and delivered in an economically and institutionally sustainable environment are to be met. It is in this spirit that the measures and mechanisms suggested to achieve improvements in resource mobilization and allocation, enhanced access to care, increased utilization, improvements in efficiency and effectiveness and improvements in clinical quality include: (i) introduction of universal social health insurance; (ii) developing an essential package of services for vulnerable areas so as to include education, sanitation and nutrition and targeting public spending on health so as to reach the poor; (iii) consolidation of institutional responsibilities, particularly as regards MOH and MOLSS; (iv) reorganizing public hospitals and granting them greater autonomy; and (v) introduction of family medicine for continuity of care. Table 9 presents a schematic view of the proposed health sector reform strategy for Turkey.
Table 9: Health Sector Reforms — Objectives and Mechanisms

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<thead>
<tr>
<th>Mechanisms</th>
<th>Intermediate Objectives</th>
<th>Ultimate Objective</th>
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<tr>
<td>➢ Risk-pooling and consolidation of health financing through universal social health insurance ⇒</td>
<td>Improvements in resource mobilization and allocation</td>
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<td>➢ Incentive-compatible provider payment mechanisms.</td>
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<td>➢ Cost-containment through managed care</td>
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<tr>
<td>➢ Financial protection through health insurance ⇒</td>
<td>Enhanced access to health services</td>
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<tr>
<td>➢ Targeted spending and regional prioritization</td>
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<td></td>
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<tr>
<td>➢ Human development approach to health</td>
<td>Increase in demand and utilization of health services ⇒ General improvements in health status</td>
<td></td>
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<tr>
<td>➢ Essential package of services to include health, education, sanitation, child care and nutrition ⇒</td>
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<tr>
<td>➢ Increased emphasis on preventive and primary care</td>
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<tr>
<td>➢ Institutional consolidation</td>
<td>Improvements in efficiency in production and delivery of health services</td>
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<td>➢ Managerial autonomy for health facilities ⇒</td>
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<td>➢ Incentive schemes to send health personnel to rural areas</td>
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<td>➢ Improved administrative capacity</td>
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<tr>
<td>➢ Introduction of family medicine</td>
<td>Improvements in clinical effectiveness of health services</td>
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<tr>
<td>➢ Enhancing quality through quality control ⇒</td>
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<tr>
<td>➢ Redefining the role of the Ministry of Health, focusing on regulation, oversight and policy formulation ⇒</td>
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Challenging and daunting as the set of reform measures may appear, implementation is by no means impossible. Consider, for example, the experience of Mexico, a country of 97 million people and a profile few years ago quite like Turkey today. Like Turkey, Mexico is also undergoing an epidemiological transition, and childhood diseases such as diarrhea, respiratory diseases and malnutrition are still significant causes of illness and death. At the same time, cardiovascular diseases and cancer are on the rise, contributing significantly to the total of potential productive years lost among adults. Like Turkey, the major pillar of health care financing in Mexico is a mandatory social insurance program that covers formal sector
employees, employers and government, but unlike Turkey, the social insurance system covers only half the population in Mexico, substantially lower than the coverage in Turkey. On the supply side, Mexico health care system is characterized by duplication, excess capacity, and an inefficient and inequitable distribution of resources. Each institution is responsible for a specific population with a specific financing source, quite like the situation in Turkey. As percentage of GDP, Mexico spends only 4.3 percent, compared to 3.9 percent in Turkey, and almost 8 percent in OECD countries on average.

In a series of reform measures adopted between 1995 and 2000, however, Mexico has made remarkable achievements. Probably the most innovative of all measures has been the formation of several decentralized public agencies charged with providing essential health services to the uninsured and the poor. Adapted to suit the local characteristics, the health financing and delivery model is based on 13 low-cost high-impact health interventions that meet the health needs of the rural poor. The results have been very impressive (see Box 1).

No two countries are alike, and it does not necessarily follow that what worked in Mexico will also work in Turkey. However, given that the conditions in the two countries at the time of designing major systemic reforms are so similar, success in one surely bodes well for the other. At the very least, it reinforces the practicality of reform measures that are otherwise based on sound theoretical reasoning and have been successfully tested in several countries.

Besides Mexico, the experience of the ten EU accession countries – Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia – with health sector reforms provides useful examples for Turkey. The epidemiological and health status profile in these countries is very different from that of Turkey and Mexico, but the principles and philosophy behind health sector reforms are very similar. Following the transition, payroll-based social health insurance emerged as a major source of public financing of health services in most of the accession countries. Health financing reforms in these countries also encompassed significant changes in the ways providers are paid. Though varying in content and scale, the general direction of these changes has been toward performance-based payment systems and away from the traditional budgetary allocations and salary-based compensation. The biggest change has come about in reimbursing physicians for primary care, with all countries shifting toward capitation-based payments for physicians.

The experience of these countries with health system reforms has been mixed. While the health financing reforms have generally been successful in safeguarding resources for the health sector, they have not been as successful in cost-containment and a fundamental challenge that has emerged in most countries is the heavy amount of indebtedness in the health care system. The debt problem highlights not only shortcomings in the allocation of resources and in the flow of financing within the system, but also the characteristics of reform which were aimed at increasing resources rather than shifting the incentives for improvements in efficiency, affordability of the health system, and in the quality of care. Turkey will do well to watch out for these pitfalls in the design of its own health system reforms measures.

The main reform measures suggested are discussed briefly in Table 9.
Box 1. Making Basic Health Accessible to All: The Case of Mexico

Mexico is one of the few countries in the developing world to successfully deliver a cost-effective package of essential health services to populations with difficult access to basic healthcare. Since the mid-1990s, the Federal Secretariat of Health (SSA) with the support of the World Bank Group has established the Programa de Ampliación de Cobertura (PAC) and the Programa de Calidad, Equidad y Desarrollo en Salud (PROCEDES) targeted to uninsured rural and peri-urban poor. Through such programs, health services delivery for the uninsured population has been decentralized and 32 public agencies created across the country. While SSA remains responsible for setting national health policies and regulating the health sector, the decentralized agencies are autonomous, have their own assets, and manage the resources needed to operate the services.

In order to overcome physical and cultural problems (more than 60 percent of the beneficiary communities are indigenous groups with more than 36 different languages), the programs developed strategies to integrate health teams in the communities by learning the native languages, knowing the customs, and becoming familiar with traditional healing practices. In addition, through the creation of Community Health Committees, project beneficiaries found a way to actively participate in the preparation and implementation of projects activities. The direct impact of these interventions is now becoming visible. Recent achievements for improving the health of the uninsured population under such programs include:

(i) Enrollment in the IMSS (the main public health care provider) voluntary social security regime of 400,000 families whose main breadwinner is in the informal sector of the economy;

(ii) Coverage of the dispersed rural population with basic health services reached 10.9 million in 2000 out of the 11.4 million targeted. PAC covered 874 municipalities, 96 health jurisdictions, and 42,900 rural localities, reaching 8.1 million persons located in 19 states;

(iii) Women and children have been the main beneficiaries of the programs; 99 percent of children under the age of five in the project area now receive a complete vaccination package. As a result, childhood morbidity and preventable mortality have been reduced (e.g., no reported cases of poliomyelitis and measles over the last three years). The emphasis placed on prenatal, child delivery, postpartum, and newborn care has reduced the risk of maternal and perinatal death. An average of 3.5 prenatal visits is now provided in project areas.

Source: World Bank (2001a, 2001b)
4.1 Universal Coverage: The Case for Social Health Insurance

The first and most fundamental challenge that the health sector reform in Turkey needs to address is that of providing adequate financial protection for health care to the entire population. At present, insurance coverage is provided through three social security institutions: SSK, Bagkur and Emekli Sandigi, and through the Green Card program for those who do not have the financial means to purchase health insurance through any of the above. Active civil servants and their dependents are funded directly from general revenues. Private health insurance coverage in the country is small, reaching only about 500,000 people. As noted earlier, this system of insurance leaves many without any coverage, and with inadequate coverage for many of those who are nominally covered. Additionally, there are many who enjoy multiple sources of coverage, either by design or by circumstances. Besides, there is much inefficiency in the existing system – the huge expenditures on drugs, for instance – that result from the inexperience and inability of all insurance providers to purchase health services for their insurees on the best possible terms.

The process of finding a solution to address the above has essentially to go through a two-stage analysis. First, it is important to determine whether leaving the present system essentially unchanged – adopting, of course, specific corrective measures to fix what’s known to be not working – can provide full coverage. If it is determined that the adoption of corrective measures alone would be sufficient to guarantee full coverage, then the second stage would involve the identification and description of the corrective measures. If, on the other hand, it is determined that a major restructuring of the present system is necessary, then in the second stage it would be necessary to determine what direction that reform should take.

In resolving the first question, it is necessary to foremost examine the merits or need of a system in which there are multiple payers and institutions that perform overlapping functions. The general argument in favor of multiple payers is couched in terms of the benefits of competitive markets. For a competitive market that yields socially desirable and optimal results, however, certain preconditions have to be met. A competitive market presupposes price competition and some form of consumer sovereignty, which in turn requires the consumer to have sufficient knowledge of price, quantity and quality of services under consideration for purchase in order to make rational choices. Market systems function by price signals, and it is necessary that prices be known in advance and consumers have time to shop. However, the nature of the health good is such that these preconditions are simply not met. The incidence of serious illness is uncertain, and consumer sovereignty is weak in deciding what types of services to purchase or arrange for. Most consumers lack sufficient medical knowledge to make their own choices regarding the kind of health inputs and services. Moreover, health financing and third party payment systems tend to be very complex and the payers can introduce many conditions and requirements that take away from many of the benefits of the competitive systems. Medical insurance products are complicated and notwithstanding the regulations covering contract terms, individual consumers are unlikely to find health insurance policies easy to grasp. Informing consumers can be a challenging process within a complex private health care insurance marketplace. As a result, therefore, of the nature of the health good – and unlike in many other areas of competition – it is not always obvious that the presence of multiple payers will lead to socially efficient production and equitable distribution of health in accordance with consumer choice.
In countries like Canada and the United Kingdom, where the government directly uses its monopsonistic position, or countries like Japan and Germany, where the use of government’s monopsonistic power is indirect, the single-payer system has been able to keep overall costs of the system more in control than has been the case of countries like the United States, where the share of GNP going to health services is nearly twice as high as in these other cases. At the same time, as Blendon et al (reported in Dunlop and Martins, 2000) note, results of recent surveys on the extent to which people in a number of countries are satisfied with their health care services show that the United States ranked well below other countries paying less for their health care.

The monopsonistic position of the single payer may not always ensure an acceptable return to the supplier. Overall, however, social acceptance and legitimacy in acting in the public interest will enable a monopsonistic single-payer to fulfill a socially acceptable role. The experience of countries like Canada suggests that the government’s use of monopsonistic power to achieve certain cost containment objectives may not always be in conflict with other health sector objectives.

Arguably, the three main purchasers of health care in Turkey are really operating in different segments of the market and to that extent not competing for the same population. However, the presence of multiple insurers in the health market has resulted in a situation marked by duplication and the lack of unity and norms on the one hand and very different capacities to perform the role of rational and responsible purchasers of health services on behalf of the insured population on the other. Any prescription for achieving 100 percent coverage that by and large keeps intact the present system but addresses the existing inefficiencies would involve not only a much greater level of coordination among the three insurers, but also a system by which the Green Card program is aligned with the existing insurance setup to ensure that there is no overlap and misuse. Such a prescription would, at the very least, involve: (i) strengthening the insurance and purchasing functions and capacities of the all the insurance agencies; (ii) reducing the “distance” between SSK, Bagkur, Emekli Sandigi and the Green card program by allowing a common database of all insurees and beneficiaries; (iii) development of a common set of norms, practices and procedures governing coverage, choice and premium levels; (iv) development of a common set of procedures and practices governing book-keeping, cost accounting and record-keeping; and (v) submission to a universal system of regulation and reporting requirements.

It is easy to see that, in principle, the adoption of the above-mentioned measures is equivalent to a system of a single-payer universal social health insurance system, particularly if there is no effective competition between the existing insurance funds, and the distance between them is reduced by so much that they all collapse into one entity. Undoubtedly, then, there are clear benefits and arguments in favor of restructuring the existing system so as to achieve 100 percent coverage, for any meaningful tinkering in the existing system would, by definition, be tantamount to precisely that! In determining the direction this reform would take, the only unanswered question that remains relates to the desirability of opening the market to private health insurance with a special budget-supported health insurance program for those unable to purchase private insurance. For sure, private health insurance is already present in Turkey, but its coverage and reach is almost insignificant at the moment. The next section examines the role and desirability of private health insurance in Turkey.
Private health insurance

Private health insurance plays a role in many nations’ health care systems, and represents a growing phenomenon in many countries of the world. To a significant extent, the particular function of private health insurance depends upon the structure of the underlying health system, including any system of social insurance, and upon how it is able to interact with the other sources of health coverage and the products and market that develop from this interface. The part private insurance plays within a health care system, and its potential and actual success, hinges upon the laws and regulations applicable to many important actors within this system, including, but not limited to, the legal standards specifically applicable to health insurers and their products.

Private health insurance is different from social health insurance in many ways, and private companies often operate under different rules and driving principles than social insurance funds. Under the principles of a market competition model, private health insurers compete on price, quality, and various other aspects of their products. They also seek to maximize profits. The laws and required structures for certain types of entities may alter or modify this motivation to some extent. For example, a non-profit health plan may be required to comply with certain requirements not required of other commercial carriers, such as accepting all applicants, or using fewer risk factors in calculating their premiums. In return for these and other obligations, they often receive favorable tax status. But ultimately, these types of entities still need to generate surpluses so they can invest in systems and infrastructure necessary to help them efficiently perform their financing and cost management functions. They also must remain solvent and be able to compete with other types of for-profit health plans.

Private health insurers’ profit-making motivation can create different incentives than those present under a social insurance system, although the precise differences depend upon the structures of, and regulations applicable to both the public and private systems. The dynamics of the private insurance market have been described as follows: “insurance is seen as a transaction between two economically “rational” actors—an individual (or group of aggregated individuals) and an insurance company. What each of these actors is trying to achieve, according to this model, is maximum economic utility. The individual (or group) wants the lowest possible price for the desired insurance coverage. The insurance company wants the maximum profit. The logic of this perspective leads to market fragmentation, the exact opposite of social insurance’s universalism.”

In noting the contradictory incentives of private insurance and social insurance, the World Health Report 2000 also notes “the social security and risk-related private insurance approaches are contradictory, and their coexistence creates different incentives for consumers. All consumers whose risk category is such that private insurance would charge them less than the amount they would have to pay under social insurance have the incentive to avoid

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contributing to social insurance and use private insurance if they are allowed to. High-risk people, however, have the incentive to contribute to social security, loading it with high-risk members and increasing the per capita cost of services for members of the pool." In other words, coverage of a broad range of the population with diverse health risks may be less of a priority for certain private health insurers, particularly as compared to social insurance funds.

Advantages of Private Insurance

A private health insurance market has the potential to offer certain advantages over solely public sources of health care financing. The availability of private insurance can permit governments to target their public system of health financing to those without access to private insurance. It also may be able to help providers rebuild infrastructure and amortize needed investments when government payments are inadequate. A private insurance financing mechanism also may promote innovation in financing and delivery, offer consumers a choice of providers, and help develop ways to systematically reward efficiency.

If a government chooses to target public coverage to certain population groups, rather than provide universal coverage, the availability of a private insurance option becomes a critical component of a nation's health financing scheme. The advantages may be different in countries where the government assures broad coverage. However, even in these cases, private insurers may relieve some portion of the burden from the public system of financing (and depending upon the delivery system, it also may relieve the public delivery system). For example, in Ireland, a survey of the Organization for Economic Co-operation and Development (OECD) found that "private health insurance has operated in a way that tries to ensure that a significant number of people stay in the private system, relieving the cost of hospital care to the public finances."9

The extent to which the private system is able to relieve a burden from the government depends on many structural aspects of the system, such as whether the privately insured are still covered through some governmental funds (whether from general revenue or payroll taxes) as well as whether private insurers are paid an additional amount that is separate from the funding stream for public coverage. The potential for relief of the governmental burden also depends upon the incentives and regulation that can impact the division of the population between the public and private systems. If the private system is permitted to cover a disproportionately younger, wealthier or healthier population, with little regulation, it may raise significant issues for the public system.

A second potential advantage of private health insurance is that it may help providers rebuild infrastructure and amortize needed investments. The combination of many factors may impact whether private financing can positively and broadly impact providers' funding and access to high quality care. Relevant issues include the risk composition of the insurers' covered populations, the presence or absence of a risk adjustment or cross-subsidization mechanism among insurers and between the public and private system, and the extent to which there are existing inefficiencies in the system that private insurance could address (and that could not

otherwise be addressed through public financing). In sum, the potential of private insurance to help the system's financing hinges on other attributes of a system and their interrelationship.

Finally, private insurers may promote innovation in financing and delivery, help offer consumers a broader choice of providers and create incentives for more efficiency in aspects of the system. Innovative methods of provider payment may emanate from the private system. If the public system does not assure consumers true access to the providers of their choice, there also may be a demand for a system of financing that does a better job of assuring consumers access to high quality providers of their choice. This might occur if some providers selectively contract with private insurers.

**Disadvantages of Private Insurance**

Yet, despite the possible advantages of private insurance, there are several problems that can arise from its introduction. Some of the more significant possible concerns with private health insurance include:

- Potential for risk fragmentation: adverse selection, cream skimming and the potential for availability and access to vary based upon health risk
- Affordability concerns
- Potential for high administrative costs
- Complex contracts pose challenges for effective information disclosure
- Possible restrictions on access to care
- Assuring plan solvency may require vigilant and technical oversight

a. Risk Fragmentation

One of the main goals and functions of insurance is to spread the risk of the cost of adverse events across a broad pool of people. Ideally, the diversity of the risk profiles of individual members will enable the funding in the pool to cover individuals who do experience a loss at any point in time, while maintaining affordable and steady premiums for all participants in the risk pool. Insurers understandably are concerned that certain activities may result in their covering a disproportionate amount of high-risk cases. (This phenomenon is sometimes known as “adverse selection”). Consequently, they often take actions to minimize risk or make it more predictable. Adverse selection represents a significant risk in the sale of private insurance, particularly when the purchase of health insurance is voluntary. Even if predictably high cost cases are spread somewhat evenly among products and insurers, if the risk is segmented among a significant number of insurers and products proportional to the population, the occurrence of a few unanticipated high cost cases can cause an unstable situation for a particular product pool or insurance company.

Conversely, policymakers and consumers may be concerned that insurer activity results in “cream skimming”, an activity whereby insurers cover individuals or groups with a lower than average risk profile. Such activity can enable insurers to make higher profits and spend more on administration and marketing, because they have to pay fewer claims. Cream skimming can be done by refusing to offer or renew coverage to high-risk individuals, or charging significantly higher rates to such individuals, thereby reducing the likelihood that they will purchase coverage.
and making them pay a higher premium if they do. Another common method of reducing the risk they cover is to exclude coverage of certain "preexisting conditions." This practice can serve the important purpose of protecting insurers against adverse selection. If misused, however, it can enable insurers to reduce the extent to which they cover medium and higher risk individuals' health needs.

b. Affordability Concerns
Rising medical costs can make it challenging for a private insurer to maintain affordable rates, just as it poses challenges to a publicly financed system. If rates are permitted to vary based upon risk, affordability can become an acute issue for those with health concerns. Furthermore, depending on the level of market fragmentation and the size and diversity of risk pools, there is a risk of "rate spirals." These spirals occur when premiums increase substantially on an annual basis due to an increasingly high risk case load within an insurer's or a product's pool of covered individuals. This risk may be especially high in relatively small marketplaces or in the case of smaller insurers.

c. Administrative Costs
There can be significant variation in the extent to which private insurers use the funds they receive for administrative purposes. Private insurers' expenditures on administrative and non-benefits-related costs, such as marketing, sales, agent commissions and profits (in the case of for-profit entities) may be in stark contrast to the percent of premiums paid on administrative costs by social insurance funds. In the U.S., administrative costs for the Medicare program (a program for the elderly and certain disabled individuals), as a proportion of overall expenditures, was 2.66 percent in 1997,\textsuperscript{10} the administrative and non-benefits related costs associated with private policies in the U.S. are reported to be much higher.

d. Complex Contracts Pose Challenges for Effective Information Disclosure
The ability of insurers to offer many different products increases choice and may benefit competition, but medical insurance products can be very complicated and not very easy to understand. In the absence of standardization of policies, and even in its presence in some cases, consumers may purchase duplicative coverage, as was the case in the U.S. even after standard packages for certain Medicare supplemental coverage was developed. If consumers are able to have a more complete understanding of their existing coverage and insurance options, significantly impact their choices and ultimate satisfaction. Meaningful information disclosure and dissemination can be a challenging but important piece of a successful private health coverage marketplace.

e. Possible Restrictions on Access to Care
Some health insurers impose stringent mechanisms to control the utilization of services as part of a cost-containment strategy. While these mechanisms can prove useful, it is important that those with appropriate expertise make decisions. Safeguards may be necessary to ensure an appropriate balance between access to appropriate care and containing costs.

f. Consumers' Ability to Challenge Plans' Claims and Care Decisions
It is important that consumers be accorded channels to appeal insurers' decisions to deny claims, or in some cases, to deny access to certain services. Particularly acute concerns may arise if there are not adequate mechanisms for insured individuals to grieve insurers' decisions regarding access to certain providers or services. These mechanisms may or may not be present within the insurer's operations or the government, but it is desirable that they be present in both arenas.

g. Assuring Plan Solvency May Require Vigilant and Technical Oversight
Assuring insurers' solvency and ability to pay claims and other liabilities is another important endeavor. If an insurer becomes insolvent, there can be many victims of this problem. The ability of insurers to enter and exit a market in short order without repercussions may also lead to a cycle of short-lived operations that exit the market when they run into financial troubles.

Coverage Options under Private Health Insurance

a. Supplemental Coverage
Under one common option, private health insurance supplements coverage provided by the government or social insurance fund(s). This supplementation can take several forms. If a benefit package does not include certain commonly desired coverage, the insurance coverage can complement the government benefits. For example, the insurance contract may guarantee reimbursement for the cost of specific health services omitted by the public benefit package. Alternatively, or together with this type of supplementation, the insurance can provide reimbursement for any costs associated with receiving services covered by the public system. Examples of countries with supplemental private health insurance include Australia, Canada, France, Spain and the United Kingdom.

b. Comprehensive or Primary Private Coverage
Private health insurance may cover a range of benefits, including comprehensive coverage. The scope of benefits is determined by the coverage contract, as well as by the applicable laws and regulations. There may be circumstances in which this coverage serves as an individual or family's only protection against the cost of expected and unexpected health services. This can occur if there is no social insurance system, or individuals are not eligible for coverage under such a system or they are permitted to opt out of the social insurance system if they purchase private coverage. The latter type of coverage, referred to as “substitutive coverage,” is an option in the Netherlands, Switzerland, Germany, and Chile.

c. Parallel Coverage
Another coverage option is parallel coverage. Such coverage may or may not offer a comprehensive benefit package. Rather than focusing on filling particular gaps in a social insurance system, as is the case with supplemental coverage, this coverage may offer access to higher quality or more comfortable accommodations in connection with the same health care services also covered by the social insurance system. It also may enable individuals to bypass any waiting lists that develop. Examples of such “alternative” private insurance can be found in Ireland, Great Britain and Spain.
Public versus Private Financing

Private insurance can have a significant impact on an overall national system of health financing and delivery. If the private insurers' payment structures and arrangements with providers (or absence thereof) result in payment for medical charges with little control over the amount of spending, it can result in runaway spending and impact nationwide spending patterns. Provider-driven cost escalation occurred in the U.S. prior to government regulation beginning in the 1970's and the regulation of the doctor-patient relationship by market forces in the 1980's. In addition, since private insurance is not inherently accountable to government and national objectives, “external incentives and regulation are needed to make sure that benefit packages and insurance practices are coherent with national priorities and policies regarding health, financial fairness and responsiveness.”

The existence or potential establishment of public and private financers of health care leaves open the possibility that certain players in the overall system may try to take advantage of each other. The tendency of private insurance markets to cream skim, together with the potential that insurers may be selected against by consumers who choose to use the private system when it suits their needs, and when it makes good economic sense at the moment, further exacerbates the potential for risks to be fragmented among insurers and between private and public financers of health care. In order to avoid such occurrences, it is important to introduce incentives and craft a regulatory structure that tries to maximize pooling and minimize gaming both within and between the public and private systems.

The potential for significant impact – both good and bad – underscores the need for coordinated rules and structures governing both public and private financing. As detailed herein, private insurance can be a complicated mechanism of financing health care and its results may not always be compatible with broader social goals of universalism and equal access. In fact, certain attributes of private insurance make it particularly challenging to avoid the segmentation of risk, even though such activity contradicts another fundamental principle of insurance, the pooling of risk. Until a regulatory infrastructure is well prepared, and the role and additional contribution of private health insurance is clearly articulated and agreed upon, a significant role for private health insurance in Turkey is not recommended. At this time and in the present macroeconomic context, a quick movement towards private health insurance could destabilize the Turkish health care marketplace and set in motion certain roles and activities amongst actors in the health care system that may be difficult to undo in the future.

Moving toward a single-payer universal social health insurance system

The previous analysis suggests that the different health insurances being offered through SSK, Bagkur and Emekli Sandigi, and the coverage provided to civil servants and welfare programs like the Green Card should – in the interest of efficiency, risk-pooling and consolidation of financing – be combined into one compulsory social health insurance system, or a Health Fund. Setting up a Health Fund will alter the flow of funds, and Figure 17 provides a stylized description of the flow of finances and health services in this system.

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11 See Rosenblatt at 131-2.
12 World Health Report at 111
Figure 17: Health System in Turkey (after reform)
The establishment of the Health Fund should be done in a phased manner, and should fully draw upon the lessons learned in the management of the existing social security institutions. The phased implementation is being recommended so as to provide time and security to the existing institutions and providers to adjust to the new system. The proposed phasing will ensure that nothing will change till the Health Fund is fully set up and becomes functional, and the providers and consumers alike become familiar with the new system.

The establishment of the Health Fund – which should be founded as an autonomous legal umbrella organization, preferably under the Ministry of Labor and Social Security, the only government administrative body with experience in managing insurance – should be part of an overall reform of the social security system, so that SSK and Bagkur continue to function as social security institutions but transfer all health insurance premium collections to the Health Fund. Similarly, all active civil servants should become members of the Health Fund, with their parent departments paying the health insurance premiums directly on their behalf. Likewise, Emekli Sandigi should also transfer all health insurance premiums to the Health Fund, and the Green card program should be folded into the Health Fund, with the state paying premiums on behalf of those who cannot afford to pay themselves. The Health Fund should be managed as an autonomous institution, and should have professional management drawn from among those with relevant actuarial experience and demonstrated results. The government may appoint a Board of Directors to oversee the governance and administration of the Health Fund, and draw upon members from the Ministry of Labor and Social Security, Ministry of Health, Ministry of Finance, State Planning Organizations, Turkish Medical Association, trade unions, and consumer advocacy groups.

Given the size of Turkey’s population, it is suggested that the Health Fund have region-level branches, each of which should enjoy a high degree of administrative autonomy over routine day-to-day functions.

The services covered by the Health Fund should include routine physician visits, routine obstetrics and gynecological visits, well baby visits, immunizations, emergency room visits, general ward hospital stays, surgeries, ambulatory surgeries, chemotherapy and radiation therapy, deliveries, mental health and substance abuse, routine eye exams, hearing aids, laboratory services, X-rays, and prescription drugs (generics where available). The Health Fund should determine limits, lifetime maximums, copayments and deductibles from time to time. Services not covered by the Health Fund include over-the-counter drugs, brand name prescription drugs where generics are available, frames, lenses and contact lens, cosmetic surgery unless required as rehabilitation, non-emergency use of emergency room, shared and single-room stays in hospitals, speech therapy for non-acute medical conditions, long-term rehabilitation, home health care, durable medical equipment purchase or rentals, and home nursing.

Initially, patients should have limited choice of inpatient providers. In the first phase, the recommended length of which is 5 years, all SSK enrollees will be limited to the use of SSK facilities only, unless referred by the SSK facility to other providers. Bagkur and Emekli Sandigi enrollees will be required to exercise a choice of hospital at the beginning of the year, and no
change should be permitted during the year once that choice is made. Those whose premiums are being paid by the state should initially be limited to the use of MOH hospitals only.

The Health Fund will contract with medical service providers and purchase services on behalf of the insurees. In the first phase, SSK facilities will be the fundholders for SSK enrollees for all covered health services. Similarly, the facilities chosen by Bagkur and Emekli Sandigi enrollees will be the fundholders for these enrollees for all covered health services. MOH facilities will be the fundholders for those enrollees whose premiums are paid by the state for all covered health services.

The description above simply points to the highlights of the proposed system. Expectedly, there are many details that will have to be worked out before the Health Fund becomes fully functional. The first phase of 5 years should provide ample time to set up the system and allow providers and related institutions to adjust to it.

Cost containment

New technology, rising expectations, increased urbanization and enhanced expectations are already putting an upward pressure on costs, and indiscriminate use of health insurance and the attendant issues of demand-side moral hazard are likely to push costs up even more. As a result, health sector outlays will increasingly become difficult to secure, particularly in the context of the volatility of the Turkish economy.

Of the many potentially volatile cost-centers in the health sector, the two that deserve close attention are salaries of health professionals and expenditures on drugs, for together they account for bulk of health care costs. In the experience of many EU accession countries where payroll-based social insurance emerged as the major source of health financing, health-financing reforms have also encompassed significant changes in provider payments. Though varying in content and scale, the general direction of these changes has been toward performance-based payment systems and away from the traditional budgetary allocations and salary-based compensation. The biggest change has come about in reimbursing physicians for primary care, with all countries shifting toward capitation-based payments for physicians (Table 10). Most countries are using fee-for-service payments for outpatient specialist care, though some – like Bulgaria and Slovakia – still pay specialists on a salary basis. As regards paying for inpatient services, some countries – like Bulgaria, the Czech Republic, Slovakia and Romania – have retained the traditional budgetary system, while some – like Hungary and Lithuania – have moved toward case-mix based payment systems. Estonia, Slovenia and Latvia compensate hospitals on a per-day basis, while in Poland hospitals are paid a lump sum per admission, with the payment varying by department.

Besides fundholding mechanisms favored by many European countries to control costs, managed care (and managed competition) is emerging as a popular mechanism for cost containment. The term "Managed Care" is an expression often used in the American health care system to refer to the great many health care systems for treating illnesses and covering the costs of illnesses. It refers to an organized system of delivery of health services designed to control costs and quality by such means as mandatory drug formulary lists, pre-admission screening, case management, etc. In a typical managed care model, there are four components: contractual arrangements,
medical guidelines, patient training and data monitoring. Basically, managed competition counters the powerful monopolistic power of the provider by establishing powerful monopsonistic buyers representing the patient. These buyers use their market power to negotiate and contract for lower prices and better quality clinical care.

Table 10: Provider payment mechanisms in EU accession countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary Care</th>
<th>Outpatient Specialist Care</th>
<th>Inpatient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulgaria</td>
<td>Capitation payment</td>
<td>Salary</td>
<td>Budget</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Capitation payment</td>
<td>Capped fee-for-service</td>
<td>Budget</td>
</tr>
<tr>
<td>Estonia</td>
<td>Mix of capitation payment and fee-for-service</td>
<td>Capped fee-for-service</td>
<td>Per-diem payment</td>
</tr>
<tr>
<td>Hungary</td>
<td>Capitation payment</td>
<td>Capped fee-for-service</td>
<td>DRG (758 categories)</td>
</tr>
<tr>
<td>Slovakia</td>
<td>Capitation payment</td>
<td>Salary/fee-for-service</td>
<td>Budget</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Capitation payment</td>
<td>Salary</td>
<td>Per-diem payment</td>
</tr>
<tr>
<td>Latvia</td>
<td>Mix of capitation payment and fee-for-service</td>
<td>Salary + points system</td>
<td>Per-diem payment</td>
</tr>
<tr>
<td>Lithuania</td>
<td>Salary/Capitation payment</td>
<td>Salary/fee-for-service</td>
<td>Case-based payments</td>
</tr>
<tr>
<td>Poland</td>
<td>Capitation payment</td>
<td>Capped fee-for-service</td>
<td>Per admission</td>
</tr>
<tr>
<td>Romania</td>
<td>Mix of capitation payment and fee-for-service</td>
<td>Capped fee-for-service</td>
<td>Global budget</td>
</tr>
</tbody>
</table>

Source: Health Care Systems in Transition (various years), European Observatory on Health Care Systems, and World Bank Health Sector Reports, as presented in the background paper on health prepared for the World Bank (2002) Expenditure Policies Towards EU Accession

Many different forms of managed care organizations have evolved in recent years, and one of the most innovative ones is the group model Health Maintenance Organization (HMO). HMOs correct market failures and lower costs by changing the structure of health care financing and delivery by combining risk pooling with delivery of services in a single organization. The HMOs accept a payment set prospectively to supply a defined set of clinical services to a defined population. To this extent, HMOs have an incentive to contain illness and produce services efficiently. Note that in many ways the SSK organization supplying health services is like an HMO without, however, the necessary incentives to contain costs, since hard budgets are neither defined nor imposed.

Another area that deserves attention for cost containment is the expenditure on pharmaceutical products, which constitutes a significant proportion of total expenditures on health in Turkey. It is estimated that the expenditure on pharmaceutical products of SSK, Emekli Sandigi and Bagkur combined in 2001 was about 1,981,672 billion TL, equivalent to about 48.5 percent of total

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13 Also see Kielhorn and von der Schulenburg (2000)
Expenditure on health by these three institutions. Expenditure on pharmaceutical products accounts for between 55 and 60 percent of total expenditures on health incurred by Bagkur and Emekli Sandigi, and between 33 and 38 percent for SSK during the period 1998 to 2002. Civil servants spent a further 579,370 billion TL on pharmaceutical products, equivalent to 52 percent of their total expenditures on health. Exact figures on pharmaceutical expenditures are not available for other consumers and for out-of-pocket payments on pharmaceutical products for the uninsured.

Clearly, Turkey spends a disproportionately high amount on drugs and pharmaceutical products (though the high percentage of pharmaceutical expenditures in terms of overall health expenditures are also a reflection of low overall expenditures on health). Several factors explain these high levels of expenditures. On the demand side, a very large proportion of the population is almost totally insensitive to pharmaceutical prices. Those insured with any of the social security institutions or belonging to the category of civil servants pay only one-fifth of the drug price, while those retired pay only one-tenth. On the supply-side of the equation, the introduction of new drugs in the market, accompanied by aggressive marketing policies of the pharmaceutical companies, has shifted the consumption of drugs toward higher price medicines. In fact, the consumption of drugs costing 5 million TL or more has increased by almost 50 percent, after adjusting for inflation, between 2000 and 2001. Thus, while the overall pharmaceutical price index has not moved out of line relative to the general consumer price index, more medicines cost more, which translates to higher expenditures especially among the insured.

Of the several cost containment measures that deserve examination, the one that is likely to yield quick results is the use of generics, where available. In fact, where generics are available, the insurance support for medicines should not cover the brand name drugs, the expenditure on which should be borne by the patient if the preference for brand names is strong. Aggressive marketing policies of the pharmaceutical companies undoubtedly pose a big challenge, and it is here that the single health services purchaser can use its monopsonistic power most effectively to bring down prices.

4.2 Developing a package of essential services and targeting public spending

As discussed earlier, the health status of Turkey’s population is poor, both in absolute terms and in comparison with other countries at the same levels of income. Maternal mortality is a particular cause of concern, with maternal mortality rates very high in absolute terms and in comparison with other European countries. The fact that a quarter of all births take place at home and a third of pregnant women do not receive any antenatal care contribute to increasing the risks associated with infections and toxemia, widely believed to be the main clinical causes of the high rates of maternal mortality. Another area of concern is the high rate of infant mortality, the chief causes of which seem to be low weight of the child at birth, short birth intervals and lack of adequate care during pregnancy and delivery. Clearly, the health system of the country has been unable to either provide medical services when needed, or generate demand for medical services if the problem is more demand-side, or both. Whatever be the reason, the fact remains that a large numbers of lives can be saved if any sort of correction is brought about in the system.
Both supply-side and demand-side factors need to be considered in designing the best approach to improving health status and outcomes in Turkey. The availability of health services alone does not guarantee utilization, and utilization alone does not guarantee improvements in health status. Recall that neo-natal mortality is affected not only by maternal health status, but also by maternal characteristics (like age and education), extent of prenatal care, prenatal maternal nutrition, and perinatal infections, and post neo-natal mortality is related not only to complications resulting from premature birth and low birth weight, but also infections (e.g., diarrhea), and feeding practices (i.e., lack of breastfeeding). Similarly, infections such as Amoebiasis and Typhoid are transmitted primarily by contaminated water (and food), indicating improved water and sanitation needs; Brucellosis is transmitted by contaminated meat, indicating the need for improved food safety and inspections programs; while measles, tetanus, pertussis, diphtheria are vaccine-preventable diseases, indicating the need to improve preventive services in primary health care.

Similarly, improving education, awareness and knowledge of the possible benefits from consumption of health services – and other factors that may promote a greater use of health services – alone will not guarantee greater utilization. Recall that a large number of health centers are understaffed and lack operating funds – in fact, one out of eight health centers does not have a doctor and two thirds of all village health posts do not have a midwife. In addition, a large number of health centers and health posts are simply closed due to lack of staff and equipment.

The two key elements in the design of a strategy to improve health status and health outcomes, therefore, are: (i) developing a package of essential services specifically targeted to reducing maternal and infant mortality; and (ii) reaching the package to the poor and the vulnerable.

**Developing a package of essential services**

Identifying cost-effective interventions to reduce maternal and child mortality and morbidity is indeed a challenge. The World Health Organization’s (WHO) “Making Pregnancy Safer Initiative” is a recommended strategic approach that can “contribute to health birth and help mothers and children cope through adequate prenatal and perinatal services. The European initiative, in particular, promotes breast-feeding, neonatal care and the use of appropriate technology for birth, through a holistic approach and cost effective interventions. It focuses on the fact that pregnancy and delivery are natural physiological processes and should be regarded as such by health professionals and communities.”

Similarly, the WHO/UNICEF strategy on “Integrated Management of Childhood Illness” is a recommended strategic approach for the reduction of mortality and morbidity through the “provision of basic care for the most common childhood illnesses, as well as preventive measures such as immunization and better infant and child nutrition, including breast-feeding) and improved family and community practices.”

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15 Ibid, at page 51.
The recommended actions under both these approaches are fairly general, however, and the challenge that lies ahead for Turkey is in describing the package of essential prenatal and perinatal services that can be easily performed at the primary health care level by general practitioners and paramedical staff. These are the details that will need to be worked out specifically for the country as a whole and for specific regions of the country.

As has been mentioned earlier as well, several factors other than health services, genetics and lifestyles affect health at the population level. Evidence from Turkey indicates that the huge regional and urban-rural differences are also a manifestation of social, economic, environmental and institutional factors. WHO’s European Health Report notes that while universal access to effective health services of reasonable quality is an essential requirement, “there is little evidence that such failures contribute substantially to gross imbalances in the European Region.”

It identifies poverty as a “typical risk condition for population health in Europe,” and lists malnutrition, poor water supply, sanitation and personal hygiene, and tobacco use among the major risk factors for population health. It is in this context that the European Health Report suggests that health policies need to aim at reducing the overall burden of disadvantage and not be isolated from other developmental policies.

Studies in Turkey also find that poverty is a key determinant of health services utilization. Demand analysis shows that the poor are more likely to not seek care when ill, and female-headed households – typically poorer than the male-headed households – are more likely to not seek treatment when ill. Larger families, again typically poorer in per capita terms compared to smaller families, are less likely to seek care when ill. The level of formal education does not have a strong impact on health care seeking behavior; however, knowledge of health conditions and treatments does have a significant bearing on seeking care. Households more knowledgeable about health conditions and treatments are more likely to seek care compared to those who are less knowledgeable.

The package of essential services aimed at reducing maternal and child mortality and morbidity should, therefore, include (i) evidence-based and cost-effective medical interventions based on such tested initiatives as WHO’s “Making Pregnancy Safer Initiative” and WHO/UNICEF’s “Integrated Management of Childhood Illness”; and (ii) a series of measures aimed at providing all-purpose health education, clean drinking water, basic household sanitation, timely immunizations, home care of pregnancy and home management of diarrhea.

One country that has some experience with a package of essential services is Mexico. Adapted to suit local characteristics, the health financing and delivery model in Mexico is based on 13 low-cost high-impact health interventions that meet the health needs of the rural poor. The package of essential health services in Mexico includes basic household sanitation; family planning; home management of diarrhea; care of pregnancy, child delivery and post natal care; periodic anti-parasite treatment; management of acute respiratory infections, general and all-purpose health education as well as specific health education for accident prevention; hypertension and diabetes case detection and control; initial management of injuries; case detection and control of cancer of the cervix and breast; prevention and control of tuberculosis; immunizations; community

\[16\] Ibid, at page 66.
\[17\] Ibid, at page 67.
involvement in self-care; and child growth and nutrition monitoring. A similar package should be
developed for Turkey suited, of course, to the particular needs of the country.

**Reaching essential services to the poor**

Developing the package of essential services by itself is not sufficient; it is also necessary to
develop ways and means of delivering the package to the poor and in eastern and southeastern
regions of the country. Recall that there are huge locational and regional disparities in health
outcomes across all indicators, and rural areas are worse off on all counts compared to urban
areas, and regions in Eastern Turkey are worse off on all counts compared to the national
average and to the regions in Western Turkey. Utilization of health services is also low among
the urban poor (especially in the slums), in rural areas generally in the whole country and in
Eastern and Southeastern Anatolia. Besides the demand-side issues that constrain utilization of
health services, supply-side issues are also important, as is borne out by the large number of
under-staffed and under-equipped health facilities in some regions of Turkey.

In order to reach the package of essential services to the poor, it is imperative that a strategy be
devised so as to get medical personnel to work in areas where the poor live. Despite an overall
increase in the last few decades in the number of practicing physicians in Turkey, a large number
of areas remain underserved. Physicians tend to concentrate in metropolitan areas (such as
Istanbul, Ankara and Izmir), perhaps because these bigger cities offer more opportunities for
income generation, professional interaction, access to modern healthcare facilities and medical
technology, continuing education and professional development, higher standards of living,
recreational facilities, and quality of education for their family members. Recruiting physicians
to rural areas has been problematic, largely because of inadequate financial rewards, professional
and social isolation, and limited access to high technology. In an effort to staff health facilities in
rural and other underserved areas, physicians have been required in the past – and a similar
system has again been reinstituted lately – to put in compulsory service in these areas for a
specified number of years after graduation. This system has all the potential for misuse and
abuse, and anecdotal evidence points to several instances in which physicians “managed” a
transfer out of undesirable postings much before the end of statutory compulsory time period. In
any case, sending medical personnel against their will to posts that are otherwise unwanted is not
likely to yield the desired results: the posting orders may well be followed, but it is doubtful
whether appropriate levels of effort can be elicited in such cases.

Indeed, only incentive-compatible schemes – whereby it is in the interest of the physician also to
take up a posting in the shortage areas – will be successful in getting the physicians to work in
rural and shortage areas. These incentives include extra remuneration, shorter duration of
posting, posting in place of choice after serving in a shortage area, and admission to
specialization programs. A study conducted in Indonesia in 1997 (see Box 2) determined the
precise nature of such incentives in influencing physician’s decisions regarding place of posting,
and provides a good reference point for efforts in similar direction in Turkey as well.

Another approach worth considering is that of cluster staffing, whereby physicians accept
posting in a district or sub-district location and, by rotation, attend to patients in nearby
traditionally shortage areas. The hospital where the medical personnel are posted should supply
transportation and support staff to facilitate the movement of physicians to these areas. Details of such an arrangement would have to be worked out.

Box 2: Staffing outlying health facilities in Indonesia

In 1997, there was a serious problem of staffing health facilities in outlying islands in Indonesia. Chomitz et al analyze two complementary sets of data about physician preferences in Indonesia: (i) actual locational choices made by graduating medical students before and after a major change in the incentive system; and (ii) survey data on choices among hypothetical assignments to determine physicians’ preferences over a set of characteristics describing compensation, career prospects, and locational amenities. Their finding suggests that incentive payments for very remote service of the order of Rupiah 1 to 1.5 million per month (1997 US$1 = Rupiah 2,500) would be attractive to outer island male graduates. They find that based on a three-year contract, this is less expensive, from the government’s point of view, than the cost of paying for specialist training for 90 percent of these doctors. Their results suggest that it is not necessary to offer a civil service appointment in addition to the specialist training, however.

Their study finds evidence of much greater willingness of people from the outer islands to serve in remote and very remote locations. This suggests very substantial gains to increasing the representation of outer island students in medical schools. This might be accomplished by scholarships and assistance in pre-university preparation.


The role and effectiveness of paramedical staff in bringing the package of essential services to the poor and the vulnerable in underserved areas also needs to be examined. While it may be difficult or expensive to get physicians to voluntarily work in rural and isolated areas, the participation constraints of paramedical staff are likely to much less stringent. The key question in this context is whether the basic services that are likely to reduce maternal and child morbidity and mortality are such that the paramedical personnel, without the direct supervision of physicians, can deliver them. This is an area that needs further research, but if it is found that a large number of services can, in fact, be delivered by nurses and other paramedical staff, then the obvious strategy would be to hire and train nurses locally in the underserved areas – so that they are less likely to feel the pressure of the location – and deliver the package of essential services for the reduction of maternal and child morbidity and mortality through them. Not only would this be a much less expensive proposition, it would lead to higher utilization of health services not only because of the effective availability of these services but also because of the greater familiarity of the patients with the health care provider.

4.3 Reorganizing public hospitals and providing greater autonomy

Recall from previous discussions that the hospital sector in Turkey suffers from much inefficiency, and although some gains have been achieved during the 1990s – average hospital occupancy rate increased from 53 percent in the mid-1980s to 60 percent in 2000, while the
average length of stay dropped from 6.7 days in 1985 to 5.9 days in 2000 – a large number of hospitals remain substantially underutilized. The rate of hospital admission varies significantly across regions and is particularly low in Southeastern Anatolia. There is wide variation in occupancy rates of hospitals among provinces, where occupancy rates range from a very low 20 percent in Tunceli to a respectable 82 percent in Karabuk. Many provinces with low provision of hospital beds also have very low occupancy rates.

Bed occupancy rates vary significantly across public providers. MOH hospitals post a significantly lower average rate than SSK and University hospitals. The latter have witnessed the most significant increase in bed occupancy rates over the past five years despite the large increase in capacity. On the other hand, they have only recorded a minimal reduction in the average length of stay which remains significantly above that of most other hospitals, including foundation hospitals although the latter post higher surgery rates than university hospitals.

There are a large number of facilities that are too small to allow for efficient operation and effective provision of care. The occupancy rate of MOH district hospitals (generally hospitals with below 50 beds in a district center) and of MOH health center hospitals is particularly low and they have very long bed turnover interval, indicating that there is little justification for these small and rarely used hospitals.

Many hospital managers lack the skills necessary to effectively carry out their job, and neither are they given any incentives to strive for efficiency improvements at the facilities that they manage. The absence of administrative and financial autonomy, coupled with a budgeting system that largely ignores the actual amount of services provided substantially prevents hospital managers from undertaking steps to achieve efficiency gains. Although this constraint has been recognized almost fifteen years ago and the legal basis was then set to turn public hospitals into autonomous units, nothing has been undertaken to move in this direction.

Health system reforms in Turkey need to focus on improving hospital efficiency, and while some gains in efficiency can be brought about simply by reducing the number of hospital beds in many provinces, further gains will come about only by improving efficiency in the use of resources and overall management and accountability. One way to achieve this is by granting, to all MOH and SSK hospitals, administrative and financial autonomy and autonomy in the procurement of necessary inputs to produce and manage health services (see Box 3).

The autonomization of MOH and SSK hospitals should be done in a phased manner. Essentially, in the first phase the collective organization of hospitals will be given autonomy (the details of which are spelt out below), while in the second phase individual facilities will become autonomous. The phased introduction of autonomy will allow time and opportunity for individual facilities to gather the required knowledge, experience and managerial acumen necessary for self-governance. It will also give time for the ironing out of the legal wrinkles.

In the first phase, all MOH hospitals should be consolidated under one quasi-public legal entity under the Ministry of Health (called, for instance, the Ministry of Health Hospital Corporation, or MOHHC), and this quasi-public legal entity should be made autonomous of the parent Ministry. Note that individual MOH hospitals are not granted autonomy in the first phase – it is MOHHC that will have autonomy from the parent Ministry of Health.
Box 3: What is autonomy?

Autonomy refers to the quality or state of being self-governing, and is defined as "the degree to which an organization has power with respect to its environment" (Van de Ven & Ferry, 1980). In other words, the greater the power the organization has with respect to its working environment, the more autonomy the organization enjoys. Holdaway, Knobbeer, Hickson, and Heron (1975) define autonomy as the "extent to which organizationally relevant decision-making is inside the organization", so that greater the extent of decision-making within the organization, greater is the level of autonomy. An issue central to both these definitions is the interpretation of the boundary of an organization. Price and Mueller (1986) consider the boundary of an organization to be "determined by the extent to which organizational norms and sanctions are officially applicable." According to this definition, all individuals and entities that are subject to the organization's rules and procedures and sanctions are within the boundaries of the organization, while all others are outside the boundary. Employees are therefore members of the organization they work in, while the customers are not.

Autonomy can be either global or dimensional. An organization is said to have global autonomy if it has power concerning its environment. The environment in government organizations is often defined in terms of territorial boundaries. Also referred to in the literature as "horizontal" division of powers and decision-making between national, state and local levels of government, territorial division of powers may take many forms. The literature is not always consistent in its use of terms (see, for instance, Bossert, 1995, Maxwell, 1995, Mills, 1991, Pescador, 1985, Rondinelli, 1981, Winkler, 1989), but it commonly distinguishes between deconcentration (or the redistribution of some amount of administrative authority to lower levels in the hierarchy), devolution (or the shifting of responsibility and authority from the central offices of the Ministry to separate administrative structures still within the public administration) and delegation (or the transfer of decision-making and management authority for particular functions to organizations that are not directly controlled by the central government ministries).

An organization is said to have dimensional autonomy – also referred to as "vertical" division of power – if it has power with respect to types of decisions, such as supervisory establishment, hiring and firing, determination of new programs, making purchases, allocation of work among available personnel, financial budgets, and assignment of responsibilities. There can be varying degrees of dimensional autonomy within each level of territorial autonomy.

Autonomy can improve efficiency in many ways. Autonomy gives those with the best information about a particular issue the discretion to make decisions pertaining to that issue, which may lead to good decision-making. Autonomy can enable mobilization and generation of resources that are not available under more centralized conditions. Autonomous institutions can involve a wider range of societal groups more actively, and these groups can be expected to contribute resources that previously, under more centralized forms of governance, were not available or were used for other purposes. This expectation is more particularly directed at the local community that is expected to express a stronger sense of commitment to the overall objective and purpose of the organization. Occur because of reduced economies of scale, Autonomy can potentially lead to a better match between demand and supply and thus to a more economical utilization of limited resources despite some losses that may.

The situation with respect to SSK hospitals is slightly different, because SSK already exists as a quasi-public legal entity under the Ministry of Labor and Social Security. However, SSK performs a variety of functions, and health insurance and provision of health services is only one of them. In the first phase, the health facilities of SSK should be separated from rest of SSK operations and consolidated under a separate quasi-public legal entity (called, for instance, SSKHC), and this quasi-public legal entity should be made autonomous of the parent Ministry of Labor and Social Security.
Note that like in the previous case, individual SSK hospitals are not granted autonomy in the first phase – it is SSKHC that will have autonomy from the parent Ministry.

Both the autonomous organizations – MOHHC and SSKHC – should have their own governing bodies, and in order to ensure coordination and collaboration, both ministries of Health and of Labor and Social Security should be represented at a senior level on both the governing bodies. Both MOHHC and SSKHC should prepare annual business plans at the beginning of the fiscal year, which will be approved by the parent Ministries and be available for public dissemination. In the first phase, the employees of MOHHC and SSKHC will retain their civil servant status; eventually, however, they will all become contract employees of the respective corporations and have long-term open-ended contracts. MOHCC and SSKHC should be permitted to make new capital investments if and only if they are able to generate and show surplus for a minimum period of three consecutive years.

In the second phase, individual facilities within MOHHC and SSKHC should be given autonomy on a selective basis. In order to become autonomous, the individual facilities would need to demonstrate their capacity and readiness for self-governance. Details of what constitutes readiness and preparedness would have to be worked out, but would include demonstration of financial independence, managerial capability and track record of patient responsiveness.

The introduction of social health insurance has triggered reforms aimed at improving efficiency in hospitals in many countries, and there is a lot of international experience that policy makers in Turkey can draw upon. In many cases, particularly in EU accession countries, these reforms have taken the form of self-governing or autonomous hospitals, and while there continues to be a debate about the nature of these autonomous hospitals, particularly insofar as it relates to legal status, ownership and market exposure, the broad consensus is that hospital autonomy contributes to better functioning and enhanced efficiency in the use of resources. Box 4 contains a short description of Poland’s experience with hospital autonomy.

**Box 4: Hospital autonomy in Poland**

All health facilities in Poland became autonomous by January 1, 1999, the date when compulsory health insurance was introduced in the country. As a result of autonomy, hospital managers got the legal ability to sign multiple institutional contracts, generate and keep surplus for investment, invest surplus without permission of MOH, borrow (short-term credit) without permission of MOH, and shift expenses among budgetary line items, including personnel, without MOH approval. The autonomous status also enhanced managers’ authority in personnel issues as well. In Poland, managers of budgetary units have traditionally been able to hire, fire and promote individuals, within certain constraints that are still in force. Following autonomy, the Directors of autonomous units also got the authority to determine the number of posts (positions) without MOH approval and the ability to set salary levels without MOH approval.

In a study of a sample of public hospitals, Campbell, Chawla et al (2000) find that autonomous units recorded superior performance across a range of indicators. Autonomous units have been introducing more medical and non-medical services, initiating more new programs to generate additional revenue, reducing staffing levels to improve efficiency, reducing institutional debt and undertaking extensive improvements in physical facilities and routine processes (such as registration) in order to improve their attractiveness to patients. However, the managers of independent hospitals were not yet found to be putting more sophisticated financial management practices into place as has been hoped by those advocating for greater managerial autonomy. Even so, this level of change is remarkable in an organizational culture carrying with it high levels of inertia from the communist past.
4.4 Consolidating and redefining institutional responsibilities

The present system in which the Ministry of Health and the Ministry of Labor and Social Security are engaged in a meaningless struggle for supremacy in the country’s health sector is untenable. The Ministries of Health and Labor between them control most financing and provision of health care in Turkey. They have facilities in the same towns and cities, conduct very similar kinds of procedures, their personnel enjoy the same civil servant status, and they are both core government ministries. Yet there is almost no coordination among them, no discussion or joint planning, and no collaboration. With insufficient demand for multiple providers that offer the same range of services, especially in the smaller cities and towns, the net result is that many hospitals are substantially underutilized, and investment made in buildings and equipment is underused.

At the same time, as has been discussed earlier, there is little or no real competition between the two, with neither organization functioning on the principles of profit making, neither seeking each other’s patients, and neither competing for the same scarce human resources – because the human resources are not scarce. Yet both Ministries, one way or the other, get budgetary support from the government for their health-related activities.

There is no doubt that both Ministry of Health and the Ministry of Labor and Social Security have critical roles to play in the health care system in the country, given their experience, their existing investments and their respective influence in the health sector. Yet, the present responsibilities and relationships – that result in much duplication and waste in the use of resources – are the least efficient of all possible configurations and need to be altered forthwith. In a sense, neither Ministry should really be in the direct business of producing and providing health care, a function that is so central to both in the present setup, for both have other more critical functions to perform that are given relatively low priority at the moment. Furthermore, the relationship between the two ministries needs to be completely overhauled so that they function as two arms of the same government with the same shared values and beliefs, instead of the present adversarial stances that the two adopt.

As far as the Ministry of Health is concerned, its primary role and responsibility should be that of policy formulation and providing regulatory oversight. Presently, the Ministry of Health is organized along specific vertical programs and specific service delivery functions in primary and secondary care, and tends to be absorbed in running day-to-day curative services. As a result, it has neither developed the capacity to focus on policy making and priority setting for the health sector, nor does it leave itself enough resources and time to focus on quality monitoring and regulation, accreditation of institutions and licensing of professionals, insurance regulation and oversight and leading public health functions and epidemiological surveillance. Redefining the role and responsibilities of the Ministry of Health and equipping it carry out these functions are important prerequisites for sustaining a broad-based health sector reform.

Regulation is the key to making any health system function more effectively, particularly where the focus of public spending is to contribute to efficient functioning of the economy and redistribute resources in favor of the poor. Several aspects of health insurance systems need to be monitored and regulated – and a minimal list would include premium-setting and collection, restrictions of requirements relating to agreements with providers (such as payment mechanisms,
conditions for accessing services, referrals to specialists, etc.), financial solvency, managed care practices, consumer complaints and redressal, and appeals and procedures for disposing off the appeals. Developing suitable and effective regulatory mechanisms requires a high level of sophistication, for there are many constraints that restrict the scope and use of instruments for enforcement of the regulation, and impose limits within which the regulation can take place (Box 5). A key task in the appropriate role of the Ministry of Health in Turkey is to develop the capacity and know-how to effectively regulate the health sector so that the overall objective of improving health status of the population is achieved.

A second area that the Ministry of Health in Turkey needs to focus is policy formulation and stewardship. As has been repeatedly emphasized, the health status of Turkey’s population is poor, both in absolute as well as in relative terms, and there are many different ways in which the available resources can be allocated to have a direct impact on many of the adverse indicators of health status in the country. The extreme rates of maternal and infant morbidity and mortality in the country are a case in point; there are many other areas where rapid gains can be recorded if the policy efforts are so directed and appropriate priorities are established.

**Box 5: Regulatory constraints**

Informational, transactional and political constraints prevent a regulator from implementing the preferred policy. Informational constraints arise when the regulator’s action are contingent upon information that is available only with the entity being regulated, hereinafter simply referred to as the firm. The two common types of informational constraints are moral hazard – which arises when the firm has more information about some endogenous variables and takes discretionary actions that affect its cost or quality, and adverse selection – which arises when the firm has more information about exogenous variables, and can therefore extract a rent from its interaction with the regulator. Needless to say, only information availability can address informational constraints. Transactional constraints arise because it is costly for the regulator to write and enforce contracts. Three common types of transactions costs include costs of future contingencies, operational costs of contracts, and monitoring and enforcement costs. Administrative and political constraints arise when the regulators are constrained by administrative procedures, legal requirements or political imperatives. These constraints restrict the scope of regulation and the use of instruments for enforcement of the regulation, and impose time limits within which the regulation must take place.


This is not to say that health policy formulation, per se, has taken a backseat in Turkey. In fact, improvements in equity and access to health services have been targeted since before 1980 and repeated in successive five-year plans, but the results have not been obvious. Prior to 1980, the Government of Turkey sought to enhance access to health services through the Integrated Health Service Scheme (IHSS), designed to cover rural areas and extend basic health care services to the whole population. The policy thrust was to achieve coverage though infrastructure development and establishment of hospitals and health centers all over the country. However, the big capital investment that this entailed left inadequate funds for equipment and vehicles, and with salaries
consuming most of the operating budget, there was little left for drugs, supplies and fuel and the IHSS did not succeed in meeting its objectives. In 1987, the Basic Law on Health Services (BLHS) was enacted, which again emphasized equity and access. Despite increased budgetary allocations, the success of the BLHS was also limited, primarily because the BLHS was not accompanied by any strategy for systemic reform in terms of financing, delivery and management of health services. The challenges of equity and access to health services remained unmet.

In 1993, a document titled “The National Health Policy” (NHP) was published by the Ministry of Health, which provided a detailed and comprehensive enunciation of priorities and strategies in the health sector in Turkey. The three main thrusts of this document were specific health targets, service delivery reforms and requirements of support services. The health targets underlined concern for maternal and child health, burden of diseases and equity, and set medium (7 years) and long-term (12 years) benchmarks. Concern with maternal and infant mortality was voiced though targets that call for 30-50 percent reduction in mortality rates, and communicable diseases (tuberculosis, measles etc.), cardiovascular diseases and cancer were recognized as major killers.

Despite its title, however, the NHP appears not to have been formally accepted as government policy. Almost no aspect of this framework was implemented and the NHP was regarded as an externally conceived document that had few supporters within the government. The 7th Five Year Plans (1996-2000) and the 8th Five Year Plan (2001-2005) documents also echoed some of the recommendations of the National Health Policy, but nothing has really been put into practice.

In short, the Ministry of Health needs to assume the role of a leader in policy formulation and priority setting in the health sector, and needs to enunciate a national policy on health that involves all the major stakeholders in laying down a comprehensive strategy for reforming the health sector.

Other areas that the Ministry of Health needs to focus on are quality control and consumer education. In quality control, particular emphasis has to be placed on monitoring and regulation, accreditation of institutions and licensing and re-licensing of professional, and consumer education. And as regards consumer education, it is well established – particularly in Turkey where the analysis of household demand for health and utilization of services in Turkey highlights the positive correlation between awareness and knowledge about health issues and utilization – that health services utilization will increase among those households who are presently not consuming adequate levels of health care. Quick gains in population health status can be brought about by investments in improving consumer awareness of health and of benefits from consuming health services.

As far as the Ministry of Labor and Social Security is concerned, its primary role in the health sector should be that of providing oversight and guidance in the management and functioning of the universal health insurance system. Recall that it is proposed to establish the Health Fund under the overall supervision of the Ministry of Labor and Social Security, under which SSK and Bagkur presently function. The setting up of the Health Fund should be a part of the overall
reform of the social security institutions, and it is here that the resources and efforts of MOLSS should be fully focused.

In addition, recall that it is proposed to break away the hospitals from the other functions of SSK and spin them off into a separate legal entity. The Ministry of Labor and Social Security is in a much better position to manage this transition compared to the Ministry of Health, given the quasi-public status of SSK and the experience of SSK in managing health facilities. A key area that the Ministry of Labor and Social Security should focus on is in setting standards of best practice in managing the corporatization of SSK health facilities, standards that can then be emulated by other agencies requiring to do the same.

The need for harmonization of efforts and functioning of MOH and MOLSS cannot be overemphasized. As has repeatedly been mentioned earlier, both Ministries are key players in the health sector in Turkey, positions that call for very high levels of coordination and collaboration. A key to effecting this spirit of partnership is in understanding that the roles and responsibilities of the two ministries are complementary and that both serve the same overall objective and mission. Till such time the level of coordination and cooperation between the two ministries increases, the agenda of health sector reforms in Turkey will remain unfinished.

4.5 Strengthening delivery of primary care services

There appears to be general agreement among policy makers\textsuperscript{18} that, in principle, primary care should be the basis of a well-designed and performance-focused health care system. Well-designed and functioning primary care system can contribute significantly to improving health and reduced human suffering by reducing epidemiological risks of avoidable illnesses and premature deaths, and to alleviating poverty by minimizing lost production due to avoidable illnesses and premature deaths. In addition, an effective primary care system can prevent the health system from getting on to a high-cost trajectory in which enormous resources would be required for treating preventable illnesses.

In practice, however, this is often not the case, simply because primary care is not organizationally situated to have power and control over other levels of care. In many countries, as in Turkey, specialists tend to occupy a senior position in the hierarchy of medical specialists, and primary care providers do not have the necessary standing to play a leading role in patient care and in delivery of basic health services. Any reform in the delivery of primary care would have to start by improving the relative position of primary care providers in both the medical as well as the patient community. In other words, in delivering the essential package of services in Turkey, primary care professionals in Turkey would need to be given the necessary levers to steer patient treatment, either in home-care setting or in the hospital setting, so as to ensure integration of the different health service delivery sectors.

One such way is by adopting the concept and practice of “family medicine”. Family medicine physicians provide health services for the whole family, treating common illnesses across such medicine domains as internal medicine, gynecology, pediatrics, prevention and health propagation. Patients are provided with diagnostic services, laboratory services, and

\textsuperscript{18} Ibid, at 115.
consultations, so that almost all services are provided under a “single-window” system. Family medicine brings the physician and members of a family into closer and more personal contact, and redefines their relationship. The physician gets to know all members of the family and their health concerns, and plays an important role in their health education, prevention of diseases, and general betterment of health.

It is noteworthy that a common characteristic of major non-communicable diseases is their multifactorial etiology, and a few risk factors (smoking, dietary, obesity, sedentary lifestyles, excess alcohol consumption, hypertension, hypercholesterolemia, and diabetes) account for the bulk of heart disease, stroke, chronic obstructive pulmonary disease, common cancers, and accidents. For this reason, population-based interventions that integrate action on risk factors for cardiovascular diseases (e.g. smoking, diet) can have beneficial effect in the reduction of other non-communicable diseases (e.g. colon, lung cancers), and obtain economies in the cost of health care delivery. Family based medicine, with its emphasis on health promotion, prevention and education, can provide the required integration of preventive efforts. Treatment in family practice is based on complete and comprehensive diagnosis and not only depends on the immediate illness, but also on the general patient profile as well as on the general population profile.

Improvements in the provision of primary health care services would also require expansion and integration of clinical services with programs covering highly cost-effective interventions in preventive health such as immunization, vector control, family planning, prenatal, pregnancy and delivery care, neonatal care, AIDS prevention, STDs and TB control. Population-based interventions need to be complemented with interventions aimed at high-risk groups with risk factors or vulnerable groups. Interventions should be targeted to population groups defined by socio-demographic and geographical categories. Vulnerable target groups such as the poor, women, elderly, children and youth need attention in the design of interventions aimed at disease prevention and risk factor reduction. Interventions in those groups afford an opportunity for true prevention, namely preventing the onset of risk factors and promoting healthy lifestyles. Promoting use of clinical preventive interventions that are effective, and preventing the non-use of procedures that are not, is the first step in achieving cost-effectiveness and represents important savings for the health system. A number of countries (US, Canada) and WHO have established task forces to “grade” the scientific evidence of various clinical prevention procedures. Use of these guidelines and the translation of the recommendations in practical aids should be an important support for primary health care delivery.

Epidemiological surveillance and data collection

As indicated earlier, the analysis of epidemiological trends in Turkey is somewhat compromised by the availability and reliability of the available data: some data are simply not collected, some are misclassified and some are misrepresented. In some cases, such as in the data on maternal mortality, huge variations exist depending on when, how and by whom is the data collected. In other cases, such as in the data on adult mortality, most of the available mortality data is based on hospital deaths and thus heavily weighted towards non-communicable diseases. Incomplete and inadequate data cannot form the basis of effective policy and action; on the contrary, it poses the definite risk of distorted emphasis and attention. The importance of an effective and rigorous disease surveillance system and information and data collection cannot be over-emphasized, and this is an area that merits much greater attention than it presently gets.
5. Conclusion: An Action Plan for Implementation of the Health Sector Reforms

Timing and sequencing are critically important to allow the system to prepare itself to absorb the changes and to not overwhelm the implementation machinery. A two-phase gradual implementation is, therefore, suggested, with the first phase spread over three to five years and the second phase a further three to five years after completion of Phase I. Phase I is essentially the preparatory phase, during which all the legal and institutional requirements should be taken care of. Phase II is the completion phase, during which the reform measures are actually implemented. The timing and sequencing of activities proposed for each phase are presented in Table 11.

### Table 11: Key Health Reform Measures for the Short and Medium Term

<table>
<thead>
<tr>
<th>Objectives and Programs</th>
<th>Phase I (Three to five years)</th>
<th>Phase II (Three to five years after completion of Phase I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal social health insurance</td>
<td>Establish the legal basis of social health insurance.</td>
<td>Introduce compulsory social health insurance, unifying all existing health insurances.</td>
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<tr>
<td></td>
<td>Finalize the scope of covered services, and compute unit (and per episode) costs of the covered services.</td>
<td>Set up regional Branch offices of the proposed Health Fund.</td>
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<td></td>
<td>Establish the equalization formula for reallocation among regions based on income profile, population demographics and health needs.</td>
<td>Set up a system of complaints resolution, including patient grievances and provider complaints.</td>
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<td></td>
<td>Train staff of the proposed Health Fund on all issues related to health insurance management, including claims evaluation, claims adjustment, financial and solvency management, strategic planning, purchase of health services, contract writing and attendant obligations, etc.</td>
<td>Evaluate the functioning of the universal health insurance system annually, with emphasis on financing (flow of funds analysis) and utilization of health services.</td>
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<td></td>
<td>Setting up a unified data base of all insurees and providers of health care.</td>
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<td>Establishing package of low-cost high-impact health</td>
<td>Establish and cost the package of low-cost high-impact health</td>
<td>Continue to sustain the production and delivery of the essential package of health services.</td>
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<tr>
<td>Objectives and Programs</td>
<td>Phase I (Three to five years)</td>
<td>Phase II (Three to five years after completion of Phase I)</td>
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<tr>
<td>essential services and targeting delivery to the rural and urban poor and to under-served regions</td>
<td>interventions that meet the health needs of the urban and rural poor. Establish protocols for delivering this package of essential services in a sustained manner. Identify agencies and assign responsibilities for delivering the package of essential services to the rural and urban poor and in under-served regions. Involve other agencies and institutions as needed, including education, sanitation, public health engineering etc., in ensuring effective delivery of this package.</td>
<td>essential services as needed, phasing out very gradually where possible.</td>
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<tr>
<td>Staffing rural health facilities</td>
<td>Establish sub-district level clusters of physicians and anesthesiologists in areas where staffing is not currently an issue, and provide these clusters with transportation and logistical support to cover the outlying areas within a 50 km radius. In collaboration with field-level administrators, hospital directors and professional organizations of doctors, review the functioning of this system frequently to make sure that the outlying areas re being served adequately.</td>
<td>Pilot implementation of new incentive program to motivate recent medical school graduates to choose to be stationed in areas that are currently suffering from a shortage of medical staff.</td>
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<tr>
<td>Hospital autonomy and reorganization</td>
<td>Establish legal basis for hospital autonomy. Establish legal basis for consolidating all MOH hospitals under one quasi-legal organization and all SSK hospitals under one quasi-legal organization, separate from their</td>
<td>In a phased manner, grant autonomy to individual hospitals, starting with the larger hospitals in big cities.</td>
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<tr>
<td>Objectives and Programs</td>
<td>Phase I (Three to five years)</td>
<td>Phase II (Three to five years after completion of Phase I)</td>
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<td>respective parent bodies</td>
<td>Lay down measurable standards for accountability and good governance for autonomous public health facilities.</td>
<td>Refine standards for accountability and governance based on results and experience.</td>
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<td>Create these two hospital organizations as above, and grant managerial and financial autonomy to the two hospital organizations.</td>
<td>Set baseline performance indicators so as to track benefits from autonomy.</td>
<td>Review periodically and compare with baseline indicators.</td>
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<td>Institutions Establish a national advisory body on health comprising officials from Ministry of Health, Ministry of Labor and Social Security, State Planning Organization, and Universities, with broad responsibility for planning, coordination and monitoring health policies, indicators and status of the population.</td>
<td>Establish regional level coordination bodies with the same representation.</td>
<td>Continue with this system to ensure overall coordination and cooperation among the major players.</td>
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<tr>
<td>Empowering Ministry of Health for regulation and policy formulation Establish legal basis for regulation, oversight and monitoring, giving MOH widespread responsibility for monitoring production, delivery and quality control in the entire health sector. Establish principles of regulation, including clear enunciation of scope and extent of regulation.</td>
<td>Review and revise the principles of regulation on the basis of experience gathered in the first few years. Continue training of MOH staff in regulation, monitoring and control. In conjunction with Universities, establish a system of financing health services research. Continue to sustain the development of</td>
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<tr>
<td>Objectives and Programs</td>
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<td>Train MOH staff to carry out the regulatory and oversight functions.</td>
<td>National Health Accounts annually and Burden of Disease periodically.</td>
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<td>Establish an inter-disciplinary committee under the MOH, with representation from the Ministry of Labor and Social Security, researchers and administrators, to draw up a policy research agenda for the health sector.</td>
<td>After every three years, update, expand and improve upon this health sector study, with emphasis on health status and regional developments in the health sector.</td>
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<td>Establish institutional mechanisms to sustain the development of National Health Accounts and Burden of Disease after the first rounds results become available.</td>
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<tr>
<td>Strengthening primary care</td>
<td>With emphasis on total care and continuity of care, consolidate the delivery of preventive and curative care.</td>
<td>Introduce the practice of family medicine on a pilot basis in selected districts.</td>
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<td>Establish protocols for training and accreditation of family medicine practice.</td>
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<tr>
<td>Epidemiological surveillance and data collection</td>
<td>Standardize reporting of diseases so as to allow comparability and tracking over time.</td>
<td>Strengthen reporting and analysis by computerizing surveillance and data collection.</td>
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<td>Establish protocols and clear case definitions of reportable diseases.</td>
<td>Strengthen diagnosis by equipping and modernizing field level laboratories.</td>
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<td>Train medical staff to recognize the clinical manifestations of reportable diseases.</td>
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<td>Identify laboratory needs for diagnosis.</td>
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<tr>
<td>Quality assurance and control</td>
<td>Establish external advisory groups for setting standards for clinical care in hospitals and outpatient settings, administrative</td>
<td>In collaboration with other professional organizations, establish quality assurance and control guidelines.</td>
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Objectives and Programs

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<td>(Three to five years)</td>
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and financial services, and physical plant and equipment. Establish reporting and data collection protocols to facilitate effective quality control and monitoring.

Establish legal basis for setting up an autonomous agency for quality control with powers and responsibility of enforcing quality guidelines.

Designate one University in each region to be the “quality leader” and guide research and studies related to quality and patient satisfaction.

Operationalize the reporting and data collection protocols in a phased manner, starting with one hospital in every region so as to cover all facilities by end of seven years.

Establish the agency for quality assurance and control.

Firmly place quality on the policy research agenda and use the results to inform policy decisions:

The exact nature and extent of all costs associated with the reforms are not easy to estimate, particularly since many measures are institutional in nature. A very rough back-of-the-envelope calculation puts the one-time costs associated with these reforms as US$550 million, as per details presented below in Table 12.

Table 12: Estimated one-time costs of the measures proposed as part of the reform package

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<tr>
<th>Reform Measure</th>
<th>Significant Cost Items in the Proposed Reform Measure</th>
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<tr>
<td>Universal social health insurance (estimated cost US$200 million)</td>
<td>The most cost-intensive item in this reform measure is the setting up of a consolidated computerized database that will allow access to patient records, including utilization of health services and premium payment history. Including the required hardware, this component could cost up to US$2 per person, or about US$140 million, in terms of fixed costs. A second one-time cost item is the integration of all existing insurance systems, like SSK, Bagkur, Emekli Sandigi and Green Card program. Including the logistics and all necessary hardware and software requirements, it is estimated that this will cost about US$20 million. Another cost item in this measure is training staff of the proposed Health Fund on all issues related to health insurance management, including claims evaluation, claims adjustment, financial and solvency management, strategic planning, purchase of health services, contract writing and</td>
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<td>Reform Measure</td>
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<td>attendant obligations, etc. It is estimated that this may cost up to US$5 million. The remaining items of expenditure are (i) finalization of the scope of covered services, and compute unit (and per episode) costs of the covered services; (ii) establishment of the equalization formula for reallocation among regions based on income profile, population demographics and health needs; (iii) setting up a system of complaints resolution, including patient grievances and provider complaints; and (iv) setting up a process of ongoing evaluation of the functioning of the universal health insurance system annually, with emphasis on financing (flow of funds analysis) and utilization of health services. These and other technical elements associated with the introduction of social health insurance are expected to collectively cost about US$25 million. A sum of US$10 million should be budgeted for miscellaneous expenditures associated with the introduction of universal social health insurance.</td>
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<tr>
<td>Package of essential services and targeting delivery to under-served regions (estimated cost US$50 million)</td>
<td>The main items of reforms under this component are: (i) development of the package of low-cost high-impact health interventions that meet the health needs of the urban and rural poor; (ii) establishment of protocols for delivering this package of essential services in a sustained manner; (iii) equipping cluster clinics with necessary supplies and transportation facilities; (iv) identification of agencies and assignment of responsibilities for delivering the package of essential services to the rural and urban poor and in under-served regions; and (v) involving other agencies and institutions as needed, including education, sanitation, public health engineering etc., in ensuring effective delivery of this package. These and other technical elements associated with the development of a package of essential services and targeting delivery to under-served regions are expected to collectively cost about US$50 million in fixed costs.</td>
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<tr>
<td>Hospital autonomy and reorganization (estimated cost US$150 million)</td>
<td>The main items under this reform measure are: (i) establishment of the legal basis for hospital autonomy; (ii) establishment of the legal basis for consolidating all MOH hospitals under one quasi-legal organization and all SSK hospitals under one quasi-legal organization, separate from their respective parent bodies; (iii) developing strategic business plans for each corporation and for each facility and training managerial staff; (iv) creating the two corporations and sustaining them for the first five years; (v) laying down measurable standards for accountability and good governance in each corporation; for autonomous public health facilities; and (vi) establishing protocols and baseline performance indicators to track benefits from autonomy. Providing support to the autonomous bodies, developing business plans for each facility, developing managerial capacity and supporting other technical elements associated with the introduction of</td>
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<tr>
<td>Reform Measure</td>
<td>Significant Cost Items in the Proposed Reform Measure</td>
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<td>Hospital autonomy is expected to cost about US$150 million.</td>
<td>The main items of reform under this component are: (i) establishment of a national advisory body on health comprising officials from Ministry of Health, Ministry of Labor and Social Security, State Planning Organization, and Universities, with broad responsibility for planning, coordination and monitoring health policies, indicators and status of the population; (ii) setting up protocols for enhanced and continuing cooperation and collaboration; (iii) developing regulatory and policy formulation capacity in MOH and setting up a regulatory agency; and (iv) developing the necessary capacity in MOLSS for providing general oversight to the insurance system. These and other technical elements associated with institutional consolidation and redefining institutional responsibilities are expected to collectively cost about US$50 million in fixed costs.</td>
</tr>
<tr>
<td>Strengthening primary care (estimated cost US$100 million)</td>
<td>The main items of reform under this component are: (i) development of family medicine practices and training medical personnel; (ii) development and implementation of a primary health care master plan; (iii) expansion and integration of clinical services with programs covering highly cost-effective interventions in preventive health such as immunization, vector control, family planning, prenatal, pregnancy and delivery care, neonatal care, AIDS prevention, STDs and TB control; and (iv) strengthening epidemiological surveillance. These and other elements associated with institutional consolidation and redefining institutional responsibilities are expected to collectively cost about US$100 million in fixed costs.</td>
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The review of the health sector highlights the need for major restructuring of the health system, and suggests that this reorganization is necessary to achieve the twin objectives of universal access to quality health services and the ability to deliver these services in an economically and institutionally sustainable manner. Piecemeal changes at the margin are unlikely to revitalize the health system, particularly when the past performance record has been less than satisfactory. At the end of the day, however, the success of the health reform would depend much on the force of the political will and public acceptance, without which even the best-designed measures are most likely to fail.
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