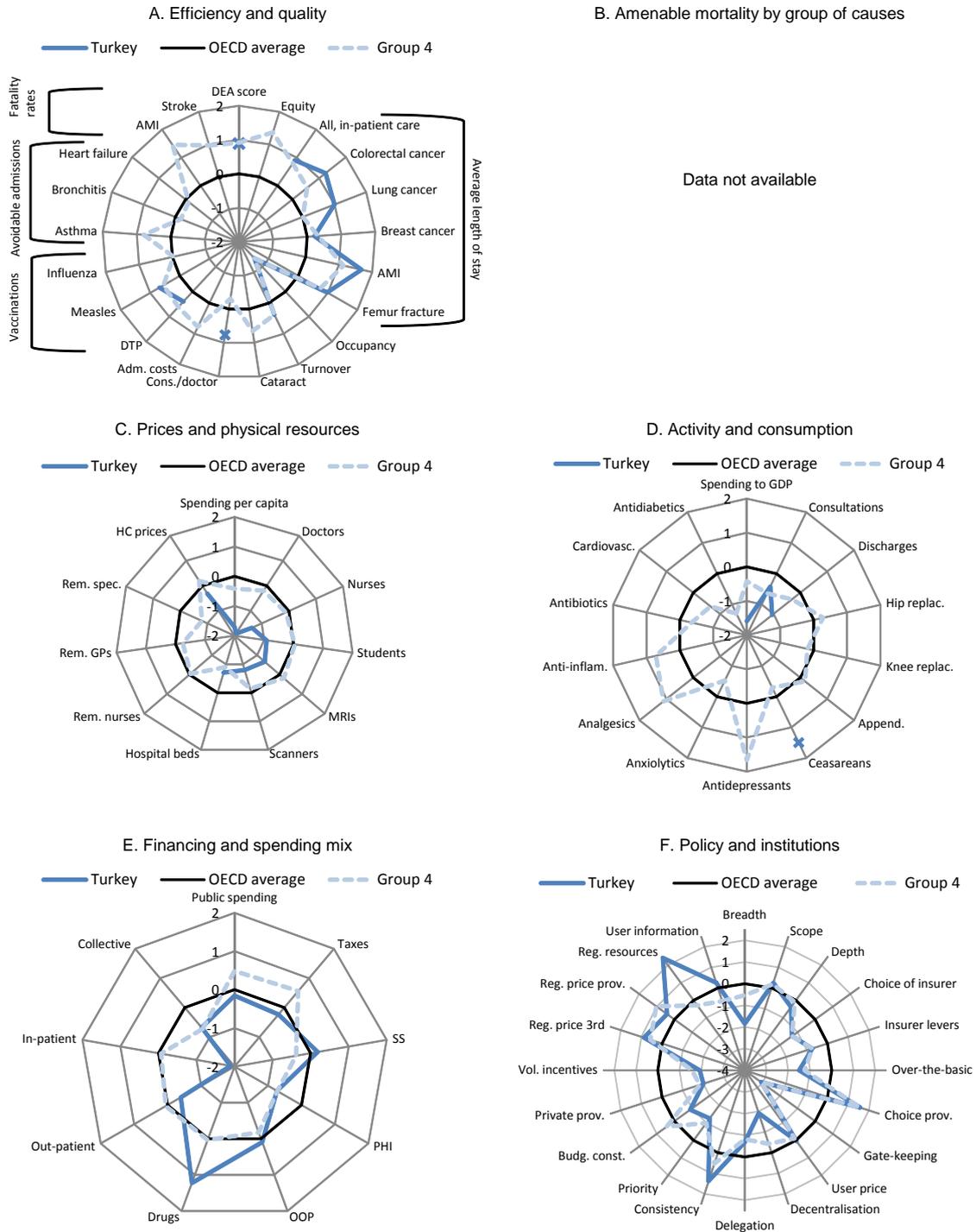


## Turkey: health care indicators

### Group 4: Iceland, Sweden, Turkey



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the average OECD country).

In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).

In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.

In Panel F, data shown are simple deviations from the OECD average.

Source: OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

## TURKEY

**GROUP 4:** Mostly public insurance. Users are given ample choice of providers but private supply is limited and prices tightly regulated. Gate-keeping is virtually inexistent.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
High DEA score but still lower health status (life expectancy)	Health care spending <i>per capita</i> and as a share of GDP both remain well below the OECD average			A large share of the population is still not covered by a basic insurance package	Pursue efforts to increase population coverage for the basic insurance package
Rather high output efficiency in the in-patient care sector, except a low occupancy rate of beds	Less acute care beds, high-tech equipment and nurses <i>per capita</i>	Less hospital discharges <i>per capita</i>	Low share of in-patient care	Ample user choice of providers and no gate-keeping	Consider strategies to manage efficiently existing hospital beds. Incorporating some elements of activity-based funding to the current line-item funding for hospitals could be considered
Data missing on the quality of care and on administrative costs	Less doctors <i>per capita</i>		High share of expenditure on drugs	Tight regulation of resources and prices, combined with little private provision and volume incentives	Improve availability of internationally comparable data on the quality of care, compensation levels of health professionals and administrative costs
				Less decentralisation coupled with little priority setting and expenditure control <i>via</i> the budget process	Strengthening the budget and prioritisation process ( <i>e.g.</i> by introducing expenditure targets) could help better controlling both the level and allocation of public health care spending