Social protection in Turkey: Fragmented — and disconnected from the supply of hospital care

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While Turkey's social protection structure and its hospital system both comprise a number of arrangements and strata predicated on the occupational situation of beneficiaries, there is no equivalence between them, in terms of either scope of benefits provided, benefit conditions or terms of reimbursement. Different social protection schemes and types of hospital are effectively sealed off from each other: the resulting fragmentation of access to care is at the origin of shortcomings in the social security coverage of the population. It explains the emergence of stopgap arrangements devised by various social actors, including the State, charitable foundations, community associations, municipal authorities and private enterprise.

The social protection structure

The organization of social protection in Turkey reflects the confrontation between the ideological orientation of public health and its financial constraints. It is made up of several mechanisms operating in parallel, with benefits dependent on occupational affiliation.

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Published by Blackwell Publishing Ltd, 9600 Garsington Road, Oxford OX4 2DQ, UK and 350 Main Street, Malden, MA 02148, USA

Three periods in public health policy

From 1923 up to the 1960s, health was not a priority for the public authorities. Programmes of hospital construction were nevertheless launched, as well as campaigns against malaria and tuberculosis (Tapar and Erigüç, 2001).

The 1960s were characterized by the passing of the Socialization Act of 1961, which, in accordance with the will of the military who were in power at the time, gave effect to the aspiration expressed in the Constitution of 1960 and the role attributed to the State in relation to medical care and the physical and psychological well-being of citizens. The objective of this Act was to promote an egalitarian health system, financed principally through taxation, with cost-sharing by users.

This transformation was to be accompanied by the implementation of a hierarchically organized care structure, ranging from health centres (principally located in rural areas)[1] through to specialized hospitals in towns and cities, providing care virtually free of charge and staffed by referring general practitioners.

Never challenged in theory and still incomplete, this system does not operate as such. It has not been possible to close certain establishments established before the reform, which continue to operate — in particular, mother-and-child clinics, family planning units and tuberculosis centres — while the transfer of prevention personnel to large hospital complexes, scheduled from 1960, resulted only in greater neglect of preventive care.

Since the 1990s, Turkey has operated a policy of economic deregulation and privatization in partnership with the major international financial institutions, namely the World Bank and the International Monetary Fund. The financing allocated to the health sector is conditional upon the implementation of reforms, particularly confining the role of the State to policies of prevention and support, and according the private sector a leading role in financing and investment (World Bank, 1986 and 1990).

In overall terms, if Turkey is compared with countries with a similar or very similar living standard (Table 1), it may be seen that life expectancy at birth is almost identical. The same applies to the level of expenditure on health, the differences from other countries being explained by differences in living standards. However, the supply of hospital care and the level of its use are lower in Turkey.

1. Health centres, or "dispensaries", have several names according to their location or function and the responsible authority. Here, the term "health centre" is used throughout.

Table 1. *Key health statistics in Turkey and countries with a comparable living standard*

	GDP per capita[a]	Life expectancy at birth[b]	Total health expenditure[c]			Acute hospital care			
			As a percentage of GDP	Per capita[d]	Public expenditure as a percentage of total expenditure	Number of beds[e]	Admissions[f]	Average stay (days)	Bed occupation rate (%)
Hungary	12,213	71.93	5.7 (2001)	830.48	74 (2001)	6.4 (2000)	24.2	7	76.9
Slovakia	10,591	73.45	6.5 (2000)	709.60	90 (2000)	6.7	18.8	9.2	70.9
Poland	9,305	73.95	6.2 (1999)	535.00	75 (1999)	n.a.			
Estonia	8,355	65.4	6.10 (2001)	543.08	77.10 (2001)	5.1	17.9	6.9	62.3
Croatia	7,387	73.00	9.0 (1994)	357.98	100 (1996)	4.0	13.9	8.9	85.5
Russian Federation	7,473	65.43	2.9 (2000)	209.24	n.a.	9.1	21.6	13.2	85.8
Belarus	6,876	64.8	4.40 (2001)	295.67	94.10 (2001)	n.a.			
Turkey	6,815	69.80	4.3 (1998)	316.00	80 (2000)	2.1	7.6 (2000)	5.4	58.8
Romania	6,041	64.0	2.60 (2001)	146.85	100 (2001)	n.a.			

[a] US dollars at purchasing power parity.
[b] 2001.
[c] Year in brackets.
[d] 2001.
[e] Per 1,000 inhabitants, 2001.
[f] Per 100 inhabitants, 2001.
Source: World Health Organization, Regional Office for Europe, in Savas et al. (2002).

Table 2. *Nature of coverage, by type of scheme*

	Coverage		
	Hospital care	Consultations	Medication
Social protection scheme			
Memur Saglik[a]	Yes	Yes	Partial
Emekli Sandigi[a]	Yes	Yes	Partial
SSK	Yes	Yes	Partial
Individual insurance	Yes	Yes	Partial
Bag-Kur	Yes	Yes	Partial
Private insurance schemes	Depends on type of contract		
Without coverage			
Green card	Yes	No	
Social Assistance Fund	Yes	No	
Municipal schemes	Yes		

[a] Often grouped together under the title "Government Employees' Retirement Fund" (GERF).
Source: Author.

Fragmented coverage

Social protection in Turkey is based on various mechanisms, which together are far from covering the whole of the Turkish population (68 million inhabitants in 2000). Four public social protection schemes coexist: the *Memur Saglik*,[2] covering active employees in the public service and their direct dependants; the *Emekli Sandigi*, for retirees from the public service and their direct dependants; the SSK,[3] covering employees in the private sector and wage-earners in the public sector; and the *Bag-Kur* (Social Insurance Organization for the Self-Employed), insuring craftworkers, shopkeepers and members of the professions.

There is a form of personal insurance allowing voluntary membership of the SSK. Such membership may be individual or collective, voluntary or compulsory. Individually, any person may be voluntarily affiliated by paying an insurance premium. Collectively, insurance is either voluntary or

2. The spelling of Turkish names and terms in this paper is imperfect because the word processing programs available are not equipped for the Turkish alphabet.

3. *Sosyal Sigortalar Kurumu*: Social Insurance Institution.

compulsory. At the voluntary level, it concerns groups that are excluded from automatic coverage by the SSK and freely negotiate their affiliation in exchange for the payment of contributions. At the compulsory level, the arrangement is the same except that the groups involved oblige their members to be affiliated.

There are around 30 private insurance companies covering 270,000 persons, offering their services to people who do not have social security coverage and cannot afford the cost of affiliation. The number of people insured by these companies increased during the 1990s.

The variety of schemes is matched by great diversity in quality, scope, accessibility and availability of coverage (Table 2). The most efficient scheme is for military personnel, and the least efficient is the *Bag-Kur* (Tapar and Erigüç, 2001).

A Bill that is currently being discussed by Parliament is intended to unify the various social security schemes and move in the direction of universal coverage.

Stopgap arrangements for categories not covered

As mentioned, the different mechanisms outlined above do not cover the whole of the Turkish population. In particular, agricultural workers and the urban poor are excluded as the level of their income does not allow any recourse to supplementary private insurance schemes. This situation was aggravated by the reform of the SSK (which covers half the population), requiring a minimum of 120 days' contributions to become eligible.[4] To compensate for shortcomings in coverage, various arrangements have been put in place:

- the green card;
- the Social Assistance Fund;
- municipal schemes;
- foundations.

The green card. Since 1992, citizens without coverage have been able to apply to the State for a green card covering the cost of hospital care. Beneficiaries must have an income that is lower than a threshold considered to be close to poverty, and their share of family income must be equivalent to at least one-third of the minimum wage.

4. Previously, when a single day's work provided entitlement to coverage, certain enterprises only registered their employees in the event of an employment accident or occupational disease.

The green card is granted for five years, but eligibility conditions are reviewed annually. It is an arrangement that in theory is closely monitored, though how widely the conditions are respected varies between regions. Before granting a green card, the competent authority asks various administrative services to verify the degree of need of the applicant: the tax authorities (for income tax record), the municipal authorities (local tax), the police (vehicle registration) and social security (to check for any affiliation).

In practice, owing to the lack of computer capacity, time and personnel, the information provided is not always based on adequate research. For this reason, people have no hesitation in applying for a green card even when they are not entitled to it. According to the Ministry of Health itself, there are shortcomings in the figures for applicants and holders of the green card. It is estimated that of the 14 million Turks who applied, 11 to 12 million obtained one, and only 9 million of these are considered to meet the eligibility criteria.

In theory, the green card is backed up by a system of referring general practitioners, who decide whether the patient should be admitted to hospital. If such a decision is taken, the holder of the green card has two days to go to a hospital. Obviously, this system of referral by a doctor does not apply in emergency cases.

The Social Assistance Fund. Turkish citizens who have neither coverage nor green card may apply to the Social Assistance Fund of the Ministry of Health. This often happens while an application for a green card is being reviewed, and the costs of hospital care and medication are then met from the fund.

Municipal assistance schemes. The role of municipal authorities in public health and environment matters is long-established in Turkey (Varol, 1998). Since the adoption of legislation in 1963, municipal authorities have had more freedom to implement their own care access policies by establishing and managing emergency rooms, hospitals, health centres, baby clinics and old people's homes.

Even though the provision of healthcare is one of the responsibilities of the State, municipal authorities which have the means to do so have developed primary and secondary healthcare services. This is not necessarily unconnected with political considerations. For example, Istanbul city council (Islamic moderates) has made extending health coverage to excluded populations one of the central planks of its policy. Its project is both broad in scope and ambitious, and has two main axes:

- responding to spontaneous demand;
- more proactive measures for target populations, based on local neighbourhood networks (see below).

Foundations. The role of charitable foundations in meeting healthcare (and other) costs goes back to the Ottoman Empire. Today, many of them meet the healthcare costs of the most needy; some finance ambulances specially equipped to provide care to the very poor on the spot. They often coordinate their action with local community associations.

Similarly, religious groups have clinics located in disadvantaged neighbourhoods and provide good-quality services at low cost in premises that are more than adequate. However, their operations are restricted by a law forbidding them to charge fees that are lower than a defined threshold.

The foundation system has developed to such a point that there is a Ministry of Foundations and there are some run by the public authorities themselves. For example, the Ministry of Health finances the Social Assistance Fund, which is administered at the prefectural level. The existence of the Ministry of Foundations demonstrates the authorities' desire to restrict their activities. Indeed, right from the creation of modern Turkey, Atatürk had sought to combat their political influence.[5] Still today, the State is distrustful of the proselytizing that may be hidden behind social action.

The hospital system

Like the social protection schemes, the supply of hospital care is also fragmented, even though it gives the visitor the impression of an efficient system. Two major categories may be distinguished: private hospitals and public hospitals. This latter category includes state hospitals and those of the SSK. The state hospitals may be further subdivided into those of the Ministry of Health, those under the responsibility of other ministries (Defence, Police, Interior and so on) and university hospitals (Table 3).

Public hospitals

Several parallel networks. Turkey has 1,256 hospital establishments for a total of 176,121 beds, to which should be added the network of health centres. The latter number around 5,700, each covering an average population of 7,500 and controlling several subunits.

5. Mustafa Kemal, known as Atatürk, emblematic leader of the transition from the Ottoman Empire to modern Turkey.

Table 3. *Types of hospitals in Turkey*

State			SSK (Social Insurance Institution)		Municipal authorities, community associations		Private	
Type	Hospitals	Beds	Hospitals	Beds	Establish-ments[a]	Beds	Hospitals	Beds
Ministry of Health	744	86,117						
Other ministries	57	19,060						
of which Defence	42	15,900						
Universities	43	24,200						
Total	844	129,377	140	34,504	32	6,740	230	11,500

[a] Municipal authorities operate clinics and health centres.

Source: Author, based on www.saglik.gouv.tr

Public health facilities are subdivided as follows:

- Ministry of Health establishments (commonly known as "state hospitals");
- hospitals belonging to particular ministries (Defence, Police, etc.), of which there are several. These too are state hospitals,[6] but access is as a rule reserved for officials of the ministries concerned;
- university hospitals, which are state hospitals with a teaching and research role;
- the hospitals of the SSK, the Turkish social security body, which are public hospitals but not dependent on the State.

Not all public hospitals have a central pharmacy, so patients or their families, even in the event of hospitalization, have to go outside to get their prescriptions and any other materials required for treatment. Since Ministry of Health and university hospitals are among those that do not provide medication, they are easily recognizable from the dozens of drugstores established in the immediate vicinity.

The hermetic separation that initially existed between the public hospitals, particularly between state hospitals and those of the SSK, is gradually giving way to a form of integration, albeit still very spasmodic and incomplete (Table 4).

6. Not to be confused with the hospitals of the Ministry of Health, which are state hospitals in the proper sense of the term, in the same way as university hospitals.

Istanbul alone has 39 Ministry of Health hospitals, three university hospitals and 16 SSK hospitals. It has 234 health centres, of which 220 are attached to the Ministry of Health.

The relation between health centres and Ministry of Health hospitals. One of the specific features of Ministry of Health hospitals is that they are associated with health centres — up to 10 or 15, depending on the residential area. Central health centres serve as an interface between local health centres and the hospital or hospitals to which they are attached. They are responsible in particular for prevention policies and support for public health campaigns in such fields as vaccination, early detection and family planning. They offer access to an outpatients' clinic which provides basic care. Their clientele is made up of persons of limited financial means; other people prefer direct access to hospitals, both public and private, getting around the system of referring general practitioners. This organizational structure particularly obtains in the towns and cities, many rural areas having to make do with just a local health centre in the absence of a hospital.

For all patients of a Ministry of Health hospital, whether they are outpatients or hospitalized, the central health centre to which it is attached is contacted for the patient's history and any tests that have already been carried out. In turn, the central health centre asks the local one for the information and, where necessary, dispatches a team to make contact with the family and anyone else who knows the patient well, making use of local community records.

In parallel, patients of a health centre may be referred to the hospital to which it is attached for a diagnosis, additional tests or surgical procedures. Where necessary, a Ministry of Health hospital may refer a patient to another public establishment (attached to a university or another ministry) by means of a transfer document, known as a *Svek* (Table 4).

Private hospitals

There are around 230 private hospitals, accounting for a total of 11,500 beds. This part of the health sector is booming, at the behest in particular of the major international financial institutions, which are pressuring the Turkish authorities to liberalize care supply.

Examples of private institutions are the *Acibadem* chain of hospitals and the *Universal Vatan* (52 establishments). In Istanbul, the "national" hospitals — French, American, German, Italian, Bulgarian, Armenian, Greek and so on — are very active.

Table 4. *Access to Turkish hospitals by type of social security coverage*

	Types of hospital				
	State			SSK	Private
	Ministry of Health	Ministries	University hospitals		
Scheme					
Memur Saglik (active public servants and their direct dependants)	Direct access. No advance payment. Medication covered: — 20% to be paid by persons in employment — 10% by retirees — nothing to be paid in the event of chronic illness	Access reserved for members of the Ministry. Exceptional access when beds available	Direct access	Access possible but not chosen (overcrowded hospitals considered to be of lower quality)	Access in exchange for payment unless an institutional agreement has been concluded, in which case a transfer document *(Svek)* is required
Emekli Sandigi (retired public servants and their direct dependants)		Exceptional access when beds available	In principle, a transfer document *(Svek)* is required. In practice, direct access		Access in exchange for payment
SSK (private sector employees and public sector wage-earners)	Access possible under certain conditions: — no SSK hospital available — specialized surgical procedures or consultations	Institutional agreement necessary. A transfer document *(Svek)* is required. Specialized surgical procedures or consultations		Direct access. No advance payment. Medication covered: — 20% to be paid by persons in employment — 10% by retirees — nothing to be paid in the event of chronic illness	Agreements concluded with certain hospitals for surgical procedures or additional sophisticated tests; in such cases, a transfer document *(Svek)* is required

Bag-Kur (self-employed shopkeepers, craftworkers, professionals)	Direct access. Medication covered: — 20% to be paid by persons in employment — 10% by retirees — nothing to be paid in the event of chronic illness		Access possible provided that the costs of treatment are paid in advance	Access possible but reluctance to use them (overcrowded hospitals considered to be of lower quality)	Access in exchange for payment unless an institutional agreement has been concluded, in which case a transfer document *(Svek)* is required
Private insurance schemes (certain banks and insurance companies)	Private insurance companies that do not have their own facilities contract with private hospitals whose service meets the standards their plan members' premiums entitle them to expect				
Persons not covered					
Green card Social Assistance Fund Municipal authorities (particularly Istanbul)	Yes	No	No	No	Yes, in principle, for between 3 and 5% of the care provided by the hospital

Source: Author.

Private hospitals are often especially well provided with staff and equipment. The world's first Siemens PET[7] scanner was installed in an *Acibadem* hospital. They have the full range of diagnostic and treatment equipment, including laboratories, blood transfusion centres and casualty departments.

Social protection and the hospital system

In Turkey, access to hospital care is complicated by the fact that different social protection schemes and types of hospital are effectively sealed off from each other (Table 4) — with the exception of the SSK, which is uniquely both insurer and care provider. Hospital care supply can be broken down into the private and the public; within the latter, it is split between the State and the SSK.

The situation of private establishments is the simplest. Private hospitals are accessible to everyone on condition of direct payment, unless an institutional agreement has been concluded with a social insurance scheme and the patient has been sent by a public hospital covered by that scheme. In such cases, a transfer document *(Svek)* between the public system and the private hospital is required. Private insurance companies that do not have their own facilities contract with private hospitals whose service meets the standards their plan members' premiums entitle them to expect.

In the public sector, analysis of access to hospital care based on the type of social security coverage is more complex. A distinction has to be made between two groups: persons who are covered, and those without any social protection. The first group may be further divided into four subgroups (not including individuals covered by private schemes): active public employees, retired public employees, members of the SSK, and the self-employed affiliates to the *Bag-Kur*.

Access to hospitals by type of coverage

Civil servants. As we have seen, civil servants are covered by the *Memur Saglik* while they are active and by the *Emekli Sandigi* once they retire, with their direct dependants benefiting from the same protection in each case. Both active and retired civil servants have direct access to the hospitals of the Ministry of Health and to university hospitals. In cases of chronic illness, their prescriptions are completely covered; otherwise they share the costs (20 per cent for those in activity and 10 per cent for retirees). The ab-

7. Positron Emission Tomography, a category of extremely effective scanners which, among other functions, make it possible to diagnose certain forms of cancer at a very early stage.

sence of a central pharmacy in Ministry of Health hospitals means medication has to be bought from one of the numerous drugstores in their vicinity.

The hospitals run by the ministries are reserved for their own staff, with access possible for other civil servants only if beds are available. The latter may also use SSK hospitals, but few choose this option as they are overcrowded and considered to be of lower quality than state hospitals (Table 4).

Members of the SSK. The employees in the private sector and wage-earners in the public sector that belong to the SSK have direct access to its hospitals: no advance payment is required. The conditions for coverage of their prescriptions are identical to those for civil servants (100 per cent for chronic illnesses, otherwise cost-sharing).

Persons covered by the SSK may have access to state hospitals under certain conditions. For hospitals of the Ministry of Health, there must not be an SSK establishment available and/or surgical consultations or procedures must have been prescribed; for university hospitals or those of other ministries, the need for surgical consultations or procedures is sufficient. In all cases, an institutional agreement is necessary; a *Svek* is required for university hospitals and the hospitals of the ministries.

Persons covered by the Bag-Kur. The self-employed workers who constitute the membership of the Bag-Kur have direct access to Ministry of Health hospitals and those of the other ministries under the same conditions as civil servants. Access to university hospitals is possible provided that the costs are paid in advance, but not for primary care. Again as with civil servants, the SSK hospital option is rarely taken up, for the same reasons.

Hospital care with no social security coverage

Persons without any social security coverage can have access to Ministry of Health hospitals but, except in an emergency, only for primary care. They may subsequently be referred to university hospitals, which do not accept patients with a green card for primary care. The green card only covers costs related to hospitalization, not medication or outpatient consultations.

Hospitals are reimbursed for the costs advanced in such cases, belatedly and in part. Sometimes, they are not paid at all: either the patients leave before being discharged[8] or, as cheques are uncommon in Turkey, they make

8. It should be noted that in private hospitals the admissions service is held financially responsible for any failure by a patient to make payment, through the negative attribution to its budget of the unrecoverable debt.

an acknowledgement of debt *(Senet)* in lieu of settling the bill. However, the very low penalties for failing to make good a debt acknowledgement are hardly dissuasive. It is therefore tempting to default, to such an extent that people's lack of social security coverage is sometimes a result of not wishing to pay contributions, with those who make this choice preferring to issue *Senet* that they know they will not ultimately honour. Very often it is the emergency services that bring these patients to hospital; they will then be tempted to apply for a green card although they are ineligible. It should be recalled that only 9 million of the 12 million holders of the green card are considered to fulfil the eligibility conditions.

While waiting for their green card and/or to cover the cost of medication or outpatient consultations, patients who are insolvent or very poor may apply to the Social Assistance Fund or one of the many foundations (private or religious). The difficulty comes because the Fund does not meet the whole cost of all care, some treatments being covered only up to 50 per cent. Moreover, it is only possible to have recourse to this system once.

The most needy persons covered by municipal public health schemes follow the same course as those holding green cards, with the difference that the full cost of healthcare, including consultations, hospitalization and medication, is met by the municipality that is assisting them.

Emergency services and the complexity of the system

The fragmentation of hospital structures and forms of social security coverage is aggravated by the multiplicity of emergency services. The public emergency telephone number 112, the most important and the best known, comes under the responsibility of the Ministry of Health. But there are also the casualty departments of private hospitals as well as private ambulance services, while some municipal authorities, notably Istanbul, have their own emergency services.

Patients are first questioned about their insurance status. If they are not covered, the mobile emergency team will take them to the casualty department of a Ministry of Health hospital for treatment. Patients who do have coverage will be taken to a compatible hospital: for example, a serviceman to a Ministry of Defence hospital, a company employee to an SSK hospital, a shopkeeper or a civil servant to a Ministry of Health hospital, and so forth.[9]

9. For more detailed information on the emergency services in Turkey, see Özsahin (1998).

Table 5. *Insured persons and dependants, by scheme, 1980-2000*

	1980				2000			
	Number	Percentage of total insured persons	Percentage of total population	Including dependants	Number	Percentage of total insured persons	Percentage of total population	Including dependants
Memur Saglik Emekli Sandigi	5,426,000	6.04	12.13	3,606,000	9,766,000	16.49	14.35	6,305,700
SSK	10,674,000	51.23	23.86	7,834,000	34,140,000	57.66	50.18	24,488,000
Bag-Kur	4,540,000	21.79	10.15	3,302,000	15,036,000	25.39	22.10	10,446,000
Private insurance schemes	196,000	0.94	0.44	106,000	271,000	0.46	0.40	121,000
Total number of insured persons	20,836,000	100.00	46.57	14,848,000	59,213,000	100.00	87.03	41,360,700
Persons without insurance coverage	23,901,000	—	53.43	—	8,823,000	—	12.97	—
Total population	44,737,000	—	100.00	—	68,036,000	—	100.00	—

Source: State Planning Organization, 2001, in Savas et al. (2002).

Organizational deficiencies

Healthcare supply and social protection: An inequitable social system. There is inequality not only between the situations of those who have social security coverage (87 per cent of the population) and those who do not, but also between different categories of the population that do. The mechanisms of social security coverage are not equivalent, in terms of either scope of benefits provided, benefit conditions or terms of reimbursement. Public employees, whether active or retired, are the most favoured group in terms of free access to care, while in contrast craft workers, shopkeepers and members of the professions (covered by the *Bag-Kur*) have to pay their medical costs in advance; these are only reimbursed in part and after a long delay. A total of 57 per cent of insured persons are covered by the SSK, 25 per cent by the *Bag-Kur* and 17 per cent by the *Memur Saglik* and the *Emekli Sandigi* (Table 5).

Around 13 per cent of the population have no social security coverage and 23 per cent are without medical coverage. The poorest people have very limited access to basic healthcare and, when they do obtain it, it is of lower quality.

The variation in quality, equipment and expertise between the different hospital structures reflects the varying extent of social security coverage provided by the different schemes, a significant proportion of the population being without any social protection at all. Hospitals are not all of the same quality, not so much with regard to the qualifications of their staff as the resources allocated for their operation and equipment and, in particular, their use rate. SSK establishments have the worst reputation; they are less well resourced and their limited care supply is disproportionate to the number of SSK members — and therefore of potential users. The hospitals of the ministries and the university hospitals have the best reputations in the public sector.

The geographical distribution of healthcare supply is unbalanced. Hospitals are concentrated in the towns and cities, while rural areas are mainly provided with health centres, where the level of care provided cannot be compared to that of a large hospital complex. Within urban areas themselves, the siting of healthcare facilities does not correspond to any planned supply. For example, in Istanbul, cardiology departments are concentrated on the Asian side of the river while the SSK hospitals are in the European part. The same applies to the distribution of doctors throughout the country. One of the objectives (not achieved) of the Nationalization Act of 1961 was to make it more uniform. The failure is due to inadequate numbers of general practitioners and the unattractiveness to them, in terms of remu-

Table 6. *The three levels of care in Turkey*

Primary level of care and prevention	Secondary level of care	Tertiary level
Health centres Family doctors	Dedicated public and private hospitals	Hospitals in competition
Health policies, health protection	Medical treatment	Rehabilitation

Source: Author.

neration and living standards, of the regions that are under strength (Gülesen and Bilgel, 2001).

The failure of the system of referring general practitioners. Hospitals are in principle the second level of access to care. The first consists of health centres, and particularly those of the Ministry of Health (Table 6). The rule is that patients are supposed to be referred to the second and third levels by those involved in the provision of primary care.

Even though this system of referring general practitioners is long established, Turks remain reluctant to follow the care chain; they use hospital outpatient consultations as their first level of care. According to a 1995 study by the Ministry of Health, 48.7 per cent of users showed a preference for hospitals as the first level of access to care; in towns, the figure rose to 57.6 per cent. In rural areas, 41.5 per cent of people first go to a health centre, compared with 14.1 per cent in the towns.

These figures need to be interpreted in light of the national distribution of hospital facilities. Most large hospital complexes are located in urban areas, whereas health centres are principally in the country. The concept of "choice" therefore needs to be seen in relative terms. The further east and the further from major cities one goes, the lower the number of doctors per inhabitant. People in urban areas make more use of health services, with university graduates and high earners going to the doctor more often than others.

At work and in a domestic emergency, the first choice is a public hospital (38.8 per cent). The same applies in "general cases" (22 per cent). The choice also depends on the seriousness of the situation: in a case of medium gravity, people tend to prefer a health centre; if it is serious, they will consult a specialist. In the event of chronic illness, patients give priority to SSK hospitals and those of the Ministry of Health.

There are two main reasons for this unwillingness to follow the established system:

Table 7. *First three determinants of choice of primary care structure*

	Health centres	Mother-and-child clinics	Urban GPs	Hospitals			
				Ministry of Health	SSK	Universities	Others
1	Low cost (28.3%)	Low cost (23.3%)	Trust (36.3%)	Social security (22.8%)	Social security (59.4%)	Trust (36.9%)	Social security (26.8%)
2	Easy access	Easy access (20.0%)	Familiar with staff (12.6%)	No alternative (17.6%)	Low cost (8.3%)	Social security (13.8%)	Trust (21.4%)
3	No alternative (15.2%)	Trust (16.7%)	Good relations (11.4%)	Low cost (16.3%)	Trust (8.0%)	Good relations (10.8%)	Easy access (12.5%)

Conclusion: 28.3% of the persons who chose to be treated in a health centre did so because the cost was lower than elsewhere.
Source: Ministry of Health, 1992 survey of 27,408 persons (6,600 households), available at www.saglik.gov.tr

• consumers of healthcare are not interested in a system of bonus/malus based on the respect or otherwise of the rules in force;

• people adopt a preventive attitude to the supposed mediocrity of the first level of care: both the standard of care and the equipment are of higher quality in hospitals in large towns than in the health centres of rural or remote areas (Tapar and Erigüç, 2001).

The Turkish Ministry of Health carried out a survey to rank patients' reasons for choosing their entry point into the healthcare system (Table 7). When people were asked for the top three factors determining their choice, the most common responses were the following:

- trust;
- low cost;
- compatibility with social security scheme;
- ease of access;
- dealing with someone familiar and/or good relations with medical staff;
- absence of alternatives.

Thus, the most important factor in opting for the health centres and mother-and-child clinics is price; trust is the main reason given for choosing urban doctors and university hospitals; and Ministry of Health and SSK hospitals are chosen principally because of compatibility between the patient's social security arrangements and the hospital system. Turks choose their structure for first-level care under a financial constriction: it is this that gives health centres and mother-and-child clinics their popularity despite their poor reputation and equipment, and which motivates patients to choose Ministry of Health and SSK hospitals, with the agreements con-

cluded between social security scheme and hospital system obviating the need to pay up front for care and/or medication.

It may be noted here that for five of the seven structures available, the choice is somewhat constrained. If we discount the fact that trust is ranked the third determining factor in opting for mother-and-child clinics and SSK hospitals, and the second for other hospitals, the remaining factors are all constraints: low cost, ease of access, lack of alternatives, and compatibility between social security scheme and hospital system. In contrast, for general practitioners and university hospitals, the determining factors are more an expression of preference — namely trust and dealing with someone familiar, or having good relations with staff — the exception being compatibility between social security scheme and hospital system, the factor ranked second in the choice of university hospitals.

Admission and treatment of disadvantaged population groups

Turkey is a country with an avowed social vocation: the duty of charity has an influence on the role of the State in relation to social protection. Ambiguity arises, however, in the contradiction between the minimalist role attributed to the State and the concern — a central pillar of Kemalism[10] — to combat the influence of religious foundations.

At the same time, Turkey is experiencing a phenomenon of internal migration, particularly from the countryside to the major urban areas and from east to west, with Istanbul the most common destination. A number of these internal migrants speak Turkish haltingly — if they speak it at all. Originating from Anatolia, where Kurdish is spoken, and from south of the Black Sea, they have a standard of living significantly different from people in the European part of the country, and their own very distinct culture. This population group makes up the majority of Turkish emigrants to European countries. The problems encountered in accommodating them in Turkey are no different from those that have occurred in the rest of Europe.

Specific budgetary allocations in hospitals

In private hospitals, a specific budget allocation is made for the admission and care of the most needy persons — even with no social security coverage — as the price to be paid to encourage the general public to accept private competition, since privatized hospitals which exercised discrimination

10. From the name of Mustapha Kemal Atatürk.

would run the risk of losing legitimacy and jeopardizing their own objectives. As a general rule, private hospitals underwrite between 3 and 5 per cent of the cost of treatment for members of disadvantaged population groups, both for emergency and non-emergency care.

The situation is the same in public hospitals. Irrecoverable debts due to a proportion of patients having no social security coverage are considered to be an invariable element in annual hospital budgets, estimated to represent between 10 and 15 per cent of the total. For the *Haydarpasa Numune* hospital, which has the biggest casualty department in Turkey, the estimated cost is 10 per cent of the annual budget of €35 million (US$ 43 million approx. in early March 2004).

Population networks and mobility of care

Community networks. One of the great difficulties is to provide care for persons without social security coverage who do not spontaneously seek out services for assisting the most needy, particularly in the municipalities. Pride and the fear of being stigmatized prevent them from doing so. The Turkish expression denoting these people is *Onurlu Fakirler*, the "poor with honour".

Neighbourliness is very important, always because it is the duty of believers to help those around them, the founding principle of community networks. Neighbourhoods come under a *Muhtar* (the equivalent of a mayor or community leader), part of a decentralized administrative structure common throughout Turkey, in charge of coordinating day-to-day life in the area for which they are responsible. One of their functions is to keep up to date the local medical records which, house by house and block by block, note the most important aspects of the health of the residents (pregnancy, disability, chronic illness and so on).

These documents — whose existence raises questions about respect for personal privacy — once updated by the *Muhtar* are forwarded to the representatives of the appropriate authorities, namely the central or local health centres. This arrangement involving the *Muhtar* and the local health centres thus constitutes another tier in the organizational structure.

Municipal action for those most in need. A hard core of people excluded from hospital care appears to persist in Turkey. A certain number of municipal authorities, Istanbul foremost among them, have responded by developing arrangements to cover the most vulnerable population groups. In addition to meeting any spontaneous demands made upon it, the "medical service of the municipality of the grand metropolis of Istanbul" has system-

atically divided the city up into zones based on the medical records maintained by the *Muhtar*.

The presence in a residential building of anyone who is sick, pregnant or disabled signals the dispatch of a mobile team tasked with proposing solutions in relation to care and/or cost of treatment. The decision to send a mobile team is based on several elements: level of income, number of persons in the household, sanitary conditions in the building, or the existence of a "certificate of poverty" *(Fakir Balgeri)*, a document issued by the *Muhtar*. In 2002, eight subprefectures[11] were the object of such initiatives and they were expected to extend to 19 subprefectures in 2003.

This system, implemented in 1999 by the moderate Islamic majority which governs the city, is based on a network of ten primary healthcare centres receiving requests for assistance or notification of persons in need, including one offering access to the full range of specialized care. Contact with the most vulnerable members of the population is also established via other channels, such as community associations and at prefectural and subprefectural levels.

The work of the medical service of the municipality is not confined to the provision of care, but also covers:

- assistance and education in the fields of nutrition and hygiene;
- information and prevention;
- training close relatives and friends to assist sick people and those with disabilities;
- transporting older people and those with disabilities to specialized centres when required.

The object is not only to bring those who are excluded from care into a health structure but also to cover all related costs, follow through the provision of treatment and provide support for families for as long as they need it. To complete the range of provision available, the municipal authorities of Istanbul concluded an agreement in 2002 with a private hospital whereby they pay for the care of the most seriously ill patients. In 2003, an agreement was concluded with the Ministry of Health hospitals: patients coming under municipal authority provision can therefore obtain care and medication in these hospitals without paying in advance. And recently, the municipal emergency call service was merged with the 112 system.

Only Istanbul has a system of this scope. The city of Izmir is proposing a similar arrangement (hospitals run by the municipal authorities, provision of care to disadvantaged persons), but on a smaller scale. The health centres of the municipality of Istanbul are coming into direct competition with the

11. The metropolitan area of Istanbul is composed of several subprefectures.

state health centres, not least because they provide a comparable service with far fewer resources.

Conclusion: Uncertainties and uneven information

The fragmentation of hospital supply in Turkey is leading to a segmentation of demand. Thus the SSK — social security body and care provider combined — deals with two-thirds of reported chronic illnesses, among the most expensive complaints to treat. As resources are lacking, 50 per cent of the surgical procedures carried out on patients covered by the SSK are undertaken in state or private hospitals which, in many cases, survive solely off this activity. The provision of care to disadvantaged population groups or those with a green card results in a loss for hospitals, or creates cash flow difficulties due to delays in reimbursement. As a result, except in emergency cases, university hospitals refuse these patients, at least for primary care. The most impoverished persons therefore go primarily to the SSK hospitals, or Ministry of Health hospitals if they have a green card.

Many vulnerable people are without social security coverage because they are ignorant of their rights. The fear of going to hospital or not having the means to pay for care may explain the low occupation rate of Turkish hospitals. In 1999, it stood at 57.8 per cent in acute care hospitals and 59.4 per cent in all hospitals.

Hospital supply in Turkey is of good quality, which does not mean that this is true of healthcare supply as a whole. The hospitals are concentrated in large conurbations, particularly Istanbul. In rural areas, the health centres are the providers of care, and neither their medical standards nor their equipment bear comparison with those of large hospital complexes.

It is not therefore so much the quality of hospital supply that is in question as the structural coordination between the different hospital networks on one hand (Ministry of Health, other ministries, university hospitals, SSK and private hospitals) and the variety of social security schemes on the other (active or retired civil servants, *Bag-Kur*, private insurance, and so on). Moreover, as in other countries with a comparable level of development, the general state of health of the Turkish population is related more to the need for healthy living standards than care supply. In this respect, addressing poor nutritional habits and life-threatening practices — most especially the high rate of tobacco consumption — would appear to be the obvious priorities for any public health policy.

The existence of a multiplicity of social security and hospital structures makes information an essential element in access to care. As has frequently been demonstrated, the people most capable of obtaining thorough infor-

mation on the intricacies of a complex system — which means those best integrated into a society — are the ones who manage to benefit the most from it. In contrast, the people with the least educational qualifications, the lowest pay and the fewest personal contacts have neither the means nor the ability to find their way around a mechanism which they find impenetrable.

The Turkish government has included a number of objectives for the improvement of public health in its Eighth Five-Year Plan, 2001-05, particularly in response to the requirements of Article 11 of the European Social Charter ("Measures to remove as far as possible the causes of ill-health"), including:

- reorganizing the Ministry of Health and redefining its functions;
- making the necessary arrangements for greater involvement on the part of general practitioners in the provision of primary healthcare;
- granting autonomous status to all public hospitals, to enable them to compete with private health facilities;
- studying the introduction of universal health coverage;
- organizing secondary and tertiary health services into autonomous structures;
- unifying social security bodies and the various benefits provided in the context of health insurance.

These objectives for improvement follow a couple of recent reforms: that of 1987, intended to adapt the health sector to the new conditions created by a free market economy; and that of 1993, which was the result of a three-year study process. Yet in the final analysis the ambitious 1993 reform, which addressed the administrative organization of social protection and its financing (particularly the establishment of universal social security coverage), care access arrangements, staff training, and information system, resulted in just one measure of any note: the creation of the green card.

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