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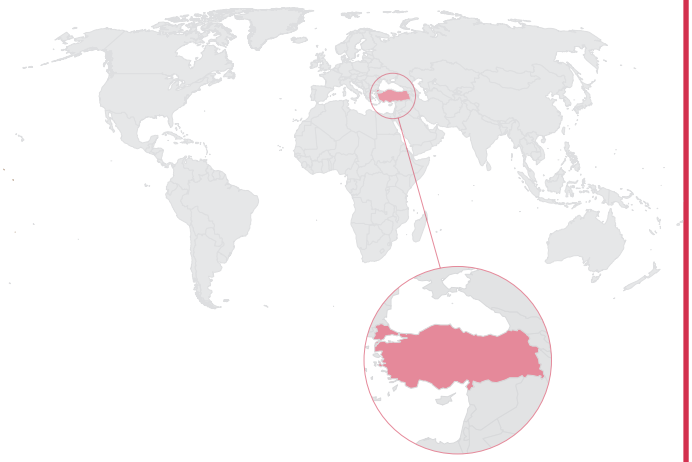
Social Policy
Country Briefs

Turkey



Özden Güdük

The Health Care System in Turkey

Global Dynamics of Social Policy CRC 1342

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Özden Güdük
The Health Care System in Turkey
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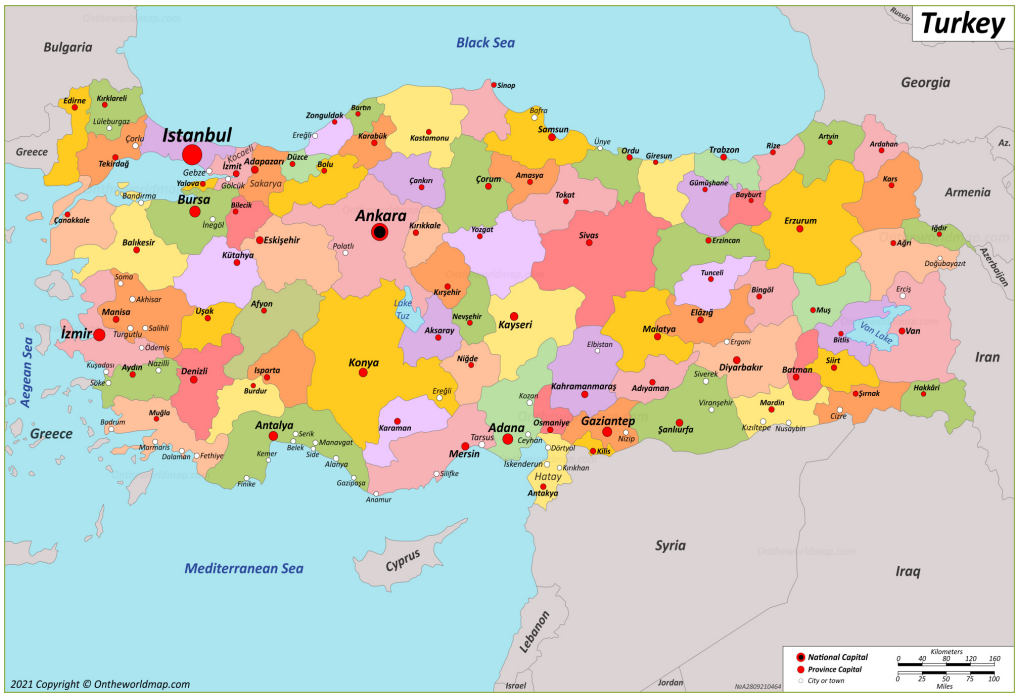
1. Country Overview



Source: https://ontheworldmap.com/turkey/ (Accessed: March 01, 2022).

- Sub-Region: Western Asia
- Capital: Ankara
- Official Language: Turkish
- Population size: 84339067 (2020)
- Share of rural population: 75.6% of total population
- GDP: 771355 (million current US$) (2020)
- Income group: Upper middle income
- Gini Index: 41.9 (2019)
- Colonial period and independence: Turkey was Ottoman Empire until the Republic of Turkey was established on 29 October 1923.

2. Selected Health Indicators

Indicator	Country	Global Average
Male life expectancy (2019)	75.9	70.6
Female life expectancy (2019)	81.3	75
Under-5 mortality rate (per 1,000 live births) (2019)	11.2 in thousand (2019)	37.7
Maternal mortality rate (per 100.000 Live Births) (2019)	13.1	211
HIV prevalence (per 100.000 Population)	0.1	0.7
Tuberculosis prevalence (per 100.000 Population) (2019)	13.5	130

Source: TurkStat (2019), MoH, Health Statistics 2019 (2021), World Health Organisation (2019), World Bank (2021).
Note: Statistics, latest data available.

3. Legal beginning of the system

Name and type of legal act	Law No: 3 Sihhiye ve Muaveneti İçtimaiye Vekâleti (Ministry of Health and Social Assistance 1920)
Date the law was passed	02 May 1920
Brief summary of content	This law aimed to establish the health organization structure and to take the health services under the responsibility of the government. Previously, only a small part of the population (the palace residents and the soldiers) benefited from the health services provided by the government. The organization of health services was not sufficient. (Aslan and Erdem 2017; Fedai 2019). The aim of the law was to expand the services to the whole country and to benefit all individuals from the service. During this period, no regular information on health was collected and disseminated, rather was more focused on healing the wounds of war and developing legislation (MoH 2015; Tekir 2019).
Socio-political context of introduction	Health was among the top priorities of new state (Republic of Turkey) and the necessity of an autonomous and specific ministry was accepted. For this reason, one of the first actions of the legislative branch was to establish the Ministry of Health. The central and the provincial organization were restructured with the establishment of the Ministry (Tekir 2019). The first aims of the Ministry of Health were to determine the priorities of the health sector, to increase health status of people, and to distribute the resources according to the determined criteria. (Ş. Çavmak and D. Çavmak 2017; MoH 2015).

4. Characteristics of the system at introduction

a. Organisational structure

- Centralization of HCS system: Previously, health services had been not structured. In the initial years of the Republic of Turkey, an effort was made to structure the health services in a way that would spread throughout the whole country. Hospitals and outpatient health services were tied to the Ministry to operate centrally (Karabulut 2007; Yılmaztürk 2013).
- Responsibility for the healthcare system: In order to establish and provide nationwide service delivery, all responsibility was gathered in the Ministry of Health (Yılmaztürk 2013).
- During the period of the Ottoman Empire, health services were mostly provided by foundations or charitable institutions to citizens who were not part of a small group including courtiers, the wealthy, and the soldiers. It was also offered by private doctors for a fee. Health services were not spread widely throughout the country. Access to health services was easy only in big cities, but organized healthcare services in rural areas were almost non-existent. No separate ministry for healthcare existed. Healthcare services were carried out under the Ministry of Interior (Arslan and Erdem 2017; Fedai 2019; Ş. Çavmak and D. Çavmak 2017; Tekir 2019).
- Coverage

Percentage of population covered by government schemes	Unknown
Percentage of population covered by social insurance schemes	No social insurance scheme
Percentage of population covered by private schemes	No private insurance scheme
Percentage of population uncovered	Unknown

b. Provision

- In the first years of the Republic of Turkey, efforts were made to increase the number of doctors and health professionals. The number of physicians was 344, the number of midwives was 560, the number of pharmacists was 60, and the number of health technicians was 560 in 1923. These numbers were as follows,

respectively, 1182, 1268, 127, and 1268 in 1930. The number of nurses in 1923 was unknown, but in 1930 this number was only 202 (Karabulut 2007).

» There were 86 health institutions serving with 6437 beds in 1923. It increased to 182 institutions and 11,398 beds in 1930, and 176 institutions and 13,038 beds in 1935, respectively. Thus, while the number of people per bed was 1.92 in 1923, it decreased to 1.26 in 1930 and to 1.24 in 1935 (Karabulut 2007; Tekir 2019).
» Since it was just after the War of Independence, epidemics were common. During those years, more emphasis was placed on preventive health services and the fight against infectious diseases (Tekir 2019; Fedai 2019).

c. Financing

In 1925, health financing was provided by general budget and the share of the Ministry's budget in the general budget was 2.64% of the GDP (Karabulut 2007).

d. Regulation

» At that time, all responsibility for the regulation and the organisation of the healthcare system belonged to the government. The priority was to increase the number of physicians, health professionals, and health institutions (Karabulut 2007).
» At that time, only basic health laws could be enacted regarding providers' regulation, for e.g., the law regulating the professional rules for doctors and other health professionals, and the law on the establishment of the Central Public Health Institution (Merkez Hıfzısıhha Kurumu) (Karabulut 2007).
» As epidemics were frequent, services mainly covered preventive health services and the fight against infectious diseases (Tekir 2019; Fedai 2019).

5. Subsequent historical development of public policy on healthcare

a. Major reform I

Name and type of legal act	The First Ten-Year National Health Plan
Date the law was passed	The Plan was announced on 12 December 1946
Date of *de jure* implementation	Due to the change of government, it could not become a law.
Brief summary of content	Although the entire Plan could not be implemented because it could not be enacted, most of the ideas it contained deeply affected the healthcare structure of Turkey (İleri et al. 2016; MoH 2008; MoH 2015) Those were aimed to manage treatment services centrally and to expand preventive services throughout the country (MoH 2015; Fedai 2019; İleri et al. 2016).
Socio-political context of introduction	As a basic structure, inpatient treatment institutions, which had been under the control of local governments until then, started to be managed centrally (MoH 2008). Primary healthcare institutions were established for citizens in rural areas. Services were planned to improve maternal and child health. In that period, due to the high rate of child deaths and deaths due to infections, population-increasing policy was implemented. Efforts were made to increase human resources in healthcare sector. In 1947, the Biological Control Laboratory was established, and vaccine development studies were started. The first vaccines produced were the BCG (Bacillus Calmette-Guerin) vaccine and the Pertussis vaccine. A Maternal and Child Health Development Center was established in Ankara in 1953, with support from international organizations such as the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). The Workers Insurance Institution (for only labours and their dependants) was established in 1946.

to be continued

... continued	There were 11 separate pension funds that provided coverage for different civil servants between 1934 and 1947. These pension funds were combined with the Pension Fund Law in 1950 (SGK, 2015). Since 1952, health institutions and hospitals have started to be established for insured labourers. Some laws were announced such as: Turkish Medical Association Law (1953/6023) Pharmacists and Pharmacies Law (1953/6197) Nursing Law (1954/6283) (MoH 2015; Fedai 2019).

b. Major reform II

Name and type of legal act	Law No. 224 on Socialization of Health Services
Date the law was passed	05.01.1961
Date of *de jure* implementation	12/1/1961
Brief summary of content	The 1961 Law promoted the establishment of an integrated health service scheme (Atun et al. 2013). Socialization in health actually started in 1963 and spread to the whole country in 1983 (MoH 2015).
Socio-political context of introduction	Healthcare has been accepted as an area that increases social welfare. In accordance with the principle of equality, the emphasis was placed on benefiting from healthcare services (Fedai 2019). An alternative to the "one-way service in the wide region" principle, the "multi-directional service in the narrow region" approach has been adopted.

c. Major reform III

Name and type of legal act	Law No 1479 Bağ-Kur
Date the law was passed	02.09.1971
Date of *de jure* implementation	6 months after the law was passed
Brief summary of content	It was aimed to expand the scope of social health insurance. Until that time, there was no social health insurance to cover self-employed workers, artists, farmers etc. (Atun et al. 2013).
Socio-political context of introduction	It was aimed to protect those individuals who were not covered by social health insurance against health expenditures (SGK 2014).

d. Major reform IV

Name and type of legal act	1982 Constitution
Date the law was passed	18/10/1982
Date of *de jure* implementation	9/11/1982
Brief summary of content	The new constitution was enacted in 1982. According to Article 60 of the Constitution, everyone has the right to social security and the government takes the necessary measures to ensure this and establishes the organization for social health insurance (Official Gazette, date: 09/11/1982, no:17863). There were different health insurance organizations, but still, some people, especially the poor, were out of its coverage. It was aimed to gather the social security institutions under one roof and establish the General Health Insurance, but it could not be realized (İleri et al. 2016; MoH 2015).
Socio-political context of introduction	The duty of government was determined to regulate and supervise the healthcare system. Until then, providing healthcare services were expected from the government. With that constitution, private actors such as private hospitals actively became involved in the system (Fedai 2019; MoH 2015).

e. Major reform VI

Name and type of legal act	Urgent Action Plan of the 58th Government (Health Transformation Program-HTP)
Date the law was passed	16 November 2002
Date of *de jure* implementation	It has been implemented gradually since 2003.
Brief summary of content	The Health Transformation Program (HTP) was designed to address the existing problems of inadequate financing, shortage and inequitable human resources, and inequities in health outcomes, of the health sector and to solve other related problems. The program aimed to increase the health-welfare of the people (Ş. Çavmak and D. Çavmak 2017; MoH 2003; Atun et al. 2013).
Socio-political context of introduction	In the late 1990s and early 2000s, the Turkish health system faced major problems, especially in three areas. The first was inadequate and inequitable financing of the health system. The second was an absolute shortage and inequitable distribution of physical infrastructure and health related human resources. The third was the most serious problem related to inequities in health outcomes, especially between the deprived eastern areas and the more developed western regions of the country, between the rich and poor segments of the population, and between rural and urban areas (Atun et al. 2013). As a result of the studies carried out in cooperation with the World Bank and WHO in the 1990s, it was planned to make some arrangements in the field of health (Küçük 2010).

6. Description of current healthcare system

a. Organisational structure

- HTP aimed at a decentralized health system in Turkey. Although a draft law on that issue was prepared, it could not be implemented due to some problems such as lack of clarity in terms of responsibility between institutions, coordination problems, and inefficiency in resource use (Hayran 2017). All hospitals were intended to be administratively and financially autonomous institutions and to be managed by a board for effective use of resources. Decentralization was partially implemented. A trust was established in each province (more than one in big provinces) to ensure the management and supervision of public hospitals, and an organization was established (Türkiye Kamu Hastanaleri Kurumu - Public Hospitals Institution of Turkey) to supervise all trusts in 2011. Additionally, the Public Health Institution of Turkey (Türkiye Halk Sağlığı Kurumu) was established in the same year. But a decentralised system caused some coordination problems between new establishments and the health directorate of provinces. In 2017, these two institutions became two general directorates of the Ministry of Health. Public hospitals have been supervised again by the health directorates of provinces.
- Turkey is not a federal state. There are 81 provinces in Turkey, and each includes a health directorate affiliated with the Ministry of Health. Municipalities do not play an active role in health service delivery or decision-making on healthcare. Only some offer small-scale home healthcare.
- Health services are provided equally to all citizens according to the principle of universal coverage. All individuals registered with the General Health Insurance can benefit from public health institutions free of charge (only by paying contribution). However, those who wish can also have private health insurance. Individuals with private health insurance do not have the option to opt out of compulsory general health insurance. In other words, they have to pay premiums to both insurances separately (Özsarı and Güdük 2020). In addition, services can be obtained from private health service providers through out-of-pocket payments.
- As of 2012, all citizens are required to be registered with the General Health Insurance and pay a contribution from their income. Unemployed spouses and children can benefit from the registered person as dependents. In addition, the premiums of some determined people (for example, the poorest, soldiers, children cared for by social services etc.) are paid by the state (SGK n.d.). Tourists and foreigners applying for a residence permit are required to have "travel health insurance" or "health insurance for foreigners".

» Coverage

Percentage of population covered by government schemes	0
Percentage of population covered by social insurance schemes	98.8 (in 2019)
Percentage of population covered by private schemes	9.0 (in 2019)
Percentage of population uncovered	1.2 (in 2019)

b. Provision

Healthcare resources

- The number of health professionals is quite low when compared to OECD countries. The number of total physicians is 160,810 and the number of total physicians per 100,000 population is 193. The number of total nurses is 198,103 and midwives is 55,972, the number of nurses and midwives per 100,000 population is 306 (MoH 2021).
- Hospitals and hospital beds are predominantly publicly owned. There were few private hospitals, but after the encouragement of private health provision from 1982, many private hospitals have been established. Regardless of whether it is private or public, the approval to establish a hospital, the number of beds and the number/qualification of personnel working in hospitals are determined by the Ministry of Health. The number of public hospital beds is 143,412, the number of hospital beds in university hospitals is 42,925, and in private hospitals is 51,167. The total number of hospital beds in the country is 237,504 (MoH 2021).

Healthcare sectors

- In 2010, the Family Medicine System was launched to strengthen primary healthcare services. Everyone must register with a family doctor. Due to the high number of patients per physician, there are no gatekeeper's role in the health system.
- The total number of family physicians in 2019 is 26,476. The number of patients per family physician is approximately 3,000 (min. 2953-max. 3241 patients) (MoH 2021).
- As a result of the regulations made within the scope of the Health Transformation Program, access to health services has become easier. Previously, individuals with different health insurances had to receive services only from hospitals that their insurances accepted. HTP gathered all individuals under a single insurance institution and ensured that individuals could receive services from any hospital they wanted. For this reason, the number of physician visits per capita has increased, especially the use of secondary and tertiary healthcare services. While this number was 3.1 in 2002, it was 9.8 in 2019 (MoH 2021).

c. Financing

- Compared to OECD countries, the share of GDP spent on health is low. It was 4.3% of GDP in 2019 (OECD 2022).
- The main source of health financing is social health insurance. Every individual is compulsorily a member of social health insurance. However, 9% of the population has private health insurance. Although the number of out-of-pocket payments made by individuals for health has decreased after the general health insurance became compulsory, out-of-pocket payments are still the main financing source for some special services. Out-of-pocket health expenditure per person was $221 in 2019 (MoH 2021).

d. Regulation of dominant system

Actors/institutions responsible for healthcare:

Ministry of Health: Ministry of Health is the most important actor which regulates, controls, and evaluates the system.

Social Security Institution: the relevant institution of the Ministry of Labor and Social Security. Social Security Institution is the only social health insurance organization in Turkey. The Institution collects premiums from insured people to a pool to finance the social health system. The Institution decides the cost of services by creating a price list.

Ministry of Treasury and Finance: Determines the salaries of the personnel working in public health institutions and makes the payments.

Some private healthcare associations: Private Hospitals and Health Organizations Associations (Özel Hastaneler ve Sağlık Kuruluşları Derneği; OHSAD), Private Hospitals Platform (Özel Hastaneler Platformu). These associations represent the private health sector and play an important role in determining the policy about the private healthcare sector.

Some health professionals' associations: The Turkish Medical Association, Turkish Nurses Association, Turkish Pharmacists Association, Turkish Dental Association. Associations represent the occupational groups to which they belong. They carry out activities such as increasing the knowledge and quality of the group they represent, improving working conditions, etc.

Health Institutions of Turkey (Türkiye Sağlık Enstitüleri Başkanlığı; TUSEB): TUSEB is a public organization leading the studies for innovation in the field of health science and technologies. And supports the practitioners and researchers scientifically, technically, and financially (TUSEB, 2020).

Turkish Medicines and Medical Devices Agency (Türkiye İlaç ve Tıbbi Cihaz Kurumu; TİTCK): TITCK is a public organization that has a regulatory, supervisory and guiding role for products such as pharmaceuticals and medical devices (TİTCK n.d.)

Regulation of providers

License and Operating Permit: Regardless of ownership status (public or private), all healthcare organizations must have a license from the Ministry of Health.

Health Professionals Diploma Registration: The diplomas of all health professionals are registered by the Ministry of Health.

Healthcare Quality Standards: All public and private hospitals, ambulance services, haemodialysis units, dental clinics must provide services that comply with health quality standards determined by the Ministry of Health. They are assessed in terms of the standard set by a team appointed by the Ministry once a year (MoH 2020).

Healthcare Accreditation Standards: TUSKA (Türkiye Sağlık Hizmetleri Kalite ve Akreditasyon Enstitüsü): The national health accreditation body, was established in 2015. The desired health institution (hospitals, dental units, haemodialysis units, laboratories, outpatient services) can apply for accreditation. Although healthcare standards are mandatory to comply with, accreditations are not (TUSKA n.d.).

Assessment of Efficiency of Public Hospitals: All public hospitals and public dental centres are assessed in terms of efficiency according to a guide developed by Ministry of Health once a year (MoH 2018).

Benefit Package

The scope of social health insurance is quite comprehensive. It covers outpatient and inpatient health services, dental services, medicine, and medical appliances. But patients must contribute in varying proportions (for example, 5 TL for a doctor visit in a secondary hospital, 12 TL for a doctor visit in a tertiary hospital) for these services. Specified societal groups and some services (primary healthcare services, treatment of some chronic diseases, etc.) are exempt from user contribution (SGK n.d.).

Social Insurance Institution decides the scope of the insurance package, the amount of contribution, and the price for the service. However, while doing this, the Institution takes the opinions of health professionals, economists, and other ministries and makes decisions according to the suggestions of the experts. All information about social insurance coverage and prices is declared in the Health Implementation Communiqué (SGK 2017).

7. Co-existing systems

a. Private Health Insurance

Although there have been many insurance companies offering private health insurance policies since the 1980s, the market share of private health insurance is still low. The reasons behind this are that (a) the scope of social health insurance is very comprehensive, (b) individuals have to pay additional premiums for private health insurance, (c) individuals with chronic disease are excluded or have to pay very high premiums etc. Mostly individuals with higher incomes and better socio-economic status prefer to have a private health insurance. Also, some companies provide private health insurance to their employees as an additional benefit (Tarım and Güdük 2019).

Insurance Association of Turkey, a public institution under Ministry of Treasury and Finance, determines strategies and policies and monitors the sector. There are 39 private health insurance companies (Türkiye Sigorta Birliği n.d.; Özsarı and Güdük 2020)

b. Immigrant Health Centre

To provide more effective and efficient primary healthcare services, to overcome the problems arising from language and cultural barriers, and to increase access to health services through preventive health services Migrant Health Centres have been established in areas where Syrians live in greater numbers. The operating expenses of these centres and the salaries of the employees are covered within the scope of the SIHHAT Project founded by European Union (MoH n.d.; Sıhhat n.d.).

As of October 21, 2021 the number of registered Syrians under temporary protection in Turkey is 3 million 723 thousand 674 people (Mülteciler Derneği 2021).

8. Role of global actors

- Global actors do not directly interfere with the system in Turkey. The Ministry of Health and other relevant organizations follow the publications of global actors and their recommendations to the countries. Some regulations and improvements have been influenced by the recommendations of global actors to all countries (Agartan 2020; Atun et al. 2013). However, funds from institutions such as the World Bank and the European Union are used especially for large-scale projects.
- WHO has two offices in Turkey (the second was established in Istanbul last year). WHO makes some scientific events and research in the field of health in cooperation with some universities and Ministry of Health.
- United Nation has an office in Turkey. Along with other services, it plays a role in services for Syrians.
- World Bank financially supports research. Health Transformation Program was shaped by reports done by the Ministry of Health in cooperation with WHO and the World Bank.

9. Role of the churches

- 99% of population in Turkey are Muslim (DİB 2014). Mosques or any kind of religion establishment don't play a role in providing and financing healthcare. Small charity organizations exist, but their services are generally limited.

10. List of additional relevant legal acts

Regulations on Expertise in Medicine (Official Gazette, Date: 19/6/2002, No: 24790)

Regulation on Private Hospitals (Official Gazette, Date: 10/1/1983, No: 17924)

Social Insurance and General Health Insurance Law No: 5510 (Official Gazette, Date: 16/6/2006, No: 26200)

Regulation on the Providing of Home Care. (Official Gazette, Date: 10.03.2005 No: 25751)

Regulation on the Providing of Home Health Care Services by Ministry of Health and Related Organizations (Official Gazette, Date: 27/02/2015 No: 29280)

Regulation on Assessment of Efficiency of Public Hospital Trust (Official Gazette, Date: 10/12/2014 No: 29201)

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