



**THE REPUBLIC OF TURKEY
MINISTRY OF HEALTH**

**HEALTH SYSTEM IN
TURKEY, 2002**

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**Arslan Ümit GİRAY, MD., PhD.
DIRECTOR**

**DEPARTMENT OF EUROPEAN UNION
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PREFACE

A reform process has been initiated in the Health Care System in Turkey in conformity with the country's and world's changing and as an effort to improve the health status of the Turkish population. The aim of the Health Reform is to make health care available to all citizens of Turkey in an efficient and equitable manner. The restructuring of the Health System will allow more funds to be allocated to primary and preventive care and create a managed market for secondary and tertiary care. The autonomization of secondary and tertiary care within a social market system will allow improved quality and efficient health care. Well-collected and analyzed data having become a necessity for efficient management, Health Information Systems have become a major part of the reform process.

The Turkish Constitution guarantees the right to access to health services for all Turkish citizens. The Health Reform aims at providing the Turkish citizens with the physical as well as financial access, the Health Insurance System provides the tools for ensuring financial capacity to serve underprivileged citizens.

The Turkish Health Care Reform package which will restructure the overall health care system is prepared by a group of multi-disciplinary experts with backgrounds from health and non-health sectors. The initial implementation activities have already been initiated, and following the promulgation of the necessary legislation, implementations will be started.

The Ministry of Health has undertaken many researches, studies and workshops in the course of designing National Health Policies as well as the Health Insurance, Health Enterprises and Family Practitioners system, which are expected to become fully operational soon.

Turkey is already sharing the valuable experiences acquired throughout the reform development process with the countries undertaking such activities.

***MINISTER OF HEALTH
TURKEY***

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
Bağ-Kur	The Social Insurance Agency of Merchants, Artisans and Self-Employed
BHSM	Basic Health Statistic Model
CHRMS	Core Health Resources Management System
CMoH	Central Ministry of Health
Emekli Sandığı	Government Employees Retirement Fund
EPI	Expanded Program on Immunization
GB	Gigabyte
GDP	Gross Domestic Product
GNP	Gross National Product
HDI	Human Development Index
HFA	Health for All
HIA	Health Insurance Administration
HIS	Health Information System
HISSG	Health Information Systems Steering Group
HIV	Human Immune Deficiency Virus
HMIS	Hospital Management Information Systems
HR	Human Resources
ICD-10	International Statistical Classification of Diseases Version 10
IS	Information Systems
IT	Information Technologies
LB	Live Birth
MB	Megabyte
MCH/FP	Mother and Child Health and Family Planning
MDIP	Ministry of Health Department of Information Processing
METU	Middle East Technical University
MoH	Ministry of Health
N.A.	Not Available
n/a	Not Available
NGO	Non-Governmental Organization
NMDS	National Minimum Dataset
OECD	Organization for Economic Cooperation and Development
PCU	Project Coordination Unit
PHCSIS	Primary Health Care Services Information Systems
PHD	Provincial Health Directorate
PPP	Purchasing Power Parity
RAM	Random Access Memory
SPO	State Planning Organization
SSK	Social Insurance Organization
TDHS	Turkish Demographic and Health Survey
UN	United Nations
UNFPA	United Nations Population Fund
USD	United States Dollar
WHO	World Health Organization
WSPI	Wholesale Price Index
YOK	Higher Education Council

1. INTRODUCTION

Turkish people, throughout their history, showed great respect to physicians and gave paramount importance to the constant and proper fulfilment of health care services all over the country. In particular, in the era of Seljuk and Ottoman Empires, hospitals were established under the name of “*şifaiye, bimarhane, darüşşifa, maristan*” by the support of foundations. These hospitals, in general, were formed as a complex of buildings called “*külliyeye*” consisting of a mosque, university (*medrese*), Turkish bath and cook-house. All patients had been delicately cared and treated free of charge. Moreover, training of physicians and other health care staff had been carried out in these buildings within the framework of foreman-apprentice relationship.

The first hospital in Anatolia was founded in Mardin by *Eminüddin* from “*Artukoğulları*” family, between 1108-1122. During the period of Seljuk Ruler *Gıyaseddin Keyhüsrev*, the medical school called “*Darüşşifa ve Tıp Mektebi*” was founded in *Kayser* as required in the will of *Gevher Nesibe Sultan* in 1205, who was the sister of *Gıyaseddin Keyhüsrev*. This monument has a substantial place in our medical history as the first medical school of Seljuk Empire,

Furthermore, during the period of Ottoman Empire, new hospitals, medical schools, pharmacies, libraries and social service institutions (with in the complex of these hospitals and schools) were also founded.

In the context of developments and reformist movements having taken place in the 19th century, we witness the establishment of new hospitals and training of the physicians in line with western notion by the inception of modern medical education in 1827. In the beginning of the 20th century, country hospitals were founded by Provincial Administrations in various places in the country and the hospitals belong to foreigners and minorities also offered their services.

In the course of the Republican age, a new approach was introduced regarding the maintenance, improvement and the expansion of in-patient clinic services and it was considered as an obligatory task of governments. In addition, these services have been brought into the current level of progress by further development.

This document purposes to present the type and fundamental elements of Turkish Health Reforms and to share the experiences gained by the designers of these Reforms.

In the second part, an overall view of the prevailing situation is presented by using indicators of health status such as mortality and morbidity rates.

Consequently, this document is finalised after emphasising brief and substantial suggestions and theories with regard to the phases of formulation and enforcement of health care reforms in Turkey. It is possible to have a general idea on the formulation and the implementation of Health Reforms and be able to benefit from them by following the general approach underlined in this document.

2. CURRENT HEALTH CARE SYSTEM

2.1. Demographic Overview

According to 2000 census, total population of Turkey is 67 803 927 with an average density of 88 inhabitants per square kilometre, where 64.9% of the residents live in urban areas.

Table 1 Human Development Index in WHO European Region, 2002

HDI rank	COUNTRY	Life Expectancy at birth (yrs) 2000	Adult literacy rate (%) 2000	Real GDP per capita (PPP\$)2000	Human Development Index (HDI) value 2000	Real GDP per capita (PPP\$) rank minus HDI rank
85	Turkey	69.8	85.1	6,974	0.742	-18
	All Developing Countries	64.7	73.7	3,783	0.654	-
	Least Developed Countries	51.9	52.8	1,216	0.445	-
	Sub-Saharan Africa	48.7	61.5	1,690	0.471	-
	High Income OECD	78.2	---	27,848	0.932	-
	World	66.9	---	7,446	0.722	-

Source: UNDP, Human Development Report, 2002

According to the Human Development Index indicated in Human Development Report, 2002, measuring the average achievements in the stated countries in terms of longevity, knowledge and decent standard of living, Turkey is ranked as number 85 (Table 1).

The demographic profile of Turkey is relatively young when compared to other European countries. 32.3% of the total population is under the age of 15 and only 4.8% are over the age of 65 (1995). The projections to determine the age distribution of the population for the year 2025 are 22.9% and 9.0% for the respective groups, with an aging population creating different health care service demand in the 21st century. The crude birth rate is 22.3 per 1000 in 2000. Life expectancy at birth during the period of 1972 to 2000 increased from 57.6 to 69.1 years.

Gross National Product per capita is 2,103 USD (2001), with an annual rate of inflation 30.8%(2002) WSPI (Wholesale Price Index), and 11.8% of the total population is unemployed in March 2002.

2.2. Mortality ve Morbidity

Although there are some weaknesses in the quality of epidemiological data, especially in rural areas, the most important causes of mortality are infectious diseases during infancy and infectious diseases and their complications, mostly associated with malnutrition among 1-4 years old children. Accidents among adolescents and the population in their early twenties; heart diseases and accidents among the 25-44 age group; and heart diseases and respiratory disorders among the 45-64 age group are the leading causes of mortality (Table 2).

Table 2 First Five Leading Causes of Death in All Ages in Turkey (%) (1999)

CAUSES OF DEATH	%
Heart diseases	35
Cancers	12
Symptoms & Non Diagnosed Cases	8
Serobro-vascular Disease	8
Other Causes of Perinatal Mortality	3

Source: State Institute of Statistics (2001), DİE, 2002, .123.

According to the results of the 1998 Turkish Demographic and Health Survey, Infant mortality, 42.7 per 1,000 live births in 1998 and this is one of the most significant health problems in Turkey.

The most commonly reported communicable diseases according to the reports to MoH by Provincial Health Directorates for the year 2001 and the number of cases reported are listed in Table 3.

Table 3 Number of Some Selected Communicable Diseases Reported, Turkey, 2001

DISEASES	NUMBER OF CASES REPORTED	MORBIDITY RATE (PER 100.000)
RUBELLA	30.509	43.2
A.DYSENTERY	25.756	36.5
TYPHO	25.626	36.3
TUBERCULOSIS	18,038	25.5
BRUCELLOSIS	15.510	21.9
MALARIA	10.812	15.3
HEPATITIS A	10.661	15.1

Source: MoH, Health Statistics, 2001, p.70.

Major causes of mortality due to the communicable diseases according to the reports received from provinces and number of deaths reported in Turkey for 2000 are shown in Table 4.

Table 4 Number of Deaths Reported Due to Some Selected Communicable Diseases, Turkey, 2000

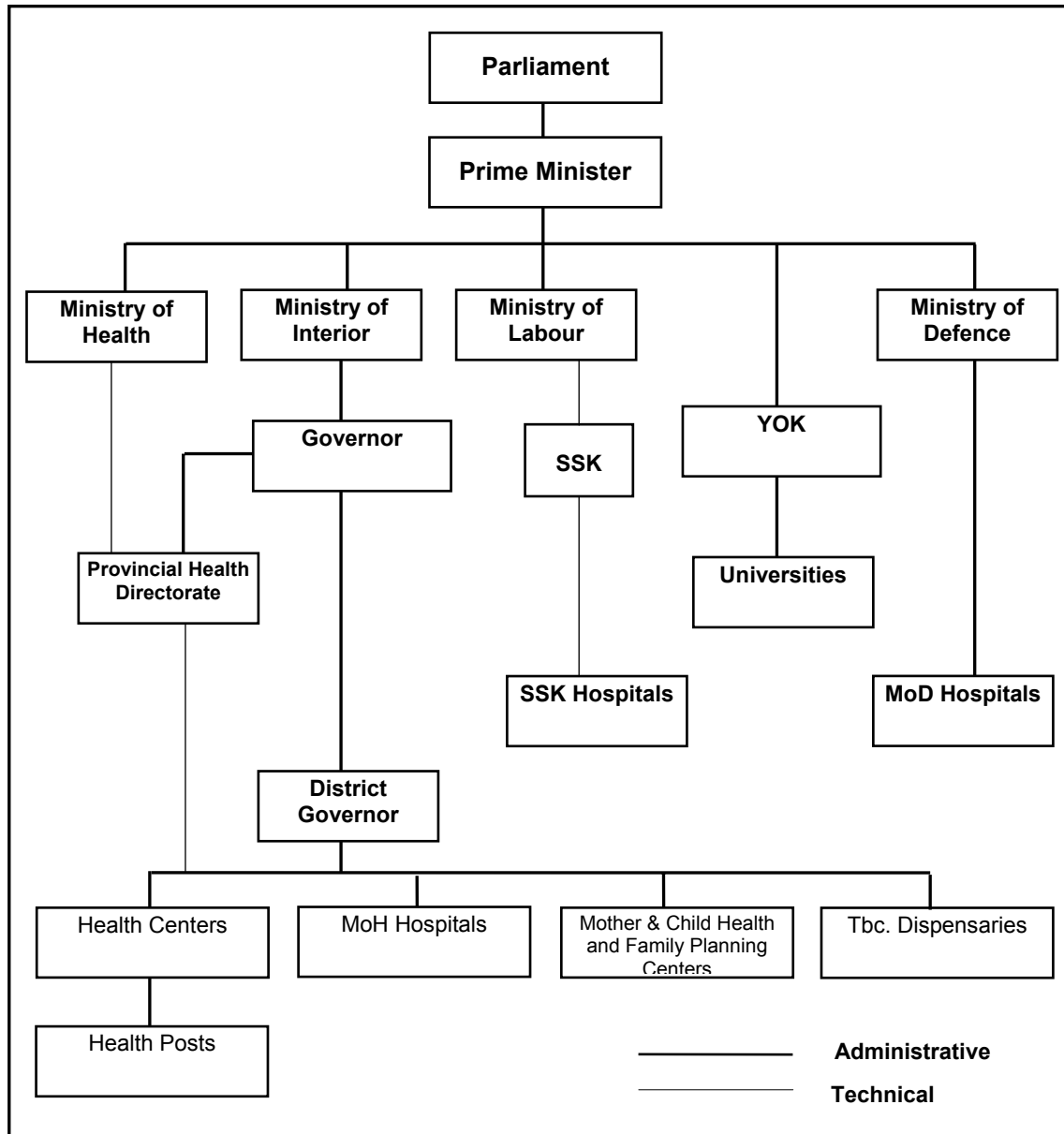
DISEASES	NUMBER OF DEATHS REPORTED	MORTALITY RATE (per million)
O.BACTERIAL DISEASES	957	13.5
RESP.SYSTEM TBC	511	7.2
ENTERITIS	405	5.7
INFECTIOUS HEPATITIS	203	2.9
VIRUTIC ENCEPHALITIS	174	2.5

Source: MoH, Health Statistics, 2001,p.53..

2.3. Organizational Structure And Management

Health services in Turkey are provided mainly by the Ministry of Health, SSK (Social Insurance Organization), Universities, the Ministry of Defence, and private physicians, dentists, and pharmacists, nurses and other health professionals. Other public and private hospitals also provide services, but their total capacity is low. The fragmented structure of the agencies, which provide health care, makes it difficult to ensure effective coordination and delivery of health services. (Figure 1)

Figure 1. Organization Model of State Health Sector in Turkey



The Ministry of Health is the major provider of primary and secondary health care and the only provider of preventive health services. At the central level, MoH is responsible for the country's health policy and health services. At the provincial level, provincial health directorates accountable to the provincial governors administer health services provided by MoH.

2.3.1. Planning, Regulation and Management

The parliament is the ultimate legislative body and regulates the health care sector. The two main bodies responsible for planning the health care services are the State Planning Organization (SPO) and MoH. The role of SPO is to define the macro policies. Objectives, principles and policies in health system are determined regularly in "Five Year Development Plans". MoH develops operational plans regarding the provision of health care services. MoH is also responsible for the implementation of defined policies. In every province there is a provincial health directorate which is responsible administratively to the governor of the province and technically to the Ministry of Health. Administrative responsibility mainly involves administration of personnel and estates management, whereas technical responsibility involves decisions concerning health care delivery, such as the scope and volume of services. The Ministry of Health appoints the provincial health directorate personnel with the approval of the Governor.

The Ministry of Health operates an integrated model and provides primary, secondary and tertiary care. Primary care is provided by the Ministry of Health, through the health centers, health posts, mother and child health and family planning centers, some vertical units such as tuberculosis dispensaries, malaria control centers and cancer control centers.

2.4. Health Care Delivery System

2.4.1. Primary Health Care

Since the law on socialization of health services enacted in 1961, the government has committed to a program of nationalization of public health services with the main objectives of providing primary care in rural areas and providing both preventive and curative services.

The basic health care units are health centers and health posts at the village level. According to the current legislation health posts staffed by a midwife serve a population of 1.000 – 2.000 in rural areas. As of 2001, there are 11,737 health posts in Turkey. Health centers serve a population of 5,000-10,000 and are staffed by a team consisting of physician, nurse, midwife, health technician, and medical secretary. The main functions of health centers are the prevention and treatment of communicable diseases; immunization; maternal and child health services, family planning; public health education; environmental health; patient care; and the collection of statistical data concerning health. There are 5,773 health centers as of 2001 in Turkey.

Due to the priority given to certain programs especially in urban areas, there are 295 MCH/FP (mother-child health/family planning centers), 273 tuberculosis dispensaries, 12 dermatology – venereal diseases dispensaries, 3 leprosy dispensaries and 2 mental health dispensary. These health facilities with their specialized personnel offer preventive and curative health services as well as training for health personnel working in other primary health care units.

The services pertaining to protect public health and conducting laboratory based services are among the duties of MoH and have been carried out by Refik Saydam Hygiene Center, which is an affiliate institution of the Ministry of Health. The Center also acts as the "Reference Center" of the provincial public health laboratories offering services all over the country.

2.4.2. Secondary and Tertiary Health Care

MoH, the Ministry of Defence, the Ministry of Labor and Social Security, some State Economic Enterprises, Universities, and the private sector provide secondary and tertiary health care services. Of the total of 1,240 hospitals, MoH runs 751. These provide 50.1 percent of the hospital beds in the country, with an average occupancy rate of 59.4 percent.

SSK provides mainly curative services to its members in 118 hospitals with 28,517 beds (16.3 percent) and an occupancy rate of around 65 percent. The 43 university hospitals provide health services with 24,754 beds (14,1 percent) with an average occupancy rate of 61.7 percent.

The Ministry of Health is the largest health services provider in Turkey, and employs about 204,932 staff. Number of hospital beds per 10,000 population in Turkey is 26 beds in 2001.

A head medical doctor, together with an assisting hospital administrator administrates each Ministry of Health hospital and both are appointed by the Ministry of Health.

Since the referral chain is not pursued properly, hospitals are usually used heavily as outpatient clinics.

Table 5 Bed Distribution among Institutions in Turkey, 2001

Institutions	Number of Hospitals	Number of Beds	Beds (%)
Ministry of Health	751	87,709	50.1
Ministry of Defense	42	15,900	9.1
SSK	118	28,517	16.3
State Economic Enterprises	8	1,607	0.9
Other Ministries	2	680	0.4
Universities	43	24,754	14.1
Municipalities	9	1,341	0.8
Associations	19	1,448	0.8
Foreigners	4	338	0.2
Minorities	5	934	0.5
Private	239	11,922	6.8
TOTAL	1,240	175,190	100.0

Source: MoH Curative Services General Directorate, "Health Statistics Yearbook 2001", 2002, p.43.

Table 6 Utilization and Performance of Secondary and Hospital Care in Hospitals, Turkey, 2000-2001

	TOTAL 2000	TOTAL 2001	MoH 2000	MoH 2001	Others 2000	Others 2001
Outpatient Ratio (%)	158	175	N.A.	N.A.	N.A.	N.A.
Inpatient Ratio (%)	4.8	4.4	4.5	4.3	5.2	4.6
Average Length of Stay (days)	5.9	5.8	5.5	5.5	6.3	6.2
Occupancy Rate (%)	60.5	60.2	58.5	58.1	62.5	62.4

Source: MoH Curative Services General Directorate, "Health Statistics Year Book 2001", Ankara, 2002, p.34.

2.5. Human Resources

The number of health service personnel in Turkey in 2000 is indicated in Table 7.

Private sector employment in Turkey is very high for dentists, pharmacists and specialist doctors, while other health personnel are employed mostly in the public sector. Many specialist doctors have dual employment; they work part time in public hospitals and have their own private practice.

Average figures of Turkey in 2000 are 797 people per physician, 4,237 per dentist, 2,914 per pharmacist, 947 per nurse, 1,630 per midwife and 1,437 per health officer. Ratio of population to medical personnel varies greatly among regions. The eastern parts of the country and rural areas have fewer personnel in all categories per unit of population. The reasons of geographical distribution imbalance are the imbalance in distribution of health institutions, economical, socio-economical and regional conditions.

A Personnel Directorate within the Ministry of Health carries out recruitment and placement of staff for all these facilities. Remuneration is done in accordance with the Law of Civil Servants, which establishes a pay scale based mainly on education, duration of public service and job title. There are automatic cost-of-living raises during the year, but the basic salary is not supplemented by incentives for better performance. Public employees are granted lifetime employment. Individual hospitals or provincial health managers have little autonomy to recruit, fire or administer their own staff.

Table 7 Human Resources for Health Services, 2000

Type of Personnel	PUBLIC						Per/Popu
	TOTAL	MoH	SSK	University	Other	Private	
Physician	85,117	42,820	8,112	17,346	5,304	11,535	797
• Specialist	38,064	13,837	4,801	8,586	2,175	8,665	1,781
• Practitioner	47,053	28,983	3,311	8,760	3,129	2,870	1,441
Dentist	16,002	2,423	583	863	741	11,392	4,237
Pharmacist	23,266	793	864	621	240	20,748	2,914
Health Officer	46,528	33,708	3,059	3,347	2,880	3,534	1,457
Nurse	71,612	43,694	8,489	10,399	4,543	4,487	947
Midwife	41,590	38,674	1524	110	156	1,126	1,630

Source: MoH, "Health Statistics Yearbook 2001", 2002, p.30.

2.6. Health Care Finance and Expenditure

In the period 1980-2002, the ratio of the budget of the ministry of health to the budget of state fluctuated between 2.40% and 4.71%. In 1980 this ratio had been 4.21% and following a period of gradual increase, the share of the budget of the MoH reached its peak of 4.715 in 1992. however the year 1992 marked the beginning of a downward trend in terms of the share of the budget of the MoH in the state budget. In the year 2002, the above mentioned share was 2.40%. On the other hand, portion of the budget of the Ministry of Health in Gross National Product fluctuated between 0.38% and 0.91% throughout the same period.

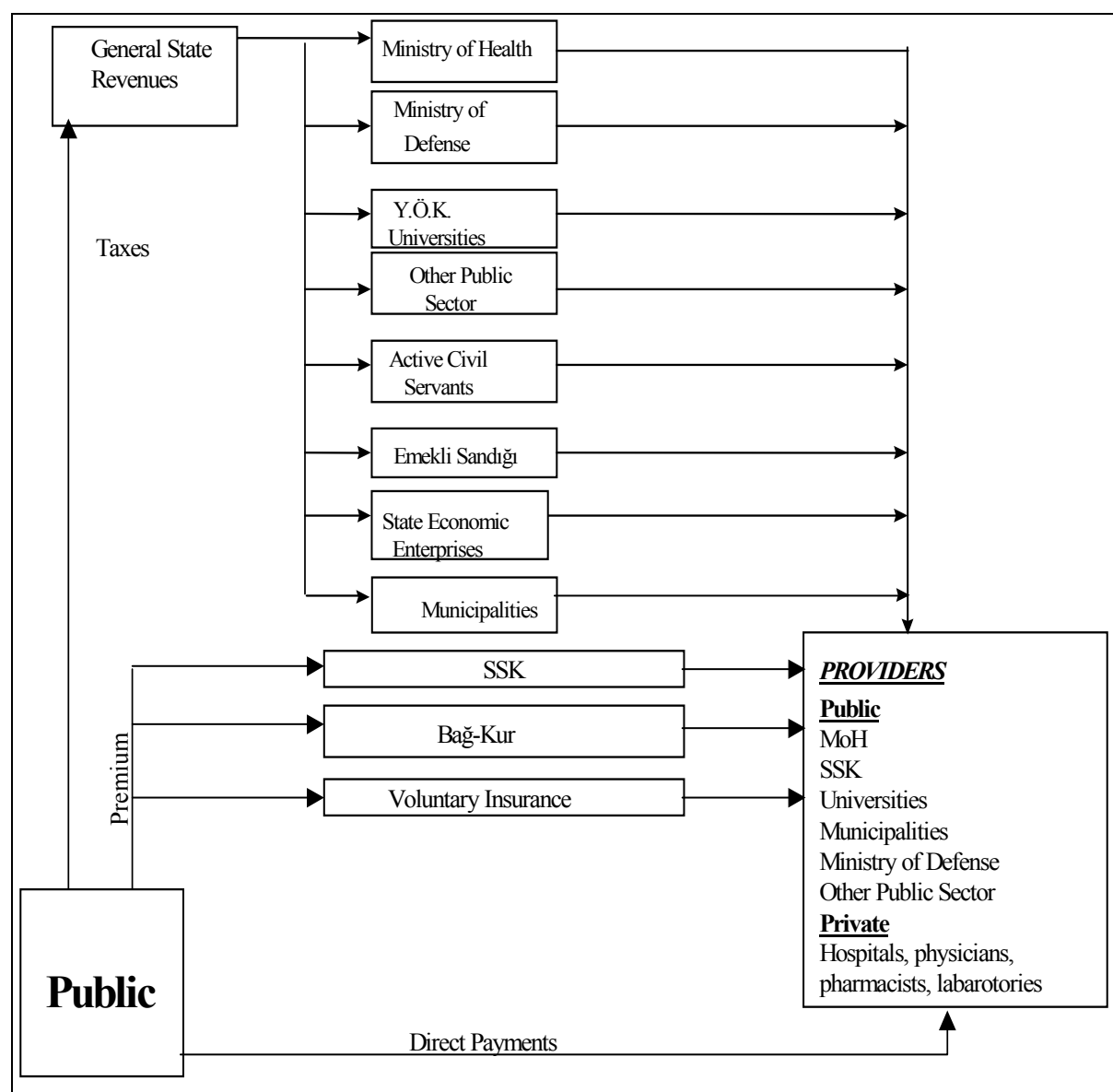
The funds derived from private and public sector sources are transferred to service providers;

- Through Ministry of Health, Ministry of Defense, social health security schemes; Social Insurance Organization (SSK), the Government Employees Retirement Fund (Emekli Sandığı), the Social Insurance Agency of Merchants, Artisans and Self-Employed (Bağ-Kur), and active civil servants, YÖK (university hospitals), state economic enterprises, municipalities, other public institutions and establishments, special funds, foundations and private health insurance companies.
- Directly by users in the form of out-of-pocket payments.

Additionally, there is a large number of agencies involved in the finance of health care services and most of them also perform the service provision, and this makes quite complex the structure of health care financing in Turkey.

2.6.1. Structure of Health Care Financing In Turkey

Figure 2 Structure of Health Care Financing In Turkey



Source: PCU , MoH 1997.

2.6.1.1. Ministry of Health

Ministry of Health is accounting for the majority of Turkish health care expenditures. Approximately 34% of the total health care expenditures is financed by Ministry of Health which accounts for 1.9 billion US \$ in 1995.

The major sources of funds for Ministry of Health hospitals are;

1. State Budget Allocations

The basic source of Health Ministry Hospitals is state budget allocations. They are prepared through simple adjustments by taking the previous year's inflation rates into consideration. In recent years, inflation has presented a major challenge to efforts to control public expenditure. It has, therefore, become routine to revise the initial general budget allocations during the financial year.

2. Direct payments by individuals to revolving funds of hospitals

Revolving fund revenues are basically fees paid for services by individuals or third party insurers. Fees paid for the health services are determined by a commission consisting of Ministry of Health and Ministry of Finance representatives without considering the actual cost of the services.

3. Special Funds

Since 1988, additional funding has been available from earmarked taxes on fuel, new car sales, and cigarettes.

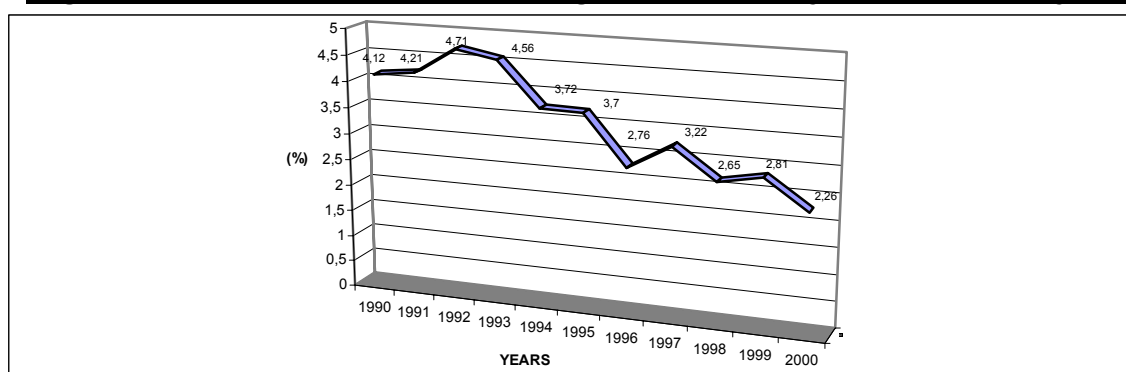
In Figure 11, it is shown that, the usage ways(preventive health services, outpatient care, hospital expenditures and administrative expenses) of the above mentioned finance resources of MoH in percentage distribution.

In 1992, hospital expenditures were 51% of total MoH expenditures and it increased to 51.4% in 1998. At the same period, the resources allocated for preventive health services gradually decreased from 7% to 3%.

The Ministry of Health has started the Green Card implementation as inpatient care services and coverage of the operations services costs for the citizens who are not covered by existing social health security schemes and unable to pay costs of health care services in 1992. From 1992 to 1997 January, approximately 6.7 million people included in the Green Card implementation. From the beginning to 1997 June, approximately 385 millions USD expent for inpatient care services of these citizens.

During the period of 1923-2002, the share from the state budget allocated to the Ministry of Health fluctuated between 2.02% and 5.27%. In 1992, a downward trend began and the share fell from 4.71% in 1992 to 2.40% in 2002. (Figure 4)

Figure 3 Allocation of the State Budget to the Ministry of Health, Turkey,2000.



Source MoH: Health Statistics Yearbook,2000, p.24.

2.6.1.2. University Hospitals:

University hospitals have two main funding sources: The state budget allocations and universities' revolving funds. The state budget covers both recurrent expenditure and capital expenditure. Through rational pricing policies, the revolving fund revenues have been strengthened when compared to state hospitals. The expenditure of the university hospitals made through the revolving fund is controlled by the State Planning Organization.

2.6.1.3. Social Health Security Schemes:

- Persons working under a service contract and their dependants, SSK,
- Merchants, artisans and other self-employed persons and their dependants, Bağ-Kur,
- Retired civil servants worked according to Personnel Law No.657 and persons retired from State Economic Enterprises, widow and orphan wage earners, their dependants, Emekli Sandığı,
- Active civil servants working according to Personnel Law No.657 and their dependants, by their institutions,

covered by social health insurance.

2.6.1.3.1. Social Insurance Organization (SSK):

SSK is a social security organization for private sector employees, blue-collar public workers, and functions both as an insurer and as a health care provider. The members use SSK services but are referred when needed to MoH, University and private health institutions. The SSK in general does not provide or pay for preventive services. SSK health services are funded by premiums paid by employees and employers. While a single system is used to collect both retirement and health insurance premiums, health premiums and health expenditure are separately identified in the SSK accounts. There are two other sources of funding in addition to premiums: income from fees paid on behalf of non-members using

SSK facilities (for example Bağ-Kur members), and income obtained through co-payments (10 percent for retired and 20 percent for actives) of drug costs for outpatients.

Even though efforts are made so that the different insurance branches of SSK finance themselves, the branches having revenue surplus such as health insurance branch have been used to subsidize other SSK insurance branches such as retirement until 1994. General State Budget transfers have been realized amounting to 2.662.1 million USD in 1999 and 656 million USD in 2000 to compensate for the loss of SSK.

One of the major problems that SSK management faces today, is the over emphasis on cost containment policies at the expense of quality. Today most of the SSK users are complaining about the quality of health care and accessibility to SSK health facilities.

Furthermore there are private funds established in accordance with the provisional article 20 of the SSK Law. These funds are open to insurance, banking and stock market institutions, and provide services to their members on at least the same level of autonomy in structure as permitted by the SSK Law. The generally used system is back payment of the expenses made by members. The users find quite satisfactory the access to quality services being granted through these funds.

2.6.1.3.2. The Social Insurance Agency of Merchants, Artisans and the Self-Employed (Bağ-Kur)

Bağ-Kur is the insurance scheme for the self-employed. All contributors have the same entitlement to benefits covering all outpatient and inpatient diagnosis and treatment. Bağ-Kur operates no health facilities of its own, but purchases the services by entering into contracts with public service providers. The scheme works on reimbursement system where fees are determined independently by the institution. Drug purchases require a 20 percent co-payment from active members and a 10 percent co-payment from retired members as in SSK.

2.6.1.3.3. Government Employees Retirement Fund (Emekli Sandığı):

Government Employees Retirement Fund, primarily a pension fund for retired civil servants, also provides other benefits including health insurance. There is no specific health insurance premium collected from either active civil servants or pensioners. The scheme is basically financed by state budget allocations, which are major component of the Fund's general revenues. Government Employees Retirement Fund finances all health care needs of retired government employees with only a 10 percent drug co-payment paid by users.

Government Employees Retirement Fund has no control over its rapidly growing health expenditures and basically pays invoices made out by the health facilities and pharmacies for its members. No technical analysis is done within the Fund about the service expenses or service utilization rates.

2.6.1.3.4. Active Civil Servants :

Health care expenditure of all active civil servants is covered by their organizations through specific state budget allocations. When these are insufficient, new allocations are made.

2.6.2. Private Health Insurers in Turkey

In 2001 about 40 insurance companies were providing private health insurance, with a total coverage of 655.703 insureds and a total Premium income of 188 million USD. A major part of the insureds are already insured by social insurance organisations and therefore pays the premium to the institution they are legally a part of, but also, get better service to their private insurance fund. Private health insurance is the country's fastest developing insurance branch (Table 1, Table 2)

Table 8. The Premium Amount Collected by Private Health Insurers (US\$)

	1998	1999	2000	2001
Premium Income	179.800.413	199.686.335	281.132.658	187.822.544
Annual Increase	% 5 1.96	%11.06	%40.79	%-33.19

Source: Association of the Insurance and Reinsurance Companies of Turkey, 2001 Annual Report

Table 9. Private Health Insurance Policies and Insureds

	1998	1999	2000	2001
Individual Policies	112.075	124.435	141.068	160.381
Number of Insureds	205.787	258.050	250.813	260.202
Group Policies	2.818	3.401	3.311	48.912
Number of Insureds	393.916	475.290	439.550	395.501

Source: Association of the Insurance and Reinsurance Companies of Turkey, 2001 Annual Report

The important number of private health insureds are covered by existing social health security schemes, therefore these people faced with the situation that they have to pay premiums to both social security organization by law and private health insurance firm in order to receive better health services.

2.6.2.1. Some of the Developments in Private Health Insurance at 2001

The economic crisis facing the country and the revaluation of the US Dollar against the Turkish Lira affected also the premium production of the Health branch, the 2001 premium of which increased by 43.17% over the previous year, reaching 270.383 Billion TL., remaining below the inflation rate.

During the year 2001 both the insurance companies and the health institutions tried to keep their rate increases below the level of medical inflation. The 2001 Turkish Physicians Association's coefficient increase percentage materialised at approximately 56%. Thus, it was the first time after so many years that the coefficient increase percentage remained below the wholesale goods as well as retail price indexes.

The number of total health insureds decreased by 5.02% from 690,363 in 2000 to 655,703 in 2001.

The 2001 premium income in this branch where 40 companies were active, increased to 270.383 billion Turkish Liras showing a 43.17% increase in current prices and 33.19% decrease in terms of the US Dollar over the previous year.

Consequently, the share of the Health branch's premium within the total increased from 10.55% in 2000 to 10.79% in 2001.

The loss ratio in this branch was of 77.15% in 2001 showing an increase compared to the previous year.

This branch's share within the total technical profit increased from 10.92% in 2000 to 12.95% in 2001.

Studies on the quality have been started in most of the private and state hospitals and it is noteworthy to mention that some of the hospitals which rank among the top big ones obtained ISO certificates in 2001.

By the coming into force of the Individual Pension Savings and Investment System the insurance companies which were active in both the health and life branches were obliged to make re-arrangements and the life companies which will be active in the Individual Pension Savings and Investment branch will no longer operate in the health branch in two or three years.

As of the 1st September 2001 the application of the Tax Identification Number in insurance transactions started. Therefore, as of this date the persons who bought insurance cover in the health branch were obliged to declare their tax identification numbers.

The Banking and Insurance Transactions Tax (BSMV) that was applied in the Health insurances was abolished as of the 7th October 2001 as per the 12th article of the Law No.4697 which was published in the Official Gazette No.24458 dated 10th July 2001. As this meant a decrease of 5% in the premiums of health insurances paid by the insureds, it is considered as an important encouraging development in this branch. Again, by the same law the rules and limitations relating to the deduction of premiums from the Income Tax of the insureds of the health branch have been changed as of the 7th October, 2001, and accordingly the health insurance premium to be paid by the persons who are on bordereau can be deducted from their Income Tax Value on the condition that the health insurance premium should not exceed 5% of the gross monthly salary from which the insurance premium is paid and/or the minimum salary fixed by the government per annum.

The Turkish Physicians Association's requesting for the first time the points of view of the insurance companies active in the health branch regarding their 2001 booklet can be considered as an important step taken in respect of common studies to be carried out in the future.

The companies operating on the health insurance branch have offered wide spread service all around the Turkey by making contracts with approximately 157 hospitals, 294 medical centers and laboratories and 444 pharmacies. They played an important role on financing of

health system by paying 77.15 TL., which have reached 145 million US dolar, for each 100 TL. premium they received by the end of the year 2001.

3. CONCLUSION

A big health reform is on the way in Turkey. The success of reform depends on some different components. These components are:

- In general participation of whole society and particularly motivation and participation of health sector workers,
- Effective management of reform by MoH,
- Effective usage of current sources and these contain financial, material and most importantly human sources.

In order to realise the reform activities, the crucial factors to be taken into consideration were identified as followings:

- Reform activities should address the main causes but not indirect causes or secondary symptoms,
- The team preparing the reform should concentrate on substantive issues but not political or transitory aspects of the reform,
- The team must incorporate various professionals and expertise, and work in a multidisiplinary manner to resolve different aspects of the problems,
- The team should consist of technical experts who are not under pressure to bend the reform program to the view of decision-makers. The team must possess adequate independent decision-making powers.

As with any serious reform movement, the main difficulties are twofold:

- Individual and organizational conservatism,
- Unfulfilled expectations.

In as large and as old organization as the Turkish MoH, conservatism is unavoidable and has to be managed tactfully. Change can be quite threathening for many units and individuals. A continuous process of education, negotiation, participation and consultation has been quite effective so far. A crucial element is that the reforms have not been brought from outside, but essentially designed, managed and implemented by members of MoH themselves. In many instances, the strongest proponents in project activities have been the staff at provincial health directorates. This, of course agrees with one of the fundamental aims of the health reforms; Decentralization of health management.

Unfulfilled expectations arise from far-reaching but possibly unrealistic aims that may have arisen at the earlier stages of the projects. When people set out with too many and too ambitious expectations, deliveries, when they start to realize, may be perceived as insufficient and late. In a setting with a population of 63 million, 80 provinces and more than 215.000 staff, however, change, especially if it will be effective, has to come slowly and cautiously.

Turkey has opportunity to provide health services to enable its citizens to lead their lives healthier and longer. The attainment of this aim will depend on the implementation of rational policies and management of resources. The following six elements of good planning have been guiding the design and the implementation of Turkey's health care reform;

- Exact and true analysis of the current situation,
- Identification of objectives,
- Determination of the most cost-effective option for current situation,

- Realistic calculation of the necessary resources,
- Identification of priorities considering that needs are infinite and resources are limited,
- Preparation of realistic plans for action.

Through the effective implementation of the reforms, Turkey will be able to increase accessibility, to distribute resources rationally throughout the country and to use them effectively, to provide universal coverage, to deliver health services in accordance with community needs, eventually to reach a healthier society.

- The Program of the Government and the Health Sector

The program of the 58th government of the Republic of Turkey gives importance to the modernization of the health system. It is indicated that:

“Our existing health system has been brought to a position which could not respond the needs from the point view of institutional structure, check out, personnel structure and distribution. Our government is determined to establish a high quality and effective health system which everybody can access.

Unfortunately, only 81% of the total population could have been included into health insurance system. The rest of the population (19%) do not have any health assurance.

Effective, accessible and high quality health system is indispensable for a well-qualified society. Government have to fulfill the basic health needs of everybody, when necessary, by making co-operation with private sector.

Existing health system has lagged behind contemporary developments with all its aspects, the costs have been increased due to corruptions in the system, health system has become unaccessible, the standart association has been destroyed. In order to bring up a healthy generation, it is inevitable to make the health system accessible by all citizens. Social security institutions have become unproductive as they are engaged in health affairs that prevent their works they have to do.

For a well-qualified health system;

- *The hospitals will be reached to autonomous structure considering administrative and financial aspects by removing the difference among state hospitals, insurance hospitals and institutional hospitals. The Ministry of Health, will be reorganised according to this new system and the competition will be brought into the health sector.*
- *The delivery and financing of health system will be seperated from each other. Health insurance, will be excluded from the branch of long term insurance. A General Health Insurance System which will include the whole population will be established, the health premium which some people could not afford will be paid by the government.*
- *A sound patient transfer chain system will be set up by passing into family practician implementation.*
- *In carrying out health services health information system which allows to benefit from information technology utmost will be set up.*

- *The lack of legacy on the protection of patient rights will be overcome by preparing Patient Rights Regulations as to the world standard.”*

In accordance with the objectives identified in the Government Programme, Turkish Ministry of Health has launched a transformation programme in the field of health. The principles of this programme are as follows:

- İnsan merkezli Human Oriented
- Etkili Effective
- Verimli Efficient
- Hakkaniyete uygun In Compliance With Equitable Principles
- Katılımcı Fostering Participation
- Ulaşılabilir Available
- Sürekli gelişime açık Seeking Consistent Development

The above mentioned programme will be composed of the following:

- Sağlık hizmetlerinin sunum ve finansmanının birbirinden ayrılması - The Separation Of Delivery and Financing of Health Services.
- Sosyal güvencenin toplumun tamamına yayılması Spreading Social Security to the Whole Society
- Aile hekimliğine dayalı birinci basamak sağlık hizmetlerinin oluşturulması The Formation of a Primary Health Service to be Based On Family Practitioner.
- Kamu hastanelerinin özerkleştirilmesi Autonomization of Public Hospitals.
- Sağlık sevk zincirinin etkinleştirilmesi - Rendering Health Transfer Circle Effective
- Sağlık Bakanlığı teşkilat yapısının yenilenmesi ve yerel yetkilerin artırılması. Renewing the Organizational Structure of the Ministry of Health and Strengthening Local Authorities
- Sağlık Bilgi Sistemi'nin kurulması The Establishment of Health Information System
- Hasta haklarının evrensel düzlemde geliştirilmesi Enhancing Patients' Rights In Accordance with Universal Principles
- Sağlık Akademisinin kurulması The Establishment of Health Academy
- Akreditasyon ve Kalite Güvencesi Kurumu'nun kurulması The Establishment of the Institution of Accreditation and Quality Assurance
- İlaç ve Tıbbi Cihaz Kurumu'nun kurulması The Formation of Institution of Medicines and Medical Devices
- Sağlıkta Ar-Ge çalışmalarının başlatılması. Launching R&D in the Field of Health.

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