

# International Observer

**Editor's note:** This article by Kisa and Younis details the attempts at providing health care coverage to Turkey's underserved and low income population. Globally Turkey ranks the 19th in population, with a 2006 estimate of approximately 70.4 million people. Some of the population trends in Turkey are favorable with a literacy rate of over 86% and a life expectancy of 72.6 years. Unfortunately, others are not; the infant mortality rate was 41.0 per 1,000 population in 2005, but it is down from 48.9 in 2000.<sup>1</sup>

The period for which this research was conducted has shown an increase in the ratio of insured. The authors estimate that about 15% of the population is using a green card for insurance. At the time, this was an innovative approach to equalize health care access. As with all programs across all countries, there have been problems with eligibility and awareness on the part of those most in need of this kind of coverage.

Turkey's move in the next decade, possibly, into the EU will make this and other reforms necessary. The author has published an earlier work asking the question: Is the Turkish health care system ready to be part of the European Union?<sup>2</sup> For now the experiment continues, and hopefully more members of the population will take advantage of the government supported programs. While the authors are somewhat critical of the success of the program, it is, in some respects, a rather comprehensive and thoughtful approach, even with its shortcomings.

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## FINANCING HEALTH CARE FOR THE POOR IN TURKEY: IS A TEMPORARY SOLUTION BECOMING A PERMANENT SCHEME?

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Today, not only Turkey but many developing countries are struggling to support their poorer citizens' access to health care. Lack of adequate and timely health care, lack of available drugs, lack of health professionals, and unaffordable user fees can have a negative impact on disease outcomes of the poor. Many of the world's poor, despite regional differences in geography, culture, and commerce, experience the same discouraging cycle: being healthy requires money for food, sanitation, and medical care, but to earn money, one must be healthy. Families in this situation face a particularly heavy burden in that family members are kept from their most basic roles of supporting and being supported by each other. A parent who attempts to bear the burden of any disease, either as patient or caregiver, can as a result lose the wages required to pay for treatment, while the children, lacking preventive medical care because of the lack of family funds or adequate attention, are themselves at risk of remaining in a cycle of illness due to poverty and poverty due to illness.

In addition to affecting disease outcomes negatively, lack of access to adequate health care services can worsen existing health conditions.<sup>1-6</sup> Without resources for medical or social services, a remediable health problem can become a permanent condition. For example, a survey in North Vietnam showed that the poor generally delay treatment, make less use of government health facilities, and pay more for each episode of illness than wealthy people.<sup>7</sup> In Mexico, Leyva-Flores et al.<sup>8</sup> reported that people who live in poverty undergo inadequate self-care rather than receive appropriate medical care for their chronic diseases, due to the expense of treatment. A U.S. study reported that the vulnerable populations in poverty areas and areas with a shortage of health care professionals are less likely to receive necessary care and preventive care and are more likely to have higher rates of avoidable outcomes.<sup>9</sup>

The ongoing reform of public institutions and state-owned enterprises in urban China has had a great negative impact on those who have lost jobs, and who, as a result, are experiencing greater difficulties in accessing health care. Among those in the lowest income group who reported illness, nearly 70% claimed financial difficulty as the major reason for not obtaining treatment of any kind. The lowest income group reported decreased use of inpatient services due to the rapid rise of per capita expenditures on health services and the decline in insurance coverage.<sup>10</sup> Liu et al.<sup>11</sup> reported

that since the 1990s health care coverage for the rural population has been reduced, and this places an extra financial burden on the poor when they get sick. In addition, 30%–50% of rural households living under the poverty line became impoverished due to illness.

### HEALTHCARE FINANCING IN TURKEY

Today, three main mechanisms for financing health care can be seen worldwide. These are taxation, insurance (social, private, and other forms, including micro-insurance) and non-insurance funding systems. Taxation-based systems involve direct taxes (such as income tax), indirect taxes (such as value-added tax), earmarked taxes, or other sources of government revenue. Insurance-based programs, where members pay a premium to an insurance company or fund in exchange for an agreed entitlement to a defined package, are another way of financing health care. In some countries, a single social insurance plan covers the entire population. In others, national health insurance systems are composed of a number of separate plans. Social health insurance systems involve mandatory and earnings-related contributions to institutions independent from general government revenue. Micro-insurance provides a complementary strategy for improving equity of access to health care for those excluded by many factors, including substantial costs of care and drugs, under-the-table payments, and the cost of traveling, especially from rural areas. Other forms of financing include medical savings accounts

involving the setting aside of a percentage of income for health care and user fees.

The Turkish healthcare system is financed by taxes (41%), insurance premiums (31%), and out-of-pocket payments (28%).<sup>12</sup> (See Table 1.) The Turkish system is a combination of national health insurance and private health insurance. The coverage of compulsory health insurance provided by social security foundations is comprehensive.<sup>13</sup> The private sector is small but growing rapidly, and complements rather than competes with the state system. The country has three main social security organizations, which are public institutions, namely, the Government Employees Retirement Fund (GERF) to serve pensions for civil servants, the Social Insurance Organization (SIO) for blue-collar workers, and Bag-Kur for the self-employed.<sup>14</sup> These are also the public providers of the health care system.

Today the three main social security organizations are suffering worsening financial imbalances. To correct this problem the government is introducing short-term adjustments such as changes in legislation and medium and long-term comprehensive structural reforms to put pensions and the healthcare system on a sound financial basis. The health insurance system provided by the state has a few problems. For example, in Table 2, which shows the Turkish population covered by social security programs in Turkey, the majority of the population (87%) is covered by some type of health services program, but a significant portion of the people do not have any type of insurance coverage for health care in Turkey. In addition, there are

**Table 1. Total health expenditures of Turkey**

	1992	1993	1994	1995	1996	1998
Total health care expenditures (million \$)	6,024	6,715	4,721	5,704	6,772	10,970.7
Public	4,041	4,465	3,256	4,043	4,827	8,295.2
Private	1,984	2,250	1,464	1,661	1,945	2,675.5
Classification of health care expenditures (million \$)						
Preventive health care	130	108	52	54	59	74.6
Outpatient	3,807	4,377	3,095	3,588	4,338	6,106.7
Inpatient	1,519	1,735	1,267	1,643	1,956	2,796.3
Other	569	496	306	419	419	553.1
Financial sources of the health care expenditures (million \$)						
Taxes	2,776	3,135	2,170	2,457	2,921	3,853.7
Insurance premiums	1,361	1,472	1,136	1,547	1,708	3,001.5
Out of pocket payments	1,887	2,109	1,415	1,700	2,143	2,675.5
Per capita health expenditures (\$)	103	112	77	91	108	149.5

SOURCES: Ministry of Health (Turkey). Health expenditures and financing in Turkey 1992–1996. Ankara-Turkey: Republic of Turkey, Ministry of Health, Health Project Coordinator Unit Publications; 1998.

Ministry of Health (Turkey). Health expenditures and financing in Turkey 1998. Ankara-Turkey: Republic of Turkey, Ministry of Health, Health Project Coordinator Unit Publications; 1998.

**Table 2. Population covered by social security programs in Turkey**

<i>Institutions</i>	1995	1996	1997	1999
The Retirement Fund	7,185,000	7,802,000	7,947,000	8,434,000
The Social Insurance Organization	28,726,000	30,573,000	32,752,000	36,367,000
The Social Security Institution of Craftsmen, and Other Tradesmen and other self-employed private funds	11,833,000	11,823,000	12,680,000	13,876,000
Private funds	291,000	308,000	315,000	333,000
Social insurance coverage with respect to health services	41,668,000	43,754,000	47,008,000	56,017,000
Population of Turkey	61,075,000	62,003,000	62,983,000	64,814,000
Ratio of insured population in Turkey	78.6	81.5	85.3	91.0
Ratio of population covered by health services	68.2	70.6	74.6	86.4

SOURCES: State Planning Organization (Turkey). Developments in economic and social sectors. Ankara (Turkey): State Planning Organization; 1999.

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substantial differences across the institutions in the health coverage offered.

As is the case in other countries, Turkey has initiated health reform studies to tackle these problems. In Turkey, the government officials have been trying to implement a general health insurance system since the early 1990s, but there have been no improvements up to now. The suggested system will be financed from the premiums based on actual contributions. The suggested strategy was for the poor to meet their premiums from the government budget. The spread of the system throughout the country was predicted to take six years after ITS initiation in pilot provinces. In the transition period to the general health insurance system, the “green card” system was started in 1992 as a step toward ensuring equity in the distribution of state subsidies to needy citizens for health services.<sup>13</sup>

### GREEN CARDS

Health care entitlements known as green cards are issued to Turkish citizens who cannot pay for health services, and their declared revenues are controlled in a detailed manner. The major problem in implementation is the determination of people’s incomes. For these matters to be solved during the General Health Insurance implementations, the Ministry of Health conducted various research studies and the results of these are reflected in the prepared model and in draft legislation.

The pilot application of green card use began in January 1992. Five counties from different regions were selected for the pilot implementation and for detecting possible problems with green card use. By the eighth month of the pilot application, the legal

base and implementation rules for the whole country had been developed. The pilot areas’ population was 450,000 people, of whom 5,900 (less than 2%) received green cards according to the eligibility criteria. The Turkish National assembly passed the bill that is called the green card law. The purpose of the law is to meet the health expenditures of Turkish citizens whose total income level is one-third below the minimum wage. An economic coordination group was set up under the leadership of the state minister of economic relations in addition to the ministers of internal affairs, finance, labor, and social security. Based on the per capita health expenditures of green card holders, the coordination group meets to determine the amount of money needed in the government budget, and to coordinate with other government and private institutions to ensure that all green card holders receive the health care they need. Table 3 shows the number of green card holders and their utilization of health services.<sup>15</sup>

### PROBLEMS OF THE GREEN CARD SYSTEM

The aim of the green card system is to provide equal access to health care, but the system has many problems. The first is that the green card holders receive care only when hospitalized. Thus, many green card holders delay seeking treatment until the last minute, because they know that when they are admitted they will be asked for co-payments in some hospitals (see Table 4).<sup>16</sup> Second, although it is illegal to reject any patient with a green card, the majority of public university hospitals do not admit green card holders due to delay in reimbursement from the government. State hospitals struggle to close the fiscal year with balanced budgets.

**Table 3. Number of green card holders and their service use**

Years	Number of applications	Percent	Given green cards	Percent	Inpatient service utilization	Percent	Outpatient service utilization	Percent
1992–1993	2,971,722	23.4	2,211,341	21.8	127,420	2	27,975	0.5
1994	1,498,213	11.8	1,460,111	14.4	620,485	8	236,956	4.6
1995	1,674,712	13.2	1,325,276	13.1	1,242,000	17	301,903	5.9
1996	970,889	7.6	716,338	7.1	867,673	12	390,872	7.6
1997	1,298,526	10.2	953,912	9.4	835,897	11	626,552	12.2
1998	1,345,953	10.6	1,093,465	10.8	942,176	13	844,461	16.5
1999	1,352,148	10.6	961,186	9.5	1,092,592	15	1,184,896	23.1
2000	1,610,828	12.7	1,404,677	13.9	1,576,856	22	1,510,736	29.5
Total	12,722,991		10,126,306		7,305,099		5,124,351	

SOURCE: Ministry of Health (Turkey). Statistical information on green card holders. Ankara (Turkey): Republic of Turkey, Ministry of Health; 2000.

Therefore, many state hospitals are reluctant to provide medical equipment, drugs, etc., for green card holders from their stock, even though it is required by law. Third, the government has not allocated sufficient funds for green card holders' prescribed drugs and other goods. Some payments are made late; as a result, some pharmacies are reluctant to provide the prescribed drugs, or cardholders may be asked to pay for prescribed drugs from their own pocket. Fourth, the procedure for issuing green cards is not uniformly equitable. To receive a card, an applicant's income must be under a certain level, but this assessment is difficult because of the lack of information systems among the government institutions. Fifth, many poor people who are eligible for the green card are not aware that they are entitled to it; thus, they do not apply or cannot overcome the bureaucratic hurdles to obtain the card.

## CONCLUSION

This article discusses how the Turkish poor currently gain access to medical care, and presents implications for policy changes and suggestions toward increasing

service utilization. Despite the progress that has been made in recent decades to improve the health status of the poor in Turkey, most poor do not receive adequate care due to financial and administrative problems. It is reported that 13% of the Turkish population are using the green card system to receive medical care, and these numbers are increasing due to the recent economic crises in Turkey. The green card model has had many successes in addition to problems arising from legal and budgetary restrictions and incomplete coverage. These problems relate to eligibility criteria, lack of awareness about eligibility status, and bureaucratic hindrances to access. The green card implementation was a temporary solution at the beginning; now the system is becoming a permanent program for the poor. Thus, the government officials should try to identify new financial sources for the program, although the country is currently suffering from a heavy load of increased taxes and premiums.

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**Table 4. Number of hospitals in Turkey by institutions, 1999**

	Number of hospitals	Percent	Number of inpatient beds	Percent
Ministry of Health	734	63	84,022	50
Social Insurance Organization	115	10	27,062	16
Universities	42	3	24,094	14
Ministry of Defense	42	4	15,900	10
Other public institutions	10	1	2,217	1
Private	260	19	14,077	8
Total	1,110	100	162,670	100

SOURCE: Ministry of Health (Turkey). Statistical abstract of hospitals. Ankara (Turkey): Ministry of Health Publications; 1999.

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