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Study on the Social Protection Systems in the 13 Applicant Countries

Turkey
Country Study

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Social Protection in Turkey

1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

1.1.1 Economic and financial indicators

Turkey, the 13th candidate country for accession to the EU, has as per capita income one third of the EU average (expressed in terms of PPP). As Table 1.1 in the Annex illustrates, the GDP average annual growth rate for the first two years of the *7th Plan* period (1996-2000) was realised at above 7 percent. However, this rapid growth could not be maintained in the following years, and the GDP growth rate dropped to 3 percent in 1998. In 1999, a reduction of about 5 percent was recorded in the GDP growth rate because of the financial crisis that hit the country. Following a recovery in 2000, the country was shaken by yet another crisis at the beginning of 2001. Thus, in the period of 1996-99, the GDP average annual growth rate was realised at 3 percent. The country experienced a further reduction of about 7 percent in its GDP growth rate in 2001.

While the turmoil was triggered by an apparently isolated incident in the banking sector, this occurred in a context of falling investor confidence given the perception of a slowdown in the reform implementation and growing macroeconomic risks. In this environment, the problem quickly spread throughout the banking sector, leading to a massive outflow of foreign exchange and a rapid rise in domestic interest rates, which put a heavy burden on the budget and the banking system. This, in turn, made the anchored exchange rate system unsustainable, which was a crucial factor for guiding inflation expectations. Consequently, the faith of the public in the inflation targets was weakened by the crisis: As pointed out in Table 1.1 (see the Annex), the inflation rate was at around 50 percent per year just before the crisis—a considerably high figure compared to other European Countries—which was in fact relatively low, compared to 1995 when the inflation rate was at around 88 percent. The inflation target figure was at around 30 percent before the 2001 crisis.

It should be noted that the sudden turmoil that hit Turkey's financial sector in early 2001 is currently affecting the economy, and it is feared that it will continue to have adverse effects in the coming years (see, *e.g.*, *OECD Economic Surveys: Turkey*). The social impact of the crisis is presently

being felt as lay-offs and rising prices, and the crisis has certainly increased the risk of poverty on the poor, both in urban and rural areas.

Turkey's social expenditures have been fluctuating at around 8 percent of GDP; the tendency is increasing, but compared to other European countries it is still at a relatively very low basis. The total shares of the education and health expenditures on GDP fluctuate at around 4 percent each, and the public contributes more than 70 percent in both cases. It should furthermore be noted that although the financing of the social security system is based upon the contributions of the employers and employees, the increasing deficits of the social security institutions have constantly been compensated by means of transfers from the general budget, constituting a heavy burden for Turkey in keeping its budgetary balance. The 1999 reform of the social security system was launched to correct this rather unsustainable system.

In considering these figures, as well as the figures to be presented subsequently, one should be aware that the economy is believed to have a large informal sector (mainly in and around the big cities). One should furthermore acknowledge lack of data in some areas and an overall unreliability in most areas.

1.1.2 Demographic indicators

Significant changes have been observed in the demographic developments in Turkey, which are the basic dynamics of the economic and social development of the country. The population was estimated to be 60.5 million in 1995, and 66.3 million as of 2001, with an almost equal relation between the number of women and men. Over 60 percent of the population live in urban areas. The annual growth rate, which was estimated as 1.57 percent in 1995, is expected to have dropped to 1.49 percent in 2001. Turkey has a young population—around 70 percent of the population is below the age of 35. This said, however, it is also estimated that the share of the 0-14 age group fell between 1995 and 1999 (around -2 percent), whereas the share of the 15-64 age group (+1.5 percent) and 65+ age group (+0.5 percent) have increased (see for more details Table 1.2 in the Annex). The demographic dependency ratio, accordingly, has been at 0.648 in 1990 and at 0.553 in 2000.

Infant mortality was reduced from around 50 per thousand in 1997 to below 40 per thousand in 2000 (cf. the EU average of 4.9 as of 2000). A similar reduction trend is also observed in the birth rate (from 21.8 per thousand in 1995 to 20.4 per thousand in 1998), the mortality rate (from 6.6 per 1000 inhabitants to 6.5), and the total fertility rate (from 2.62 in 1995 to 2.38 in 1998).

Attention should be given to the fact that the death and birth figures are not reliable in Turkey. There are many reports indicating that it is not rare that families do not report, especially in rural areas, the birth of their girl babies and that many deaths, again, especially in rural areas, are not

reported. Furthermore, care should be given to the net population change and net migration figures. These figures are being computed on the basis of the projected population increase figures and the reported death and birth figures, but since the death and birth figures are not reliable, the net change in the population and migration figures would not be reliable either (see Table 1.2 in the Annex). The same problem applies to data on ethnic groups: citizens of Turkey do not come from a single ethnic group—however, the only minorities officially registered as such in the country are the non-Muslim minorities (approximately 1 percent of the population) who are in fact internationally recognised by the Treaty of Lausanne. Note in passing that Turkey is constitutionally a secular state.

It is estimated that the life expectancy at birth has approximated 69.4 years in 2000, but this figure continues to be very low when compared to European countries (EU average is around 77.4). Estimates for life expectancy at the age 65 are however more optimistic with 12.7 years for male and with 14.3 years for women in 1998.

1.1.3 Social indicators

According to the State Institute of Statistics, the unemployment rate was 6.9 percent in 1995, 7.7 percent in 1999, and was estimated to be at 8.5 percent in 2001 (due to the financial crisis). In addition to this, one should consider the phenomenon of underemployment, which is not well documented in official reports, as there are no statistics available: According to the *Report on Vocational Education and Training* by the European Training Foundation, the rate of the inactive labour force is increasing to around 9 percent. The report also states that unemployment is still occupying a very special place in the public opinion of Turkey, an issue that has to be tackled and treated with the utmost delicacy. (In a relatively recent survey representing urban Turkey, 26 percent of respondents have indicated that unemployment is the number one or number two problem of the country from a given set of problems; see Adaman et al., 2001.)

According to the declaration made by the Employment Agency of Turkey, İŞKUR, not being able to find employment even at minimum wage, even with the will, skill and ability, leads to serious social and economic problems regarding the individual and country. The manifestations of these come as income loss, not being able to get their share from an increase in welfare, despair, fear of the future, and living in bad conditions with regard to the individual; all these are the cause of social problems. Not having job opportunities or not being able to increase them to a sufficient level affects the national economy and brings poverty, unemployment and social exclusion. (See their website <www.iskur.gov.tr>.)

A breakdown of population and unemployment by age groups and by gender reveals the fact that women in general and those in the 15-25 age group are in fact the most vulnerable segments of the society needing

special attention. Consequently, this first group, the women, have a labour force participation rate in urban areas of 14.9 percent (as of 1998), whereas in rural areas the participation rate of women is considerably higher (41.5 percent in 1998). In comparison to this, the labour force participation rate of men in urban areas was at 64.7 percent and at 80 percent in rural areas as of 1998. However, compared to figures in 1995, one can observe that employment in the agriculture field/rural area had a diminishing trend (see Table 1.3 in the Annex). This is valid for men and for women. (For further discussions, see Akpınar and Ercan, 2002.)

According to the State Institute of Statistics in Turkey, the labour force structure consists of around 35 percent regular employees, around 8 percent of casual employees, around 25 percent of self-employed, and around 26 percent of unpaid family workers (all figures as of 1998).

With regard to regional differences, population and economic activities are unequally distributed in Turkey. Economic growth has been concentrated in certain urban areas and in the Western part of the country. As a consequence, one could observe large waves of migration from the rural environment to the cities and from East to West within the country. The clashes that were intense in the 1990-1994 period between the separatist fighters and the army in the Eastern and Southeastern parts of Turkey were an additional factor in such migration. In this framework, the main metropolitan cities contribute to the growth with their economic potential, while the East and Southeastern parts of the country are relatively less developed. Regarding these regions, however, it has to be said that after the completion of the Southeastern Anatolian Project (GAP) considerable improvement has been observed in the well-being of the people in that region. (See <www.gap.gov.tr> for more information on the Southeastern Anatolia Project.)

Regional policy issues have also to be seen against the background that Turkey has always had a strongly centralised administrative structure. The need to better adapt to regional demands (on social, economic and political realities of the country), and thus to involve stakeholders other than the representatives of the central State, is slowly bringing attempts towards decentralised models that have still to be further developed and adapted to the reality of Turkey.

With regard to sectoral differences, there have been considerable changes in the last decade in Turkey, too, as modernisation and growth have affected not only the agricultural sector but also the industrial sector, which has undergone a process of modernisation from basic production towards diversified and technological processes. Changes have also occurred in the service, tourism, transport, and financial and commercial sectors, as a consequence of which major transformations can be observed with a broad impact on the labour market, with an increase in the demand for more skilled and educated personnel. One should also note the radical agricultural reform programme that has been initiated quite recently, aiming at reducing

subsidies, and substituting a support system for agricultural producers and agro-industries, with incentives to increase productivity (see *Turkey: Agricultural Reform Implementation Project*). Taking into account the fact that the agriculture sector accounts for approximately 15 percent of the country's GDP and approximately 40 percent of the labour force, the reform programme is expected to have important impact on the societal level at large.[1]

As of today, there are no official statistics in Turkey with regard to the personal income distribution. The most recent one, the one conducted eight years ago in 1994[2], indicated a rather unequal income distribution: With a GINI coefficient at around 0.49, the average income of the highest quintile in income distribution was found to be 10.9 times the level in the bottom quintile. Compared with the EU15 average GINI coefficient of 0.31, it becomes too obvious a fact that Turkey has been experiencing a very severe inequality. In the post 1994 era, furthermore, it is feared that this unequal distribution might have further deteriorated and that the 1994, 2000 and 2001 crises are all expected to have affected the poor segments in a stronger way.

The main trends regarding family structures in Turkey can be described as follows: According to the *UNDP Report on Women in Turkey*, the crude marriage rate was at 8.14 percent in 2000 and the crude divorce rate was at 0.46 percent in 2000. The mean age at first marriage was reported as 22 years for women and for 25.1 years for men in 2000. The mean age of the mother at childbirth was 26.6 years in 1999. In this regard, it is interesting to note that the mean age at childbirth was 27 years in 1995.

1.2 How does the described background affect social protection?

1.2.1 Forecasts and projections

In the long term, it is estimated that the population growth rate will slow to an average annual rate of 1.1 percent, and after the year 2020 it will fall below 1 percent. The major concerns in the long-term include the population's capacity to replenish itself and maintain its dynamic structure and the attainment of stability in population growth and fertility rates. The State Statistical Institute's estimates for the year 2010, presented below in

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1 One of the priorities of the reform programme has been to target the production of tobacco. With the removal of the old incentive system, where the government was declaring a subsidised price system with a guarantee to buy tobacco at any quantity, farmers have shifted to other crops, the immediate impact of which was reported to be high unemployment figures among agricultural workers, as tobacco happens to be a very labour intensive crop.

2 Take note that the 1994 survey collected data from 19 cities, corresponding to seven regions of the country, with the differentiation between rural and urban. The sample size was 26,256, out of which 18,264 were carried out in the urban area and the remaining in the rural area.

Table 1.4 in the Annex (State Statistical Institute's unpublished report on *Demographic Forecasts for 2010*, 2001), are indicative in this regard.

The economy as of today has not recovered from the February 2001 crisis, and the likelihood of its being hit by another financial crisis cannot be ruled out either. It is a must, however, that Turkey should grow at a rapid rate so that per capita income can go up, taking into account that the population growth rate is expected to remain higher than 1 percent in the coming years.

The unemployment rate has gone up dramatically over the past years (estimates are around 10 percent, including the informal market, for the year 2002). It is believed that the recovery in the economy will gradually move this figure down, opening new job opportunities and thus stabilising the social system, yet the system as of today continues to be very sensitive to even minor political events.

1.2.2 Influences of economic, demographic and social developments on the social protection system

Lack of data and insufficient research do not allow one to position properly where Turkey stands with regard to social risk, poverty, deprivation and social exclusion, as will be discussed at length in the following chapters. From what is available, however, one can observe that, while Turkey is the world's 17th most industrialized nation, it ranks 85th out of 174 countries according to the *Human Development Report* of the United Nations (*Human Development Report, 2000*). 16 percent of Turkey's adult population is illiterate, including 25 percent in adult females. The infant mortality rate, close to 40 per 1000 live births, is high relative to comparable middle-income countries, not to mention EU countries. Furthermore, only 50 percent of Turkish children are immunized against polio, BCG, DTP, and measles in the first year of life; the average and severe malnutrition percentage in children below 6 years old is around 10; maternal mortality is at 180 per 100,000; the life expectancy of 69.4 years is also below that of comparable countries.

All these figures should not be surprising, as the share of social expenditures in the GDP is rather low compared to Western and Eastern European countries and as there are severe inequalities in the distribution of social services. Furthermore, public services in general are far from being efficient due to either organisational and more structural problems and red tape, or the existence of corruptive activities.

The lack of proper education (and even basic education) and a proper insurance system have forced, and continue to force, families, especially those living in the outskirts of big cities and in rural areas, to have many children—hence the high population growth rates that put a strain on the economy in general. In addition to this, important migration moves, especially during the period of 1990-1994, from rural to urban areas and

from East to West, have contributed to an increasing pressure on large urban areas, for instance, in the access to basic social services.

Although the percentage of those living under the absolute poverty line is not high, those who are considered as vulnerable form a large segment of the society. There are many poverty eradication schemes in the country, most by the government, but the means are rather too limited. The GINI coefficient and other data indicate a rather unequal income distribution. Although according to the Constitution governments should follow welfare-oriented policies, there are severe indications and in some cases evidence that, due to widespread corruption and/or ineffective public administration, taxes are not appropriately collected (recall the existence of a large informal sector) and investments are conducted not on a need basis but rather on a patronage basis.

1.3 Annex to chapter 1

Table 1.1. Main Economic and Financial Indicators

	Year	Eurostat	State Institute of Statistics Hacettepe Ins. of Pop. St.	OECD Figures	Recent Demographic Developments in Europe
GDP at current prices in million ECU	1995	129.6			
	1996	143.1			
	1997	167.8			
	1998	177.8			
	1999	173.1			
	2000	217.4			
GDP per head at current prices in EURO	1995	-			
	1996	2,300			
	1997	2,700			
	1998	2,800			
	1999	2,700			
	2000	3,200			
Annual Growth Rate In Constant Prices	1995	7.2			
	1996	7			
	1997	7.5			
	1998	3.1			
	1999	-4.7			
	2000	7.4			
Social Expenditure As Percentage of GDP	1995			8	
	1996			9	
	1997			10	
	1998				
	1999				
	2000				
GDP at current prices in Bn PPS	1995	-			
	1996	346.5			
	1997	385.1			
	1998	402.8			
	1999	392.6			
	2000	433.3			
GDP per head at current prices in PPS	1995	-			
	1996	5,500			
	1997	6,200			
	1998	6,300			
	1999	6,100			
	2000	6,400			
Inflation rate (consumer price indices-base year 1994)	1995		88.6		
	1996	81.2	80.3		
	1997	87.3	86.0		
	1998	81.4	84.7		
	1999	61.9	65.0		
	2000	54.3	54.6		

Inflation rate (Wholesale price indices-base year 1994)	1995		85.6		
	1996		75.9		
	1997		82.1		
	1998		71.8		
	1999		53.2		
	2000		51.1		

Table 1.2. Demographic Indicators

Demographic Indicators	**Year**	**Eurostat**	**State Institute of Statistics Hacettepe Ins. of Pop. St.**	**Recent Demographic Developments in Europe**
Female-Male Population* (in thousands)	**1990 Census Results**			
Ages 0-4			3,215.4 / 3,386	
Ages 5-9			3,275.4 / 3,438.9	
Ages 10-14			3,227.4 / 3,381.4	
Ages 15-19			2,911.7 / 3,059.7	
Ages 20-24			2,561.8 / 2,660.6	
Ages 25-29			2,416.1 / 2,525.6	
Ages 30-34			2,038.1 / 2,149.8	
Ages 35-39			1,704.1 / 1,782.6	
Ages 40-44			1,374.8 / 1,413.7	
Ages 45-49			1,112.1 / 1,090	
Ages 50-54			1,027 / 958.2	
Ages 55-59			970.1 / 968.6	
Ages 60-64			807.3 / 742.4	
Ages 65-69			498.4 / 465.1	
Ages 70-74			298.3 / 242.9	
Ages 75+			427.9 / 341.5	
1995 Projected (State Institute of Statistics-unpublished report)				
Ages 0-4			3,062.8 / 3,270.1	
Ages 5-9			3,231.7 / 3,448.6	
Ages 10-14			3,318.8 / 3,538.1	
Ages 15-19			3,099.2 / 3,294.3	
Ages 20-24			2,731 / 2,863.9	
Ages 25-29			2,510.5 / 2,628.4	
Ages 30-34			2,231.4 / 2,338.3	
Ages 35-39			1,934.5 / 2,022.2	
Ages 40-44			1,624.4 / 1,700.9	
Ages 45-49			1,346 / 1,378.3	
Ages 50-54			1,100.5 / 1,082.2	
Ages 55-59			975.8 / 968.2	
Ages 60-64			897.3 / 862.6	
Ages 65-69			664.1 / 629.3	
Ages 70-74			448.9 / 389.7	
Ages 75+			522.9 / 384.8	
2000 Projected (State Institute of Statistics-unpublished report)				
Ages 0-4			3,263.8 / 3,393.8	
Ages 5-9			3,047.6 / 3,249.6	
Ages 10-14			3,224.6 / 3,437.4	
Ages 15-19			3,310 / 3,521.3	
Ages 20-24			3,087 / 3,269.1	
Ages 25-29			2,717.3 / 2,837.6	
Ages 30-34			2,495.1 / 2,602.9	

Ages 35-39			2,213.7 / 2,311.6	
Ages 40-44			1,913.6 / 1,991.2	
Ages 45-49			1,598.7 / 1,661	
Ages 50-54			1,314.2 / 1,325.8	
Ages 55-59			1,061.6 / 1,016.5	
Ages 60-64			921.2 / 878.2	
Ages 65-69			813.8 / 742.9	
Ages 70-74			559.5 / 498.1	
Ages 75+			581.2 / 439.8	
Population Aged Less Than 15 Years (in thousands)	1995		20,025	
	1996		20,059	
	1997		20,128	
	1998		20,211	
	1999		20,294	
	2000		20,233	
Population Aged More Than 65 Years (in thousands)	1990		2,273.2	
	1995		3,039.7	
	2000		3,635.3	
Demographic Dependency Ratio (0-14+65+/15-64)	1990		0.648	
	1995		0.609	
	2000		0.553	
Net Population Increase (in thousands) (growth rate, percent)	1995	-		915,000
	1996	-		1,227,000
	1997	-		678,000
	1998	-		983,000
	1999	1.48e		-
	2000	-		-
Fertility: Birth Rate per 1000 inhabitants	1995	-	21.8	
	1996	-	21.2	
	1997	-	20.8	
	1998	-	20.4	
	1999	21.6e	-	
	2000	-	-	
Total Fertility Rate	1995	-	-	2.62
	1996	-	-	2.55
	1997	-	-	2.42
	1998	-	2.6	2.38**
	1999	2.5e	-	-
	2000	-	-	
Net Reproduction Rate	1995			1.2
	1996			1.17
	1997			1.11
	1998			1.1
	1999			-
	2000			-

Life Expectancy at Birth Men/Women	1995	-	65.2/69.8	65.7 / 70.3
	1996	-	65.5/70	65.9 / 70.5
	1997	-	65.7/70.3	66.3 / 70.9
	1998	-	65.9/70.5	66.5 / 71.2
	1999	-	66.1/70.7	-
	2000	66.9e/71.5e	66.2/70.9	-
Life Expectancy at Age 65 Men/Women	1995			12.6 / 14.2
	1996			12.7 / 14.3
	1997			12.7 / 14.3
	1998			12.7 / 14.3
	1999			-
	2000			-
Mortality Rate per 1000 inhabitants	1995	-	6.6	
	1996	-	6.5	
	1997	-	6.5	
	1998	-	6.4	
	1999	6.8e	6.5	
	2000	-	6.5	
Infant Mortality per 1000 live births	1995	-	45.6	44.4
	1996	-	44	42.2
	1997	-	42.4	39.5
	1998	-	41.2	37.9
	1999	-	40.3	-
	2000	35.3e	39.7	-
Migration: Main Developments In Absolute Figures (Net Migration)	1995			-61,000
	1996			256,000
	1997			-287,000
	1998			40,977
	1999			-
	2000			-

*No socio-economic and demographic data from the October 2000 population census is available as yet.

**This figure is given as 2.55 by OECD reports.

e: Estimated

Table 1.3. Social Indicators

	Year	Eurostat	State Institute of Statistics Hacettepe Ins. of Pop. St.	OECD Figures (Total/men/ women)	Recent Demographic Developments in Europe
Unemployment Rate	1995	6.9	6.9	7.1 / 7.3 / 6.7	
	1996	6	6	-	
	1997	6.7	6.7	-	
	1998	6.8	6.8	7.7 / 8 / 6.9	
	1999	7.6	7.7	-	
	2000	6.6	6.6	-	
	2001	-	8.5e	-	
Employment / Population Ratios	1995			52.7 / 74.6 / 31.5	
	1999			51.9 / 71.7 / 32	
Labour Force Participation Rate-Women (urban / rural)	1995		15.2 / 48.5		
	1996		14.5 /48.4		
	1997		16.1 / 37.9		
	1998		14.9 / 41.5		
	1999		-		
	2000		-		
Labour Force Participation Rate-Men (urban / rural)	1995		66.6 / 80.9		
	1996		66.2 / 80.5		
	1997		66.8 / 79.2		
	1998		64.7 / 80		
	1999		-		
	2000		-		
	2000				
Percent of Wage Earners (Regular employee)	1995		31		
	1996		33		
	1997		34		
	1998		35		
	1999		-		
	2000		-		
Percent of Wage Earners (Casual employee)	1995		8		
	1996		9		
	1997		10		
	1998		8		
	1999				
	2000				
Percent of Self-employed	1995		25	-	
	1996		24	-	
	1997		26	-	
	1998		25	-	
	1999		-	-	
	2000		-	29	

Percent of Unpaid Family Workers	1995		31		
	1996		29		
	1997		25		
	1998		26		
	1999		-		
	2000		-		
Percent of Employer	1995		5		
	1996		5		
	1997		5		
	1998		6		
	1999		-		
	2000		-		
Percent of Population Affected by Poverty Local cost of minimum food basket	1994		7.3		
	1996		-		
	1997		-		
	1998		-		
	1999		-		
	2000		-		
Average household size	1990		4.90		
	1993		4.50		
	1998-average		4.30		
	1998-urban		4.00		
	1998-rural		4.90		
Mean age at childbirth	1995		27.00		
	1996		26.90		
	1997		26.60		
	1998		26.60		
	1999		26.60		
	2000		-		
Total number of divorces	1995		28,875	6.2*	
	1996		29,552	-	
	1997		32,717	-	
	1998		33,115	6.3*	
	1999		-	-	
	2000		-	-	
Percentage of Single Households	1990		4.5		
	1996		-		
	1997		-		
	1998		-		
	1999		-		
	2000		-		

*These figures refer to the number of divorces in 100 marriages.

Table 1.4. Demographic Forecasts for 2010

PROJECTION FOR THE YEAR 2010		
	Female	**Male**
0-14	9,845.8	10,239
15-64	24,457.8	25,396.3
65+	2,525.6	2,094.5
Total	36,829.2	37,729.8

Source: *Demographic Forecasts for 2010*, SIS, unpublished report, 2001.

2. OVERVIEW ON THE SOCIAL PROTECTION SYSTEM

2.1 Organisational structure

2.1.1 Overview of the system

The social protection in Turkey consists of the social insurance system, and the social services and assistance system. The social insurance system aims at providing insurance to the society at large, mainly in the form of health care services and pensions, with the principle of self-financing, whereas the second system targets alleviating poverty and providing social care for needy persons and groups.

With regard to the organisational chart of the social protection system in Turkey, a functional division is observed in that institutions can be divided, broadly speaking, into two categories, the first being those institutions that provide social insurance and the second those that provide social services and assistance.

Institutions providing social insurance

Here we observe

- Pension Fund (Emekli Sandığı)
- Social Insurance Institution (SSK)
- Social Security Organisation of Craftsmen, Tradesmen and Other Self-Employed (Bağ-Kur)
- Private Funds

One should also add to the above list the newly established unemployment insurance programme that became active at the beginning of the year 2002.

As of 2000, the proportion of the population covered by the social insurance system was approximately 90 percent (86 percent of the population were covered by insurance schemes that provide health care). Table 2.1 provides the basic information with regard to the population covered by the social insurance programme (providing the data of 1995 as well, to enable the reader to make a comparison). Note that a detailed picture will be presented in Chapters 3 and 5. As will be discussed in detail in the proceeding Chapter, this coverage rate seems upwardly biased.

Table 2.1: Coverage of social security

INSTITUTIONS	1995	2000
Emekli Sandığı (in thousands)	7,185	9,766
Dependency ratio	2.82	2.98
SSK (in thousands)	28,726	34,140
Dependency ratio	4.09	4.23
Bağ-Kur (in thousands)	11,833	15,036
Dependency ratio	3.43	3.53
Private Funds in total (in thousands)	291	271
Dependency ratio	3.11	3.22
General Total (in thousands)	48,035	59,213
Dependency ratio	3.68	3.83
Insurance Coverage with respect to Health Services (in thousands)	41,668	56,487
General Population in Total (in thousands)	61,075	65,784
Ratio of Insured People	78.8	90
Ratio of Insured Population with respect to Health Pension	68.3	85.9

Source: *8th Five-Year Development Plan.*

As Table 2.1 makes clear, a vast majority is covered by Emekli Sandığı (which is under the Ministry of Finance, and covers active and retired civil servants), SSK and Bağ-Kur (both are under the Ministry of Labour and Social Security, the first covering those working in private firms and blue-collar public workers, and the second covering self-employed people), all of which are public institutions. These institutions are under the legal obligation to provide insurance services to the population at large. With regard to private funds, on the other hand, one can observe a set of institutions providing additional coverage to either single individuals/families or members of institutions/organisations (OYAK being an important one, formed by the members of the Turkish Armed Forces). These institutions might either be juridical entities usually tied to ministries or trusts, or private insurance companies, all of which are voluntary to join.

Institutions providing social services and assistance

Here we observe the following two institutions as the main institutions:

- The Social Aid and Solidarity Encouragement Fund (Sosyal Yardımlaşma ve Dayanışmayı Teşvik Fonu, or in short SYDTF);

- General Directorate of Social Services and Child Protection (Sosyal Hizmetler ve Çocuk Esirgeme Kurumu, or in short SHÇEK).

Detailed information on SYDTF and SHÇEK will be provided in Chapter 4, as both institutions' main function lies within the poverty alleviation issue.

In addition to these institutions, the following public/private institutions offer services towards the provisioning of social protection, either as their main or secondary task:

- Ministry of Justice
- Ministry of Youth and Sport
- Interior Ministry
- Justice Ministry
- Municipalities
- General Directory of Foundations
- Charity Organisations and other NGOs working on social protection

Of these, the Ministry of Youth and Sport has, as of 1999, 107 youth centres, in which approximately 55 thousand young people have benefited from off-curriculum activities; the Ministry of Youth and Sport also offers camps, sport activities and cultural festivals. The Justice Ministry offers supportive activities to prisoners. The General Directory of Foundations (Vakıflar Genel Müdürlüğü) gives social support mainly to needy people. Municipalities have been given the responsibility of providing social services and aid to the needy, though an aggregate figure with regard to these activities is not available. Additionally, at the central level, there exist a set of bodies, as the Family Research Institution (Aile Araştırma Kurumu), the General Directorate of Women's Status and Problems (Kadının Statüsü ve Sorunları Genel Müdürlüğü) and the General Directorate of Handicapped Persons (Özürlüler İdaresi Başkanlığı), the main task of which is to help coordinate various activities in their fields. And finally, the Interior Ministry has the duty of overseeing and auditing the activities of NGOs.

At the civic engagement level, approximately 73 thousand associations and 4 thousand trusts are currently active in Turkey, some of which are in the areas of social assistance. Of the active associations, around 34 percent can be categorised in the area of "social assistance", 23 percent in the area of "charity" and 29 percent in the area "culture". The majority of trusts are in the areas of charity (31 percent) and education (22 percent).

It is of vital importance that, as the *8th Five-Year Development Plan* acknowledges, collaboration among public units, local administrators, and charity establishments as well as NGOs should be ensured to have a widespread, efficient and prevailing social assistance system, but observations show a rather unsuccessful picture in that regard.

2.1.2 Centralisation/De-centralisation of the system

As the above information suggests, the bulk of services provided for social protection are centralised, with local governments having a less significant role in the social protection system. Private institutions and NGOs exhibit

either a centralised or a decentralised organisational chart. With regard to centralised public institutions, one should also note that the decisions regarding the ways in which some services are being carried out and the eligibility conditions to be set for profiting from these services can be left to the discretion of local units, though in the vast majority of cases Ankara applies strict rules and regulations.

2.1.3 Supervision

Public institutions, apart from being supervised by their own auditing bodies, are supervised by the State Audit Court (Sayıştay). The Prime Ministry Auditing Institution also has the power to conduct auditing whenever they see the need. Municipalities are subject to auditing by the State Audit Court. And finally, NGOs are subject to supervision exercised by the Ministry of Interior, as noted above.

2.2 Financing of social protection

2.2.1 Financing sources

The main financing sources of the three social insurance institutions (SSK, Emekli Sandığı and Bağ-Kur) consist of premiums paid by their members, the state's contributions, and the returns on their investments. Municipalities make their expenses through their budgets, consisting of local taxes, local people's voluntary contributions, and the state's contributions. NGOs and private insurance companies are financed through private contributions. And finally, central government institutions (such as SHÇEK) are financed mainly through the central government's budget, advertisement revenues of the state television, traffic fines, taxes on petroleum, and income taxes. The World Bank's recent contribution of 500 hundred million USD, which aims at alleviating the impact of the recent economic crisis on poor households, and improving their capacity to withstand such risks in the future, should also be referred to in that regard (*Turkey: Social Risk Mitigation Project*).

2.2.2 Financing principles

One can observe three principles: The first is a voluntary basis (as in the case of contributing to an NGO or of joining a private insurance company's scheme). The second is a compulsory basis (as in the case of SSK, where insurance premiums are deducted from gross salaries). The third is an eligibility basis (as in the case of elderly people in need of support). One may finally include international support and assistance.

2.2.3 Financial administration

The social security system is now subject to restructuring, which was initiated in 1999. Prior to this, contribution rates were fluctuating at around 30-35 percent. The contribution rates are 33.5 and 35 per cent for SSK and

Emekli Sandığı, respectively. For Bağ-Kur, on the other hand, the contribution rates now depend on the insured's choice of the initial layer from a set of 1-12 layers. The contributions made to SSK and Bağ-Kur cover both the pension and the health care systems. The contributions made to Emekli Sandığı cover the pension and the health care expenses during the retirement period; their institutions pay health care expenses of active civil servants, however. This said, it should be underlined that both SSK and Bağ-Kur have been unable to collect fully the revenues declared by employers. Furthermore, governments in the past occasionally pardoned these debts, as a result of which people developed an expectation for their debts to be waived in the future. More precisely, one should note that the ratio between active and passive insured was on the average 1.98 and the premium appropriation rate was around 85 percent for SSK and around 56 percent for Bağ-Kur—which means that both institutions have been unable to collect fully the revenues declared by employers.

The contribution rate for the recently established unemployment insurance scheme is 2 per cent for the employee and 3 per cent for the employer; the state contributes the remaining 2 per cent. The contribution base is the gross income. (For more information, visit the website of the Employment Agency of Turkey, İŞKUR, <www.iskur.gov.tr>.)

2.3 Overview of allowances

2.3.1 Health care

The health care system in Turkey (both preventive and curative services) is composed of four layers: The first layer consists of private individual units, health posts and centres, mother and child care centres, and dispensaries; the second is composed of provincial state hospitals; the third consists of urban state hospitals and private hospitals; and the fourth is composed of university and training hospitals. Mainly the Ministry of Health, SSK, the universities with medical schools, the Ministry of Defence, and private health personnel and hospitals provide health services in Turkey. Sources of funds are the state budget contributions, compulsory insurance, private insurance funds, and out-of-pocket payments.

As noted above, 86 percent of the total population is said to be covered by a health insurance scheme. But, once again, this percentage is believed to be upwardly biased. With the implementation of the "green card" system, on which more will be said in Chapters 4 and 5, those people with no health insurance have been targeted in an extension of in- and out-patient treatment services.

As of the end of 2000, there are 1,226 hospitals, 5,700 health centres and 11,747 health posts. The population per physician is 789 and the number of population per bed is 351.

The eligibility requirement to be protected during illness is simply to be a member of any public insurance institutions that have been listed above. The public insurance system (*i.e.* SSK, Emekli Sandığı and Bağ-Kur) covers members as well as their dependents. Active civil servants (and their dependents) are, however, covered by their institutions. Private insurance coverage during illness varies from one scheme to another.

The public insurance system is comprehensive, covering expenses such as consultation, examination, operation, care, and prosthesis; drug expenses are also largely funded by these institutions. The public health insurance system covers 80 percent of health related expenses consisting of medicine and prosthesis of eligible members and their family members; the coverage goes up to 90 percent if members are retired. The contribution asked from members will be waived in case the member is faced with an occupation-related illness or injury. SSK also finances all the expenses of its members who must be sent to a foreign country in case there is such a need (*e.g.* in some cancer cases).

The private system's coverage depends on the specific contract one has chosen, though the share of the private insurance case in the overall system is minimal for the time being.

2.3.2 Sickness

Sickness cash benefits paid out by SSK require a medical certificate and are paid starting from the third day of illness. Benefits amount to 50 per cent of the average earnings during the last four months in the case of hospital treatment and to two-thirds of the average earnings in the case of out-patient treatment.

2.3.3 Maternity

SSK provides maternity support. An insured mother-to-be who has paid at least 90 days maternity premiums, or a wife of an insured man who has paid at least 120 days maternity premiums will be eligible for maternity benefits.

Benefits include health care during pregnancy and birth, suckling support, paid leave for insured women, and, if required, sending the mother within the country to a more suitable place.

Municipalities and NGOs provide assistance and support during the pregnancy period and after birth to those in need as well. Terms differ in private insurance schemes.

2.3.4 Invalidity

A person who has been a member for at least five years in SSK, Emekli Sandığı or Bağ-Kur will be eligible for invalidity insurance if s/he suffers

from an incurable illness or becomes unable to work following a work accident. The person in question is asked to prove his/her case through an examination in a public hospital. Invalidity is defined as the loss of two-thirds of one's working capability.

The person in question will receive monthly invalidity payment that will be based on his/her past salaries and whether or not s/he has any dependents. For SSK, the payment will consist of 60 percent of the average yearly salary and it will go up to 70 percent if the person in question is in need of permanent care. The ratios are 65 percent and 75 percent, respectively, in the case of Bağ-Kur. The ratio is 75 percent in the case of Emekli Sandığı. In case of death, the person's dependents will be paid a pension (see below, the section on survivors).

In the long term, the care of children is under the responsibility of SHÇEK, which is in charge of providing child care in their "kindergartens" for those children aged 0-12 who are in need of support and of providing care and training for those children aged 13-18 who are in need of support in their "training centres". As such, SHÇEK provides long-term care to those children in need of support.

With regard to the disability issue, as of 1999, it is estimated that there are 3-7 million handicapped people, half of which are estimated to be children. Most of them are born disabled because of preventable reasons or carry the risk of becoming handicapped. Education services are provided for 32,542 handicapped children at 904 schools. In the year 1999, the ILO Convention No. 159 on Vocational Rehabilitation and Employment of Disabled People was ratified and came into force. SHÇEK, Emekli Sandığı, municipalities and NGOs have been providing support in kind and in cash to disabled people by and large as well.

2.3.5 Old-age

Elderly people receive retirement benefits if they are members of a public insurance institution, depending on their total service years and in some cases their ages (e.g. in the case of SSK, women should be 58 or more and men 60 or more, and both should have paid at least 4,050 days of premiums).

Benefits are in the form of pensions. The pension will be based on two parameters: First, the person's complete past salaries (expressed in present values); second, the total amount of work the person has given. Once the salary is computed, it will be adjusted yearly with reference to the consumer goods price indices.

Emekli Sandığı and SHÇEK also give support, in kind and/or in cash, to elderly people who are in need of assistance. Municipalities, NGOs and other public or private institutions provide services or aid to elderly people

as well. There are about 140 rest homes in Turkey for elderly people with a capacity of around 12 thousand.

2.3.6 Survivors

The public insurance institutions' death insurance coverage is in the form of providing payments to their members' widows, orphans and parents. For all the three institutions there is a requirement of a five-year minimum work period. (But if the insured dies because of a job-related accident, then this minimum work requirement will be lifted.) Payments are made on the basis of the salary of the insured; the payment percentages depend on the relationship of the survivor to the insured and the survivor's age and occupational and marital status. Priority is given to the widow of the survivor. Boys are supported till 18 years old (the age limit goes up to 25 if the boy is enrolled into a university programme); girls are supported till they get married. Benefits given to children will be halted if they start working and earning money. Fathers and mothers may also be given a partial support, provided that they prove that the insured was supporting them.

2.3.7 Employment injuries and occupational diseases

If a member of public insurance institutions becomes unable to work, psychologically or physically, for a certain period of time while performing his/her job, these institutions are obliged to support the person in question. All the three institutions cover health care related expenses of the insured. Both SSK and Emekli Sandığı also provide financial support; active civil servants (under the coverage of Emekli Sandığı) will continue to get their salaries, and members of SSK will receive a payment that will be based on their past salaries of three months. There is no minimum requirement of work to become eligible for financial support. Bağ-Kur does not provide financial support. Members of Emekli Sandığı and SSK should provide documentation from a public hospital in order to become eligible to receive financial support. Note that all private and public employers have to secure working conditions for a safe and healthy environment, as otherwise they will be subject to legal prosecution.

In the case of death, the person's dependents will be paid a pension (see the section on survivors). And finally, private insurance companies offer coverage depending on their schemes.

2.3.8 Family benefits

With regard to family benefits, the *8th Five-Year Development Plan* makes clear that measures to help the family adjust into social and economic changes should be taken, and policies to strengthen ties among members of family should be given emphasis. The *Plan* also indicates that necessary arrangements should be made in order to provide continuity of income, to meet the requirements of health care and education services, and to provide

social security and social assistance for the family. For that, the *Plan* acknowledges that support should be given to families by training on the subjects of child, aged and disabled care. Coordination should be provided among related institutions. SHÇEK is the main institutional body responsible in that regard. Municipalities and NGOs also give supportive services to family institutions.

2.3.9 Unemployment

With the Law No. 4447, which was enacted quite recently, an unemployment insurance program has been established, which envisages granting unemployment payments in case of redundancy, paying illness and maternity insurance premiums, helping find a new job, and providing educational facilities such as vocational training, vocational courses and retraining, to be financed by the premiums paid by the workers, employers and the state to those insured who are included within the 2. Article of the Social Insurance Law No. 506, to insured workers subject to the provisional Article 20 of the same Law, and to foreign workers who are working according to agreements concluded on a reciprocal basis.

The qualifying condition for receiving an unemployment benefit is an insurance period of at least 600 days. The benefit amounts to 50 per cent of the net income during the last four months. This benefits is paid up to 180 days if the insured has paid contribution for 600 days, for up to 240 days if the insurance record is 900 days and up to 300 days if the insurance record is 1,080 days.

2.3.10 Minimum resources/social assistance

Social assistance is provided to those under the poverty line, and to the elderly and disabled people with no social support, to help them have their minimum resources to survive. The main bodies are the SYDTF and SHÇEK, the central government, municipalities and NGOs. Benefits are in the form of cash and/or in kind.

2.4 Summary: Main principles and mechanisms of the social protection system

The first observation with regard to the social security system is that to be covered by the system requires having a job in the formal sector. To add to this, to be able to benefit from the recently-established unemployment insurance scheme, one has to have worked similarly in the formal sector. It goes without saying that such a system excludes those without a connection to the formal labour market (as seasonal or casual workers). Considering that approximately one out of four workers in Turkey are casual employees, the share of vulnerable groups with respect to social protection is therefore quite large.

The second equally important observation is that the above presentation has not provided any information with regard to the service quality and the efficiency level of the whole protection system. The satisfaction level has not been questioned in details. In connection with this, the effectiveness of the service delivery should also be analysed. And finally, attention should equally be given to the issue of the efficiency of service delivery.

3 PENSIONS[3]

3.1 Evaluation of the current structures

3.1.1 Public-private mix

Institutions providing pension schemes in Turkey are:

- The Pension Fund (Emekli Sandığı)
- The Social Insurance Institution (SSK)
- The Social Security Organisation of Craftsmen, Tradesmen and Other Self-Employed (Bağ-Kur)
- Private Funds

Emekli Sandığı covers active and retired civil servants and is under the control of the Ministry of Finance. SSK and Bağ-Kur are both under the control of the Ministry of Labour and Social Security, the first covering those working in private firms and blue-collar public workers, and the second covering the self-employed. All three institutions are public and are under the legal obligation to provide insurance service to the population at large. The pension system comprising these three is a state-managed scheme that pays, at least at a theoretical level, a benefit financed on a pay-as-you-go basis. As noted in Chapter 2, these administrations' responsibility is to provide social security at a general level, pensions and health care being its major components. Those working either in the public or in the private sector are required to join their respective social security systems. However, the existence of those working in the informal sector, and thus not under any security system, indicates that the present structure is unable to identify and enforce compliance from a large amount of paid workers who do not contribute to the pension system; to this one should also add a rather large amount of unpaid (family) workers especially in rural areas. Furthermore, the collection rates in SSK and Emekli Sandığı are rather low, causing severe financial burdens to the state.

With regard to private funds, on the other hand, we observe a set of institutions providing coverage either individually or to members of institutions/organisations. These institutions might either be juridical entities usually tied to trusts, or private insurance companies. Individuals may join into a pension scheme on a voluntary basis. Private schemes are therefore seen as supporting the compulsory system and having a complementary function. Therefore, those who join a private pension scheme continue to contribute to one of the three public schemes. By 2001 the government started to construct the legal framework for a privately funded pillar in the pension system, with the aim of offering a variety of additional coverage

[3] In the preparation of this Section the report *Sosyal Güvenlik: Özel İhtisas Komisyonu Raporu* has been used widely. See also Tuncay and Alper, 1997; Koray, 2002.

schemes without impacting the financial bottom line of the public coverage. As a secondary advantage, the voluntary scheme is expected to contribute to increased savings (and thus the capital market), while providing opportunities for better pensions for individuals.

The private pension scheme is designed in such a way that it will be under the regulation and inspection of the state through the Undersecretariat of Treasury (which will mainly be responsible in granting permission to private pension companies) and the Capital Markets Board (which will mainly be controlling the investment policies of private pension companies). Thus, the two institutions aim at

- Developing an effective regulatory and supervisory framework to protect both beneficiary's rights and financial viability;
- Setting out investment rules and risk management systems;
- Forming effective monitoring (through an information technology structure and information disclosure rules);
- Introducing a tax incentive to increase individuals' participation.

Contributions are constrained so that they shall not be above 10 percent of the gross wages of contributors. Although the tax system provides incentives for joining such schemes (contributions up to 10 percent of wage earnings with a ceiling of 50 percent of the annual minimum wage are tax exempt), Turkey should move the entire tax structure closer to international norms, ensuring a set of tax advantages that will provide clear incentives in favour of longer-term savings instruments.

Regulations with regard to the operationalisation of the private pension scheme have recently been completed (as of 28th of February, 2002), and the application procedure for companies willing to operate private pension schemes was later announced (as of 6th of April 2002). The Undersecretariat of Treasury, the institution in charge of the regulation of the private pension scheme, is in the process of evaluating the applications of the companies.

The public institutions provide an all-encompassing social coverage that includes, apart from pensions and health services, invalidity payments, monthly salaries to the dependents of the insured after his/her death, and aid following the death of the insured. Private insurance coverage depends of course on the terms of the agreement.

Although casual observations indicate that by and large elderly people's income depends mainly on the three public schemes, reliable statistics to determine the exact breakdown are unavailable. In passing, one should also note that both the family institutions and the more extended family ties (kinship), along with other social networks (neighbourhood, co-locality etc.), provide a wide range of social support that also includes the elderly (Buğra, 2001). People who live below or close to the poverty line manage to

survive through such networks. In addition, in low-income families, the number of children is higher, as children are seen as security for old age.

By the year 2000, the proportion of the population covered by the social insurance system was given as approximately 90 percent (86 for those covered by social insurance programs with health care systems). The detailed breakdown of the population under coverage is given in Table 3.1, where the total number of pensioners for the year 2000 appears as close to six million, out of which only 71 thousand are covered by private schemes (the bulk of these private schemes are under the life insurance packages of health insurance companies, the remaining being under the coverage of foreign private pension companies). One may therefore conclude that security in old age is by and large secured by the public sector. The table also makes clear that the balance between active and passive insured indicates a rather negative picture: the ratio of active insured per passive insured has been fluctuating at around 2. Similarly the dependency ratio (the total number of pensioners and dependents to active insured people) has been close to 4. It goes without saying that those who are currently responsible for paying their premiums constitute a rather low percentage of the grand total that benefits from social insurance programs.

This said, one should raise concern with regard to the coverage percentage for the pension (90 percent) and the health care (86 percent) systems. Because of double counting, it is feared that these figures are upwardly biased. Double counting seems to be occurring due to the following two reasons: (i) The *a priori* estimation of the dependency ratio might be a realistic one if only one individual (the husband *or* the wife) works, but an unrealistic one if both the husband and the wife do work together. (ii) If one insured changes a system (say from Bağ-Kur to Emekli Sandığı) and fails to report this, he or she can be double counted.

Finally with regard to the financial institutions, capital market and the banking sector, until the recent February 2001 crisis, the finance sector was largely unregulated, but since then efforts have been under way to clarify the regulatory framework.

Table 3.1. Coverage of the pension schemes (in thousands)

INSTITUTIONS	1998	1999	2000
EMEKLİ SANDIĞI IN TOTAL	**9,320**	**9,566**	**9,766**
1.Active Insured	2,072	2,118	2,164
2.Pensioners	1,173	1,257	1,297
3.Dependants*	6,076	6,191	6,305
4.Active Insured/Passive Insured (1)/(2)	1.77	1.69	1.67
5.Dependancy Ratio (3+2)/(1)	3.5	3.52	3.51
SSK IN TOTAL	**33,373**	**32,943**	**34,140**
1.Active Insured	5,323	5,031	5,283
2.Voluntary Active Insured**	910	901	844
3.Active Insured in Agriculture	228	194	185
4.Pensioners	2,931	3,149	3,340
5.Dependants*	24,380	23,668	24,488
6.Active Insured/Passive Insured (1+2+3)/(4)	2.2	1.95	1.89
7.Dependancy Ratio (5+4)/(3+2+1)	4.23	4.38	4.41
BAĞ-KUR IN TOTAL	**13,220**	**13,876**	**15,036**
1.Active Insured	1,911	1,940	2,173
2.Voluntary Active Insured**	201	264	264
3.Active Insured in Agriculture	797	861	876
4.Pensioners	1,105	1,180	1,277
5.Dependants*	9,207	9,632	10,446
6.Active Insured/Passive Insured (1+2+3)/(4)	2.63	2.6	2.59
7.Dependancy Ratio (5+4)/(3+2+1)	3.55	3.53	3.54
THE PRIVATE FUNDS IN TOTAL	**318**	**333**	**271**
1.Active Insured	78	79	78
2.Pensioners	66	69	71
3.Dependants*	175	185	121
4.Active Insured/Passive Insured (1)/(2)	1.18	1.14	1.1
5.Dependancy Ratio (3+2)/(1)	3.1	3.22	2.45
GENERAL TOTAL	**56,632**	**56,718**	**59,213**
1.Active Insured	9,384	9,167	9,698
2.Voluntary Active Insured**	1,111	1,166	1,108
3.Active Insured in Agriculture	1,025	1,055	1,061
4.Pensioners	5,274	5,654	5,986
5.Dependants*	39,838	39,676	41,360
6.Active Insured/Passive Insured (1+2+3)/(4)	2.18	2.01	1.98
7.Dependancy Ratio (5+4)/(3+2+1)	3.92	3.98	3.99
SOCIAL INSURANCE COVERAGE WITH RESPECT TO HEALTH SERVICES* **	**53,691**	**53,807**	**56,487**
GENERAL POPULATION IN TOTAL***	**63,864**	**64,815**	**65,784**
RATIO OF INSURED POPULATION (PERCENT)	**88.7**	**87.5**	**90**
RATIO OF INSURED POPULATION WITH RESPECT TO HEALTH PENSION (PERCENT)	**84.1**	**83**	**85.9**

Source: *8th Five-Year Development Plan,* Emekli Sandığı, SSK, Bağ-Kur, SPO

* Estimation

** Dependents of voluntary active insured have been considered within the insurance coverage.

*** Active and passive insured, subject to Laws No 1479 and 2926 and their departments have been considered within health insurance.

**** Provisional population estimates, according to the results obtained in the year 1997.

3.1.2 Benefits

After it was seen that, with the elimination of minimum age requirements in 1992, all three schemes faced severe financial crises (the average actual retirement ages were 47 for SSK and 48 for Emekli Sandığı), with the 1999

reform programme the minimum retirement age was redefined as 58 for women and 60 for men. The political cadre finally acknowledged that no security system could sustain a situation in which people are spending more time collecting benefits than they spend contributing to the system (life expectancy is now 69 years). The age requirement of 58 and 60 has been set for new entrants, whereas current contributors are allowed a gradual transition period (starting with a minimum retirement age of 38 (women) and 43 (men) for those who are less than two years away from retirement and increasing to 52 (women) and 56 (men) for those who are more than ten years away from retirement).

The minimum contribution period was also redefined with the 1999 reform. This period was defined as 20 years for SSK and 25 for Bağ-Kur and Emekli Sandığı (for both women and men).[4]

The determination of the benefits for the three systems as of today is as follows:

- For SSK and Bağ-Kur: New entrants after the 1999 Reform Programme will receive a 3.5 percent accrual rate for the first ten years, a 2 percent accrual rate for the next 15 years, and a 1.5 percent accrual rate for each year thereafter. (For example, the replacement rates for 10 and 30 years would be 35 and 72.5 of the reference wage, respectively.)
- For Emekli Sandığı: (The 1999 Reform Programme brought no change) Beneficiaries will receive 75 percent for their 25 years plus 1 percent for each additional year of the reference wage.

The reference period for benefits after the 1999 reform is the full contribution period for SSK and Bağ-Kur and the last year for Emekli Sandığı. The reform provided (for SSK and Bağ-Kur) a gradual expansion of the reference wage period to the full contribution history. As such, the reform aimed at establishing an equilibrium between contributions and benefits and removing the incentive to under-report early earnings in order to minimise contributions and to over-report during their last years, on which benefits were calculated.

Prior to 1999, contribution rates to social security institutions were fluctuating at around 30-35 percent: 33.5 percent for SSK (20 percent for pensions, 12 percent for health care and 1.5 percent for other expenses), 35 percent for Emekli Sandığı (combined for both) and 32 percent for Bağ-Kur (20 percent for pensions and 12 percent for health care). As of today, the contribution rates for SSK and Emekli Sandığı remain intact, but for Bağ-Kur the contribution rates now depend on the insured's choice of the initial layer from a set of 1-12 layers. Pension indexation, which was generally based on civil service wage increases, but also subject to political manipulations, was replaced following the 1999 reform programme by

[4] The minimum contribution period goes down to 12.5 years for SSK and to 15 years for Bağ-Kur for those who are above 50 (women) and 55 (men) years old.

indexation to the consumer price index. The ceiling on SSK contributions was substantially raised to four times the minimum contribution base. The ceiling will also be automatically indexed to the consumer price index and the real GDP growth rate.

The pension system in the country as of today does not incorporate any "social" elements such as child-rearing benefits or insurance periods granted for education. The benefits one would get at his/her retirement are only a function of the amount of contributions made to the system (see above).

With regard to private (life insurance) pension schemes, their terms change from one insurance company to another.

The system has so far fostered high intergenerational inequities, as younger participants have contributed to a non-sustainable system. It has not so far addressed the broader needs of low-income workers, since low-income workers may not be able to accumulate enough savings under the compulsory retirement system to provide themselves with an adequate income level for old age. In should also be noted that a substantial amount of people work in the informal sector, or as unpaid (family) workers, with no coverage at all.

When the issue of poverty among elderly people is raised, the following information might be of help: Based on the income distribution study of 1994, Erdoğan (1997) calculated that among those below the poverty line, defined as the minimum required food expenditures, 4.23 percent corresponds to people 65+ years old.

3.1.3 Financing of the pension system

The pension system in Turkey as of today continues to be a major fiscal burden on the budget. The transfers that have been made to social insurance institutions with distorted actuarial balances by the Government Budget fluctuate at around 2 percent of GDP. Table 3.2 provides information on the revenues and expenses of the public social insurance scheme. There is an obvious improvement in 2000 (due to the 1999 reform) and deterioration in 2001 (due to the 2001 crisis, which made it difficult to collect premiums and increased the expenses on insurance and health services). The improvement that was observed in 2000 can be taken as a signal that the reform initiative of 1999 made a positive impact over the financial burden of the pension scheme in the country.

Table 3.2. Benefits and Revenues of Public Social Security Systems as percentage of GDP

	1999	2000	2001*
REVENUES	6.1	6.4	6.5
Premiums	5.3	5.3	5.4
Other	0.8	1.1	1.1
EXPENSES	9.1	8.4	9.0
Pensions	6.7	5.9	6.4
Health	1.6	1.7	1.8
Other	0.8	0.8	0.8
REVENUES-BENEFITS	**-3.0**	**-2.1**	**-2.5**
SSK	-1.5	-0.4	-1.0
Bağ-Kur	-0.8	-0.7	-0.6
Emekli Sandığı	-0.7	-0.9	-0.9
BUDGET TRANSFERS	**2.8**	**1.9**	**2.0**

Source: *2002 Government Programme.*

* Estimation

As noted above, the premium appropriation rate has been low, thus putting extra pressure on the system: The rate was around 85 percent for SSK and 56 percent for Bağ-Kur, meaning that both institutions were unable to collect fully the revenues declared by employers. With such low rates, any pension system will be unable to generate revenues. Furthermore, governments in the past occasionally pardoned these debts, as a part of their rent-distribution policy. As a result, people developed an expectation for their debts to be waived in the future. Similarly, governments have also decided to ease those who were in debt by allowing them to make their payments in instalments.

Although estimates indicate that the residual deficit of the public insurance bodies may go down to a level of 1.5 percent of the GNP in the medium term, the deficit may climb to some 5 percent of GNP by 2050, due to an expected increase in life expectancy and an expansion of the coverage, under the assumption that no further changes would be made in the system (on which, see more below).

3.1.4 Incentives

The high level of unregistered employment suggests that, on the one hand, there is a lack of implementation of mandatory insurance and that, on the other hand, there is a lack of incentives to join the system. The private pension insurance programme does provide a limited incentive, as noted above.

The high share of the informal sector in the economy should further be investigated in order to provide an answer to the high prevalence rate of

non-registration. Studies suggest that in addition to petite-corruption types, where firms can manage not to be detected by remaining informal (and thus employing unregistered workers), the government may not have the will to push all those in the informal sector into the formal one, as this move could increase labour costs and reduce the competitiveness of the Turkish exports (textile being a typical example). (See, *e.g.*, Özar, 2000.)

Coverage

In 2000, the proportion of the population covered by the social insurance systems was given as 90 percent. But, as already touched upon, the fear is that this ratio is upwardly biased

The abundance of unpaid family workers (especially in agriculture) is still an important problem area. It is estimated that throughout the country the ratio of unpaid family workers to total employment is close to 30 percent. These people (around 6 million), are, by and large, not covered by any social security system. Attention should be paid to the fact that women account for more than 60 percent and men for about 10 percent of the working population who are unpaid. As of 2000, out of approximately 14 million paid workers only about 10 million are actively insured, leaving around 4.5 million uninsured. Some of these people who are employed in the informal sector might already be on retirement but continue to work, but others may be forced to work in the informal sector with no social security coverage. As already noted, the existence of a large informal sector in the country keeps a substantial amount of working people out of the pension system. The estimates indicate that a total of around 4 million workers are in the informal sector and have no social coverage.

Therefore, a great majority of unpaid (family) workers and those in the informal sector are excluded from the system, and women are likely to be more affected than men. The gender inequality in the pension system is also apparent when one considers the actively insured population. Considering the entitlements that women receive independent of men in their families, women constitute a proportion of only 17 percent of the total insured population (see, *e.g.*, Topal and Özbilgin, 2001).

Public acceptance of the system

Although there is no recent study on people's attitudes to the pension system in general, the following set of problems has been on the agenda and under press coverage. A combination of these may well be affecting people's attitudes towards these institutions:

- There are intergenerational equity problems.
- The three different pension systems provide different coverage.

- The administrative and financial efficiency of the system has been questioned—the lack of transparency and accountability accentuating the claims on inefficiencies.
- There exist petite-corruption cases.
- An important portion of business cannot be forced to comply.
- Premium debts have been subject to pardon, implying patronage-networks, therefore creating unfairness to those who paid their premiums in time.

3.2 Evaluation of future challenges

3.2.1 Main challenges

The main challenges can be categorised as follows:

- As already discussed, all the three social security institutions were severely affected by the elimination of the minimum age at retirement in 1992. This problem was aggravated by the fact that the contribution period for collecting a pension was kept at low levels, as low as 10 years for some cases. The 1999 reform programme has been to some extent effective in tackling the problems that created financial burdens in the system. However, the relation between contributions and benefits is still far from the ideal case where the ratio of the average benefit to the average contribution should be equal to the ratio of the contribution period to the retirement period. Furthermore, with increasing life expectancy, the system in the future will aggravate its burden on the general budget. The 1999 reform extended the base for calculating pension benefits to the full working life of the contributor for SSK and Bağ-Kur, excluding Emekli Sandığı. The case of Emekli Sandığı is likely to continue to put financial pressure to the system, apart from its being subject to fairness discussions.
- Coverage and compliance represent an equally important structural problem.
- The technological competence level of the institutions is rather low. As an insured person necessarily means that there is a file to be updated during his/her lifetime and possibly longer if this person has an unmarried female child, there is an immense load of information for these institutions to deal with, yet none of them is fully computerised. To add to the current situation, as with the 1999 reform for both SSK and Bağ-Kur, the base for calculation of pension benefits was set as the full working life, the system's capacity to generate, store and categorise information and share this information with other units is a challenge, as the technological level and human qualifications of the system appear to be rather low.
- The system is open to political manipulations.

- The current situation of providing both health insurance and pension coverage seems to create an administrative burden; the management, finances and accounting of pensions and health insurance are effectively merged in a manner that inhibits efficient and transparent operation.
- There seems to be a long list of differences (procedures, benefits, etc.) among the three schemes, causing inequities among participants.
- The system suffers from administrative and financial inefficiencies; the system as a whole is not transparent and accountable to third parties.
- A co-ordination between the three institutions seems to be far from a required level.

3.2.2 Financial sustainability

Although, as presented in the above section, the burden of a residual deficit on the budget will go down in the medium term, projections are such that it will go up to some 5 percent of GNP by 2050, as life expectancy will go up and coverage will expand (*Turkey: Country Economic Memorandum—Structural Reforms for Sustainable Growth*).[5] Future reforms should therefore consider this head-on, as otherwise the system's financial sustainability will be questionable. It goes without saying that in the long run a further reform programme must be proposed to either increase retirement age or to cut benefits and/or increase contributions, or a combination of these, should the system maintain its financial sustainability.

3.2.3 Pension policy and EU accession

On the issue of EU accession, for full harmonisation with the EU, the social security legislation should be extended to cover all employees, both paid and unpaid. Attention should also be given to the case of foreigners working in the country—the current situation being that foreigners decide whether or not to take long-term insurance policies on a voluntary basis. This should be compulsory.

Currently the Ministry of Labour and Social Security is working on the modifications that need to be introduced to the social security legislation in order to harmonise with the EU acquis on social policy and co-ordination of social security (*Turkish National Report for the Adoption of the Acquis*).

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[5] In passing, one should note that the Treasury estimates of the financial sustainability of the system as more optimistic. The Treasury's projections suggest that the social-security-deficits-to-GNP ratio will decline gradually to 1.52% by year 2011 and then will reach 2.81 by the early 2030s. For a critique of this approach see the above-mentioned Report, p. 35.

3.3 Evaluation of recent and planned reforms

3.3.1 Recent reforms and their objectives

As already noted, the September 1999 programme aimed at giving the social insurance systems a sustainable structure by taking into consideration actuarial balances to solve current problems.

The 1999 Reform programme, initiated mainly by the World Bank and the ILO, aimed at restructuring the pension scheme and the health sector in the country (as well as social services and social assistance). The financial burden of the pension system on the budget provided a clear incentive for the bureaucracy and the politicians alike to accept the reform, despite the fact that this would make millions of insured people worse off. The technical support of the World Bank was, and continues to be, instrumental in the realisation of the reform package.

By this Law (which also introduced unemployment insurance, and thus it is usually referred to as the "Unemployment Insurance Law"), as already mentioned, the minimum retirement age was increased to 52 for women and 56 for men, for those who are already within the system. For those who are newly entering, the retirement age for women was set at 58 years and 60 years for men. Furthermore, the minimum premium payment period required to gain the right of retirement has been prolonged, the average ratio granting pensions has been pulled down, and the reference period considered for calculating pension has been designated as being the whole working period (with the exception of Emekli Sandığı).

This law was launched as the first phase of a two-phase reform programme and was targeted at easing the financial burden of the system on the budget, lowering the residual deficit to around 1.5 percent of GNP per year over the medium term (recall the current deficit fluctuates around 2.5 percent).

The second phase of the reform programme, still in progress, considers the administrative and institutional aspects of the social security system, and the harmonisation of the three schemes, namely SSK, Bağ-Kur and Emekli Sandığı. More specifically, the second stage will focus on:

- The introduction of supplementary and voluntary private pension schemes;
- Steps to increase insurance coverage;
- Steps to increase compliance;
- Separation of health insurance and pension schemes;
- Integration of public pension systems;
- Establishment of an information technology structure that will enable the systems to follow individual insured members;

- Ensuring the autonomy of the public pension systems, so that the overall transparency and efficiency of these institutions will increase.

Thus, the second stage can be thought of as an attempt to improve the administrative and financial structures of the social insurance system of the country.

3.3.2 Political directions of future reforms

The following items emerge as the areas in which future reform initiatives have to be given:

- ✓ Financial balance needs to be achieved, ensuring a longer-term sustainability by either raising contribution periods, lowering benefit periods, raising contribution rates, lowering benefits rates, or a combination of these.
- ✓ Coverage and compliance should be improved.
- ✓ Broader needs of low-income workers need to be addressed.
- ✓ Progressive integration of the three funds under a single administration should be designed. Developing uniform norms and standards and their integration will enhance the efficiency and effectiveness of the overall system.
- ✓ It goes without saying that the three pension institutions will need to integrate their existing databases into a shared information system.
- ✓ Administrative and institutional structures of the pension system must be rendered more efficient and effective; the whole system should be transparent and accountable and should have autonomy, free from all possible political interventions. Increased transparency and accountability should have a positive impact on the trust of individuals in the system, an incentive towards their compliance.
- ✓ The administrative separation of pensions and health insurance will help improve service to contributors and beneficiaries.
- ✓ A regulatory framework should be operational for voluntary-funded private pensions system.

3.3.3 Conclusions

The 1999 reform programme should be seen as a starting point to the reform of the whole pension system in Turkey in a radical way. The system still continues to constitute a major fiscal burden, impairing the country's macroeconomic stability.

Coverage and compliance remain the two interrelated issues that need immediate attention, as the 1999 reform did not address this dimension, since it was designed to target the most urgent and immediate issue, *i.e.* dealing with the financial burden. The system still has problems in fostering

high intergenerational inequities, as younger participants contribute in a non-sustainable manner. The problem of low-income workers should be considered, as they may not be able to accumulate enough savings under the compulsory retirement system to provide for an adequate income level during old age. The gender inequality that is present in the current system should also be given specific attention.

The system should consider the private pension system, in terms of its harmonisation with the public one, its legal framework and the incentive structures. To add to these, administrative and institutional improvements are in need towards increasing efficiency, transparency and accountability.

4. POVERTY AND SOCIAL EXCLUSION[6]

4.1 Evaluation of current profiles of poverty and social exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

In the *8th Five-Year Development Plan* it is indicated that "[d]ue to urbanisation, migration, high inflation, the deterioration of income distribution, poverty and changes in the cultural structure of families, the need for social assistance and social services is increasing fast" (p. 121).

To alleviate poverty, the *Plan* targets, first, to reduce inequalities in income distribution and between regions to enable each segment of society to have a fair share of an increase in welfare benefits (p. 111). Secondly, the *Plan* aims at making social services and assistance more accessible to the poor and the needy ones. With regard to the first target the *Plan* does not provide a detailed path, and with regard to the second it acknowledges "there are important problems stemming from disorganised institutional and financial structures, a lack of co-ordination and collaboration among institutions, constituting hindrances to the smooth implementation of social services" (p. 121). In both the *8th Five-Year Development Plan* and *2002 Government Programme*, the central government, after reiterating the increased importance of the poverty issue and the problems associated with the lack of co-ordination and collaboration, underlines the need to establish a so-called "Social Services Master Plan". Combating poverty certainly occupies a place among social policy aims, at least at the discursive level. Furthermore, local governments and a set of NGOs have also been echoing the importance of the poverty issue in the case of Turkey.

With regard to social exclusion, however, there is no official (central government's) acknowledgement and thus no definition of this problem at a national level. This said, however, the central government has been providing services and aid to, and taking measures for, those people who are excluded, or are at the margin of being excluded, from society.

At this point, attention should be given to the efforts of providing services to disabled persons, improving women's status, taking care of the children

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[6] In the preparation of this Section the reports *Sosyal Hizmetler ve Yardımlar: Özel İhtisas Komisyonu Raporu, Çocuk: Özel İhtisas Komisyonu Raporu*, *Gelir Dağılımının İyileştirilmesi ve Yoksullukla Mücadele: Özel İhtisas Komisyonu Raporu* and *Sosyal Güvenlik: Özel İhtisas Komisyonu Raporu* have been widely used. See also Akder and Güvenç (2000), Oğuz and Pınarcıoğlu (2001), Şenses (2001, 2002f), Sönmez (2002) and the report prepared by the Social Democrat People's Party [Sosyal Demokrat Halk Partisi] (2002) for recent and current discussions on the poverty issue in Turkey.

and elderly who are in need of support, and of giving support to inmates following their imprisonment terms. Especially in the last years there have been attempts and institutional (re)formations to improve the status of women (*e.g.* the *Directorate General on the Status and the Problems of Women*).

Although these issues have been formally acknowledged and are being addressed (the question whether the services provided are satisfactory is another matter), there has been no official acceptance of the possibility of people's being socially excluded because of their ethnic and/or religious background or their sexual choices, or their carrying contagious diseases (*e.g.* HIV). Some local governments and a few NGOs have in fact raised these issues, but limitations in democratic rights (*e.g.* the ban on education in Kurdish) continue to constitute a barrier in fully addressing these issues. The Copenhagen criteria that Turkey has to adopt in its accession to the EU are expected to clear the way. In fact, the government's recent acceptance of a set of rights at the end of 2002 summer (the major one being the lifting of the death penalty and the second one being the ease on the ban on the Kurdish language) is indeed a sign in this direction. Note, in passing, that the majority, though perhaps not a strong one, of the society supports Turkey's access to the EU (see *Eurobarometer21*; Çarkoğlu and Kirişçi, 2002).

4.1.2 National definitions of poverty and social exclusion

With regard to poverty, four different poverty incidence figures can be provided, all based on the 1994 Household Income and Consumption Expenditure Survey (see Table 4.1). (For a detailed discussion see *Turkey: Economic Reforms, Living Standards and Social Welfare Study*.) As the table makes clear, absolute poverty is low but economic vulnerability is widespread. For absolute poverty, two methodologies can be applied: the first is the internationally acknowledged one-dollar-a-day per capita (at 1985 PPP prices) and the second is the local cost of the minimum food basket; the corresponding poverty incidences are found to be 2.5 and 7.3 percent, respectively. Both the *8th Five-Year Development Plan* and the *2002 Government Programme* give reference to these figures that position Turkey in the range of countries with a small incidence of absolute poverty.

However, when attention is shifted to those below the economic vulnerability line, which is equal to the food line plus an allowance for non-food items, more than a third of the whole population (36.3 percent) are found to be economically vulnerable. The fourth measure of "relative income poverty", which is the percentage of those whose income is below one-half of the monthly median expenditure per equivalent adult, is computed as 15.7 percent. However, the official documents do not refer to such measurements. As the recent survey on income distribution and poverty was conducted in 1994, we are unable to assess the current situation

clearly. Note in passing that the GINI coefficient used to be 0.43 in the year 1987, indicating that the system got more unequal from 1987 to 1994.

Table 4.1. Poverty Indices in Turkey under Different Methodologies, 1994

Methodology	Poverty Line	Poverty Incidence
Absolute poverty (international standard)	One-Dollar-a-Day per capita at 1985 PPP prices	2.4%
Absolute poverty	Local cost of minimum food basket	7.3%
Economic vulnerability	Local cost of basic needs basket (inc. Non-food)	36.3%
Relative income poverty	One-half of national income	15.7%

Source: *Turkey: Economic Reforms, Living Standards and Social Welfare Study*, 2000.

The recent study *Turkey; Economic Reforms, Living Standards and Social Welfare Study* by the World Bank investigates at length the issue of poverty and vulnerability and comes up with the following findings:

- Education is the single characteristic with the strongest correlation to poverty risk;
- Labour market status is another important correlate of poverty;
- There are big differences in poverty incidence among regions of the country;
- There are only small differences in vulnerability and poverty among urban and rural areas.

Furthermore, the *United Nations Human Development Index* reduced Turkey's position of 69 in 1995 to 85 in 1998 (*Human Development Report 2000*), although Turkey has made progress in the said period: HDI figures for 1980, 1985, 1990 and 1995 are, respectively, 0.588, 0.639, 0.682 and 0.715 (*İnsani Gelişme Raporu 2001*). It is clear that these improvements were not sufficient enough to move Turkey to higher levels.

As already noted, the last research on personal income distribution was conducted in 1994. The SIS has recently launched a new personal income distribution study, which is to be completed by the year 2003. This research will eventually answer many questions about income distribution data. Daily superficial observation seems to indicate that income distribution has further deteriorated. Therefore, the fact that Turkey is a country with large and entrenched inequalities across people, social groups and regions is to be taken very seriously.

A complementary data set, borrowed by Gürsel et al. (2001), addresses the issue of basic distribution properties of income components, which is presented in Table 4.2.

Table 4.2 Sources of Income

Income Components by Deciles Groups (OECD Scale)			
	Bottom 30%	Middle 40%	Top 30%
Labour Income			
1987	0.013	0.313	0.584
1994	0.095	0.316	0.589
Capital and Self-Employed Income in Agriculture			
1987	0.037	0.238	0.725
1994	0.054	0.262	0.684
Capital and Self-Employed Income			
1987	0.012	0.127	0.861
1994	0.031	0.203	0.766
Interest Income			
1987	0.055	0.219	0.726
1994	0.032	0.087	0.881
Transfer Income			
1987	0.05	0.188	0.762
1994	0.018	0.187	0.796
Private Transfer			
1994	0.018	0.164	0.818
Government Transfer			
1994	0.019	0.173	0.808

Source: Gürsel S. H. Levent, R. Selim, Ö. Sarıca, *Türkiye'de Bireysel Gelir Dağılımı ve Yoksulluk; Avrupa Birliği ile Karşılaştırma*, 2000.

Comparisons in or between periods reveal the following conclusions:

- Non-agricultural capital and self-employment income (NCSI) was the most unequally distributed income component in 1987 as well as 1994, but in 1994 the NCSI inequality decreased compared to 1987.
- In interest incomes, the share of the highest 30 percent income group in total interest income was 72.6 percent in 1987, and it increased to 88 percent in 1994. In 1994, agricultural capital and self-employed income were distributed less equally than in 1987.

- There was not any significant distribution change in labour income between these two dates. Moreover, this type of income had the highest stability in distribution among the income types.
- The essential fact about the transfer income inequality is that the largest share belongs to the top 30 percent. This is a situation in sharp contrast with the developed welfare states.

With regard to social exclusion, on the other hand, although there is no official definition, there are in passing references when the problems of women, disabled, elderly people and children in need of support are referred to.

The following groups can be considered as vulnerable to discrimination for a set of economic, cultural, ideological and religious reasons.

- Ethnic minorities (*e.g.* Gipsy, Kurdish—more information to be presented below);
- Nomadic people with no IDs; their number is estimated to be minimal (a few thousand);
- Unemployed and underemployed people (see Chapters 1 and 4);
- Homeless people (no reliable information);
- Street children (no reliable information—though sporadic media coverage mentions a total figure of five to ten thousand for the city of Istanbul);
- Fundamentalist people (the reference here should exclusively be given to those women who are not allowed to go to schools because of their insistence of wearing a head scarf—but there is no reliable information with regard to their number);
- Non-Muslims (1 to 2 percent of the total population);
- Alevi Muslims (although the Government states that the Directorate of Religious Affairs treats equally all who request services, some groups claim that the Directorate reflects solely the beliefs of the Sunni Islamist mainstream to the exclusion of Alevi adherents);
- Women living in rural and squatter areas with low education levels (see below);
- Disabled people (see Chapter 2; the total number of disabled people is estimated to be between 3 and 7 million—5 to 10 percent of the population, roughly speaking);
- Elderly and young people who are in need of social support (no reliable information);
- Those who have no health insurance and are unable to pay for their health expenses (approximately 10 percent of the population is not covered by any health insurance scheme);

- People who are below the absolute poverty lines (see above);
- Homosexuals and transsexuals (no reliable information);
- Sex workers (no reliable information);
- People carrying contagious diseases (no reliable information);
- Illegal migrants (no reliable information).

These people are likely to be subject to discrimination in various ways. However, needless to say, social exclusion is a multi-dimensional reality, consisting of barriers to the labour market, poor income, lack of educational opportunities, improper health care, and an environment where human rights are not completely respected.

The 18 EU indicators of social exclusion are presented below.

Table 4.3: 18 EU Indicators of Social Exclusion

	Indicator	Year	OECD Scale	EUROSTAT	State Institute of Statistics
1a	Risk-of-poverty rate after transfers by sex and age	1994	-	total :23 men: 23 women: 24 0-15 years: 29 16-24 years: 23 25-49 years: 19 50-64 years: 19 65+ years: 26	
1b	Risk-of-poverty Rate by activity status	1994	-	employed: 13 self-employed: 20 unemployed: 35 retired: 10 inactive/other: 22	
2	Distribution of Income S90/S10	1987	6.76	7.09	
	Distribution of Income S90/S10	1994	6.07	6.42	
	Distribution of Income S75/S25	1987	2.66	2.72	
	Distribution of Income S75/S25	1994	2.59	2.61	
3	Persistence of Risk-of-poverty	-	-	-	
4	Relative Risk-of-poverty Gap	1994	-	27	
5	Regional Cohesion (unemployment with respect to regions) (thousands) (urban – rural)	1995 1997	-	-	1086 – 521 1071 - 391
6	Long Term Unemployment Rate	-	-	-	
7	Persons Living in Jobless Households	-	-	-	
8	Early School leavers not in education or training (gross enrolment ratio) (both sexes – male – female)	1994 1995 1996	-	-	76.8–83.9–69.2 77.9–85–70.3 78.9–86.1–71.4
9	Life expectancy at birth	See Table 1.2.			
10	Self defined health status by income	-	-	-	

	level				
11	Dispersion around the Risk-of-poverty threshold	-	-	-	
12	Risk-of-poverty rate anchored at a moment in time	-	-	-	
13	Risk-of-poverty rate before transfers	-	-	-	
14	GINI coefficient	1987			0.437
		1994			0,492
15	Persistence of Risk-of-poverty (below 50% of median income)	-	-	-	
16	Long Term Unemployment Share (unemployed people in thousands)	1995 1996 1997 1998 1999		-	574 610 585 590 483
17	Very long term Unemployment Rate (unemployed people in thousands)	1995 1996 1997 1998 1999		-	294 328 291 252 201
18	Persons with low educational attainment	-	-	-	

Lack of data makes us unable to provide a detailed picture on the basis of 18 Euro indicators. However, even if data were available it would not be possible to get the full picture due to the existence of a large informal sector.

4.2 Evaluation of policy challenges and policy responses

4.2.1 Inclusive labour markets

Unemployment has risen quite dramatically in the last year (at around 10 percent), mainly as a result of the 2001 crisis, with negative short-medium-

long run impacts on the society's welfare. Another important aspect of the labour market in Turkey is the high proportion of the informal sector in the total economy (mainly in the textile sector). A large amount of workers work in the informal sector, with no insurance or pension coverage, and mostly in improper working conditions—though there is no reliable data on the informal labour market. Although there is no comprehensive study on Turkey, local surveys indicate that most people working in the informal sector live in squatter areas, and have difficulties in meeting the basic demands of their families. Gender segregation is also an important dimension in the labour market, and studies by and large indicate discrimination against women workers. (See *e.g.* Eyüboğlu et al., 2000.) Another important characteristic of the labour market in Turkey is the abundance of unpaid family workers. The ratio of unpaid family workers to total employment was 28.4 percent as of 1999, women workers representing a share of 64.2 percent and male workers 12.4 percent. Attention should also be given to the fact that, again as of 1999, the unemployment rate was 11.7 percent in urban and 3.4 percent in rural areas. All in all, these figures indicate that there are segregations in the labour market both in terms of gender and of the rural-urban dichotomy. Furthermore, when data on occupations are investigated, it is seen that women face considerable difficulties in finding jobs in the manufacturing or service sectors.

The *8th Five-Year Development Plan* sets out the following target with regard to the employment issue: "The employment rate shall be increased and unemployment reduced, by increasing productive investments and achieving stable economic growth" (p. 113). The *Plan* further underlines the necessity to support small and medium-sized enterprises on the basis of their employment potential and backing up the development of the industry sector by providing input. The *Plan* finally indicates that attention should be given to those groups that need special consideration, especially women, children and disabled persons. However, these challenges are formidable, and it seems that a proper answer can only be given by undertaking a structural reform programme.

4.2.2 Guaranteeing adequate incomes/resources

The United Nations Human Development Report for Turkey, *İnsani Gelişme Raporu 2001,* provides the information that the average and extreme malnutrition percentage in children below 6 years is around 10 percent. Furthermore, as of 2000, 18 percent of the population has no access to safe water, and 10 percent of the population has no access to adequate sanitation (*UNICEF Statistics*). Even these two data are indicative that, although the system does have a set of institutions (see below) to cope with the provisioning of adequate resources, their capabilities may not be of the required magnitude to provide basic subsistence necessities.

In that regard, *Turkey: Economic Reforms, Living Standards and Social Welfare Study* indicates that the government's social protection framework

is plagued by several problems, the first being that social assistance schemes are dispersed and disjointed, the second being that social insurance fails to reach the most vulnerable households, the third being that the social insurance system is fiscally unsustainable, and the fourth one being that the educational system does not provide enough access for the poorest.

4.2.3 Combating educational disadvantage

The UNDP Human Development Report for Turkey, *İnsani Gelişme Raporu 2001,* indicates that on the basis of the 1998 figures a percentage point increase in the literacy rate would increase the HDI by 0.002 and a percentage point increase in the schooling rate would increase the HDI by 0.001. The combined schooling rates through time indicate some improvement: From 51.1 percent in 1980, the rate went up to 56.4 in 1985, to 58.4 in 1990, and to around 60 percent after 1990. Since as of 1999 the literacy rate was around 85 percent and that of schooling around 61 percent, there is much room for increasing the HDI through investing in education. As the *8th Five-Year Development Plan* acknowledges, "[c]hildren out of the formal and adult education system work under inconvenient conditions both economically and socially, and their mental and physical health is affected adversely" (p.88).

According to 1999 data, the literacy rates for the population age 12 and over were 77 and 94 percent, for women and men, respectively. In 1999-2000 there were about 12.7 million students and 484 thousand teachers in 60 thousand public and private primary and high schools. However, the share of private schools in student numbers is only about 2 percent. Regarding informal education activities, about 3 million people have been trained at 6,531 public and private institutions. In 1999-2000, the enrolment rates were 10 percent in pre-school education, 98 percent in primary education, and 60 percent in secondary education, of which 23 percent was in vocational technical schools and 37 percent in general high schools (lycées). The average educational level of the population is as follows: 64 percent of the employed are primary and secondary school graduates, and 13.4 percent high school graduates. As of 1999, the share of university graduates in the population is only 4.3 percent.

As to the gender dimension, there are important discrepancies: Table 4.4 provides the schooling rates with a breakdown between women and men for the year 1998, clearly showing the gender dimension.

Table 4.4. Gender Breakdown of Schooling Rates, 1998

	Primary	Secondary	Lycée	University
Men	93.1	74.0	59.0	21.9
Women	88.3	53.9	42.2	14.7
Total	90.7	64.5	50.9	18.4

Source: SPO.

As a separate issue the number of schools for special education (for physically and mentally handicapped) is known to be much lower than what is needed.

4.2.4 Family solidarity and protection of children

Although it is common knowledge that family breakdowns are important in making women and children more vulnerable to social risks, reliable data on this issue is limited. Research on homeless/stray children indicate that family breakdowns are one of the important factors in explaining these children's positions.

The 1994 Household survey has identified a set of characteristics of the most vulnerable households. The survey suggested that the following facts were likely to increase poverty in households:

- Families with many children and extended families with many children;
- Single-parent families;
- An increase in unemployment would disproportionately affect families with many children.

More and more studies (see, for example, Buğra, 2001) underline the fact that the traditional welfare regime that is based on informal networks of reciprocity (*e.g.* family members, relatives, neighbours, members of ethnic and/or religious communities) plays an important role in supporting individuals in risk situations. Divorced families, single parents, abandoned/orphaned children, and divorced/separated women would therefore be more prone to poverty and social exclusion. But to what extent such informal networks will continue to exist is an important issue.

Governmental institutions, municipalities and NGOs (including trusts) have had a two-tiered strategy: To support and assist families and other social networks in order to prevent breakdowns and, in case they do break down, to provide support to the needy ones (women, children, etc.). In that regard, it should be noted that, however important the role the civil society

has been playing with regard to poverty alleviation, their contribution has been, and most likely will continue to be, a complementary one.

A recent important development in the education system was the increase in the duration of compulsory education from five to eight years (in 1997). The *8th Five-Year Development Plan* indicates that preparations are under way to further increase compulsory education to 12 years.

The same *Plan* sets out (p.91) its target for vocational-technical training as increasing professional standards, establishing functional co-operation with work life, and emphasising the need for further applied education. The plan also indicates the need to develop all sorts of extended education based on the approach of life-long learning.

The *Plan* also points to the necessity of extending pre-school education, reforming the higher education system, and using new techniques (such as the open university education), and technological facilities (computer technology). The *Plan* also underlines the importance of establishing co-ordination between private and public education institutions.

Given the fact that 1.7 percent of students are in private schools, improvements will depend on state funding. However, considering the fact that currently the share of social expenditures on total state expenditures is around 25 percent (compared to Spain with 48.3, Germany with 69.8, Finland with 55.3, Greece with 35.0, Argentina with 63.6—see *World Development Report*, 2001), a radical shift at policy level seems necessary, should the government really want to achieve these objectives.

The other side of the coin is child labour: it is estimated that 1 million children between 6 and 14 are at work, a third of them under 12. The World Bank project of *Turkey: Social Risk Mitigation* provides qualitative evidence on the withdrawal of children from school as a result of the 2001 crisis. Field visits were undertaken to Eastern Anatolia, Southern Anatolia, Central Anatolia, Istanbul slums, Ankara slums and the Black Sea region. When asked, the poor replied that because of the crisis they are not going to be able to send their children to school. Needless to say, this will have an adverse effect on the social capital of the country.

4.2.5 Accommodation

We have no reliable data on the number of homeless people, though one may expect the number not to be very high, because of strong social networks.

The *8th Five-Year Development Plan* estimates the number of houses to be built in the 8th plan period as 1.3 million and the need as 2.54 millions. The *Plan* further observes that the non-fulfilment of the housing requirement is leading to unauthorised construction to bridge the gap. Unfortunately, no accurate data are available on the amount of illegal buildings. It is estimated

that illegal buildings in Istanbul, Izmir and Ankara number around 2 million. To add to the severity of housing shortage, the 1999 Marmara and Düzce earthquakes that took more than 20 thousand lives also destroyed something like 100 thousand homes and work places.

The lack of sufficient housing, both as a basic need and as a very important consumption item, reflects the extent of poverty that many socio-economic groups experience. "Gecekondu", which is the Turkish version of squatter housing, provides shelter for the urban poor and "have-nots" in and around big cities (metropolises) and invades more and more rural (agricultural) land every day. Of the estimated total urban population of 37.8 million (that is, 60.9 percent of the total population) in 1995, nearly a quarter still live in gecekondu-type settlements. However, the formation of gecekondus has not been stopped due both to the scarcity of national financial resources and to rising poverty levels.

Apart from damaging the environment quality of cities, these illegal buildings have two impacts over poverty and social exclusion. The first is that it is now more difficult, if not impossible, to take measures against disasters, most notably earthquakes and fire in big cities. The second is that municipalities may have difficulties in bringing services, such as tap water, sewage and natural gas, to squatter areas, as a result of which people will lack basic necessities.

Although both the central government and local governments have been referring to the need for developing financing models to encourage housing production, especially to deal with the housing problems of low-income groups, not much progress has been achieved so far. Even though new financing models of housing have been introduced, such as the "Housing Development Administration" and the "Mass Housing Fund" (1984), as most of those who migrate to cities and who demand new shelters work in the informal sector, collecting taxes is almost impossible, thus jeopardising the financing of housing projects. Similarly, despite the fact that there is a continued emphasis on measures to be taken to prevent illegal buildings and squatters, patronage networks usually make these attempts ineffective.

A last point worth mentioning is the fact that Turkey prepared during Habitat II, under a close co-operation among a considerable number of public agencies and NGOs, a National Plan of Action, addressing the issues of human settlements in both urban and rural areas, including the assessments of shelter, infrastructure and service needs, the review of the effectiveness of existing urban policies, and the identification of issues and bottlenecks to local development that call for action. Issues pertaining to poverty alleviation and job creation, pollution reduction and environmental improvement, as well as community participation and new modes of governance are also addressed in the Plan. However, there has not been much progress with regard to its implementation.

4.2.6 Ethnicity

The ethnic issue has always been an important social and political problem and concern. Public opinion surveys indicate that there is a lack of confidence in non-Turks among Turks who constitute the overwhelming majority. Similarly, a recent survey by Çarkoğlu and Kirişçi (2002), for example, reveals that a majority of the society has a pro-Turk feeling and has a tendency to treat minority, especially non-Muslim, groups with prejudice**.**

More specifically, people from Kurdish origin have been subject to discrimination in some areas. Minority rights are strictly controlled, and some important ones are still illegal (*e.g.* education and broadcasting in Kurdish). Although it will be inappropriate to talk about social exclusion for the minorities, restrictions on and discrimination against ethnic minorities continue to persist, particularly for the Kurdish people (*Human Rights Practices Report on Turkey of the Department of State of US*).

Recent years have witnessed an increased debate on the minority issue stemming from ethnicity. Some, if not most, of these discussions have been the results of Turkey's attempt to join the EU. However, two recent surveys indicate that there is an important resistance from the society to the provision of such rights. More specifically, approximately half of the 1219 business people surveyed opposed lifting the death sentence and granting educational rights in Kurdish. (See Adaman et al., 2002; Çarkoğlu and Kirişçi, 2002.)

4.2.7 Regeneration of areas

Both geographic factors and urban/rural concentrations play an important role in explaining poverty and social exclusion. Table 4.5, reproduced from *İnsani Gelişme Raporu*, provides the human development indices (consisting of life expectancy, education, and per capita income) figures for the seven regions of Turkey as of 1997. There is a considerable gap between the Eastern and Western regions of Turkey.

Table 4.5. Human Development Index – Regional Breakdown

Regions	**HDI**
Marmara	0.801
Aegean	0.757
Central Anatolia	0.736
Mediterranean	0.713
Black Sea	0.694
South-East Anatolia	0.612
East Anatolia	0.612

Source: *İnsani Gelişme Raporu*, 2001.

In passing one should take note that as of 2001 the share of the agricultural sector in GDP was around 15 percent, while its share within total employment was around 45 percent. This is in conformity with the above table, as per capita income is one of the three components of the HDI, and as industry and services are more concentrated in the Western parts of the country.

With regard to the urban/rural differentiation, the 1994 household survey indicated that the ratio of per capita income in urban areas to that in rural areas was 1.92. Information with regard to the rural/urban dichotomy is further given by the difference between urban and rural population percentages of those who are under the absolute poverty line and those with the risk of absolute poverty. The absolute poverty ratio of rural and urban areas is 11.8 and 4.6 percent, respectively, whereas the ratio of the population under risk of poverty of basic consumption needs is 25.4 for rural areas and 21.7 percent for urban areas. It is further estimated that 73.1 percent of poor households are rural. About 73.5 percent of the poor earn their living from agriculture. In addition to agriculture, a large number of the poor are found in small family enterprises. Since there is no persistent long-term basis for rural development, the difference in the level of welfare between rural and urban areas is gradually increasing, and the migration of the rural population to big cities is leading to excessive aggregation, increased unemployment, and problems with regard to settlement, housing, environment, infrastructure, transportation, education, health and public security.

We are led to think that although rural areas are relatively poorer than cities, income distribution is more equal in rural areas. In fact the 1994 household survey results confirm this: in rural areas the income ratio of the

richest quintile household group to the poorest was 8.5, whereas in urban areas this figure was 11.9.

Further analysis of the 1994 Survey, as conducted in *Turkey: Economic Reforms, Living Standards and Social Welfare Study*, indicate that a significant share of total inequality in Turkey is explicable by differences in endowments, geography, and opportunities faced in the labour market. More precisely, it is found that regional factors explain 11 percent of all observed inequality in the country. The same study also claims that inequality between regions is growing: the share of overall inequality explained by differences in regional means is found to have grown by 10 percent between 1987 and 1994.

The *8th Five-Year Development Plan* targets two policies to address the issues of local/urban differences in poverty and social exclusion and of regional discrepancies: The first is to increase the productivity in the agricultural sector, through projects that aim at increasing the productivity and vocational guidance programs. The ongoing agricultural reform initiative should be understood within this framework. The second is to increase not only economic investments but also investments in education, health and social services in the Eastern and Southeastern parts of the country. The GAP project, a reference to which has already been given, is certainly a mega project towards that aim.

4.2.8 Other factors influencing poverty and social exclusion

As already discussed above, cultural and ideological reasons play a role in socially excluding or pushing to the poverty line some groups; of these one can mention ethnic minority people (Kurdish being the most numerous one), fundamentalists, homosexuals, sex workers (especially trafficking women), migrants and those carrying contagious diseases. The official public welfare service by and large does not cover these issues. There are, however, community based organisations and NGOs that have been trying to give support to these groups.

Furthermore, violence against women, particularly spousal abuse, continues to remain a problem, as does the abuse of children. In addition, one may wish to draw attention to problems in human rights and discrimination as factors in social exclusion (*Human Rights Practices Report on Turkey of the Department of State of US*).

A final reference should be made to high prevalence of child labour; as already discussed, there are an important number of children in the labour market. It is very likely that these children will have no proper education and will thus very likely find themselves in the vulnerable groups in the coming years.

4.2.9 Administration of, access to and delivery of services

At the central government level, as already discussed in Chapter 2, there are two main bodies of institutions in charge of combating poverty and social exclusion:

- The Social Aid and Solidarity Encouragement Fund (Sosyal Yardımlaşma ve Dayanışmayı Teşvik Fonu, or in short SYDTF);
- The General Directorate of Social Services and Child Protection (Sosyal Hizmetler ve Çocuk Esirgeme Kurumu, or in short SHÇEK).

SYDTF was legally established in May 1986 (Law No 3294) with a mandate of "assisting citizens in absolute poverty and need and other persons that have been admitted to or entered Turkey, to ensure a fair distribution of income by taking measures for strengthening social justice, to promote social assistance and solidarity". SYDTF is an extra budgetary fund that is financed by earmarked taxes (*e.g.* 50 percent of proceeds from traffic fines, 0.02 percent of proceeds from fuel oil consumption tax), and it works in conjunction with 931 regional Social Aid and Solidarity Associations (Sosyal Yardımlaşma ve Dayanışma Vakıfları, or in short SYDVs) that are given the task of implementation (SYDTF only provides funds to these 931 affiliated SYDVs). On the whole, resources are allocated at the beginning of each year on a regional basis with attention paid to population and socio-economic indicators. Benefits are of two sorts: In-kind benefits include food, clothing, fuel, medicine and small productive projects (*e.g.* greenhouses); cash benefits are in the form of grants and scholarship programs and emergency and after-disease assistance. SYDVs apply individual criteria to define those in need; each SYDV is thus independent in the decision-making process in granting social assistance (SYDVs are chaired by governors or district governors, and the rest of the running committee consists of the mayor, the provincial head of finance, the provincial director of social services, a health official and three private citizens.) The "green card" program, enacted in 1992 following a protocol between SYDTF and the Ministry of Health, provides free health-care services to all citizens of Turkey who are not covered by any social security system and who have a monthly income of less than one-third of the minimum wage amount (see <www.yargitay.gov.tr>). As of July 2002, "green cards" have been granted to a total of 12 million persons. Still, as of today approximately 10 percent of the total population do not have any kind of health coverage, and of these some are unable to pay for their health care; SYDTF gives limited support to those people who have no coverage at all.

SHÇEK, on the other hand, is a general directorate with a budget and a public legal entity, providing services and aid to vulnerable groups, including children, the young, the disabled, women, the aged and families in need of protection, care and assistance. Although the law that set forth regulations affecting the social services for children dates back to 1926, there have been promulgations since then, and SHÇEK's establishment dates back to 1983. SHÇEK gives 24-hour services to more than 30

thousand people (mostly children and the elderly) and to more than 75 thousands citizens during the daytime.

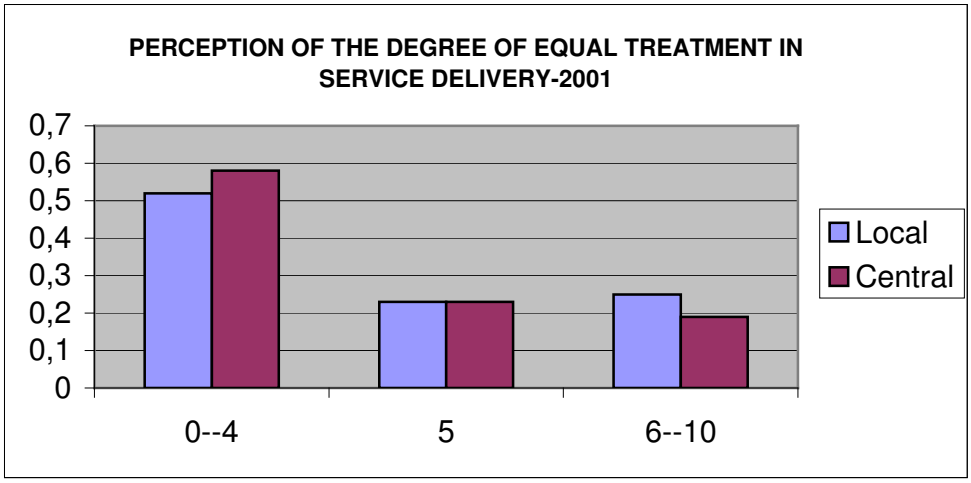
Apart from these two main institutions, there are a set of public institutions that are given the task of alleviating poverty and dealing with the social exclusion and discrimination problem. Among these, the General Directory of Foundations (Vakıflar Genel Müdürlüğü) can be singled out in that it provides meals every day in its 40 kitchens to approximately 11 thousand needy people, it provides monthly cash aid to approximately one thousand needy and handicapped persons, and it lodges more than 12 thousand students in more than 60 dormitories.

Finally, at the central level, one can observe institutions such as the Family Research Institution (Aile Araştırma Kurumu), the Directorate General on the Status and the Problems of Women (Kadının Statüsü ve Sorunları Genel Müdürlüğü) and the General Directorate on Handicapped Persons (Özürlüler İdaresi Başkanlığı), whose main tasks are to help coordinate various activities in their respective fields and to conduct research. Municipalities, at local levels, have been given the responsibility of providing social services and aid to the needy. One should of course note a long list of community-based and non-governmental organisations whose main or secondary aims are to alleviate poverty, provide social assistance, and reduce social risk and exclusion.

The *8th Five-Year Development Plan* acknowledges the lack of co-ordination and collaboration among institutions, as noted at the beginning of this Section, and sets out its target as follows: "A sound collaboration among public establishments and institutions providing social aid and social services, local administrations, and charity establishments shall be ensured" (p.123).

Data problems prevent us from making an assessment of decentralisation of social services and social aid toward municipalities and of the mobilisation of community-based and non-governmental organisations. A very rough guide might be the perception of citizens with regard to the degree of equal treatment given by central government and local governments in service delivery. A household survey conducted in 2000 with 3021 people (Adaman et al., 2001) focused on this issue, where individuals were asked to reveal their perception with regard to equal treatment on a scale of 0-10—0 meaning full discretion and 10 total equality:

Figure 4.1.Perception by the household of the degree of equal treatment in service delivery—the Local vs Central Governments.



Note 1: 0 represents full discretion and 10 corresponds to a total equality in the service delivery.

Note 2: The average figures above are based on a household survey that was conducted in 2000 with a sample of 3021 people.

Source: Adaman, F., A. Çarkoğlu and B. Şenatalar, *Hanehalkı Gözünden Türkiye'de Yolsuzluğun Nedenleri ve Önlenmesine İlişkin Öneriler*, 2001.

Although local governments score a bit better than the central one, people at large think that patronage networks play an important role in service delivery at all levels. The same survey also asked people to reveal their intensity of trust in a set of institutions, including local governments and the central government. Again on a scale of 0-10, where 0 meant no trust and 10 full trust, people's answers averaged at 4.4 for municipalities and at 3.9 for the central government.

With regard to the protection of the rights to provision, in the case of the central government, although eligibility conditions are usually stated in an explicit way, there is room for discretion, whereas in the case of municipalities and community-based and non-governmental organisations, units set out their own eligibility criteria, usually informally.

The above set of figures and the results of the survey are indicative in that the delivery of services to vulnerable groups is hindered because of a variety of reasons: Certainly, there is a lack of capacity as public institutions are under-funded and under-staffed; there may be problems of effectiveness and efficiency in the delivery of services, as public institutions randomly check the impact of their services; and finally, at least in the eyes of the public, both the central and local governments do not act in a fair and just way.

4.3 Evaluation of future challenges

4.3.1 Main challenges

The high rate of population growth, the low level of education, over employment in low productive agriculture, rapid and unplanned urbanisation, unplanned industrialisation, unequal distribution of income and limited coverage of social security programmes are basic challenges to be overcome to reach balanced growth and sustainable development, and thus social inclusion, in Turkey.

Furthermore, there is no systemic methodology for targeting allocation of resources, let alone measuring the impact of any social aid policy to be able to make improvements. At the central government level, to be more specific, SYDVs' individual criteria may not be consistent with each other. They may also be open to patronage-type discretions.

Apart from efficiency and equality perspectives, resources allocated to social services and social aid at the central and municipality levels are much less than required to achieve targets. Private contributions do not seem to fill the gap either. All in all, although on paper the welfare system in Turkey seems to be all-comprehensive, the total realised set of activities seems to be far away from the required ones. To give an example, it has been noted above that within the framework of SYDTF close to 1 million elderly people in need are being financially supported. Although the scheme is impressive, it must be added that the monthly financial support is only around 20 USD (which is roughly speaking one tenth of the per capita income).

4.3.2 Links to other social protection policies

A reform program for social risk mitigation, social assistance and poverty reduction policy is under way with financial and technical support from the World Bank. As noted above, in both the *8th Five-Year Development* Plan and the *2002 Government Programme*, the government underlines the need to enact a so-called "Social Services Master Plan" to be able to better co-ordinate activities in the area, yet not much progress has been achieved in that regard.

A recent development is the launch of the unemployment insurance scheme. Although there have been discussions with regard to unemployment insurance since 1959, the law was enacted in 8.9.1999 with effect as of 1.6.2000. The first implementation took place in March 2002, and as of September 2002 approximately 40 thousand people have benefited from this insurance scheme.

4.3.3 Political directions of future reform

Although terms like "poverty reduction, social risk mitigation, and social assistance" have been in the political discourse for many years, it is a common observation that the paternalistic nature of the Turkish state began to be dismantled in the early 1980s, following a shift toward a liberal policy. Local governments and community-based, non-governmental organisations started to play a greater role to counterbalance the dismantling of state paternalism. After the 2001 crisis, however, the government decided to put an emphasis on these issues, and the signing of the *Social Risk Mitigation Project* (500 million USD) with the World Bank, starting as of October 2001, opened up some opportunities.

However, as of today, the political and social agenda seems to be overwhelmed by discussions on how to solve the financial crisis that hit Turkey in 2001. Attention has also been given to reforming the public sector, the fight against corruption being one of the most-referred items. This said, however, with the new government, some references to the issue of poverty have been spelled out.

4.3.4 Social exclusion, poverty and EU accession

The main expected effects of EU accession on poverty related issues would be in the labour market, and these can be grouped as follows (*Turkish National Report for the Adoption of the Acquis*):

- ✓ Use of child labour will be strictly regulated;
- ✓ Work conditions will be redefined;
- ✓ Measures will be taken to prevent gender discrimination.

It is also expected that discrimination stemming from ethnic background would be addressed in a more explicit way.

4.4 Conclusions

Lack of data and insufficient research do not allow one to position Turkey properly with respect to social risk, poverty, deprivation and social exclusion. From what is available, however, one can observe that, as already noted, while Turkey is the world's 17th most industrialized nation, it ranks 85th out of 174 countries according to the *Human Development Index* of the United Nations. 16 percent of Turkey's adult population is illiterate. The basic health indicators such as infant mortality, child mortality below age 5, maternal mortality and immunization rates have not improved sufficiently (more on these on Chapter 5). This insufficiency stems not only from the problems concerning the health sector, but also from the environment, nutrition, housing, distribution of income, provision of clean drinking water, and water for use, to list a few. As of today we have no information with regard to the personal income distribution; the 1994 survey indicated a

rather unequal income distribution, and the years since have probably further deteriorated the distribution.

All in all one may conclude that although abject poverty (defined as pervasive poverty below biological or nutritional standards) may not be a problem in Turkey, extensive relative poverty certainly is, and the number of poor with less than adequate nutrition, housing and health standards have increased in recent years. In addition, the 2001 economic crisis has further deteriorated the conditions of the poor. Furthermore, the relatively low income of the rural population is the main cause for regional and urban-rural disparities in Turkey.

Turkey's existing social assistance to combat poverty is limited to *ad hoc* assistance, mostly in kind, channelled through SYDTF, and limited institutional care for children and the elderly, administrated mainly by SHÇEK. The fact that Turkey has no child allowances (unlike many neighbouring countries of Western and Eastern Europe) should be seen as a concern, since the presence of children in a household increases the risk of poverty substantially.

The public sector suffers from inefficient organisational structures and from corruption. In addition, the share of welfare services has been eroded in the last years. Thus, although the central government has a set of institutions to cope with the social issues of risk, poverty and exclusion, with well defined tasks and responsibilities, they either lack necessary funds, suffer from bureaucratic red tape and other inefficiencies, or are entwined by patronage networks, or a combination of all these. Municipalities do not fare much better. Community-based and non-governmental organisations usually perform better than central or local government institutions, but they are usually short of providing what is asked for.

Thus, the first step in reconsidering the welfare system of Turkey should be to address the utmost necessity of reforming the public sphere and to consider macro policies that will help reduce income inequalities.

5. HEALTH CARE[7]

5.1 Evaluation of current structures

5.1.1 Organisation of the health care system

A tour d'horizon of the health care system in Turkey

The structure of the health care system in Turkey comprises four layers.

- The first layer consists of individual health personnel (*e.g.* physicians, dentists, pharmacists) working privately; privately/publicly owned health posts and centres where diagnosis can be made and very basic treatment be performed; mother and child centres where attention is given to child care, pregnancy and post-birth problems; family planning centres; various dispensaries (of *e.g.* leprosy, tuberculosis, syphilis, mental health); and a few voluntary and international organisations providing basic health care and advice (*e.g.* "Fight Against Aids" type of organisations).
- The second layer is composed of small-scale (mostly provincial) hospitals in which only minor operations can be performed and emergency first-aid services be provided.
- The third and fourth layers comprise larger hospitals that can perform further treatments, including complex surgeries. The fourth layer is also responsible for conducting research in health-related issues, though units at lower layers may conduct research as well.[8] In passing, one should note that some of the health personnel have dual employment—*e.g.* some working on a part-time basis at public hospitals, while allocating their free time to their private practice.

It goes without saying that forming a filtering system, aiming at dealing with minor and basic problems at lower units and transferring more complex cases to higher units, would enhance efficiency (as more trained and competent units would not have to spend their time to issues that can easily be dealt with by lower units that have only basic training) to the extent that the collaboration and co-ordination of different layers is well secured and that such transfers do not entail high costs.

Health services in Turkey are provided mainly by the Ministry of Health (MoH), the Social Insurance Organisation (SSK), universities (those that have a medical school), the Ministry of Defence (MoD), and private

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[7] In the preparation of this Section the reports *Health System in Turkey*, *Sağlık: Özel İhtisas Komisyonu Raporu* and *Turkey: Health Sector Reform Project* have been widely used.

[8] It is possible to encounter references to three, instead of four, layers—the third and fourth layers being collapsed into one layer.

physicians, dentists, laboratories and pharmacists. Other public (state economic enterprises and municipalities) and private hospitals and health centres, together with voluntary health care/advice/support units, provide services as well, but their total capacity is relatively low. In passing, one should also note that institutions employing 50 or more workers/civil servants, as well as schools and universities, are required to employ a team of medical personnel, and thus one observes the existence of health units (sometimes with specialists and sophisticated equipment) in public and private institutions (*e.g.* universities, banks).

It is noteworthy that the MoH provides almost all preventive services. Table 5.1 presents in a tabular form the institutions that provide health services in Turkey, grouped on a public, private and voluntary basis.

Table 5.1. Health Service Providing Units in Turkey

Public
MoH
SSK
University Hospitals
Municipalities
MoD
State Economic Enterprises
Other Ministries
Private
Physicians
Dentists
Pharmacists
Laboratories
Local and International Hospitals
Voluntary Units
Dispensaries
Advice/Support groups

Planning, regulation and management of health care in Turkey

The Parliament is the ultimate body that has both the responsibility and the power to formulate an overall public health policy in the country. The two main bodies responsible for planning health care policy and the provision of services are the State Planning Organisation (SPO) and the MoH. More specifically, the role of the SPO is to define, within the framework of Five-Year Development Plans, the macro objectives, principles and policies. The MoH in turn develops operational plans regarding the provision of health care and preventive services, in conjunction—at least in theory—with the broad picture provided by the SPO. The MoH is vested with the authority to provide medical care and preventive health services, train health personnel,

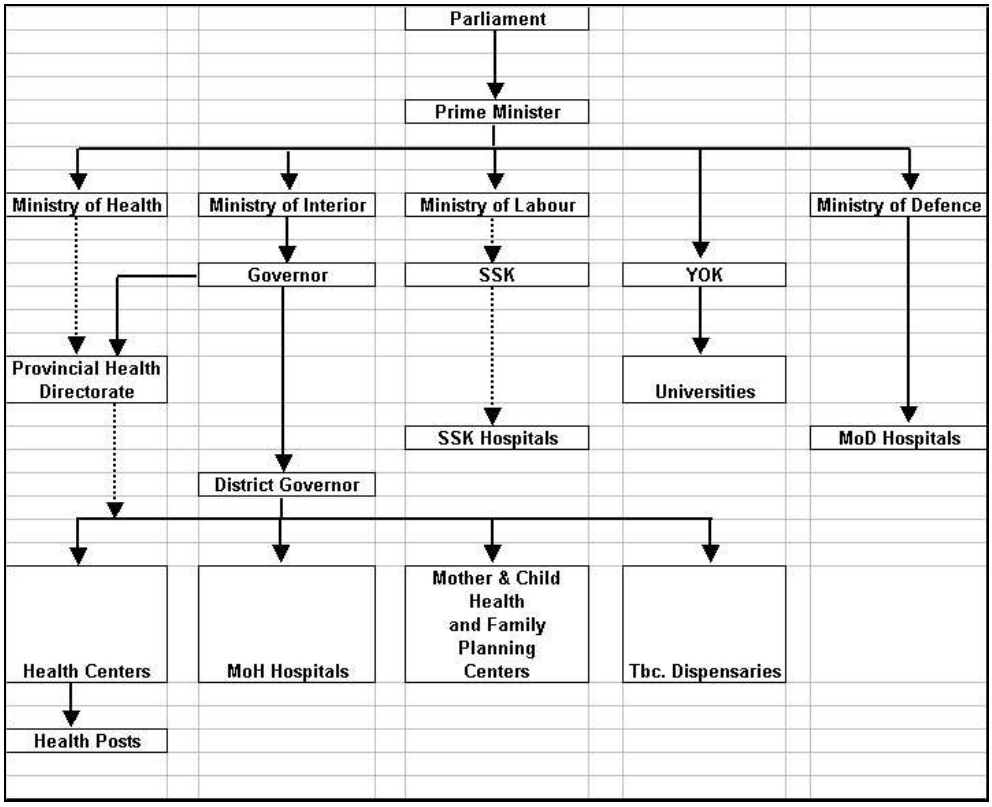
provide pre-service and in-service training, establish and operate health institutions, and oversee medical institutions of other public and private organisations. The MoH also regulates the prices of medical drugs, and controls drug production and the operations of pharmacies.

At an operational level, in every province there is a provincial health directorate, that is, an administration accountable to governors in cities and to district governors in districts, and technically responsible to the MoH. Their administrative responsibility mainly involves the administration of personnel and local units, whereas technical responsibility involves decisions concerning health care delivery, such as the scope and the volume of services. The MoH with the approval of the governor makes appointments of the provincial personnel. Apart from physicians, the distribution of the personnel to the provider units is undertaken by the provincial health administration. The governor and the district governor have the authority to relocate staff if need be. Actually, however, governors do not usually play an important role in the decision-making processes of health-care related issues.

The MoH operates an integrated model, providing primary, secondary and tertiary care and to some extent research. The MoH, through health centres, mother and child health and family units, and some vertical units such as tuberculosis dispensaries and health posts, provides the bulk of primary care. It also operates secondary and tertiary hospitals. The MoH is the decision maker of financial resource allocation for current and investment expenditures, once its budget is approved by the Parliament. The Ministry of Finance directly allocates funds to some budget lines, such as salaries, to the accounts of hospitals or to the provincial health administrations, following the authorisation of the MoH.

Apart from the MoH, the Ministry of Labour and Social Security, the municipalities, universities (those with medical schools) and several state institutions that have health-care units have largely autonomous provider units, mainly hospitals, that are administratively responsible to the respective organisation and technically responsible to the MoH. The organisational chart of the state health sector in Turkey is provided in Figure 5.1. Units of minor importance, such as municipalities' hospitals or state economic enterprises' health units, are not shown in the figure.

Figure 5.1: Organisational Chart of the Public Health Sector in Turkey



Dotted lines: Technical responsibility

Single lines: Administrative responsibility

Source: *Health System in Turkey, 2001*, Giray, A.Ü., Department of European Union Coordination, MoH; see also for an earlier treatment *Health Care Systems in Transition: Turkey*, World Health Organization, 1996.

As will be seen later, such a fragmented structure of the health care providing agencies makes it difficult to ensure an effective and efficient co-ordination and delivery of health services, be they preventive or curative.

Finally, private units have administrative autonomy but are technically responsible to the MoH. Individual health personnel working privately have their own associations (the Chamber of Medical Doctors being the most important) that have some regulatory power over their members.

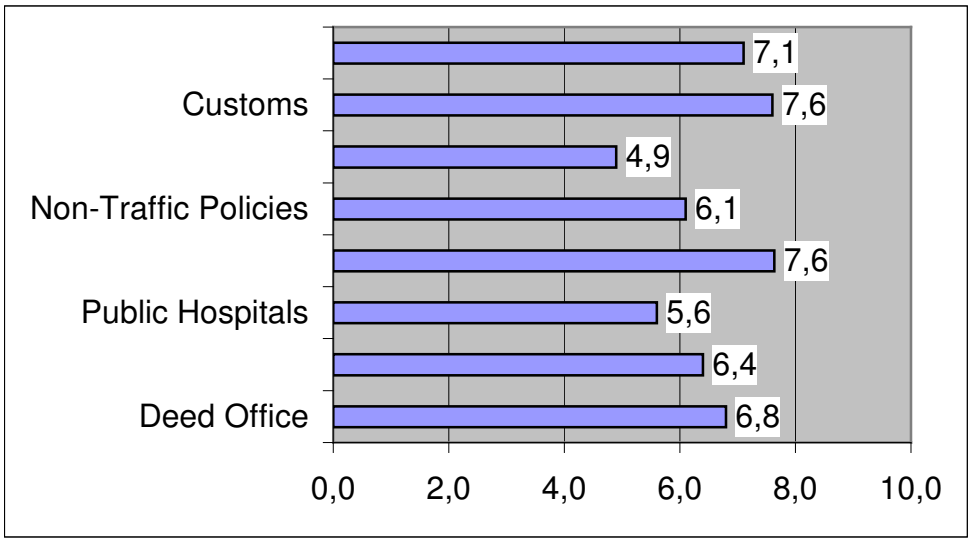
Informal sector and corruption/bribery in the health care system in Turkey

Although informality in the sense of unregistered doctors/ pharmacies/laboratories is practically nonexistent in Turkey, some of the health care units may well behave in a corrupt way. The spectrum may be categorised as follows:

- ✓ Doctors, especially in the big cities, working in the public sector may force their clients to undertake tests at private laboratories that will pay doctors back a "premium" on the charges they get from clients. Given such a scheme, doctors will have an incentive to request excessive and sometimes unnecessary tests from their clients. A typical example for this "network" is the MR tests (in metropolitan cities) that are requested almost as a routine procedure irrespective of whether or not the patient really needs it.
- ✓ The relationship between physicians, especially specialised ones, in the public sector and drug companies or medical equipment selling firms may take an unethical nature, as these firms may offer gifts (*e.g.* computers), provide financial support to enable physicians to attend international conferences, etc., in expectation of preferential treatment.
- ✓ One can get frequent references to the provision of "green cards" (on which see below) on the basis of patronage networks.
- ✓ It is also frequently reported that in public hospitals people at large either pay bribes or use their "connections" to get preferential treatment, at least to shorten their waiting time (on which see below).
- ✓ It has been put forward that the relationship between business and the public in Turkey with regard to the health care system is contaminated with corruptive elements. These fall under two headings:
  - Private companies operating in the health care system (*e.g.* private hospitals, pharmaceutics chemistry) may pay, bribes, or may use their political "connections", to have an impact over the health legislative body (*e.g.* to get the approval for the operation a private hospital);
  - Private companies providing services of different sorts to the public health sector (*e.g.* building a hospital, selling equipment/medicine, providing services of different sorts) may pay, or may be forced to pay, bribes, or may use their political "connections", to have an impact over the decisions of public health units.

Indeed, two recently conducted surveys that aim at understanding the corruption issue in Turkey shed light on this dimension. The first survey was conducted in late 2000 with a sample of 3021 adults representing the urban population of the country (see Adaman et al., 2001), and the second one in late 2001 with 1219 small and medium-sized enterprises (see Adaman et al., 2002). One of the questions in both surveys was the perceived degree of corruption in a set of public institutions, the results of which are presented below. People and businesses were asked to reveal their perceived degree of corruption on a scale of 0 to 10 (0 meaning no corruption and 10 meaning full corruption) for a given set of institutions, including public hospitals (see Figures 5.2a and 5.2b).

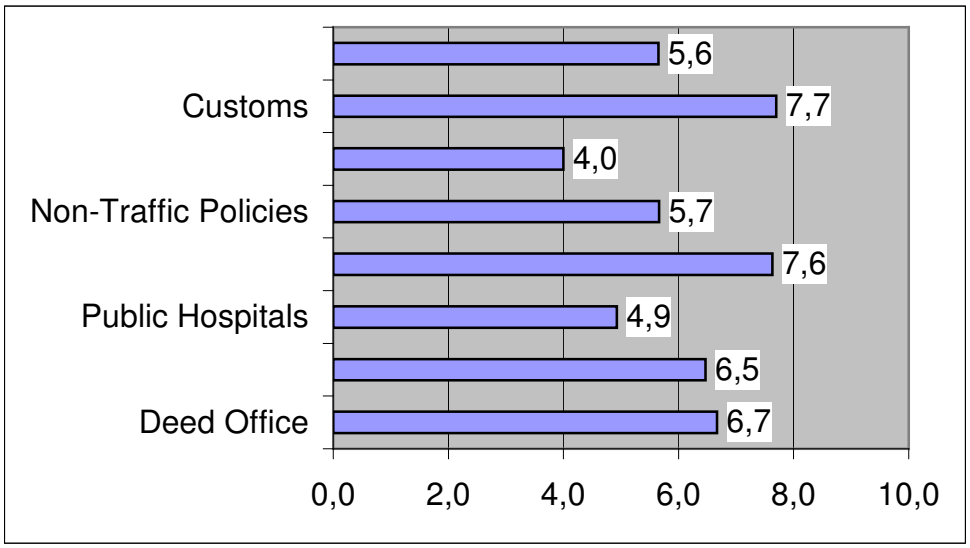
Figure 5.2a. *Level of Perceived Corruption at Institutional Level: The Household (2000) Survey Results*



Note 1: 0 represents no corruption at all and 10 corresponds to full corruption.
Note 2: The average figures above are based on a household survey that was conducted in 2000 with a sample of 3021 people.

Source: Adaman, F., A. Çarkoğlu and B. Şenatalar, *Hanehalkı Gözünden Türkiye'de Yolsuzluğun Nedenleri ve Önlenmesine İlişkin Öneriler*, 2001.

Figure 5.2b. *Level of Perceived Corruption at Institutional Level: The Business (2001) Survey Results*



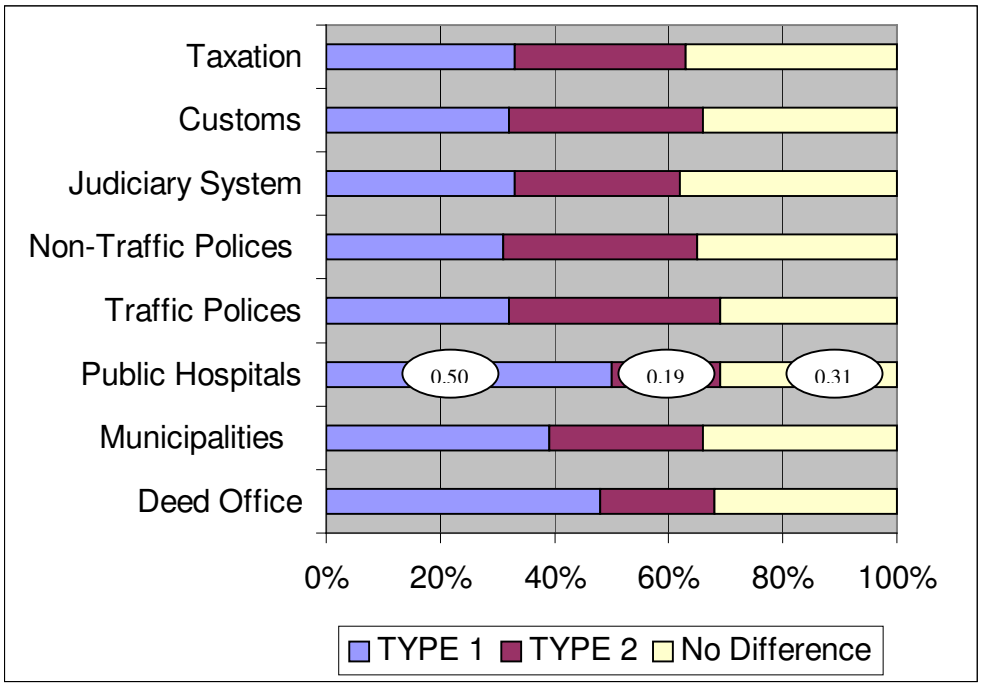
Note 1: 0 represents no corruption at all and 10 corresponds to full corruption.
Note 2: The average figures above are based on a business survey that was conducted in 2001 with a sample of 1219 small and medium-sized enterprises.

Source; Adaman, F., A. Çarkoğlu and B. Şenatalar, *İşdünyası Gözünden Türkiye'de Yolsuzluğun Nedenleri ve Önlenmesine İlişkin Öneriler*, 2002.

Although the relative position of state hospitals is not among the worst, the public and to some extent businesses at large think that bribery and corruption is a problem for public hospitals: The bribery/corruption average grade is computed as 5.6 in the household survey and 4.9 in the business survey; furthermore, 46 percent and 38 percent of the respondents, in the household and the business surveys, respectively, gave grades between 6-10, meaning that bribery/corruption has been perceived as an important problem by an important percentage of the urban population.

The above-mentioned surveys also inquired about the "type of briberies" paid to these institutions (Figures 5.3a and 5.3b). Both surveys introduced a differentiation between the motivation of those bribes that are paid on the grounds that people find themselves unable to get a public service that they think it is their right to get either because of red tape, insufficient capacity, or civil servants' perceived laziness (Type 1), and the motivation of those bribes that are paid to get a service for which they have no right whatsoever (Type 2).

Figure 5.3a. Perceived Reasons for Bribery at Institutional Level-Results from the Household Survey (2000)

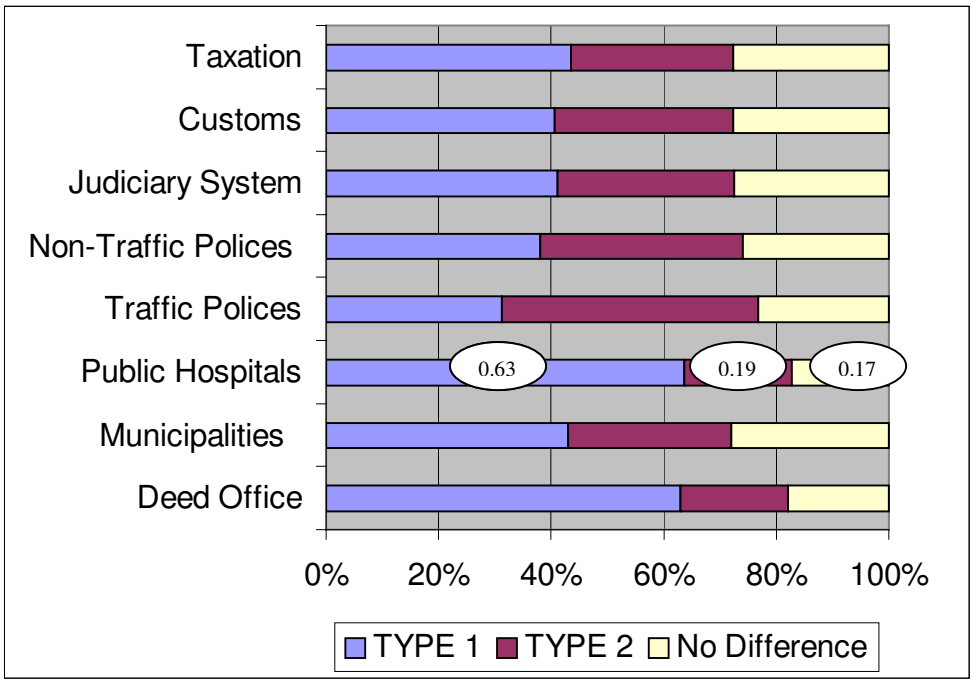


Note 1: Type 1 corresponds to those bribes that are paid on the ground that people find themselves unable to get a public service that they think it is their right to get; Type 2, on the other hand, refers to those bribes that are paid to get a service that people acknowledge that they have no right whatsoever to use.

Note 2: The average figures above are based on a household survey that was conducted in 2000 with a sample of 3021 people.

Sources: Adaman, F., A. Çarkoğlu and B. Şenatalar, *Hanehalkı Gözünden Türkiye'de Yolsuzluğun Nedenleri ve Önlenmesine İlişkin Öneriler*, 2001.

Figure 5.3b. Perceived Reasons for Bribery at Institutional Level-Results from the Household Survey (2000)



Note 1: Type 1 corresponds to those bribes that are paid on the ground that people find themselves unable to get a public service that they think it is their right to get; Type 2, on the other hand, refers to those bribes that are paid to get a service that people acknowledge that they have no right whatsoever to use.
Note 2: The average figures above are based on business survey that was conducted in 2001 with a sample of 1219 small and medium-sized enterprises.

Source: Adaman, F., A. Çarkoğlu and B. Şenatalar, *İşdünyası Gözünden Türkiye'de Yolsuzluğun Nedenleri ve Önlenmesine İlişkin Öneriler*, 2002.

The figures are self-explanatory, in that of the institutions considered, the bribery in public hospitals has been largely explained by both households and small and medium size businesses as a Type 1 corruption (50 and 63 percent, respectively), suggesting that an increase in the resources of public hospitals may largely decrease corruptive activities in these units.

The surveys also looked into the actual illegal payments/gifts given to these institutions in the last two years. 7 and 16 percent of the total household and the total business respondents, respectively, who have had a relation with public hospitals in the last two year period of the time of the surveys, admitted openly that they actually made illegal payments or gave gifts for opportunistic reasons. Needless to mention, these figures, certainly of a significant level in themselves, should be seen as minimal. This is, of course, alarming.

Decentralisation of the state health care system

Decentralisation of the state health care system at an administrative level in Turkey is in line with the way in which the system is structured at different layers (see Figure 5.1 above). While technically responsible to the MoH, provincial health units are administratively responsible to governors (at city or at district level) who ensure the inter-ministerial co-ordination at the provincial level. Financially, on the other hand, these units do not have much control over the allocation of their financial resources. All in all, public health care units are subordinate units of the MoH. Other public health units (such as universities with medical schools) are also heavily controlled by their respective central organisations.

Although financial decentralisation has been on the agenda for a while, the *8th Five-Year Development Plan*, which covers the 2001-2005 period, acknowledges that administrative and financial autonomy of state hospitals so far could not be secured (by reference to the 7th planning period). In a similar vein, like all public universities, those that provide health care related services (through, *inter alia*, medical schools, hospitals, research centres on health care) lack financial and administrative autonomy. They are under strict regulation of the Higher Education Board (YÖK)[9]. One can therefore hardly speak of decentralisation in the health care system in Turkey.

5.1.2 Benefits

Primary health care and public health services

The basic health care units are health centres and health posts, mostly at the village level. According to the current legislation, health posts are staffed by a midwife, and serve a population of 2,500-3,000 in exclusively rural areas. As of 2000, there are 11,747 health posts. Health centres, on the other hand, serve a population of 5,000-10,000, and are staffed by a team consisting of a physician, a nurse, a midwife, a health technician and a medical secretary. The main functions of health centres are, apart from providing basic general treatment, the prevention and treatment of communicable diseases; immunisation; maternal and child health services, family planning; public health education; environmental health; and the collection of statistical data concerning health. There are 5,700 health centres as of 2000. Table 5.2 gives the figures of population per health centre, from 1997 to 2000, disaggregated at regional levels.

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[9] The Higher Education Board consists of 22 members. 7 are appointed by the President, another 7 by the government, 7 by universities and the remaining one by the Turkish Military Forces.

Table 5.2. Population per Health Centres

Regions	**1997**	**1998**	**1999**	**2000**
Marmara	18,933	18,742	19,810	19,434
Aegean	9,213	8,805	9,273	8,973
Mediterranean	11,161	10,741	11,805	10,678
Middle Anatolia	10,427	10,117	10,418	10,165
Blacksea	8,324	8,088	7,971	7,650
East Anatolia	10,394	10,187	9,658	10,226
Southeast Anatolia	15,857	15,420	16,253	15,893
Total	11,734	11,306	11,805	11,461

Source: *Temel Sağlık Hizmetleri Genel Müdürlüğü Çalışma Yıllığı 2000*, Ministry of Health, 2001.

As the table makes clear, the situation is unsatisfactory in general, and particularly in the Marmara and Southeast regions. The case of the Marmara region can be explained by the weight of Istanbul, a metropolitan city whose population is around 10 million, where the population per health centre climbs to 48,076 as of 2000. Lack of health centres in Istanbul makes Istanbul citizens go to private clinics to get basic treatment. It is indicated that the number of private clinics in Istanbul is more than twice that of health centres.

One can hardly speak of progress in the establishment rate of health centres (note the 1997 and 2000 aggregate figures [as 11,734 and 11,461, respectively]), nor can one speak of regional equity. One may conclude that public primary care in cities is *de facto* supplemented by private units (private physicians or private clinics). Furthermore, one should also underline that in public health units patients do have make payments to speed up the waiting list. Apart form illegal payments (bribes or "gifts") on which a reference has already be made above, in some units these payments can be made "legally"—units charge patients and provide a speedy service.

As to the health posts that provide primary health service at the village level, the total number of posts declined from 11,905 in 1997 to 11,747 in 2000. Taking into account the continuing rural migration, due to economic and political reasons, one may assume that the population figure per health post has not considerably changed over the last years.

These above figures do not tell us anything about the quality of the services provided. As the *2002 Government Programme* acknowledges, there are no physicians in 665 health centres and there are no midwives in 7,713 health posts in the year 2000, and this information should provide a signal with regard to the kind of service one may get at these units (*2002 Government Programme).*

As already discussed, the MoH has started the "green card" implementation in 1992 as an in-patient care service, covering the costs of operation services for those citizens who are not covered by existing health security schemes and are unable to pay their health-related expenses. The "green card" entitles those poor segments of the society to health care without any co-payments (see Chapter 4). Although the card does not cover drug purchases, district governors have some available funds for that purpose as well. Furthermore, elderly people (65 or more) may be assisted with their health-related problems through the Social Aid and Solidarity Encouragement Fund.

This said, insured people all in all are able to cover most of their expenses at these units together with drug purchases (see below the Section on Financing). We should add, however, that for the drug purchases insured patients are asked to make co-payments, which fluctuate around 10-20 percent, with the exception of such drugs that are necessary to be used continuously.

These primary units' responsibilities are clearly set out through regulations, and these units have, at least theoretically speaking, clear guidance as to what and how to do and when to transfer the patient to a higher-level unit. However, one should add that, as of today, it is difficult to speak of a well-defined basic package of services, not to mention an effective referral to higher units (on which see below).

In addition to these, there are 288 mother and child health centres and family planning centres, 271 tuberculosis dispensaries, 12 syphilis dispensaries, five leprosy dispensaries and one mental health dispensary as of 1999. These health facilities with their specialised personnel offer preventive and curative health services as well as training for health personnel working in other primary health care units. In getting services from these centres and dispensaries, patients may be asked to make contributions, but usually at low levels, *i.e.* below operational costs. Finally, there are voluntary advice and support groups, mainly in metropolitan cities, that aim at providing different kinds of support to those in need of (*e.g.* to HIV positive patients).

Secondary, tertiary and quaternary care

As noted above, the MoH, the MoD, the Ministry of Labour and Social Security, some state economic enterprises (SEEs), universities, municipalities and the private sector also provide secondary and tertiary health care services. Out of a total of 1,226 hospitals (as of 2000), the MoH runs 744. These provide more than 50 percent of the hospital beds in the country. SSK provides exclusively curative services to its members in 118 hospitals with 27,900 beds. The third important providers are universities that have medical schools, with a bed capacity of 24,647. See Table 5.3 for further details. Yet, in evaluating these data one should pay attention to the

fact that hospital beds do not signify much with respect to the capacity of health units, unless supported by medical staff, technical equipments, etc. The Ministry of Defence's hospitals are exclusively for military personnel and their families, though in exceptional circumstances (natural disasters, accidents, etc.) they may give treatment to non-military people as well. All in all, as of 2000, there are a total of 322 thousands health personnel, including physicians, dentists, pharmacists, nurses, midwifes, health officers and veterinarians. Of these, 72.4 percent are in the public sector. The private sector provides mostly out-patient, laboratory and diagnosis services.

Table 5.3: Total Number of Hospitals and Bed Capacities by Institutions

	2000		**2001(1)**	
Institutions	**Number of Hospitals**	**Number of Beds**	**Number of Hospitals**	**Number of Beds**
MoH	744	86,117	755	86,787
MoD	42	15,900	42	15,900
SSK	118	27,900	120	28,350
SEEs	8	1,607	8	1,607
Other Ministries	2	680	2	680
Universities	42	24,647	42	25,497
Municipalities	9	1,341	9	1,341
Foreign	4	338	4	338
Minorities	5	934	5	934
NGOs	18	1,318	18	1,318
Private	234	11,667	240	11,967
TOTAL	1,226	172,449	1,239	174,719

Source: MoH, SPO.

(1) Estimation

All in all, of the total insured population a great majority are covered under the three health insurance schemes of the social security system (*i.e.* SSK, Emekli Sandığı and Bağ-Kur); the remaining insured are in fact active civil servants and their dependents whose health care benefits are funded directly from general revenues. As already noted, more than 12 million people (precisely 12,021,827 as of July 2002) receive subsidies for health care through the "green card" scheme operated by the MoH. Finally, as will be touched upon later on, private health insurance covers something more than half a million people, most of whom are also insured under one of the social insurance schemes but are willing and able to afford to get better treatment.

With regard to the extent to which the layer system works, the following information representing the situation as of 1998 is noteworthy: Of about 100 million applications to clinics of the MoH, 53 million were made in hospitals, a figure far greater than one would like to have (see Soyer, 2001).

To complete this picture, Table 5.4 provides the main health indicators, in terms of population per bed, bed occupancy rate, population per physician, population per dentist, population per nurse, for the years 1995 and 2000. Note that beds in military hospitals are included in these figures. The

projection figures for the year 2005 as set out in the *8th Five-Year Development Plan* are based on the projection figures of population, graduation of schools of medicine, investment plans, etc.

Table 5.4. Main Health Indicators

	1995	**2000**	**2005(1)**
Number of Beds	150,565	172,449	200,000
Population per Bed	402	379	351
Bed Occupancy Rate	58	61	75
Number of Health Centres	4,927	5,700	6,300
Number of Physicians	69,349	80,900	89,000
Population per Physician	872	807	789
Number of Dentists	11,717	14,200	16,000
Population per Dentists	5,163	4,598	4,389
Number of Nurses	64,243	71,000	77,100
Population per Nurse	942	919	910
Life Expectancy at Birth	68	69.1	73.3
Infant Mortality	57.6	35.3	28.8

Source: MoH, SPO.

(1) Target figure

The following observations may give a general idea as to Turkey's position on the matter of health care delivery:

- ✓ The first observation is that the number of beds and the number of physicians per 10,000 inhabitants is quite low in Turkey when compared to other OECD countries. The figures of 26 for beds and 12 for physicians are much lower than those of European Union countries (Greece with 49 and 44, France 84 and 30, Germany 92 and 35, respectively, to cite but a few countries. Cf. *OECD Health Data*).
- ✓ Life expectancy at birth is for the time being close to 70, though this figure for most European countries is above 75 (*OECD Health Data*). Furthermore, there are large geographical differences: for 1997 it was 58.3 in Şırnak (a city in the Southeastern part of Turkey) and 73.3 in Istanbul (*İnsani Gelişme Raporu*).
- ✓ The infant mortality rate is close to 40 (per 1,000 live births), though for most European countries the figure fluctuates at around 5 (*OECD Health Data*).[10] Though there has been progress in the last five years, the current rate is still too high. Furthermore, infant mortality greatly varies across regions and across income levels: It is close to 100 in the poorest 20 percent and it goes down to 25 in the richest 20 percent chunk of the population; it fluctuates at around 60 in the East and is in the lower 30s in the West. The educational level of mothers

[10] The figures given for infant mortality rate by different statistical sources show some differences: For the same year (2000), MoH and SPO give the figure of 35.3, confirmed by Eurostat, but UNICEF quotes the figure of 38 and OECD the figure of 39.7.

affects this mortality rate as well: the figure is almost twice the average if the mother is illiterate. (See for further discussion, Soyer, 2001.)

- ✓ One factor affecting infant mortality is surely access to safe water and to adequate sanitation. As of 2000, as already mentioned, 18 percent of the population has no access to safe water, and 10 percent of the population has no access to adequate sanitation (*UNICEF Statistics*).
- ✓ The ratio of population to medical personnel and hospital beds varies greatly among regions. The Southeastern parts of the country and rural areas in general have fewer personnel in all categories and hospital beds per unit of population. For example, as of 1998, the population figure per physician was 2,309 in the Southeast, as opposed to the country average of 859 (Soyer, 2001).

Given these constraints, beneficiaries of health care in Turkey are those insured and those with a "green card". Insured people (including dependents), who constitute 85.9 percent of the total population, are asked to make a contribution of around 10-20 percent of the expenses on drugs (see below the Section on Financing). This tells us that the great majority of the population of Turkey seems to get insured, that is to say, they get health care (putting aside the quality) and a substantial support for drug use. However, care should be given to the fact that the above cited figure for the insured population is very much upwardly biased (for the set of reasons discussed in our earlier Chapters). To give an additional evidence to this bias, remember the total amount of "green card" holders (who get in-patient treatment free of charge but have to get their own drugs [yet, as noted above, the poor may get help for that item as well]), which is approximately 20 percent of the total population. As the official figure for those insured is 85.9 percent, a logical conclusion emerges that some of the insured people must have a "green card", which is of course not possible according to the law! And finally, those who are privately insured pay their premiums, depending on the coverage of their insurance scheme.

5.1.3 Financing the health care system

In the last 20 years the share of GDP devoted to total (*i.e.* private and public) health care expenditures has fluctuated around 4 percent (the 1998 figure being 4.8 percent, corresponding roughly to 300 USD per capita, converted by using PPP figures [*OECD Health Data*]. But the Ministry of Health's data is much lower: the 1998 figure has been given as 2.65 percent). This figure is quite low when compared with European figures that fluctuate around 8 percent (*OECD Health Data*).

Of the total health expenses, the public resources cover approximately 70 percent. The funds for supporting the health system in Turkey are derived from different sources. State budget allocations account for the majority of

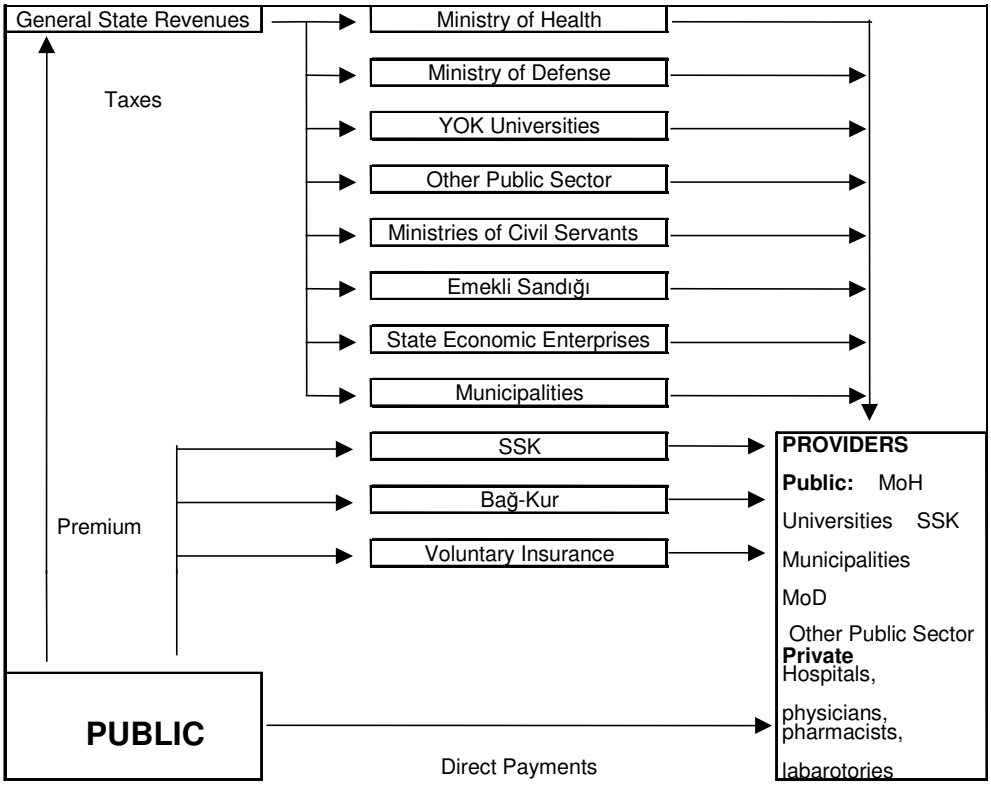
health expenditures. Approximately 43 percent of the total expenditure is financed by taxation, 25 percent by social insurance funds, and the remaining 32 percent by direct out-of-pocket payments. (Needless to add, one should also take into account those extra-legal payments, which do not account in official figures, that patients give to get preferential treatment, mainly at the hospitals.)

The funds derived from these three resources are transferred to service providers;

1. Through the MoH, the MoD, social health security schemes (namely, SSK, Emekli Sandığı and Bağ-Kur), ministries of active civil servants, YÖK (university hospitals), state economic enterprises, municipalities, other public institutions and establishments, special funds, foundations and private health insurance companies.
2. Directly by users in the form of out-of-pocket payments.

These different institutions' financial links are presented in a tabular form in Figure 5.4.

Figure 5.4: Structure of Health Care Financing



Source: MoH.

To understand the financial structure, a few comments should be added to describe the institutions that are within the financial structure of the health care system.

Ministry of Health

As already noted, the MoH accounts for the majority of health-care expenditures in Turkey. When the expenditures of the MoH are considered (see Table 5.5) over the years 1992-1998, we see that the main entry has always been the expenditures to hospitals (four-fifths, approximately). The "others" entry refers to ministerial expenses. Note further that drug expenses are not seen in the MoH budget, as different ministries with which individuals are associated cover these expenses depending on whether they are fully or partially subsidised.

One should also take note of the decline in the share of preventive care expenditures (the main entry being vaccination), which dropped from 7 percent in 1992 to 3 percent in 1998. The MoH is practically the only body taking preventive measures. As of 1998, among children 12-23 months old,

54.3 percent were not *fully* immunised, and this ratio has gone up in the last five years (Soyer, 2001).

Table 5.5: Expenditures of the MoH

	1992	**1994**	**1996**	**1998**
Preventive Health Expenditures	7.2	4.1	3.2	3
Out-patient Expenditures	24.5	24.2	21.6	20.2
Hospital Expenditures	51.1	60.8	62	63.9
Other	17.2	10.9	13.2	12.9

Source: *Türkiye Sağlık Harcamaları ve Finansmanı 1992-1998*, Ministry of Health, 2001.

Hospitals form the bulk of the expenditures of the MoH, and their financial structure needs further attention. The major sources of funds for MoH hospitals are: (i) State Budget Allocations: As the basic source of funds, they are usually prepared through simple adjustments by taking the previous year's inflation rates into consideration. Revising the initial general budget allocations during the financial year has become a routine operation. (ii) Direct payments by individuals to revolving funds of hospitals (around one third of their income): These 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 the MoH and the Ministry of Finance representatives. This commission does not necessarily consider the full actual cost of the service. The payment can be made by an insurance organisation (Emekli Sandığı, SSK, Bağ-Kur, or private), by the organisation where the patient works (governmental or non-governmental), directly by the state (for those entitled to the "green card"), or by the patient him/herself as an out-of-pocket payment. And finally, (iii) Special funds: These have been made available, since 1998, from earmarked taxes on fuel, new car sales and cigarettes (see *Health Care System in Transition: Turkey*).

Care should also be given to the fact that the MoH's funds are mostly used to finance the operational costs part, salaries being an important entry. Investment costs are allocated in a hierarchical way and often with a bias influenced by personal and/or political networks rather than by objective needs. Fees collected by users are by and large centralised, and local units have little influence over the money they have created (*Turkey—Health Sector Reform Project*).

University hospitals

University hospitals have two main funding sources: The state budget allocations through the Higher Education Board (YÖK) and universities' revolving funds. The state budget covers both current expenditure and investment expenditure. The State Audit Court controls the expenditure of

the university hospitals made through the revolving fund. Universities have some leverage over the use of funds they have created.

5.1.4 Social health security schemes

The following groups of people are covered (for a general exposition, see *Health System in Turkey*).

- Persons working under a service contract and their dependents, covered by SSK;
- Retired civil servants, persons retired from state economic enterprises, and their dependents, covered by Emekli Sandığı;
- Merchants, artisans and other self-employed persons and their dependents, covered by Bağ-Kur,
- Active civil servants and their dependents, covered by their institutions.

SSK

As noted in previous chapters, SSK is a social security organisation for private sector employees and blue-collar public workers. It functions both as an insurer and as a health care provider. Members are normally asked to use SSK services (recall that SSK has 118 hospitals with a bed capacity close to 28 thousand), but may be referred when needed to other health institutions (*e.g.* university hospitals). A single premium is collected for both retirement and health insurance. There are two other sources of funding in addition to premiums: fees paid on behalf of non-members using SSK facilities, and income obtained through co-payments (10-20 percent) of drug costs for out-patients with the exception of such drugs that need to be used permanently. Patients get their drugs from SSK hospitals.

Bağ-Kur

Bağ-Kur, an insurance scheme for the self-employed, offers its members the same entitlement to benefits covering all out-patient and in-patient diagnosis and treatment. Bağ-Kur operates no health-care facilities of its own, but purchases services by simply entering into contracts with state hospitals. Patients get health services free of charge. There is a 10-20 percent co-payment for drug expenses, with the exception of such drugs that need to be used permanently; patients get their drugs from pharmacies and make their co-payments, the rest being paid by the institution itself.

Emekli Sandığı

Emekli Sandığı, the main purpose of which is to provide pension coverage, also provides health insurance to retired government servants. The health scheme is mainly financed through state budget allocations, as there is no premium collected from either active civil servants or pensioners. Retired

employees are asked to make a contribution of a 10 percent drug co-payment, with the exception of such drugs that need to be used continuously. Patients get their drugs from pharmacies and make their co-payments, the rest being paid by the institution itself.

Active civil servants

Health-care expenditures of all active servants are covered (with a 10 percent co-payment for drug use except such drugs that need to be used permanently) by their organisations through specific state budget allocations. Patients get their drugs from pharmacies and make their co-payments, the rest being paid by the institution itself.

Private health insurers

About 30 institutions offered private health insurance, in 1995, with a total coverage of 500,000 people. The related figure for insurance companies in 2000 was about 35, with a total coverage of 690,363 insured and a total premium income of 281 million USD (see Table 5.6). Most subscribers are already insured by social insurance organisations, and therefore pay the premiums to the institution they are legally a part of, but also to their private insurance fund to obtain a higher quality service. Private health insurance is the country's fastest developing form of insurance (see Table 5.7). Those covered by private insurance include the employees of banks, insurance companies, chambers of commerce, computer companies, and the like.

Table 5.6: Private Health Insurance Policies and Insured

	1997	1998	1999	2000
Individual Policies	94,347	112,075	124,435	141,068
Number of Insured	172,113	205,787	258,050	250,813
Group Policies	1,913	2,818	3,401	3,311
Number of Insured	355,878	393,916	475,290	439,550
Grand Total	527,991	599,703	733,340	690,363

Source: Association of Insurance and Reinsurance Companies of Turkey, Istanbul, 2000.

Table 5.7: The Premium Amount Collected by Private Health Insurers (in USD)

	1997	1998	1999	2000
Premium Income	118,317,792	179,800,413	199,686,335	281,024,139
Annual Increase	50.94%	51.96%	11.06%	40.73%

Source: Association of Insurance and Reinsurance Companies of Turkey, Istanbul, 2000.

Payments to physicians

The MoH and university physicians are civil servants and their remuneration is paid from the General Budget. SSK physicians are

employees of the organisation, and their salaries are funded through the premium contributions paid by members. However, SSK may also contract physicians from the outside market, either paying them a salary or employing them on a fee-for-service basis. Civil servants' salaries have been under erosion in the last ten years or so; thus physicians and other health officers working as civil servants have been adversely affected (see Soyer, 2001). It should also be added that the basic salary is not supplemented by incentives for performance; yet, civil servants are granted lifetime employment. In the last few years some physicians (mostly specialists) have chosen to work abroad (note that in most European countries their degrees are accredited). It is also a common observation that some health personnel, especially those in big cities, have been moonlighting.

Incentives

The public sector providing health-care services does not have an effective incentive structure that will ensure efficiency both at the unit and at the macro levels. On the one hand, public hospitals have not been converted into institutions having administrative and financial autonomy and offsetting their expenses by their own income and have not been reinforced with an understanding of modern management. Within this framework, attention should be given to the fact that the patient referral system among service levels continues to be by and large ineffective, causing inefficiencies. As indicated in *Turkey—Health Sector Reform Project* of the World Bank, the institutional fragmentation has led to considerable overlap in medical infrastructure, personnel and resources that are usually underused as well as to duplication of facilities and excess capacity. On the other hand, lack of co-ordination and co-operation among institutions and their service units continues to persist. As a sign of the ongoing lack of efficiency, the bed occupancy rates that fluctuate around 60 percent can be given. This low occupancy rate (note that the EU average is close to 80 percent) may either be due to financial constraints of the population, to poor service quality, or to both. One should also add that bed occupancy rates in district hospitals are relatively low, going down to 25 percent, which indicates that patients flow to hospitals in big cities. This is an indication of the need for planning the capacity of hospital beds by way of giving priority to branches in which needs are high and services inadequate.

As already touched upon, due to the fact that a large percentage of fees collected from consumers at the MoH hospitals are centralised and allocated to health service providers by the MoH officials, the regulations surrounding the use of these resources create disincentives for efficiency in the system, limit transparency and sometimes fail to reduce inequity.

Furthermore, due to the part-time work of specialist physicians at public hospitals, manpower and infrastructure are under-utilised. This also adversely affects the quality of education in medical schools.

The overall utilisation of health services is quite low, when data on bed occupancy, admission rates and annual doctor contacts are taken into account. For reasons of this, we may think of financial problems of the population and the low quality of services (on which see below).

5.1.5 Coverage of the system and access to care

As noted above, an important portion of the society is not covered by public health insurance. Although some of those people with no insurance coverage have managed to get a "green card", some have not. However, above all, coverage does not guarantee high-quality service delivery. Recalling the rather unsatisfactory health outcomes in Turkey (*e.g.* infant and maternal mortality, life expectancy), one may even conclude that the actual coverage may be much lower. As indicated in *Turkey: Country Economic Memorandum—Structural Reforms for Sustainable Growth*, long waiting times and lack of drugs and qualified staff discourage people from seeking care even when they are in fact covered by insurance.

The unbalanced distribution of health personnel and infrastructure in the country, as noted above, is serious and affects people adversely in the Eastern and Southeastern parts of the country. To add to this, an effective model to meet the primary health care of the urban population, gradually increasing in line with rapid urbanisation, has not been developed. As evidence, as of 1998, of 100 women who give birth, 27.5 do so at outside health centres; this number climbs to 55.6 in the Eastern regions, declining to 13.4 in the Western ones (Soyer, 2001).

The need persists to extend emergency and first aid services countrywide, together with the desire to improve mobile health services. Private insurance companies usually have their own emergency services. Preventive health care services (especially vaccination) have not been given due priority, and continual and effective provision of these services has not been ensured. As already touched upon, approximately 20 percent of 1-year-old children are not fully immunized (the ratios for the year 1999 are 11 percent for BCG, 21 percent for DPT3, 21 percent for Polio3, and 20 percent for Measles—see *UNICEF Statistics*). Again, wealthy people would normally get preventive services through private units.

An effective patient referral system working across service levels has not been set up yet. As a result, the system's efficiency and effectiveness remains low. Although people have to go first to primary units and then get transferred to higher layers by these units, they tend to go to higher units even if their problems could well be dealt with at low levels, as otherwise transfers may take weeks if not months due to red tape, inefficient management, etc. This puts pressure on higher-layer units, the consequence of which is a reduction in the quality of services provided and longer waiting lists.

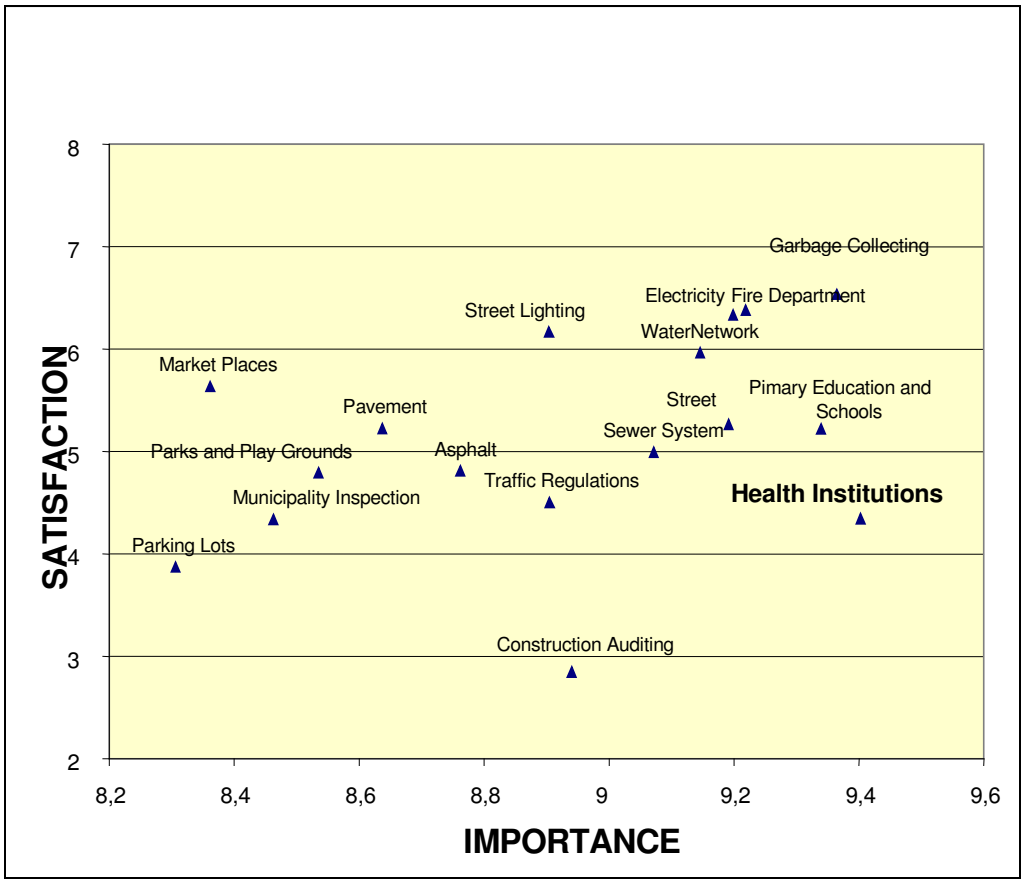
5.1.6 Public acceptance of the system

The health status of Turkey's population compares unfavourably to that of other middle-income countries and falls significantly below the OECD average. When one looks at the major indicators such as life expectancy, infant mortality, maternal mortality, attendance at childbirth, and immunisation, one observes a rather dark picture. (Note for example that, as already mentioned, the infant mortality rate per thousand, which is close to 40, is far higher than the EU average, which is around 5; care should also be given to the fact that life expectancy, which is close to 70, is almost 8 years below the EU average.) Related to this, access to health care in Turkey is highly skewed. There are large gaps in health status between urban and rural areas, between rich and poor in big cities, and between Eastern and Western regions. As some indicators presented above have made clear, the poor carry the highest burden of disease and premature death (see, *e.g.*, Soyer, 2001).

Inefficient use of limited resources and poor management have resulted in a largely run-down public provider system. As mentioned above, due to long waiting times and lack of drugs and qualified staff insured people may even refuse to go to health units.

Given this picture, one should not expect to observe a high satisfaction level in the mind of the general public with respect to health-care services. Indeed, the results of a survey conducted in 1999 on a population of 1206 adults representing the urban population shed some light on this issue (Adaman & Çarkoğlu, 2000). Respondents were given two lists of public services, one provided at the country level and the other at the local level, and were asked to reveal the intensity of importance they attach to these institutions as well as the degree of satisfaction. Figures 5.5a and 5.5b give these results in a matrix form. Of many services, the health-care service was also questioned both at the country level and at the local level. At the country level, one should refer to the macro policy on health care; and at the local level one should understand the health units in one's city. For both cases, as the figures make clear, people attach great importance (around 9.4 out of a scale of 0 to 10, where 0 means not important at all and 10 the most important, respectively), whereas the satisfaction level turns out to be very low (at around 4 out of a scale of 0 to 10, where 0 means no satisfaction at all and 10 full satisfaction). It is therefore telling that health services, which are perceived as the most important issues among the given items (with a value of around 9.4 out of 10), are far from satisfying the urban public at large (with a value of around 4 out of 10).

Figure 5.5a.Importance and Satisfaction at Public Institutions: Local Governments

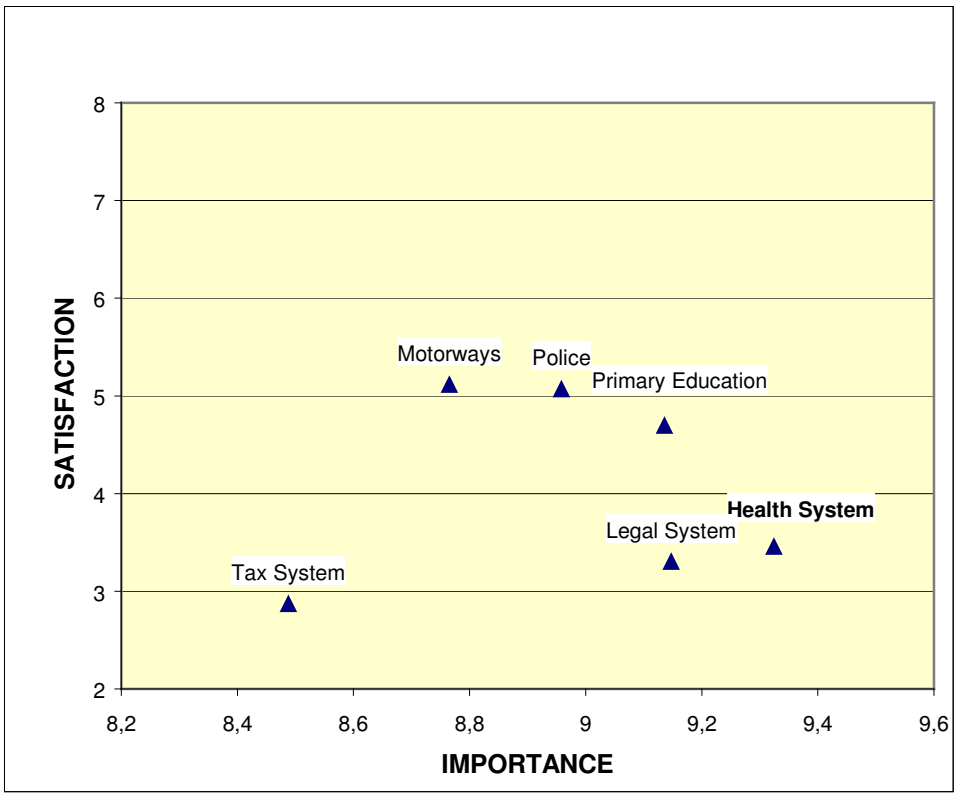


Note 1: Both scales consist of a valuation between 0 and 10.

Note 2: The average figures above are based on household survey that was conducted in 1999 with a sample of 1206 people.

Source: Adaman, F. and A. Çarkoğlu, *Türkiye'de Yerel ve Merkezi Yönetimlerde Hizmetlerden Tatmin, Patronaj İlişkileri ve Reform*, 2000.

Figure 5.5b. Importance and Satisfaction at Public Institutions: Central Government



Note 1: Both scales consist of a valuation between 0 and 10.

Note 2: The average figures above are based on household survey that was conducted in 1999 with a sample of 1206 people.

Source: Adaman, F. and A. Çarkoğlu, *Türkiye'de Yerel ve Merkezi Yönetimlerde Hizmetlerden Tatmin, Patronaj İlişkileri ve Reform*, 2000.

5.2 Evaluation of future challenges

5.2.1 Main challenges

The main challenges facing the system are (as stated in, *inter alia*, Soyer, 2001; *Turkey: Country Economic Memorandum—Structural Reforms for Sustainable Growth; Turkey—Health Sector Reform Project; Government 2002 Programme; 8th Five-Year Development Plan*):

- ✓ To enhance manpower, technology and management capacities of health care units by taking into account international (and EU) norms and standards;
- ✓ To make sure that the patient has the right to receive a basic package of health services;
- ✓ To use the existing resources more effectively and efficiently;

- ✓ To separate the health insurance schemes from the pension system, as the three social security institutions (SSK, Emekli Sandığı and Bağ-Kur) provide both services at the same time;
- ✓ To fight corruption in the health sector;
- ✓ To improve the information database of the health care system—as better data collection being a first step to improve management and to secure collaboration;
- ✓ To render the health care system more transparent and accountable;
- ✓ To give attention to preventive health services;
- ✓ To establish more effective co-operation and collaboration among health units;
- ✓ To develop health education programmes (in order to increase vaccination rates, to prevent sexually transmitted diseases, etc.);
- ✓ To attach importance to the health care of elderly people as the ageing process of the population of Turkey is continuing;
- ✓ To ensure the administrative and financial autonomy of public health units;
- ✓ To restore countrywide equity and fairness;
- ✓ To make sure that the three social security schemes (SSK, Emekli Sandığı and Bağ-Kur) do not generate disparities between services provided;
- ✓ To render the patient management system more effective;
- ✓ To initiate a family practitioner system with an aim at improving primary health care in urban areas;
- ✓ To increase control of food health and safety.

Yet, needless to say, all these are formidable challenges, the totality of which requires not only a substantial increase in the resources allocated to the health sector but also a very major restructuring and reforming of the system.

5.2.2 Financial sustainability

Previous sections have made clear that the share of health expenditures in GDP (that fluctuate at around 4 percent) is relatively small when compared to EU countries. It has also been indicated that the overall satisfaction level of the public at large is low and the basic health indicators are not promising. To increase the satisfaction level and to improve the health status one would normally ask to have a greater share for the health sector. However, without increasing the efficiency level, any attempt to provide better health services may impose a too heavy financial burden on the system. Efficiency depends on, *inter alia*, delivery, management and organisational aspects of the sector.

Within this context attention should be given to the fact that all three social security institutions (Emekli Sandığı, SSK and Bağ-Kur) provide both health insurance and pension coverage, and currently income and expenditures for health insurance are not clearly separated from pension accounts, rendering the assessment of the costs and benefits of health insurance very difficult. Thus, as the World Bank's report on the social security, *Turkey: Country Economic Memorandum—Structural Reforms for Sustainable Growth*, indicates, "Separating the accounts for pension and health would increase transparency, provide comparative information, and facilitate actuarial calculation for long-term sustainability of the health system".

Finally, good governance, accountability and transparency are all needed to fight corruption in the health sector, which would in turn have an important role in increasing the efficiency of the sector.

Financial sustainability thus heavily requires an overall restructuring and reforming of the health sector in Turkey.

5.2.3 Health care policy and EU accession

In the context of the harmonisation process with EU norms, the duties and organisational structure of the Ministry of Health are to be revised in order (*Turkish National Report for the Adoption of the Acquis*):

- ✓ To make preventive health services more effective;
- ✓ To integrate the family physician with initial health services;
- ✓ To convert hospitals into more competitive and autonomous undertakings;
- ✓ To encourage health care staff employed in the public sector to work on a full-time basis;
- ✓ To develop the Refik Saydam Public Health centre as a national reference institution for the purpose of providing laboratory and control services for vaccination, medicine, food, and the environment;
- ✓ To ameliorate the working conditions and specifications of the assistant health care staff;
- ✓ To increase the quality and control in foodstuff safety and security;
- ✓ To fine-tune the medical school curriculum in line with the EU manpower norms.

These priorities are very much in line with the main targets of the State Planning Organisation as set out in the *8th Five-year Development Plan*. The harmonisation process is mainly under the responsibility of the MoH and the Ministry of Labour and Social Security.

A parallel effort has been made for the items of health and safety at work in conjunction with EU accession. The implementing institutions for this heading are the Ministry of Labour and Social Security, the Head of State Personnel, SPO, and the State Statistics Institute.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms and their objectives

Successive governments have in fact attempted to introduce reforms aiming at providing universal coverage to the entire population. The establishment of a general health insurance system, with an aim at covering the entire population, still remains to be realised.

Currently the MoH has been working on a health care reform programme, with technical and financial support from the World Bank, the main phases of which are (*Turkey—Health Sector Reform Project*):

- ✓ To improve access to health care and increase public satisfaction (extending health financing coverage to 100 percent of the population; strengthening delivery of health care through the implementation of an integrated primary health care system; building institutional capacity at the central and provincial levels to implement structural reform changes);
- ✓ To separate the health insurance schemes from the pension system (see above and the Chapter on Pensions) so as to address health insurance and pension issues separately;
- ✓ To consolidate a health investment programme to support investments in further hospital rationalisation and restructuring (including decentralisation);
- ✓ To establish a school of public health.

The objective of providing all citizens with effective access to quality health services on equitable terms with an aim to improve health outcomes remains as a challenge to be met. Such a challenge requires an effective and efficient management of public resources and an effective collaboration and co-operation of health units. Undoubtedly, this long-term goal requires a long-term vision and careful sequencing of reform steps. However, as of today, there is no available information with regard to the details of this long-run programme.

5.3.2 Political directions of future reforms

Apart from general references to the health care issue, in the sense of providing efficient and fair health care coverage to the entire population, a detailed discussion on the ways in which a reform programme with regard

to the health care system could be implemented is not an issue that appears on the political parties' agendas, despite the fact that the State Planning Organisation openly acknowledges the severity of problems in health care. Public opinion by and large, including the media, almost always has a critical tone when the issue of the health-care system is discussed, but one does not see much effort toward a solution for the deep-rooted problems of health care in Turkey. The Chamber of Medical Doctors and a few think tanks, along with some academics, have been trying to analyse this issue, but their impact does not seem to be very high either.

5.4 Conclusions

The *8th Five-Year Development Plan* sets out the health care target as clearly as possible: "Adequate means shall be provided for infants and children to start their lives in a healthy way; for young people to have the knowledge and ability to protect and improve their own health; for individuals to increase their life-span and quality far from disability and illness and for the aged particularly, to continue their living activities without help and thereby contributing to the society." As it stands, of course, no one would object to this statement.

However, the challenges are formidable: more funds should be made available to the health care sector, and the whole sector should be rendered more efficient, transparent, accountable, fair and equitable. This necessitates, on the one hand, reconsidering social priorities (note the low share of health care in the GDP) and, on the other, designing and implementing a public reform programme aimed at restructuring the health sector by paying attention to different dimensions of the system, that is to say its delivery, management and organisational aspects. The poor health status of the population relative to the country's income level, inequitable access to health care, insufficient preventive measures, inefficient use of actual resources in health care, and ineffective public governance on health-related issues are all indicative of the need for a radical reshaping of the sector. Furthermore, bribery and corruption are widespread as well as patronage networks, all of which make the whole system less efficient and probably less effective. Piecemeal reform programmes have so far been initiated, but their impacts remain marginal.

The question that needs to be answered, therefore, is whether the society, and to a larger extent the state, is prepared to launch an all-encompassing reform initiative in the health sector, and if so, who is going to pay the costs of such a transformation and whether there exists the required competence to run this reform.

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