ESPN Thematic Report on Inequalities in access to healthcare

Turkey

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The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary/Highlights

The current healthcare system in Turkey is shaped by the 'Healthcare reform', which has been in place since 2003, a major component of which is a premium-based general health insurance system, established in 2008 and extended to the total population in 2012. For general health insurance, employees registered with the Social Security Institution have their premiums automatically deducted from their pay. For the registered self-employed, premiums vary with reported income and, unlike those for employees, are paid directly by the insuree. For low-income households, defined as those with per capita household income less than one third of the gross minimum wage, premiums are paid by the government following a means-testing procedure. The premiums paid by employees and self-employed people cover dependants as well. Those younger than 18 years old are automatically covered as long as they are registered with the system, even if their parents are not insured. Health insurance has a wide coverage that includes inpatient and outpatient care, prescription drugs, physical therapy and dental care: but not cosmetic surgery that is not medically necessary, or cosmetic dental care. A great number of self-employed people are currently in arrears with their premiums and are thus in debt to the insurance system.

All individuals, insured or not, are registered with a family physician, who is responsible for primary healthcare, and access is free even if health insurance premiums have not been paid. Secondary and tertiary care is provided by public and private providers. Although coverage is comprehensive, insurees have to pay additional user fees for the services they utilise.

The current system, although improved with the 2003 reform initiative, has some flaws. First, there are regional differences in the provision of care. Second, public providers have waiting times, especially in diagnostics and surgery; and although it is possible to access these through private providers, the charges are usually difficult to afford for low-income households. Third, the emphasis has been on curative services over preventive ones, hence damaging the comprehensive approach in medical practice. Fourth, the quality of care is claimed to be an issue, especially for low-income households: this is because payment schemes for specialists are based on fee-for-service, which incentivises the quantity of services at the expense of quality. Fifth, out-of-pocket expenditure, especially informal payments to providers, which may be large, continue to exist. Last but not least, the new health insurance system has failed to provide universal coverage; the prevalence of informal working, and difficulties in observing household incomes, lead the authorities to use proxies which often fail to identify low-income households.

1 Description of the functioning of the country's healthcare system for access

The current healthcare system in Turkey is shaped by the 'Healthcare reform', which has been in place since 2003 (Akdağ, 2010, 2011). A major component of the system is a premium-based 'general health insurance' system, established in 2008 and extended to the total population in 2012. Although private health insurance is also available, it is rather expensive and only 5.4 percent had it by 2015 – most through their employers in white-collar jobs, to complement public health insurance (OECD, 2017).

For general health insurance, employees registered with the Social Security Institution (SSI) have their premiums (12.5 percent of their reported income, of which 7.5 percentage points is paid by the employer) automatically deducted from their pay. For the registered self-employed, premiums vary with reported income and, unlike those for employees, are paid directly by the insuree. The premiums paid by employees and self-employed people cover dependants as well.

Unemployed and informal workers, unless they qualify as a dependant of an insured person, are required to make a premium payment of 60.88 TL (€12.22)[1] per month per person. For low-income households, defined as those with per capita household income less than one third of the gross minimum wage, premiums are paid by the government following a means-testing procedure.

Self-employed people and workers registered with the SSI cannot apply for means-tested assistance to pay for public health insurance. While deductions are automatically made from the pay of workers, it is common among self-employed people to fail to make premium payments.

Those younger than 18 years old are automatically covered as long as they are registered with the system, even if their parents are not insured. Students are covered as dependants if their parents are insured while they are studying; and also for two years following graduation, as long as they are younger than 20 years old in the case of high-school students and 25 in the case of university students.

Those individuals who do not pay their premiums become indebted and have to pay the full cost of healthcare: otherwise they cannot access hospital services. Official figures, also found in the OECD 'Health Statistics', indicate a health insurance coverage rate of 98 percent in 2015 (OECD, 2017). This figure, however, reflects the compulsory nature of insurance, and also counts those who are in arrears in paying premiums and thus unable to make use of hospital services. In 2014, during an amnesty for premium debts, the number of those in arrears was announced by the SSI to be around 7 million, around 9 percent of the total population. Of these, around 5 million were automatically registered for health insurance but had never paid their premiums (Bülbül, 2015).

Uninsured people are composed of unemployed individuals, informal workers, and formal and informal self-employed people, as well as their dependants. As statistics are unavailable with regard to who lacks coverage, the exact composition is not known. However, it would be safe to assert that informal employment and unemployment are the major risk factors.

Health insurance has a wide coverage that includes inpatient and outpatient care, prescription drugs, physical therapy and dental care. Cosmetic surgery that is not medically necessary and cosmetic dental care are not included. *In vitro* fertilisation (IVF) is covered until the age of 39.

Regarding healthcare provision, all individuals, insured or not, are registered with a family physician, who is responsible for primary healthcare. Access to primary care is free

[1] At 4.98 Euros/TL: average exchange rate for April 2018.

even if health insurance premiums have not been paid. In 2016 the average number of individuals per family physician was 3,267, ranging between 3,011 in north-eastern Anatolia and 3,395 in Istanbul (MoH 2017). Family physicians also provide services at home to elderly and disabled people, as well as those in remote locations in rural areas one day per week. There is work in progress to extend office hours to cover evenings and weekends.

Secondary and tertiary care are provided by public and private providers. All public and most private providers have contracts with the SSI, hence their services are covered under the general health insurance scheme. Although coverage is comprehensive, with only a few private hospitals outside the network, insurees have to pay additional fees (user fees) for the services they utilise. A user fee is paid for outpatient clinic services (except for family physician visits), medication prescribed in outpatient clinics, prosthetic and orthotic aids, and IVF services. Additionally, in the case of attendance at secondary and tertiary healthcare services, a user fee is charged. These fees were first implemented in 2009, stayed the same for seven years, and were increased by 20-25 percent in 2017. The charge is 6 TL (€1.20) for public providers and 15 TL (€3.01) for private providers. There also are co-payments for prescription drugs.

Private providers are also allowed to charge users, at rates ranging from 30 to 200 percent of the payment by the SSI, for medical procedures. It is often reported that charges exceed these thresholds. Although there are private complementary health insurance schemes that cover additional charges, take-up of these is low, especially among the low-income population.

Hospitals cannot charge co-payments or any additional payment for: cancer treatment; emergency care; intensive care; burn treatment; services to the new born; organ, tissue and cell transplantation; surgery for congenital anomalies; dialysis; and cardiovascular surgery. Emergency care is provided free of charge even in private hospitals that do not have a contract with the SSI. Informal payments to providers constitute another component of out-of-pocket health expenditure. Official data are lacking, and the available evidence is discussed in the next section.

Health expenditure was 4.6 percent of GDP in 2016, lower than in all EU countries, corresponding to 1,524 TL (€305) per person per year. All in all, out-of-pocket health expenditure per capita was 249 TL (€50) in 2016, corresponding to 16.3 percent of all health expenditure according to the Turkish Statistical Institute (TurkStat) (calculated from the household budget survey). 41 percent of it was on hospital services, 17 percent on outpatient services, 36 percent on medical goods, and the rest on other items. Catastrophic health expenditure, defined as health expenditure of 40 percent or more of payment capacity, was incurred by 0.29 percent of households, and 0.1 percent of households were impoverished due to such expenditure.

There are regional differences in the provision of care. The number of hospital beds per 10,000 population is lower than average in south-eastern Anatolia and urbanised western provinces. On the other hand, these regions have a higher-than-average number of intensive care unit beds per 10,000 population. The prevalence of magnetic resonance imaging (MRI), computed tomography (CT) and other diagnostic devices is lower in eastern regions. In recent years, the Ministry of Health (MoH) has invested in vehicles such as air, sea and snow-track ambulances to provide emergency services to remote areas, having served about 10,000 people in 2016 (MoH, 2017).

Although there is a significant variance in the use of hospital services across regions, it is difficult to interpret the data, as information on needs is not easily available. However, the number of surgical operations displays an interesting picture. While minor operations per 1,000 population are similar across provinces, the incidence of medium-level operations in eastern regions is about three quarters of the national average rate, and that for major operations is half of it.

The number of physicians per 100,000 population is 122 in the south-eastern region, significantly lower than the national average of 181, which in turn is lower than the figure

in all EU countries – the closest to it being 151 in the mid-eastern region.[2] A similar picture is observed in the distribution of dentists, pharmacists, nurses and midwives.

While the south-eastern, mid-eastern and north-eastern regions have a shortage of healthcare staff, they have a higher age-dependency ratio and higher under-five mortality (17.7, 16.6 and 15.7 per 1,000 live births respectively, compared with the nationwide average of 11.9) (MoH, 2017). Considering that Turkey's nationwide average of 11.9 is below that for Romania, the EU's lowest figure, it is clear that the situation in those regions is alarming. Third-dose immunisation coverage against major diseases is lacking for 5 to 7 percent of the population in eastern regions, while the average for Turkey is 2 percent.

Public providers have waiting times, especially in diagnostics and surgery. It is possible to access these through private providers, but the charges are usually difficult to afford for low-income households. A number of big hospitals, called 'city hospitals', have been constructed and are gradually coming into operation. The first city hospital started to provide health services in Yozgat in 2016, and since then four others have been begun operating in Adana, Isparta, Kayseri and Mersin.[3] City hospitals were established as 'public-private partnerships' (Öncü, 2017). A total capacity of 41,000 beds will eventually be added thanks to the project. It is argued that once these are working at full capacity, waiting times will be largely reduced. It is, however, also pointed out that these hospitals are usually outside the cities, creating concerns regarding travel expenses for access, etc. Other important issues that need to be addressed are the risk of interruption of health services because of the huge sizes of the campuses, shortages of health personnel in such large units, and the economic cost to be paid when the capacity guarantee cannot be provided. Symposiums, panels and other scientific organisations are continuing to examine city hospitals, and their reports share common criticisms.[4]

The main criticism is over the emphasis on curative services rather than preventive services, which is damaging to a comprehensive approach in medical practice. More specifically, it is indicated that whereas there was a quantitative improvement, albeit limited, in those services (such as immunisation, and monitoring of pregnant women and infants) included in the performance-based contracting system, those services not covered by performance targets (such as family planning, postpartum follow-ups, and chronic disease management) were by and large neglected (Öcek et al., 2014).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The healthcare reforms initiated in 2003 were designed to improve access and efficiency. During the reform process, satisfaction with health services increased to 72 percent of the population in 2015, among the higher rates for OECD countries. Local studies highlight the fact that the population finds healthcare services more accessible and available relative to pre-reform years (Ali Jadoo et al., 2014). That being said, there still are issues waiting to be addressed.

To begin with, the new public health insurance system has failed to provide universal coverage. Means-tested public assistance for premiums covers about ten percent of the population. The prevalence of informal working, and difficulties in observing household incomes, lead the authorities to use proxies that often fail to identify low-income households. For example, someone is not considered for assistance if they are registered with the SSI. Self-employed people, who make premium payments themselves, often fail

[2] MoH, 2017: page 206.

[3] See MoH's website for a list of city hospitals in operation and under construction (in Turkish): http://www.saglikyatirimlari.gov.tr/TR,33960/sehir-hastaneleri.html

[4] See, for example, Turkish Medical Association's City Hospitals Watch Group website: http://www.ttb.org.tr/kollar/_sehirhastaneleri/

to pay them and are not covered. Although the premiums of 60.88 TL (€12.22) for 2018, for those not registered with the SSI, appear low, it is a significant burden considering that informal wages are usually below the minimum wage level of 1603 TL (€321).

Erus et al. (2015) find that a considerable proportion of the population in poverty is without health insurance. In their analysis of EU-SILC data from 2007, they find that, among those below the means-testing income threshold, non-take-up was as high as 44 percent; and it was 28.56 percent among those with income below the 'complete poverty threshold' calculated by TurkStat. In a separate survey conducted by the authors of the above article, targeting those lacking social security coverage, they found that among those without health insurance coverage 9.13 percent had out-of-pocket expenditure on healthcare exceeding 10 percent of their income.

As TurkStat stopped collecting information on health insurance coverage following the introduction of the universal health insurance scheme, we cannot measure coverage in recent years. However, it should be noted that the share of those who have free means-tested public health insurance has stayed about the same since 2007. As noted above, during the amnesty of 2014, it was found that as many as 7 million individuals, around 9 percent of the population, had not paid their premiums and hence were not covered.

Apparently, the amnesty in 2014 did not resolve the issue, and new legislation in 2018 has restructured the debt once again and granted access to hospital services until the end of 2018 to those in arrears. Repeated amnesties and restructuring of the debt indicate that the government continues to have difficulties in collecting the premiums, which inevitably creates concerns about the sustainability of the system in the long run.

Another barrier is out-of-pocket expenditure, especially informal payments to providers, which may amount to large payments. Erus (2016) finds from the household budget survey that 71 percent of households made a payment for healthcare in 2013. Both the prevalence of payments and their share of household budgets increase with household income level.

As noted above, data are lacking regarding informal payments. An analysis of out-of-pocket payments (Tatar et al., 2007), based on a survey conducted in 2002, found that informal payments constituted 25 percent of all out-of-pocket health expenditure and 38 percent of payments to public care providers. Spending on medication ranked first in both formal and informal payments to public providers. Among insured patients, however, almost 80 percent of all informal payments were made to physicians; the major reason for this was "to receive more careful attention from doctors". According to the authors, these findings indicate under-insurance and the prevalence of physicians working part-time in the public sector. Unfortunately, no similar study was conducted after the reforms that banned public hospital physicians from operating their own private practices.

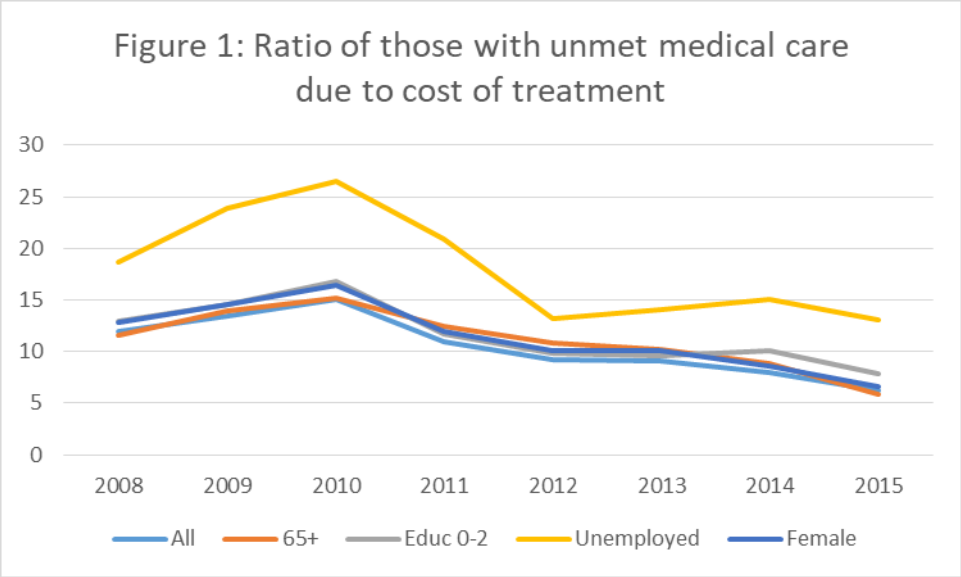
The latest comprehensive survey on corruption in Turkey was conducted in November 2008, replicating a similar one conducted in 2000. Aiming at measuring citizens' perception of public service delivery, the survey provides important clues (Adaman et al., 2009) and gives an opportunity to compare the years 2000 and 2008. The survey had a sample size of 2,040 – representative of urban Turkey, which comprises roughly 70 percent of the total population. Respondents said that the prevalence of bribery in hospitals, although continues to be a problem, had decreased in the last eight years. On a scale of 0-10, where 0 denotes no bribery and 10 full bribery, the average for prevalence of bribery in health services decreased from 5.6 to 4.3 between 2000 and 2008; the proportion saying that bribes were common for health services they had the right to access decreased from 50 percent to 42 percent between 2000 and 2008. When people were asked about their own experiences, among those who visited public hospitals, 1.5 percent revealed that they had had to give bribes in the past year. A relatively recent study conducted worldwide by Transparency International, 'Global

Corruption Barometer 2013'[5], indicates that in the 'medical and health' sector, the level of perceived corruption in Turkey was reported to be 3.2, on a scale of 1-5, where 1 indicates not at all corrupt and 5 extremely corrupt. This figure still tends to indicate significant levels of corruption, despite the AKP's government efforts to combat corruption in its early years.

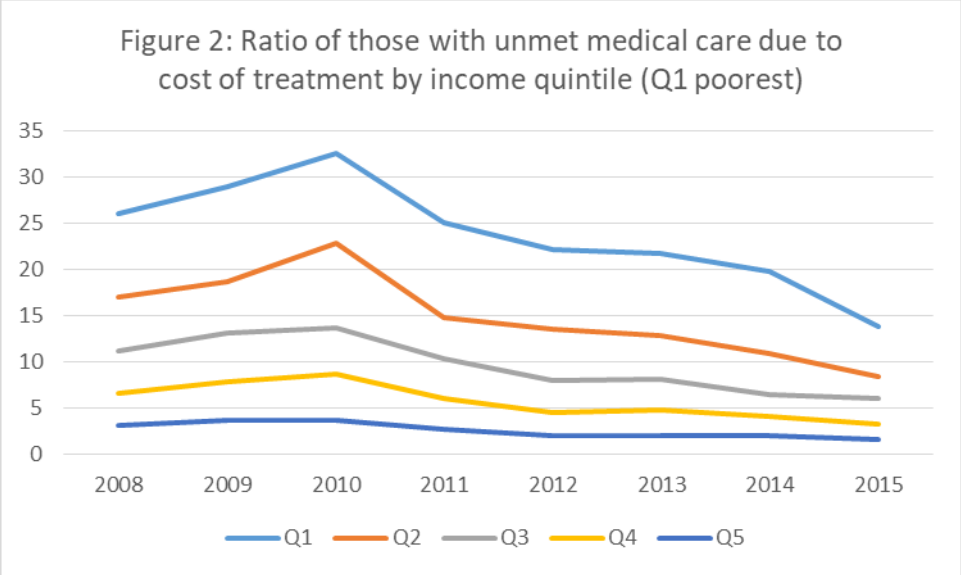
Both the lack of universal coverage and the significant level of out-of-pocket expenditure contribute to issues in accessing healthcare services. According to EU-SILC statistics, the ratio of those above the age of 16 who could not access a medical examination for financial reasons was 6.2 percent in 2015. The rate was clearly higher than the EU average of 1.9 percent. The rate was similar for elderly people, at 5.8 percent, but slightly higher for women, at 6.6 percent. The rate was significantly higher for unemployed people, at 13.1 percent. There has been a significant improvement over recent years as the overall rate was 15.1 percent in 2010 (see Figure 1).

Inability to access a medical examination for financial reasons was found to be correlated with income. 13.8 percent of those in the poorest quintile cited financial reasons for their inability to access medical care, but only 1.6 percent of those in the top quintile (8.4 percent in the second-lowest, 6 in the middle, and 3.2 percent in second-highest income quintile). Just as with the ratio for the whole population, there have been large drops in these figures since 2008 (see Figure 2).

[5] https://www.transparency.org/gcb2013



Source: EU Statistics of Income and Living Conditions.



Source: EU Statistics of Income and Living Conditions.

The share of those who cited travelling distance as a reason for their inability to access medical care was 0.6 percent. This nonetheless appears to be an issue, though, as the rate among those older than 65 was 2.1 percent. The share of those who cited waiting lists as a reason was 0 percent in 2015 and 0.4 percent in 2014.

Shortages of health personnel are an issue, especially in less developed regions. To address the issue, the MoH has a compulsory service requirement for new graduates. The term of the service ranges from 6 months to 2 years depending on the location. While the policy provides health personnel for less developed and remote areas, the motivation of the personnel and the high turnover rate make the quality of care questionable. It should be noted that in the last decade there has been a significant increase in the number of medical school students. Hence, the shortage of physicians may be less of a concern, especially in non-specialised care, in the years to come. The quality of education that accompanies a higher number of students, however, is an important concern, as indicated in the reports by the Higher Education Council of Turkey.

The quality of care may also be a particular issue for low-income households, as the payment schemes for specialists are based on fee-for-service, which rewards quantity of services at the expense of quality. There have been claims that the system has created demand inducement and unnecessary surgical operations/treatments. Only high-income households are able to use private treatment to secure good-quality health services.

Finally, we should note three important issues regarding access. First, for those who have their premiums paid by the government, the means-testing procedure involves a thorough investigation of a household's circumstances, which often results in their application status being exposed to their neighbourhood – an infringement of their privacy.

Second, we should note that, although there has been a significant improvement in healthcare access over the last decade, the lack of ID cards creates a barrier of access. Lack of an ID card used to be a common problem among Roman people till the last decade; currently it is of much lesser level. Still, it is as of today thought that Romans without an ID card, mainly due to under-age births, constitute around 1 percent of the total Roman population in Turkey—which is about 500,000-750,000, or 0.6-0.9 percent of the total population (Foggo, 2018).

Third, the recent influx of Syrian refugees (of around 3.5 million) has created serious shortcomings in the health system. Recently, partly with the help of EU funds, health services have been made available in a more systematic way. Refugee health centres have been opened. The target for each primary healthcare service centre is to serve 4,000 refugees. In addition to camps that are far from public hospitals and in locations with more than 20,000 refugees, comprehensive health centres have been opened to provide internal medicine, paediatrics, obstetrics, dental care, psycho-social support services and imaging, along with primary healthcare services. There will be a total of 171 such centres. In some of these centres, in cooperation with the United Nations Population Fund (UNFPA), women's health consultation centres have also been established.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Turkey lacks adequate statistics regarding public health insurance coverage. As the SSI provides figures based on the automatic enrolment of individuals, and disregards the fact that a large number of individuals fail to pay premiums, the statistics do not capture the extent of non-insurance. As TurkStat has also stopped asking about health insurance coverage in its surveys, arguing that universal coverage has been reached, there exist no public data to assess insurance coverage other than occasional announcements by politicians/academics/journalists.

Regarding out-of-pocket expenditure, the household budget surveys are the most common tools used. However, TurkStat does not provide a breakdown by household characteristics. An important indicator to track lower-income households is catastrophic health expenditure. The lack of a distinction between informal and formal payments is a major shortcoming in assessing barriers to access.

The MoH publishes statistics on the healthcare infrastructure and workforce at regional and provincial levels. These can be considered as accurate, but may fail to reflect variations within provinces.

The major shortcoming in health-related statistics is the lack of indicators of healthcare quality. While the EU-SILC question on unmet medical needs provides a measure of those who cannot get medical care, it does not reflect problems in the quality of care.

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