



International  
Labour  
Organization

# ▶ Extending social health protection: Accelerating progress towards universal health coverage in Türkiye

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## ▶ 1. Introduction

Türkiye is an upper-middle-income country with a population of 84,680,273 in 2021 (TURKSTAT 2022). With a GDP of US\$906 billion, and US\$10,616.1 per capita, Türkiye is the 19th-largest economy in the world. The country's Human Development Index (HDI) was 0.853 in 2023, ranking Türkiye as the 51st country worldwide (UNDP 2025). The share of people below the US\$5.50 per day poverty line fell by three-quarters to 8.5 per cent between 2002 and 2018. High inflation and high unemployment have been exacerbated by macro-financial instability since August 2018. In addition, the COVID-19 crisis has deepened gender gaps, exacerbated youth unemployment and increased the poverty rate (World Bank 2022). The total informality rate declined between 2004 to 2018 from 50.1 per cent to 33.4 per cent, and the informal employment rate among salaried workers reached 13.7 per cent in 2021 (Bank for International Settlements 2023; Bağır et al. 2021).

Türkiye launched a series of reforms under the Health Transformation Programme (HTP) between 2003 and 2013. Its main goal was to provide universal health coverage and ensure equitable access, strengthening primary care services and expanding the capacity of hospitals. The HTP undertook several measures to achieve these goals. First, all public health facilities were merged under the Ministry of Health to consolidate the provision of public health care services under one authority. The second major reform was realized through the financing of health care service use via the establishment of the *Genel Sağlık Sigortası* General Health Insurance Scheme (GHIS), which covers the whole population. The third area of reform was in primary care: A pilot family practitioner scheme was introduced and this scheme was later extended to cover the whole population at the end of 2010 (European Observatory on Health Systems and Policies 2011).

Overall, the HTP has positively impacted all aspects of the national social health protection system, resulting in the substantial extension of population coverage, which reached 98.8 per cent of the population by 2021 (from 69.8 per cent in 2002), as well as improved access to and financing of health care services (OECD n.d.-c).

## ▶ 2. Context

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The foundations of the current public health system for Türkiye were established during the period 1923-46. The focus was on preventive public health programmes and programmes to control communicable diseases such as tuberculosis, malaria and leprosy. In 1961, the Law on Socialization of Health Services (Law 224) was adopted. The law provided the basis for the establishment of national health services in Türkiye and stated that health services should be delivered in an equitable manner, continuously and in accordance with the needs of the population. The law aimed at providing free (or partly free) health care to all citizens, and financing came from co-payments and allocations from the government budget (OECD 2009).

In 1963, for the first time, health was included in the five-year development plan. The objectives of the first five-year development plan for the health sector were to: i) Give priority to preventive health care; ii) provide public health services through the Ministry of Health; iii) distribute health personnel evenly throughout the country; iv) promote community health services; v) encourage the domestic pharmaceutical industry; vi) support the establishment of private hospitals; vii) establish Universal Health Insurance; and viii) set up revolving funds in government hospitals. A general Health Insurance Law promoting the idea of Universal Health Insurance was subsequently drafted, but it was not until 1971 that this was forwarded to the Turkish Grand National Assembly, and ultimately it was not adopted (OECD 2009).

The series of reforms initiated under the HTP in 2003 have led to the achievement of UHC and improvements to the current health care system (Bump et al. 2014). The GHIS — a universal health insurance scheme placed under the social security institution — is one of the main pillars of the programme, which was introduced in 2008 and extended to all in 2012 (Adaman et al. 2018). The GHIS is compulsory for all and includes both contributory and non-contributory pathways for enrolment (SGK 2021).

Before the reform, the social health protection system was characterized by fragmentation into separate schemes, each of which had different benefit packages and requirements: The *Emekli Sandigi* Government Employees Retirement Fund (GERF) for retired civil servants; The *Sosyal Sigortalar Kurumu* (SSK) Social Insurance Organization for white and blue collar public and private workers and their dependents; *Bag-Kur* for the self-employed; and the Green Card scheme to provide health benefits to the poor and vulnerable who were incapable of paying for health services. The Green Card programme was considered a transitional solution until universal health insurance was introduced (OECD 2009). It was expanded from 2003–2006 and provided citizens with extended benefits which helped to reduce OOP spending and catastrophic health expenditures for those in the upper end of health spending distribution (Tirgil et al. 2019). Active civil servants were not included in GERF, and their expenses were directly financed from the state budget. Service delivery was similarly fragmented, since many public health facilities were implemented under SSK, and the others were overseen by the Ministry of Health (Menon et al. 2013). By October 2008, the health care schemes were harmonized entirely, and all service users were covered by GHIS under a single umbrella (Burcu 2013).

Türkiye undertook extensive reforms in order to merge different insurance schemes and achieve integration and cross-subsidization. In 2006, the GHIS was established under the Ministry of Labour and Social Security to merge all existing health schemes (social insurance for merchants, artisans and the self-employed, the Green Card scheme and the GERF) under one umbrella, namely the social security institution known as SGK. In addition, various health care users were granted access to additional health care services. For example, Green Card holders were given access to outpatient care and pharmaceuticals, whereas SGK beneficiaries were given access to all public hospitals and pharmacies. Moreover, in 2006, the pharmaceutical list was integrated across all health insurance schemes, including that of Green Card holders. In 2007, legislative measures mandated that all Turkish citizens have access to free primary care, even if not covered under the social security system. Subsequently, under the Health Implementation

Decree of 2007,<sup>1</sup> benefits across the health insurance schemes were further harmonized and finalized in 2008 (Bazyar et al. 2020).

According to the new Social Insurance and General Health Insurance Act No. 5510 of 31 May 2006,<sup>2</sup> the same benefit package is provided to all. All individuals registered with the GHIS can benefit from public health facilities without or with very limited co-payments. Although private health insurance is also available on a complementary or supplementary basis, it is relatively expensive, and only 7.6 per cent of the population were members in 2020 (OECD n.d.-d). Moreover, individuals with private health insurance cannot opt out of compulsory public health insurance; they have to pay premiums and contributions to both schemes separately (Dorlach and Yeğen 2023).

The Ministry of Health developed a new Strategic Plan for 2019-2023. It aims to strengthen primary health care services and increase their efficiency, ensuring improved access, greater efficiency and higher quality of health care services by focusing on service users and medical personnel satisfaction with the use and provision of health care.

## ► 3. Design of the social health protection system

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### Financing

Türkiye's public health care spending as a share of GDP was among the lowest of the OECD countries in 2020. In 2020, Türkiye spent 4.6 per cent of its GDP on health, while the average value for OECD was 8.8 per cent. In the first three years following the introduction of the HTP in 2003, although health expenditures rose rapidly, increases in both total and public spending on health care seem to have remained affordable because economic growth in Türkiye was also rapid. However, Türkiye's current health spending represents a decline since 2009 when it reached 5.5 per cent (WHO 2020; OECD 2009).

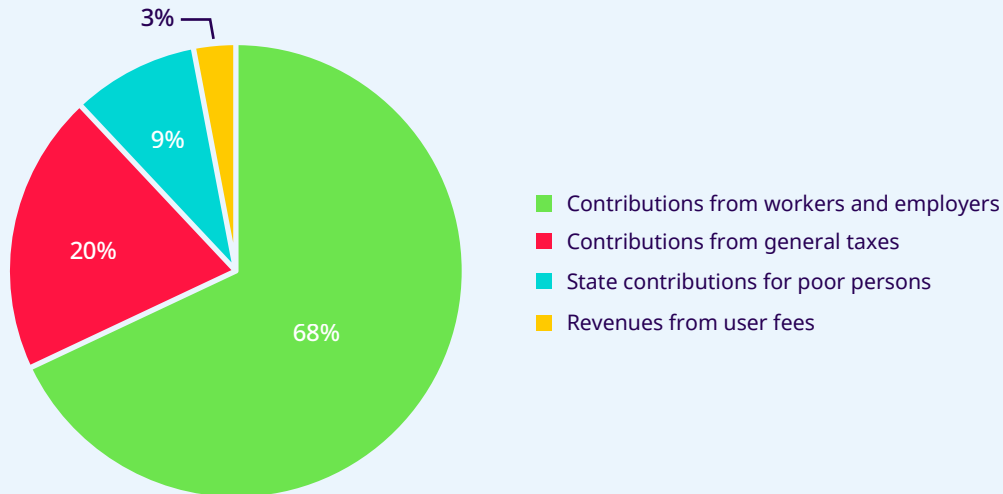
Türkiye's GHIS is a compulsory universal health insurance scheme, which both employers and workers contribute to. According to Law No.5510, the total contribution rate for the scheme is 12.5 per cent, whereby employers pay 7.5 per cent and employees pay 5 per cent. Contributions for employees, civil servants, the self-employed and foreigners are defined as a share of their wage. The Unemployment Fund pays the contributions of persons who are eligible for unemployment benefits. Contributions of pensioners are paid either by SGK or the State depending on their status. Unemployed persons who are not eligible for unemployment benefits and informal workers pay contributions for themselves, based on a means-test assessment.

Contributions are collected and pooled through the account of the SGK and operated by the General Department of Universal Health Insurance (see below). The Government contributes to the revenues of the SGK by financing the groups that are included on a non-contributory basis. Furthermore, through the Ministry of Finance, the state subsidizes the SGK by compensating the institution's deficits from general government funds and transferring funds amounting to 25 per cent of the collected contributions in monthly instalments as per the Law of 5510 (Tuncer et al. 2017) (Venkateswaran and Singh 2022).

<sup>1</sup> Social Security Institution Health Implementation Notification No. 26532 dated 25 May 2007, available (in Turkish) at: <https://www.mevzuat.gov.tr/File/GeneratePdf?mevzuatNo=17229&mevzuatTur=Tebliğ&mevzuatTertip=5>

<sup>2</sup> Social Insurance and General Health Insurance Law No. 5510 dated 31 May 2006, available (in Turkish) at: <https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=5510&MevzuatTur=1&MevzuatTertip=5>

Figure 1. Revenue source distribution of Universal Health Insurance Fund of Türkiye, 2019



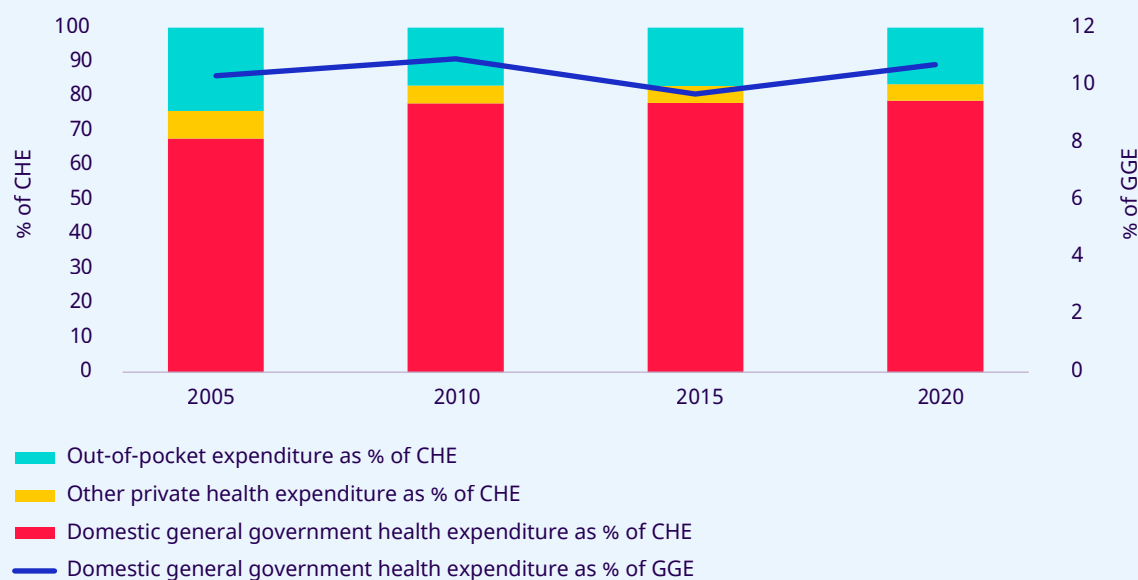
Source: SGK 2021.

For the period 2013-2022, there has been an upward trend in revenue collection from SGK, with a slight decrease following COVID-19. Contributions make up the majority of the total revenues, followed by State contributions (see figure 45). A challenge was first posed to SGK related to the collection of contributions for persons who pay for themselves—those who have a per capita income exceeding the threshold for contribution exemption as per means-testing. In 2017, there were 1.9 million individuals (2.3 per cent of the population) in this category, most of whom were informal workers. SGK therefore experienced difficulties in collecting regular contributions from this population group. As a solution, contribution amnesties were issued every few years. However, since 1 April 2017 (in line with Law No. 6824),<sup>3</sup> contributions are now fixed at 3 per cent of the monthly gross minimum wage for all persons in this group (Yenimahalleli 2019).

There has been a decline in OOP payments since GHIS became compulsory. The ratio of household OOP expenditure as a share of total health expenditure was 16.0 per cent in 2020 (TURKSTAT 2021).

<sup>3</sup> Law on Restructuring some Receivables No 6824, issued in Official Gazette No. 30001, dated 8 March 2017, available (in Turkish) at: <https://www.mevzuat.gov.tr/MevzuatMetin/1.5.6824.pdf>

Figure 2. Composition of current health expenditure (CHE) in Türkiye, by source of financing, 2005-2020



Source: Based on data from the WHO Global Health Expenditure Database.

## Governance

The SGK is an autonomous public authority with administrative and financial functions and the only government institution that has a mandate for social protection in relation to health in Türkiye. Its legal structure is based on the Law No. 5510 on Social Security and General Health Insurance.<sup>4</sup> According to this law, SGK is responsible for implementing and managing the social security system in Türkiye, including collecting social security contributions and providing various social security benefits to eligible individuals. The institution is overseen by an Administrative Board, composed of 12 members (SGK 2020). Six members are appointed by the State: One member from the Ministry of Family, Labour and Social Services, two members from the Ministry of Treasury and Finance, and three members representing the SGK (the SGK president and two of the vice presidents). The other six members are elected for a three-year period by social partners in the General Assembly, and represent employees, employers, civil servants, pensioners, self-employed persons in the agricultural sector and self-employed persons outside the agricultural sector. The Administrative Board is chaired by the President of SGK and meets at least once a week (SGK 2020).

At central level, the SGK General Directorate for Universal Health Insurance administers the GHIS scheme, including reimbursements, benefits, pricing for health care services and purchasing services from health care service providers. Social contributions are collected through the account of the Institution and operated by the Directorate (SGK 2021).

## Legal coverage and eligibility

The right to health is enshrined in the Constitution of Türkiye, according to which “everyone has the right to live in a healthy and balanced environment.” Articles 60 and 61 refer to social security rights. Article 60 states that: “Everyone has the right to social security. The State shall take the necessary measures and

<sup>4</sup> Social Insurance and General Health Insurance Law No. 5510 dated 31 May 2006, available (in Turkish) at: <https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=5510&MevzuatTur=1&MevzuatTertip=5>

establish the organization for the provision of social security.” Article 61 emphasizes the State’s duties to protect children, widows, orphans, disabled persons and older persons.

The Social Insurance and General Health Insurance Act No. 5510 of 31 May 2006 entered into force on 1 October 2008 alongside the social security reform. The national law guarantees health insurance for all based on mandatory enrolment.

The GHIS applies different eligibility criteria based on vulnerability and income level. The GHIS consists of a contributory scheme and a non-contributory means-tested scheme that provides health coverage to all citizens and residents of Türkiye. In addition, nationals and foreigners residing in Türkiye for more than one year, who do not have health insurance coverage from another country, qualify. Registration is made on a family basis, whereby family members, including spouses, children under the age of 18, high school students under the age of 20, higher education students under the age of 25, disabled children, and parents determined by SGK as indigent are covered as dependants. This applies only if these family members are not insured or are not receiving any pension or benefit from SGK. Children continue to be considered dependants within two years of their high school or university graduation, provided they are no older than 25 and are not already included as contributors. During this period, they are not obliged to pay contributions, without an income test (Ezer 2023).

In order to be covered under GHIS as a self-registered contributor, a minimum contribution payment period of 30 days is required within one year prior the date of accessing health care. Self-employed persons should have no more than 60 days of contribution debt (SGK 2021). Exemptions are applied to all persons below the age of 18, pregnant women, those employed by SGK, stateless persons, refugees, those with incomes below one-third of the minimum wage in Türkiye, and those in receipt of social assistance benefits (ESCAP 2019). Coverage of vulnerable groups is subsidized by the State. Diplomats, short-term visitors, temporary residents who are residing in the country less than a year, convicts, detainees, prisoners and illegal immigrants are not eligible as per the Social Insurance and General Health Insurance Law of 2006.

In addition, the following groups are not covered by the GHIS because their own institutions pay their health care costs (SGK 2021).

- ▶ Members of the cabinet appointed from the Grand National Assembly of Türkiye whose appointments are terminated, and deputies and their dependents.
- ▶ Presidents and members of higher judicial bodies including retirees and their dependents.
- ▶ Chiefs of General Staff and Force Commanders and those who are in the ranks of General/Admiral, including retirees and their dependents.
- ▶ Participants of funds established for banks, insurance and reinsurance companies, chambers of commerce, chambers of industry, stock exchanges or their associations and their dependants.

## Benefits

Under the GHIS, free access to health care is the right of affiliates and their dependents. There is a rigid rule against establishing any relationship between contribution levels and health care benefits level and duration under the system. Therefore, everyone is entitled to receive equal benefits on the same basis, with the system broadly applying the principle of solidarity (SGK 2016).

Primary health care facilities of the Ministry of Health, as well as workplace doctors within the public administration, provide services for free. The GHIS benefit package is an addition to these services and provides a comprehensive package and entitlements for a range of preventative, diagnostic and curative services, providing both inpatient and outpatient care services. GHIS benefits include the following (SGK 2021):

- ▶ Medical treatment, preventive health care services and emergency health care services;
- ▶ Pregnancy and maternity care;
- ▶ Laboratory tests, analysis and other diagnostic methods;
- ▶ Surgery;
- ▶ Vision, hearing and dental care;
- ▶ Prescribed medicines, medical and optical devices, vaccinations, orthosis and prosthesis, vaccines, and blood and bone marrow treatments;

- ▶ Reproductive care;
- ▶ Transplantation of organs;
- ▶ Rehabilitation services;
- ▶ Orthodontic treatment for those under the age of 18;
- ▶ Travel expenses, daily allowance and companion expenses in cases whereby treatment takes place outside of the patient's place of residence.

Other specialized services such as cancer treatment; emergency care; intensive care; burn treatment; assistance to newborns; organ, tissue and cell transplantation; surgery for congenital anomalies; dialysis and cardiovascular surgery are also provided free-of-charge. Moreover, emergency care is provided for free in private hospitals, even those that have no contract with the SGK (Adaman et al. 2018).

While most of the free health care services are provided by national and local health care providers, some cases that require highly specialized medical interventions offered only by international medical providers might also be financed by the GHIS scheme (SGK 2016).

Cost sharing through formal co-payment is applied broadly in the general health insurance scheme. Co-payment, co-insurance and additional payment are three types of OOP payments provided for by the law (Law no 5510/2006). The Turkish health care system involves varying levels of co-payments from patients for outpatient visits and 20 per cent co-insurance for prescription drugs (Kaymaz 2020). Co-payments are made at varying rates based on the level of the health care provider, the service type and the insured person's socio-demographic characteristics. Co-payments are not reimbursable through private health insurance (SGK 2021).

A co-payment is required for physical examinations, orthotics and prostheses, healing materials, medicines and fertility treatments (ESCAP 2019). No co-payment is required for primary care visits or hospitalizations. Health services provided in cases of work accidents, occupational injuries, military maneuvers, disasters or war and pandemics, as well as medicines for chronic illnesses, are exempt from co-payment obligations. Furthermore, certain segments of the population are exempt from co-payments (See box 19). Beneficiaries pay 6 lira (US\$1.23) for outpatient specialist care in public hospitals, 8 lira (US\$1.65) in university hospitals and 15 lira (US\$3.09) in private hospitals (Social Security Administration 2018). Balance-billing is authorized for private providers. Private health care providers are allowed to charge insured persons for the standard services they provide, up to twice as much as the standard prices established by the Health care Services Pricing Commission (HSPC), the SGK price-setting organisation (SGK 2021).

#### ▶ Box 1. Population groups exempt from co-payments in Türkiye

- Honorary pensioners and persons who receive a pension according to provisions of the Law on Military Service Planning, and their spouses
- Pensioners and their dependants
- Disabled veteran pensioners and their dependants and persons who receive a pension under the Law on Fight Against Terrorism
- Persons and children under age of 18 who benefit from free rehabilitation services
- Persons who receive a duty invalidity pension that is granted due to a public mission
- Cadets who receive education in military academies, police academies, or staff colleges of the armed forces or the general directorate of security
- Persons who are victims of terrorist attacks, until the end of their treatment
- Soldiers serving compulsory military service and candidate cadets (students) of the military schools
- Foreign soldiers, who are receiving training and education under the International Training Cooperation Agreement in Türkiye, and their dependants.

Source: SGK 2021.

In addition to health care benefits, SGK also guarantees cash benefits for accidents at work, occupational diseases and sickness and maternity for employed and self-employed insured persons as part of the broader social security system. Civil servants are covered by a special scheme. Contributions are calculated for all short-term benefits and the rate is 2 per cent of the earnings of the insured person, paid by the employer (there is no employee payment) (SGK 2020). Insured women are entitled to maternity cash benefits for each day of maternity leave, for up to 16 weeks (eight weeks before and eight after the expected date of childbirth). This can be extended by two weeks for multiple births. The benefit amount is the same as that applied for all short-term benefits: Two thirds (66.7 per cent) of average daily earnings in cases of outpatient care and half of average daily earnings in cases of inpatient care. There is also a nursing benefit for mothers that equals a lump sum of 133 lira (ISSA 2018).

### Provision of benefits and services

On the health service provision side, centralization is a key attribute of the Turkish governance model for health care, both geographically (limited local autonomy) and functionally (keeping control of duties within the Ministry of Health). The Ministry of Health leads on governance, planning and supervision, and the system provides primary, secondary and tertiary care throughout the country. The Ministry of Health coordinates all health care services, including the running of hospitals, monitoring of private hospitals and pharmacies, accreditation, and Health Technology Assessments (OECD 2014).

Türkiye has attempted to decentralize the health care system; although some transformations have been accomplished, decentralization was not successful due to coordination challenges. All hospitals were intended to be administratively and financially autonomous, and some functions have been transferred to newly created agencies affiliated with the Ministry of Health, covering medicines and devices, public health, public hospitals, borders and coastal agencies (Nurşen 2022; Yildiz et al. 2018).

The majority of health facilities in Türkiye are public. In 2020, out of a total of 1,534 hospitals there were 900 Ministry of Health hospitals, 68 university hospitals and 566 private hospitals (WHO 2022).

Primary care comprises general practitioners (family physicians) settled in family health centres under the Family Medicine Programme. Primary care and preventive services are financed by general taxes through the central government budget allocated to the Ministry of Health. Medicines prescribed in primary health centres (Family Health Centres) are financed by GHIS (Venkateswaran and Singh 2022; SGK 2021). In 2019, general practitioners (family physicians) accounted for 33 per cent of all physicians (OECD, n.d.-a).

Secondary care is provided by hospitals in the private and public sectors, while at the tertiary level services are provided by research and education hospitals under the Ministry of Health and university hospitals (Tuncer et al. 2017). Although the GHIS finances secondary care, insured persons must make co-payments for outpatient clinic services (both public and private), drugs, and services at secondary and tertiary health care facilities. An exception applies to family physician visits (SGK 2021).

SGK purchases health care services from health care providers in the public and private sectors. For public sector providers of secondary care, there are no contractual agreements where facilities are owned by the Ministry of Health; the SGK transfers funds on a global budget basis to the Ministry of Health for services provided to its beneficiaries (European Observatory on Health Systems and Policies 2011).

The following private providers have signed agreements with the SGK: Private university hospitals, private hospitals/medical centres, pharmacies, medical device sales centres and opticians. An exception applies in emergency cases, whereby health care services can be delivered by a non-contracted health care provider. For private providers, payments are made per capita per unit utilized (fee-for-service) (Venkateswaran and Singh 2022).

The Directorate General for GHIS undertakes the following duties: Determines public prices of health care services provided by the SGK; updates the Health Implementation Communiqué (HIC), which includes terms regarding reimbursement of treatment services, medicines, medical devices and materials; and concludes contracts with health care service providers for health services, making payments to them in return for their services (SGK 2021).

A claims and utilization management system called MEDULA has been in place since before the creation of the GHIS to process claims for all the health insurance funds including the Green Card scheme. Under the 2007 Health Budget Law (SUT), all public and private health facilities contracted by SGK are required to submit claims through the MEDULA system. The establishment of a unified claims management system has standardized the submission of claims and contributed to the establishment of a virtual single-payer system, which was unified across all the health insurance funds even prior to the establishment of GHIS (SGK 2024).

Currently, no formal care coordination or referral process between primary and secondary care and primary care structures have been defined for GHIS beneficiaries (Sumer et. al. 2019; Bener et al. 2019). Co-payment exemptions for primary care are in place to incentivize people to obtain a referral before accessing secondary and tertiary care (WHO 2022).

## ► 4. Results

### Coverage

In 2021, 98.8 per cent of the population in Türkiye was covered by GHIS, up from 69.8 per cent in 2002 (OECD, n.d.-c). In addition, 9 per cent of the population had voluntary private health insurance, primarily to cover care in private hospitals not under (or under a limited) contract with the SGK, or as complementary health insurance to cover services outside the basic benefits package (WHO 2022).

In the past, people who did not make their contributions on time were excluded from the scheme. In 2016, around 7 million people (about 9 per cent of the population) failed to make contributions, and 5 million people (approximately 6 per cent of the population) did not undergo a means-testing assessment which would allow them to benefit from the scheme without making contributions (Adaman et al. 2018; Bülbül 2015). As such, informal workers, low-income self-employed persons, the unemployed, and their dependents are at risk of exclusion from coverage (Adaman et al. 2018; Bağır et al. 2021).

► Table 1. Number of persons covered by GHIS in Türkiye in 2020

Year	2020
Total Population	83 614 362
Active Insured Persons	23 344 547
Passive Insured Persons (Pensioners)	13 264 220
Dependents	35 556 141
Social Insurance Holders	72 593 383
Registered only as GHIS Holders	9 767 789
Total Coverage of GHIS (Proportion to the total population)	98.5 %

Source: SGK 2021.

Türkiye hosts the world's largest refugee population, with 3.6 million refugees and asylum seekers (majority of whom are Syrians 3.5 million) recorded in 2022 (UNHCR 2023). According to the Law on Foreigners and International Protection, refugees and asylum-seekers may benefit from one year of health care insurance services. With Turkish identification documents, refugees are included in the scheme on an equal footing with Turkish citizens under GHIS. This means that refugees have access to all medical services provided by Turkish health institutions, including family care centres, state hospitals and university hospitals. They can also benefit from primary health services free of charge in their place of residence. If refugees are not registered with the Turkish authorities, only emergency services at

hospitals are available and accessible to them free of charge. Therefore, millions of unregistered refugees and migrants still face challenges in accessing health care (UNHCR, n.d.; Barış et al. 2023).

### Adequacy of benefits/financial protection

The social health protection system in Türkiye guarantees substantial financial protection for the population. Generally, private health insurance remains limited in Türkiye, due to adequate social insurance coverage (Ozsari and Güdük 2020). Through GHIS, free-of-charge services are provided for primary and emergency care, while co-payments are required for physical examinations, outpatient medicines, orthotics and prostheses, healing material and fertility treatment services. Co-payments for physical examinations are generally low at a fixed nominal amount, while the rest represent a percentage of the cost (10-20 per cent) (SGK 2021). Before the 2003 reform, Türkiye's health care sector experienced a high rate of informal payments. Although public funding for health care increased after the introduction of GHIS, data suggest that some informal payments persist, potentially impacting financial protection (Yılmaz 2021; Adaman et al. 2018).

After introducing GHIS in 2008, OOP spending as share of total health expenditure decreased from 23.89 per cent in 2007 to 16.43 per cent in 2020 (OECD, n.d.-b), which remains low compared to other countries in Central and Western Asia. Although the co-payment rate appears low, OOP spending places an unbearable burden on the poor and vulnerable in Türkiye. Households in the bottom socio-economic decile allocate nearly 70 per cent of their budget to food and housing (Baez et al. 2021) and the poor in Türkiye often face financial hardship due to payments for health care services. This limits access to health care, undermines health conditions, deepens poverty rates and increases inequalities. In 2016, 3.19 per cent of the population or over 2.5 million people in Türkiye, primarily the poor and vulnerable, spent at least 10 per cent of their household budget on health care (WHO 2023a). It is noteworthy that while OOP expenditure has decreased since the early 2000s, the share of households experiencing catastrophic expenditures increased marginally between 2012 and 2019 (Venkateswaran and Singh 2022).

One study drawing on national Income and Living Conditions surveys data revealed a high level of unmet needs due to a lack of availability of services reported by the rural population. This was attributed to insufficient rural health services in the family practice-centred system, that was established in 2010 to replace Türkiye's traditional district-oriented health service model dating back to the 1960s. The same study concluded that access to health care has improved with the reform process in Türkiye, but that disparities in access to care between income groups have grown, disadvantaging the poorest. These results suggest that high informal employment and unemployment pose a challenge to ensuring equal access to care in middle-income countries with unstable economies such as Türkiye (Yardim and Uner 2018).

### Responsiveness to population needs

#### Availability and accessibility

The Government has focused on reducing regional disparities in the distribution of the health workforce across the country by implementing the Family Medicine Programme, which encourages doctors and other health workers to serve rural populations. Appointment and transfer of doctors to rural areas ensures a more balanced distribution of health care personnel across all regions. Under this initiative, family doctors are contracted by the GSK to provide primary health care for those living in rural areas, including the provision of mobile health services for those unable to travel to clinics. Additionally, since 2009 Türkiye introduced mobile pharmacy service to improve access to medication in rural areas (Atun et al. 2013). Furthermore, the Government has taken steps to prohibit the practice of dual work (combining public and private practice) and raised salaries for public sector health workers. These measures have helped to increase the recruitment and retention of health workers in the public health sector (Venkateswaran and Singh 2022).

While there has been a continuous increase in the numbers of nurses, health officers, physicians and health care providers in the last ten years, Türkiye still lags behind many OECD countries in this regard (Gürsoy 2015). Despite a substantial increase in physicians by 46 per cent in 2020, the current number of doctors (205 per 100,000) is the lowest among OECD countries, slightly lower than the average in CWA

countries (269 per 100,000) and lower than the Europe and Central Asia average (372 per 100,000) (OECD, n.d.-a). This predominantly impacts on the health of marginalized populations. The shortage of doctors and irregular distribution in all regions of the country leads to gaps in availability and accessibility. The estimated number of in-person consultations per doctor was 5,033 in 2019, which is the highest among OECD countries. An increased workload seriously burdens physicians and substantially impacts the quality of care, especially in regions experiencing staff shortages. Data from the Ministry of Health shows that due to COVID-19 restrictions, the number of visits to a physician per capita declined by 26 per cent in 2020 (from 9.8 in 2019 to 7.2 in 2020) (OECD 2021; Dierks 2024).

In rural areas, health care service availability remains more limited than in urban areas, with rural residents incurring transportation costs when attempting to utilize available services in neighboring districts (UNHCR 2021). Moreover, in 2019, 9 per cent of the lowest income quintile had no access to medical care, compared to 0.4 per cent of people in the highest income quintile (OECD 2021).

The number of hospitals has grown in line with the increase in health care spending, with the number health care providers almost tripling from 2002 to 2012, reaching nearly 30,000 hospitals. The increase in the number of private hospitals is especially noteworthy when compared with a smaller change in the number of Ministry of Health-operated hospitals. The increase in private hospitals stems from the increase in GHIS coverage and contracting of private providers, and the extensive benefit package; the private sector has taken advantage of this transformation, investing in health services (Gürsoy 2015).

The HTP has improved health care utilization rates as a result of increased accessibility. For example, an increase was observed in doctor's consultations per capita between 2013 and 2018 (from 100 visits to 117 visits). A significant upward trend was also observed with regard to the "Diagnostic Examinations" indicator (including both CT and PET scans), which increased from around 140 to 250-300 diagnostic examinations in the same period (Torun and Aslan 2022).



### Quality and accessibility

Life expectancy in Türkiye increased from 71.9 in 2002 to 77.7 years in 2014. The under-five mortality rate fell sharply from 61 per 1,000 live births in 1993 to 37 per 1,000 live births in 2013. Similarly, infant mortality fell from 53 per 1,000 live births in 1993 to 15 per 1,000 live births in 2013. Between 2000 and 2020, the maternal mortality rate fell by 46 per cent from 32 to 17 per 100,000 live births. Between 2002 and 2012, the overall health workforce increased by 36 per cent, growing from 295,000 to 460,000. Moreover, Türkiye's health expenditures increased from 5.4 per cent of GDP in 2000 to 6.7 per cent in 2011, which led to substantial reductions in OOP spending for health services (World Bank 2018; WHO 2023b).

Since the implementation of the HTP, which radically changed the Turkish health system, trust in the health system has been persistently high and satisfaction with health care services has steadily increased. According to Life Satisfaction Statistics in 2016, 75.4 per cent of respondents indicated that they were either satisfied or very satisfied with public health care services (Ertong 2018). Notably, the Ministry of Health has established Migrant Health Centres in 29 provinces, where Syrian doctors provide primary health care services to Syrians under temporary protection. This measure has helped to improve access to health care by reducing language barriers and increasing human resource capacity.

## ► 5. Way forward

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Over the last 20 years, with the introduction of the HTP reform, the provision of comprehensive benefits and improved service delivery, health care coverage in Türkiye has substantially expanded, reaching near-universal coverage through GHIS. Overall, Türkiye achieved great success in health care delivery and equity, with decreased health costs and high levels of satisfaction with the health system among the population. However, there is a need to increase the primary health care medical workforce and build capacity in this area (Bener et al. 2019). Despite advancements, further efforts are needed to protect and improve citizens' health and provide equal access to health care for all.

Currently in Türkiye, the share of health expenditure in GDP remains below the average rate of OECD countries (OECD 2023). However, health expenditure in Türkiye is expected to increase in parallel with the National Development Plan (2019-2023). Unless the demographic window of opportunity is thoroughly utilized and necessary measures related to retirement and the broader social security system are put in place, increasing health expenditures will squeeze the social security system and public finances in the upcoming period (Presidency of the Republic of Türkiye, Directorate of Strategy and Budget, n.d.). In this respect, it is essential to consider elements that impact the financial sustainability of the health system, namely the organizational structure of the health care sector, including university hospitals, the persistence of unnecessary medical interventions and examinations, an inefficient reimbursement system and performance-based supplementary payment system, the breadth of the SGK benefit package, and outdated medicine prices (Balci and Gümüş 2021).

High-quality primary care plays a critical role in the population's health protection. National policies should aim at increasing per capita primary care utilization by shifting citizens' negative perceptions of primary care. The Turkish Government has proposed restructuring primary care for efficient functioning, capacity building of primary care personnel, and redesigning the performance system for staff with a focus on labour productivity and health outcomes. This requires developing family medicine referrals, increasing family medical units and raising awareness about family medicine services. Currently, the referral system is not mandatory; patients are free to enter the system at whichever point they prefer, and the primary care level is not working as effectively as it should. The main reason underlying the lack of a compulsory referral system is related to the general undersupply of doctors nationwide and, in particular, the low number of doctors working at the primary care level who can act as gatekeepers. Currently, outpatient care, either primary or specialist, is provided by family practitioners, hospital outpatient departments (public and private) and private practitioners (European Observatory on Health Systems and Policies 2011).

In the context of a continuous rise in the number of migrants and refugees in Türkiye, there is a need to abolish administrative barriers and facilitate enrolment in the national system. In addition, the effectiveness of migration health services should be strengthened by improved targeting mechanisms and raising awareness of health care services. The involvement of health professionals from the countries of origin of refugees could potentially tackle the communication barriers between health care providers and service users. Moreover, enhancing access to health care for migrants and refugees by expanding the number of migration health centres and extending the duration of health insurance coverage would significantly improve financial protection and equity for this population.

OOP payments in Türkiye are relatively low; however, they disproportionately impact the poor population and more efforts need to be made to improve equity in effective access to health care between rural and urban populations. Continued development and implementation of policy measures to reduce OOP expenditure on health is recommended, ensuring more efficient contribution collection mechanisms, an increase in government spending, investments in the health care sector, the consolidation of primary care, and improved awareness among the population on health care services (Jalali et al. 2021).

## ▶ 6. Main lessons learned

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- ▶ Substantial progress towards Universal Health Coverage has been made during the last 15 years in Türkiye. Reforms to extend both legal and effective population coverage and increase health expenditure have reduced OOP spending on health, increased financial protection and improved access to health services, positively impacting on health outcomes.
- ▶ Merging the different health insurance schemes into a single GHIS scheme accelerated the extension of coverage while consolidating the social health protection system's financial sustainability, by facilitating the combination of contributions and tax-based revenues. The previously fragmented nature of the system, which caused complexities in terms of the flow of funds to providers, causing unnecessary inefficiencies, has been addressed.
- ▶ Raising awareness among the population about social health protection is vital for an operational and efficient health care system. Lack of knowledge and negative perceptions among the population negatively affects primary care, thus increasing OOP payments for secondary and tertiary care.
- ▶ Ensuring long-term financial sustainability of the GHIS scheme, while maintaining its comprehensive scope, is crucial. This is particularly important in the context of rising health care expenditures and changing demographics, disease burdens and economic factors. There is a need to increase fiscal space for health, improve contribution compliance, achieve efficiency gains and enhance cost containment measures.

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This country profile was prepared by Artiom Sici, Salma El Gamal, and Mathilde Mailfert with the support of Yesle Kim and Marie Stijns (ILO). It benefited from the review, inputs and quality assurance of Professor Mahmut Yardim (Hacettepe University).

#### Contact details

**International Labour Organization**  
 Universal Social Protection Department  
 Route des Morillons 4  
 CH-1211 Geneva 22  
 Switzerland

**T: +41 22 799 7239**  
**E: [socpro@ilo.org](mailto:socpro@ilo.org)**  
**W: [www.ilo.org](http://www.ilo.org)**  
**[www.social-protection.org](http://www.social-protection.org)**