AN EVALUATION OF THE TURKISH GENERAL HEALTH INSURANCE WITHIN THE SCOPE OF THE HEALTHCARE REFORM

(Research Article)

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Abstract

In line with the recommendations of the World Bank, the Health Transformation Program [Sağlıkta Dönüşüm Programı] was accepted in Türkiye in 2003. Within this scope, reform movements in healthcare delivery were initiated. A universal health insurance model (named general health insurance) was accepted with the Social Insurance and General Health Insurance Act No. 5510 [5510 sayılı Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu] adopted in 2006. General health insurance, which came into effect gradually since 2008, fundamentally changed the system of benefiting from health services, which had been built as employment-oriented until then. General health insurance aimed to cover not only those included by social insurance but also all citizens or foreigners residing in Türkiye. In the general health insurance system, the principle of purchasing health services from health service providers (providing the financing of health services) has been adopted instead of providing them by the Social Security Institution [Sosyal Güvenlik Kurumu]. This study aims to evaluate the healthcare reform carried out in Türkiye through general health insurance. Therefore, the study first includes the healthcare (and social security) reform in Türkiye and then explains the implementation of general health insurance. Afterward, the study evaluates whether general health insurance meets the healthcare reform targets today and determines the problematic aspects of general health insurance.

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Keywords

Turkish healthcare system, Healthcare reform, Social Insurance and General Health Insurance Act No. 5510, General health insurance, General health insured

TÜRK GENEL SAĞLIK SİGORTASI SİSTEMİNİN SAĞLIK REFORMU KAPSAMINDA DEĞERLENDİRİLMESİ

(Araştırma Makalesi)

Öz

Dünya Bankası'nın önerileri doğrultusunda 2003 yılında Türkiye'de Sağlıkta Dönüşüm Programı kabul edilmiş ve bu kapsamda sağlık hizmetleri sunumunda reform hareketleri başlatılmıştır. 2006 yılında kabul edilen 5510 sayılı Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu ile evrensel nitelikli bir sağlık sigortası modeli (genel sağlık sigortası) kabul edilmiştir. 2008 yılında yürürlüğe giren genel sağlık sigortası, o güne değin çalışma odaklı uygulanmakta olan sağlık hizmetlerinden yararlanma sistemini temelden değiştirmiştir. Genel sağlık sigortası, önceki uygulamanın aksine, yalnızca sosyal sigorta kapsamında olanları değil Türkiye'de ikamet etmekte olan vatandaş ya da yabancı herkesi kapsama almayı amaçlamıştır. Genel sağlık sigortası sisteminde, sağlık hizmetlerinin Sosyal Güvenlik Kurumu tarafından doğrudan sunulması yerine, sağlık hizmeti sunucularından hizmet satın alma yoluyla alınması (sağlık hizmetlerinin finansmanının sağlanması) prensibi benimsenmiştir. Bu çalışma, Türkiye'de genel sağlık sigortasının kabul edilmesi yoluyla gerçekleştirilen sağlık reformunun değerlendirilmesini amaçlamaktadır. Bu nedenle çalışmada ilk olarak Türkiye'deki sağlık (ve sosyal güvenlik) reformu ele alınmış, ardından genel sağlık sigortası uygulaması anlatılmıştır. Devamla çalışmada, günümüz itibariyle genel sağlık sigortasının sağlık reformu hedeflerini karşılayıp karşılamadığı hususu değerlendirilmiş ve genel sağlık sigortasının sorunlu yönleri ortaya koyulmuştur.

Anahtar Kelimeler

Türk sağlık sistemi, Sağlık reformu, 5510 sayılı Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu, Genel sağlık sigortası, Genel sağlık sigortalı

INTRODUCTION

The development of social security in Turkish law has been gradual since the proclamation of the Republic in 1923. However, the first regulations made within the scope of social security covered particular segments of society or assured limited issues (related to social risks) rather than being inclusive[1]. Guaranteeing the right to health has gone through similar stages. Since the 1950s, regulations regarding health services covering various insured groups have been adopted within the scope of different insurance branches. On the constitutional level, the right to health was first included in the abolished 1961 Constitution. Also, in 1961, the condition of premium and contribution fee to benefit from health services was first introduced by Act No. 224[2].

Today, the right to health is regulated and guaranteed by the Constitution of the Republic of Türkiye (1982)[3] article 56. According to article 56/1, everyone has the right to live in a healthy and balanced environment. Afterward, according to article 56/3, the State shall regulate the central planning and functioning of the health services to ensure that everyone leads a healthy life physically and mentally, and provide cooperation by saving and increasing productivity in human and material resources. It is also regulated in article 56/5 that to establish widespread health services, general health insurance may be introduced by law.

International treaties and sources constitute the other bases of the right to health in Turkish law. For example, Türkiye ratified the Social Security (Minimum Standards) Convention, 1952 (No. 102) of the ILO, which guarantees health benefits and implemented it in 1975. Türkiye also ratified

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1 *See generally* **Üçışık**, H. Fehim: Sosyal Güvenlik Hukuku [Social Security Law], Ötüken Publishing, Ankara 2015, p. 32-48; **Centel**, Tankut: Sosyal Güvenlik Hukuku [Social Security Law], On İki Levha Publishing, İstanbul 2021, p. 13-24; **Arıcı,** Kadir: Türk Sosyal Güvenlik Hukuku [Turkish Social Security Law], 2nd Edition, Gazi Bookstore, Ankara 2022, p. 80-100; **Tuncay**, A. Can/**Ekmekçi**, Ömer: Sosyal Güvenlik Hukuku Dersleri [Social Security Law Courses], 20th Edition, Beta Publishing, İstanbul 2019, p. 89-100; **Tatar**, Mehtap/**Mollahaliloğlu**, Salih/**Şahin**, Bayram/**Aydın**, Sabahattin/**Maresso**, Anna/**Hernández-Quevedo**, Cristina: "Turkey: Health system review", Health Systems in Transition, V. 13, N. 6, 2011, p. 16-20; **Yılmaz**, Volkan: The Politics of Healthcare Reform in Turkey, Palgrave Macmillan, Cham, 2017, p. 48-66.

2 **Üçışık**, p. 250.

3 For a formal translation of the Constitution of the Republic of Türkiye (1982) [Türkiye Cumhuriyeti Anayasası], *see* https://www5.tbmm.gov.tr/yayinlar/2021/TC_Anayasasi_ve_TBMM_Ic_Tuzugu_Ingilizce.pdf (last visited January 21, 2023).

the articles of the European Social Charter (1961) (and also Revised European Social Charter, 1996) on the right to health, social security, and social and medical assistance in 1989[4] and the articles of the International Covenant on Economic, Social and Cultural Rights (1966) on the right to social security and benefit from a standard of health in 2003, without any reservation. Revised European Code of Social Security (1990), European Convention on Social Security (1972), and European Convention on Social and Medical Assistance (1953) are other international documents that Türkiye ratified and that form an international basis for the right to health.

Until a universal health insurance model (named *general health insurance*) was enacted in 2006, Turkish law had no separate health insurance. Health services were provided under the provisions of sickness insurance (and in some cases maternity insurance and work accident and occupational disease insurance)[5]. Within the framework of the Health Transformation Program [Sağlıkta Dönüşüm Programı][6] initiated in 2003, general health insurance was established in Türkiye. Reforms started to be made in the healthcare field[7]. Today, the Turkish national health system is carried out under the general health insurance regulation in the Constitution

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4 Türkiye signed the European Social Charter in 1961 and ratified it in 1989. Türkiye also signed the Revised European Social Charter in 2004 and ratified it in 2007.

5 *See* **Dilik**, Sait: Sosyal Güvenlik [Social Security], Ankara University Publishing, Ankara 1992, p. 176-181; **Aydemir**, Cahit/**Altundağ**, Salahattin/**Köroğlu**, Necmi: "5434, 506, 1479, 2925, 2926, 3816 ve 5510 Sayılı Kanunlarda Sağlık Sigortasının Gelişim Süreci [Development Process of Health Insurance in Acts No. 5434, 506, 1479, 2925, 2926, 3816 and 5510]", Dicle University Social Sciences Institute Journal, V. 11, N. 22, 2019, p. 53-69.

6 For the full text of the report in Turkish and English, *see* https://www.saglik.gov.tr/TR,11415/saglikta-donusum-programi.html (last visited January 21, 2023).

7 The World Bank report titled "Turkey: Reforms in the Health Sector to Improve Expansion and Efficiency" [Türkiye: Yaygınlığı ve Verimliliği İyileştirmek Amacıyla Sağlık Sektöründe Yapılan Reformlar] (2002) which discusses the reform proposals that can be realized in the health sector in Türkiye, had a significant impact on the implementation of this program. In line with the recommendations in this report, the government of the time presented to the public opinion the health reform program, consisting of eight essential components, in 2003. For more information on health reform, *see* **Pala**, Kayıhan: "Türkiye'de Sağlık Reformu Sağlıkta Dönüşüm Programı Süreci [Health Reform in Turkey, Health Transformation Program Process]", in İnsana Karşı Piyasa Türkiye'de Sağlık ve Sosyal Güvenlik, Editor: Gülbiye Yenimahalleli-Yaşar et al., Nota Bene Publishing, İstanbul 2017, p. 46-69; **Altındağ**, Özgür/**Yıldız**, Ahmet: "Türkiye'de Sağlık Politikalarının Dönüşümü [Transformation of Health Policy in Turkey]", Individual and Society Journal of Social Science, V. 10, N.1, 2020, p. 173-175; **Yılmaz**, p. 124-129.

and Social Insurance and General Health Insurance Act No. 5510 (2006)[8]. As a result of the acts adopted in 2006, social insurance reform was carried out in Türkiye, and national health insurance was established.

The enforcement of general health insurance (GHI) and the process of covering the entire population have been gradual. Employees and self-employed workers were taken into the scope of GHI on 10/1/2008, while civil servants on 1/15/2010 and other segments of society on 1/1/2012. This study aims to discuss the stages of GHI since its effective date and to evaluate GHI under health reform reasons. For this reason, the study first approaches the social security and health reform process in Türkiye and then discusses the current GHI system. Finally, GHI will be evaluated on the axis of its current practices.

I. A BRIEF SUMMARY OF THE TURKISH NATIONAL HEALTHCARE SYSTEM FROM PAST TO PRESENT

A. The Reasons for Social Security Reform in Türkiye

At the beginning of the 21st century, social security reform took place in Turkish law. This reform has made various changes in the field of social insurance[9]. Before the law amendment took place in 2006, there was a triple social insurance system in Türkiye: Social Insurance Institution [Sosyal Sigortalar Kurumu - SSK][10], Social Insurance Organization for Craftsmen, Artisans and the Other Self-employed Workers [Esnaf ve Sanatkarlar ve

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8 For a formal translation of the Social Insurance and General Health Insurance Act (2006) [Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu] *see* https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/74711/133294/F-379338786/TUR74711%20Eng.pdf (last visited January 18, 2023). However, it should be remembered that this translated text is the original version of the Act and has changed many times until today. For an updated text, *see also* https://www.mevzuat.gov.tr/MevzuatMetin/1.5.5510.pdf [In Turkish] (last visited January 22, 2023).

9 For social security reform in Türkiye, *generally see* **Alper**, Yusuf/**Özgökçeler**, Serhat: "Turkish Social Security Reform and Social Justice*",* Journal of Social Security, V. 6, N. 2, 2016, p. 10-24; **Aydın**, Ufuk: "Social Security Reform Process in Turkey and Two Years After*"*, İş Dünyası ve Hukuk: Prof. Dr. Tankut Centel'e Armağan, V. 720, 2011, p. 71-97; **Duyulmus**, Cem Utku: "Social Security Reform in Turkey: Different usages of Europe in shaping the national welfare reform", 2009, p. 10-22, http://www.cccg.umontreal.ca/rc19/pdf/duyulmus-c_rc192009.pdf (last visited January 23, 2023).

10 Established by Social Insurance Act No. 506 (1964) [506 sayılı Sosyal Sigortalar Kanunu].

Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu - Bağ-Kur][11], and Pension Fund of Civil Servants [Emekli Sandığı][12]. SSK was the insurance organization of the employees who worked under an employment contract; *Bağ-Kur* was the insurance organization of the self-employed workers, and *Emekli Sandığı* was the insurance organization of civil servants[13]. Moreover, there were multiple foundation funds.

Emekli Sandığı has covered health benefits since 1949, while *SSK* since 1965 and *Bağ-Kur* since 1985[14]. These organizations were providing their insureds both social insurance benefits and health services. And they had different practices for providing health services[15].

There were various reasons and aims for social insurance reform in Türkiye[16]. Before the reform, there was a social insurance system in Türkiye

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11 Established by Social Insurance Organization for Craftsmen, Artisans and the Other Self-employed Workers Act No. 1479 (1971) [1479 sayılı Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu Kanunu].

12 Established by Pension Fund of Civil Servants Act No. 5434 (1949) [5434 sayılı T.C. Emekli Sandığı Kanunu].

13 *See generally* **Uşan**, M. Fatih: Türk Sosyal Güvenlik Hukukunun Temel Esasları [Fundamentals of Turkish Social Security Law], Seçkin Publishing, Ankara 2009, p. 38-40; **Tuncay/Ekmekçi**, p. 85-88; **Alper**, Yusuf: Sosyal Sigortalar Hukuku [Social Insurance Law], 12th Edition, Dora Publishing, Bursa 2022, p. 30-31; **Güzel**, Ali/**Okur**, Ali Rıza/**Caniklioğlu**, Nurşen: Sosyal Güvenlik Hukuku [Social Security Law], 19th Edition, Beta Publishing, İstanbul 2021, p. 72-73. *See also* **Doğan-Yenisey**, Kübra: Social Security Law in Turkey, Kluwer Law International, Alphen aan den Rijn 2013, p. 32-33; **Tatar/Mollahaliloğlu/Şahin/Aydın/Maresso/Hernández-Quevedo**, p. 27.

14 **Güzel/Okur/Caniklioğlu**, p. 791-792; **Centel**, Social Security Law, p. 372; **Centel**, Tankut: Turkish Social Law, Springer Publishing, Cham 2021, p. 249.

15 Health services were not provided through separate health insurance. It was provided through sickness insurance and, in some cases, maternity insurance, and work accident and occupational disease insurance. *Generally,* **Aydemir/Altundağ/Köroğlu**, p. 53-69. *See also* **Sözer**, Ali Nazım: Türk Genel Sağlık Sigortası [Turkish General Health Insurance], 3rd Edition, Beta Publishing, İstanbul 2020, p. 4; **Centel**, Social Security Law, p. 214, 242, 255; **Güzel/Okur/Caniklioğlu**, p. 791-792; **Korkusuz**, M. Refik/ **Uğur**, Suat: Sosyal Güvenlik Hukuku [Social Security Law], 8th Edition, Ekin Publishing, Bursa 2022, p. 291; **Arıcı**, Turkish Social Security Law, p. 463-465.

16 The Prime Ministry of that period listed the reasons for the social security reform in an exclusive report. *See* **T.C. Başbakanlık:** Sosyal Güvenlik Raporu: Sorunlar ve Çözüm Önerileri [Social Security Report: Problems and Solutions], The Prime Minister's Office, Ankara 2005, p. 52-53. *See also* **Tuncay/Ekmekçi**, p. 116-119, 142-148. For example, *Arıcı* addresses the main problems of Turkish social security as the lack of autonomy of social insurance institutions, populism disease, which prevents the system from being sustainable, economic problems, political interventions, and mismanagement of the social security system. *See* **Arıcı**, Turkish Social Security Law, p. 56-58.

that frequently ran into fiscal deficits and tried to cover fiscal deficits from the state budget. In this system, which did not have a standard union, there was discriminatory treatment among the insureds according to which institution they belonged. The current system was far from covering the entire population. The system was allowing retirement at early ages, and because of early retirement rates, the ratio of active/passive[17] insured was relatively low. Substantially, social insurance institutions were experiencing financial difficulties.

There were also multiple problems in terms of health services. No health insurance covered the entire population[18]. The way to benefit from health benefits was to be covered by social insurance (as an insured, dependant, or beneficiary). Health services were carried out by *SSK*, *Bağ-Kur,* and *Emekli Sandığı*, and the conditions for benefiting from health services differed for each institution[19]. Since each social insurance institution did not have its own hospitals, there were great difficulties in the delivery of health services. In particular, there were crucial problems with access to health services by self-employed insureds. A large part of the population could not benefit from public hospitals, and the health services provided by social security institutions were insufficient. Health services were provided by scattered health institutions which did not have standard and minimum quality[20].

In 1992, Act No. 3816[21] came into force so that people without financial situations could benefit from health services free of charge. This

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17 For example, by the beginning of the 2000s, the insured active/passive ratio had fallen below 2/1. The active/passive ratio, 1.78 in 2009, was still below 2/1 and was 1.97 as of June 2022, finally reached 2.01, the first time in many years as of December 2022. Today, the desired level has yet to be reached at this rate. For December 2022 statistics, *see* https://www.sgk.gov.tr/Istatistik/Aylik/42919466-593f-4600-937d-1f95c9e252e6/ (last visited March 22, 2023). In the same view, the Turkish social insurance system needs a healthier outlook regarding the ratio of active/passive insured, *see also* **Centel**, Social Security Law, p. 23; **Alper**, Social Insurance Law, p. 23-24.

18 *See generally* **Ministry of Health:** Turkish Health Transformation Program Assessment Report (2003-2011), The Ministry of Health, Ankara 2012, p. 79-85. https://ekutuphane.saglik.gov.tr/Home/GetDocument/452 (last visited January 23, 2023).

19 **Orhaner**, Emine: "Does Everyone in Turkey Benefit from Health Services with General Health Insurance?", in Chaos, Complexity and Leadership 2014, Editor: Şefika Şule Erçetin et al., Springer Publishing, Cham 2016, p. 57.

20 **Tuncay/Ekmekçi**, p. 143, 579.

21 Act on Covering the Treatment Expenses of Citizens Who Do Not Have Solvency by the State by Given Them a Green Card (1992) [Ödeme Gücü Olmayan Vatandaşların

Act covered people, not in the scope of social insurance and had no financial condition. According to this Act, each citizen who did not have solvency was given a green card [yeşil kart], and the green card holders were provided with free healthcare services from public hospitals[22]. However, the green card practice began to be used unlawfully in a short time. Citizens with solvency also began to receive free treatment as green card holders[23]. These unlawful uses caused the green card practice to be cancelled, and the transition to the general health insurance system accelerated.

All these reasons indicated social security reform in Türkiye. The social insurance system needed a reassuring, sustainable, and financially strong system. The reform had various aims, for example, to ensure standard unity among the insured categories, to reduce the differences in benefiting from insurance, to prevent early retirements by raising the retirement age, and to reduce social insurance financing gaps by increasing the ratio of active/passive insured. Finally, another aim of the reform was to implement the idea of universal health insurance, which had been in the state development plans for many years.

B. The General Scope of the Social Security Reform

The social security reform consists of four components: the unification of all social security institutions under one institution (single roof model), the establishment of the new social insurance system, the establishment of a universal health insurance model (named general health insurance)[24], and the

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Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun].

22 The main conditions sought to benefit from health services with the green card practice were not to be covered by social insurance, to have a per capita income less than one-third of the gross minimum wage, and to be a Turkish citizen. *See* **Karadeniz**, Oğuz: "Extension of Health Services Coverage for Needy in Turkey: From Social Assistance to General Health Insurance*"*, Journal of Social Security, V. 2, N. 2, 2012, p. 106-117.

23 It has been determined that 14,650,000 people were given green cards until the end of 2008, but about half were illegally issued cards. Although the illegally used cards were cancelled and the green card application was abolished with Act No. 5510, the green card continued to be applied until the general health insurance came into force (1/1/2012). As of this date, low-income people have been able to benefit from health services within the scope of GHI without paying premiums by being subjected to an income test. *See* **Tuncay/Ekmekçi**, p. 581-582, 585.

24 Although the name of the accepted health insurance is general health insurance, it should be noted that the word "general" emphasizes the universal nature of the insurance. As a matter of fact, "universal health insurance" is used instead of "general health insurance" in the official documents of SSI. For example, *see* **Social Security**

establishment of the non-contributory system[25]. However, the legislative work on the non-contributory system has not been completed yet. In other words, the non-contributory legislation is still scattered today.

As a result of the reform process, many draft laws were prepared in the 2000s. Finally, in 2006, the Social Security Institution (SSI) [Sosyal Güvenlik Kurumu] was established with the Social Security Institution Act No. 5502, and current institutions (*SSK*, *Bağ-Kur*, and *Emekli Sandığı*) combined under a single institution[26]. Thus, from this date on, the administrative structure of the Turkish social insurance system has been radically changed[27]. In the same year, Social Insurance and General Health Insurance Act No. 5510 (SIGHIA) was also adopted. However, the enactment of the SIGHIA took place gradually. Most of the articles of the act entered into force as of 10/1/2008. With the enactment of Act No. 5510, many provisions of Social Insurance Act No. 506, Social Insurance Organization for Craftsmen, Artisans and the Other Self-employed Workers Act No. 1479, Pension Fund of Civil Servants Act No. 5434, and other relevant laws have been repealed[28]. Many provisional articles have been added to Act No. 5510 to ensure the adjustment of the insured working under these laws.

In SIGHIA article 4, the compulsory insurance holders are divided into three main groups: insureds according to article 4/1-a (mainly employees who work under an employment contract) [previously who were subjected to *SSK*], insureds according to article 4/1-b (mainly self-employed workers) [previously who were subjected to *Bağ-Kur*] and insureds according to article 4/1-c (mainly civil servants) [previously who were subjected to *Emekli Sandığı*][29]. Furthermore, partial insured (SIGHIA article 5), general

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Institution: Universal Health Insurance System in Turkey, Ministry of Labour and Social Security, Ankara 2021, p. 2. https://www.sgk.gov.tr/Download/DownloadFileStatics?f=GSS_Sistemi_Kitabi_ENG.pdf&d=YAYINLARIMIZ (last visited March 21, 2023).

25 **Alper/Özgökçeler**, p. 18.

26 **Centel**, Social Security Law, p. 50; **Güzel/Okur/Caniklioğlu**, p. 31; **Tuncay/Ekmekçi**, p. 97, 115; **Alper**, Social Insurance Law, p. 20; **Arıcı**, Turkish Social Security Law, p. 98. *See also* **Doğan-Yenisey**, p. 23; **Centel**, Turkish Social Law, p. 36; **Tatar/Mollahaliloğlu/Şahin/Aydın/Maresso/Hernández-Quevedo**, p. 21, 26.

27 **Tuncay/Ekmekçi**, p. 116; **Alper**, Social Insurance Law, p. 30.

28 **Centel**, Social Security Law, p. 30-31.

29 In terms of ease of understanding, these insureds are referred to as "insured in 4/I-a status", "insured in 4/I-b status", and "insured in 4/I-c status" in Turkish law.

health insured (SIGHIA article 60), and voluntary insured (SIGHIA article 50) categories are built. Thus, who are covered by short-term and long-term insurance are defined as "insured"[30], and covered only by general health insurance are defined as "general health insured". General health insured refers to persons who cannot benefit from long-term and short-term insurance (not in the scope of social insurance) and who only benefit from general health insurance.

Family members of the insured are also included in the scope of social insurance as long as they meet the necessary conditions. If the insured is alive, these people are referred to as dependants (SIGHIA article 3/10). If the insured dies, they are referred to as the beneficiary (SIGHIA article 3/7)[31]. Family members covered by social insurance benefit from GHI as beneficiaries or dependants.

The most significant aspects of the social insurance reform in terms of the healthcare system are the adoption of the Transformation in Health Program [Sağlıkta Dönüşüm Programı][32] and the establishment of general health insurance in Türkiye[33]. In fact, the establishment of general health insurance has been included as an objective in state development plans since

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30 **Alper**, Social Insurance Law, p. 62-63. There are two types of social insured: compulsory insured and voluntary insured. About the scope of social insurance in terms of insured in Turkish law, *see generally* **Güzel/Okur/Caniklioğlu**, p. 799-800; **Centel**, Social Security Law, p. 142-159; **Centel**, Turkish Social Law, p. 73-74, 99-106; **Tuncay/Ekmekçi**, p. 301-344; **Korkusuz/Uğur**, p. 197-241; **Sümer**, Haluk Hadi: Sosyal Güvenlik Hukuku [Social Security Law], 3rd Edition, Seçkin Publishing, Ankara 2022, p. 37-63; **Arıcı,** Turkish Social Security Law, p. 222-257.

31 **Centel**, Social Security Law, p. 164; **Karadeniz**, p. 116; **Güzel/Okur/Caniklioğlu**, p. 200-202; **Doğan-Yenisey**, p. 55.

32 According to the Ministry of Health report (2003), the health transformation program comprised eight components. These are; the Ministry of Health as the planner and controller; general health insurance gathering everybody under a single umbrella; widespread, easily accessible, and friendly health service system (strengthened primary health care services and family medicine; effective and staged referral chain; health enterprises having financial and administrative autonomy); health manpower equipped with knowledge and competence and working with high motivation; education and science institutions supporting the system; quality and accreditation for qualified and effective health services; institutional structure in the management of rational medicine and equipment; access to effective information at decision-making process: health information system. **Ministry of Health:** Transformation in Health, Ministry of Health, Ankara 2003, p. 27-37, https://www.saglik.gov.tr/TR,11415/saglikta-donusum-programi.html (last visited January 21, 2023). On the health transformation program, *see also* note 7.

33 *See generally* **Güzel/Okur/Caniklioğlu**, p. 791-798.

the 1960s. In the Constitution of the Republic of Türkiye (1982), it was regulated that general health insurance could be established, and the state was authorized in this regard[34]. However, general health insurance stipulated in the Constitution could not be established for many years. Every institution (*SSK, Bağ-Kur,* and *Emekli Sandığı*) used to do its own health benefits by itself before.

Within the scope of the health transformation program, health benefits are gathered under a single roof. All the public institution hospitals, particularly *SSK* hospitals, were transferred to the Ministry of Health[35]. Health benefits were taken out of the insurance branches. Only fiscal benefits were started to be made from the long-term and short-term insurance branches[36]. In other words, social insurance benefits (for example, temporary or permanent incapacity allowances) are to be provided to the insured in case of illness, and health services are separated from each other. According to Act No. 5510, health services will be provided to the patient within the scope of general health insurance and only fiscal benefits will be provided from other social insurance branches[37]. Thus, a separate premium was not paid for health services since health services were covered under other insurance, and premiums have begun to be paid for health services within the scope of general health insurance.

With the ratification of general health insurance, a significant population that was not covered by health insurance until then became covered by GHI[38]. This feature constitutes the universal coverage aspect of general health insurance. With the GHI, the existing distinctions between institutions in terms of benefiting from health services were eliminated, and the same principles were accepted as a rule[39].

Although it was aimed to regulate general health insurance with a separate act in the draft acts prepared within the scope of the social security reform, it has yet to be successful in this regard. For this reason, general health insurance is regulated as a separate section in Act No. 5510. While most provisions of Act No. 5510 came into force in 2008, the articles on

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34 **Tuncay/Ekmekçi**, p. 582.

35 **Ministry of Health**, Turkish Health Transformation Program Assessment Report, p. 51.

36 **Uşan**, p. 45; **Centel**, Social Security Law, p. 373-374.

37 **Korkusuz/Uğur**, p. 265.

38 **Orhaner**, p. 58.

39 **Altındağ/Yıldız**, p. 176.

general health insurance entered into force gradually, and repealing the green card practice took more time.

Those who are in the scope of the non-contributory regime, and insureds or their beneficiaries who receive a pension from the SSI were included in the scope of GHI since the beginning (7/1/2008)[40]. Insureds according to SIGHIA article 4/1-a (employees) and insureds according to SIGHIA article 4/1-b (self-employed workers) were included in the scope of GHI as of 10/1/2008, while insureds according to SIGHIA article 4/1-c (civil servants) were included in 1/1/2010. Green card holders and those who are only general health insured in 1/1/2012[41]. The green card practice continued until the general health insurance came into force on 1/1/2012.

General health insurance (GHI), which forms the basis of the current Turkish national healthcare system, is discussed in detail below.

II. CURRENT PRACTICES IN THE TURKISH NATIONAL HEALTHCARE SYSTEM: GENERAL HEALTH INSURANCE

A. Concept and Administrative Structure of GHI

Multiple actors are responsible for determining and managing health policies in Türkiye. The prominent role is in the Ministry of Health, institutions affiliated with the Ministry of Health, and other relevant Ministries. The actors responsible for carrying the general health insurance are the Ministry of Labour and Social Security, its affiliates, and other relevant ministries, particularly the Ministry of Family and Social Services. Social Security Institution (SSI) [Sosyal Güvenlik Kurumu - SGK], the organizational unit of social security services, operates under the Ministry of Labour and Social Security. In Act No. 5502, it is regulated that Social Security Institution is administratively and financially autonomous. However, it is stated in the doctrine that SSI is not fully compatible with the autonomous management model in practice[42]. SSI has multiple general directorates and service units to meet the functions. The General Directorate of General Health Insurance is one of them and is responsible for general health insurance services.

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40 For detailed information on the enforcement of GHI, *see* **Sözer**, p. 7-9.

41 **Sözer**, p. 7-9; **Güzel/Okur/Caniklioğlu**, p. 815; **Karadeniz**, p. 104-106.

42 For different views on the autonomy of the SSI, *see also* **Alper**, Social Insurance Law, 34-36; **Üçışık**, p. 120-122; **Centel**, Social Security Law, p. 49-50; **Tuncay/Ekmekçi**, p. 120.

The fundamental legislation in terms of general health insurance is Social Insurance and General Health Insurance Act No. 5510 (SIGHIA). However, the national health system is managed with various regulations and circulars, e.g., General Health Insurance Practices Regulation (GHIPR) (2014), General Health Insurance Registration, Premium and Beneficial Ownership Transactions Regulation (2014), Circular No. 2019/17 on General Health Insurance Registration and Premium Procedures, etc[43]. In terms of financing health services, Healthcare Implementation Communique (HIC) [Sağlık Uygulama Tebliği - SUT][44] is carried out.

GHI is a system that pays the costs of the health services to the health service providers that the insured receives service from, with specific procedures and conditions[45]. General health insurance is operated according to the insurance techniques and takes part in the social security premium model. As a rule, the insured should pay insurance premiums to benefit from the insurance. However, there is no proportional relationship between the insurance premiums paid and the health services provided (SIGHIA art. 62/3)[46]. According to their income, those who pay less and those who pay more premiums benefit from health services equally. Benefiting from general health insurance is a right for the insured, and financing the health services is an obligation for the Social Security Institution (SIGHIA art. 62/1)[47]. Inclusion in general health insurance is not optional. Accordingly, being in the scope of general health insurance is both a right and an obligation for the insured[48].

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43 *See* General Health Insurance Practices Regulation (2014) [Genel Sağlık Sigortası Uygulamaları Yönetmeliği] https://kms.kaysis.gov.tr/Home/Goster/187716 [In Turkish]; General Health Insurance Registration, Premium and Beneficial Ownership Transactions Regulation (2014) [Genel Sağlık Sigortası Tescil, Prim ve Müstehaklık İşlemleri Yönetmeliği] https://kms.kaysis.gov.tr/Home/Goster/43377 [In Turkish]; Circular No. 2019/17 on General Health Insurance Registration and Premium Procedures [Genel Sağlık Sigortası Tescil ve Prim İşlemleri Hakkında 2019/17 sayılı Genelge] https://kms.kaysis.gov.tr/Home/Goster/154304 [In Turkish] (last visited January 9, 2023).

44 This communique was adopted in 2013. However, there are frequent changes in the text of the communique. *See* https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=17229&MevzuatTur=9&MevzuatTertip=5 [In Turkish] (last visited June 9, 2023).

45 **Tuncay/Ekmekçi**, p. 586.

46 **Uşan**, p. 269; **Sümer**, p. 264; **Korkusuz/Uğur**, p. 292; **Üçışık**, p. 261; **Alper**, Social Insurance Law, p. 403.

47 **Sözer**, p. 19; **Üçışık**, p. 260-261; **Sümer**, p. 264; **Alper**, Social Insurance Law, p. 403.

48 **Arıcı**, Turkish Social Security Law, p. 463.

General health insurance is one of the insurance categories regulated in the Turkish social insurance system by Social Insurance and General Health Insurance Act No. 5510. General health insurance is defined as insurance that primarily protects the people's health and finances the expenses incurred in case they encounter health risks (SIGHIA art. 3/8). The GHI system allows people to obtain private health insurance in addition to GHI.

General health insurance came into force on 10/1/2008 (for insureds according to SIGHIA article 4/1-c on 1/1/2010) and started to be carried out all around Türkiye as of 1/1/2012. As of this date, regardless of their income or will to stay out of the scope, people who are enacted as general health insured in SIGHIA mandatorily were included in the scope of GHI. The main features of GHI can be listed below[49]:

- It is mandatory and impossible to be out of scope voluntarily (restrictive clause).
- It includes citizens and foreigners who reside in Türkiye (residence clause).
- As a rule, it is financed by premiums, and each person pays premiums based on his income (insurance model).
- Health services are provided by purchasing from the health service providers instead of producing services directly (purchase method).

B. Scope of GHI in Terms of Insured

As mentioned above, everyone (citizen or foreigner) residing in Türkiye is compulsorily covered by general health insurance regardless of their income (poor or wealthy). The primary provision for being in the scope of the GHI is residing in Türkiye. In SIGHIA article 60, those included in the scope of GHI are counted one by one in a casuistic way. Moreover, the coverage group has been expanded with various law amendments from the enforcement date of the act (2008) until today[50]. Considering the extent of this study, it would not be a practical approach to enumerate those general health insureds one by one. For this reason, it is possible to consider those covered by the GHI as some main groups:

- Those who work as insured (employees, self-employed workers, civil servants, and other types of workers) are covered by paying premiums on their income (compulsory insured),

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49 **Centel**, Social Security Law, p. 373; **Güzel/Okur/Caniklioğlu**, p. 815.

50 *See also* **Tuncay/Ekmekçi**, p. 588-597.

- Those who are in the scope of the social insurance voluntarily (voluntary insured),
- Those insured or their beneficiaries who receive a pension from the SSI (pensioner),
- Those relatives (wife/husband, children, and parents) of the insured who meet the conditions to be in the scope of GHI as a dependant,
- Those insured or their beneficiaries who are in the scope of a foundation fund,
- Those who are in the scope of the non-contributory regime and subjected to social protection,
- Those who do not have work-related income are covered in GHI by paying a minimum premium,
- Those who do not have work-related income and cannot afford the minimum premium payment are covered in GHI by paying the premiums by the state (low-income person).

It is also possible to divide the insured into *four* categories in the scope of GHI; those who are obliged to pay the premiums according to their working income, those who are obliged to pay the premiums without having a working income, those whose premiums are paid by the state because they are not able to pay, and those who are not obliged to pay any premiums because of their dependant or pensioner status[51].

As can be seen, family members are also directly covered by general health insurance as beneficiaries (if the insured has died) or dependants (if the insured is alive), in line with the ILO Convention No. 102. According to SIGHIA, three types of family members (spouses, children, and parents) are considered dependants[52] or beneficiaries. However, for these members to benefit from GHI as dependants, they must meet the conditions regulated in SIGHIA article 3/10. For the spouse to be counted as a dependant, he or she must not be (compulsory or voluntarily) insured and not receive a pension from SSI due to his/her own social insurance. These two provisions are also sought for children and parents. Additionally, for the children to be counted as dependants, they must not be older than 18 (20 if attending high school or

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51 *See* **Alper**, Social Insurance Law, p. 394; **Korkusuz/Uğur**, p. 293-297.

52 SIGHIA counts which general health insureds do not have dependants. For these exceptions, *see* SIGHIA art.5/1-b, art. 60/1-c-1, art. 60/1-c-2, art. 60/1-c-7, art. 60/7, art. 60/8, and art. 60/12. For dependant categories, *generally see* **Centel**, Social Security Law, p. 165-166, 378-380; **Sümer**, p. 269-274; **Sözer**, p. 167-170.

its equivalent, 25 if attending higher education) years old and not be married[53]. Additionally, for the parents to be considered dependants, their livelihood must be provided by the insured.

Those family members to benefit from GHI as beneficiaries must meet the conditions regulated in SIGHIA article 34. For the spouse to be counted as a beneficiary, he or she must not be compulsory insured (in Türkiye or abroad) and not receive a pension from SSI due to his/her own social insurance, and not be re-married (SIGHIA art. 34/1-a). For the daughter to be counted as a beneficiary, she must not be compulsory insured (in Türkiye or abroad) and not receive a pension from SSI due to her own social insurance, and not be married (SIGHIA art. 34/1-b-3). For the son to be counted as a beneficiary, he must not be compulsory insured (in Türkiye or abroad) and not receive a pension from SSI due to his own social insurance, and not be older than 18 (20 if attending high school or its equivalent, 25 if attending higher education) (SIGHIA art. 34/1-b-1)[54]. For parents to be counted as a beneficiary, they must not have an income more than the net amount of the minimum wage and not receive a pension from SSI due to his/her own social insurance (SIGHIA art. 34/1-d).

Act No. 5510 also regulates on which date the insured will be included in GHI (SIGHIA art. 61)[55]. For example, the most prominent groups within the scope of GHI are insureds under social insurance and their dependants and pensioners who receive pensions from SSI through their social insurance relationship or as beneficiaries. Those who are included in the scope of social insurance because of their work (or voluntarily) are accepted to be insured in GHI as of the social insurance registration date (without a specific notification regarding GHI). The spouse, children, and parents of the GHI holder are also included in the scope of GHI without any registration. These benefit from the health services within the scope of GHI as long as they meet the conditions of the dependant category. Those entitled to have a pension as a beneficiary/pensioner or those who receive a pension under the non-

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53 There is no age requirement for children who are determined as disabled by SSI, only that they are not married.

54 There is no age requirement or marital status provision for (male or female) children who are determined as disabled by SSI, only that they are not compulsorily insured (in Türkiye or abroad) and do not receive a pension from SSI due to their own social insurance (SIGHIA art. 34/1-b-2).

55 *See also* **Sözer**, p. 216-230; **Sümer**, p. 275-279; **Korkusuz/Uğur**, p. 298-299; **Üçışık**, p. 186-188; **Centel**, Social Security Law, p. 385-386; **Tuncay/Ekmekçi**, p. 609-611; **Arıcı**, Turkish Social Security Law, p. 478-481.

contributory regime are deemed GHI holders as of the date of entitlement. When the residence period of foreigners in Türkiye exceeds one year, they can register themself in GHI (voluntarily) with the entry declaration they will submit as of this date. General health insureds who are covered only by GHI (for example, those whose status as dependants have ended, those who are not in the scope of social insurance, etc.) are registered according to their income test result[56]. Accordingly, it is possible to categorize the beginning of the insurance under GHI as ex officio registration, registration according to the income test result, and registration with notification[57].

Those who are out of the scope of social insurance or who become out of the scope afterward are obliged to be registered as general health insured within the scope of the GHI and to have an income test within one month. Persons who receive pensions or social allowance from the state within the scope of the non-contributory regime are also registered within the general health insurance. The income test is essential in determining who pays the insurance premiums of the general health insured. This issue is discussed separately under the heading "requirements and provisions" below.

In SIGHIA article 60/3, it is also stated that who is out of the scope of the GHI[58]. They are foreigners who are sent to Türkiye on behalf of a foreign organization, who come to Türkiye for a job and are insured in their own countries or foreigners who have a residence permit but reside in Türkiye for less than one year; Turkish citizens who reside abroad; those who are entitled to a pension by foreign service debt but do not reside in Türkiye; prisoners and detainees in penitentiary institutions and detention houses; those who do their military service as rank and file and students of the officer candidate school; members and retirees of the Turkish Grand National Assembly and their dependants; members and retirees of the supreme courts (Constitutional Court, Council of State, Court of Cassation, and Court of Account) and their dependants; members of the pension funds created for the staff of some banks and insurance companies, etc[59].

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56 **Centel**, Social Security Law, p. 382. Those registered in GHI in this scope must apply to Social Assistance and Solidarity Foundations and have an income test within one month from the registration date. Otherwise, it is assumed that their income to be calculated within the scope of GHI premium equals the minimum wage. *See also* note 76.

57 **Arıcı**, Turkish Social Security Law, p. 478-481.

58 *See generally* **Sözer**, p. 209-216.

59 Those excluded from the scope of GHI are excluded for two reasons: residing outside Türkiye or benefiting from health services under another law. For example, prisoners and detainees; rank and file and students of the officer candidate school; members and

As is seen, almost everyone residing in Türkiye is covered by the GHI[60]. In general, starting to reside outside of Türkiye and death are causes for ending GHI status[61]. However, changes in the benefiting status or occupation (for example, ending work life, starting to work, working in another type, going out of the scope of dependant or beneficiary status, etc.) do not exclude the person from the scope of GHI. In these cases, only the benefiting status from GHI changes.

C. Scope of GHI in Terms of Healthcare Services

General health insurance aims to protect the health of individuals when faced with social risks and also to finance the health expenses incurred (SIGHIA art. 63)[62]. GHI mainly includes health benefits against risks arising from a work accident, and occupational diseases, sickness, and maternity[63].

Health services financed within the scope of general health insurance are regulated separately in SIGHIA article 63. According to SIGHIA article 63/1, the health services financed by GHI are aimed to ensure that the insured stays healthy, to provide the medically necessary health services as a result of an occupational accident, occupational disease, illness, and maternity, and to ensure the elimination or reduction of incapacity for work. In addition, it is essential that health services are provided until the insured's health improves.

Services covered by GHI as a whole are "preventive health services", "medical health services" and "rehabilitative health services"[64]. It is also possible to list them in detail as below:

- Regardless of the insured's illness, preventive health services and services to prevent drug and other harmful addictions.
- Outpatient or inpatient medical care and treatments in case of illness, including medical and clinical examinations, laboratory tests,

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retirees of the Turkish Grand National Assembly and their dependants; members and retirees of the supreme courts and their dependants; members of the pension funds created for the staff of some banks and insurance companies are out of the scope of the GHI, as they currently benefit from health services under another regulation. *See also* **Sümer**, p. 274-275; **Arıcı**, Turkish Social Security Law, p. 476-478; **Social Security Institution**, Universal Health Insurance, p. 18-19.

60 **Uşan**, p. 116.

61 **Arıcı**, Turkish Social Security Law, p. 482; **Tuncay/Ekmekçi**, p. 611.

62 **Korkusuz/Uğur**, p. 292-293; **Üçışık**, p. 253; **Uşan**, p. 270.

63 **Sümer**, p. 263; **Korkusuz/Uğur**, p. 292; **Doğan-Yenisey**, p. 173.

64 **Sözer**, p. 251-268; **Centel**, Social Security Law, p. 388; **Tuncay/Ekmekçi**, p. 612.

analyses, and other diagnostic methods; patient follow-up and rehabilitation services; organ, tissue, and stem cell transplantations and therapies; emergency health services.

- Outpatient or inpatient medical care and treatments due to maternity, including clinical examinations, childbearing, laboratory tests, analyses, and other diagnostic methods; uterine evacuation, medical sterilization, etc.
- Outpatient or inpatient mouth and dental examination, including clinical examinations, laboratory tests, analyses, and other diagnostic methods, tooth extraction, root canal treatment, dental prosthesis, orthodontic dental treatment of minors[65], etc.
- Assisted reproductive methods for insureds who meet the provisions specified in SIGHIA article 63/1-e.
- Other complementary services related to the health services listed above.

The insured's health condition determines which of these health services will be provided to the insured. Healthcare is provided until the insured regains his health and the need lasts, even if the insured loses the conditions of being covered by GHI. (SIGHIA art. 63/3)[66].

Medicines, medical tools, and equipment related to health services (e.g., blood, blood products, vaccine, prosthesis, hearing aid, eyeglass, bone products, marrow, stent, etc.), travel expenses in case the patient is referred to another service provider, and daily allowances, companion expenses, accommodation, and food expenses are also covered by GHI. However, the types, quantities, and duration of use of drugs, tools, and equipment to be provided within the scope of GHI are determined by the SSI Health Services Pricing Commission[67]. Expenses such as travel expenses, daily allowances,

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65 GHI does not cover the costs of orthodontic dental treatments for those over 18. According to Healthcare Implementation Communique, half of the amount specified in SIGHIA art. 72 for orthodontic treatments of people under 18 and dental prostheses of people under 18 or over 44 are covered by GHI. The insured is liable to pay the remaining 50%. *See* **Arıcı**, Turkish Social Security Law, p. 487.

66 **Sözer**, p. 301. Until 1991, there was an upper limit of 18 months for the duration of treatment in the social insurance legislation. However, the Constitutional Court annulled this provision in 1991, and there was no upper limit in the social insurance law. Act No. 5510 also did not foresee an upper limit for the duration of treatment. *See* **Doğan-Yenisey**, p. 191.

67 **Sözer**, p. 92-93; **Korkusuz/Uğur**, p. 308; **Tuncay/Ekmekçi**, p. 618-619. Medicines financed by SSI are divided into three categories: medicines procured domestically,

and companion expenses are also determined by the same commission on a fixed basis (SIGHIA art. 72/1)[68].

The health services provided within the scope of GHI are provided by domestic health service providers[69]. However, in some exceptional cases, it is possible to receive these health services from abroad (SIGHIA art. 66). For example, in emergencies for insured sent abroad by their employers on temporary duty; in all necessary cases for insured who are sent on permanent duty[70] by their employers; and (provided that the approval of the Ministry of Health) for people whose treatment is not available in the country[71] health services may be provided abroad. However, the costs to be covered by SSI for the health services provided to the insured abroad cannot exceed the amount to be paid to the contractual health service providers in Türkiye (SIGHIA art. 66/6)[72].

In addition to the health services financed within the scope of GHI, not financed health services are also listed in SIGHIA article 64. Whereas all kinds of health services for aesthetic purposes, except services to ensure physical integrity; aesthetic orthodontic dental treatments (for majors); health services that are not considered medical health care (traditional, complementary, or alternative medicine practices) and foreigners' chronic diseases existing before the date of being insured in the scope of GHI are not be financed within the scope of GHI. As a rule, all health services other than these exceptions are covered by GHI[73].

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from abroad, and by alternative reimbursement methods. Depending on the characteristics of the drug, the procedures for being included in the reimbursement lists by SSI vary. *See also* **Social Security Institution**, Universal Health Insurance, p. 36.

68 **Alper**, Social Insurance Law, p. 408-409.

69 **Tuncay/Ekmekçi**, p. 622; **Sümer**, p. 284.

70 Unless otherwise stipulated in bilateral social security agreements, assignment abroad for more than six months is considered to be sent abroad on a permanent mission (SIGHIA art. 66/9; GHIPR art. 30/2). *See* **Sözer**, p. 316; **Sümer**, p. 285.

71 Before the health reform in Türkiye, additional conditions were sought to be met to receive treatment abroad. In addition, those who benefited from health services with a green card did not have such an opportunity. Act No. 5510 abolished discriminatory practices regarding receiving treatment abroad and regulated that each insured can benefit from this opportunity under the same conditions. *See* **Korkusuz/Uğur**, p. 309.

72 If the insured has been sent abroad by his employer, the parts exceeding this amount are paid by the employer. The provisions of international social security agreements are reserved. *See also* SIGHIA art. 66/3.

73 **Sümer**, p. 283.

D. Requirements and Provisions for Benefiting from GHI

Since GHI is a type of social insurance and essentially operates with the premium contribution of the parties, to benefit from GHI, the requirement of paying premiums should be met, and there should be no premium debt[74].

In the Turkish social insurance system, the premium rates to be paid on behalf of the social insured are calculated over the income called "earnings based on premium"[75]. Act No. 5510 clearly states what constitutes the number of earnings subject to the premium of the social insured (SIGHIA art. 80). On the other hand, earnings subject to the premiums of those who are only subject to GHI are regulated as fixed in SIGHIA article 80/4[76]. Accordingly, the GHI premium rates given below are calculated over the earnings of social insureds and general health insureds, as determined in SIGHIA article 80.

General health insurance premium rates and premium payer vary according to the insured (SIGHIA art. 81/1-f)[77]. The GHI premium rates of those covered by social insurance can be summarized as follows:

In the employee insured (SIGHIA article 4/1-a) and civil servant insured (SIGHIA article 4/1-c) status, the GHI premium rate of the insured is 12,5 %. The employer is responsible for 7,5 % of this, and the insured is responsible for 5 %. In the self-employed insured status (SIGHIA article 4/1-b), the GHI premium rate of the insured is 12,5 %, and the self-employed worker is responsible for the entire it. The GHI premium rates of the

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74 Premiums paid by insureds within the scope of GHI do not affect long-term insurance coverage. In other words, the GHI premiums they have paid or the premiums they have not paid do not affect whether or not they receive a future pension or the amount they will receive. GHI premiums are only substantial regarding health benefits to be provided to the insured. *See* **Korkusuz/Uğur**, p. 292.

75 *See generally* **Alper**, Social Insurance Law, p. 192-206; **Güzel/Okur/Caniklioğlu**, p. 247-259; **Tuncay/Ekmekçi**, p. 174-191; **Centel**, Social Security Law, p. 72-77; **Sümer**, p. 108-120.

76 According to SIGHIA art. 80/4, the earnings subject to premium for foreigner GHI holders are twice the lower limit of the earnings subject to premium specified in Act No. 5510; in the number of their minimum earnings for those who receive unemployment benefit or short-time working allowance; and in the amount of the minimum wage for the other GHI holders who are covered only by GHI. *See also* **Karabacak**, Emre: "Genel Sağlık Sigortası ve Gelir Testinde Yeni Dönem [New Term of General Health Insurance and Income Test]", Anadolu University Faculty of Law Journal, V. 1, N. 5, 2017, p. 34-36; **Alper**, Social Insurance Law, p. 207-208; **Güzel/Okur/Caniklioğlu**, p. 257-259.

77 *See also* **Sözer**, p. 237-240; **Korkusuz/Uğur**, p. 314.

partially insured only subject to short-term insurance vary between 4,5 % and 12,5 %, and their employers or the relevant institutions specified in the SIGHIA are responsible for these premiums[78]. In the voluntary insured status (SIGHIA article 50, article 60/1-b) the GHI premium rate of the insured is 12 %. The voluntary insured is responsible for paying his own GHI premium amount. In this context, the state contributes to SSI at the rate of one-fourth of the GHI premiums collected by SSI per month (SIGHIA art. 81/3).

However, pensioners and dependants benefit from health services within the scope of GHI without paying any premium. In addition, dependants continue to be considered GHI holders within two years from their high school or university graduation, provided they are at most 25 and are not included in the social insurance coverage. In this period, they are not obliged to pay premiums without having an income test (SIGHIA art. 67/4).

On the other hand, determining the payer of the premiums and the premium rate differ for general health insured for those not covered by social insurance. As mentioned above, persons who receive pensions or social allowance from the state within the scope of the non-contributory regime are part of the general health insurance, and the state pays their GHI premiums. Moreover, there are multiple beneficiary groups whose GHI premiums are paid by the state, e.g., persons under international protection, stateless or refugees, persons under legal protection and rehabilitation, persons who receive unemployment benefits, etc.

Persons who neither receive any payment within the scope of the non-contributory regime nor are covered by social insurance are also part of general health insurance; nonetheless, they are obliged to have an *income test*[79] which is held by Social Assistance and Solidarity Foundations [Sosyal Yardımlaşma ve Dayanışma Vakfı]. The income test aims to determine the person's monthly income (per capita income in the household), and the wife/husband, single children, and parents living in the same household are taken as the basis for the calculation of income.

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78 For example, the premium rate for apprentices and students receiving vocational training in enterprises is 5%; 4,5% for trainees; 6% for trainee lawyers; 12% for those who receive unemployment allowance, short-time working allowance, or job loss compensation. *See also* **Centel**, Social Security Law, p. 399; **Sümer**, p. 123-124.

79 For more information about the income test, *see* **Arıcı**, Kadir: "Genel Sağlık Sigortasında Gelir Testi Meselesi ve Çözümü [Income Test Issue in General Health Insurance and Its Solutions]", Sicil Labour Law Journal, N. 34, 2015, p. 30-39; **Karabacak**, p. 30-37; **Güzel/Okur/Caniklioğlu**, p. 815-821; **Tuncay/Ekmekçi**, p. 598-602.

As a result of the income test, people whose household monthly income is less than one-third of the minimum wage are registered within the scope of general health insurance and are paid their insurance premiums by the state. Those beneficiaries overlap with the group that previously benefited from the health services under the green card system[80].

As a result of the income test, people whose household monthly income is higher than one-third of the minimum wage are obliged to register within the scope of general health insurance and pay their insurance premiums. The GHI premium rate for these beneficiaries is 3 % as of 3/1/2017 (SIGHIA art. 80/1-f). Before this date, the GHI premium rate was 12 %; however, due to beneficiaries' inability to pay their premiums on time, this rate was reduced from 12 % to 3 %[81]. Persons who are not included in the GHI within the scope of social insurance and who do not have an income test are also obliged to pay a 3 % premium within this framework[82].

As can be seen, it is mandatory to pay premiums on behalf of each insured and general health insured. These premiums are paid by the insureds (and their employers) and general health insureds, or in some cases, by the state[83]. However, as an exception, pensioners and dependants are included in the scope of GHI without paying any premium.

Beneficiary status	**Premium rate**
Insured (according to SIGHIA art. 4/1-a and 4/1-c)	12,5 % (7,5 % by the employer; 5 % by the employee/civil servant)
Insured (according to SIGHIA art. 4/1-b)	12,5 % by the self-employed worker
Voluntary insured	12 % by themselves
Partially insured	4,5 % to 12,5 % by the employer/institution
Pensioner	-
Dependant	-

80 **Tuncay/Ekmekçi**, p. 581-582; **Doğan-Yenisey**, p. 177.

81 **Karabacak**, p. 35-36; **Alper**, Social Insurance Law, p. 208, 213; **Güzel/Okur/Caniklioğlu**, p. 819. However, the President can increase this rate to 12 % again (SIGHIA art. 81/1-f).

82 **Sümer**, p. 280; **Alper**, Social Insurance Law, p. 397.

83 **Centel**, Social Security Law, p. 381.

General health insured (Low-income person, social allowance beneficiary, non-contributory regime pensioner, etc.)	12 % by state
General health insured (others)	3 % by themselves

Table-1: General health insurance premium rates according to beneficiary status

As mentioned above, the second condition that the general health insured must meet to benefit from GHI is to have 30 days of GHI premium payment in the last year before the date of application to the health service provider. An additional condition has been added to this condition for insureds subjected to article 4/1-b SIGHIA and their dependants (SIGHIA art. 60/1-a-2) and those only in the scope of GHI (SIGHIA art. 60/1-g) and pay their own premiums. Accordingly, on the date of application to the health service provider, these insureds must not have a debt of any kind premium for more than 60 days (except those deferred or paid in instalments) (SIGHIA art. 67/1-b, art. 67/1-c). Voluntary insureds and foreigners residing in Türkiye with a residence permit and their dependants should not have any kind of premium debts at the time of application to the health service provider (SIGHIA art. 67/1-c, 67/1-d)[84].

However, there are some exceptions to the provision about having 30 days of GHI premium payment in the last year before the date of application to the health service provider. It is not stipulated for general health insured whose premiums are paid by the state, pensioners and dependants, children under 18 (minors), foreign students who study in Türkiye according to international agreements, persons in need of medical care, etc. Moreover, having paid a 30-day GHI premium in cases of emergency, work accident and occupational diseases, notifiable contagious diseases, substance abuse, preventive health services, maternity, natural disasters and war, strike and lockout, and traffic accidents is not required (SIGHIA art. 67/1). An exclusive regulation exists for those whose dependant status has ended due to age limit or high school/university graduation. These persons continue to benefit from the GHI as dependants as long as they are not covered by social insurance as an insured and do not reach the age of 25.

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84 *See also* **Güzel/Okur/Caniklioğlu**, p. 840-841; **Sözer**, p. 376-378.

E. Providing Healthcare Services in GHI

General health insurance does not provide healthcare services on its own, and there are no healthcare providers operated by GHI. The Social Security Institution does not provide healthcare services at its own facilities; it purchases services from health service providers[85] (purchase method) for the insured. Accordingly, the SSI's function in providing health services is to ensure the costs of health services received by insureds from the health service providers. (SIGHIA art. 73/1).

Unlike before the health reform, health services in the implementation of general health insurance are provided by private service providers as well as public service providers[86]. In order to receive service from private service providers within the scope of general health insurance, it is necessary and sufficient for these institutions to have a contract with the SSI (service procurement agreement). However, receiving healthcare services from a private or a public service provider has some differences, as discussed below.

The calculation of the costs to be paid for the health services or the minimum and maximum limits of these costs are arranged by a central system instead of by each health service provider[87]. According to SIGHIA article 63/2, the Social Security Institution is authorized to determine the types and amounts of health services to be financed, the diagnosis and treatment methods of health services, the amount and duration of in-kind and cash benefits, and the procedures and principles of payments to be made to the insured or health service providers, by consulting the Ministry of Family and Social Services and the Ministry of Health[88]. SSI uses this authority through the Health Services Pricing Commission (SIGHIA art. 72). Health service providers that make a contract with SSI undertake to provide health services within these limits[89].

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85 Health service provider is defined in Act No. 5510 as "real persons and legal entities of public and private law and their branches providing and producing health services" (SIGHIA art. 3/25).

86 Before the health reform in Türkiye, public institutions, and hospitals (and partly private practice of the doctors) dominated the delivery of health services. Although private hospitals emerged in the 1980s, the coverage of private health services was relatively limited before the health reform. After the state incentives provided to the private health sector, private hospitals have become notable service provider actors. *See* **Yılmaz**, p. 204-206.

87 *See generally* **Centel**, Social Security Law, p. 403-405.

88 **Sözer**, p. 90.

89 **Arıcı**, Turkish Social Security Law, p. 507.

The transactions between SSI and healthcare service providers run via MEDULA (medical communicator) system[90]. The MEDULA system consists of different components, e.g., hospitals, pharmacies, opticians, and medical device suppliers[91]. Through the MEDULA system, SSI can control health expenditures. The Healthcare Provision Activation System follows up the conditions of people benefiting from general health insurance.

In terms of providing health services, there are ***service steps*** in Türkiye. According to the envisaged system, health service providers are classified into three steps in Healthcare Implementation Communique (HIC)[92]. There are family physicians[93], community health centres, medico-social units of universities, municipal polyclinics, private polyclinics, private oral and dental health institutions, pharmacies, and workplace health and safety units, etc. in *primary care health institutions* (HIC art. 1.4.1). *Secondary health institutions* consist of state hospitals, district polyclinics, oral and dental

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90 For the MEDULA system, *see* **Social Security Institution**, Universal Health Insurance, p. 58-63.

91 MEDULA system consists of six components such as MEDULA-Hastane (for hospitals), MEDULA-Eczane (for pharmacies), MEDULA-Optik (for opticians), MEDULA-Şahıs Ödemeleri (for personal payments), MEDULA-Medikal Market (for medical device suppliers) and MEDULA-Medikal İşitme Merkezi (for hearing centres). *See* **Social Security Institution**, Universal Health Insurance, p. 59.

92 Some healthcare providers and health institutions, such as dialysis centres, diagnosis, examination, and imaging centres, laboratories, medical device, and material suppliers, spas, and opticians, are excluded from this triple service steps (HIC art. 1.4.4.). *See generally* **Sözer**, p. 130-132; **Arıcı**, Turkish Social Security Law, p. 495; **Güzel/Okur/ Caniklioğlu**, p. 856.

93 The first act on family physicians in Türkiye (Family Physicians Act No. 5258) was adopted on 11/24/2004. However, family physician legislation has been amended frequently until and after family physician services were put into force. Family physician services started to be implemented in a limited way with the pilot application in 2005, and it was implemented in all of Türkiye as of 11/11/2010. The "healthcare centre" practice was implemented and terminated before this date. Family physicians are employed in various statuses (employment of the Ministry of Health physician as contracted personnel, employment of the physician as a family physician affiliated with the Ministry of Health, and employment of the physician who is not a civil servant as contracted personnel) by the Ministry of Health. For example, in the family physician system, people are registered with a family doctor according to their residence addresses. However, individuals can choose and change their family physician, if they comply with the stipulated periods. Family physician services are provided free of charge to individuals. *See generally* **Taşdemir**, Yasemin: "Türk Hukukunda Aile Hekimliği Sistemi ve Aile Hekiminin İşveren Sıfatına İlişkin Bir İnceleme [The Family Physician System in Turkish Law and a Review of the Employer Capacity of Family Physicians]", Maltepe University Faculty of Law Review, N. 2. 2021, p. 274-283. *See also* **Sözer**, p. 107-114; **Tuncay/Ekmekçi**, p. 642-648.

health centres affiliated with the Ministry of Health, municipal hospitals, medical centres belonging to public institutions, private hospitals, and medical centres, etc. (HIC art. 1.4.2). *Tertiary health institutions* are training and research hospitals affiliated to the Ministry of Health and affiliated polyclinics, university hospitals, and dental faculties (HIC art. 1.4.3). There is not any private health service provider in the tertiary step.

In SIGHIA, a ***referral chain procedure*** has also been adopted to ensure that health services are carried out effectively. SIGHIA imposes an obligation to comply with the service steps to benefit from health services for people covered by the GHI (SIGHIA art. 70/2). This application aims to provide an effective and efficient health service by creating a referral chain between service providers and to prevent unnecessary applications and congestion in the system[94]. According to the referral chain, if the family physician cannot provide treatment, he/she has the authority to refer the patient to (subordinated to the Ministry of Health) secondary or tertiary healthcare providers. In case of non-compliance with the referral chain, it is stated in the GHIPR that health services costs, travel expenses, daily allowances, and companion expenses are not covered by SSI (GHIPR art. 25/4)[95]. However, in some exceptional cases (for example, occupational accidents, occupational diseases, disasters, war, and other emergencies), it is possible not to comply with the referral chain.

However, although the referral chain procedure was regulated in Act No. 5510, establishing the referral chain was given to the Ministry of Health. Even though the Ministry of Health established the referral chain system in the first years, when the health transformation program was put into use (when the family physician was implemented as a pilot), it abolished the referral chain procedure in a short time due to the intensity experienced in the primary health institutions[96]. The referral chain system has not taken effect to date[97]. For this reason, these regulations regarding the referral chain in the legislation are *ineffective provisions* and have no application[98].

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94 **Tuncay/Ekmekçi**, p. 640.

95 **Sözer**, p. 306; **Arıcı**, Turkish Social Security Law, p. 493; **Centel**, Social Security Law, p. 408.

96 *See* **Turkish Medical Association Report:** "Sağlıkta Dönüşüm Programı Çöktü Aile Hekimliği: Ne Dediler, Ne Oldu? [Transformation in Health Programme Collapses: General Health Insurance: What Did They Say, What Did Actually Happen?]", Community and Physician, V. 33, N. 6, 2018, p. 470-472.

97 **Turkish Medical Association Report**, Transformation in Health Programme Collapses, p. 471.

98 For the view that there is no referral chain application in Türkiye, *see* **Yılmaz**, p. 205.

Since the Social Security Institution makes a contract with the health service providers from which it will purchase services, it is also possible to divide the health service providers into two those who have an agreement with the SSI (contractual providers)[99] and those who do not (non-contractual providers). Accordingly, a person residing in Türkiye has two options for receiving health services from private or public institutions (hospitals, health centres, etc.). However, to cover the health service cost within the scope of GHI, the insured must have applied to the private or state institutions with which SSI has a contract (contractual providers). Otherwise, the cost of the health service provided to the insured is not covered by SSI.

However, in emergencies, the health service fee is covered up to the amount determined to be covered in applications made to institutions that do not have a contract with the SSI. For this, the insured must first pay the health service provider and then demand the payment from the SSI. In non-emergency cases, the cost of health services received from non-contractual providers is not covered by SSI.

Even though the health service payments are financed under the GHI (regardless of whether the health service is received from contracted service providers or not), two types of payments are paid by the insured, not under the scope of GHI[100]. These ***out-of-pocket payments*** are co-payment and additional payments.

Co-payment (patient share) is determined in different amounts depending on the type of health service (e.g., outpatient care, dental examination, extracorporeal orthotics and prosthesis, outpatient medications,

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99 According to the SSI annual report, as of the end of 2021, SSI has contracts with 2,412 healthcare providers, 869 of which are public, 1,411 private, and 132 university hospitals. The number of pharmacies contracted with SSI is 27,893. **Sosyal Güvenlik Kurumu:** 2021 Yılı Faaliyet Raporu [2021 Annual Report], Ministry of Labour and Social Security, Ankara 2022, p. 61. https://www.sgk.gov.tr/Download/DownloadFileStatics?f=2021FaaliyetRaporu.pdf&d=FAAL%C4%B0YET_RAPORLARI (last visited April 13, 2023). Although the 2022 annual report was announced a few days ago, it does not include the total number of contracted healthcare providers as of the end of 2022.

100 It impossible to pay the co-payment by anyone other than the insured. However, it is possible for additional payment to be paid by someone other than the insured, for example, employers or private health insurance. *See* **Social Security Institution:** Organizational Profile & An Overview of the Social Security System in Turkey, Ministry of Labour and Social Security, Ankara 2020, p. 63-67, https://www.sgk.gov.tr/Download/DownloadFileStatics?f=kurum_tanitim_kitabi_ENG.pdf&d=YAYINLARIMIZ (last visited March 21, 2023).

inpatient treatment by disease group, etc.) and on the health service provider from which the health service is received (e.g., primary care, secondary or tertiary health institutions, and public or private health institutions)[101]. This contribution is paid by the insured or the dependant receiving the health care. The co-payment is deducted from the pensions of beneficiaries and the salaries of employees/civil servants or is collected on behalf of SSI through pharmacies or other institutions and organizations[102].

As a rule, all insureds are obliged to pay the co-payment. However, there is an exceptional regulation in terms of general health insured whose GHI premiums are paid by the state (e.g., those who are determined to be low-income as a result of the income test, who receive pensions within the scope of the non-contributory regime, stateless people, asylum seekers, etc.). These insureds can withdraw the paid co-payment from the Social Assistance and Solidarity Foundations later[103].

There are other exceptions regarding the co-payment for some insureds and cases. For example, in cases of work accidents and occupational diseases, preventive health services, natural disasters, and war, treatment of chronic diseases, organ, tissue, and stem cell transplantations, control examinations, and for health services of persons who receive a pension from the non-contributory regime, no co-payment is charged (SIGHIA art. 68).

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101 There is no co-payment for the medical doctor and dentist examination for outpatient treatments given by the public primary healthcare service providers and family physicians. The co-payment is 6 Turkish Lira in secondary public health institutions; 7 Turkish Lira in the education and research hospitals of the Ministry of Health, which are used jointly with universities; 8 Turkish Lira in tertiary public health institutions (university hospitals); and 15 Turkish Lira in private health institutions, regardless of their service steps. It is possible to receive a co-payment of up to 1% of the cost of health services offered in inpatient treatments. The co-payment for extracorporeal prostheses, orthoses and outpatient medicines is 10% of the cost for pensioners and their dependants, and 20% for other insureds and their dependants. Additionally, there is a prescription co-payment applied in case of outpatient treatment, and it is 3 Turkish Lira for up to 3 medicines prescribed plus 1 Turkish Lira for each additional medicine. Regarding assisted reproduction methods, the co-payment margin was gradually arranged according to the number of trials (SIGHIA art. 68/5). *See* **Social Security Institution**, Organizational Profile, p. 63-64; **Social Security Institution**, Universal Health Insurance, p. 46-48. *See also* **Sözer**, p. 355-363.

102 **Güzel/Okur/Caniklioğlu**, p. 851, 853; **Tuncay/Ekmekçi**, p. 638; **Korkusuz/Uğur**, p. 318; **Centel**, Social Security Law, p. 406; **Alper**, Social Insurance Law, p. 412-413.

103 This arrangement is rightly criticized in the doctrine because it is impractical. Counting these people among the groups who are not charged any co-payment would be more practical. *See* **Centel**, Social Security Law, p. 408; **Güzel/Okur/Caniklioğlu**, p. 853.

Whether the health institutions with a contract[104] with the SSI are public or private, financing the health service differs. Private health institutions have the right to demand ***additional payment*** from the patient regarding provided health services, apart from the health service fee determined by the SSI Health Services Pricing Commission. The upper limit of this payment is determined by the same Commission[105]. As a rule, there is no additional payment application in public health institutions for standard healthcare services[106]. However, there are three exceptions to this rule. These are hotel services, exceptional (exclusive) health services, and health services provided by faculty members in public universities (SIGHIA art. 73). Faculty members can request additional payment for health services they give. The same Commission also determines the upper limit of this payment.

Type of healthcare provider	**Contractual provider**	**Non-contractual provider**
Public health service provider	SSI covers the health service fee (determined amount).	SSI does not cover the health service fee. Exception: in case of emergencies (in determining amount).
	No additional payment can be requested from the patient (except for faculty members' examinations, hotel services, and exceptional health services).	No additional payment can be requested from the patient (except for faculty members' examinations, hotel services, and exceptional health services).
	SSI covers the health service fee (determined amount).	SSI does not cover the health service fee. Exception: in case of emergencies (in determining amount).

104 For the contract types of private health service providers, *generally see* **Sözer**, p. 31-49.

105 Private healthcare providers may charge an additional payment of up to twice the standard prices set by the Healthcare Pricing Commission for standard healthcare services and up to three times for the exceptional services and hotel services specified in the Healthcare Implementation Communique. *See* **Social Security Institution**, Organizational Profile, p. 66-67.

106 *See* **Alper**, Social Insurance Law, p. 419; **Güzel/Okur/Caniklioğlu**, p. 857-858.

Private health service provider	An additional payment may be requested from the patient (provided that it does not exceed the determined upper limit).	An additional payment may be requested from the patient (provided that it does not exceed the determined upper limit).

Table-2: Benefit from health services according to the type of service provider and whether the service provider has a contract with SSI or not

On the other hand, it is regulated that no additional payment will be charged for some patients or some services, regardless of whether they receive health services from public or private health providers. Persons who will not be charged additional payment are, for example, those who receive honour pensions, those who receive pensions within the scope of the fight against terrorism and their dependants, those who receive military disability pensions, etc. (HIC 1.9.2.). Health services that will not be charged an additional payment, for example, emergency health services, intensive care services, burn treatment services, cancer treatment within the scope of radiotherapy and chemotherapy, new-born health services, organ, tissue, and stem cell transplants, dialysis treatments, etc. (HIC 1.9.3.)[107].

The person applying to the health service provider must report his/her identity, except in emergencies[108] (SIGHIA art. 71). In emergency cases, identification of the insured is made after the end of the emergency. The purpose of this regulation is to prevent someone else from receiving healthcare services instead of the insured.

III. EVALUATION OF THE CURRENT GHI PRACTICE

As mentioned above, the health transformation program was implemented in 2003. With this program, the targets in terms of health services were, in general, as follows:

- Creating a financially sound health system,
- Ensuring the unity of norms and standards,
- Ensuring that everyone enjoys the right to health,

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107 **Centel**, Social Security Law, p. 411-412; **Tuncay/Ekmekçi**, p. 655-656; **Güzel/Okur/Caniklioğlu**, p. 858; **Social Security Institution**, Universal Health Insurance, p. 52-53.

108 The General Health Insurance Practices Regulation states the emergencies. These are when there is a risk of loss of life or health integrity if medical intervention is required within 24 hours or is not immediately performed (GHIPR art. 27).

- To benefit from health services free of charge for those who have low income,
- Eliminating physical difficulties in accessing the right to health,
- Increasing satisfaction with health services in general,
- Building an effective healthcare system.

It was aimed to achieve these goals through general health insurance. In this direction, general health insurance came into effect gradually in 2008 as a part of Act No. 5510[109].

This section examines whether the purposes of introducing general health insurance have been fulfilled until today, mentions the positive and negative aspects of general health insurance, and evaluates some suggestions to eliminate still-existing problems.

The most significant aim pursued with general health insurance was to expand the scope of the health insurance beneficiaries. As a matter of fact, in past practices, a large part of society had difficulties in accessing the right to health through health insurance. When the health services implemented in line with the green card method and by *SSK*, *Bağ-Kur* and *Emekli Sandığı* are compared with today's GHI practice, it is possible to say that the primary goal of expanding the scope of health insurance has been achieved. As can be seen from the table below, almost everyone in Türkiye is covered by general health insurance today. Those who are exceptionally excluded from GHI are those who do not reside in Türkiye, are insured abroad, and are temporarily in Türkiye, and are not covered by the GHI because their health services are covered differently[110].

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[109] Although it was aimed to regulate the GHI with a separate act, the GHI was accepted as a part of Act No. 5510 during the enactment process. Thus, the already complex Act No. 5510 has become even more complicated. For example, two concepts of insured (social insured and general health insured) have emerged. Although this issue is a technically faulty arrangement and created various problems at the beginning, it can be stated that today it is no longer a problem in itself. In other words, discussing more critical problems of the general health insurance implementation is possible.

[110] These people, who are excluded from the scope of the GHI because health services are financed by their own institutions, bring into disrepute the ideal of GHI to provide a unity of standards and norms. This issue is also criticized in the doctrine as it is against the principle of equality. *See also* **Arıcı**, Kadir: "Sosyal Güvenlikte Eşitlik Meselesi [Equality Problem in Social Security System]", Ankara Hacı Bayram Veli University Faculty of Law Review, V. 23, N. 1, 2019, p. 15-19.

Type of the scope	Total population
Insured (Compulsorily or voluntarily)	26.344.234
Pensioner	13.933.020
Dependant	34.813.357
Foundation fund beneficiary	438.989
Registered as general health insured	9.088.043
Total population within the scope of GHI in Türkiye	**84.617.643**

Table-3: Distribution of the covered by GHI in Türkiye *(December 2022)*

According to the Ministry of Labour and Social Security official statistics[111], 89 % of Türkiye's population is covered by social insurance as insured, pensioner, or dependant status by 2022. It means that 89 % of the population is covered by general health insurance under social insurance. Only general health insureds are approximately 10 % of the population. This means that according to official statistics, almost all of the population is included in the GHI[112].

On the other hand, including everyone in general health insurance has created some negative consequences (e.g., income test issues), especially in paying GHI premiums. These will be discussed further below.

The other significant aim pursued with general health insurance was ensuring the unity of norms and standards. However, it is impossible to draw such a clear picture of whether the unity of norms and standards is achieved regarding access to the right to health because GHI has brought various exceptions to the rule of ensuring norm unity. Although, as a rule, the same principles are used in accessing the right to health under the scope of the GHI, some differences have been made in the axis of the understanding of substantive equality. For this reason, it is possible to say that the ideal of ensuring the standard unity of the GHI (having the same rights and conditions in benefiting from health services) has been *partially* fulfilled[113].

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111 https://www.sgk.gov.tr/Istatistik/Aylik/42919466-593f-4600-937d-1f95c9e252e6/ (last visited March 22, 2023).

112 That GHI covers 99% of the population, *see* **Social Security Institution**, Universal Health Insurance, p. 14; **Sosyal Güvenlik Kurumu:** 2022 Yılı Faaliyet Raporu [2022 Annual Report], Ministry of Labour and Social Security, Ankara 2023, p. 74. https://www.sgk.gov.tr/Download/DownloadFileStatics?f=2022FaaliyetRaporu.pdf&d=FAAL%C4%B0YET_RAPORLARI (last visited April 13, 2023).

113 *See* **Orhaner**, p. 59.

The significant example of these differences is undoubtedly in terms of the premium rates and premium payers. Especially for the partially insured within the scope of short-term insurance, GHI premium rates are lower than those of other insureds. In determining the premium payer, the state is also responsible according to the insured's income. In other words, low-income persons are exempted from paying GHI premiums according to the results of the income test they have, and the state is authorized to pay the premiums of these individuals.

The income test practice, introduced to prevent the abuse of benefiting from the right to health without paying a premium, like the green card system, is a proper regulation. As a matter of fact, with the transition to the income test practice, there has been a significant decrease in the number of people who benefit from free (without paying a premium) health services as green card holders[114]. However, the income test practice has some difficulties in practice[115]. Although various changes[116] have been made to reduce the problems created by the income test, it is difficult to say that these problems have entirely disappeared. For example, while determining a person's income in the income test practice, the household (spouse living in the same household, unmarried children, and grandparents') income is taken as the basis, not the person's own income[117]. This regulation, on the other hand, leads to the determination of low-income individuals who would typically not be able to fulfil their premium payment obligations as premium payers[118]. Additionally, people in this situation do not have the right to choose to remain in the insurance coverage of their own volition and not pay premiums. Although the premium rate for these people has been reduced from 12 % to 3 % and the premium amount has decreased significantly, it is impossible to discuss the disappearance of the problems thoroughly.

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114 *See* **Tuncay/Ekmekçi**, p. 581-582.

115 On the opinion that the income test practice is one of the most problematic areas of Act No. 5510, *see* **Alper**, Yusuf: "Genel Sağlık Sigortası ve Gelir Testi Uygulaması [General Health Insurance and Income Test Practice]", Türk-İş Journal, N. 397, 2012, p. 58-59.

116 *See* **Arıcı**, Income Test, p. 37-39.

117 For the income test implementation, *see* **Arıcı**, Income Test, p. 30-39.

118 To critique of this arrangement, *see* **Güzel/Okur/Caniklioğlu**, p. 820; **Alper**, Income Test Practice, p. 59. **Dertli**, Nail: "Genel Sağlık Sigortası ve Gelir Testi: Statü Eşitsizliğinden Gelir Eşitsizliğine [Universal Health Insurance and Income Test: From Statue Inequality to Income Inequality]", Mülkiye Journal, V. 39, N.3, 2015, p. 286-287. For the view that this regulation is unconstitutional, *see* **Arıcı**, Income Test, p. 32-36.

One of the disadvantaged groups of the income test practice is the young people whose education life ends but who do not start working life. In the first version of the income test arrangement, these young were obliged to take an income test after their dependant status expired. Those who did not have an income test or whose household monthly income is higher than one-third of the minimum wage due to the income test were included in the scope of GHI on the condition that they pay their premiums.

As a result of forming a public opinion of these young people's premium problems, some changes were made in the legislation in 2016 These people could keep their dependant status for two years (up to 25 years old)[119]. Thus, young people who were not covered by social insurance were allowed to benefit from GHI for a while with their dependant status (without paying GHI premium on their behalf). This arrangement provides a temporary solution. It may be an appropriate arrangement to maintain the dependant status (regardless of age requirement[120]) for young people who are not involved in working life and are not covered by social insurance even though the two-year period has expired (or have reached the age of 25) or to give them the initiative to stay out of the scope of GHI. As stated in the doctrine, it may be another solution for these people to be subjected to an income test *individually* after the temporary solution period expires and to pay the GHI premiums by the state according to the income test results[121].

Another exception to the standard unity ideal of GHI is that some insured must not have premium debts to benefit from the health services. As a rule, the general condition required to benefit from GHI is that the insured must have paid a 30-day GHI premium within the last year before the application date to the health service provider. However, this general rule has been made more difficult for self-employed workers and their dependants, other GHI holders (who pay their own premiums), and voluntary insureds and foreigners. On the date of application to the health

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119 **Arıcı**, Income Test, p. 38-39; **Alper**, Social Insurance Law, p. 396, 411.

120 In fact, the age requirement in the *SSK*, *Emekli Sandığı*, and *Bağ-Kur* practices before the reform was not a condition that abolished the dependant status of daughters. However, in Act No. 5510, the maximum age requirement for daughters besides sons has been accepted. On the other hand, a transitional provision was introduced in terms of this regulation, and daughters' vested rights were protected. Accordingly, daughters who were considered as dependants before the entry into force of Act No. 5510 are considered as dependants in the period of Law No. 5510, regardless of their age, provided that they fulfil the other conditions (SIGHIA provisional art. 12/8). Thus, they can benefit from general health insurance in this status. *See* **Sözer**, p. 169-170.

121 *See* **Arıcı**, Income Test, p. 39-40.

service provider, self-employed insureds and their dependants and those only in the scope of GHI must not have a debt of any kind premium for more than 60 days (except those deferred or paid in instalments). Additionally, voluntary insureds and foreigners residing in Türkiye with a residence permit and their dependants should not have any kind of premium debts at the time of application to the health service provider. These conditions constitute an obstacle for those who are included in the scope of GHI under the relevant statutes and their dependants[122] to access the right to health[123]. This condition, which is not required for other GHI holders, is only required for these general health insureds since they pay their own premiums[124]. Moreover, the provision of not having all kinds of premium debts to benefit from the GHI is also not reasonable and fair. Even if such a condition is to be sought, it should only be sought in terms of GHI premium. As a matter of fact, due to the problems that arise in these people's access to the right to health, deferral and instalment arrangements are often brought for these insureds regarding their premium debts[125].

Another purpose of general health insurance was to eliminate the physical difficulties in accessing the right to health. Before the healthcare reform, one of the significant problems of the health system was physical difficulties in accessing health services. Within the scope of the health transformation program, various attempts have been made to eliminate or reduce these problems, such as increasing the number of contractual service providers with SSI[126], increasing the number of hospitals[127], developing an

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122 Although this provision is regulated to include dependants, there is a general exception for those under 18 regarding accessing health services covered by GHI. Those under 18 can benefit from health services within the scope of GHI, even if their parents have premium debts. *See also* SIGHIA art. 67/1.

123 For the critics regarding the regulation that there should be no premium debt to benefit from the right to health, *see* **Güzel/Okur/Caniklioğlu**, p. 842 844.

124 The condition of having a 30-day GHI premium before applying to the health service provider is reasonable, and it should be sufficient to seek this condition for everyone. *See* **Okur**, Ali Rıza: "Genel Sağlık Sigortası Açısından Yeni Sosyal Güvenlik Sisteminin Değerlendirilmesi [Evaluation of the New Social Security System in Terms of General Health Insurance]", Journal of YU Faculty of Law, V. 6, N. 2, 2009, p. 109.

125 For example, *see* https://www.alomaliye.com/2022/01/12/cumhurbaskanligi-karari-karar-sayisi-5089/ (last visited February 2, 2023).

126 As of the end of 2021, the number of contractual hospitals (public, private, or university) is 2412, the number of contractual pharmacies is 27,893, the number of contractual medical markets/pharmacies is 13,156, the number of contractual opticians is 6.589, and the number of contractual hearing centres is 1.425. *See* **Social Security Institution,** Universal Health Insurance, p. 33; **Sosyal Güvenlik Kurumu**, 2021 Annual Report, p. 61.

online appointment system[128], and expanding family physician practices[129]. There has been a significant increase in the total number of applications to physicians and the number of physician applications per person over the years[130]. Thus, in this context, it can be said that the health reform has mainly eliminated the physical problems experienced in accessing health services.

The health transformation program also aimed to increase satisfaction with health services. In terms of patient satisfaction and financial protection before the health reform, Türkiye was in the lower ranks of OECD countries and WHO's European region[131]. However, with the health reform, satisfaction with the health system changed rapidly in a positive way[132]. When the annual statistics in the field of health are analysed as a whole from the beginning of the health reform to the present, it can be observed that the rate of satisfaction with health services has gradually increased[133]. For

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127 As of 2021, the number of hospitals in Türkiye is 1547. *See* **The Ministry of Health of Türkiye:** Health Statistics Yearbook 2021, Ministry of Health, Ankara 2023, p. 118. https://dosyasb.saglik.gov.tr/Eklenti/45317,siy2021-ingilizcepdf.pdf?0 (last visited April 22, 2023). According to the 2020 data, the number of outpatient medical institutions is 33087. A large part of outpatient medical institutions is family physicians. *See also* https://data.tuik.gov.tr/Bulten/DownloadIstatistikselTablo?p=EBiEoUc7BpEm8laGP9uvfuvTnLEZ4iIqzuLiBGVhlkTQDMDWUgaKm8mAWpF0aaxX (last visited March 15, 2023).

128 For the centralized doctor appointment system, *see* https://mhrs.gov.tr/vatandas/#/ (last visited June 9, 2023).

129 According to 2021 data, the number of family physician units in Türkiye is 26,928. *See* **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 145.

130 The number of applications per person, was 3.1 in 2002, increased to 6.7 in 2008, 8.2 in 2011, and 9.8 in 2019. In 2020, this number decreased to 7.2; in 2021 was 8,0 (probably due to COVID-19 pandemic conditions). *See* **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 153.

131 **World Health Organization:** Successful Health System Reforms: The Case of Turkey, WHO Regional Office, Copenhagen 2012, p. 6, https://disab.saglik.gov.tr/Eklenti/2106/0/successful-health-system-reforms-the-case-of-turkeypdf.pdf (last visited May 2, 2023).

132 **World Health Organization**, The Case of Turkey, p. 6*; see also* **World Health Organization:** Strategic Planning for Health: A Case Study from Turkey, WHO Regional Office, Copenhagen 2015, p. 2, https://www.euro.who.int/__data/assets/pdf_file/0017/272321/Strategic-Planning-for-Health_Turkey.pdf (last visited May 2, 2023).

133 For statistics on satisfaction with the services of health institutions (2003-2022), *see* **Türkiye İstatistik Kurumu:** Yaşam Memnuniyeti Araştırması 2022 [Life Satisfaction Research 2022], Türkiye İstatistik Kurumu, Ankara 2023, p. 29-30. https://biruni.tuik.gov.tr/yayin/views/visitorPages/yayinGoruntuleme.zul?yayin_no=590

example, in 2020 comparative statistics, the rate of satisfaction with health services in Türkiye (72,1 %) is above the average of OECD countries (71 %)[134]. However, in 2021 comparative statistics, this rate was measured as 68,1 % in Türkiye, as belove the average of OECD countries (70 %)[135].

On the other hand, this increase in the satisfaction rate with health services should not be interpreted as all problems in the provision of health services being solved. Although there has been positive momentum in the satisfaction statistics, there has yet to be a similar development in the ratio of the total population to the number of physicians. According to 2021 data, the number of physicians per 100,000 persons in Türkiye is 217. When compared to the average of OECD countries (356) and EU countries (397), it is possible to say that there has not been a sufficient improvement in this regard[136]. Apart from this, the ratio of the current health expenditures within the year to GDP has not reached the expected level (according to WHO, this ratio should be at least 5 %). The share of the current health expenditures in GDP is below the OECD and EU averages[137].

Another of the goals of the health transformation program was to create an effective health system. For this purpose, the referral chain practice and the service steps regarding health providers were accepted in Act No. 5510. However, it is impossible to say that health reform has succeeded in this regard. Although there is legislation regarding referral chain implementation, the Ministry of Health still needs to reactivate the referral chain. This situation has led to the inability to operate the service steps system, which is accepted in terms of health service providers, and the inability to provide adequate health service in this context. In applications made without complying with the referral chain (for example, applying directly to tertiary service providers), there is no sanction, such as not financing health services within the scope of GHI. The only difference in applying to a primary, secondary, or tertiary health service provider is the amount of the patient's co-payment.

(last visited May 4, 2023). According to the same statistics, health services is the third field with the highest satisfaction (65,6 %) after public security services (75,9 %) and transportation services (69,7 %). *See* **Türkiye İstatistik Kurumu**, p. 27.

134 **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 184-186.

135 **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 184-186.

136 The total number of physicians per 100.000 population in Türkiye was 138 in 2002, 158 in 2008, 175 in 2014, 186 in 2017, and 193 in 2019. *See* **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 215-217.

137 **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 245-248.

As mentioned, before the health reform, primary healthcare services in Turkey were quite limited and ineffective. With the health transformation program, the family physician system was introduced as a primary care provider; thus, it is aimed to prevent backlogs in second and tertiary health service providers. However, from today's perspective, the family physician practice could not meet these expectations since the referral chain practice needed to be implemented. Although there has been a significant increase in the total number of applications to physicians and the number of physician applications per person, this increase has not been directly proportional to the gradation of health service steps. Since health reform was introduced, applications to secondary and tertiary care providers have consistently exceeded the ones to primary care providers[138]. Family physician units are still far from fulfilling their mission of being the first application centre in the service steps[139].

Another aim of general health insurance was to create a financially strong system. The expectation from the GHI was to increase and centralize income for health expenditures and to reduce health services' costs[140]. Health service delivery would not be carried out within SSI, and SSI would only provide financing for health services. Moreover, in addition to previous incomes, there would be an additional income from GHI premiums[141]. However, giving up the provision of health services and only financing for health services did not reduce the cost. These costs continued to increase during the implementation of Act No. 5510[142]. As a matter of fact, one of the

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138 *See generally* **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 152-156. For critical reviews, *see* **Turkish Medical Association Report**, Transformation in Health Programme Collapses, p. 470-472.

139 According to the statistics for the year 2022, the first health institutions to apply for the illness in terms of those covered by social insurance are state hospitals (47,2 %), family health centres (35,4 %), and private hospitals (13 %). On the other hand, for those who are not covered by social insurance, the first health institutions applied for the illness are state hospitals (58 %), family health centres (34 %), and private hospitals (4,9 %). **Türkiye İstatistik Kurumu**, p. 33-35.

140 **Orhaner**, p. 59-60.

141 According to SSI data (2019), 68 % of GHI revenues are from insured premiums, 9 % from the premiums paid by the state on behalf of the insured, 20 % from the state contribution, and 3 % from the co-payments. *See* **Social Security Institution**, Universal Health Insurance, p. 7.

142 According to the report of the Turkish Medical Association (TTB), the financing deficits of the SSI were tried to be compensated by the premiums collected within the scope of the GHI, as well as the budget transfers. For this reason, the financially targeted table could not be reached with the GHI. *See generally* **Turkish Medical Association**

most problematic areas of general health insurance is the cost of health services. Accordingly, it is possible to say that actuarial balance problems continue in the GHI implementation[143].

Apart from these, out-of-pocket payments due to health expenditures are another problematic issue. Although out-of-pocket payment rates are below the EU and OECD averages[144], these expenditures remain a significant problem in Türkiye. In fact, in the Turkish Statistical Institute (TÜİK) Life Satisfaction statistics data, the most complaints are the high co-payments and private hospital additional payments related to health services[145]. So much so, when the excess of the types of out-of-pocket payments such as prescription co-payment, additional medicine payment, examination participation payment, and additional payments for the price difference between medicines are taken into account, it can be seen that the matter has merit[146]. In other words, although it started to be implemented for purposes such as curbing service demand and preventing abuse, out-of-pocket payments have passed the purpose of regulating health services and have become a part of the financing of health services[147].

Although the health services financed under the GHI have significantly increased compared to the pre-reform policies, the pricing policy in the covered health services still needs some fixing. For example, there are a large number of health services that are covered by the GHI but financed at a

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Report: "Sağlıkta Dönüşüm Programı Çöktü Genel Sağlık Sigortası: Ne Dediler? Ne Oldu? [Transformation in Health Programme Collapses: General Health Insurance: What Did They Say, What Did Actually Happen?]", Community and Physician, V. 33, N. 6, 2018, p. 466-469.

143 *See also* **Alper**, Yusuf: "Sosyal Güvenlik Reformu (2008-2016): Kapsamla İlgili Gelişmeler [Turkish Social Security Reform (2008-2016): Coverage Developments]", Journal of Social Policy Conferences, V. 68, N. 3, 2017, p. 3; **Alper**, Income Test Practice, p. 57.

144 **The Ministry of Health of Türkiye**, Health Statistics Yearbook 2021, p. 252-255.

145 **Türkiye İstatistik Kurumu**, p. 40.

146 *Hamzaoğlu* argues that at least 72 Turkish Lira of every 100 Turkish Lira of current health expenditures is made by individuals. *See also* **Hamzaoğlu**, Onur: "AKP'li Yıllarda Sağlık Hizmetlerinin Finansmanı: Cepten Devlete, Devletten Patrona [Financing of Health Services Under AKP: From Pocket to State, from State to Bosses]", Community and Physician, V. 32, N. 6, 2017, p. 445, 447.

147 It is unconstitutional that co-payments are regulated as a mandatory condition for benefiting from health services; *see also* **Batırel**, Ömer Faruk: "Türkiye'de Sağlık Hizmeti Sunumunda Katılım Payı Uygulamasının Anayasaya Uygunluğu [Constitutionality of Co-Payment Application While Providing Health Service in Turkey]", MÜHF-HAD, V. 20, N. 1, 2014, p. 1014-1020.

low amount. Moreover, there are also many medicines and medical supplies that the SSI does not finance because they are not included in the Health Implementation Communique or they have equivalents in the Communique[148]. In fact, the expenses made by the insured and the procedures for reimbursement of these payments by the SSI to the insured constitute one of the workload items of the judiciary[149].

When evaluated, implementing of general health insurance is a notable development regarding healthcare delivery in Türkiye. World Health Organization (WHO) also evaluated the health reform in Türkiye as successful for various reasons[150]. When the annual healthcare statistics are examined together from the beginning of the health reform to the present, it can be determined that the rate of satisfaction with health services has gradually increased[151]. However, despite the elapsed time, the deficiencies in the general health insurance application are still not fully completed. In this aspect, it is possible to mention that the system intended to be introduced with the healthcare reform has been partially fulfilled, not precisely.

CONCLUSION

As a method of the health transformation program adopted in 2003, general health insurance was accepted in Turkey in 2006 with Social Insurance and General Health Insurance Act No. 5510. General health insurance, which came into effect gradually in 2008 and was implemented all over Türkiye in 2012, brought together the health services carried out under the different social security institutions. General health insurance is a model that covers everyone, is financed by premiums, and is operated with the purchase method. This study discussed whether general health insurance meets the targets set in the health transformation program. The main results obtained under the official statistics and GHI application are as follows.

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148 For example, as of the end of 2022, there are 8,303 medicines in the medicine reimbursement lists. *See* **Sosyal Güvenlik Kurumu**, 2022 Annual Report, p. 75.

149 *See generally* **Kabakcı**, Mahmut: "Sağlık Uygulama Tebliğinde Sağlık Hakkı [Right to Health in the Communiqué on Healthcare Practices]", Journal of Labor and Society, N. 74, 2022, p. 1770-1788. Unless a change is made in the legislation, the actions filed by the general health insurance holders to SSI for the medicines and medical devices they own paid for will not end, *see* **Kabakcı**, p. 1772.

150 **World Health Organization**, A Case Study from Turkey, p. XI, 26. *See also* **World Health Organization**, The Case of Turkey, p. 6.

151 For statistics on satisfaction with the services of health institutions (2003-2022), *see* **Türkiye İstatistik Kurumu**, p. 29-30.

General health insurance has covered everyone residing in Türkiye as intended. Accordingly, the GHI fulfilled the aim of being universal. Nevertheless, covering everyone in Türkiye has some disadvantages for GHI holders who want to stay out of the scope, especially for those who do not have a working income and pay their GHI premiums alone since it is impossible to go voluntarily beyond the scope of GHI.

The ideal of ensuring the norm and standard unity was partially realized. Although the same principles are accepted as a rule for benefiting from GHI, exceptional regulations are included, especially for self-employed workers and other GHI holders (who do not have a working income and pay their own premiums). These regulations, which are against the insured's benefits from health services, contradict to the norm unity ideal of the GHI.

While accepting general health insurance, it was acted with the aim that the health service purchasing method would eliminate the financial problems of the GHI. However, statistics show that the financing problems of GHI continue to increase.

Various improvements have been made in health services delivery to eliminate or reduce the physical problems in accessing health services. In this context, health services delivery has shown a positive development compared to the pre-reform. As a matter of fact, the satisfaction rates with health services and the annual number of applications to the physician per person show this. However, the number of physicians per capita is still far from meeting expectations.

Another aim of the health reform was to create effective healthcare delivery. For this purpose, the referral chain and service steps were accepted in Act No. 5510. However, this aim could not be fully realized due to the lack of implementation of the referral chain system. Primary health care services cannot fulfil the expected function in health services delivery.

Considered as a whole, the general health insurance system is an essential reform in terms of Turkish law and has led to radical developments in Turkish health services. However, in the time that has passed since the general health insurance came into effect, the problematic aspects of the GHI have still not been completely eliminated, and the objectives of the reform have not been fully met.

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