

HEALTH INEQUITIES IN TURKEY: A HISTORICAL ANALYSIS AND FUTURE PERSPECTIVE

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Abstract

Health is an individual condition of well-being and a core element of social wellness and social justice. This study adopts a qualitative research approach based on historical and documentary analysis. To examine the historical development of health inequalities in Turkey, 27 academic articles and 10 policy reports were reviewed.

These sources chronologically analyzed Turkey's health policies and evaluated them within the context of health inequalities. The study aims to explore how health inequalities in Turkey have evolved, to identify the social, economic, and political dynamics that have contributed to their persistence, and to propose comprehensive, justice-oriented strategies for addressing current disparities. The findings indicate that despite several public health reforms, including the socialization policies of the 1960s and the Health Transformation Program launched in 2003, deep-rooted structural inequalities related to income, education, gender, geography, and ethnicity continue to shape unequal health outcomes. The study concludes that tackling health inequalities requires integrated, multisectoral approaches that address the broader social determinants of health and promote inclusive governance, civil participation, and equitable service delivery.

Keywords: Health inequality, health inequity, social determinants of health, health equity, social policy

1. Introduction

Health has been one of the most significant challenges faced by societies throughout human history. Today, health is recognized as a fundamental human right, and achieving the highest possible level of health is the most important global social goal. The definition of health initially focused on the absence of disease but has evolved into a psychosocial concept that includes genetic, social, cultural, and behavioral factors. Along with this shift in the scope of health, concepts such as wellness, wellbeing, and welfare have also enriched the understanding of health. In addition to the 1948 WHO definition, health is also described as "Optimal health is defined as a balance of physical, emotional, social, spiritual, and intellectual health".

Today, despite all the developments, one of the most pressing global issues is health inequality. Health inequalities refer to systematic differences in the health status of individuals or population groups. Some of these differences are avoidable and unjust, and are therefore defined as health inequities. These inequities represent both injustice and unfairness. The term disparity is often used, especially in U.S.-based literature, to refer to measurable differences in health outcomes between population groups. Despite the widespread implementation of health promotion programs aimed at reducing such inequalities, the issue remains a major concern at the international level.

The social dimension of health has been a significant focus since the era of Hippocrates, Socrates, and Plato. One of the most significant efforts in this regard was the Black Report, published in the United Kingdom in 1980. Prepared by Douglas Black and his team, the report highlighted the connection between poverty and poor health. It contended that health inequalities were not solely the result of deficiencies in the health system but were fundamentally rooted

in social determinants such as income, education, housing, employment, and environmental conditions (DHSS, 1980)

The global institutionalization of efforts to reduce health inequalities gained momentum with the launch of the Millennium Development Goals in 2000, followed by the adoption of the 2030 Sustainable Development Goals (SDGs). Goal 10 of the SDGs explicitly identifies the reduction of inequalities within and between countries as a development priority. Consequently, health inequalities are now viewed not merely as issues of service delivery but as deeply rooted in social structures and public policy

According to the World Health Organization (WHO, 2008), the social determinants of health encompass the entire social context in which individuals are born, grow, live, and work. Systematic differences in these determinants result in significant disparities in life expectancy, disease burden, and access to healthcare services.

In Turkey, health inequalities are closely linked to the social determinants of health, particularly education, income, gender, and geographical factors. Structural differences in these areas lead to significant disparities across various health-related domains, including access to healthcare services, health literacy, life expectancy, and health behaviors. These inequalities not only impact individual health outcomes but also have extensive implications for social justice, equal opportunity, and quality of life at the societal level.

This study employs a qualitative research approach grounded in historical and documentary analysis. To comprehend the historical evolution of health inequalities in Turkey, 27 academic articles and 10 policy reports were reviewed. These sources chronologically analyzed Turkey's health policies and assessed them within the context of health inequalities. The study aims to explore how health inequalities in Turkey have historically developed, identify the social, economic, and political dynamics that have influenced them, and provide recommendations for creating comprehensive, justice-oriented strategies to tackle ongoing inequalities.

2. Historical Development of Health Inequities in Turkey

Health policies in Turkey have undergone various reforms and implementations throughout different historical periods. In this process, certain policies and measures have either alleviated or worsened health inequities. Historically, health inequities in Turkey have been influenced by a range of social, economic, and geographical disparities, resulting in significant differences in health indicators, access to healthcare services, and the distribution of resources (Özen, 2009). Below is an evaluation of these policies and developments concerning health inequities, organized chronologically by historical period.

2.1. The Ottoman Period

During the Ottoman era, healthcare services were concentrated in a limited number of urban centers, while rural and eastern provinces were largely deprived of institutionalized medical services. A comprehensive and equity-oriented public health system based on the principle of public welfare had yet to emerge. Instead, healthcare services were primarily structured around the needs of the military and the imperial court, while the general population could only

access care through charitable foundations, particularly via charity-based hospitals and Gurabahane institutions (hospitals for the destitute) (Akdur, 1999; Karaboğa, Çağlar, & Şener, 2023).

The concentration of health institutions in a few major cities exacerbated access barriers for people living in rural and eastern regions. According to 1897 records, while there were 956 practicing physicians across Ottoman territories, nearly 90% were concentrated in just a few urban centres, leaving most of Anatolia without medical professionals. Although some reforms were initiated during the reign of Sultan Abdülhamid II—such as the reorganization of the Chief Physician’s Office and the revitalization of Darüşşifa, these efforts proved insufficient in addressing the underlying structural inequities in access to healthcare (Turkey Health Inequities Report, 2024).

2.2. The Period of 1920-1946

With the proclamation of the Republic, the expansion of healthcare services nationwide and the fight against infectious diseases became top priorities (Çavmak & Çavmak, 2017). The first national health plan, drafted in 1925, outlined objectives such as enhancing organizational infrastructure, increasing the number of healthcare personnel, and combating infectious diseases.

Despite these efforts, inequities in access to healthcare services, particularly in rural and eastern regions, persisted. The centralized administration of healthcare services, the limited authority granted to local governments, and the uneven regional distribution of health infrastructure further exacerbated these disparities (Istanbul Planning Agency, 2025; Ministry of Health, 2015; Çam, Yelsiz, & Eke, 2023).

During this period, health planning was primarily focused on urban centres, while rural settlements remained underserved, especially regarding primary care services such as health clinics, maternity hospitals, and infectious disease control units. Given that the majority of the population lived in villages at the time, geographic barriers emerged as a key determinant of health inequalities.

2.3. The Period of 1946-1960

In 1946, to implement a more organized health system, the “First Ten-Year National Health Plan” was introduced following approval by the Supreme Health Council. The plan aimed to establish one health center for every forty villages and to increase the availability of services in rural areas. During this period, the foundation for health financing structures was also laid. The Social Insurance Institution (SSK) and the Retirement Fund were established, and in 1946, the Workers’ Insurance Institution began opening hospitals for insured laborer (Dedeoğlu, 2021).

However, despite these structural advances, a significant portion of the population remained without social security and thus excluded from health insurance-based services. In particular, the lack of adequate prenatal and postnatal care for women in rural areas, combined with gaps in child healthcare, exacerbates health inequities. Additionally, World War II's economic strain and population growth further hindered access to basic health services (Akın, 2020; Ministry of Health, 2023).

2.4. The Period of 1960-1980

The most significant development of this period was the enactment of Law No. 224 on the Socialization of Health Services in 1961. This law aimed to ensure that all individuals, regardless of geographic or socioeconomic differences, would receive equitable healthcare. It promoted the widespread implementation of primary care services through health centers and community health posts (Akdağ, Aydın, & Demirel, 2008; Pala, 2008).

However, in practice, the envisioned goals of equity could not be fully realized due to shortages in human resources, logistical support, and financial resources. In some regions, limitations in healthcare personnel and medical equipment hindered service delivery. Thus, the ideal of health equity remained largely unattained, particularly in the context of spatial justice, which refers to the fair geographic distribution of services and resources, due to existing class-based disparities (Moç, 2023).

Notably, eastern regions, rural areas, and low-income areas lacked enough healthcare professionals (Pala, 2021; TÜSİAD, 2004). Although national development plans implemented during the 1960s and 1970s signaled a more holistic approach to healthcare planning, delays in implementing key structural reforms, such as the Full-Time Law (Tam Gün Yasası), contributed to the persistence and even deepening of health inequities.

2.5. The Period of 1980-2000

In the 1980s, the adoption of neoliberal economic policies in Turkey significantly influenced the healthcare system. Privatization and the commodification of health services have become more prevalent. The export-oriented economic model adopted during this period suppressed domestic demand and exacerbated socioeconomic disparities (Şahinoğlu & Yılmaz, 2022).

As co-payment systems and the role of private insurance expanded in health financing, the scope of free or low-cost public healthcare contracted (Çavmak & Çavmak, 2017; Turancı & Bulut, 2016). This trend disproportionately affected low-income individuals, making access to healthcare more difficult and deepening existing health inequities. Reducing funding for preventive healthcare services also led to a long-term deterioration in health indicators.

Additionally, individuals covered by different social security institutions receive services under varying conditions, leading to institutional inequities within the system (Aydın, 2022). The Green Card program, introduced in the 1990s, aimed to improve access for impoverished individuals who were not covered by social insurance. However, the bureaucratic obstacles and limited coverage of the program meant that it fell short of achieving true equity in access.

Moreover, the unequal regional distribution of healthcare personnel further reinforced inequities, particularly in rural and eastern regions. While most physicians, midwives, and nurses were concentrated in western provinces, a severe shortage of healthcare workers persisted in rural areas (Akdur, 2008). As a result, access to healthcare varied widely depending on individuals' geographic location, income level, and social security status, ultimately institutionalizing structural inequities within the health system.

2.6. The Period of 2000-2020

At the beginning of the 2000s, Turkey's health indicators lagged behind international standards, and access to healthcare services was unevenly distributed due to social, economic, and regional disparities (CSEP, 2022). In response, the Health Transformation Program (HTP) was launched in 2003, initiating a structural overhaul of the healthcare system. Within the scope of this program, the General Health Insurance (GHI) system was introduced; social security institutions such as SSK, Bağ-Kur, and the Retirement Fund were merged under a unified structure, aiming to ensure that all citizens could access healthcare through a common system.

A family medicine model was implemented, private hospitals and pharmacies were made accessible to all, and public hospitals were consolidated under a single administrative umbrella. These reforms contributed to a decline in infant and child mortality, an increase in average life expectancy, and a transition from communicable diseases to chronic illnesses as the predominant health concern (Özalp, Nalçacı, & Hamzaoğlu, 2006).

Despite these improvements, the equalizing impact of the reforms on service accessibility was not uniformly felt across regions. For instance, the construction of city hospitals in locations far from urban centers, combined with limited public transportation options, created access barriers for residents of peripheral areas (Gür & Samastı, 2021). This particularly affected vulnerable groups such as the elderly, individuals with chronic conditions, and people with disabilities. Furthermore, the centralized nature of the system and the expanding role of the private sector led to variations in the quality and speed of care based on income level. Indeed, studies from this period reveal a rise in catastrophic health expenditures (where over 40% of household income is spent on healthcare) among low-income groups. Thus, although structural reforms under the HTP improved many key health indicators, their failure to directly target the social determinants of health resulted in the reproduction of inequities in certain regions. Regional disparities, migration, gendered access to services, and lack of social security remained critical factors shaping health inequities during this period.

2.7. The Post-2020 Period

In the post-2020 period, health inequities deepened further due to the combined effects of pre-existing structural imbalances, the socioeconomic fragility's exacerbated by economic transformation, migration, and the COVID-19 pandemic. In addition to creating a major health crisis, the pandemic became a turning point by making social inequalities in access to healthcare more visible.

Curfews, income loss, unemployment, and the increased burden of unpaid domestic work all hindered equal access to healthcare services (Kocabaş, 2020). During this period, education level, gender, age, social security status, and geographic location emerged as key determinants of access. Vulnerable populations -including the poor, the elderly, women, informal workers, and marginalized ethnic communities- were disproportionately affected.

Although the pandemic was initially perceived as a "universal crisis," over time it became clear that it amplified existing inequalities. As cited by Özen (2009), individuals without social security could access healthcare only in emergency cases; difficulties in obtaining medication and bureaucratic delays often pushed them toward out-of-

pocket spending or the use of non-prescription treatments. This phenomenon illustrates how health-related poverty can reinforce other forms of poverty.

During this period, growing spatial inequities between city centers and informal settlements brought renewed attention to the health impacts of urban poverty (Buğra & Keyder, 2003). The increasing refugee population also introduced a new axis of inequity in Turkey’s healthcare system. Refugees faced access barriers not only due to their legal status, but also because of language, cultural differences, and discrimination, resulting in the emergence of new vulnerable groups.

In the post-2020 period, health inequities are characterized by a dynamic, multilayered, and interwoven structure. Determinants such as not only access to healthcare but also social protection, spatial justice, access to information, gender roles, and migration have further illuminated the multidimensional nature of these inequities. Inequities now extend beyond access to services and encompass broader issues such as social protection, spatial justice, access to information, gender roles, and migration, revealing the deeply multifaceted nature of health inequity in Turkey today.

Overall, as summarized in Table 1, health inequities in Turkey have taken shape primarily in the form of access-based disparities rooted in geographic, structural, class-related, income-based, and social security-related factors.

Table 1: The evolution of health inequities in Turkey

Period	Period-Specific Developments and Emerging Health Inequities
Ottoman Period	Health services were primarily focused on the palace and military. Services delivered through charitable foundations remained limited, while rural and eastern regions were systematically neglected. This led to severe geographic and structural inequities in healthcare access. The centralized nature of services resulted in the majority of the population being deprived of basic health rights.
1920-1946 Period	With the foundation of the Republic, healthcare planning began, but urban centers were prioritized. Infrastructure and personnel shortages in rural areas persisted, thereby reproducing the urban-rural divide and exacerbating spatial inequities. The lack of authority granted to local governments hindered horizontal equity in service delivery.
1946-1960 Period	The establishment of social security institutions enabled insured groups to benefit from health services, while uninsured individuals were excluded. Centralized planning led to continued regional disparities. In rural areas, maternal and child health services remained inadequate.
1960-1980 Period	Law No.224 aimed to socialize health services and expand primary care centers. However, due to shortages in human resources and funding, implementation was uneven across regions. The east-west divide continued, and regional and socioeconomic inequities became more visible.
1980-2000 Period	Neoliberal policies led to privatization in healthcare and the introduction of co-payments. Access to healthcare became increasingly dependent on income level. Although programs like the Green Card offered limited protection, they failed to systematically reduce inequities. Physician shortages in rural areas persisted.
2000-2020 Period	The Health Transformation Program improved basic health indicators, but its impact varied regionally. The expansion of the private sector and income-based differences in access deepened disparities. Access to city hospitals and catastrophic health expenditures emerged as new sources of inequity.
Post-2020 Period	The COVID-19 pandemic deepened pre-existing inequities. Particularly, refugees, the elderly, and women were unable to adequately access health services. Issues such as spatial injustice, inadequate care services, and multidimensional determinants of inequity became more apparent.

3. Current Forms of Health Inequities in Turkey

Although there has been an overall improvement in Turkey's health indicators, these advancements have not been equally reflected across all segments of society. Key social determinants of health, including income, education, gender, social security status, geographic location, disability, migration status, and age, continue to shape both access to healthcare and health outcomes.

3.1. Inequities Based on Income and Social Security

Income level is one of the most fundamental factors affecting individuals' access to healthcare and their overall health status. Individuals with low income often have limited access to social security, and the share of out-of-pocket healthcare spending is significantly higher in this group. Consequently, for many people living in poverty, the inability to afford care leads to foregoing needed healthcare services.

The increase in the rate of catastrophic health expenditures indicates a shift of the healthcare system's financial burden onto individuals (Koçkaya, Oğuzhan, & Çalışkan, 2021). Secondary effects such as inadequate housing conditions, poor nutrition, and exposure to preventable diseases further contribute to the vulnerability of this population.

Although individuals covered by the General Health Insurance (GHI) system generally have better access to healthcare, those without any social security or who rely on the Green Card program still face numerous bureaucratic barriers and service limitations.

Another critical problem relates to individuals who are unable to complete income assessment procedures, who are assessed as "not poor enough" despite their actual need, or who remain unable to access services due to unpaid GHI premiums, despite being technically insured. These individuals often resort to seeking care only in emergencies, which results in delayed treatment processes and worsened health outcomes.

3.2. Inequities Based on Education

Education level directly affects individuals' ability to acquire, interpret, and effectively use health-related information and services. Individuals with lower educational attainment are generally disadvantaged in terms of health literacy. The Turkey Health Literacy Survey (2023) revealed that half of the population has inadequate or problematic levels of health literacy. This situation negatively affects both the effective use of healthcare services and individual health behaviors (Ministry of Health, 2024). As education levels increase, individuals are more likely to utilize healthcare services, seek preventive care, and adopt healthy lifestyle behaviors (TNSA, 2018).

3.3. Inequities Based on Gender

Gender roles significantly restrict women's access to healthcare in multiple ways. Particularly in rural regions, women face disadvantages due to cultural norms, economic dependence, limited transportation, and difficulty accessing health facilities. In areas such as maternal health, reproductive care, family planning, and sexual health, women encounter substantial inequities (Baştarcan & Oskay, 2022).

Data show that uneducated and impoverished women face higher risks for complications such as high-risk pregnancies, lack of prenatal monitoring, and maternal mortality (Çöl & Şeker, 2024; Çelik & Hotchkiss, 2000). Additionally, the burden of caregiving and traditional gender roles often cause women to deprioritize their health.

Low levels of health literacy among women further limit both their access to healthcare services and their ability to benefit from available care (Altıparmak & Coşkun, 2016). In Turkey, early marriage, domestic violence, frequent childbirth, and economic deprivation continue to create health problems and contribute to deepening health inequities among women.

3.4. Regional and Geographic Inequities

In Turkey, significant disparities exist between rural and urban areas in terms of access to healthcare services. In regions such as Eastern and Southeastern Anatolia, key indicators-including life expectancy, infant mortality rate, and the number of physicians per capita-are considerably lower compared to Western regions. For instance, between 2017 and 2019, the average life expectancy in Turkey was 78.6 years, but this figure varied by as much as seven years between provinces (Pala, 2021).

The concentration of infrastructure, health workforce, and technological investments in major cities has created a deep urban-rural divide in terms of service quality. Additionally, geographic barriers to transportation significantly restrict access to care for individuals living in rural settlements and remote areas.

3.5. Inequities Among Disadvantaged Groups

Disadvantaged groups, including individuals with disabilities, the elderly, rural residents, LGBTI+ individuals, people living in poverty, ethnic minorities, migrants, and refugees, face multiple layers of inequity in the healthcare system. These inequities arise not only from societal prejudices but also from gaps and inadequacies in service provision (Şahin, 2018; 17 Mayıs Association, 2022; Karakuş, 2018).

Despite the system's claim to equality, many in these groups experience exclusion, denial of services, or disparities in service quality. Ethnic differences also influence healthcare utilization. In particular, language barriers significantly undermine access to preventive services, treatment, patient satisfaction, the patient-physician relationship, and adherence to medical advice (Bülbül, 2020).

Older adults, despite increasing health needs, encounter various barriers to accessing care. This is especially evident in rural areas, where transportation difficulties impede their ability to reach health services (Sönmez & Çevik, 2021). Moreover, older individuals with lower income and educational levels often fail to fully benefit from the healthcare system.

In recent years, with the rise in the refugee population, a new axis of health inequity has emerged between refugees and the local population. Refugees face exclusion from health services due to insufficient health insurance coverage, language barriers, and lack of knowledge about the system. Specific areas of concern include reproductive health among refugee women, vaccination of children, and chronic disease monitoring for elderly refugees (Öngen & Kırca, 2020; Danış & Dikmen, 2022).

Although there has been an overall improvement in health indicators in Turkey, it is clear that these gains have not been equitably distributed across all segments of society. Deepening inequities related to income, education, gender, region, and ethnicity demonstrate that health is not merely an individual concern but also a societal and structural issue. Accordingly, future health policies must adopt holistic approaches that go beyond service delivery and directly address these underlying social determinants of health.

4. Health Policies Grounded in Social Determinants

Although there has been an overall improvement in Turkey's health indicators, it is evident that these gains have not been distributed equally across all segments of society. Deepening inequities related to income, education, gender, region, and ethnicity demonstrate that health is not solely an individual concern but also a societal and structural issue.

Therefore, future health policies in Turkey must move beyond a narrow focus on service delivery and adopt holistic approaches that directly address the social determinants of health.

4.1. Policy Recommendations Based on Social Determinants of Health

Developing policies that focus on social determinants of health is among the most effective strategies for preventing health inequities. In this regard, the following measures are essential:

- Ensuring a more equitable distribution of income,
- Increasing the inclusiveness of social security systems,
- Integrating anti-poverty policies with public health objectives,
- Reducing financial barriers that limit access to healthcare services,
- Eliminating structural obstacles such as unpaid insurance premiums that hinder equitable access.

4.2. Strengthening Health Literacy

Individuals with low levels of health literacy often face difficulties in effectively utilizing both preventive and curative health services. Therefore, the following actions are recommended:

- Develop curriculum-based approaches within the education system to strengthen health literacy,
- Expand targeted health education programs for vulnerable groups,
- Encourage active involvement of local governments, media outlets, and digital platforms in strengthening health communication.

4.3. Gender-Based Interventions

Programs must be developed to facilitate women's access to healthcare services, particularly in rural and low-income regions, by prioritizing women's health. In this context:

- Services related to family planning, reproductive health, and maternal and child health should be expanded in a manner that is responsive to regional needs.
- Models such as mobile health units and outreach services should be strengthened to overcome economic and physical barriers faced by women.

4.4. Investments to Reduce Regional Inequities

In regions disadvantaged in terms of infrastructure and health workforce, particularly in Eastern and Southeastern Anatolia, the following measures should be prioritized:

- Develop incentive policies for the recruitment and retention of healthcare personnel,
- Implement region-specific health planning strategies,
- Expand the use of digital health systems (such as telemedicine and telehealth) to reduce geographic barriers in service delivery.

4.5. Inclusive and Participatory Health Policies

Establishing a participatory health policy that ensures representation from all segments of society is essential for reducing inequities in the long term. To achieve this:

- Local stakeholders, professional organizations, academia, and civil society should be actively involved in the policy-making process.
- The health needs of marginalized groups, such as refugees and ethnic minorities, should be identified and addressed through dedicated strategies.

4.6. Adopting an Equity-Based Approach

Health policies should be guided not only by the principle of equality but by a strong commitment to equity. It must be recognized that each individual has different needs and circumstances, which must especially be considered when addressing disadvantaged populations. Healthcare services should be restructured to reflect and accommodate this diversity. This requires a shift from equality to equity in service provision -offering not the same care for everyone, but fair care for each.

Conclusion

This study has examined the historical roots of health inequities in Turkey and revealed how these inequities have evolved and been reproduced through various social dynamics. From the Ottoman period to the present day, the organization and delivery of healthcare services have undergone significant changes. However, inequities based on geography, economy, education, and gender have persisted in various forms throughout all historical periods.

In the early years of the Republic, important steps were taken toward the institutionalization of health services. The health socialization policies of the 1960s aimed to ensure equal access for all. Nevertheless, these efforts fell short

of eliminating health inequities due to structural challenges and implementation limitations. Although access to healthcare improved following the neoliberal reforms of the 1980s and the launch of the Health Transformation Program in 2003, the increasing marketization of the health system led to the emergence of new forms of inequity.

Today, health inequities in Turkey are closely linked to key social determinants of health, including income level, educational attainment, gender, geographic location, and ethnic background. Structural disparities in these determinants directly affect individuals' access to health services, their ability to obtain health-related information, and their overall health outcomes.

Achieving equity in health today requires more than a restructuring of healthcare service delivery. It demands a holistic approach that addresses social determinants in an integrated manner, supported by intergovernmental collaboration, the empowerment of civil society, and evidence-based decision-making. The Sustainable Development Goals place the principle of "leaving no one behind" at the centre of this vision.

The 2025 WHO World Report on Social Determinants and Health Equity emphasizes that health inequities stem not only from unequal access to health systems but also from structural determinants such as education, income, housing, working conditions, social protection, and environmental factors. The report recommends expanding universal social protection systems, improving the quality and accessibility of public services, eliminating discriminatory practices reflected in policies, laws, and social norms, strengthening local governments, supporting civil society, and ensuring that healthcare professionals are trained in inclusive and equity-oriented approaches. In line with this report, the present study demonstrates that developing policies centred on the social determinants of health is one of the most effective strategies for preventing health inequities.

Health inequities in Turkey stem not only from service delivery mechanisms but also from structural disparities embedded within the broader social fabric. Reducing these inequities is not only essential for a fairer healthcare system but also for building a more inclusive, resilient, and sustainable society. While equity is essential for addressing structural disparities, equality remains a fundamental health right and a prerequisite for social cohesion.

In terms of future policy development, reducing health inequities will require policies that centre equity, address social determinants holistically, and promote intersectoral collaboration. Unless a health system is established that is inclusive, participatory, and responsive to local dynamics, the goal of "health for all" will remain unattainable.

CONFLICT OF INTEREST

The authors have no affiliations with or involvement in any organization or entity with any financial interest or nonfinancial in the subject matter or materials discussed in this manuscript.

AUTHOR STATEMENT

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