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Pensions, Health and Long-term Care

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List of Abbreviations

	Turkish	**English**
ASAG	Aile ve Sosyal Araştırmalar Genel Müdürlüğü	General Directorate of Family and Social Survey
DPT	Devlet Planlama Teşkilatı	State Planning Organisation
IMF		International Monetary Fund
GSS	Genel Sağlık Sigortası	General Health Insurance
KEİG	Kadın Emeği ve İstihdam Girişimi	The Initiative For Women's Labour and Employment
MoH	Sağlık Bakanlığı	Ministry of Health
MoLSS	Çalışma ve Sosyal Güvenlik Bakanlığı	Ministry of Labour and Social Security
OECD		Organisation for Economic Cooperation and Development
SHÇEK	Sosyal Himetler ve Çocuk Esirgeme Kurumu	Social Services and Child Protection Institution
SGK/SSI	Sosyal Güvenlik Kurumu	Social Security Institution
TISK	Türkiye İşverenler Sendikası Konfederasyonu	Turkish Employer Association
TÜİK	Türkiye İstatistik Kurumu	Turkish Statistics Institution
WB		World Bank

1 Executive Summary

Pensions: The economic crisis has affected the financial situation of the pension system, leading to a decrease in the number of insured and the rate of premium collections. The transfers from the general budget to the pension system reached 5.8% of GDP in 2009. The reformed pension system, which came into effect in 2008, has tried to align premium and benefit payments of employees, civil servants and the self-employed. The scope of the social security system has also been narrowed. The pension programmes for low income groups, such as tradesmen, craftsmen, farmers and temporary agriculture workers, which offer lower premium rates, have gradually been phased out. Moreover, tax-financed social assistance programmes have provided a minimum income guarantee which is far below the poverty threshold. The Draft Law of Non-contributory Payments and Social Assistance, which aims to unite and improve all the programmes for the poor, has not been passed yet. With the regulation in 2010 pensions have increased above the inflation rate, which has been a great step in terms of pension adequacy in Turkey.

Health care: With the general health insurance put into effect in 2008, everybody has been brought under the scope of general health insurance in Turkey. With the Programme of Transformation in Health, which was launched in 2004, access to health care has been facilitated. The rate of public health expenditures has increased by 80% in the last five years and reached over 5% of GDP in 2009. The rapid increase in medicine and treatment expenses in particular has resulted in some measures in order to make the system sustainable. The price of medicines has been decreased by between 25% to 50%. Moreover, the insurers' share of co-payments, which are required at the second or third step health institutions and private health institutions, has been increased. The Social Security Institution and the Ministry of Health have agreed on a global budgeting approach, which will eliminate the issuing and submission of co-payment receipts, thus simplifying the system. On the other hand, at the beginning of 2010, the Social Security Institution categorised all private hospitals in order to define any co-payments payable by the patients. A new legislation, which came into effect in February 2010, regulates that doctors working for public hospitals have to close their private surgeries. Thus, the problem of patients paying extra fees by seeing a doctor in their private establishment before going to a public hospital has been solved and the accessibility of health services has been increased. The financial sustainability of the health system depends in principle, firstly, on the introduction of a family physician system, as well as the establishment of a referral route system, and secondly, on the increase of premium income by registered employment.

Long-term care: In Turkey, there is no long-term care insurance for the elderly at this point. There are not enough care facilities to meet the demand. It is expected that elderly people are cared for within their families. In order to support families on low income caring for disabled people, a new tax-financed programme was introduced in 2005. Irrespective of age, a monthly payment of the net minimum wage is paid by SHCEK to the family member caring for a needy disabled person at home. If the person is cared for in a care home, a payment of double the minimum wage is paid by SHCEK. Elderly people can, obviously, also benefit from this system. The number of people benefitting from the system has increased by 100% in the last two years and has reached 230,000.

The economic crisis badly affected Turkey at the beginning of 2009, and the economy decreased by 4.7% in 2009. In the last quarter of the year, the economy started to recover and grew by 6%. While in 2008 64.6% of expenses were covered by premium payments, this figure only amounted to 57.6% in 2009. A large employment stimulus package has been

introduced in order to avert the negative effects of the crisis. It includes programmes such as workfare, vocational training and apprenticeships for unemployed, as well as premium incentives for employers who take on new workers. The number of insured workers increased by 7% in the period between February 2009, when the effects of the crisis were felt most, and February 2010, as a result of positive developments in the economy and the premium incentives. However, the number of self-employed insured decreased by 6%.

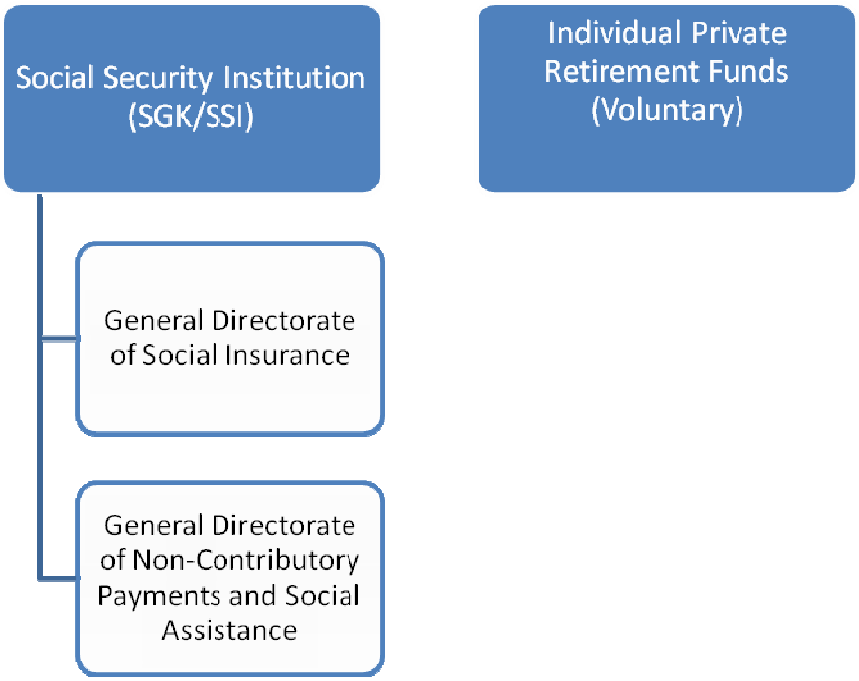
2 Current Status, Reforms as well as the Political and Scientific Discourse

2.1 Pensions

2.1.1 Overview of the system's characteristics and reforms

The pension system in Turkey consists of programmes which provide a tax-financed minimum pension, as well as voluntary private pension funds financed by defined contribution and a PAYG-financed social insurance system (see Figure 1).

Figure 1: Turkish Pension System after the pension reforms



Source: Karadeniz, O.

The pension system in Turkey has experienced financial deficits since the beginning of the 1990s, for various reasons such as the high number of undeclared work, low premium collection, high replacement rates and early retirement. In 1999, the implementation of Law Number 4447 brought changes in the pension parameters. For example, the retirement age of women was increased from 38 to 58 and the retirement age of men was increased from 43 to 60. However, the retirement age of those people who started work before the reform was not increased. Instead, it was equated according to the year they started to work. Thus, the cost of early retirement has been transferred to future generations. With the 1999 reform, the minimum pension was decreased from 70% to 35% of minimum wage. Moreover, the average income of all years was taken as the basis for pension calculations, instead of focusing on the average of the last ten years (Law Number 4447). These precautions were not enough to reduce the deficit of the social security system, so a new law (Law Number 5510) was implemented on 1 October 2008, designed to tackle the deficits of the pension system by reducing the accrual rate and increasing the retirement age. Moreover, pension premium payments of self-employed, workers and civil servants who started work after the reform were aligned.

Number of the contributory days and retirement age

The required number of contributory days is 7,200 for workers. Civil servants and self-employed workers, however, have to accrue 9,000 days (Law Number 5510, Article 27). The retirement age is 58 for women and 60 for men who started work for the first time after the 1999 reform. But the retirement age will gradually increase for persons who started work for the first time after this reform and will reach 65 years for both men and women by 2048. Moreover, there are simplified retirement conditions for part-time workers, miners, people deemed incapable of work and disabled people.

a) Those who cannot reach the required number of contributory days

In order to qualify for a pension, 7,200 contributory days are required. There are, however, provisions for people unable to accrue the required number of contributory days due to part-time work, seasonal work, etc. Those insured with a lower number of contributory days pay premiums for a minimum of 5,400 days. In order for them to qualify for a pension, an additional three years is added to their retirement age as defined by the law (Law Number 5510, Article 28)[1]. However, pension payments for those groups will be lower, as the premium contributions are lower.

b) Disabled and people deemed incapable of work

There is an opportunity of simplified early retirement for people partially incapable of work (i.e. with a work capacity of less than 60%), who do not qualify for a disability pension, and for those people who had a disability before they started work for the first time (Law Number 5510, Article 28).

Disabled people who lost 60% or more of their working power before they started work for the first time are eligible for a pension regardless of their age, providing they have a minimum of 3,960 contributory days and they have been insured for a minimum of 15 years (including non-contributory periods)[2] (Law Number 5510, Article 28).

Disabled people with a work power of between 50% and 59% qualify for a pension, providing they have a minimum of 4,320 contributory days and they have been insured for a minimum of 16 years[3]. Similarly, disabled people with a work power of between 40% and 49% qualify for a pension providing they have a minimum of 4,680 contributory days and they have been insured for a minimum of 18 years[4] (Law Number 5510, Article 28).

For people deemed incapable of work the retirement age is 55, providing they have accrued the required number of contributory days (Law Number 5510, Article 28).

c) Miners

For workers who work underground the retirement age is 55 providing they have worked for 20 years (Law Number 5510, Article 28).

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1 The minimum of contributory days is 4,600 days for workers who started work between 30 April 2008 and 31 December 2008. 100 days per year are added to the 4,600 days as long as the total does not exceed 5,400 days beginning from 1 January 2009 (Law Number 5510, Temporary Article 6).

2 The minimum of contributory days is 3,700 days for insured workers who became insured between 1 October 2008 and 31 December 2008. The period of 3,700 days is increased by 100 days per year until 2011, and will amount to 3,960 days in 2011. (Law Number 5510, Temporary Article 6).

3 The minimum of contributory days is 3,700 days for workers who started work in the period between 1 October 2008 and 31 December 2008, and in the following years 100 days are added to the number of the days per year as long as the total does not exceed 4,320 days (Law Number 5510, Temporary Article 6).

4 The minimum of contributory days is 4,100 days for workers who started work in the period between 1 October 2008 and 31 December 2008, and in the following years 100 days will be added to the number of days per year, as long as the total does not exceed 4,680 days (Law Number 5510, Temporary Article 6).

d) Insured women caring for disabled children

Women who care for disabled children will accrue 450 contributory days for each insured 360 days according to the new reform. These periods will, in effect, decrease their retirement age (Law Number 5510, Article 28).

e) Insured people working in hazardous work environments

Insured employees and civil servants who work in hazardous work environments (such as coal mining) have early retirement rights. Depending on the type of hazardous work, between 60 and 180 days are added to their contributory days for each 360 days of actual service and 50% of these added extra days are deducted from their retirement age, giving the possibility of retiring earlier (with a maximum of 3 years) (Law Number 5510, Article 40).

Accrual rate

The Turkish pension system had the highest annual accrual rate among the OECD countries before the reform (MOLSS 2008:4). It was 2.6% for a person with 25 years pensionable service (MOLSS 2008:10-11). The new accrual rate has been established as 2% per year for new contributors joining the scheme. The total rate of allowance cannot be more than 90% (Law Number 5510, Article 29).

Revalorisation coefficient

Under the previous legislation, the incomes of workers and the insured were indexed for pension calculation purposes based on the consumer price index (CPI) and gross domestic product (GDP), while under the new regulation the indexing will be based on the sum of 30% of the development pace of the GDP plus the CPI plus 1 (Law Number 5510, Article 3). This means that the old-age pension income will decrease when compared to the previous system. Thus, there will be a decrease in the average income, for which a substitution rate will be applied.

Invalidity pension

A minimum of 1,800 contributory days and 10 qualifying years is required to qualify (Law Number 5510, Article 25) for an invalidity pension.

Survivor pension

A minimum of 900 contributory days, except all credited periods (such as maternity, military services, etc.), and 5 qualifying years is required for the surviving family to receive a pension. This period is 1,800 days for civil servants and self-employed people (Law Number 5510, Article 33). If a girl in receipt of survivor pension gets married, she is eligible to receive a lump sum of 24 months of survivor pension payments in advance as a marriage bonus. (Law Number 5510, Article 37).

The rate of premiums

The premium rate of invalidity, old-age and survivors insurance is 20%. 11% are paid by the employer and 9% by the employee. Self-employed people pay all of the premiums. The State contributes to the scheme one fourth of all invalidity, old-age and survivors insurance

premium payments collected by the SSI per month (Law Number 5510, Article 81). In the last two years, there has been a discount in premium payments for employers under certain circumstances (see section 3).

Other pension income

- Individual Pension Funds

The private pension system providing complementary pension income was introduced in 2001. In Turkey, there is no additional second pillar pension scheme available beyond the PAYG defined-benefit first pillar system, which is financed by public social security funds (MoLSS, 2007:18). The voluntary private pension system serves as a third pillar, and not as a second pillar, unlike in many other countries. Joining the private pension system is optional. There is a tax incentive for participants and employers who pay contributions. The same incentive is provided, regardless whether the participant receives a lump sum or a pension payment. The person is required to be over the age of 56 in order to receive a pension from this system (Law Number 4632, Article 6).

There are 13 private pension companies within the private pension system. In April 2009, 2,077,078 people paid contributions. The amount of contributions by April 2010 (from 2003) was TL 7,496,403,374, and the total funds were TL 9,868,200,000.[5]

- Social Assistance

Social assistance and services financed by taxes are structured and organised within various institutions and programmes. Social assistance includes old-age pension, invalidity pension, war veteran pension, survivor pension and orphan pension.

A means-tested pension scheme was introduced in 1976 (Law Number 2022). It includes the following pension provisions:

a) Means-tested old-age pension: It provides old-age pension for poor and elderly citizens above 65 years of age. The poverty threshold in April 2009 was TL 92.67 per person. In April 2010, the pension amount was TL 92.67 (SSI 2010/a).

b) Means-tested old-age pension for needy disabled persons: It provides old-age pension for poor needy disabled elderly citizens above 65 years of age. The poverty threshold in April 2010 was TL 92.67 per person. The pension amount in April 2009 was TL 278.02 per person for people who are disabled to a degree of 70% or more (SSI 2010/a).

c) Means-tested disability pension for disabled people and their families: It provides a disability pension for poor disabled persons aged 18 to 64. The poverty threshold in April 2010 was TL 92.67 per person. The pension amount in April 2010 was TL 185.35 for disability degrees between 40% and 69%. If the disability is 70% or more, the disability pension amounts to TL 278.02. (SSI 2010/a). If a disabled person under the age of 18 is cared for by a relative who is in financial hardship, this carer is eligible for a disabled relative's pension (TL 185.35).

[5] Retrieved from: http://www.egm.org.tr/weblink/BESgostergeler.asp#.

2.1.2 Overview of debates/political discourse

The pension system has experienced deficits since the beginning of the 1990s because of the early retirement system. These deficits have been balanced by the transfers from the state budget. While in 2008, the rate of transfer from the state budget to the Social Security Institution was 3.7% of GDP, it was 5.68% in 2009. It is estimated that it will be 5.61% in 2010 (DPT 2010 Year Programme:64). However, 2.52% of these budget transfers consist of invoiced payments to the Social Security Institution, such as additional allowances, additional payments to retirees, premium incentives, and state contributions to the social security system. When these transfers are excluded, the actual financial deficit of the system has been estimated to be 3.09%. The basic cause of this deficit is the economic crisis, which has resulted in a decrease in the number of insured workers and premium collections. The Medium-Term Programme estimates that in the period 2010-2012 the deficit in percentage of GDP will be 2.1%, due to deficits of social security caused by deadweight debts (Medium-Term Programme:38). The Medium-Term Programme aims at structuring the social security system in a way that enables it to meet the needs of the society, to include all the population and to become financially sustainable, through the implementation of efficient control mechanisms and the provision of high quality service. (Medium-Term Programme:29).

One of the system's biggest problems is the collection of premium debts. There will not be an amnesty for premium debts. With the regulation designed in 2008, which included the restructuring of debts, 50% of premium debts could be collected. In order to tackle the system's deficit, general discussions focus on tracking down unregistered employment[6]. The demand of the retirees for pension increase related to the rate of inflation was partially met by an increase in pension by monthly TL 60 in 2010.

Social partners have criticised the pension reform in respect of its scope and the rights it provides and have made some demands to change the rights in various areas. The Confederation of the Turkish Trade Unions (TÜRK-İŞ) demands that the replacement ratio of workers with 7,200 contributory days should be increased from 40% to 50%. Moreover, they are against a provision to increase the number of contributory days from 7,200 to 9,000 days for part-time or seasonal workers who opt to pay additional premiums in order to qualify for pension[7]. KEİG (The Initiative For Women's Labour and Employment) claims that the system only includes people who pay their premiums, instead of including everybody, and that people who fail to pay their premium debts will be excluded. According to KEİG, the system also makes women insurees dependant on their husbands. Moreover, they claim that the system excludes women working for home services, casual agricultural workers, tradesmen and craftsmen whose incomes are below the minimum wage, as well as unpaid family workers. The increase in the premium rates of the voluntary insurance system, to which only few women are contributing, is also criticised by them (KEIG 2009: 16-17).

2.1.3 Impact Assessment

In the last two years, there have been only few studies or publications about projections, including the effects of the public pension reform on workers, its financial sustainability and predictions for its future.

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6 SGK, Prese Statement "SGK Başkanı M. Emin Zararsız, Gazetecilerle Sohbet Toplantısında Bir Araya Geldi", retrieved from: http://www.sgk.gov.tr.

7 TÜRK-İŞ, "The topics suggested to be discussed in the meeting of SGYDK" (in Turkish), without date, retrieved from: http://www.turkis.org.tr/source.cms.docs/turkis.org.tr.ce/docs/file/sr113.pdf.

In a study conducted by Gürsoy using the PROST model (2010), it is estimated that the pension system's financial deficit will decrease to 1% of GDP by 2075 with the reform, while it would be 4% according to the previous system. It is estimated that in the years between 2010 and 2075 the savings in the pension system accumulate to 154% of the GDP. In the same study, it is suggested that the ageing population will affect the financial deficits at the rate of 49% of GDP (Gürsoy 2010: 43).

One of the basic problems of the social security system in Turkey is unregistered work. The SSI experiences serious premium losses because of unregistered work. In relation to this issue, The Revenue Administration Department has prepared an action plan called the "Strategy to Tackle the Unregistered Economy" covering the years 2008-2010. The action plan includes extensive measures such as the reduction of bureaucracy, premium discounts, a notification hotline which unregistered workers can contact easily, awareness training for workers and employers, increased inspection, as well as strengthening of the coordination and cooperation between public bodies and institutions (GİB 2009).

The World Bank published a study about unregistered work in Turkey in March 2010. According to the study, most of the unregistered workers consist of very young and very old workers (WB, 28 April 2010). Most of the early retirees receive pension payments, but carry on working without insurance. It is estimated that the number of retirees in unregistered employment is 2,000,000 (MoLSS 2007; WB 2010).

Other studies focus on the individual pension system. One of them is related to the yield of the individual pension funds in Turkey. The study states that the yield of the individual pension funds is uncertain depending on the fluctuations in capital markets. It estimates the cost of presenting a minimum income guarantee to investors in the individual pension system financed by a defined premium base (Şahin, Elveren 2009).

In another study (Korkmaz et al 2010), the factors and processes affecting the volume of the individual pension funds have been analysed. In this study, the positive effects of the Euro currency, the Istanbul Stock Exchange Share Index and the increase in industrial production on the fluctuation of individual pension funds and total contributions have been ascertained.

A study focusing on the investors in individual pension funds (Altıntaş 2009) states that most potential investors receive enough information about the kinds of pension investment funds, their contents, and the aims of the foundations of the investment funds. The study also made clear that individual pension companies should provide investors with a financial education support system instead of providing limited and irresponsible counselling, which would bring more beneficial results in the short and medium term (Altıntaş, 2009:167).

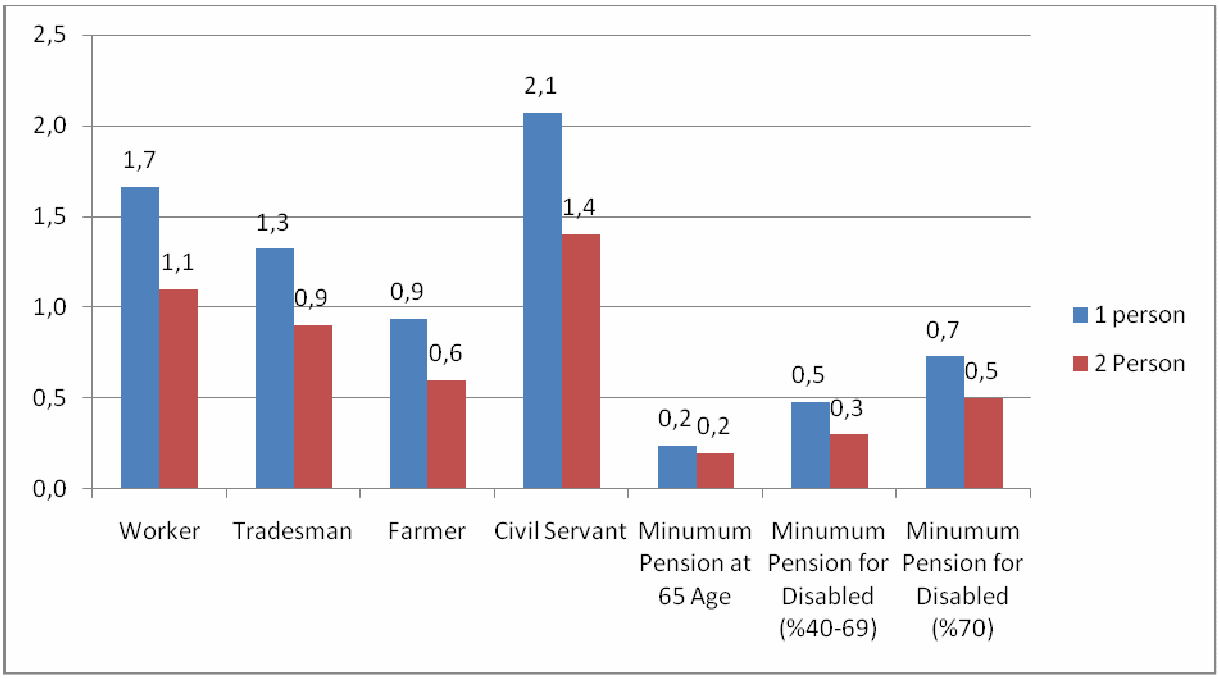
2.1.4 Critical assessment of reforms, discussions and research carried out

85.28% of all retirees think that their pension is not enough (TÜİK Life Satisfaction Survey 2009). In Figure 2 below, the averages of minimum pensions are compared with the poverty threshold[8] valid in the year 2009. As it can be seen from the figure, the pensions of workers, civil servants and tradesmen are all above the poverty threshold of 1.0. However, the minimum pension of farmers is just below the poverty threshold (0.9). The tax-financed minimum old-age pension only amounts to 20% of the poverty threshold and is, therefore, too low. The number of retired women within the system is low because of the low rate of

[8] The poverty threshold is defined by TÜİK. It shows the total food and non-food poverty thresholds. The poverty threshold is TL 365 per capita and TL 551 for two people in 2009. See: http://www.tuik.gov.tr/.

women's participation in work in Turkey. When cohabitation of married couples is taken into account, the pension income of tradesmen and craftsmen falls below the poverty limit (0.9).

Figure 2: Minimum Pensions in relation to Absolute Poverty Lines (in TL)



Source: Calculations by Karadeniz O. TUIK, 2010, SSI, 2010/a-b.

The increase in the workers' and civil servants' pension is designed to track the rate of CPI (inflation) increase of the previous six-month period. The pensions were, therefore, supposed to increase by 4.62% in January. But with a new regulation, which came into effect in January 2010, there was an increase of TL 60 for incomes up to TL 1,298. The increase for pension payments above TL 1,298 was at the rate of inflation (SSI 2010/Press Statement). Thus, especially people on low pension income have benefitted from the new regulation.

Table 1: Minimum Pensions and Increases and Rates 2009-2010

	2009 in TL	2010/11 in TL	2010/12 in TL	The year 2010/11 increase	The year 2010 Cumulative increase
Farmers	306	368.6	379.6	20.40%	24.10%
Temporary agriculture workers	403	466.2	480.2	15.70%	19.20%
Tradesmen and craftsmen	476	538.7	554.8	13.20%	16.60%
Workers	601	663.5	683.4	10.40%	13.70%

Source: SSI 2010 Press Statement.

Within the new system, premium payments of part-time workers are estimated in proportion to the period they have worked. A part-time worker will, therefore, retire three years later, even if they complete the minimum of 5,400 contributory days and they will receive a low

pension income, as they have paid low premiums. Part-time workers may, however, opt to pay any missing contributory days on a voluntary basis. But as part-time workers generally earn a low income, they may have difficulty paying the missing premiums.

One may think that increasing the retirement age within a social security reform and decreasing accrual rates may raise the demand for individual pension funds by people who want to gain additional old-age income. With the assumption that everybody paying premiums to individual pension funds also pays premiums to the public social insurance system, the rate of people additionally insured within the individual pension programme is 15%[9]. 78% of those paying premiums to the system are below the age of 45[10]. The inclusion rate of the population above the age of 65 is low in Turkey. With the reform in 2008 the scope of the social security system was narrowed. The reform also tried to align the benefit rights of employees, self-employed and civil servants. The previous system used to include social insurance programmes aiming, in particular, to protect casual agricultural employees and farmers on low incomes, offering low premium payments[11]. These programmes were phased out by the social security reform. Since the reform, the insurance premiums of farmers have gradually been increased each year. This situation often excludes casual agricultural workers and farmers from the premium system. On the other hand, the Draft Law of Non-contributory Payments and Social Assistance which will restructure aids without premiums for the poor and include new regulations about minimum pension, has not been passed yet.

The critical issue in terms of sustainability of the pension system is unregistered work in Turkey. According to the data provided by TÜİK, in January 2010, 40.8% of all employment was unregistered (TÜİK 2010). However, some of the unregistered employees (such as farmers on low income and casual employees) are already excluded from the social insurance system. Thus, while estimating the premium losses for the Social Security Institution, employment outside the agricultural sector and salaried employment should be taken into account. 22% of all employment with regular or casual pay (i.e. 2,598,000 people) in sectors other than the agricultural sector is unregistered (TÜİK 2010). This causes huge contribution evasion. Reducing contribution evasion would help to decrease the social insurance system's financial deficits.

2.2 Health Care

2.2.1 Overview of the system's characteristics and reforms

The Turkish general health insurance system includes everybody, with a few exceptions, and came into effect on 1 October 2008. Although the health expenditures of civil servants were previously paid by their own health insurance institutions, since 15 January 2010 they are also included in this general health insurance[12]. Health services for people with an income below the gross minimum wage per capita are provided for via a tax-financed green card programme. Green card holders will be included in the general health insurance system by 2011. The general health insurance is financed by premiums. The premiums are collected by the General Directorate of Social Insurance Administration and the SSI. The General

9 The total number of compulsorily insured in February 2010 was 14,956,000 (SSI, 2010/c).

10 Retrieved from: http://www.egm.org.tr/weblink/BESgostergeler.htm.

11 See the Laws Number 2925 and 2926. The Law Number 2925 includes temporary agricultural workers and is still valid. However, new members are not accepted to the system. The Law Number 2926 regulated the social insurance programme of farmers and was abolished with the reform in 2008.

12 The Social Security Institution (SSI) Announcement of public staff being included in the General Health Insurance, 18 December 2009, Official Gazette number 27436.

Directorate of General Health Insurance purchases health services. It does not have its own health care services, which means that health services have to be purchased from external health services institutions (Tuncay, Ekmekçi, 2009: 404). Health services can be purchased at a lump sump price from health service providers. (Law Number 5510, Article 73). The price of the health services provided and the price of expenditures for travelling, bed and daily wages paid by Social Security Institution are determined by the Commission of Health Service Pricing (Law Number 5510, Article 72).

The services available through the general health insurance are listed below (Law Number 5510, Article 63):

1. Protective health services
2. Outpatient and inpatient care
3. maternity care (outpatient and inpatient)
4. dental care (outpatient and inpatient)
5. artificial insemination treatment (in-vitro fertilisation)
6. Within the scope of the provided treatment methods and services are: blood and blood products, vaccines, medicines, prostheses, medical equipment for individual use, medical materials for diagnosis and treatment, repair, renewal and maintenance of medical equipment, etc.

Applying general health insurance effectively depends on following the referral routes.[13] The referral route has been categorised into three steps. Family physicians are determined as the first step of the health institution (Law Number 5510, Article 70).

In order to be covered under the general health insurance scheme, a minimum contributions payment period of 30 days is required. This is irrelevant for people employed by public institutions, stateless persons, refugees, and people in receipt of social assistance payments. There is also no obligation to fulfil such requirements for persons below the age of 18, those who are in need of immediate medical care, in the case of emergencies, in the case of work accidents and occupational diseases or contagious diseases which should be reported, in the case of protective health services, for pregnant women or when there is a natural disaster, war, strike or lock-out (Law Number 5510, Article 67). In order for self-employed people to be covered, they are not allowed to have premium debts or debts related to premiums amounting to more than 60 days, when they apply to the institution (Law Number 5510, Article 67/b).

Moreover, those who benefit from health services have to pay a share of the costs. A contribution share (patient participation) is payable in the case of physical examination, ortheses, prostheses, healing materials, medicines or adjunct fertility treatments. The aim of the contribution share is to prevent redundant usage (Tuncay, Ekmekçi 2009: 397). However, this sum cannot exceed 75% of the minimum wage per service received or per item purchased.

The contribution share for ortheses, prostheses and healing materials is 10 to 20% of the total cost. A 20% contribution share is due for any outpatient treatment of the insured, and 10% for treatments of persons the insured cares for, of any dependant and of pensioners. A 10% contribution fare has to be paid for dental prostheses, 30% for initial adjunct fertility treatment and 25% for any subsequent try (Law Number 5510, Article 68).

In the case of occupational accident or occupational disease, military operation, natural disaster or war, chronic disease, need for vital transplantation of organs or tissue or stem cell

[13] However, official referral routes have not been implemented yet.

and their control examination, there is no contribution share. Moreover, employees of programmes related to payments without premium are not charged with a contribution share (Law Number 5510, Article 69)

In addition to the fee for health services determined by the Commission of Health Service Cost, all health institutions other than public health institutions, will be able to charge additional fees up to double the contribution share determined by the cabinet (Law Number 5510, Article 73)[14].

The General health insurance is financed by premiums. The contribution rate of the general health insurance is 12.5%. 5% is paid by employees and 7.5% by employers. The contribution rate is 12.5% for self-employed and 12% for people who do not work. The state contributes to the system, at a rate of one fourth of the universal health insurance premiums collected per month. (Law Number 5510, Article 81). The contributions of people with incomes below one third of the minimum wage will be paid by the state. There is an option to pay lower contributions for those whose income is above one third of the minimum wage but below minimum wage (Law Number 5510, Article 80).

The contribution share (co-payment) for physical examination of the insured was TL 2 in all steps. However, this fee was increased in September 2009 in order to prevent the excessive use of health services. Thus, the insured will pay a contribution share of TL 2 in the first step, TL 8 in the second and third step in public hospitals and TL 15 in private hospitals[15]. The aim is for the insured not to apply for second or third step public hospitals and private health institutions unless necessary. The Social Security Institution has classified private health institutions it purchases services from[16]. Depending on their classification, private hospitals can now charge extra fees of between 30% and 70% of costs from the insured.

2009 saw some reforms in the health service in order to make the system sustainable. The reforms include the reduction in the prices of medicines, an increase in the contribution rate and the introduction of global budgeting (lump sum price) for health services to the Ministry of Health.

With an agreement signed between the Ministry of Health and the Social Security Institution, the Social Security Institution can now purchase health services at a lump sump price[17]. Thus, the Social Security Institution will pay a determined sum of money to the Ministry of Health for health services.

The cabinet passed a new regulation in September 2009, which stipulates a reduction in the prices of medicines by an average of between 25% and 50%[18]. This means that the insured will pay 25-30% less for outpatient treatments, too. This regulation is expected to save the Social Security Institution TL 2.5 billion annually[19].

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14 While the maximum additional fee was initially set at 30%, it was increased to 70% by a Cabinet Decision in 2009. See Cabinet Decision dated 16 November 2009 and 2009/15627 dated 8 December 2009 and Number 27426 Official Gazette.

15 Social Security Institution Announcement, Official Gazette Number 27353 dated: 18 September 2009.

16 See SSI, http://www.sgk.gov.tr/.

17 The Institution will buy health services for 2009 at a lump sum of TL 7,910,000,000 from the Ministry of Health. TL 725,000,000 of this sum is for health services within the first step, while TL 7,185,00,000 is for health services within the second and third step. See: the agreement on a lump sump contract between the Social Security Institution and the Ministry of Health 2009, retrieved from: http://www.sgk.gov.tr/ (Legislation).

18 The decision of the cabinet on the change in prices of medicines number: 2009/15434, 18 September 2009.

19 Social Security Institution, Press statement dated 23 December 2009, Official Gazette Number 27353, retrieved from: http://ww.sgk.gov.tr.

Moreover, physicians working for public hospitals are no longer allowed to run their own surgery according to Law Number 5947, published in the Official Gazette on 30 January 2010[20]. Before the reform, 20% of such physicians were also running their own surgeries[21]. In such a case, if a patient wanted to receive a health service in a public hospital, he was supposed to see the physician in his surgery first and pay a fee to them. According to the new regulation, physicians are to work either for the public or the private sector. Physicians working for the public sector are to close their own surgeries. This regulation enables citizens to access health services without any intermediary and without paying an extra fee in the physician's own surgery before being treated in the public hospital. Thus, citizens pay less for health services, which will facilitate access[22]. Simultaneously, the new law stipulates an increase in salaries of physicians working for the public sector. Moreover, a financial liability insurance scheme has been introduced in order to protect physicians from having to pay for damages caused by occupational mistakes[23].

2.2.2 Overview of debates/political discourse

The annual and medium term programmes aim to facilitate health services transformation. The programmes not only focus on facilitating access to health services and reducing inequalities within the system, but also aim to provide the financial continuity of the health system. Within the Framework of the Transformation in Health project, which started in 2004, the access of citizens to health services has been facilitated. The demand for health services has increased steadily. Between 2006 and 2008, the demand for public hospitals increased by 26% while it was up by 149% for private hospitals (DPT 2010 Annual Programme:205). The increase in this health demand may be seen as a result of increased access to health services. In 2009, the rate of public health expenditure is expected to be 5% of GDP (DPT 2010 Annual Programme:206).

Despite the improvements in health services, the inadequacy problems regarding physicians and nurses have continued. In 2008, there were 14.3 physicians and 13 nurses for every 10,000 people in Turkey. These figures, however, were 31.8 and 73.1 respectively in EU countries. These numbers show that there is still not enough medical staff (DPT, 2010 Annual Programme: 206). Thus, between 2007 and 2009 the capacity of medical faculties was increased by 56% and the capacity of nursing departments was increased by 16% (Republic of Turkey, Pre-Accession Economic Programme 2009:87).

In order to have an efficient health system and reduce costs, the family physician system should be widened from 40 to 81 cities and official referral routes should be implemented. Widening the family physician system is one of the planned actions by the end of December 2010 (DPT 2010 Annual Programme).

It is also planned to update the costs according to the real costs in the Health System Announcement of the Social Security Institution and medium term programme between 2010 and 2012 and to start costing services depending on diagnosis. Moreover, some provisions

[20] Official Gazette dated 30 January 2010 number 27478, Ministry of Finance, Announcement about the introduction of Treatment Contribution Share.

[21] Ministry of Health (Sağlık Bakanlığı), "Kanun Tasarısı Hakkında Doğrular", retrieved from: http://www.saglik.gov.tr.

[22] Prime Minister Recep Tayyip Erdogan stated that in the previous system citizens had to go to physicians' own surgeries in order to be operated and had to pay a fee for that. He added that one of the aims of the regulation is to get rid of the intermediary in the health service and to let citizens benefit from the health service without any intermediary. News dated 12 January 2010, retrieved from: http://www.nethaber.com.

[23] Ministry of Health (Sağlık Bakanlığı), "Kanun Tasarısı Sağlık Çalışanlarına Ne Getiriyor?", retrieved from: http://www.saglik.gov.tr.

will be implemented in order to prevent unnecessary use of medicines and services (DPT Medium Term Programme:8). The global budgeting approach will be broadened to include university hospitals from the beginning of 2010. Thus, it is expected that the rate of health expenditures of GDP in 2010 will be the same as in 2009 (Republic of Turkey, Pre-Accession Economic Programme:88).

The main aim of these health policies is to provide for the citizen's participation in the economic and social life as healthy people and to increase the quality of life. In this medium-term framework, the focus lies on the years 2010-2012 to implement the following policies (DPT, Medium Term Programme: 29):

- The family physician system will be extended to cover the entire country.
- Protective health services will be strengthened and made available more widely.
- The access to health services will be increased.
- The efficiency in health expenditures will be increased by implementations such as the rationalisation of medicine use and costing of services depending on the diagnosis.

The reforms carried out in the health sector are part of the Transformation in Health project prepared in 2003 and introduced in 2004. This project aims to increase access to health services. However, the reforms have negative effects on the occupational mechanisms in the health sector.

The first effect is that physicians have to close their own surgeries, and their negative reaction is related to the new law concerning full-time work in public hospitals. The Turkish Physicians Union (TTB) is not opposed to full-time work in principle. However, they criticise that doctors closing their surgeries and working full-time in hospital settings will not increase their wages despite having to look after more patients. As the system depends on the physicians' performance, this will affect the quality of health services (TTB 2009). TTB and 11 health organisations stopped work on 19 January and protested against the new law concerning full-time work[24].

Another reform in the health sector is a Draft Law about the Association of Public Hospitals. This draft law, which is currently discussed in the Turkish Grand National Assembly, provides for the hospitals in one or even several cities to be linked up and administered by a joint committee. Fixed-term contract personnel will work in these hospitals and their salaries will be paid by the budget of the establishment. Hospitals will have points in terms of basic facilities of services, patient satisfaction, quality of services and efficiency, and they will be classified in five categories. All the trade unions, societies and occupational organisations concerning people working in the health sector, including the TTB, are against this draft law. Their arguments against this law is that staff will have to work for low wages and lose their job security, that the new law will increase geographical inequalities, and that citizens will pay more money for health services and hospitals will be commercialised[25].

The General Health Insurance is seen positively by the Turkish Trade Unions (TÜRK-İŞ), as it covers everybody. However, they are also apprehensive of an increase in health expenditure and criticise that the insured will pay more. Moreover, they believe that the contribution share (patient participation) and the differences in fees payable at private hospitals prevent many

[24] The chairman of the TTB, Gencay Gürsoy stated that "the TTB always defends full-time work in principle. However, the issue with the draft law is not about full-time work, it is about physicians and health sector workers working in a commercialised environment. "Cannot be excluded in spite of Us" News Tıp Dünyası, 1 February 2010, Number 172, page 6.

[25] Press statement dated 4 March 2010, retrieved from: http://www.ttb.org.tr.

people, especially the poor, from benefitting from health services[26]. Besides, the obligation of the insured to pay a contribution share prevents many from accessing the health services early, and when they access them late, i.e. after a disease has developed, the treatment expenses are much higher[27].

2.2.3 Impact Assessment

With the Transformation in Health project, which was implemented in 2004, the access to health has increased causing a fast increase in health expenditures. Figure 3 shows the rates of health expenditures as % of GDP per year. While public health expenditure was 2.91% of GDP in 2000, this rate is expected to be 5.13% in 2009. While the rate of increase has been estimated as 3.9% per capita in terms of real health expenditure (the parity of purchasing power was corrected in 2000) in OECD countries in the years 1995-2005, this rate is 11% for Turkey (Yılmaz 2010). In other words, Turkey is the country with the fastest growth in health expenditure among OECD countries. It can, however, also be said that Turkey's rate of health expenditure of 8.0% of GDP in 2006 is still low when compared to OECD countries (Yılmaz 2010). However, it is important to note that Turkey has a young population and that there is no problem with population ageing yet. Thus, it can be expected that expenses are lower than in other countries.

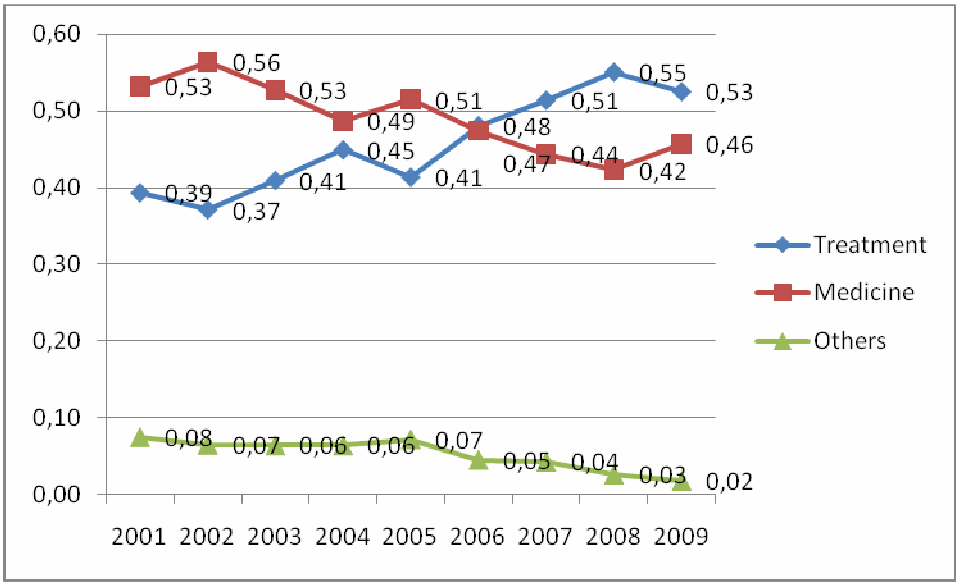
The increase in health expenditures and easier access to health has improved satisfaction with the health services. Before the Transformation in Health project, the number of people who felt satisfied with the services received was 47.6%, this figure has increased to 72.68% in 2009 (TÜİK 2003-2009 Life Satisfaction Survey).

Figure 3 shows the proportion of health expenditures according to the type of cost between 2001 and 2009. The highest increase in health expenditures is in treatment costs. However, while treatment costs decreased by 2 points in 2009 compared to 2008, costs for medicines increased by 4 points. On the other hand, expenditure has increased and premium income has decreased due to the economic crisis in 2009. While the rate of health expenditure was 47% of premium income in 2008, it is estimated that this figure will rise to 55% due to the increase in health expenditure and losses in premium income. This trend poses a threat for the financial continuity of the general health insurance (Teksöz, Helvacıoğlu 2009: 3, 9). In the long-term care, the implementation of referral routes and a family physician system is considered to help reduce costs and provide financial sustainability of the system (Teksöz, Helvacıoğlu 2009:10).

[26] TÜRK-İŞ; "Sosyal Güvenlikte Yapılan Yasal Düzenlemelerin Bir Yıllık Uygulaması Sosyal Güvenlik Sisteminin Sorunlarını Çözemediği Gibi, Yeni Sorunların Kaynağı Olduğunu Gösterdi", retrieved from: http://www.turkis.org.tr.

[27] TÜRK-İŞ," SGYDK Toplantısında Gündeme Alınması Önerilen Konular"), retrieved from: http://www.turkis.org.tr.

Figure 3: The proportion of health expenditures according to the type of cost



Source: SSI 2010/d.

However, the fact that the population is getting old will bring the problem of fast increase in expenses. Thus, in order to provide the efficient use of sources, the implementation of data bases collecting data about mortality, incidence and prevalence of sicknesses, life expectancy, and quality of life is recommended (Yılmaz 2010).

Socio-economic indicators may reflect on people's health indicators. Inequalities are partially caused by the social security system and by the unequal geographical distribution of the health care personnel (Özen 2009:15). As a result of studies comparing the best and worst cities in terms of health care professional per inhabitants ratio, the problem of unequal geographical distribution of health personnel could be tackled and the ratio reduced from 1/24.6 to 1/7 in respect of medical specialists, from 1/7.4 to 1/2.7 in respect of general practitioners, from 1/6.4 to 1/3.9 for nurses between 2002 and 2008 (DPT 2010 Annual Programme:206).

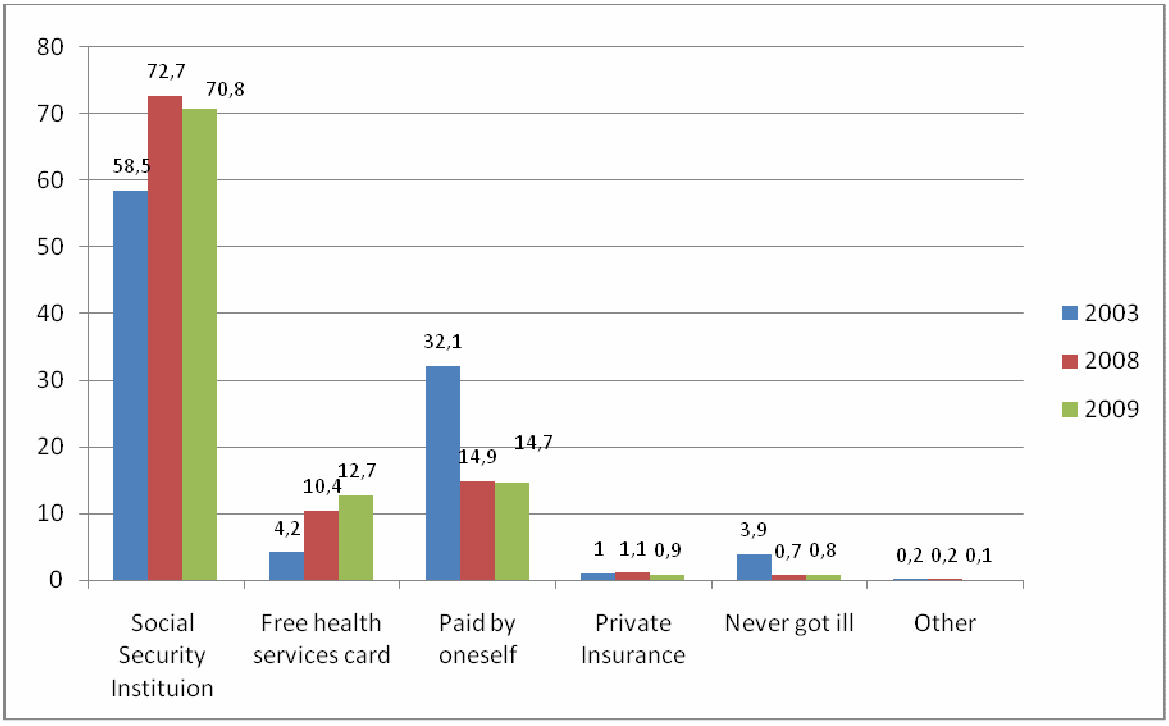
Self-employed workers, voluntarily insured and those who pay health insurance premiums for themselves are not allowed to have premium debts in order to benefit from health services. However, the premium payment rate is low among self-employed workers. Thus, those having premium debts will not benefit from health services, unless they pay their premiums (Yenimahalleli, Yaşar 2009; Alper 2009). According to data from January 2010, the rate of the insured self-employed workers such as craftsmen and tradesmen without any premium debts is 33.8%, while this figure is 31.2% for farmers. The rate of self-employed workers who have never paid premiums is 18.1%. and 14.7% for farmers (SSI 2010/b). Most of the self-employed workers who pay premiums irregularly and those who never pay cannot benefit from the health system, due to their premium debts. A study analysing the data between 1984 and 2006 estimates that the income elasticity of public health services is lower than 1, but higher than 1 in respect of private health services (Sülkü, Caner 2009). This estimation shows that private health care is a luxury good (Sülkü, Caner 2009). Especially not being able to benefit from the public social security system in low income groups causes extra spending. However, this situation will be seen as luxury especially in crisis period by people whose income becomes lower. Thus, these people will not be able to benefit from health services as much as they require.

Another problem which the GSS encounters in terms of access is that people themselves pay for the health care costs. However, it is predicted that this situation will get better with the law of full-time work. But, people who are not registered with the GSS will continue spending from their own budget.

2.2.4 Critical assessment of discussions and research carried out

Access to health services has been facilitated within the framework of the Transformation in Health project. While the percentage of people paying for health services out of their own pocket was 32.1% in 2003, this rate was 14.9% in 2008 and 14.7% in 2009. The percentage of people who received health services through the health insurance system was 58.5% in 2003, rising to 72.7% in 2008, but falling again to 70,8% in 2009. The figures for health service recipients in the green card scheme were 4.2%, 10.4% and 12.7% respectively. The number of people who benefitted from the social security system decreased by 1.9% from 2008 to 2009, and the number of green card holders increased by 2.4%. This situation may have arisen from the economic crisis. Moreover, the number of people who pay for health services out of their own pocket is 14.7%, which is a quite high percentage. While 45% of people who do not have social insurance pay for their own health services, 45.8% of them are eligible for health services via the green card system (TÜİK Life Satisfaction Survey 2009). The fact that self-employed workers, voluntarily insured people and those who have to pay premiums out of their own pocket and those who have incurred premium debts cannot benefit from health services which causes inequalities in terms of access to health services.

Figure 4: Channels to meet the medicine and therapy costs (%)



Source: TÜİK, Life Satisfaction Survey2003-2008-2009.

On the other hand, the fact that the population under 18 is unconditionally included in the scope of the health service system is an important development in terms of access to health services. Thus, even if the parents of a child under the age of 18 have premium debts or if the

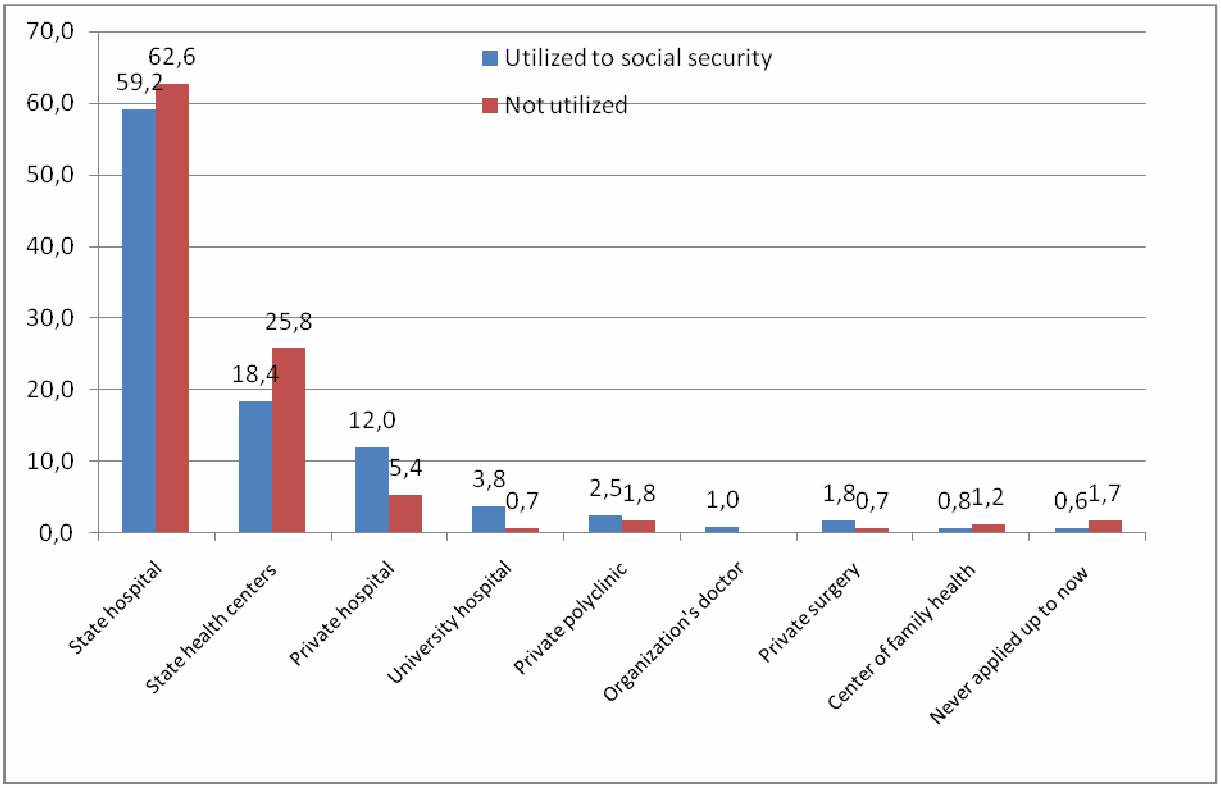
child is not eligible for a green card because his parents are not considered poor, the child will be able to unconditionally benefit from the health services of the General Health Insurance. According to the estimations of the Household Budget Questionnaire in 2006, 43% of those without health insurance are under the age of 19 (TÜİK 2006 HHBA). This means, that health services have become accessible for this group. Moreover, the obligation of the publicly employed physicians to work full-time at hospitals and close their surgeries or give up work in the private sector will increase the accessibility of health services, as they will work full-time at the hospitals and the hospitals, therefore, will be used more efficiently, which will reduce waiting times. Moreover, payments of patients for private examination will also diminish.

A central hospital appointment system has been introduced in Erzurum and Kayseri as a pilot project. The aim of this project is to facilitate access to health services and to promote a more efficient and active use of sources[28].

One of the most important problems in terms of financial sustainability is that the family physician system has not been rolled out and the referral route system not been implemented yet. Figure 5 below shows the health care settings insured and uninsured people go to first when they become ill. 59.2% of the insured and 62.6% of the uninsured go to public hospitals, which are second step health institutions. State health centres are first step health institutions, and 18.4% of the insured and 25.8% of the uninsured go there first. In this set-up, it is inevitable that unnecessary examination and treatment will be frequent. It is, therefore, important that the family physicians system is rolled out and the referral route system implemented. But the number of family physicians needs to be increased to meet the demands such systemic change will bring. It seems a difficult task, however, to increase the quality and quantity of family physicians in a short period of time. In order to provide financial continuity, the second important issue is that premium incomes should be increased. Increasing premium income mostly depends on increasing recorded employment.

[28] Retrieved from: http://www.saglik.gov.tr.

Figure 5: The health care settings first used in case of illnesses 2009



Source: TÜİK Life Satisfaction Survey, 2009.

2.3 Long-Term Care

2.3.1 Overview of the system's characteristics and reforms

In Turkey, there is no long-term care insurance system. The elderly are usually taken care of within their own family. In addition, there are the Social Services and Protection of Children Institution (SHCEK), publicly and privately run care homes and care services at home. Elderly poor people can benefit from SHCEK care homes and a limited number of them can receive care services free of charge in private care homes and care centres. A tax-financed scheme designed in 2005 provides payments to families of poor and disabled people cared for at home, and payments to a care centre, if they are cared for there.

The SHCEK care homes may be run by public institutions and other real or legal persons. Elderly people who cannot afford to stay at the SHCEK care homes benefit from care home services free of charge.[29] 5% of the capacity of private care homes is dedicated to care for poor old people who cannot afford the fees for the service. The elderly eligible for free care

[29] "[…] An old person is eligible for free care in a care home if it is clear that this person has nobody legally responsible to look after them, and they do not receive old-age, widow or survivor pension of social security institutions, and they have no movable or immovable property registered in their name or, if they have immovable property registered in their name, their income is still too low to be able to survive. Also eligible for free care are, old people whose income is documented to be below the poverty threshold and those who have a family member responsible to look after them but whose income is to low to be able to care for them. Those who can afford the fees, but are socially deprived are accepted on the condition that they pay the fee." Regulation of care homes, elderly care in care homes and rehabilitation centres, article 62/a, Official Gazette Number 24325 dated 21 February 2001.

services are determined by the SHCEK branch management in the respective towns and cities.[30]

Apart from care homes, home care services can be provided by SHCEK, public institutions and private legal personalities[31]. These institutions dedicate a maximum of 5% of their capacity to free care for people on low income in need of the services who do not have any relatives to care for them. The elderly eligible for free care services are determined by the SHCEK branch managements.[32]

As mentioned above, there is no long-term care insurance system in Turkey. Elderly or frail people in need of long-term care satisfy their needs through the tax-financed social assistance system. If a person cares for an elderly family member, there is a monthly cash benefit available amounting to the net minimum wage. If the person is cared for at a care centre, twice the minimum wage is given to the person receiving care. This form of benefit is available to people whose individual income is below two-thirds of the net minimum wage.[33]

Since 2005, a sound long-term care service for disabled people has been run by SHÇEK (the Social Services and Child Protection Institution). Although it was initially set up to provide for disabled people, it is understood that there is not much difference between the burden of disability or of old age in terms of mobility. Thus, this scheme includes the elderly as well (Seyyar 2005). The scheme is tax-financed and provides four different types of long-term care services:

- Care at SHÇEK care centres (inpatient)
- Care at SHÇEK care centres (outpatient)
- Care at private care centres (cost per month TL 1,153)
- Care at home (if the carer is a family member, the net minimum wage (TL 576.57) is paid to that person each month).

People in need of care who live with their family and whose combined income lies below two-thirds of the monthly minimum wage per person are entitled to benefits (SHÇEK 2008), so even a pensioner in need of long-term care can benefit from these services.[34]

The number of people who benefit from these long-term care services is shown in Table 2 below. As it can be seen from the figures, the number of people who are cared for by relatives at home has reached 223,955 in February 2010.[35]

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30 Regulation of care homes and elderly care in care homes and rehabilitation centres, article 27/7, 7 August 2008, 26960 Official Gazette.

31 Regulation about home care and day care services provided at care centres for the eldery. Offizial Gazette Number 26960, dated 9 August 2008.

32 Regulation about home care and day care services provided at care centres for the elderly. 25/5

33 In Turkey long-term care benefits are means-tested and, thus, available only to poor and middle-income families. But SHÇEK has announced that it will prepare a new draft law for a general long-term care insurance for disabled people (SHCEK, 2008).

34 For instance, an elderly woman in need of care lives with 5 family members. She gets TL 800 of old-age pension from the SSI. Her son works and earns TL 700.
Total family income: TL 1,500
Family income per person: 1,500/5 = TL 300
Net monthly minimum wage: TL 576.57.
Benefit threshold: 576.57*2/3=TL 380.50
She can benefit from long-term care services, as the family income per person lies beneath the benefit threshold.

35 It should be mentioned that the numbers represent all age groups. Data providing a break-down into age groups who benefit from cash benefits could not be attained. However, the proportion of people above the

2.3.2 Overview of debates/political discourse

There are not enough elderly care centres in Turkey. Moreover, there are disparities between the quality of care services provided and the number of elderly care centres (DPT 2007:67). "The Situation of Elderly People in Turkey and National Plan of Action on Ageing" was prepared by the State Planning Organisation, which involved the United Nations Population Fund, various public institutions and organisations, universities and non-governmental organisations, representatives of cooperations and the management of DPT and SHCEK between 2004 and 2005. This plan was accepted by the Turkish High Plan Committee in 2007 (DPT 2007:VII). According to this plan, one of the main objectives is to provide health and long-term care services to promote health and welfare of the elderly. (DPT 2007:66).

Table 2: The SHCEK Plan for care of disabled and elderly people

	2009	2010	2011	2012	2013	2014	Increase rate
Care of disabled at home	200,000	230,000	255,000	275,000	290,000	300,000	50%
Care of elderly at home/ day care	-	1,000	2,000	3,000	4,000	5,000	new scheme
The number of elderly staying at SHCEK care homes and care centres for the elderly	7,500	7,800	8,040	8,440	8,640	8,640	15%
Private care homes/care centres for the elderly	111	127	143	159	175	191	72%
Private/other public care centres for the elderly	0	7	12	22	32	32	new scheme
Other care homes (Local administration STK)	67	77	87	97	107	117	75%
SHCEK care homes	53	3	2	2	2		17%
SHCEK Rehabilitation centres for the elderly	21		2				10%

Source: SHCEK 2009/b:40,54,55,56.

SHCEK states their aims relating to disabled and elderly care in their 2009-2014 Strategic Plan. According to this plan, it is aimed that the number of people who benefit from disability care will increase by 50% and rise from 200,000 to 300,000, the number of people who are cared for at home or in day care centres will rise from 1,000 to 5,000, the number of people staying at SHCEK care homes and care centres for the elderly will rise from 7,500 to 8,640, representing a 15% increase. it is aimed that in the medium term, namely by 2025, the number of disabled people being cared for at home will rise to 400,000, and the number of elderly people being cared for in day care centres will rise to 5,000 (SHCEK 2009/b:83).

Between 2009 and 2014 it aimed to increase the number of private care homes by 72%, care homes of local administrations and STK by 75%, SHÇEK care homes by 17% and SHCEK rehabilitation centres for the elderly by 10%. It is also aimed that the number of STK care homes and care centres for the elderly and other public and private sector institutions being involved in care for the elderly at home will surpass those of SHCEK. However, there is no information about how to finance elderly care in the private sector.

age of 50 who are incapable of work to a degree of 70% or more is estimated to be 30% (SSI, 2009). Thus, it can be assumed that 30% of these numbers refer to needy elderly people.

2.3.3 Impact Assessment

The best way of caring for the elderly is perceived to be looking after them at home, as long as there is no problem between the old and the carer. However, a restructuring of human resources as well as infrastructure investments to improve social conditions and health are needed (Öztop et al 2008:46). In Turkey, the system related to long-term care is a kind of scheme without premium regime including the poor. Moreover, the poverty threshold is quite high when compared to other social benefits[36]. However, it is suggested that the system should be completed with a care insurance financed by premiums and that it should be a mixed system in order to safeguard continuity (Seyyar 2005; Oğlak 2008). Moreover, a commission decision suggests including the elderly person and the carer in the scope of any care insurance with the implementation of the Family Council (ASAG 2008:38). However, there is still no regulation regarding this issue.

Elderly people who are not poor can benefit from care homes, care centres for the elderly, day care centres and care services at home, as long as they pay the fee. However, care homes and care centres for the elderly are inadequate. As it can be seen in Table 3 below, there is a total number of 269 public and private care homes of SHCEK and care centres for the elderly, with a total capacity of 21,472. The number of people registered in these institutions is estimated to be 18,056. In other words, 84% of the current capacity is used. On the other hand, the percentage of people above the age of 65 is 7% of the total population in Turkey, a total of 5,083,084 people (TÜİK 2009). 0.3% of these people benefit from care homes and care centres for the elderly. Thus, it can be said that the issue of care of the elderly is solved within the families and the responsibilities of the state are transferred to the families (Ecevit 2008:164).

Table 3: The number of care homes, care centres for the elderly, their capacities and the number of people benefitting from these in Turkey

	Number	Capacity	The number of people registered
SHCEK Care homes, care homes for the elderly and rehabilitation centres	84	8,333	7,375
SHCEK care centres for the elderly	5	n.a.	951
Private care homes and other public care homes	180	13,139	9,730
Total	269	21,472	18,056

Source: SHCEK, 2010.

2.3.4 Critical assessment of discussions and research carried out

In Turkey, solidarity is very strong in a typical family and the elderly are taken care of by their families. While 55% of the elderly prefer to live with their children, 27.1% of them prefer to receive care in their own home or to live in a care home (TÜİK, Research of Family Structure 2006). Moreover, because of migration from rural areas to the big cities and the change to nuclear family types as well as a fast population ageing, there is a need to implement institutional mechanisms in order to provide care for the elderly. It is estimated

[36] For example, in order to benefit from free health services, the poverty threshold should be one-third of the gross minimum wage per capita per month (TL 240.50). However, it is TL 380.50 per capita monthly for the benefit in respect of needy disabled people.

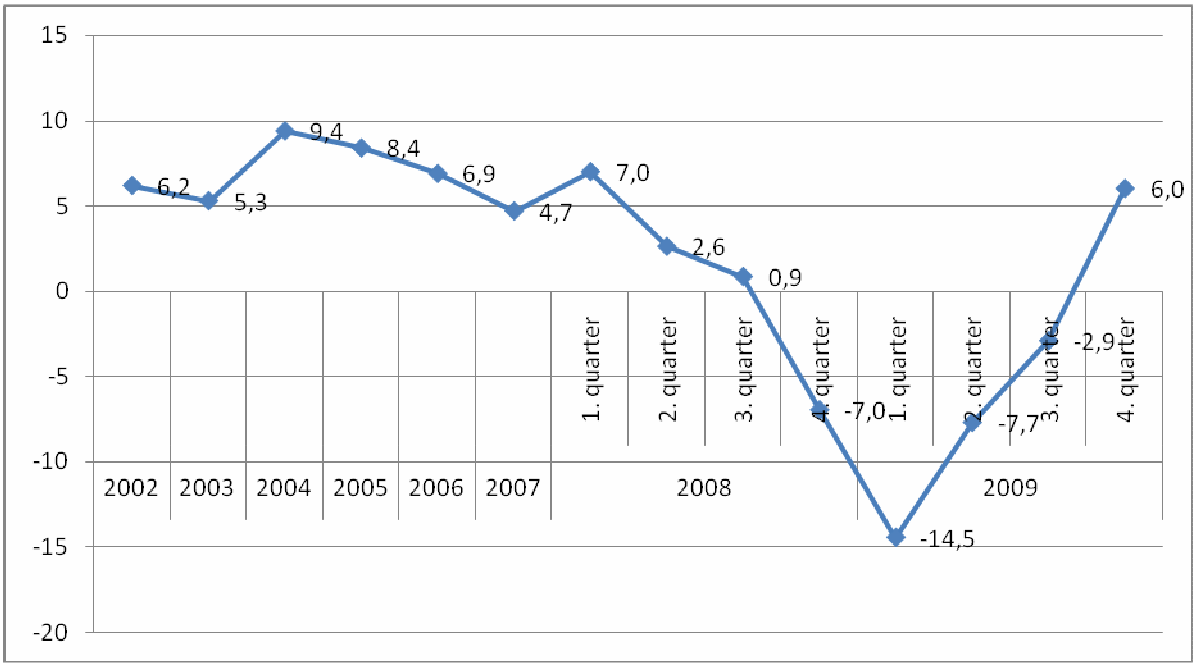
that, compared to the total population, the percentage of people over the age of 65 will rise to 9.8% by 2025 (TÜİK 2010). This rate is estimated to rise to 17% by 2050 (SHCEK 2009/b:22). Thus, the design and implementation of a long-term care insurance scheme financed by premiums and taxes is required.

3 Impact of the Financial and Economic Crisis on Social Protection

3.1 Recession, increasing unemployment and their effects on the Social Protection System

The Turkish economy was one of the most consistent economies, which has grown by 7% for six years. However, as a result of the economic developments and subsequent recession at the beginning of 2008, the economy shrank by 14.5% in the 1st quarter of 2009. Economic recession decreased in the 2nd quarter of 2009 (-7,7%), and was only -2,9% in the 3rd quarter of 2009. Economy gave recovery signals at the end of 2009 and grew by 6%.

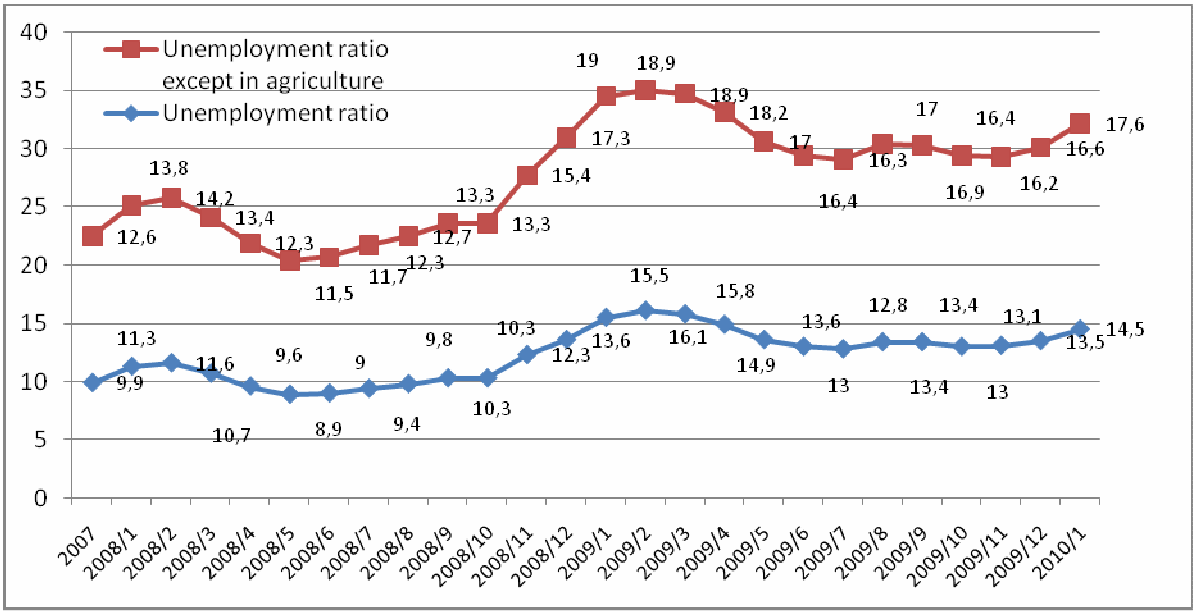
Figure 6: Economic Growth Ratio (2002-2010)



Source: TÜİK, 1998-2007, TÜİK 2009.

The economic crisis began to show its effect last August and the unemployment rate has increased since then (Figure 7). The unemployment rate had increased to 15.5% by January 2009. After January 2009, it decreased to 12.8% in August 2009 and began to increase again before autumn, reaching 14.5% by January 2010.

Figure 7: Unemployment Rate in Turkey 2007-2010



Source: TÜİK Household Labour Survey 2007-2008-2009-2010.

The economic crisis also affected the number of people with social insurance. Especially, the number of insured employees decreased by 9% between June 2008 and February 2009 (SSI 2010/a). However, as employment opportunities increase in summer time, the number of insured people began to rise and became similar to the rate before the crisis, thanks to economic growth in the last quarter of 2009 and premium promotions. While the number of insured workers was 8,362,290 in February 2009, when the economy was mostly affected by the crisis, in December 2009 the rate increased by 7,4%, reaching 9,030,202. However, the number of insured self-employed workers did not increase; on the contrary, between February 2009 and December 2009 it decreased by 7,7% (See Table 3).

Table 4: Number of Insured (December 2008-December 2009)

	Employees Insured	Self Employed Insured
Dec 2008	8,802,989	3,260,719
Jan 2009	8,481,011	3,306,273
Feb2009	8,362,290	3,306,273
Mar2009	8,410,.214	3,310,817
Apr2009	8,503,053	3,067,756
May2009	8,674,726	3,085,783
Jun2009	8,922,743	3,051,391
July2009	9,013,349	2,877,507
Aug2009	8,977,653	2,837,520
Sep2009	8,950,211	2,878,242
Oct2009	9,046,769	2,891,157
Nov2009	8,975,981	2,898,808
Dec2009	9,030,202	2,847,081
Increase or decrease in %	7.4*	-7.7*

*Source: SSI 2010 /b *Feb. 08-Dec 09*

Because of early retirement and high pension payments, the deficit in the Social Security Institution's budget has increased dramatically with the economic crisis. The deficit has been compensated with transfers from the state budget. As outlined in Table 4, the premium income rate has increased by 0.1% in 2009 compared to the rate of 2008. In premium income, the rate of compensation for pension and health expenditures has decreased to the rate of 56.7% While the percentage of deficit in the social security system of GDP was 3.69% in 2008, it was 5.56 in 2009 (SSI 2010/b).

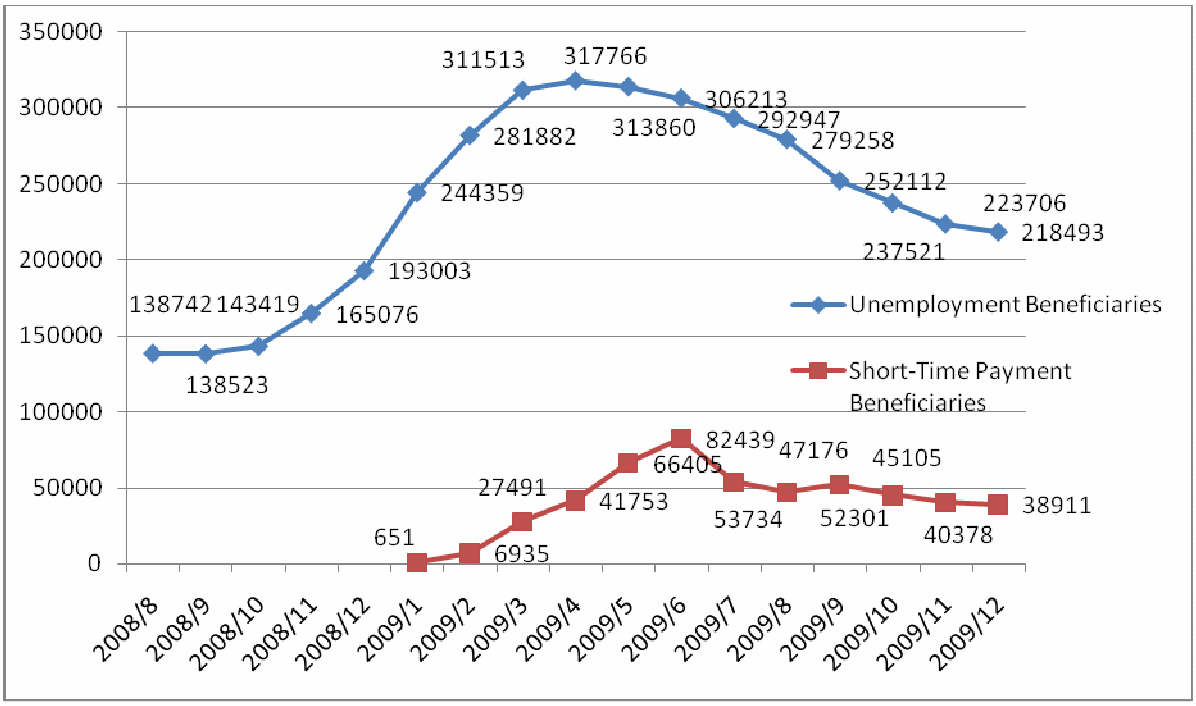
Table 5: Premium Revenues, Pension and Health Payments of the Social Security Institution (2000-2010)

	Premium Revenue (TL)	Rate of Change	Pension Payments (TL)	Health Payments (TL)	Total Payments	Compensation Rate of Pension and Health Payments by Premium Income in %
2000	6,575,348		6,756,700	2,633,552	9,390,252	70
2001	9,739,521	48.1	10,696,600	4,575,995	15,272,595	63.8
2002	14,822,260	52.2	16,687,400	7,629,027	24,316,427	61
2003	21,178,425	42.9	25,174,200	10,661,718	35,835,918	59.1
2004	27,423,675	29.5	30,660,700	13,150,129	43,810,829	0.626
2005	30,883,672	12.6	38,537,100	13,607,884	52,144,984	0.592
2006	41,619,875	34.8	45,075,855	17,666,674	62,742,529	0.663
2007	44,051,677	5.8	52,311,728	19,983,613	72,295,341	0.609
2008	54,546,453	23.8	59,136,539	25,345,913	84,482,452	0.646
2009	54,579,182	0,1	67,408,100	28,810,684	96,218,784	0,567
2010 (Jan-Feb)	9,452,119		12,517,379	3,878,160	16,295,539	0,577

Source: SSI, 2010/b.

The economic crisis has also reflected badly on the number of people who receive unemployment benefit (See Figure 8).

Figure 8: Unemployment Insurance Beneficiaries (August 2008-December2009)



Source: Turkey Employment Institution, 2009-2010.

The number of benefit beneficiaries increased to 317,766 in April following the peak of the crisis in February, an increase by 300% when compared to the rate in August before the crisis. After the facilitation of the conditions to benefit from short-time work payments in 2009, the number of workers benefitting from these payments increased to 82,439 in June. However, when the economy improved in the last quarter of 2009, the number of people benefitting from both unemployment insurance and premium promotions decreased, with the effect of higher premium income. It is essential, however, to emphasise that in December 2009 only 6.5% of the unemployed benefitted from unemployment benefit (Karadeniz 2010). The basic reasons for this are cutthroat preconditions to be eligible for unemployment benefit (i.e. unemployment insurance premiums paid for a minimum of 120 days continuously in the four months prior to unemployment and a minimum of 600 days in the last three years) (Akgül et al 2008:8), the difficulties of the scope of the unemployment insurance (i.e. self-employed workers and people working for their family in agriculture, people on temporary contracts and people who stop working on their own accord cannot benefit), as well as the high rate of unregistered employment. However, 41% of the people who lost their jobs applied for this benefit in December 2009 (Karadeniz 2010). The others who became unemployed did not apply to the Employment Office because they were outside the scope of the unemployment insurance, i.e. they had worked in unregistered employment or worked without insurance, or they could not complete the minimum number of premium payment days (because of working part-time, etc).

The Unemployment Fund was founded in 2000 and began to pay benefits in 2002. It has saved a great amount of funds in unemployment insurance since then. It is estimated that the Fund held TL 43,371,614,373.44 in March 2010. According to an assessment at the end of

March 2010, 0.75% of the total funds is held in foreign currency accounts, while 55.91% is in government bills, 36.18% in government debenture bonds, 1.35% in foreign currency debenture bonds and 5.52% in deposit (Turkey Employment Institution 2010:3-4).[37]

Table 6: Yield of Unemployment Security Fund and its comparison with producer price index and foreign currency basket

Years	Yield of Fund %	Producer Price Index	Foreign Currency Basket %
2005	21.37	2.66	-6.71
2006	17.91	11.58	10.92
2007	16.46	5.93	-12.75
2008	17.07	8.1	27.37
2009	14.90	5.93	-0.75
April 2009-March 2010 (Annually)	13.42	8.57	-9.27

Source: Turkey Employment Institution, 2010: 4.

As the analysis of the table shows, the fund has provided yield from both inflation (producer price index) and the foreign currency basket between 2005 and 2007. In 2008, 2009, and 2010 in particular, with the appreciation of Euro and US dollar, the income of the fund has been below the rate of the foreign currency basket.

3.2 Precautions taken by the Government against the economic crisis and unemployment

In addition to the measures taken to increase employment and cope with the crisis in 2008, various active and passive employment policies were implemented in 2009 and 2010.

In order to counteract the negative effects of the crisis on unemployment, an unemployment stimulus package including active employment measures was declared on 4 June 2009. This employment stimulus package includes insurance premium incentives, professional training schemes, implementation of apprenticeship programmes in companies and working programmes for the benefit of communities (Giresun, 2009).

According to the Law Number 5921[38], parts of the share of the insurance premiums of employers who have taken on unemployed workers are provided by the unemployment insurance fund for six months; the maximum amount is based on the minimum wage. In order to benefit from this regulation, valid for employment contracts starting no later than 31 December 2009, employers had to take on people who had been out of work for three months or more, and had to prove that these new employees were an addition to the number of already employed workers, based on employment figures for April 2009. The Law Number 5951[39] extends this incentive. According to the new regulation, the employment figures for October 2009 are taken into account. 20,043 companies benefitted from the Law Number 5921 in December 2009, and 55,093 unemployed people were given job opportunities (Social

[37] Retrieved from: http://statik.iskur.gov.tr.
[38] Official Gazette Date: 18.08.2009 Number 27323.
[39] Official Gazette Date: 05.02.2009 Number:27484.

Security Institution, personal contact). This regulation is aimed to create employment for approximately 70,000 unemployed people in total (Giresun 2009).

Another regulation, which came into force with Law Number 5921, is that, if a recipient of unemployment benefit is employed, the period during which they benefitted from unemployment benefit serves as a basis for premium subsidy calculations. Both employer and employee premiums, up to a maximum based on the minimum wage, will be paid by the unemployment insurance fund for the same amount of time as the unemployment benefit was paid (for example, if a person was unemployed for 7 months prior to employment, the insurance premiums for both employee and employer, up to a maximum based on the minimum wage, will be paid by the government for 7 months). The employer needs to prove that this employee is an addition to the average number of employees of the past six months.

It is intended that 200,000 people benefit from professional training schemes in 2009 and 2010, and that 120,000 people benefit from working for the benefit of communities programmes, either part-time or full-time. Moreover, 10,000 people who graduate from high school or above are provided with the opportunity of apprenticeship in a company, and it is planned that 10,000 people attend entrepreneurship courses. It is further planned that 500,000 people benefit from active employment measures in 2009 and 2010 (Giresun 2009). In the period between 2009 and February 2010, it is estimated that, 76% of the total number of available professional training courses which are aimed at working for the benefit of communities was reached (Karadeniz 2010).

While short-time work payments have been increased by 50% with the measures in 2008 and 2009, the period for payment has also been increased from three months to six months. According to the Law Number 5951, the short time work payment is available until 2010.

Moreover, the same law stipulates that extra investments are made within the priority regions for development, as determined by 31 December 2004. The compensation of the employer's share of insurance premiums in those regions is extended until 31 December 2012. In accordance with the Law Number 5510, the National Treasury has compensated 11% of the employer's share concerning disability, old-age and survivors insurance since October 2008. This scheme included 5,126,556 insured in nearly 700,000 companies in December 2009 (Social Security Institution, personal contact). Moreover, with a regulation which came into force in 2008, the employer's share of insurance premiums of male and female workers aged between 18 and 29 have been compensated by the unemployment insurance fund. In December 2009, 19,534 companies and 53,296 employers benefitted from this scheme (Social Security Institution, personal contact).

With the Temporary Article 6, which was added to the Law Number 4447 in 2009, it has been provided that some of the money earned through unemployment insurance has been transferred to the national budget for the Southeast Anatolia Project. This figure amounts to TL 6,011,988,844 (TEI 2010:3).

The employment incentive measure of decreasing the employer's part of the insurance premium by 5% has been estimated to cost between TL 60,000 and TL 120,000 (Akgül et al 2008:3). Research needs to be done into the extent to which premium incentives played a part in the rise in female employment in manufacturing sectors by 12,000 people, especially during the crisis period. (Gürsel et al 2009:1).

Turkey has introduced some broad measures to fight the crisis in 2008, 2009 and 2010. However, critics say these measures have been late and inefficient. It has been stated that giving importance to infrastructure investments and human capital, such as building schools and energy centres, would have a positive effect on the economy and revitalise it, too (Aydoğuş 2009:47).

According to some views, employment does not increase because of measures securing employment which show that the Turkish labour market is strict (Akgül et al 2008; Süral, 2009). On the contrary, it is suggested that working time should be shortened and temporary and part-time working should be widened in the labour market (Süral 2009).

According to the Confederation of Turkish Trade Unions (TÜRK-İŞ), employment should be protected and developed in crisis situations. Real economy should be supported, interest rates should be reduced and the premiums of additionally employed workers should be compensated by the government. Regarding the dismissal of workers, it is the easiest way for a company, but will aggravate the crisis, as purchasing power will diminish. For this reason, job security at ILO standards should be put into practice and present job security should be for the advantage of the workers, in order to reduce the rate of dismissals (TÜRK-İŞ 2008). According to the Confederation of Turkish Trade Unions (TÜRK-İŞ), instead of dismissing people, the practice of long working hours should be stopped. The inspection of companies should be increased, in order to reduce unregistered employment. Moreover, the conditions for benefitting from unemployment insurance should be eased and every worker should earn at least the minimum wage (TÜRK-İŞ 2008).

According to the Turkish Employer's Union Confederation (TİSK), a big proportion of incentives are for new employment. In order to protect the employment of workers already working, some basic burdens to the employer such as severance pay and social insurance premiums should be decreased. TİSK also suggests some measures in order to reduce the negative effects of a crisis on employment in many countries. Employers who take on long-term unemployed and young female workers working in SMEs and workers having family responsibilities should receive some financial support, payment of their social insurance and tax debts should be delayed; the procedures involved to benefit from short-time payments should be eased; ways of flexible working should be devised; long-term unemployed and workers facing the danger of unemployment should be trained; and people should be motivated to build up their own business. All these are active employment measures (TİSK 2009). Moreover, TİSK suggests that the problem of unemployment should generally be dealt with in the Economic and Social Council, one of the most important social dialog institutions (TİSK 2009).

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TÜRK-İŞ (2008). Ekonomik Krize Karşı Önlemler Raporu, Kasım, Ankara, http://www.turkis.org.tr/source.cms.docs/turkis.org.tr.ce/docs/file/ekonomikkriz.pdf

TÜRK-İŞ. "SGYDK Toplantısında Gündeme Alınması Önerilen Konular", http://www.turkis.org.tr/source.cms.docs/turkis.org.tr.ce/docs/file/sr113.pdf

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4 Abstracts of Relevant Publications on Social Protection

[R] Pensions

[R1] General trends: demographic and financial forecasts
[R2] General organisation: pillars, financing, calculation methods or pension formula
[R3] Retirement age: legal age, early retirement, etc.
[R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
[R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health

[H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
[H2] Public health policies, anti-addiction measures, prevention, etc.
[H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
[H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
[H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
[H6] Regulation of the pharmaceutical market
[H7] Handicap

[L] Long-term care

[R1] GÜRSOY, Kadir, "The Effects Of Latest Parametric Reform On Financial Sustainability And Actuarial Fairness For Pay-As-You-Go Pension System in Turkey And Some Alternative Reform Options", 2009, http://www3.iam.metu.edu.tr/iam/images/9/9a/Kadirgursoy.pdf

"Especially for the last 25 years, regulations that do not take into account actuarial balances, the globalisation phenomenon and changes in the population structure have brought great burden on the pension systems all over the world. Moreover, factors such as a governments' desire to decrease contribution rates to provide international competition due to increasing labour costs, high level of informal employment, generous pension systems, increase in life expectancy, a low level of fertility rates and ageing has begun to threaten the sustainability of the pension systems. As in the light of such events, countries have had to develop new measures/methods in order to maintain sustainability of the pension systems. The unsustainability of these systems will result in not fulfilling their future liabilities. This means that future generations can not obtain their pensions although they contribute to the system. Aiming to prevent this condition, implementing necessary arrangements has been of great importance to cope with those threats.

In Turkey, parametric reforms such as increasing retirement age, reducing the accrual rate to a more reasonable level, providing incentives to work for a longer period and decreasing valorisation of past wages are crucial. Consequently, it is possible to maintain the sustainability of the system through the creation of a less generous system. Furthermore, strengthening the link between the contributions paid and pensions obtained will enable people to remain in the system longer by maintaining the transition to a fairer system.

The aim of this term project is to examine the effects of parameters such as retirement age, valorisation of past wages, accrual rate and indexation of pensions amended with the Act No. 5510 Social Insurance and Universal Health Insurance Law in Turkey on the deficit of the system and actuarial coverage ratio. According to the results, alternative proposals such as decreasing accrual rates based on ages and gender will be introduced for those amendments to maintain sustainability and ensure actuarial

fairness. The effects of these alternatives will be discussed comparatively in the light of the results of the calculations made."

[R2] KORKMAZ, Turhan, UYGURTÜRK, Hasan, ÇEVİK, İsmail, "Bireysel Emeklilik Yatırım Fonlarının İşlem Hacmine Etki Eden Faktörlerin Analizi", TİSK, Akademi, C.5., S.9, March 2010,
http://www.tisk.org.tr/download/akademi/tiskakademi_09.pdf
"The Analysis of Affecting Factors of Individual Pension Funds' Trading Volume"

"The contributions paid by the participants of the individual pension system are investigated through different types of financial instruments. The contributions paid to the pension funds are very important for the deepening and development of the system. This study aims to determine the factors that affect the amount of contributions paid by the participants to pension funds during January 2004 to July 2009 in Turkey. The related factors are evaluated in the financial and macroeconomic aspects and the way these factors affected the trading volume of pension funds was researched empirically with the help of three different models. The least squares method was adopted in the estimation of models. Assessing the information gained from analysis, it was determined that financial and macroeconomic parameters had an influence on the contribution payments made by the participants to individual pension systems. The results suggested that the increase value of Euro, ISE Index and industrial production parameters have a statistically positive effect on contributions."

[R2] KAYALI, Cevdet, "Türkiye'de Hayat ve Bireysel Emeklilik Sigortasının Gelişimi ve Etkinlik Değerlemesi", Finans Politik & Ekonomik Yorumlar, Cilt: 46 Sayı: 529, http://www.ekonomikyorumlar.com.tr/dergiler/makaleler/529/Sayi_529_Makale_06.pdf
"Development of Individual Life and Pension Insurance and Evaluation Activities in Turkey"

This paper investigates the changes in structural and concentration indicators for the last five years in Turkish life insurance and private pension companies. Moreover, the developments in the life and private pension insurance companies' efficiency scores are examined for the period 2003-2007. The efficiency scores are evaluated by using Data Envelopment Analysis. The results of the analysis show that scale efficiency scores of companies were increased during the period of 2003- 2007.

[R2] ALTINTAŞ, Kadir, Murat, "Belirlenmiş katkı esaslı emeklilik planlarında finansal eğitimin önemi: Katılımcıların finansal okur yazarlığı çerçevesinde alternatif bir yatırım modeli", Zonguldak Karaelmas Üniversitesi Sosyal Bilimler Dergisi,C..5 S.) pp.151-176, 2009, http://iibf.karaelmas.edu.tr/sbd/makaleler/1303-9245/200905009151176.pdf

The importance of financial education in defined-contribution pension plans: An alternative investment educational model within the context of beneficiaries' financial literacy

In the defined-contribution pension plans, improvement in financial literacy of beneficiaries or constitution of a minimum investment culture for beneficiaries is of strategic importance for the socioeconomic development of society. In fact, most of the academic and social research done in many developed and developing countries strongly indicates that beneficiaries do not have adequate financial literacy and knowledge. The aim of this study is to reveal the necessity of investment education from the beneficiaries' perspective in defined-contribution pension plans. In other words, this study aims at evaluating the financial literacy level of potential beneficiaries and developing an alternative investment curriculum for basic investment education. The results show that investment education can remarkably

scale up the financial knowledge of the subjects who participate in the survey and this outcome is verified with the help of statistical analysis.

[R5] ŞAHİN, Şule; ELVEREN, Adem Yavuz, "Designing a Minimum Pension Guarantee for the Individual Pension System in Turkey", 2009, Department of Economıcs Working Paper Series, No: 13, http://www.ime2009.net/fileadmin/user_upload/abstracts/046.pdf

"The study aims to contribute to the literature by constructing a minimum benefit guarantee mechanism for the Individual Pension System (IPS) in Turkey, a privately managed defined-contribution scheme, which was introduced in 2003 as a complementary system to the traditional pay-as-you-go system. The returns of the individual accounts are subject to fluctuations in capital markets. This increases income uncertainty for the beneficiary and exposes individuals to the risk of fluctuations in the economy in general, and of the stock market in particular. This fact has been widely considered by the policymakers recently. Pension guarantee is a way to avert this pitfall. There are two alternative pension guarantee mechanisms, namely minimum rate of return and minimum benefit guarantee. While the former entitles participants to receive payments at least equal to their life time contributions to the system plus some rate of return, the latter provides a minimum annuity regardless of actual investment performance of individual accounts. We propose a minimum benefit guarantee mechanism for the IPS in Turkey following Lachance and Mitchell (2003) and argue for the necessity of such a pension guarantee."

[R5] SAHIN, Şule; ELVEREN, Adem Yavuz, "Gender Gaps in the Private Pension Systems: A Minimum Pension Guarantee Application For Turkey", 2009, http://www.econ.utah.edu/activities/papers/2009_13.pdf

"A sizeable literature on social security reform includes an analysis of gender impacts of defined-contribution schemes, in which it is recognised that due to the gender division of labour, including unpaid family work and informal paid work, women are less likely to have the same level of benefits and social protection as men. Also, the returns of the individual accounts are subject to fluctuations in capital markets. This increases income uncertainty for the beneficiary during retirement and exposes individuals to the risk of fluctuations in the economy in general, and of the stock market in particular. Pension guarantee is a way to avert this pitfall. In this study we show that it can also be used to benefit women with specific regulations."

[H] Health

[H1] SÜLKÜ, Seher Nur; CANER, Asena, *"Health Care Expenditures And Gross Domestic Product: The Turkish Case"*, TOBB University of Economics and Technology Department of Economics Working Papers, No: 09-03, 2009, http://ikt.web.etu.edu.tr/RePEc/pdf/0903.pdf

"Our study examines the long-run relationship among per capita gross domestic product (GDP), per capita health expenditures and population growth rates in Turkey during the 1984-2006 period, employing the Johansen multivariate cointegration technique. Related previous studies on OECD countries have mostly excluded Turkey, an OECD country itself. The only study on Turkey examines the 1984-1998 period. However, after 1998, major events and policy changes that had a substantial impact on income and health expenditures took place in Turkey, including a series of reforms to restructure the health and social security system. In contrast to the earlier findings in literature, we find that the income elasticity of total health expenditures is less than one, which indicates that health care is a necessity in Turkey in the period of analysis.

According to our results, a 10% increase in per capita GDP is associated with an 8.7% increase in total per capita health expenditures, controlling population growth. We find that the income elasticity of public health expenditures is less than one. But, in the case of private health care expenditures, the elasticity is greater than one, meaning that private health care is a luxury good in Turkey."

[H1] YARDIM, Mahmut Saadi; CİLİNGİROĞLU, Nesrin; YARDIM, Nazan, "Catastrophic Health Expenditure and Impoverishment in Turkey", 2010, Health Policy, 94, p: 26–33, journal homepage: www.elsevier.com/locate/healthpol

"Objectives: This study aims to identify the level of catastrophic health expenditure (CHE) in Turkey and, to reveal household factors predicting this outcome. Methods: CHE is calculated from a national representative data derived from TurkStat, Household Budget Survey, Consumption Expenditures, 2006. The methods introduced by Ke Xu and colleagues are employed for calculations. Results: The proportion of households with CHE is 0.6%. Impoverished households are 0.4% of total. Average out-of-pocket health payment is USD 7.36 (PPP USD-2006) in the lowest fifth, which is approximately one tenth of the highest fifth (USD 70.18, according to PPP USD-2006). In the logistic model, the probability of facing CHE increases by each unit rise of per capita expenditure. Household per capita health insurance is closely related with catastrophe. Rural households face 2.5-times more catastrophe than the urban area residents. Having a preschool child in the household is seen as a protective factor for catastrophic expenditure. On the other hand, elderly or disabled person increase the risk of catastrophe. Conclusions: Results indicate that more people in Turkey benefitted from risk pooling/health insurance by 2006 and were, therefore, on average better protected from catastrophic medical expense, than in many other countries with comparable income levels at that time."

[H3] YOLTAR, Çagri, "When the Poor Need Health Care: Ethnography of State and Citizenship in Turkey", Middle Eastern Studies, Vol: 45, No: 5, p:769-782, 2009, http://www.informaworld.com/smpp/content~content=a914721772~db=all~jumptype=rss

"This article is about the everyday building of state and citizenship in Turkey. Drawing on ethnographic observations from the provincial city of Adıyaman in south-eastern Turkey, The author explores the ways in which categories of state and citizenship are substantiated at local level over the mundane workings of a specific social assistance mechanism, the Green Card Scheme, which was designed to provide free health care services to poor citizens."

[H3] TÜRKKAN, Alpaslan,; AYTEKİN, Hamdi, "Socioeconomic and Health Inequality in Two Regions of Turkey", Journal of Community Health, Vol: 34, No: 4, p:346-52, 2009, http://www.ncbi.nlm.nih.gov/pubmed/19333742

"This study investigated health inequalities between two areas within the city of Bursa, Turkey, from a socioeconomic perspective. Information was gathered from 582 subjects over 15 years old using self-assessed health of the respondents, a general health questionnaire, and disability records. Health service access and health inequalities with respect to demographic and socioeconomic data are reported. The study indicates that the health of people living in socioeconomically less advantaged neighbourhoods of Bursa is worse than that of people in more affluent areas. However, socioeconomic status has no effect on disability, as ascertained with a Brief Disability Questionnaire. The results of this large-scale study provide a contemporary view of regional health disparity in a major urban setting in Turkey."

[H3] ÖZEN, Yelda, "Türkiye'de Sağlıkta Eşitsizlikler", Çalışma Ortamı Dergisi, Sayı:103, p: 12-16, 2009, http://www.isguvenligi.net/co/calisma_ortami103.pdf
Inequalities in Healht in Turkey

"It is not a coincidence that the poverty and ill health are discussed so much lately. For the last approximately 30 years, both in Turkey and in the world the neoliberal transformations taking place in various areas have deepened social inequalities, including health inequalities. In this process, the increase of polarisation of wealth and poverty reflects directly onto health indicators. Although there are common components in measurement of inequalities in health, there are different analyses for each country. In this article we examine the data and studies that exist in Turkey and investigate what kind of inequalities are associated with social variables in health."

[H3] YENİMAHALLELİ YAŞAR, Gülbiye, "Türkiye'de Genel Sağlık Sigortası Uygulaması: İlk Gözlemler", Çalışma Ortamı Dergisi, Sayı:103, p:17-19, 2009, http://www.isguvenligi.net/co/calisma_ortami103.pdf
"The General Health Insurance System in Turkey: First Observations"

This study aims to explain, whether the General Health Insurance Law can provide equitable and equal health service to the whole population. For this aim, we examine early implementation results of this law. The general health insurance does not cover self-employed persons who have premium debts to the SSI. System is based on policies which narrow it to a basic guarantee packet and increases the contribution share for health services. The author claims that, general health insurance will not solve health inequalities.

[H4] DUYULMUŞ, Cem Utku, "Social Security Reform in Turkey: Different usages of Europe in shaping the national welfare reform", Paper Prepared for the RC 19 Conference, 2009, http://www.cccg.umontreal.ca/RC19/PDF/Duyulmus-C_Rc192009.pdf

"The reform of the social security system in Turkey has been enacted in 2008, but the reform of the system was on the agenda since the 1990's. IMF and World Bank have insisted on institutional and parametric changes regarding the social security system in order to reduce the fiscal imbalances. The social security reform process initiated by the Justice and Development Party (Adalet ve Kalkinma Partisi, AKP) government in 2005 has concurred with the EU membership process. The Copenhagen criteria, the adoption of the acquis communautaires and the accession negotiations on social policy and employment chapters required from Turkish policy makers to consider EU requirements and recommendations on social inclusion. This paper inquires to what extent the EU membership process has shaped the content of the social security reform process adopting an actor-based theoretical framework of Europeanisation as "usages of Europe on national welfare reform" suggested by Paolo Graziano, Sophie Jacquot and Bruno Palier. The "usages of Europe" approach permits one to focus on where, what and how national actors have been using EU resources, references and developments as a strategic device for their own strategies within the dynamics of national reforms. The enacted reform bills, the Social Security and General Health Insurance Law and the Social Security Institution Law, have three pillars: changes in the administrative structure of the social security institutions, the introduction of universal health care and the reforms in the parameters of the pension schemes. The AKP government has taken into consideration the requirements of the EU membership process in framing the reform measures referring to EU standards, policy recommendations, acquis communautaires, as well as EU member state's experiences. This study has found that the social security reform has been shaped through the

interaction of domestic actors with the international financial institutions, World Bank and IMF and with the EU membership process."

[H4] ÇAKIR, Izgi; ÇAKIR, Bugra, "Legal applications that are supporting and improving quality systems of health care service in Turkey", Menadžment totalnim kvalitetom & izvrsnost, Vol: 37, No: 3, P: 427-433, 2009, scindeks-clanci.nb.rs/data/pdf/1452.../1452-06800903427C.pdf

"Due to some problems and difficulties with the implementation of the ISO 9001 Standards in health care organisations, the guideline named as 'System of Quality Development and Measurement of Institutional Performance' is published by The Turkish Ministry of Health to support quality management system implementations and to sustain continual improvement. This article is about this system and includes details of the development."

[H4] CHAKRABORTY, Sarbani, "Health Systems Strengthening: Lessons from the Turkish Experience", ECA Knowledge Brief, Vol:12, 2009,
http://www.worldbank.org/eca,
http://www.tusak.saglik.gov.tr/MakaleveYayin/HSS_TUR.pdf

"Health Systems Strengthening (HSS) is currently at the top of the World Bank's health agenda and is critical for countries to achieve good health outcomes. Implementing HSS is a complex process that requires a balance of technical and operational details. Country evidence on how well HSS Works and impacts health systems' performance, so far, is weak. Turkey has been successfully implementing HSS reforms since 2003, supported by the World Bank through a lending programme and policy dialogue. The country has achieved considerable success in expanding health insurance coverage for its population (especially poor people), improving access to health services (especially in rural areas) and building institutional capacity to sustain the HSS reforms. The lessons from Turkey are that, with political commitment and a flexible, results oriented approach, HSS interventions can be successfully implemented to have an important impact on the performance of the health sector."

[H4] KAHVECİ, Rabia; MEADS, Catherine, "Is Primary Care Evidence-Based in Turkey? A Cross-Sectional Survey of 375 Primary Care Physicians", Journal of Evidence-Based Medicine, Vol: 2, p: 242–251, 2009
http://www.ingentaconnect.com/content/bpl/jebm/2009/00000002/00000004/art00005

"Objective: Family medicine (also called general practice) is a specialty with a focus on primary care. In Turkey, not all primary care is provided by specialists. Efforts are underway to improve primary care by improving the provision of primary care, establishing referral chains, and having care provided by general practitioners after transition training or by family medicine specialists. We investigated the relationship between evidence-based medicine (EBM) and primary care in Turkey, to provide a snapshot of the current situation and baseline data to assess the effects of current and future reforms.

Methods: A cross-sectional survey was done of 375 primary care physicians: 138 general practitioners (GPs), 121 family medicine (FM) trainees, and 116 FM specialists. They were asked 30 questions assessing general characteristics, knowledge, and training in EBM; general attitudes towards EBM; resources used to support clinical decisions; possible barriers to EBM practice; and opinions on future practice of EBM. Data were analysed with SPSS 12.0.

Results: Compared with the other physicians, FM specialists had significantly more Internet access, used the Internet for medical purposes more often and for longer hours, had published more scientific papers, searched MEDLINE or similar databases more often, and were more confident about conducting literature searches. FM specialists had significantly higher rates of training in EBM and critical appraisal. For all types of physicians surveyed, the main reported barrier to practicing EBM was lack of training in EBM.
Conclusions: Attitudes toward EBM differ significantly between GPs and FM specialists working in primary care in Turkey, which we believe results in variation in medical provision. The differences between these two groups of physicians should be investigated further, and means of improving the provision of care should be reported to policy makers."

[H4] GÖRPELİOĞLU, Süleyman; GÜREL, F. Serdar; ERSOY, Füsun, "Family Medicine Transition Period Training in Turkey", Procedia Social and Behavioral Sciences, Vol.1, p: 2748–2753, 2009, http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B9853-4VVXVR8-JW&_user=1010270&_coverDate=12%2F31%2F2009&_alid=1312943263&_rdoc=1&_fmt=high&_orig=search&_cdi=59087&_sort=r&_docanchor=&view=c&_ct=1&_acct=C000050262&_version=1&_urlVersion=0&_userid=1010270&md5=421330402a1ee981c961de5cb4f687c7

"Vocational training of general practice is a subject of discussion since 1970 in many European countries. In 2003, a health care reform was decided to be implemented in Turkey and by the time of implementation of reform studies, there had been negotiations among the stakeholders within general practice and it was decided that a retraining programme was essential for the practising physicians who are medical faculty graduates or specialists, other than family medicine, to practice in primary care. A two-phased temporary retraining programme that is called transition period training (TPT) was planned to meet the urgent need of practising doctors as family physicians. TPT covers all the physicians who want to work as a family physician, except the family medicine specialists. The first phase of TPT is an adaptation course, conducted face-to-face and the second phase is a blended learning (b-learning), that is a combination of e-learning and face-to-face competency based skills training."

[H4] ROBINS, Philip, "Public policy making in Turkey: faltering attempts to generate a national drugs policy", 2009, Policy & Politics, Vol.37, No.2, p: 289-306, 2009, http://www.ingentaconnect.com

"The caricature of public policy making in Turkey persists: a monolithic state and top-down political authority. There is some secondary literature, albeit limited, that challenges this image, and suggests greater state fragmentation. This cross-cutting case study of drugs policy in Turkey confirms this more differentiated experience. It illuminates the difficulties of process in the development of policy. It points to the disparities in capacity between different government agencies in generating change. For drugs policy itself, the article concludes that in the absence of domestic political will, other rewards, notably the benefits of international prestige and the resources that flow from it, are crucial in bringing about a nominal compliance with global norms."

[H4] HIDIROĞLU, Seyhan; ÖNSÜZ, M. Fatih, SÜLÜN, Serdar, TOPUZOĞLU Ahmet, KARAVUŞ, Melda, "Ümraniye İlçesinde Birinci Basamakta Görevli Sağlık Çalışanlarının Genel Sağlık Sigortası Hakkındaki Bilgi Düzeyi", TAF Preventive Medicine Bulletin, Vol: 8, No: 3, p: 245-250, 2009, http://www.korhek.org/makale.php?mno=545

"Knowledge about General Health Insurance of Health Workers Working in the Primary Health Care in Ümraniye"

"AIM: The aim of our study was to determine the knowledge of general health insurance of health workers working in the primary health care in Umraniye.

METHODS: This descriptive research performed on health workers working in 18 primary health care centres and the Province Health Dirocterate in Umraniye, between September and November 2006. We invited 250 health workers working in the primary health care centres to participate in the study. The study was carried out with 197 voluntary participants (78.8%). The data was collected with a three-part questionnaire which had 43 questions. In order to assess the knowledge points of general health insurance we gave one point for each correct answer. The data was evaluated using descriptive statistics, Mann-Whitney U test and Kruskall Wallis Variance Analysis.

RESULTS: The average age of the participants was 35.2 (±7.18, the minimum age was 22, maximum 55). 36.5% of participants had knowledge about the general health system. The most important knowledge source was media. There were significant differences between sex, group of career and knowledge point of general health insurance ($p<0.05$). The participants generally thought general health insurance had no effect (39.2%) on their families and that it was a negative effect (39.1%) on society.

CONCLUSION: In this study we confirmed that health workers had lacking knowledge of general health insurance. Also, the health workers generally thought that general health insurance would have harmful effects on their families and society or the same effects as the current system."

[H4] VUJICIC, Marko, SPARKES, Susan, MOLLAHALILOGLU, Salih, "Health Workforce Polycy In Turkey: Recent Reforms and Issues for the Future", Health, Nutrition and Population (HNP) Discussion Paper, 2009, http://siteresources.worldbank.org/

"The health status of the Turkish population has improved significantly over the past few decades, accompanying improvements in the scale and functioning of the health care system. Impressive progress has been made in expanding financial protection to the population, through expansions in the breadth and depth of health insurance coverage combined with service delivery reforms to improve equity in access to health services. This note summarises the main developments in the area of health workforce policy and how these have affected key health workforce performance outcomes. Specifically, the main objectives are to (i) summarise trends in key health workforce outcomes (ii) compare health workforce outcomes in Turkey to OECD and other countries (iii) discuss the impact of recent reforms in the health sector on health workforce outcomes and (iv) highlight key health workforce policy issues for the future."

[L] Long-term care

[L] AKSOYDAN, Emine, "Are Developing Countries Ready For Ageing populations? An examination on The Socio-Demographic, Economic and Health Status Of Elderly in Turkey", Turkish Journal of Geriatrics, Vol: 12, No: 2 p: 102-109, 2009, http://geriatri.dergisi.org/text.php3?id=427

"The proportion of older persons increases year by year and this group faces different problems than those of developed countries in terms of economic, social and political considerations. The purpose of this study was to evaluate the current situation of older persons in Turkey and discuss the challenges of interpreting the existing data regarding this population. In Turkey, from 1985 to 2000, the proportion of older persons in the total population increased from 4.2% to 5.7%. Projections show this proportion will increase to 9.1% by 2025. The majority of older persons are women, less urbanised, and have lower educational levels. 65% of them are not active in the labour force. The most common cause of death is cardiovascular disease. The increasing proportion of older persons in Turkey may lead to a decrease in families' ability to support them, and new arrangements for taking care of older persons may thus be required. Among the key issues of concern to policy makers are health and social services, home care, social security, social support, and proper education of those involved in the care of this population."

[L] ARPACI, Fatma; ERSOY, Ali Fuat, "Evde Yaşayan Yaşlıların Huzurevinde Yaşamaya İlişkin Görüşleri", Aile ve Toplum Eğitim Kültür ve Araştırma Dergisi, Yıl:11, Cilt:5, No:18, p:87-99, 2009,
http://aile.gov.tr/files/AILE_VE_TOPLUM_18_AILE_DERGI_18._SAYI.PDF
"Opinions of the Elderly Living at Home on Living in Nursing Homes"

This research was carried out to study the opinions of over 400 elderly in the city of Ankara living at home on living at nursing homes. The rate of the elderly who had not visited to a nursing home up to the time when the current study was conducted was 78.2%. 34.0% of the elderly thought that they would be able to live at nursing homes provided that it was inexpensive. According to the health status of elderly, the fact that they think of living in a nursing home in the case of mobility difficulties ($F = 5342$, $p < 0.01$) is affected by the status of education. In the case of urinary incontinence ($F = 3998$, $p < 0.01$) and faecal incontinence ($F = 3997$, $p < 0.01$) of elderly, thinking about living in a nursing home was regarded as significant, depending on age. Significant differences were at the ages of 65 years of age and younger and at the age of 81 and older among the elderly. It was found that, as the level of education of the elderly increased depending on their social status, the number of those thinking of living a nursery home increased ($p. < 0.01$). When the effects of age were examined, the fact that the elderly thought of living in a nursing home ($F = 2761$, $p < 0.05$) was found significant. The expressions of "When my family does not want me" ($t = 3:03$, $p<0.01$) and "when I feel alone" ($t = -2.27$, $p < 0.05$) varied according to the state of having children.

5 List of Important Institutions

Türkiye İş Kurumu (İş-Kur) - Turkey Employment Institution

Contact Person: Namık ATA
Address: General Directorkiye İş Kurumu Genel Müdürlüğü Atatürk Bulvarı Bakanlıklar, Ankara, Turkey
Webpage: www.iskur.gov.tr

Governmental Organisation.
Turkey Employment Institution manages and implements unemployment insurance. Main Recurring Publication: İş-Kur Bulletin.

Sosyal Güvenlik Kurumu (SGK) - Social Security Institution

Contact Person: Fatih ACAR, President of SGK Sosyal Güvenlik Kurumu
Address: Ziyabey Cad. No: 6 Balgat, Ankara/Turkey
Phone: 0090.312 207 80 00
Webpage: www.sgk.gov.tr

Governmental Organisation.
SGK manages the social security system and implements social security laws. Main Recurring Publication: Sosyal Güvenlik Dergisi / Social Security Magazine.

Sosyal Hizmetler ve Çocuk Esirgeme Kurumu - General Directorate of Social Services and Child Protection

Contact Person: Dr. İsmail BARIŞ General Director, ibaris@shcek.gov.tr
Address: T.C. BAŞBAKANLIK Sosyal Hizmetler Çoçuk Esirgeme Kurumu Genel Müdürlüğü Anafartalar Cad. No: 70, 06240 Ulus / Ankara/Turkey
Phone: 0090.312 310 24 60 – 80
Webpage: www.shcek.gov.tr

Governmental Organisation.
SHÇEK provides social services for elderly, women, children and disabled needy persons. Main Recurring Publication: Bulletins that are published by the provinces directorate of SHÇEK. Main Recurring Publication: n.a.

Sosyal Yardımlaşma ve Dayanışma Genel Müdürlüğü - General Directorate of Social Assistance and Solidarity

Contact Person: Aziz YILDIRIM General Director Social Assistance and Solidarity General Directorate
Address: Akay Caddesi No: 6 Bakanlıklar/Ankara/Turkey; Karanfil Sokak No: 67 Kızılay/Ankara/Turkey
Phone: 0090.312. 424 09 40 & 90.312.424 09 40
Email: sydgm@sydgm.gov.tr
Webpage: www.sydgm.gov.tr

Governmental Organisation.
"[...] The Social Assistance and Solidarity General Directorate as the state's most important social assistance and protection agency fulfils the state's social responsibility throughout the country by helping citizens who do not have social security , orphaned and needy and also by supporting employment-oriented training and projects."

Çalışma ve Sosyal Güvenlik Bakanlığı - Ministry of Labour and Social Security

Address:	T.C. Çalışma ve Sosyal Güvenlik Bakanlığı İnönü Bulvarı No:42 pk: 06520 Emek / Ankara/Turkey
Phone:	0090.312 296 60 00
Webpage:	www.calisma.gov.tr

Governmental Organisation.
MoLSS manages the labour and social security system. MoLSS implements and inspects labour legislation, and takes measures which regulate working life (See: Law Number 3146, Article: 2).

Sağlik Bakanlığı - Ministry of Health

Address:	T.C. Sağlık Bakanlığı Mithatpaşa Cad. No : 3 06434 Sıhhıye / Ankara/Turkey
Phone:	0090.312. 585 1000
Webpage:	www.saglik.gov.tr

Governmental Organisation.

Türkiye İşçi Sendikaları Konfederasyonu - Confederation of Turkish Trade Unions

Contact Person:	Mustafa KUMLU General President TÜRK-İŞ
Address:	Bayındır sok.No:10 06410Kızılay Ankara/TURKEY
Phone:	0090(312) 433 31 25 (pbx)
Fax:	0090.0312. 433 68 09
Email:	turkis@turkis.org.tr
Webpage:	www.turkis.org.tr

Non Governmental Organisation.
TÜRK-İŞ is the biggest Confederation of Trade Unions in Turkey. It is also the first Confederation to be established in Turkey. It was established in 1952. As of January 2008, TÜRK-İŞ has 2,154,132 members (according to the statistics of the Ministry of Labour) organised within its 33 affiliated unions in 28 industrial branches. Most affiliated unions have a membership with their corresponding ITS's. Main Recurring Publication: Türk-İş Dergisi (Magazine).

Hak İşçi Sendikaları Konfederasyonu - HAK-İŞ Trade Union Confederation "The Confederation of Turkish Real Trade Unions"

Contact Person:	Salim USLU HAK-İŞ KONFEDERASYONU
Address:	Tunus Cad. No:37 Kavaklıdere/Ankara/Turkey
Phone:	0090.312.417 80 02 - 417 79 00
Fax:	0090.312.425 05 52
Email:	hakis@hakis.org.tr
Webpage:	www.hakis.org.tr

Non Governmental Organisation.
The Confederation of Turkish Real Trade Unions (HAK-İŞ) was set up on 22 October 1976 in Ankara. Today, HAK-İŞ has 9 affiliate trade union members.

Devrimci Işçi Sendikaları - Confederation of Progressive Trade UNIONs

Contact Person:	Süleyman ÇELEBİ General President
Address:	ABİDEİ HÜRRİYET CAD. NAKİYE ELGÜN SOK. 117 Şişli - İstanbul/TURKEY
Phone:	0090 212 2910005
Fax:	0090 212 2342075
Email:	disk@disk.org.tr
Webpage:	www.disk.org.tr

Non Governmental Organisation
DİSK was established in 1967. 18 Trade Unions are members of DISK.

Türkiye İşçi Emeklileri Cemiyeti - Turkish Retired Workers Association

Contact Person:	Kazım ERGÜN General President TÜRKİYE İŞÇİ EMEKLİLERİ DERNEĞİ
Address:	Anıttepe Mh. Işık Sk. 11/1, Tandoğan - Ankara /TURKEY
Phone:	0090.0312 230 34 28-29-89
Fax:	0312 230 16 41-92
Email:	tied@tied.org.tr
Webpage:	www.tied.org.tr

Non Governmental Organisation
TİED was established in 1970. It has more than 1 million members. It has 86 branch offices. TIED is represented in the Social Security Institution and Social Security Advisory Board.

Türliye Kamu Çalışanları Sendikaları Konfederasyonu - Turkey Civil Servant Trade Union Confederation

Contact Person:	Bircan AKYILDIZ General President KAMU-SEN
Address:	Dr.Mediha Eldem Sokak No:85, Kat:1 06640 Kocatepe / Ankara/TURKEY
Phone:	00.90. 312. 424 22 00 (Pbx)
Fax:	00.90.0312 424 22 08
Webpage:	www.kamusen.org.tr

Non Governmental Organisation
KAMU-SEN is a trade union confederation for civil servants.

MEMUR-SEN Memur Sendikaları Konfederasyonu - Confederation of Public Servants Trade Unions

Contact Person:	Yusuf YAZGAN General President MEMUR-SEN
Address:	Özveren Sok. No: 9 Kat:4 Demirtepe / Ankara
Phone:	0090.312 230 48 98
Fax:	0090.312 230 39 89
Email:	info@memursen.org.tr
Webpage:	www.memursen.org.tr

Memur-Sen is a trade union confederation for civil servants.
Main Recurring Publication: Kamuda Sosyal Pollika/ Social Policy in Public.

Kamu Emekçileri Sendikaları Konfederasyonu - Confederation of Public Employees Trade Unions

Contact Person:	Sami EVREN General President
Address:	Çehre Sokak No:6/1 Gaziosmanpaşa Ankara –TURKEY Phone: 0090.312 436 71 11
Email:	90.312 436 74 70
Webpage:	www.kesk.org.tr

Non Governmental Organisation
KESK is a trade union confederation for public employees.

Türk Tabipleri Birliği - Turkish Medical Association

Address:	Gazi Mustafa Kemal Bulvarı Ş. Daniş Tunalıgil Sok. No: 2 / 17 - 23 Maltepe /Ankara 7 TURKEY 06570
Phone:	90 312 231 31 79 & 90 312 231 19 52
Email:	ttb@ttb.org.tr
Webpage:	www.ttb.org.tr

The Turkish Medical Association (TTB) is the organised voice of physicians in Turkey, under constitutional guarantee. It is a public association founded under Law number 6023. 80% (83,000) of the country's physicians are members of the TTB. Its main income source are membership fees. Main Recurring Publication: Toplum ve Hekim Dergisi (Community and Physician Review).

Türkiye İşverenler Sendikası Konfederasyonu - Turkish Employer Association Confederation

Contact Person:	Tuğrul KUTADGOBİLİK General President
Address:	Hoşdere Cad., Reşat Nuri Sokak No. 108 06540 Çankaya / ANKARA
Phone:	0090 312 439 77 17 (pbx)
Fax:	0090 312 439 75 92-93-94
Email:	tisk@tisk.org.tr & gensec@tisk.org.tr
Webpage:	www.tisk.org.tr

Non Governmental Organisation;
TISK is the biggest employer association and the unique qualified employer organisation's confederation for collective agreement.
Main Recurring Publication: TİSK Akademi Dergisi (TİSK Academy Review), Işveren Dergisi (Employer Magazine).

Türkiye Esnaf ve Sanatkarları Konfederasyonu - The Confederation of Turkish Tradesmen and Craftsmen

Contact Person/	Bendevi PALANDÖKEN General President TESK
Address:	Tunus Caddesi No. 4, 06680 Bakanlıklar / Ankara/TURKEY
Phone:	0090.312 418 32 69
Fax:	90.312 425 75 26
Email:	info@tesk.org.tr
Webpage:	www.tesk.org.tr

Non-Governmental Organisation
The Confederation of Turkish Tradesmen and Craftsmen (TESK) has a country-wide organisational structure with its 13 Sector Occupational Federations, 82 Tradesmen and Craftsmen Union of Chambers and 3,171 Local Occupational Chambers. It is representing nearly 1.8 million tradesmen and craftsmen members working in service and production sectors. All of its managers are assigned to their positions through democratic elections

carried out by its members, and it is managed by an administration board consisting of 15 persons. Main Recurring Publication: Vitrin Dergisi (Vitrin Magazine).

Türkiye Odalar ve Borsalar Birliği - The Union of Chambers and Commodity Exchanges of Turkey

Contact Person:	Rıfat HİSARCIKLIOĞLU President TOBB
Address:	Atatürk Bulvarı No:149 Bakanlıklar/Ankara/TURKEY Phone: 0090-312-413 80 00
Fax:	0090.312.418 32 68
Webpage:	www.tobb.org.tr

Non-Governmental Organisation
"The Union of Chambers and Commodity Exchanges of Turkey (TOBB) is the highest legal entity in Turkey representing the private sector.
Similar to the patterns of guilds and syndicates, which traditionally organised and represented tradesmen and producers throughout Turkish History, TOBB, too, adopted a representative role in a democratic and modern society.
Today, TOBB has 365 members in the form of local chambers of commerce, industry, commerce and industry, maritime commerce and commodity exchanges."
Main Recurring Publication: Ekonomik Forum Dergisi (Economic Forum Magazine) .

Türkiye Ziraat Odaları Birliği - Foundation and Organisation of the Union of Turkish Chambers of Agriculture

Contact Person:	Ş. Şemsi BAYRAKTAR General President
Address:	Gazi Mustafa Kemal Bulvarı No:25 Demirtepe 06440 Ankara 7, TURKEY
Phone:	0090 312 231 63 00
Fax:	90 312231 76 27
Email:	ziraatodalari@tzob.org.tr
Webpage:	www.tzob.org.tr

"As it is stated in Law No. 6964, which differs from Law No. 2979 by the first article: "Chambers of Agriculture are responsible for professional services to the agricultural sector and for assisting the government in developing its agricultural plans and programmes, covering the mutual needs of farmers, facilitating professional activities, protecting duty, professional discipline, ethic and unity. The Union of Turkish Chamgers of Agriculture is a public association which is a legal personality".
The duties of the chambers are detailed in Law No. 6964, Article 3. Chambers of Agriculture are responsible for gathering data about farmers, production input serving and distributing output, recording combines, organising courses with other agricultural organisations, meetings and giving support to social activities."
Main Recurring Publication: Çiftçi ve Köy Dünyası Dergisi (Farmer and Village World Magazine).

Türkiye Sanayici ve İşadamları Derneği - Turkish Industrialist and Businessmen's Association

Address:	TÜSİAD Türk Sanayicileri ve İşadamları Derneği Merkez, İstanbul
Phone:	90.212 249 19 29
Fax:	90.212. 249 13 50
Email:	tusiad@tusiad.org
Webpage:	www.tusiad.org.tr

Non-Governmental Organisation
TUSIAD is an important employer organisation in Turkey. TUSİAD examines economic and social problems in order to contribute to problem solving.
Main Recurring Publication: No; others: Reports about social security and health reform.

Sosyal Politika Forumu - Social Policy Forum

Contact Person/Address:	Prof. Dr. Ayşe Buğra
Address:	Boğaziçi Üniversitesi Sosyal Politika Forumu Kuzey Kampus, Otopark Binası Kat.1 No. 119 34342 Bebek-Istanbul-TURKEY
Phone:	0090.212. 359 7563-64
Fax:	0090.212. 287 1728
Email:	spf@boun.edu.tr
Webpage:	http://www.spf.boun.edu.tr

University Research Centre
Main Objectives: "The Social Policy Forum is a research and policy centre founded at Boğaziçi University with the objective of generating critical knowledge pertaining to the main issues of social policy. The Forum aims to instigate and contribute to the debate on social policy and citizenship rights, carry the European experience and perspective on social policy and welfare reform to the Turkish context, and foster a deeper interest among intellectuals, policy-makers and media in social policy-making in Turkey."
Main Recurring Publication: Working papers, reports.

Fişek Enstitüsü - Fisek Institute Science and Action Foundation for Child Labour

Contact Person:	Prof. Dr. A. Gürhan FİŞEK
Address:	Selanik Cad. 52/4 Kizilay-Ankara, 7, TURKEY
Webpage:	http://www.fisek.org.tr

Non-Governmental Organisation
The Fisek Institute is a non-governmental organsiation acting in the field of occupational health and safety at the national level. It focuses on the continuation and enrichment of the community medicine philosophy by its applicaitons especially for smal and medium scale enterprises and working children.
Main Recurring Publication: Çalışma Ortamı Dergisi (Work Environment Review).

Çalışma ve Sosyal Güvenlik Derneği - Labour and Social Security Association

Contact Person/Address:	İsa KARAKAŞ President SSK İşhanı A Blok Kat:8 No:510 Kızılay-Ankara-TURKEY
Postal Address:	404 Mithatpaşa Caddesi-Yenişehir-Ankara-TURKEY
Email:	tcsgd@tcsgd.org
Webpage:	http://www.tcsgd.org.tr

Non-Governmental Organisation

The Labour and Social Security Association aims at designing projects within social security to ensure the right to access to social security for everybody, to inform the public and to contribute to social dialogue processes. Main Recurring Publication: Sosyal Diyalog Dergisi (Social Dialogue Review).

KEİG Kadın Emeği ve İstihdam Girişimi - The Initiative For Women's Labour and Employment

Address:	SEKRETERYASI KADAV İstiklal Caddesi Gazeteci Erol Dernek Sokak Hanif Han No: 11/5 Beyoğlu İstanbul,7,TURKEY
Phone:	0090.212 251 58 50
Fax:	0090.212 251 58 51
Email:	iletisim@keig.org
Webpage:	http://www.keig.org

Non-Governmental Organisation

"*The Women's Labour and Employment Initiative Platform (KEIG) in Turkey is a newly established platform of NGOs, academics, local authorities, labour unions and semi-public institutions to promote a gender perspective in labour and employment issues[…].The main aim of the platform is to make women's domestic and public labour visible and recognised, to disseminate research and information on issues of women's labour and employment and to combat discrimination against women by proposing policies towards equal opportunities for employment, decent working conditions and decent income in Turkey.*"

Sosyal Güvenlik Müfettişleri Derneği - Social Security Inspectors Association

Contact Person/Address	Mehmet UZUN President
Address:	SSK İşhanı B-1 Blok Kat : 5 No : 226 06420 Kızılay-Ankara/TURKEY
Phone:	90.312 435 37 64
Fax:	90.0312 435 37 26
Email:	sosgum@ttmail.com
Webpage:	http://www.simder.org.tr/

Non-Governmental Organisation

The Social Security Inspectors Association aims at protecting its members' rights and publishes magazines, books, reviews about social policy and social security problems.
Main Recurring Publication: Sosyal Güvenlik Dünyası (Social Security Review).

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en