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Equity in access to care in the era of health system reforms in Turkey

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ABSTRACT

Objective: To evaluate access to healthcare from an equity perspective on the way toward Universal Health Coverage in Turkey.

Methods: The country representative data from 2006 to 2013 Turkey Income and Living Conditions Surveys were analyzed. Private household residents aged fifteen and older were asked for self-reported unmet need for medical care in the past twelve months. The dependent variable had three categories: no unmet need, unmet need due to cost, and unmet need due to availability (waiting list and distance problems). Predictors of unmet need were assessed by a multinomial logistic regression analysis.

Findings: The prevalence of unmet need declined between 2006 and 2013. While educational inequalities in declared unmet need also decreased, the income gradient becomes more important. In 2013, controlling for other factors, the propensity to report unmet need was 10 times higher for those in the poorest-income quintile compared to the richest (versus 7 times in 2006).

Conclusion: Overall access to healthcare has gradually improved in Turkey in the health reform process, but 9% of people still declared unmet need due to cost in 2013, after the implementation of Universal Health Insurance. This was nearly four times the EU average. Unfavourable economic and labour market conditions can be challenges for effective universal health coverage.

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1. Introduction

Health is a universal human right and basic human need. Improving the health of the population is a main goal in any health care system together with improving responsiveness to population needs and fairness of financing [1,2]. Access to safe and effective healthcare is an essential determinant of health. Aiming to reduce inequalities in health, many governments have targeted the health system to improve access to healthcare and to more equitably distribute health services across the population [3].

Access to healthcare points to the ability of people to reach appropriate healthcare services without any obstacle and in a timely fashion. Barriers to healthcare access include financial reasons, unavailability of healthcare providers, long travelling distance, and excessive waiting time [4].

Two interrelated essential components to achieve effective universal health coverage (UHC) are access to coverage for needed health services (prevention and treatment) and with financial risk protection [5]. Many studies have used coverage levels and equi-

table utilization of health services as proxy measures for access, but it is not always possible to identify those unable to access care precisely because their lack of utilization is unobserved [6]. Self-reported unmet need and forgone care was proposed as an important indicator for assessing access inequalities especially with disaggregation of unmet need by stated reasons that allow for a more meaningful interpretation of the indicator [3]. Daniels [7], referring Sloan and Bentkover's study, emphasized that access to healthcare cannot be considered equitable if getting care is much more difficult for some than for others. He added that process variables such as travel or waiting time might vary by income groups, and such variations were likely to be captured more by subjective (satisfaction) measures of realized access even if they did not affect objective (utilization rate) measures. Measuring equity in access to health care is a complex issue involving many theoretical aspects [7–9]. Self-reported unmet health care need is potentially a robust indicator for this contentious issue.

Turkey's healthcare system has been undergoing a transformation (Health Transformation Program, HTP) since 2003, and some important changes have occurred in both provision and financing of healthcare services [10,11]. Prior to the HTP, healthcare provision and funding were shared between the Ministry of Health (MoH) and Social Insurance Organization (SIO) with each having its own

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hospitals, benefit packages, and funding rules. Despite its relatively small share of the market, the private sector also played an important role, since many public-sector physicians had dual practice and could work part-time in private facilities [12].

In 2003, approximately 70% of total health expenditure (THE) was financed publicly in Turkey. At the core of public health financing arrangements in the beginning of the HTP was the social security system, which was established in 1946 and had evolved significantly during the 1960s and 1970s [10]. In this system, there were three separate health insurance funds: i) SIO for the wage earners in the public and private sectors, ii) the Social Security Organization for Artisans and the Self-Employed, and iii) the Government Employees Retirement Fund (GERF). Active civil servants were not included in the GERF, and their healthcare expenses were directly financed from the state budget. In 1992, the government had introduced the Green Card program that provided health benefits to the poor [10]. Each of these different insurance schemes had distinct benefits packages and access rules. Active and retired civil servants and their dependents had the most generous benefits package and could seek care in university hospitals as well as public MoH facilities; those insured by SIO (mostly wage earners) could not use these hospitals, only SIO facilities [11,12].

The HTP started at the end of 2003. An important step toward establishing a purchaser–provider split was the transfer of SIO healthcare facilities to the MoH in 2005 [11,12]. Healthcare utilization rules and benefits packages were gradually equalized between all insurance schemes [11]. Attempts to integrate the fragmented structure of health care finance resulted in a unified health insurance system in Turkey, and legislation of a universal health insurance (UHI) scheme was put in force as of January 2012 [13,14]. Aran and Hentschel have highlighted the key role of an existing non-contributory insurance program—the Green Card scheme—in the smooth transition process for UHI in Turkey [15].

The premium rate for UHI has been set at 12.5% of earnings; 7.5% is paid by the employer and 5% by the employee. Individuals whose per-capita monthly income is less than one-third of the gross minimum wage are covered by the State [16]. No copayments are required from people visiting their own family physicians. However, outpatient visits to hospitals without referral are subject to copayment at a fixed rate declared by the Social Security Institute. There are also copayments for pharmaceutical prescriptions of about 20% (10% for retirees) [16,17].

THE, as a share of GDP in 2003, was 5.3%; it increased to 6.1% in 2008–2009 then decreased to 5.4% in 2015. Government health expenditure as a share of total government expenditure increased from 72% in 2003 to 77% in 2013. While the level of per-capita out-of-pocket (OOP) expenditure increased between 2003 and 2013 (from PPP-US\$87 to PPP-US\$172), OOP payments, as a share of THE, declined from 18.5% in 2003 to 15.4% in 2013 [12,18].

Increases in health expenditures have been mirrored by increases in the supply of health care services in Turkey over the past ten years. Between 2002 and 2012, the overall health workforce increased by 36%. Despite these increases, Turkey remains below the average per-capita health workforce (GP, nurse) of OECD countries [12].

Financial protection indicators like catastrophic health care expenditure and impoverishment due to health care have improved in this period [19]. Equity in access to healthcare is one of the important aspects of UHC, and, unfortunately, little information is available over time on utilization of services across income groups in Turkey to monitor any changes [20,21]. Since social health insurance has become the primary financing mechanism for health care in the health reform process in Turkey, it will be interesting to evaluate its potential effects on the equity of access to care.

This study aimed to determine the changes in equity in access to healthcare in Turkey in the era of the HTP of the MoH. Self-reported

unmet health need was used as a proxy indicator for access to care. Health care needs were adjusted by considering gender, age, and some health status variables.

2. Materials and methods

The European Union (EU) Statistics on Income and Living Conditions (EU-SILC) is a survey aiming at collecting timely and comparable cross-sectional and longitudinal multidimensional micro data on income, poverty, social exclusion, and living conditions. Starting with seven countries in 2003, this survey now covers 28 EU member countries plus four non-EU members (Iceland, Turkey, Switzerland, and Norway). The EU-SILC is also one of the surveys conducted in Europe that reveals prevalence and reasons for subjective unmet health care need. This instrument is anchored in the European Statistical System [22].

The first implementation of SILC-Turkey was conducted in April–June in 2006 and included 12,872 households. A rotational design was used in this survey methodology, replacing 25% of the sample with new participants each year [23]. In our analysis, we could not use a panel-data approach but ran regressions separately for two years, 2006 and 2013, which was the end year of the HTP of Turkey. We have also pooled and analyzed these two years' data concertedly to obtain statistical significance of changes between these periods. Besides these two years' surveys, data belonging to the eight-year period of 2006–2013 were analyzed to reveal the trend of unmet health care need prevalence in Turkey. Descriptive statistics of the surveys were displayed only for 2006, 2010, and 2013.

Private household residents aged fifteen and older were asked for self-reported unmet need for medical care in the past twelve months as follows:

Was there any time during the last twelve months when, in your opinion, you personally needed a medical examination or treatment for a health problem but did not receive it?

A following question asked the reasons for the reported unmet health care need (please see the first column of Table 2). In our study, following Hernandez-Quivedo et al.'s approach [24], three possible reasons for “unmet need” were chosen for their importance from a policy perspective: *unmet need due to cost*, *unmet need due to waiting list*, and *unmet need due to distance*. The reasons less clearly relevant to policymakers, such as that the respondent wanted to wait to see if the problem got better on its own, did not know any good doctor, feared doctors, and could not take the time, were not treated as unmet need in this study. The dependent variable had three categories: no unmet need (responses like “fear of doctors” or “wanted to wait to see if the problem got better on its own” were also included in this category), unmet need due to cost, and unmet need due to availability (waiting list and distance problems).

Independent variables were age, gender, health outcomes, income level, education and employment status, and region of residence (rural–urban). Considering a possible age and gender interaction, six age–gender groups were created.

The EU-SILC includes three variables regarding health outcomes: self-assessed health status, presence of chronic health condition, and presence of limitation in daily activities. Income quintiles were formed by assigning individuals household disposable equivalent income. A modified OECD equivalence scale was used in this calculation. Educational statuses of the individuals were assessed according to their graduation and grouped into two categories: lower secondary or less and upper secondary or more. The self-declared main activity status in the EU-SILC questionnaire was the variable capturing the person's own perception of his or her

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