HEALTH FOR ALL BY THE YEAR 2000 AND PRIMARY HEALTH CARE: THE TURKISH CASE

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All the errors of the study are entirely mine.

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LIST OF ABBREVIATIONS

CHW : Community Health Worker

EC : European Community

EPI : Expanded Programme on Immunization

GERF : Government Employees Retirement Fund

GNP : Gross National Product

HFA : Health for All

IMR : Infant Mortality Rate

MH : Ministry of Health

MP : Member of Parliament

NUC : National Unity Committee

PHC : Primary Health Care

PLA : Provincial Local Administration

SIO : State Insurance Organization

SIS : State Institute of Statistics

SPHC : Selective Primary Health Care

SPO : State Planning Organization

UNICEF : United Nation's Children's Fund

WHO : World Health Organization

ABSTRACT

This study aims at analyzing Turkish health policy from a Primary Health Care perspective as pronounced in Alma-Ata, 1978. The Alma-Ata Declaration has long been regarded as a watershed in the health field and 134 countries, including Turkey, have endorsed the Declaration showing their support for the views expressed in the Document. However, although the international community gave its full support, in practice, different interpretations and implementation of the principles have emerged.

Turkey, one of the countries where health has rarely occupied the agenda, has been undergoing radical reforms since the mid 1980s with the ultimate aim of achieving Health for all by the Year 2000 through Primary Health Care. There is full commitment at the national policy-making level to endorse policies coherent with the principles of Alma-Ata. However, not all policies adopted seem to be consonant with what was declared in Alma-Ata, requiring a detailed analysis of the policies suggested and implemented. In the light of this, the aims of the study are: (1) to analyze Turkish health policy since the 1960s from a Primary Health Care perspective with the aim of exploring the Turkish response to Alma-Ata; (2) to explore the perceptions of Turkish health policy-makers about Primary Health Care and related issues; (3) to discuss the prospects for Primary Health Care in Turkey.

Basic principles of the Primary Health Care approach as declared in Alma-Ata have been taken as a guideline in analyzing Turkish health policy and the perceptions of the Turkish health policy-makers. These principles and their implementation, or the way they are perceived, have guided the research in answering the question "what are the prospects for Primary Health Care in Turkey?" The nature of the research, based on document analysis and semi-structured interviews, has necessitated a qualitative stance.

It was concluded that the Turkish version of Primary Health Care differs from the Declaration in a number of ways. A number of possible reasons for this have been offered. The perceptions of the policy-makers on certain issues that are closely related with the Approach, *inter alia*, has been found as one of the most possible explanations behind the current situation and a need to alter the ascendant approach towards health issues in general has been emphasized.

CHAPTER I. INTRODUCTION

A. BACKGROUND AND THE AIMS OF THE STUDY

The Alma-Ata Declaration of 1978, a joint initiative of the World Health Organization (WHO) and United Nations Children's Fund (UNICEF), has been regarded as a watershed in the health policy field. Although the evolution of the Declaration and the philosophy it pronounced go back to the 19th century, the Declaration is considered as a turning point in that the international community gave its seal of approval unanimously. In Alma-Ata, the Primary Health Care (PHC) approach was proclaimed as the sole way of attaining the WHO's global goal of Health for All (HFA) by the year 2000 and the prerequisites and requirements of a system based on the principles of the Approach were delineated.

The PHC approach emerged as a reaction to the deteriorating health conditions around the Globe. Contrary to the widely held belief in the 1960s, that economic growth would inevitably bring about improvements in health indicators, along with other social improvements, these indicators worsened in some parts of the world regardless of the achievements in economic terms. On the other hand, research on some country-wide experiences revealed the existence of countries that had poor economic indicators but better health indicators than their well-off counterparts. Their experiences became the major inspiration source for the development of the PHC approach.

PHC, an approach that is viable both for the developed and developing world, is a comprehensive approach to improving health status and is closely related to the development process itself. It not only involves the health sector but other sectors that have an impact, directly or indirectly, on the health status of the people. The principles it brings and the prerequisites it poses form a challenge to the widely held medical approach that has been the dominant thinking over time. It can be a viable solution especially for developing countries trapped in the vicious circle of economic constraints and social deprivation.

However, despite the facts that the Approach brought about a fresh challenge to the current thinking on health and the Declaration was ratified by all participants in the conference, reflecting the overall consensus reached, the same enthusiasm did not materialize in practice. Since the Declaration, a number of countries have embarked on programmes to show their commitment to what was declared in Alma-Ata. In some instances these initiatives remained on paper without any concrete attempts to deliver the promises and in some others they were restricted to piecemeal initiatives such as Community Health Worker (CHW) and community financing schemes mainly financed by external bodies. Confusion over the meaning of PHC and emergence of different definitions and interpretations of the concept appeared immediately after the Declaration. Advocacy of the Selective PHC (SPHC) approach, a narrowing down of the broad definition of the concept pronounced in

Alma-Ata, identification with cheap, low technology medicine for the poor and confusion with primary medical care services have been the major outcomes so far. Although 14 years have passed since the Declaration, a country-wide achievement or even substantial progress towards HFA is yet to be seen.

Turkey, one of the signatories of the Alma-Ata Declaration, with her development level and other indicators, including health, is a developing country by all standards. The health status indicators of the country, inequalities among regions and different segments of the society, problems related to the organization and financing of the health sector and the isolation of the health sector from others reveal the need to reconsider the current approach on health and related issues. In this case the possible contribution of the inception of the PHC approach to improve the health level of the population is evident. However, despite a need for immediate attention to the subject, the health issue in general does not generate public attention and this tendency is reflected among the academia as well. Although this apathy seems to have changed since 1987 with the reorganization initiatives and since then health and health issues are discussed more vigorously at different levels, research in the health sector is rare. The available research, however appropriate it is, is mainly on certain aspects of hospital services. On the other hand, research on health policies at the national level is virtually non-existent. In this respect, this

study is a unique example of its kind both as it adopts a policy perspective and involves the analysis of PHC policies.

The concepts of PHC and HFA did not occupy the agenda until the late 1980s. The 1990 National Health Policy Document (Sağlık Bakanlığı, 1990a), prepared to determine the objectives by the year 2000 and strategies to achieve them, is a turning point as regards the Turkish commitment to the global goal. The Document, a unique example of the involvement of the Ministry of Health (MH) in health policy-making, introduces a new model of organization and financing of health services. It also declares to the World that the Turkish government is committed to organizing health services according to the spirit of the Alma-Ata and to achieve HFA. Apart from this initiative, there is also another attempt by the State Planning Organization (SPO) that aims at reorganizing the health sector. The Master Plan Study, whose recommendations are yet to be implemented, is the major outcome of this initiative for the time being.

The aforementioned brief presentation reveals that Turkey has pronounced her commitment to achieving HFA by the year 2000 and to the PHC approach. However, at the national policy-making level, the policies adopted so far raise doubts about this commitment. Although it has been explicitly declared that the PHC approach will be the core of the reorganized health sector, the policies adopted do not seem to support this

pronouncement, nor does the practice so far. To elucidate this argument, the aims of the study can be stated as follows:

1. To analyze Turkish health policy since the 1960s from a PHC perspective with the aim of exploring the Turkish response to Alma Ata;

2. To explore the perceptions of Turkish health policy-makers about PHC and related issues; and in light of these,

3. To discuss the prospects for PHC in Turkey.

B. METHODOLOGY AND ORGANIZATION OF THE STUDY

a. Methodology

In order to realize the aforementioned aims, a qualitative approach has been adopted. Document analysis and semi-structured interviews conducted with health policy-makers constitute the backbones of this study. The nature of the study and its policy analysis perspective, together with the aim of trying to find out the perceptions of policy-makers justify the selection of a qualitative stance.

Qualitative research, defined as "a kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Strauss, Corbin, 1990: p.17), has gained impetus since the 1960s. The debate about qualitative vs. quantitative has not reached a conclusion and the aim here is not to delve into the field which requires an in depth and critical analysis. The aim, however, is to introduce the methodology used during the Study and to point out certain characteristics of the research that will shed light on the findings.

Qualitative research, developed from different traditions of different disciplines in social and behavioral sciences offers and adopts a variety of perspectives and methods (Patton, 1990: pp.66-90). The nature of this study, that inquires about the perceptions of PHC and related issues, requires a phenomenological focus. Phenomenology, that can be viewed as a paradigm, philosophy or a perspective, focuses on the question "what is the structure and essence of experience of this phenomenon for this people?" (Patton, 1990: p.69). The task of the phenomenologist is defined by Bryman where he stated that "the phenomenologist views human behaviour as a product of how people interpret their world. The task of the phenomenologist...is to capture this process of interpretation. In order to grasp the meanings of a person's behaviour, the phenomenologist attempts to see things from that person's point of view" (Bryman, 1988: p.53). The interviews conducted among the health policy-makers that aimed at exploring their views of PHC and related issues, in other words,

their interpretations of those concepts, epitomize the phenomenological focus adopted.

At the outset, a literature review, mainly with the aim of exploring the necessary areas to delve into was carried out. This review was crucial especially in determining the areas to be involved during the interviews with the policy-makers. As stated earlier, both semi-structured interviews and document analysis were adopted as the techniques to meet the aims of the Study. Triangulation of data sources (Patton, 1990: p.464) in such a way is regarded as a process that helps to avoid biases that can occur by using only one method. The document analysis part of the research, apart from providing a historical account of the health policies adopted over time and reactions from different parties to these policies, provided a reference point to verify the majority of the interviewees.

The document analysis part of the research covers mainly the period from the 1920s to the present time. The aims of such an attempt are numerous, viz. to draw a picture of the policies adopted since the foundation of the Republic; to analyze the trends and changing ideas about health; to find out the perceptions about health and related matters; to investigate reactions from different parties to certain policy options; to analyze the PHC policies from an Alma-Ata perspective; to explore the perceptions of PHC; and last but not least to extrapolate the prospects for PHC in

Turkey by adopting a critical approach especially to the recent developments. The documents analyzed to serve these aims are as follows:

1. Health legislation
2. Five Year Development Plans and Annual Programmes
3. Government programmes
4. Various publications of the MH
5. Various publications of the SPO
6. Minutes of the MH's budget meetings in the Parliament between 1963-1991[1]
7. Publications of international organizations about the Turkish health care system
8. Minutes of the meeting for the "Reorganization of Health Services" in the MH
9. Minutes of the meeting for the Socialization Act by the National Unity Committee
10. Various publications of the Ministry of Interior
11. Political party manifestos
12. Reports by outside consultants
13. Publications of the State Institute of Statistics, Social Insurance Organization, Hacettepe University, The Turkish Medical Association

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[1]. Until 1980 two different chambers formed the Parliament: The Senate and The General Assembly. The debates were made first in the Senate and then sent to the General Assembly for ratification. After the 1980 military coup the Senate was abolished. In the research both chambers' minutes were analyzed.

As stated earlier, a semi-structured interview prepared for the policy-makers constitutes a vital component of the research. As the research is mainly concentrated on policies at the national level and as the implementation process and reflection of policies at the periphery are of little concern to the study, the interview concentrated mainly on people who played a key role in determination of health policies. The ultimate aim of the interview was to find out the perceptions of policy-makers on PHC and related issues. The interview was crucial especially at a time when the Turkish health system was undergoing radical reforms supposedly in line with the spirit of the Alma-Ata Declaration. The perceptions of the major actors behind these policies are inevitably reflected in the recommendations they make. PHC is perceived differently across the World and, hence, interpretations do vary accordingly. Although the implementation process is affected by various factors, as will be discussed later, the interpretation of PHC can play a salient role in a country's practices. Since Turkish policy shows some considerable variation from the WHO's definition, there is a particular need to explore the policy-makers' perceptions on issues regarding PHC. In this case the interviews played a salient role in determining and discussing the future of PHC in Turkey.

The interview falls into the "elite interviewing" category defined as "the specialized treatment of interviewing that focuses on such people who are usually selected for interviews on the basis of their expertise" (Marshall,

Rossman, 1989: p.94). The interviewees selected occupied the highest positions as far as the state apparatus is concerned, bringing all the drawbacks of such an interview form that are elaborated in detail elsewhere (Groholt, Higley, 1972; Marshall, Rossman, 1989; Moyser, 1988). The most prominent of these, the problem of gaining access needs special consideration. As stated by Moyser (1988: p.119), gaining access is not only related to getting the permission or acceptance for the interview but also related to obtaining the cooperation of the interviewee. Both of these considerations did not create serious problems in this Study basically for two reasons. First of all, the background of the interviewer, being a member of staff in a university in Turkey and studying for a degree in a foreign university played an important role in both gaining access and later obtaining cooperation with the interviewees. In the majority of cases the request for an interview was accepted at the first contact. When this did not happen, intermediaries were used in order to gain access. Apart from an interviewee who did not accept to be interviewed, all requests for an interview were granted either after the first contact or after using intermediaries. Second, as stated earlier, this study in the health sector is a unique example as no attempt at this level has been made earlier. At the time of the interview, health was a hot political issue on the agenda as the reorganization attempts were at their peak. The policy-makers from different organizations and different quarters were keen to make their points known and to make their position clear. This element acted as an incentive both to accept the request for an interview and to collaborate.

People opposing the recent reforms saw the interview as an opportunity to declare their opposition. On the other hand, the interviewees on the opposite end who were active participants in the reorganization process also had a very strong motive to justify and explain their proposals. The most important sign of this overall collaboration was the fact that in the majority of cases, the agreed duration of time for each interview was exceeded and some of the interviewees even agreed to be interviewed after office hours. On the whole, the interviewees were frank and open. Another sign of this cooperation was their willingness to provide the researcher with documents, some of which were regarded as confidential.

The researcher's familiarity with the sector in general and some policy-makers in particular helped to identify people to be interviewed. Purposeful sampling, as opposed to random sampling in quantitative research, requires selecting information-rich cases to reach the aims of the research (Patton, 1990: p. 169). As stated earlier, this Study involved only the health policy-makers at the national level. While determining the people to interview, the major stance taken was to reach people who played an active role in determining policies. To this end, first of all the major institutions that have the responsibility for producing health policies were determined. As far as organizations are concerned two were the main targets: the MH and SPO. In the MH, identifying people who were involved directly in the policy-making process was a formidable task not only because of the complex organizational structure of the Ministry but

also because of the rigid bureaucratic rules imposed on people. The Minister and his Undersecretary were obvious actors. However, the lower levels were problematic. The Director Generals of departments mainly deal with routine day to day activities of their departments and their contribution to the policy-making process is restricted. For that reason, interviewing them would not serve the aims of the research. Besides, their contribution would have been limited because of the strict restrictions upon them regarding public statements. As experienced during the research, the interviewees at that level did not want to be tape recorded, fearing their answers would be publicized. The breakthrough came when the researcher was interviewing the Undersecretary as she was introduced to two ministerial advisors who turned out to be the main actors in the recent policy initiatives. Their position in the MH was prominent and even after the change in the government they kept their places in the Ministry and were even promoted (quite unusual for the Turkish politics). The two were the architects of the "Turkish National Health Policy Document" and recent reorganization proposals and at the time being they play a crucial role in the MH.

In the SPO, members of the Health Sector Division in the Department of Social Planning were the target population. This division is mainly responsible for the health section of the Five Year Development Plans and Annual Programmes. Although on paper the plans are the end products of the sub-commissions, as will be discussed later, the health sector

specialists in the division play the most significant part in the production of these plans and programmes. All the specialists in the department were interviewed.

The third establishment as far as health policy-making is concerned is the Parliament. As the ultimate political authority, fundamental decisions are reached by the Parliament both in sub-committees and later in the General Assembly. Here the target interviewees were the members of the health sub-committee, as the decisions first have to be approved by this committee before their referral to the General Assembly for ratification. The members of the committee are Members of Parliament (MPs) from the political parties that are represented at the General Assembly. Three people were selected to interview as they were the heads of the three different parties in the Committee and prominent members of both the Committee and the General Assembly. Two of them were also former health ministers one of whom became the State Secretary responsible for women and family affairs with the change of the government in 1991.

Apart from the above mentioned three establishments, other individuals were also of special concern for the aims of the research. Of these, the chairman of the Turkish Medical Association was a key person both as he was the voice of the most influential professional organization in the health field, indeed the only one, and as he also was the architect of the Act of Socialization passed in 1961 which is of special concern for the research

because of its intertwined relationship with PHC practices in Turkey. Another prominent member of the Association, who is also an active member of the sub-committees in the SPO was also interviewed. Last but not least, some representatives of the international organizations like the WHO and UNICEF were included in the list of interviewees with the aim of searching for the views of these organizations as they are also important partners in policies adopted. The full list of interviewees is presented in Appendix 1.

The interviews were of semi-structured nature (Appendix 2). The main questions were supported by sub-headings to remind the researcher about the topics to be covered and to avoid diversion from the context. However, due to the nature of the Study, the interviewees were not restricted by a definite list of questions and whenever needed some questions were eliminated or added to the format to elaborate the discussions. Apart from five, all of them were tape recorded. The interviewees were encouraged to speak off the record if they wanted and when this happened notes were taken.

The field work took three months to complete. At the end of it, not surprisingly, both the documents and interviews left the researcher with an enormous task of organizing the data to prepare for the final analysis. As far as the documents are concerned, all were gone through carefully and extracts that were of concern for the study were organized using a word

processor. This was mainly done for the Parliamentary Minutes and Development Plans. Interviews on the other hand, were first transcribed fully and were later translated into English word by word, sentence by sentence in order not to miss any points. In the final stage QUALPRO[2] was used in order to process the data. The crucial step at this stage was preparing a list of codes that would help to classify the answers to organize data. The interview format provided a guideline for the coding process; however, the answers from the interviewees were the basis of the codes determined. After coding and processing the researcher was left with interviews and documents classified under coded subject areas for the final analysis.

b. Organization of the Study

As far as the organization of the study is concerned, one point to be mentioned is the fact that in this study, both theory and research will go hand in hand rather than a strict division between the two. That is why the research findings will appear from the outset as related subjects emerge. Chapters II and III aim to analyze the Turkish health system in terms of the policies adopted since the 1920s, health status, health infrastructure and organization and financing of the services. The problems that are being experienced at the moment insofar as the health

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[2] QUALPRO is a software package developed to help qualitative researchers to analyze their data.

issues are concerned will become clear, as will the perceptions of the policy-makers.

Chapter IV will elucidate the PHC approach. First a brief history of the pre-Alma-Ata period will be given to delineate the events that paved the way for the Declaration. Following this, the Declaration and the PHC approach will be introduced. The *sine qua non* of the Chapter is the section on the definition of PHC as it will make an attempt to elaborate two distinct interpretations of PHC which in the end will significantly affect the implementation process. After the definition of PHC, prerequisites of a system based on the PHC approach will be detailed. The Chapter will end with a detailed analysis of SPHC, a major challenge to PHC.

Chapter V, in the light of the theoretical background presented in the preceding one, will analyze the PHC approach in the Turkish context. The definition of PHC as derived from the documents analyzed and interviews held will establish the first stage in elaborating the Turkish practices of PHC and HFA. After this discussion, the Chapter will continue by exploring the existence of the pillars of the PHC approach in Turkey. The SPHC approach and its implementation in Turkey will also be analyzed. The Chapter will end with a section concentrating on recent policy initiatives in order to find out the prospects for PHC in Turkey.

Community participation, one of the fundamental prerequisites of the approach, is the theme of Chapter VI. This principle, and decentralization in the next one, are given special consideration as they constitute the backbones of the approach and have salient implications for Turkey. In the first part of the Chapter VI, the concept of community participation will be introduced together with the rationale behind community participation attempts. In the second section, two forms that community participation can take in practice will be elaborated: CHWs and Community Financing. The last section will concentrate on community participation practices in Turkey.

Chapter VII will concentrate on another pillar of PHC: decentralization. The concept has serious implications for an over-centralized country like Turkey. The same format as in the previous chapter will be followed.

In the final Chapter, the study will conclude in the light of the theoretical and practical discussions made in the earlier chapters by concentrating on finding an answer to the question "what are the prospects for PHC in Turkey?"

CHAPTER II. TURKEY: HEALTH STATUS AND HEALTH CARE DELIVERY SYSTEM

This and the following Chapter aim at introducing the Turkish health scene in every aspect. To this end, this Chapter will first introduce the demographic characteristics and policies; second, will articulate the health status level of the country; and later will deal with the health care delivery system both in terms of organization and financing. These three sections will also provide a basis for the arguments in Chapter III, where Turkish health policy will be analyzed.

A. DEMOGRAPHIC CHARACTERISTICS AND POLICIES

Turkish population policy can be divided into two phases where in the first phase, between 1923 and 1960, a pro-natalist, and in the second phase, 1960 onwards, an anti-natalist policy has been adopted. The latter commenced with the inception of the planned development period; however, the watershed in this phase was the enactment of the 1965 Act of Family Planning (Act No 665).

The main drive for the first phase was the sparsely populated country affected severely by everlasting wars and infectious diseases. The Turkish population was a mere 13 million in the 1927 census (State Institute of Statistics, 1990: p.38). This figure increased nearly four-fold by 1985 and this increasing trend continues although there are significant developments in family planning activities and indicators related to it.

The main aim of population policy at the end of the 1920s and the early 1930s was to decrease deaths and increase births both by precluding family planning practices and by publicizing the need for a larger population. In striving for this end, the Public Health Act of 1930 (Act No 1593) urged the MH to implement this pro-natalist policy (Köroğlu, 1987: p.27), and at the same time prohibited both the import and sale of devices and pills used in family planning and abortions. To emphasize the State's devotion, the Turkish Penal Code had accepted induced abortions as a serious offence and by the same token, propagation of family planning techniques and sterilization were also precluded (Devlet Planlama Teşkilatı, 1963: p.67). The national motto of the time was, as Hale quoted, "the strength of a nation is measured by the size of its population" (Hale, 1981: p.24).

As stated earlier, this first phase terminated with the inception of the philosophy of planned development. In the First Five Year Development Plan, high population growth rate was regarded as one of the major obstacles to the economic development of the country. The Plan emphasized that although the aim was to reach a 7 per cent increase in GNP annually, this increase would not be reflected in GNP per capita if the population growth rate maintained its pace. The same plan also emphasized the health implications of the aforementioned Acts and their related articles. The main concern was traditional and backstreet abortions where twelve thousand women died annually simply because of ignorance

and lack of sanitation. The third theme in the Plan regarding this issue was the burden put on the economically active population.

In the light of these facts, the need for a new population policy was discussed and its main elements were determined. In the Plan, first and foremost, the cancellation of the articles precluding the import and sale of family planning devices was demanded together with the education of health personnel in family planning and increasing public awareness (Devlet Planlama Teşkilatı, 1963: p.73). These requirements were met by the Family Planning Act of 1965 (Act No 557) and all obstacles to family planning activities were removed. Abortion, unless medically required, was kept illegal until 1983 and with the new Family Planning Act of 1983 it was legalized for pregnancies up to 10 weeks. The responsibility for performing family planning activities was given to the MH and to this end a Directorate in the Ministry was established (Sağlık ve Sosyal Yardım Bakanlığı, 1973: p.198).

Family planning, as a policy, has been reiterated in consecutive plans and other policy documents as a national policy to enhance per capita economic growth. What impact did those policies make on the Turkish demography?

Turkey had a population of 56 million in 1990 (Devlet Planlama Teşkilatı, 1990a: p. 302) and with the high population growth rate (2.2 per cent in

1990) this figure is expected to reach 73 million by the year 2000 (State Institute of Statistics, 1990: p.33). The decrease in the population growth rate (2.8 per cent in 1960 and 2.2 per cent in 1990) did not meet the expectations from the 1965. Although there were improvements in other demographic indicators, like the decline of the total fertility rate from 5.83 in 1970 to 4.64 in 1985 (UNICEF, 1990a), these decreases were not as quick and substantial as desired.

Briefly, Turkey is passing through the second phase of demographic transition where the death rate decreases more quickly than the birth rate[3].

B. THE HEALTH STATUS OF THE COUNTRY

Turkey, classified as a lower middle income country by the World Bank with her $1210 Gross National Product (GNP) per capita in 1987 (World Bank, 1989a: p.164), suffers from similar problems to those of other developing countries. High infant mortality rate, high prevalence of communicable preventable diseases, together with cancer, circulatory diseases and others, related both to development and underdevelopment, threaten the population. Although life expectancy at birth can be considered as reasonable compared to other countries of her level, it is far

[3]In 1990 the Crude Death Rate was 7.4 (in thousands) and the Crude Birth Rate was 29.3 (in thousands) (Devlet Planlama Teşkilatı, 1990a: p.302).

behind the level reached by the developed world. On the other hand, inequalities among different segments of the population and among regions exacerbate the problems. However, attempts to elaborate these inequalities and to draw the general health status picture of the country are hindered by the lack or shortage of reliable data. This problem most severely affects the morbidity statistics and results in the reliance on mortality data that also suffers from the same problems of accuracy and reliability, though; to a lesser extent.

Infant mortality rate (IMR) and life expectancy at birth have long been regarded as the best available indicators to elucidate a country's or region's health status. Comparison of Turkish health status indicators with other countries having the same or even lesser GNP per capita reveals the fact that Turkey lags far behind the level reached by some of these countries (Table 1).

This issue of poor health indicators in relation to GNP per capita was also raised by the interviewees unanimously. The quotations below represent a sample on this subject.

> "*Turkey's social and economic development level is far above its health status level. We should have been more successful in this area considering the social and economic level we have reached*". [Chairman of the Turkish Medical Association].

Table 1: Comparison of Turkey with other Countries for Selected Health Indicators

Country	GNP per Capita/1987 $	IMR	Under 5 Mortality Rate	Life Expectancy at Birth
TURKEY	**1210**	**74**	**93**	**64**
Tunisia	1180	58	83	66
Papua New Gui	700	57	81	54
Philippines	590	44	73	64
Colombia	1240	46	68	65
Sri Lanka	400	32	43	70
China	290	31	43	70
Chile	1310	19	26	72

Source: UNICEF, 1990b, pp.76-77.

"Turkey's health problems are not parallel to her economic development level. Although we have an income of $1300 per capita, we have the same level of indicators as countries having $350, $500, $800 per capita. Our GNP per capita figure drops dramatically to $250 in the East and South-East part of the country. Uneven distribution of income, coupled with unequal opportunities together with lack of education contribute to the poor health conditions of these regions. This in turn affects the country's general state of health" [a member of the Turkish Medical Association].

"We are experiencing a dramatic decrease in IMR. It is now around 65 whereas it used to be around 100 two years ago. However, when this figure is compared with other countries' figures it is a disgrace for Turkey. We carried out a study of the countries for which we have information and found

> *that there is a huge gap between Turkey's health indicators and her socio-economic level. Today many Arab and South-Eastern countries, that can not be compared with Turkey so far as their development level is concerned, have better indicators*" [Ministerial advisor].

The same issue is raised in documents like the Sixth Five Year Development Plan (Devlet Planlama Teşkilatı, 1989a: p.284), the National Health Policy Document (Sağlık Bakanlığı, 1990a: p.55) and Parliamentary Minutes.

As stated earlier, IMR, the most quoted health status indicator, is quite high in Turkey, however, the differences among regions are even more striking. The Turkish Population and Health Surveys conducted by Hacettepe University, in spite of their shortcomings, are the major sources of information to illustrate this situation. Table 2 and Table 3 outline the findings of the last two of these surveys by region and type of place of residence.

As can be seen from the tables, the Southern region in the former and Northern region in the latter have been excluded because of insufficient numbers of observations. Taking into account the fact that both of the regions are relatively underdeveloped, the figures reached for Turkey should be interpreted with caution. Price Waterhouse states that had more technical and appropriate calculations been used, the IMR for 1985-1987 period would have reached 90-100 per 1000 (Devlet Planlama Teşkilatı,

1990a: p.61). Nevertheless keeping in mind the deficiencies of the survey, regional discrepancies and developments over time can be examined as both of the surveys followed the same methodology.

Table 2: IMRs for Turkey by Type of Place of Residence and Region for 1979-1982

Region	Neo-Natal (1-4 Weeks)	Post Neo-Natal (5-52 Weeks)	IMR (1-52 Weeks)
West	45.89	34.71	80.60
South	*	*	**
Central	47.96	54.79	102.75
North	39.19	58.17	97.36
East	38.15	80.73	118.88
Urban	30.75	27.66	58.40
Rural	50.37	74.17	124.54
TURKEY	41.70	53.61	95.31

* Fewer than 10 observations

** Fewer than 20 observations

Source: Hacettepe University, 1987, p.74.

Table 3: IMRs for Turkey by Type of Place of Residence and Region for 1985-1987

Region	Neonatal (1-4 Weeks)	Post Neo-Natal (5-52 Weeks)	IMR (1-52 Weeks)
West	20.77	26.71	44.48
South	36.80	57.38	96.26
Central	53.33	36.67	90.00
North	*	*	**
East	36.36	66.67	103.03
Urban	27.98	22.09	50.07
Rural	43.15	62.50	105.65
TURKEY	35.53	42.19	77.72

* Fewer than 5 observations
** Fewer than 10 observations

Source: Devlet Planlama Teşkilatı, 1990a, p.62.

So far as IMRs are concerned, the most striking conclusion is the difference between urban and rural figures, the latter being twice as high as the former. Inequalities among regions could also be observed from the survey results. As can be seen, the West in all three types of rates has favourable figures. However, an in depth analysis of both tables leads to some other conclusions. As can be seen from Table 3 the IMR of the West for the 1979-1982 period (80.60) has dropped to 44.48 for 1985-1987, i.e. almost halved. However, the same decline can not be observed for other regions. The rate has dropped from 118.88 to 103.03 for the Eastern region showing that the improvement in IMR between these two

periods mainly resulted from the improvements in the West rather than improvements in the most underdeveloped areas of the country, widening the gap between the developed and underdeveloped regions.

Comparison between Tables 2 and 3 also shows that the rural IMR has declined at a higher rate than the urban IMR. There might be a couple of reasons for this trend. First of all, shanty towns around suburbs of cities lacking the basic hygienic conditions and usually housing immigrants from rural areas might have a prominent influence on the urban IMR. Second, the data for the urban population is relatively easier to reach and more reliable.

The second significant health status indicator, the under five mortality rate, is also quite high. Although it has dropped from 258 in 1960 to 93 in 1988, the average level of 12 for developed countries and the existence of countries having better indicators compared to their GNP (UNICEF, 1990b: pp.76-77) indicate a need for action in this area as well.

Whatever the rate of decline in both indicators, the fact that many babies and children die from preventable causes requires immediate attention and should be the first priority problem to be solved. The National Health Policy Document, the most recent initiative of the MH for HFA by the year 2000, emphasized the government's commitment to this end as well.

However, this is easier said than done as a variety of factors have influence on improvements in these areas.

It has been estimated that, in Turkey, 35 per cent of rural and 25 per cent of urban child deaths and 35 per cent of rural and 17 per cent of urban infant deaths are from pneumonia (UNICEF, 1990a). Diarrhoea, accounting for 30 000 deaths annually (Sağlık Bakanlığı, 1990a: p.57), among under five years of age children, takes its place as another major reason for high infant and under five mortality rates. Malnutrition as a contributing factor to deaths from other causes like pneumonia, diarrhoea or measles is especially a cause of concern. The major policy initiatives adopted to this end are to increase the immunization rate for preventable diseases and carry out special programmes to attack diseases like pneumonia or programmes like "oral rehydration" in case of diarrhoea. These programmes are undertaken jointly by the Turkish Government and UNICEF. The national policy aim is to reduce deaths caused by pneumonia and diarrhoea by 25 per cent by the year 1992 (Sağlık Bakanlığı, 1990a; p.57). However, there is no evidence or information about its achievement yet.

Another important indicator of the general health status level of a country and a major contributor to IMR, maternal health, assessed mainly by the maternal mortality rate is also a cause of concern for Turkey. Although, lack of data most seriously affects this indicator, it was estimated as 210

for the 1980-1987 period (UNICEF, 1990b: p.89). The National Health Policy Document, after emphasizing the lack of data, stated that the most recent information shows that the maternal death rate was 208 in 1974-1975. According to a study by the MH inferred from hospital statistics, the maternal mortality rate now is 72 per one hundred thousand (Sağlık Bakanlığı, 1990a: p.62). However, the fact that this figure includes only the deaths reaching hospitals indicates that the exact figure would be much higher. The national policy aim is to reduce maternal mortality rate to 25 by the year 2000 (Sağlık Bakanlığı, 1990a: p.64).

There exist many factors behind maternal deaths such as socio-economic factors, early or late marriage, too many pregnancies, short birth spaces between pregnancies, lack of medical attention, education level of women and so forth. The average marriage age for women has been found as 17.6 in 1983 (18.3 in West, 16.3 in East) and 18.2 in 1987 Hacettepe University surveys. The figure is higher in urban areas and the West (Hacettepe Üniversitesi, 1983: p.6; Sağlık Bakanlığı, 1990a: p.61).

The variations between urban/rural population and East/West regions in terms of total fertility are shown in Table 4. The provinces in the first three group are mainly in the East and South-East regions of the country that represent the least developed regions. As can be seen from the table, there are substantial differences both among regions and types of settlements favouring the West over the East and South and urban over

rural. Many factors could play an important part in this trend. First of all, availability and accessibility of health services to the population is an important factor as family planning education and services are provided either by midwives or doctors. The Eastern part of the country suffers from severe shortages compared to the West. Second, religion is an important factor in utilizing family planning services. People living in the Eastern part, being more conservative in terms of religion, culturally do not accept family planning practices very easily. Third, the Eastern part is generally an agrarian society whereas the West is highly industrialised. As a consequence of that, in the East, every child born is seen as a part of the labour force in the very near future. Fourth, the infant mortality and children under five mortality rates are very high in the East. This also might have a stimulating effect on having a large family as some members of the family will be lost in their early lives. Fifth, marriage age is an important factor in fertility. It has been stated that one third of women are still marrying before the legal age of 18 especially in Eastern and Central areas (UNICEF, 1990a). This fact was also emphasized in the 1983 survey of Hacettepe University where it was found that in 1983 12.2 per cent of women in the 15-19 age group were married in the West whereas this figure reached 23.3 per cent in the East (Hacettepe University, 1987: p.29). Last but not least, the status of women also could have an effect on their fertility. Women in the West are more active economically and more educated.

Table 4: Distribution of Total fertility Rate by Province Groups and Type of Settlement (1985)

Regions	Province Centres	District Centres	Villages	TOTAL
GAP[4]	6.72	8.30	9.87	8.54
PRI	5.66	7.01	9.05	8.03
PR2	4.52	4.28	6.00	5.29
Provinces with Urban Poor	3.33	3.84	4.88	3.77
7 Best Provinces	2.78	2.93	3.37	3.13
The Rest	3.37	3.71	4.91	4.31
TURKEY	3.63	4.38	5.80	4.31

Source: UNICEF, 1990a.

Regional differences also exist so far as the place of last live birth and type of assistance are concerned. The 1983 survey revealed that 42 per cent of deliveries took place at a health unit while 58 per cent occurred at a place other than a health unit. In rural areas the figure for births taking place other than health units was 76 per cent and 84 per cent for the East,

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[4]**GAP:** 6 provinces in South East Anatolia having a major infrastructure development programme

PRI: (Priority Provinces I) The most underdeveloped 12 provinces usually in the East and South

PR2: (Priority Provinces 2) Better than the previous but still in need of attention.

Provinces with Urban Poor: (12 Provinces) half the population of the country. Grouping suggested by the UNICEF.

whereas these figures were 47.4 per cent for urban and 47.3 per cent for the West. The same trend existed for the type of birth assistance given during delivery. 83.2 per cent of the last live births in urban areas were assisted either by a doctor or a nurse/midwife, whereas this figure declined to 43.1 per cent in rural settings. As far as regional variations are concerned, in the West 84.8 per cent of the last live births were assisted by health personnel (60 per cent by doctors, 23.9 per cent by midwife/nurses), 7.6 per cent by traditional midwives and 7.6 per cent by neighbours and relatives whereas in the East 34.1 per cent of the births were assisted by a doctor or a nurse/midwife, 65.8 were assisted by traditional midwives and neighbours or relatives (22.2 per cent by traditional midwife, 43.6 per cent by neighbours) (Hacettepe University, 1987: p.76).

One of the major factors affecting both maternal and child death is malnutrition. Although Turkey is a self sufficient country in terms of food production, there exists a malnutrition problem affected mainly by income levels and education. Once again the lack of data hinders us from reaching concrete conclusions. The most comprehensive survey carried out in 1974 and a less comprehensive one made in 1984 reveal severe regional differences in terms of nutritional status. A local survey, carried out in the Etimesgut training region of Hacettepe University, indicated malnutrition as the fifth cause of deaths among 1-4 year old children (Devlet Planlama Teşkilatı, 1990a: p.50). This result is interesting as this region, being both

very close to the capital (approximately 10 miles) and being a research area for Hacettepe University, where health education and health services are supposed to be more effective compared to other areas, would be expected to have favourable conditions. Indeed other indicators such as its IMR are quite low compared to the country's general level (15 in 1987 [UNICEF, 1990a: p.2]). If it is the case for this area then one could suggest that malnutrition country-wide prevails as a major cause of deaths among this age group. There are different views about malnutrition and its reasons. However, the aim here is not to delve into this subject but to reflect the interviewees' views about malnutrition in the Turkish context. The problem of malnutrition was also pointed out unanimously by the interviewees. Some of them are as follows:

"*When talking about malnutrition I have to emphasize that this is not due to lack of food, but misuse of food. The second problem regarding this issue is not following hygienic rules in the process of preparation and cooking the food. In sum we can say that although we have enough food to provide proper nutrition for the child we do not consume properly and while doing this we also infect the child as well. In the end diarrhoea, that can easily develop with the help of malnutrition becomes an important factor affecting the health of the child*" [Ministerial advisor].

"*We are a very rich country in terms of food but we have the most severe malnutrition problem in the world. I name this as chronic hunger. Although the calorie intake and average weight of the Turkish people are up to the international standards we are chronically hungry because our nutrition is heavily dependant on carbohydrates*" [Former Health Minister].

Moving away from mortality statistics to morbidity, as stated earlier, there is not much information available. Hospital statistics, reflecting only a selective portion of diseases existing in society, although not sufficient and accurate, appear to be the only data source. Appendix 3 shows the number of patients admitted to hospitals by selected diseases together with the number of cases of notified infectious diseases. However, despite this lack of data, the general epidemiologic outlook of the country can be outlined as follows:

1. Perinatal and infectious diseases during infancy
2. Infectious diseases, together with malnutrition in 1-5 age group.
3. Accidents and other reasons in adolescence
4. Heart diseases and accidents between 25-44 age group
5. Heart diseases and circulatory diseases caused by smoking and cancers in 45-64 age group (Devlet Planlama Teşkilatı, 1990a: p.56).

Briefly it can be concluded that Turkey shows a typical epidemiologic picture of a developing country where infectious diseases and accidents prevail during childhood and where those are replaced by heart and circulatory diseases together with cancer for older age groups.

C. HEALTH CARE DELIVERY SYSTEM

It is, unfortunately, extremely difficult to analyze and describe the Turkish health system both in terms of organization and finance. The fragmented structure, i.e. multiple providers and multiple financing schemes operating independently, together with the existence of a well developed private sector, cause problems in both analyzing the system and pursuing universal health policies. This section will try to introduce the health system as systematically as possible but the aforementioned peculiarity should be kept in mind.

a. Major Organizations Providing Health Services in the Public Sector

The MH, assigned the responsibility of improving the health status of the population from the very beginning of the foundation of the Republic, is the major organization responsible for providing health services and making policies. However, there are other organizations functioning with the same aim of improving the health status of their beneficiaries.

Table 5: Distribution of Hospitals and Hospital Beds by Providers (1989)

Organization	Hospitals		Hospital Beds	
	Number	%	Number	%
Ministry of Health	542	64.7	67 658	50.6
Ministry of Defense	42	5.0	15 900	11.9
Social Insurance Organization	88	10.5	22 651	16.9
State Economic Enterprises	15	1.7	2 146	1.6
Other Ministries	3	0.4	780	0.6
Universities	24	2.9	18 050	13.5
Municipalities	5	0.6	1 160	0.8
Private	119	14.2	5 488	4.1
TOTAL	838	100.0	133 833	100.0

Source: Devlet Planlama Teşkilatı, 1990a, p.313.

As can be seen from Table 5, showing the distribution of hospitals and hospital beds by providers, the organizations involved in the provision of

health services in the public sector are the MH, Social Insurance Organization (SIO), Universities, Municipalities, State Economic Enterprises and some other ministries like the Ministry of Education, Transportation etc. In this section brief information about these organizations will be given in order to provide a clear picture of the organization of health services in Turkey.

i. The Ministry of Health

The MH, through a network of health houses, health centres, hospitals and other facilities provides primary, secondary and tertiary care to the majority of the population together with preventive services.

At the centre, the Ministry consists of directorates and the Minister is assisted by an Undersecretary and Deputy Undersecretaries (Appendix 4). At the periphery, the health director is the agent of the Ministry at the provincial level having responsibility for the delivery and coordination of all public health services within the boundaries of the province (Appendix 5).

Although the Ministry has responsibility for improving and maintaining an acceptable level of health status for the whole population, it has a little control over other organizations functioning in the area and no control over medical schools.

ii. The Social Insurance Organization

The SIO, attached to the Ministry of Labour and Social Security, is founded under the Social Insurance Act of 1964 (Act No 506). The Organization, theoretically covering all employed persons, except civil servants, the military and domestic servants, provides short term medical and maternity benefits, employment related accident and occupational disease benefits and long term benefits in terms of old age, disability and survivors' pensions (State Planning Organization, 1987: p.4). The organization generates its resources from premiums collected from both employees and employers. Health contributions to the SIO amount 11 per cent of the wage bill of which 5 per cent is shared by the employee.

In the literature there is an ongoing debate about provision of medical care by social insurance organizations and their positive and negative impacts on the whole system especially in developing countries. Zschock (1982: p.3) states that over half of the developing countries have introduced some form of medical care coverage under social security. Social insurance organizations can provide medical services either directly, i.e. by owning their own facilities and staff, or indirectly, i.e. by purchasing services from the already existing public and private facilities. Many developing countries, including Turkey, have opted for the direct method mainly because of the poor public and private services in the country which would not allow them to buy a high quality service for the insured

(Zschock, 1982: p.6). However, although this might seem logical from the point of view of the social insurance organization, it is not immune from problems.

The first issue to be raised is the problem of equity and the negative effect that the social insurance organization providing medical care can make on the whole system. The social insurance organization mainly covers people who have a regular wage and excludes people working in the agriculture sector or the unemployed. The organization can cover the agricultural sector, like in Turkey, but the accessibility of services is not always as easy as for the people working in other sectors. Midgley (1986: p.19) states this as the most serious problem inherent in this type of scheme.

Second, not the existence of such schemes, but their lack of integration with the whole system can pose problems. Roemer (1971: p.356) draws attention to this fact and claims that their independent position in terms of determining the salary levels or location of their facilities or other matters, poses intractable problems for the system as a whole. This issue has been and is being discussed in the Turkish context intensively and the SIO is accused of affecting the attractiveness of other public organizations adversely, by implementing different personnel polices especially as far as the salaries of medical personnel are concerned. Apart from adopting different policies, by wielding power and causing power struggle, they can affect the polices adopted by the MH, which has been the case in Turkey

over the issue of introducing a universal health insurance scheme. As will be discussed in the next Chapter, the MH has recently started to prepare a scheme whereby all the contributions generated from different sources are to be collected in one pool and spent from there. However, the SIO, from the outset, fiercely opposed the idea of transferring its premiums to this pool and obstructed its implementation. The case and its adverse effects were addressed by one of the Ministerial advisors who is at the centre of these discussions as follows:

> *"It is almost impossible to unify all health services although you may see this in every policy document. Why? Because the union leaders having influence on the SIO do not want to lose the power they have over the SIO's hospitals. They simply do not want to leave it and believe me they are really powerful and influential. So this in fact is a power struggle between the two Ministries".*

From the Unions' point of view, the SIO hospitals, established and run by the premiums of employees and employers, should be kept outside the universal health insurance scheme. The following quotations extracted from the symposium on universal health insurance, reflect the opinions of both the employees and employers:

> *"Employees and employers through their premiums have founded their own institutions and on the other hand they have also contributed to the State for health and education services through their taxes. We as employees require the exclusion of the SIO from this scheme"* [Representative of

Turkish Workers Unions' Confederation- Türk-İş] (Kamu Hizmetleri Araştırma Vakfı, 1990: p.20).

"*Employees covered by the SIO have established health institutions for themselves and their dependants and these are run out of the premiums paid by them. We are not opposed to the very idea of a universal health insurance scheme but we think that it should be developed gradually and the SIO and SIO facilities should be the last institutions to be included in such a scheme*" [Representative of Turkish Employers' Confederation-TİSK] (Kamu Hizmetleri Araştırma Vakfı, 1990: pp.12-13).

The reason for their resistance first and foremost lies behind the perception of the facilities as their own premises, without any State contribution whatsoever. However, there are also some considerations regarding the quality of health services after the inception of the insurance scheme. Such worries were expressed during the aforementioned symposium as well. For instance, one of the representatives of the Turkish Workers Unions' Confederation explained as follows:

"*Our worry is that, the SIO members will not be able to have better or even the same quality services that they are used to. As the government will not increase the resources allocated to the sector, in the end, we worry that, our members will virtually become the financiers of the system*" [Representative of the Turkish Workers' Unions Confederation] (Kamu Hizmetleri Araştırma Vakfı, 1990: p.23).

The third point discussed over the issue of provision of medical care under social insurance is its bias towards curative care and negligence of preventive care. The Turkish SIO provides medical care through its dispensaries and hospitals. Apart from being biased towards curative care, its lack of integration with other providers especially with the MH causes severe problems for the use of already scarce resources.

iii. Providers other than the Ministry of Health and the Social Insurance Organization

As can be seen from the Table 5, apart from the MH and SIO, other organizations have also undertaken the responsibility of delivering health care to different population groups.

The university teaching hospitals, 24 in 1989, have a prominent role in the delivery of care. Some of those hospitals, with their in-patient and out-patient departments, are also involved in socialized health services, by taking part in districts they have chosen as research areas. Anyone paying the fees determined by the university, but approved by the MH and Ministry of Finance, can use teaching hospitals without being referred from a lower level of care, whereas people covered by one of the schemes, that will be discussed later in this section, need to be referred. Although it changes with varying degrees according to the region where the university hospital is established, sophisticated and new technology are the main

characteristics of these institutions. As they are perceived as centres of excellence and because there is not a functioning referral system, the demand for their services is very high.

Among the ministries providing health care to their staff, the Ministry of Defense, providing care to military personnel and their dependants has the largest share. These hospitals and other facilities are not open to the public; nor amenable to policies adopted by the Ministry. It is almost impossible to get information about the use of these facilities, how they are operated, what amount of money is spent and so forth, making it difficult to have a complete picture of the health sector both in terms of organization and finance. Apart from having its own facilities, the Ministry does also have its own medical school and training facilities for nurses and auxiliary personnel making it totally independent from the State system.

Other ministries, though smaller in size, like the Ministry of Education, Transport and Interior and some municipalities and State Economic Enterprises have their own hospitals serving to their own personnel and their dependants. Those hospitals are established with the permission of the MH and in theory controlled from time to time.

The private sector, as another major provider of health services, should also be included here along with the public sector. Turkey, although reliable data is not available, has a substantial private health sector mainly

composed of part-time private practitioners. These practitioners usually spend their mornings in a public institution, a hospital or a health centre, and in the afternoons they perform in their own surgeries. In the past, there have been unsuccessful attempts to preclude part-time practice. The share of the private sector in terms of hospital beds is a mere 4.1 per cent; however, in the recent years there have been some important developments in this area as well with the opening of a private hospital backed by Americans, in Istanbul, which led to the establishment of new hospitals alike in big cities.

b. Financing of the Sector

Turkey, allocating 3.2 per cent of her GNP to the health sector (World Bank, 1990: p.49) of which 1.7 per cent comes from public sources and 1.4 per cent from private, suffers from severe shortages of resources. An in depth analysis of the parliamentary minutes starting from 1963 shows that this issue has always been on the agenda and has been perceived as the main reason for the problems faced by the sector. The inappropriate amount of money allocated from the budget to the MH has always been criticized fiercely although views about this issue vary among people. The first group, where the majority of the interviewees and MPs in the Parliamentary debates fall, complain about the lack of resources, consider this as the core of the general health problems and perceive more resources as the only remedy for better health services. The following

quotation from the interview made with the chairman of the Turkish Medical Association reflects the views of this group in general:

> *"Today, approximately all countries allocate 5 per cent of their GNP's to health. This figure is 12 per cent in the United States and it is approximately 6-8 per cent in other Western Societies. When we look at our figure we see that it is only 3 per cent and half of this is met by the government and the rest comes from the direct expenditures made by the patients. There are some countries having less GNP per capita but spending more. This is the evidence for the incompetence of the governments and their indifferent attitude to the health of the nation".*

In their argument, this group mainly rely on comparisons with other countries. Another example of this comes from a member of the Turkish Medical Association where he also emphasized that:

> *"Health has never been a priority on the government's agenda. Our evidence supporting this belief is the fact that the health sector is allocated only 3 per cent of the government budget whereas in some developed countries this figure reaches 20 per cent. This is the case in some developing countries as well. For instance, our neighbour, Syria, allocates around 16-18 per cent of her budget to the health sector. These examples can be enlarged. In brief, financing of the health sector is not satisfactory."*

On the other hand, there is the other group, relatively small, which puts the emphasis on efficient use of resources rather than their scarcity. As far as the amount of money allocated from the budget to the MH is

concerned, they stress that other organizations' health expenditures should also be added to reach the actual amount allocated from the government budget to the health sector. The following quotation from the interview made with one of the former health ministers reflects the opinion of this group:

> *"We have a very fragmented structure of health services. For instance, the SIO is basically an insurance organization with no relation to health services whatsoever but yet it operates its own hospitals. You can add to this list other ministries like the Ministry of Education etc. All these organizations spend money on health but when it comes to determining the proportion allocated to the health sector, it is only the MH's budget that is counted. This is not a correct way of calculation. If you bring all of them together, this percentage would be something around 13-15 per cent competing with the amount allocated in many developed countries. The question is whether this money could have been spent more efficiently and effectively".*

As in other developing countries, Turkey suffers from lack of accurate and reliable data so far as health expenditures are concerned. The problem is more intractable for the private sector but public sector expenditures are not easy to calculate accurately either. This difficulty derives mainly from the existence of multiple providers and financiers of health services. Even if all the accounts of these organizations are standardized and collected accurately, there is a problem of access to this information. For instance, it is impossible to reach the data for the expenditures made by the Ministry of Defense although it is one of the major spenders in this area.

As a result of these drawbacks, the estimates of health expenditures rather become "guestimates".

In the absence of data about expenditures made by other organizations, the money allocated from the general budget to the MH becomes an important source of information both as it is the major organization providing services and as it is responsible also for preventive services. The ratio of the MH's budget to the State budget has always been less than 3 per cent. The only time when it reached to its peak (5.27 per cent) was during the military governments in 1960. However, this ratio could not be maintained for long and it was fixed around 2.80 per cent in the 1980s (Ministry of Health, 1987: p.30). On the other hand, apart from the resources allocated from the general budget, its distribution within the ministry is also of great importance especially for the purpose of this thesis. Table 6 shows the distribution of resources by the type of the services provided.

Personnel expenditures are stated to represent 61 per cent of the total MH budget but 77 per cent of the budget allocated to PHC services. Of this already restricted PHC budget, remaining after personnel expenditures, 13 per cent of the resources is said to be spent on drugs and supplies leaving only 10 per cent for the running and maintenance of the PHC services. This obviously reflects the trend in many developing countries where the

curative services and personnel expenditures absorb the bulk of the resources.

Table 6: The Breakdown of the MH's Budget by the Type of the Services Provided (%)

Years	1984	1985	1986	1987	1988
Curative Services	49.5	46.5	48.7	50.4	44.7
Primary Health Care	24.9	30.2	33.2	28.5	28.4
Central Administration	25.6	23.3	18.1	21.1	27.0

Source: World Bank, 1990. p.57.

So far as the financing of the sector is concerned, the same fragmented structure as in the provision of the services can be observed. The population can first be divided into two groups, as people whose health expenditures are covered by one of the schemes operating in the sector and people who do not have any coverage whatsoever. The former group is divided into a further five groups according to the scheme to which they are attached (Table 7).

Table 7: Population Under Social Insurance Coverage by Social Insurance Organization (Thousands).

Organization	1985	1987	1988	1989
GERF[5]	6 770	6 958	6 982	9 692
SIO	12 453	13 299	14 752	16 411
Bağ-Kur	7 854	9 061	9 770	9 375
Private	260	287	295	319
People with Health Coverage	19 486	23 460	26 149	31 982
% of Population (health coverage)	38.73	44.39	48.26	57.6
TOTAL	27 338	29 614	31 824	38 978
% of Population	54.74	56.04	58.74	70.18

Source: Devlet Planlama Teşkilatı, 1990b, p.353; Sağlık Bakanlığı, 1990b. pp.5-6.

First of all, there are civil servants and their dependants who enjoy free health services mainly from the MH and university facilities. Their

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[5]These figures include the active civil servants and their dependants as well

expenses are paid from their department's budget from the money allocated by the Treasury for this purpose. Since 1983, 20 per cent of the prescription charge has to be paid by civil servants.

Second, the members of the SIO, as outlined in the previous section, use health services provided by their facilities financed from their contributions.

Third, the Government Employees Retirement Fund (GERF), by contracting out services to the MH facilities and university hospitals, covers the expenses of retired civil servants and their dependants. The Fund is financed by the contributions of active civil servants and the State and it is attached to the Ministry of Finance and Customs.

The fourth group comprises people covered by the latest fund established to provide social security for the self employed. Bağ-Kur, as it is named in Turkish, was established in 1972 and in theory any person who is not covered by the aforementioned schemes, including housewives, can join the scheme. The Fund is financed through its members' contributions and although its main aim at the outset was to provide long-term pension and disability benefits, it has enlarged this role to health services and in 1989 all contributors paying health premiums were covered. As in GERF, the organization provides health benefits by contracting out its services to the MH and SIO facilities or the University hospitals.

Fifth, there is a relatively small group of people whose expenditures are covered by private funds mainly working for the banks and insurance companies. These generally purchase medical care from the private sector or the university hospitals.

The second major group, i.e. people who do not have any coverage for their health expenditures formed 42.4 per cent of the population in 1989 (23 558 168 people). These people, mainly the rural population and the urban poor, have to pay their expenditures directly out of their pockets. However, upon proof of their inability to pay from their local administrator, the MH provides these services free of charge. This group of people is estimated as approximately 5 million (10 per cent of the population) by the World Bank (1990: p.18).

Private health expenditures, mainly composed of fees paid to private practitioners and prescription charges, are said to be twice the amount of the MH's budget. The share of private expenditures in total expenditures has risen from 38 per cent in 1981 to 46 per cent in 1990 (World Bank, 1990: p.5) implying a proportionate decrease in public expenditures. The main reasons for this can be stated as the existence of part-time practitioners where people use them as a step to use public facilities, people's distrust of public services and the availability of these facilities.

c. Health Workforce

Turkish health workforce policy, over the time, has had to deal with two major issues, namely, quality and quantity. There have been radical policy shifts after the establishment of the Higher Education Council, the brain-child of the 1980 military takeover, as all universities functioning independently were attached to this Council and to the Ministry of Education. The major change in this respect was the rapid increase in the number of students recruited to universities in general and to medical schools in particular. The main emphasis was on increasing the number of graduates and to this end, apart from the above-mentioned policy of increasing the number of recruits, a policy of establishing new medical schools was also adopted.

The duration of medical education in Turkey is six years with the last year being spent in a hospital, usually the teaching hospital of the university, in practical work. Doctors have to serve one year compulsory service immediately after graduation and they have another year after completing their specialized education. The increasing number of medical school graduates and their tendency towards specialization have forced the introduction of a centrally organized exam whereby graduates compete with each other to have the opportunity to become a consultant in their chosen subject area. However, with the increase in the number of medical school graduates and no change in the number of consultants required,

more and more graduates will have to remain as "general practitioners" in the future. Here, the term "general practitioner" in the Turkish context has to be clarified. In Turkey, any medical student, after completion of his/her six years of medical education is named as "general practitioner" without having any further formal training.

Nursing education can be distinctively divided into two categories as university education and vocational high school education. The former group, relatively lower in numbers, consists of women doing a degree at university after completion of their normal high school education. The duration of these courses is four years and graduates generally work in hospitals, usually the teaching hospital of the university where she graduated. On the other hand, vocational high schools, the majority of them attached to the MH, accept students who have completed their secondary school education and have been successful in the entrance exams. These schools train nurses, midwives, sanitarians *(sağlik memuru)* together with technicians trained in environmental health, laboratory, anaesthetic, orthopaedic or dental prothesis skills with four years of education composed of both cultural, educational and vocational training. Graduates of these schools, most of them boarders, whose expenses are paid by the institution to which the school is affiliated, have a compulsory service of four years. The first vocational school was opened in 1946 and the country has experienced a major expansion in 1988-1989 when fifty-six new schools were opened (Devlet Planlama Teşkilatı, 1990a: p.259).

Turkey has never had a comprehensive health workforce policy and plan; problems have always been tackled on ad hoc basis. An example of this is the regulations on "full-time" practices. The latest policy, imposed by the SPO, has been to increase the number of graduates. The SPO has always accused the universities of obstinacy about resisting an increase in their number of students and has given credit to the Higher Education Council for improvements in both the number of medical schools (from 17 to 24) and number of students recruited (from 2462 in 1978-1979 to 5403 in 1985-1986) (Devlet Planlama Teşkilatı, 1987: p.18). This view was made crystal clear in one of the organization's publications prepared by the sector specialists where increasing the number of medical school graduates was described as the major action to be taken in order to make the system work (Varlık, Tamtekin, Yıldırım, 1987: p.2).

The SPO, basing its arguments on population per doctor ratios of the members of the EC, has been criticized by people concerned with the quality of education. For instance, representing one of the members of this group, a former health minister, has stated that:

> *"The SPO and the Higher Education Council jointly decided to graduate 5000 doctors annually in order to reach the standards of the EC. At the moment we have around 42-45 000 doctors and graduate 5000 each year. This is a false policy based on false assumptions. Alright, it is true that the number of people per doctor is around 400-500 in the European countries and 1400-1600 in our country but you have to be aware of the conditions that are peculiar to your own country. Our hospitals are not prepared to train and*

provide practical experience to those doctors. You can not train doctors in these conditions and then leave the health of the people to those incompetent professionals. Another question arising from this situation is how and where are you going to employ these growing number of doctors? That implies that we have to be aware of the health infrastructure of the country".

People criticizing the SPO base their argument on the differences between Turkey and EC in terms of utilization rates. The following quotation reflects the opinions of this group.

"*The doctor per population ratio for Europe is one per 500 people and one per 1200 for Turkey. Now the SPO has decided that this ratio should be 500 per doctor as in Europe. We told them that a person in the EC countries visits a doctor approximately 4 times a year, let us assume that this number is 3, and we continued that this figure is 0.5 for Turkey and let us assume this as 1. That means that people in the European countries visit their doctors three times more than we do, meaning that if we have a doctor population that is three times less than that we will be able to solve all our problems. When we divide 1200 by 3 we will get 400 which shows that we already have enough doctors. However, they did not listen to us and insisted on this policy affecting the system very adversely indeed. The capacity of our university's medical school is 120 students, meaning that we can provide a high quality, decent education to that amount of students but we recruit 250 instead. This is a more serious problem in other universities. For instance the number of third year students I lecture at any one time in a lecture theatre that has been originally designed for a capacity of 70-80 students reaches 280. We do not have any opportunity to recognize the students both by name and face. Only one third of the total students attend classes. Well if all of them come we will not have sufficient place in the class anyway*" [A member of the Turkish Medical Association].

The major weakness of this argument is that it leaves aside factors that might affect utilization such as accessibility, availability, cultural factors and attitudes. However, whatever the stance taken as far as the quantity of workforce is concerned, almost all involved in the field agree on deficiencies in quality of the personnel educated and its inappropriateness to the country's conditions. The ratio of consultants to practitioners has always been discussed as one of the weaknesses of the system. It has been stated that 25 per cent of doctors are general practitioners whereas 75 per cent have chosen to become consultants (Varlık, Tamtekin, Yıldırım, 1987: p.17). However, this ratio was stated as 55 per cent in 1987 in the MH statistics (Ministry of Health, 1987: p.7). Apart from this tendency, the compatibility of medical school's curricula with the country's conditions and needs is considered as one of the major problems unanimously both by the interviewees and in the documents analyzed. For instance, one of the ministerial advisors has stated that:

> *"The medical education pattern followed in Turkey is utterly inconsistent with the country's needs. The majority of health problems that Turkey has can be and should be solved at the primary care level. However, all the personnel we train including doctors, nurses, midwives and administrators are oriented towards clinical medicine. All of them are directed towards clinical medicine but the majority of the problems are ones that should be solved outside the clinic. There is an Edinburgh Declaration of the WHO clarifying how medical education should be organized in order to realize the WHO's policy aims. Unfortunately, Turkish medical education is not consistent with the points stated in this Declaration. There is the Vienna Conference that relates to nursing education;*

likewise we do not have a nursing education system consistent with that conference. I mean our approach is not consistent with the PHC point of view but is consistent with the clinical point of view".

The same problem has been addressed by Price Waterhouse in their Master Plan Study where the diminishing importance of community health programmes has been emphasized. Community medicine is allocated 2 hours in the fourth year of medical education. The unwillingness of medical students to attend these courses and lack of enough space to accommodate all students if they wished to do so have also been emphasized in the Price Waterhouse Study. The study also claimed the existence of medical school graduates who do not even attend a normal delivery during their education (Devlet Planlama Teşkilatı, 1990a: pp.298-299).

The third issue raised, apart from the quality and quantity, is the distribution, or rather, maldistribution of the existing workforce. Table 8 shows the number of health personnel and developments over time. However, the imbalance favouring urban to rural and West to East poses intractable problems over provision of services or in some parts of the country "any service". Table 9 illustrates number of personnel per population in selected areas where the situation is at its worst and best.

The distribution of the health workforce is uneven within the province boundaries as well. It has been stated that there exist imbalances between different districts or villages of the same province (Sağlık Bakanlığı, 1990a: p.20). Especially personnel in the Eastern region
prefer staying in the province centre to a district or village as the living conditions are much better and private practice is more profitable.

Table 8: Health Workforce

Years	Doctors	Dentists	Pharmacists	Nurses and Midwives	Health Technician
78	25230	6826	11280	37185	11141
1980	27241	7077	12059	42760	11664
1981	28411	6790	11610	43349	12226
1982	30956	7625	11428	42697	10704
1983	32263	7763	11527	43886	10704
1984	34195	8133	11586	45797	10456
1985	36427	8305	11602	48841	10525
1986	37142	8410	12866	51519	11684
1987	39958	8590	13329	56837	11684
1988	41530	9200	14175	60700	18600

Source: Sağlık Bakanlığı, 1990a: p.19.

Table 9: Distribution of Selected Health Personnel by Selected Provinces (1987)

Province	Population per Doctor	Population per Nurse	Population per Midwife
Ankara	529	814	3574
Istanbul	537	1080	4077
Izmir	607	937	1896
Muş	6088	4623	2719
Van	6071	3373	2855
Agri	5789	2993	2404

Source: Ministry of Health, 1987.

Doctors are not the only problematic area as portrayed in some of the publications of the State. Other health personnel, for instance nurses and midwives, also suffer from similar problems to those faced by doctors. As the Tables reveal, there is a low ratio of nurses to doctors. This group of workfoce face a number of problems in practice. Especially midwives, who are the first point of contact in rural areas in health houses, have a host of problems arising from their age and inexperience. For instance, one of the representatives of UNICEF, who has been to several health houses in accordance with UNICEF programmes in Turkey, has stated during the interview that:

> "*I think there is this problem of not knowing how to use their education in practice. As far as the midwives are concerned,*

even if their education is appropriate they are very young. The age of a midwife is around 18 when she is first appointed in a village and the doctor's age is around 25. They severely suffer from loneliness as they can not find anyone around with a similar social and educational background. They do not acquire any new knowledge and they even lose the knowledge they already have. This of course affects their motivation and service adversely".

The same point about midwifery students was also raised by one of the ministerial advisors as follows:

"*We graduate very young midwife candidates when they are in their 17s or 18s and send them to a remote mountain village in the middle of nowhere and then expect them to be successful. When recruiting these midwifery students, we should tell them where they are going to work after graduation and offer some incentives like scholarships. It is also wise to send them to the areas where they originally come from as they are the ones who know the traditions and conditions of the area best*".

So as can be seen, doctors are not the only health personnel suffering from inappropriate policies as portrayed at different levels of discussions. The exaggeration of the problems of doctors can be seen from parliamentary minutes where MPs, who in this case are usually doctors, complain mainly about the degraded position of their profession in the community. It has been stated unanimously that doctors who are paid less than other professionals (mainly the legal profession) are not regarded as a valuable profession in the community, and as they are not paid very well, they are

forced to practise both in the public and the private sector, which undermines their relationship with their patients. The "civil servant" status of doctors has been stated as the major reason for the unwillingness of doctors to work in the public sector or their motivation to work both in the public and private sectors. As a civil servant they get a fixed amount of salary based on their years of experience and status. The recent Basic Act of Health Services proposed that this should be replaced by a contract system whereby some other elements such as performance will also be taken into account, but these articles were cancelled by the Supreme Court. The following quotation from the parliamentary minutes of 1987 represents the common view which has existed since the 1960s:

> *"Whichever system is applied, the first thing to do should be to establish a dialogue between the Ministry and the doctors. First and foremost we have to give back the respect that those doctors deserve and then we should expect them to do something. We believe that if we know how to treat them we have sufficient number of doctors that will solve all the problems of the country"* (Türkiye Büyük Millet Meclisi, 1987: p.786).

Although the above quotation mentions about the need for "establishment of a dialogue between the Ministry and the profession", the very fact that major positions in the MH are occupied by doctors should be kept in mind. Turkey, until 1983 did not have a non-medical health minister, and the appointment of an economist to the post in 1983 was a revolutionary attempt threatening the long existing myth that "health problems can only

be solved by doctors". Nevertheless, this change did not occur among the heads of departments and key positions in the Ministry. Not surprisingly, this appointment was not welcomed by doctors and opposition was put forward on many occasions. For instance, the following quotation from the 1987 budget discussions in the Parliament, although it criticizes the appointment of a nonmedical undersecretary, states that:

> "*Services provided by the MH are such that they could only be handled by doctors knowing all aspects of the work in detail and by being respectful to them. We do not understand why a non-doctor undersecretary has been appointed to the post. This situation insults our doctors. The Motherland Party*[6] *has tried this in the Minister of Health and caused severe problems*" (Türkiye Büyük Millet Meclisi, 1987: p.765).

The aforementioned view was expressed during the interviews by a former health minister who herself is a medical doctor. She stated that:

> "*I have to tell a very important thing that I have refrained from for a long time. When we analyze the backgrounds of people occupying the top positions in the MH since 1980, we see that approximately two thirds of those people are not doctors. There are some people among them whose only relation with the health sector occurred when they were ill at some time in the past. Alright we can say that this is the decision-making level and lower levels are going to be occupied by doctors. This is not the case as well. How can you develop a health policy with this structure?*"

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[6] The governing party then.

On the other hand, the Ministerial staff complain about its weak, almost nil, influence on the medical profession especially so far as their education is concerned. For instance, one of the ministerial advisors, who himself is a doctor, stated that:

> *"The MH is the only organization that approves medical diplomas. I mean, under every doctor's diploma, there is the signature of the Minister of Health. However, this is perceived only as a formality. The MH is the only organization that uses the majority of doctors and it is the organization that provides jobs to the doctors. The conditions of this job are clear. The doctor has to work in the health centre and deal with the problems in that area. Although the typology of the doctor required for this job is defined, universities graduate doctors that are not compatible with that definition. However, we have never raised this problem and said that we needed a certain type of doctor and demanded universities to graduate doctors having the required qualifications".*

As this section suggests, Turkey has considerable problems as far as health workforce issues are concerned starting from their education to distribution, from quality to quantity, posing important problems for attempts to pursue a system based on PHC.

In this Chapter, the Turkish demographic structure and policies, the Turkish health system and the health status level of the country have been elaborated. The next Chapter, however, will concentrate on Turkish health policy and the scene will be completed by introducing the past and latest policies adopted and by discussing issues attached to them.

CHAPTER III. HEALTH POLICY IN TURKEY: AN ANALYSIS

This chapter aims at analyzing Turkish health policies over a period from 1960 onwards, to establish the basis for the forthcoming chapters and to delineate the policies adopted. To this end, based on the major policy documents in the health sector and on interviews, an attempt will be made to articulate the picture on the road to HFA.

A. MAJOR POLICY DOCUMENTS IN THE HEALTH SECTOR

a. The Constitution

The Constitution is the first major document that gives insight about Turkish health policy. Since the first Constitution, upon which the foundations of the Republic were laid in 1923, the country has seen two major and comprehensive constitutional shake-ups. The 1923 Constitution did not mention health and the health sector but other sectors such as education and welfare were not considered either. That Constitution was merely trying to establish the principles of the new Republic and create new organizations and their relations with each other mainly because the system inherited from the Ottoman Empire had been altered substantially.

The 1961 Constitution, prepared by the intelligentsia of the country, was quite different so far as the social sectors are concerned. The Constitution itself was different in many aspects and its main emphasis was on establishing a liberal and democratic country (Ahmad, 1977: p.186).

Special consideration was given to issues like social security, health and education. Article 49 of the new Constitution stated that "...the State is responsible for the physical and psychological well-being of the people and for provision of medical care". The Act of Socialization of Health Services was passed concomitant with this article of the Constitution, reflecting the commitment of the military government to the health sector. However, that Constitution was abolished in 1980, after 20 years of its enforcement, by the third military takeover in Turkish political history.[7]

A new Constitution, again emphasizing the role of the State in the health sector, was accepted by a referendum in 1982. Article 56 of this Constitution clearly states that:

> *"Everyone has the right to live in a healthy, balanced environment. It is the duty of the State and the Citizens to improve the natural environment, and to prevent environmental pollution. To ensure that everyone can lead their lives in conditions of physical and mental health and to secure cooperation in terms of material and human resources through economy and increased productivity, the State shall regulate central planning and functioning of health services. The State shall fulfil this task by utilizing and supervising the health and social assistance institutions, both in the public and private sectors. In order to establish widespread health services, universal health insurance may be introduced by law".*

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[7]Another military intervention took place between these two,in 1971, but no constitutional change was made then.

The main differences between this article and the former can be stated as considering the citizens and the State as partners, both having the responsibility of creating a healthy environment and recommending health insurance in the financing of health services. This article and the Constitution itself are very important as according to Turkish Law, any arrangement opposing this article can be cancelled by the Constitutional Court. An example of this was experienced in 1987 when the opposition party (Social Democrat Populist Party) took the Basic Act of Health Services (Act No 3359) to the Constitutional Court on this basis and some articles of the Act were cancelled by the Court crippling the operation of the remaining part. The Act, that will be analyzed later in this chapter, basically proposed the conversion of hospitals into health enterprises by opting out of the public system and this was seen as a first step to privatizing the health services.

b. Major Acts

i. The Public Health Act of 1930 (Act No 1593)

The MH was established on 2 May 1920, with the Act No 3, during the early days of the Independence War. The responsibilities of the MH were determined by this Act as "to improve the health conditions of the country, to combat the elements harmful to the health of individuals and the nation and to provide social assistance". Although the Ministry was established

in 1920, the real attempts towards the aforementioned objectives started after the declaration of the new Republic in 23 April 1923. The Ministry started to organize the centre and the periphery from scratch. In the first programme of the MH in 1925, major areas requiring immediate action were listed as: to expand health services organization; to educate doctors, nurses and midwives; to build prototype hospitals and children's homes[8]; to combat diseases like malaria, tuberculosis, syphilis and rabies; to prepare Acts related to health; to extend the health services to the remotest villages in the country; and to establish the Institute of Public Health (*Hıfz ıssıhha Enstitüsü*) (Sağlık ve Sosyal Yardım Bakanlığı, 1973: p.38).

Following this period, crucial Acts were prepared and enacted that are still in force although some amendments have been made over time. Among these, the most important ones are the Public Health Act of 1930 (*Umumi Hıfz ıssıhha Kanunu*) (Act No 1593) and the Organization and Personnel Act of the MH, enacted in 1936 (Act No 3017).

The first articles of the Public Health Act list the responsibilities of the State and the MH. Improving the health status of the country, combatting

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[8] In Turkish "prototype" corresponds to the word "Numune" meaning a model as an example. Their aim was to provide examples of modern hospitals. Five of them were built in Ankara, Istanbul, Erzurum, Diyarbakir, Sivas and they are still among the leading MH hospitals in terms of the quality and quantity of the services provided.

the elements causing diseases and bringing up healthy generations were listed among the responsibilities of the State. This is the first Act that considers health services as a State responsibility.

At the periphery, two new positions, *Directorate of Health* in provinces and *Medical Officers (Hükümet Tabibi)* in districts, both responsible for activities related to health within the borders of their authority, were established. Responsibilities of local authorities at the periphery were also determined and apart from the task of improving environmental health, they were also given permission to operate hospitals and provide curative care for the population.

The issue of combating infectious diseases, which was the major health problem then, was tackled in detail. Many of the diseases mentioned in the Act, for instance smallpox, have long disappeared or have lost pace, but the regulations relating to them are still in force. Diseases like malaria, trachoma, syphilis and tuberculosis have been given special consideration and the bases for vertical programmes were first established in this Act. The Public Health Act is still in force, despite the facts that it is outdated, there have been changes in the conditions and it is very difficult for the younger generation to understand because of the language used. However, there is a demand from both politicians and others concerned to replace it with an updated one.

ii. The Act of Socialization of Health Services (Act No 224)

The health care delivery system between 1923-1961 can be described as chaotic. In 1946, the inception of a new system with the first Health Plan brought a minor change to the status quo.

The second phase in the Turkish health sector commenced in 1961 with the Act of Socialization of Health Services, passed by the National Unity Committee (NUC) of the 1960 military takeover just before leaving power.

The main emphasis in the new Act was on provision of health services to the entire population on the basis of equity. The system required the integration of both preventive and curative medicine, stressing the former more than the latter. The model brought by the Act was very much influenced by the Swedish mode and reflected the characteristics of the Basic Health Services Approach that was the convention in the 1960s, mainly emphasizing the referral chain in the health system starting from sub-units like health houses to health centres and finally to hospitals. However, although the intentions were good and the organization of health services sounded solid, the system did not work well in practice and people in the field are divided into two camps, one fiercely opposing the system and trying to abolish and the other, supporting the system but attributing the failures to the weak commitment of governments thus far.

a) Socialization in Theory

Socialization was defined in the Act as:

> "*Provision of health services through the premiums paid by the people for health services or budgetary allowances of the public sector organizations on the basis of equity either free of charge or by contribution of the people*" (Köroğlu, 1987: p.216).

The definition emphasizes equity as a major aim to be reached and reflects the declared commitment of the then government to social justice.

One of the points underlined both in the Act, and in subsequent legislation was the emphasis on preventive services over curative services, which later became the core of the Turkish health policy. Preventive services were favoured on the basis of being cheaper and easier to provide than curative services. Parliamentary debates also reflect this point where representatives of different political parties unanimously accepted this assumption.

The organizational model brought by this Act proposed a referral system starting from health houses for around 2-5 thousand people and staffed by a midwife. Primary aims of this unit are provision of maternal and child health services, immunization and health education concerned especially with personal and environmental hygiene. The midwife in the health

house is responsible to the team in the health centre and they work in collaboration in the area.

The second and most important unit brought by the Act is the Health Centre. The health centre, in the subsequent legislation after the acceptance of the Act, is defined as a social and medical institution that carries out its activities by following the principles of community medicine and that is responsible for 5-10 thousand people in a geographical area. The centre is staffed by at least a doctor (either a practitioner or a consultant), a nurse, a midwife and necessary other supporting staff working collaboratively as a team. Some of the responsibilities of the health centre that are explained one by one in detail are maternal and child health; malaria eradication; tuberculosis, syphilis, lepra and trachoma control; family planning; environmental health; health education; immunization; patient care; first aid; statistics; and school health.

As can be seen, the expectations from these centres are enormous requiring a considerable amount of equipment and staff. According to the Act, the patient, either after contacting the health house or as a first level of contact, should visit the health centre where s/he will be referred to the next level if s/he needs further care. The services will be provided free of charge only if s/he follows this route. If s/he decides to by-pass the health centre and visits the hospital as a first level of contact then s/he has to pay

the full charge. Many of the prescriptions are also provided free of charge.

The third level in the organization model is the hospital that serves 50-200 thousand people according to the geographical position of the province. Health centres are attached to these hospitals and they work collaboratively in performing the tasks assigned by the Act.

Every hospital and health centre in a region is attached to the Directorate of Health Group in the region. This Directorate mainly has the task of coordination between the hospitals and health centres. It also has the role of supervision and evaluation.

Socialized health services brought another radical change related to the way doctors practise. It precluded part-time practising of doctors and let free the doctors who preferred to work only in the private sector. According to the Act, a doctor who wanted to work in the socialized area had to sign a contract with the MH and serve for the duration agreed on. At the beginning, in order to motivate doctors, the salary paid under these contracts was higher than the usual salary that a doctor can get from public service. However, other Acts and regulations enacted later surpassed the salary given in the socialized areas and later the contractual arrangements were cancelled, resulting in diminishing attractiveness of these areas. The part-time practising of doctors has always been on the

agenda of Turkish health policy makers. This can clearly be seen from the parliamentary debates. The issue dominates the debates and is seen as the weakness of the system, affecting the doctor-patient relationship adversely. The main reason for doctors' choice of working part-time is usually assumed to be the low income they could get from their public service. An Act was passed in 1978 to preclude all doctors from working part-time but it did not work, as the majority of the doctors left the public service and preferred working in their private surgeries. This part-time issue is still accepted as the major weakness of the system especially by the proponents of the socialized model. The issue has been emphasized in a publication by the then Health Minister and his Undersecretary who introduced the socialization model. There, the first reason of the failure of earlier socialization attempts was stated to be the permission given to doctors to practise both in the public and the private sector. The second reason was the weak position of public health science both in the eyes of the public and professionals. The third reason was the lack of resources and low budgetary allowances (Ünver, Fişek, 1961: p.21). It was also strongly emphasized that the success of the model would heavily depend on the principle of full-time practice. However, this ambitious aim was never achieved and doctors, as a powerful pressure group, have always objected to the prohibition of part-time working and succeeded in practising both in the public and private sector.

The points made so far concern purely how the socialized system was established in theory without any consideration of how it worked in practice. However, problems started to arise from the outset and implementation of the policy became almost impossible after mid-1985 when the need for a new model began to be emphasized. The following section will discuss the implementation of the socialization model and reasons for its failure as this will also give an insight into some characteristics of the Turkish health sector.

b) Socialization in Practice and Reasons for Failure

Although the Act was passed in 1961, the socialization programme started in 1962 due to financial constraints. Before moving on to developments after the Act, it is essential to elaborate the process by which the Act was passed in order to shed light on some of the reasons for failure.

As mentioned earlier, the Act was the product of the military coup era when the NUC took power. It should be kept in mind that military personnel have certain universal characteristics such as strict rules and, as a result of their command chain, adherence to a top down approach. Some extracts taken from discussions during the process of legislation will make this point clear (Türkiye Büyük Millet Meclisi, 1961: pp.15-40).

The meeting was held on 5.1.1961 and was attended by the members of the NUC, Undersecretary of the MH and other officials from related ministries. The first important point about the process is the fact that the Act did not follow the usual path. Although it should first have been discussed in special commissions and then put before the NUC, the Act came directly to the NUC, bypassing the normal process. This was criticized fiercely by some members of the NUC who wanted it to follow the original process. The reason given for this was that the commissions were overloaded. It was claimed that had the original process been followed, it would have taken more than two months and this period of time could not be afforded as the NUC had promised the country to do something about the health issue. The Act was perceived as the most beneficial contribution of military rule to Turkish civil life and it was seen as an opportunity to show people how the NUC cared for them. That is why they rushed to pass it as quickly as possible before leaving office. There were originally three plans put before them. The first one was the socialization of the country as a whole which was eventually accepted. The second one was socialization of only the Eastern part of the country. The third plan was providing a mobile team to each district *(Kaza)* consisting of at least a doctor and auxiliaries who will visit the villages periodically and deal with the problems of each area (Ünver, Fişek, 1961: pp.41-45). Among these three plans the NUC accepted the most expensive and challenging one.

This choice has been and is being subject to criticisms on the grounds of being unrealistic. The following quotation extracted from the interview with one of the ministerial advisors is not unique and peculiar to him. He stated that:

> *"During the planning of this model there were three alternative models. One of them was socialization and this was the most developed and expensive one. The other plans were more economic and less sophisticated. I believe that had the investments made so far in socialization been made in one of the other plans, it would have been more appropriate".*

The process by which the Act of Socialization was introduced reflects the characteristics of a top-down approach, imposition rather than mutual agreement and a model accepted without consent. Participation of related parties was out of the question during the preparation process. Especially the exclusion of pressure groups like doctors, who in the end will play a crucial role during the implementation process is seen as one of the primary causes of the failures. This explanation is offered by a former Minister of Health during the interviews who is known among the strong proponents of the model:

> *"I think the reason for the failure of the system is the fact that nobody cared about obtaining the participation of the community and interest groups. The model was never clearly understood by the people and as a result they did not devote their efforts towards supporting and improving it".*

Another important point to be mentioned about the debate is the discussion concerning the contribution of the SPO which was founded during that period as well. One of the attendants at the aforementioned meeting persistently asked if there had been any consultation with the SPO (The Planning Bureau as it was called then) while preparing the plan but the answers revealed that no communication had taken place.

The pilot project area for the socialized health services was subject to fierce debate as well. Some, especially the ones who prepared the model, wanted it to start from a province of the Eastern Region, particulary to show the good will of the NUC and to see the real results of the model in areas where the infrastructure was not complete. On the other hand, some others supported the opposite and stated that the pilot study should start from a moderately developed area as the lack of infrastructure might impede the good outcomes of the model and result in abandoning it. The former group was successful in supporting their cause so the pilot study started in Muş (one of the least developed provinces of the Eastern Region). Later the model spread throughout the country and the whole country was socialized by 1984, seven years later than it was originally planned.

As the analysis of Parliamentary discussions since 1963 reveals, the objections to the model started from the very beginning of its

implementation. The model was opposed especially by the rightist governments in power then.

One of the interesting possible causes of the rejection of the system is its association with the Eastern Bloc countries. "Socialization" as a term has connotations of the doctrine of socialism in people's minds and is also associated directly with leftist policies. One of the members of the NUC defended the model in the Parliament as follows:

> "*As a person who took part in the preparation of this model I want to declare two facts. First of all, socialization of health services is not related to the socialist doctrine as the name connotes to many people. Maybe a different term like "nationalization" could have been more appropriate. Second, this project, although prepared by the NUC, has first started to be implemented during the time when the Republican Populist Party (CHP)*[9] *was in power. Although this party claims that they have achieved this reform they have nothing to do with the model whatsoever*" (Türkiye Büyük Millet Meclisi, 1966: p.148).

In the Turkish health policy field socialization has always been associated with leftist parties as they are the strong proponents of the model. However, apart from a very short period, when the Republican Populist Party took office in the 1970s and some short-lived coalition governments, since the starting point of the implementation process there have always

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[9] A left of centre party.

been rightist governments in office. These governments could not stand against socialization directly and bring forth their own policies but they did not commit themselves and showed this through depriving the model of financial and other resources. This tendency has changed dramatically after the mid-1980s, when the government in power took a clear stance in opposing the model and brought its own ideas with the introduction of the Basic Act of Health Services and following arrangements.

One of the fiercest debates during the meeting, when the model was discussed among the NUC members, occurred when discussing the payment method of doctors. As practising both in the public and private sector was precluded by the Act, a detailed plan of monetary incentives was made to compensate the losses of the doctors and to motivate them to work in the socialized areas. However, this was objected to by the members of the NUC on the grounds that other personnel like teachers, military personnel and engineers were working under the same conditions without being given extra money. The Undersecretary of the MH, the architect of the Act, tried to justify this arrangement by emphasizing the fact that doctors have an option to practise privately and that is why monetary incentives were needed to keep them in the service (Türkiye Büyük Millet Meclisi, 1961: p.32). A similar discussion took place in introducing compulsory service for doctors. Some members of the committee suggested the introduction of compulsory service for doctors

and claimed that, as it worked successfully in the military it would work for doctors as well. However this was opposed again by the Undersecretary.

As stated earlier, the model brought with the Act has never worked in Turkey. First of all, the governments that took power after the military coup were not as enthusiastic and committed as the NUC. One of the reasons for this was the financial constraints of the model. It was accepted from the outset that the financial requirements of the model could not be met out of the government budget, through general taxation. The founders of this model left the responsibility of finding financial resources to others on the grounds that it was out of their discretion. Ünver and Fişek stated that "the expenses of socialization in foreign countries have been financed through either taxes or universal health insurance premiums. The determination of the source of money is out of our discretion and should be decided elsewhere" (Ünver, Fişek, 1961: p.37) This situation sheds light on the financial problems that appeared later. The Ministry of Finance rejected the model from the outset and to symbolize this disapproval the Act was not signed by the Minister. This situation was emphasized during the interview with the founder of the model. He said that:

> *"The Act was opposed fiercely by the Ministry of Finance. If you look at the original document you will see that the Minister of Finance had not signed the Act. The Ministry of Finance impeded the project at every stage of development and implementation. All the successive Ministers opposed the*

system and did not do much to provide finance. They have never been enthusiastic to allocate money to the health sector".

This shows that, during the preparation of the model, no consideration was given to the financial burden and ways of meeting this burden. The model was established without the necessary support and the development level and resources of the country were neglected. This was made clear during the interviews with one of the ministerial advisors. He stated that:

"*The proponents of the model have always claimed that the reasons for failure were inadequate and insufficient resources and investments. But the investment requirements should also have been more realistic. The plans made should be consistent with the socio-economic development level of the country*".

The proponents of the model always claimed that the system did not work as sufficient resources were never allocated. The following two quotations from the interviews, the former from the founder of the model and the latter from another proponent represent the views of this group:

"*The Socialization model has neither been efficient nor effective as the governments did not provide the necessary financial support and as they did not follow a coherent personnel policy. Some people claim that the socialization model has failed but this failure does not stem from a failure in the organization or the Act. It arises from the financial problems and lack of a national personnel policy. The model will work once these are provided*".

> *"Socialization is appropriate for Turkey's conditions. This has been tested in many areas, not only in Ankara but in other regions, and its appropriateness has been proven. However, mainly because of the problems in financing and workforce this system did not work".*

Here the ideological stance that successive governments after the military coup had taken, needs to be elaborated further. First of all there was a widespread antipathy towards the military government, so not surprisingly the reorganizations they made were rejected as well. The political parties, who took power after the coup, generally had liberal tendencies and they also wanted to be as sympathetic as possible towards businessmen and landowners mainly to increase their votes. As mentioned above, the financial burden of the model was left to governments and this in the end required radical changes in the taxation system including the inception of new taxes. This of course would have disturbed the groups that the government least wanted to offend. It was also a threat to the status quo. So there was a mismatch between the model's philosophy and the governments' approach. This point was stated by one of the former Health Ministers during the interviews. She said:

> *"The people in the community that are responsible for the health sector did not understand socialization. Maybe they understood but did not believe in it or they believed in but it was in contradiction with their overall policies. The model was brought by social democrats during a military coup but its implementation was always when the liberal parties were in power. Once a social democrat party took power but they*

introduced the Full-Time Law that caused severe opposition from the medical profession".

Another reason for the failure of the model is related to one of the most radical requirements of the model itself, namely, integrating the health services under the auspices of one organization. The fragmented structure of the health sector had long been emphasized as one of the malaises of the system and this was accepted by the NUC as well. That is why the responsibility of providing health services was given only to the MH and integration of other organizations' health service delivery systems to the MH was required with the exemption of the services provided by the Ministry of Defence. The aim was to achieve a unified personnel policy and to standardize the functioning of health services. This aim has never been achieved and the prospect of achieving in the foreseeable future is very slim as well. Failing to achieve the above mentioned requirement resulted in different personnel policies especially as far as salaries are concerned. As stated earlier, although working in a socialized area was quite attractive at the beginning in terms of financial rewards, abolition of the contract system in 1968, introduction of a new personnel policy and arrangements in other organizations' policies took away these advantages and affected the attractiveness of the model which in the end suffered from severe shortages of workforce.

Apart from the obvious failure of the system, one can not deny the contribution it made to rural areas which otherwise would never have been able to have a health service. However, the question whether the money spent until now could have been spent more efficiently and effectively still remains unanswered.

After the inception of the model the construction of health houses and health centres gained pace and in 1990 there were 3251 health centres and 10627 health houses (Devlet Planlama Teşkilatı, 1990b: p.312). However, the process by which those health centres are built has always been under criticism. It is generally accepted that these decisions are influenced very much by local politicians rather than the real needs of the population. Apart from political influences, mistakes made in finding the construction sites and the inappropriateness of the buildings to local conditions have always been criticized. This criticism in reality is also connected to the lack of intersectoral action. For instance the Health Minister in 1965, while describing his experiences in Parliament represented the widely held contention at that time:

> *"Socialization as a principle and philosophy is perfect. There is no doubt about that. However we think that before embarking on expanding the model to other areas the results of the pilot project should have been evaluated objectively. After visiting six socialized areas I found many problems to be solved before it is too late. Unfortunately the buildings are not constructed by taking into account the regional and climatic conditions. This is an unavoidable consequence of*

> *our centralised approach as these decisions are always made at the centre, in front of a map*" (Türkiye Büyük Millet Meclisi, 1965: p.480).

The aforementioned problem is also stated in the Second Five Year Development Plan when the overall evaluation of the implementation process was made. The inappropriateness of the health centre buildings to the climatic conditions is also described there. Moreover, the Plan drew attention to the difficulties in finding appropriate sites for the centres and revealed that in many areas health centres had to be built outside villages causing problems of accessibility for the village people especially during harsh winter conditions where roads are closed six to eight months because of snow (Devlet Planlama Teşkilatı, 1967: p.223).

The connection between the aforementioned problems and lack of intersectoral action or coordination between governmental departments should also be mentioned. Intersectoral action, which will be discussed later in the thesis, has always been stated as a major problem that Turkey faces. Acceptance of the issue of health as the responsibility of the MH alone poses intractable problems during the implementation process. Not surprisingly the socialization of health services was also perceived as the task of the MH alone. The areas where health centres first built were the most underdeveloped areas of Turkey lacking proper roads, clean water supply, electricity and so on. Moreover, the people living in these areas were really poor by any standard. As stated in 1966 by an MP bluntly:

> *"A community development approach involving other ministries should have been started. Health services are socialized without socializing other services such as roads, water, agriculture and so on. This inevitably undermined the socialization of health services. Had it been together with other sectors it would have been more meaningful"* (Türkiye Büyük Millet Meclisi, 1966: p.166).

Apart from criticisms over their establishment, these centres are always criticized for lacking adequate personnel and equipment. Although it was stated in the article 17 of the Socialization Act that socialization can not be implemented in areas lacking necessary buildings, personnel and equipment, this rule has never been followed. Especially during the first 20 years, providing these centres with doctors and other personnel was quite problematic, however, some of these problems were solved after the enactment of compulsory health service for doctors in 1981 (under the military government). As can be seen, all drastic changes and measures are taken during the military coup periods as none of the opposition parties and pressure groups are allowed to express their opinions and as those measures are generally difficult ones to be taken by civil governments overnight. However, this fact itself poses problems in the implementation process. The general negative reaction to military rule is reflected in the execution of the reforms brought by them.

Until 1987 there have not been any major policy changes in the health sector. Socialization covered the entire country and some Acts like "Full-

Time", "Compulsory Service" were passed but there was not a major policy change during the period between 1961-1987. The changes in 1987 started with the Basic Act of Health Services (Act No 3357) followed by the publication of the document "*The National Health Policy*".

iii. The Basic Act of Health Services (Act No 3359)

The Basic Act of Health Services, aimed at delineating the basic principles of health services in Turkey, does not put forward substantial divergence from the Socialization Act as far as the basic principles such as provision of efficient, effective and equal services to everyone are concerned. Nevertheless the likely repercussions of the Act reflect important shifts so far as the health policies are concerned. The most striking conclusion one can reach, after analyzing the Act thoroughly, is the institutionalized stance that the Act takes as far as health services are concerned. Although at the opening paragraphs of the Act there is a brief statement about the supremacy of preventive services, the following paragraphs mainly determine the operation of hospitals, and arrangements about personnel.

Two main changes brought by this Act are; health enterprises and universal health insurance. However, the latter should not be considered new as universal health insurance has been reiterated in almost all policy statements, including the last Constitution, since the 1960s. On the contrary, the former, i.e. health enterprises is a quite new concept in

Turkey. Article 5 of the Act states that public hospitals can be converted into health enterprises i.e. they can opt out of the public system after the recommendation of the related ministry and approval of the MH. Fees charged for the services of these institutions will be the main sources of their income together with the contributions from the State. The Act also brought the idea of personnel attached to the institution by contracts rather than by the general personnel regulations of the State.

An interesting point made by the Act is the emphasis on the referral chain. Article 3(d) of the Act states that health institutions will be organized within a referral chain giving the consumers the opportunity to choose among various organizations at the same level. It is stated that users of the service will pay twice the normal price if they by-pass one level. However, how this referral chain is going to be established and what role the socialized system will play in this chain have not been considered. Although this was not clearly mentioned in the Act, "*The National Health Policy Document*", with the new arrangements it brought, like family doctors, defined this chain later.

One of the main criticisms made of this Act is its ambiguity about various issues raised in different Articles. The Act itself does not bring about concrete solutions or models of organization but describes the framework of the system and leaves the arrangements to governmental decrees which do not require parliamentary ratification. This was fiercely criticized by

the opposition parties who likened it to signing an empty cheque with the amount to be filled in later by the government (Türkiye Büyük Millet Meclisi, 1987: p.362).

After the ratification of Parliament, where the Act was criticized fiercely especially on issues like health enterprises and on arrangements about health personnel, it was brought to the Constitutional Court by the opposition party on the grounds that it contained some articles contrary to the principles of the Constitution. Articles related to recruiting health personnel on the basis of the terms of contracts signed by both parties were cancelled by the Court which in the end put a barrier on the implementation process as this was the main prerequisite of converting hospitals into health enterprises. At present the Act exists on paper and no progress has been made since then either to change it as required or to cancel it altogether.

c. Development Plans

The planned development period in Turkey started with the establishment of the SPO on 30 September 1960, with Act No 91. The Organization, responsible for preparing the five year development plans and annual programmes was also the outcome of the 1960 military coup. Six development plans have been produced thus far and after thirty years of existence, there is a fierce debate about the compatibility of the

development plans with an environment where liberal economic policies prevail. There are basically three camps in this debate: one proposing to continue the planning activities without making any changes; another proposing radical changes to meet the requirements of the time and; third, supporting the idea of abolishing the institution and practice as a whole. The fundamental argument of the last group centres around the concept of decentralization. The main point in the argument is the level of planning process rather than the process itself. For instance one of the interviewees from the MH has stated that:

> *"What we discuss today is at which level planning should be made. Until now, because of the centralized structure of Turkey, planning was centralized as well and the SPO was established above other ministries in the State hierarchy. I think that planning all the details from the centre is a mistake. We have to get the permission of the SPO to buy even very basic equipment for our hospitals which is not practical at all".*

However, this idea was challenged by one of the health sector specialists in the SPO by emphasizing the intersectoral relations needed to improve the health status of the population and it was stressed that to achieve this, all sectors should be planned together in order to harmonize the various activities of different sectors. On the contrary, no attempt to this end has been made in the Development Plans produced thus far. The health section of the Plans has always been isolated from other sectors.

i. Preparation of Plans

The SPO, attached directly to the Prime Minister, is divided into three major departments: Economic Planning, Social Planning and Coordination. It is mainly a techno-bureaucratic organization functioning in a contentious environment. The relationship between the SPO and the political authority is obtained by the Planning Council whose members are the Prime Minister, Deputy Prime Minister, three other ministers chosen by the Prime Minister, Minister of Finance, Minister of Agriculture, Forestry and Village Work, Minister of Industry and Commerce, Minister of Power and Natural Resources, Minister of Public Works and Minister of Transport. The political authority determines the goals and objectives for Turkey as a whole and for each sector and orders the SPO to produce plans consonant with these predetermined objectives. This, on paper, can be seen as an ideal way of harmonizing the goals and objectives but it is not immune to problems. The traditional conflict between politicians and bureaucrats usually blocks the opportunity to prepare sound plans and programmes. Until 1987 the Undersecretary of the SPO, and Director Generals of the Economic Planning, Social Planning and Coordination departments were included among the members of the aforementioned Council having an equal vote in decision-making. However, in 1987, mainly because of the changing attitudes towards central planning and because of the conflicts which occurred in that environment, these

members were excluded and instead new ministers were included in the Council.

The Social Planning Department, where the health sector is situated along with other social sectors, is created to show the commitment made to these areas. However, as Waterston states (1982: p.523) the Economic Planning Department, from the beginning, has dominated the activities of the Organization. Waterston (1982: p.528) defines the creation of a separate social planning department as an "artificial" separation as the goals and objectives of the social sectors are generally determined by the decisions made in the Economic Planning Department.

There are a number of problems experienced during the planning process as outlined by the sector specialists during the interviews. Lack of reliable data is claimed to be the most important factor affecting the quality of the plans. The information system of the country, as in many developing countries, is not reliable, if it ever exists.

The second problem, namely, the mismatch of goals with available resources, stems partly from the above mentioned one and from other influences such as lack of coordination among different organizations and political pressure exerted mainly by politicians.

The third problem is associated with the implementation of plans. The SPO can not exert direct power on the private sector where it has only an advisory role. On the other hand, the mismatch of resources with the goals during planning makes it difficult for the public sector as well. This could be another reason for the decreasing importance of plans that can be observed by browsing through from the first to the last.

In the preparation of sector plans, the major role, at least on paper, is played by sub-committees whose members are well known experts in the area of concern. These committees produce a report in the end which is supposed to be the basic material of the plan. In practice, however, there are certain elements to be discussed. First of all it is the government's influence which actually determines the objectives rather than those sectoral committees. Decisions like the investment level, development rate and priorities are made naturally at the government level and these are the main indicators that will determine the amount of resources to be allocated to different sectors. Second, there are certain doubts about the way in which the sub-committees operate. These doubts were raised by the sector specialists of the SPO during the interviews where one clearly stated that:

> *"Sub-committees in sectors are useless. People attending those committees use it as a means of escaping from their routine work or to show their superiority over their colleagues. I attended one of the health committees where they could not even select a chairman for a long time. The members of the committee do not get prepared on the subject beforehand*

and as a result of this everybody makes suggestions drawn from their area of experience. They never consider the budget and resources when making their suggestions. In the end the report they prepare becomes a report of recommendations and demands. The experts in the health sector department do not take into account these reports and they are shelved immediately after preparation. Publication of these reports is delayed deliberately because there are not any links between these reports and the plans prepared. So by the time they are published, the plan is already starting to be implemented".

The last comment was true for the Sixth Plan as the committee report was not published even after six months of its commencement.

ii. The Health Sector in the Development Plans

An analysis of the health sector in the Development Plans reveals the fact that, in reality, the form of the problems and solutions have hardly changed over time. The format of the health sector part of the Plans stayed almost the same from the first to the last. In terms of detail, however, the previous plans were more comprehensive and detailed, whereas in the last two the health sector section was very general.

Excluding the last plan, there have never been health outcome objectives such as the levels of IMR or life expectancy to be achieved. Instead, sentences like "IMR will be decreased" were preferred without addressing the questions when, how, and to what level? The Sixth Plan is an

exception in that sense, where concrete goals in terms of IMR and life expectancy at birth are determined.

From the beginning of the planned development period, a policy of improving preventive care and perceiving curative care as complementary to the former was adopted which later became, as stated earlier, the motto of all plans and policies. The reason given for favouring preventive care over curative care is always economy. This claim is also made by the majority of the interviewees.

In this section of the thesis instead of analyzing each plan one by one, which would be a duplication of statements, all plans will be analyzed in terms of selected subject areas.

a) Socialization in Plans

Socialization, perceived as the best model that will improve the health status level of the country through preventive care, that will decrease the regional inequalities, and that will contribute to the community development programmes was strongly supported in the first four development plans. However, the first attack to the model came in the Second Five Year Development Plan. The "Integration Model", proposed by the Second Plan in non-socialized areas, where the available health personnel in one region were organized in a way to provide preventive

services by mobile groups, found its supporters from the opponents of the socialization model. This model was implemented in three pilot areas and was claimed to be more effective and cheaper than the former by a group of MPs in the health budget discussions as well (Türkiye Büyük Millet Meclisi, 1965: p.27). However, this initiative did not live long enough to take over socialization and stayed only as a pilot study until it was totally abandoned.

The Third Development Plan, different from the other two as a new perspective plan was prepared replacing the previous one in force, aimed at covering the whole country with socialized services by the end of the plan period. It specifically recommended the socialization of the three most developed provinces, first, to provide proper health services to the urban poor and second, to have developed cities as places of rotation for health personnel. The reasons for having a new perspective plan were stated as the need to have a new plan in the light of the experiences of the First and Second Plans and the Ankara Agreement with the European Community (EC) that proposed a transition period to join the EC. This was the Plan in which the EC and the required policies for possible membership were mentioned for the first time ever.

The Fifth Development Plan, considerably shorter than previous ones, especially as far as the health sector is concerned, only referred to the aim of increasing the efficiency of the socialization programme. This Plan

mainly listed the principles and policies of the plan period such as reducing the IMR, improving the coverage of health services and so on but did not identify any specific targets or ways of achieving these. The Plan looked rather like a list of wishes.

The Sixth Plan, has an important characteristic as far as the socialized health services are concerned. It is the first example of its kind where no reference was made to the socialization model. The main strategies to achieve the aims of increasing the life expectancy at birth to 68 and decreasing the infant mortality rate to under 50 were to improve preventive services and strengthen primary health care services. Improvements in maternal and child health, family planning services, environment, health education were proposed as main policies to achieve the aims together with the establishment of an effective referral system starting from a strengthened primary care level to university hospitals. However, the characteristics of this system, where the socialized model stands in this respect and what is meant by "primary health care" have not been elucidated.

b) Curative Services

As stated earlier, curative services have always been perceived as complementary to preventive services. Apart from that, the curative services policy has always been to merge the services provided by different

organizations under the authority of one, so that a better use of resources will be achieved.

The main themes in this issue, almost in all plans, are the insufficient number of beds, their maldistribution across the country and under utilization of existing capacity due to financial constraints and lack of workforce. The aim to reach was stated as 26 beds per 10 000 population, in line with the recommendations of the WHO for developing countries. This aim was achieved during the Third Plan period not because of an effectively operating sector but through the fragmented structure and lack of coordination among organizations providing health services. In the Fourth Plan it has been stated that, the achievement of the aim of increasing number of beds earlier than the time planned should not be considered as a success both because the main reason for increasing number of beds was the fragmented structure and this achievement affected the preventive services adversely.

The Fifth and Sixth Plan address the management problems in hospitals and the lack of scientific management techniques is stated as the primary reason for the problems faced in these institutions. To solve this problem, training of the workforce with the required knowledge was proposed as the main policy.

Increased involvement of the private sector in the provision of curative services and creating incentives to this end have always been stated as a target in all of the plans.

c) Workforce

So far as the workforce issue is concerned, the main problems tackled in the plans can be stated as the quantity of workforce and its distribution. The complaint of the quantity aspect is more profound in the first plans than the last ones, mainly because of the increases in the number of students recruited in the last decade.

Until the Fifth Plan, the distribution problem is mentioned as the most prominent one affecting the services severely. The urban/rural bias was the major problem outlined as far as the distribution of workforce is concerned. However, after the introduction of the Compulsory Service Act for doctors in 1981, the distribution problem has partially been solved at least on the paper. That could be one of the reasons why the Fifth and Sixth Plans, unlike their predecessors, did not mention the distribution problems.

The emphasis in the last two plans, as far as the workforce is concerned, is on two main areas. The first is the preparation of a workforce plan which still does not exist and the second one is training health economists

and health managers to improve the efficiency and effectiveness of the services provided. The last plan, coherent with its different characteristic of setting concrete numeric objectives, sets the aim of having 1011 people per doctor, 4845 people per dentist, 3655 people per pharmacist, 736 people per nurse/midwife and 2838 people per health technician by the end of the plan period.

In all Development Plans, apart from the above mentioned three major areas of policy, there have been statements about issues like environmental health, pharmaceuticals, health education, maternal and child health, nutrition etc. However, these statements have not gone far beyond being general wishful statements.

B. OTHER POLICY DOCUMENTS

a. The Turkish National Health Policy Document

The Turkish National Health Policy Document (hereafter will be referred to as the Document), prepared with the aim of delineating the national policies to reach HFA by the year 2000, is the latest initiative of the MH. The Document is very important both because it is the first policy attempt ever made to achieve the HFA goal and because it elaborates the future shape of the Turkish health system. Besides, it is the first example of its kind where the MH is actively involved in the policy process.

The reasons behind preparing the document were stated as to determine "a health policy that will not be affected by changing governments and ministers and to pronounce the Turkish commitment to the global goal of HFA 2000". In the preface of the document it was stated that:

> "*The main aim of the policy, that is prepared in parallel with the programme "HFA 2000", is to solve the health problems of Turkey by strengthening the PHC services. Intersectoral action and community participation are the prerequisites of the achievement of these goals*" (Sağlık Bakanlığı, 1990a: p.i).

General policies adopted to this end are stated as follows:

Decreasing the Inequalities in Health: The inequalities between rural and urban populations and regional inequalities were stressed as obstacles to achieving HFA. An example of this inequality was given from the different IMRs of different regions (Sağlık Bakanlığı, 1990a: p.12).

Community Participation and Health Education: It was stated in the document that achieving HFA by the year 2000 could become a reality only with the coordinated attempts of people from every walk of life. HFA can be achieved only by educated people and that is why there is a need to develop a "health" concept in people's mind and a need to use people's intellectual capacities to the maximum. It was emphasized that to achieve the above mentioned objective, a policy of intensified health

education will be followed and genuine attempts will be made to motivate community participation (Sağlık Bakanlığı, 1990a: p.12).

Intersectoral Action: The third general policy was stated as establishing and improving intersectoral action, as health can not be under the responsibility of the MH alone and as a collaborative action with sectors like education, agriculture, environment etc is a prerequisite to achieve HFA goals. The "Expanded Immunization Campaign" of 1985 was regarded as an example of success where a comprehensive intersectoral action was achieved. The Turkish social and administrative structure was stated to be adequate for intersectoral action (Sağlık Bakanlığı,1990a: p.12).

A System Based on PHC: PHC, as declared in Alma-Ata, was accepted as the key to attain HFA 2000 and the definition of the concept as outlined in the Declaration was given. Here a contentious sentence appeared as, "Turkey does not need to make substantial changes in her legal and physical infrastructure to establish a health services system based on the spirit of Alma-Ata. However, as a country we have to review our understanding of health and health services and make our preferences in line with the Alma-Ata Declaration" (Sağlık Bakanlığı, 1990a: p.13). The validity of this statement will be discussed later, however, here it would suffice to say that the above sentence is an oversimplification of reality if the "spirit of Alma-Ata" part of it is correct.

International Collaboration: International collaboration, the last of the general policies, states that achieving the declared objectives require action beyond the national borders. Experiences of other countries, although their conditions could be quite different than Turkey, should be analyzed and views and opinions should be exchanged in the international arena to learn global and local successes and failures (Sağlık Bakanlığı, 1990a: p.13).

After outlining the general policies, main issues such as, management, financing, workforce were tackled and policy directions for these issues in support of general policies were presented in the Document. These will be discussed in detail in Chapter V, where the Turkish commitment to PHC and implementation so far will be analyzed.

The policy document analyzed in detail was published in 1990 and the next step proposed was to discuss it in public with related individuals and organizations, both national and international, to reshape and lastly to refer it to the Parliament and start the implementation process after its ratification. However, despite the fact that this process has been proceeding very slowly, the Document is very important as the first example of its kind where polices for HFA based on PHC are mentioned for the first time in the history of Turkish health policy.

b. The Master Plan Study

The Master Plan Study, contracted out to Price Waterhouse Management Consultants, London, by the SPO in 1989, with the aim of "providing information and recommending courses of action for each major area in the health sector which will form the basis for the development of a master plan" (Price Waterhouse, 1990: p.2), is the first step to meet one of the requirements of the Sixth Five Year Development Plan. Although there were a number of problems at the beginning, the Study was completed in December 1990 with the presentation of the final report to the SPO and acceptance of the recommendations by the Turkish authorities. Now the next step is to prepare the "Master Plan" in the light of the recommendations made in the "Master Plan Study". The problems at the outset of the Master Plan Study were mainly due to the financing of the study and the organizational conflicts between the MH and the SPO.

The Master Plan Study Group, after analyzing the health sector in depth, concluded by proposing four options of action for the Turkish authorities. These were; the status quo option, the national health service option, the free market option and the intermediate option (Price Waterhouse, 1990: pp.10-13). Among the four, the last one was proposed by Price Waterhouse to the SPO and was approved officially as the "best approach to reforming the health sector" (Price Waterhouse, 1990: p.20).

The major theme in the "intermediate option" is the separation of the provision of health care from financing and purchasing. The key element in the proposal is the establishment of a local authority at the provincial level that would prepare plans for the area and become a budget holder in the long run. The health authority, instead of providing services will purchase them from hospitals and primary health care teams.

The authorities' financial resources will come from the amount allocated by the MH for preventive and promotive services, from the existing social security organizations and last but not least from the universal health insurance scheme that will be introduced to cover the populace without any health insurance coverage. The insurance schemes proposed by Price Waterhouse and by the MH differ in terms of the implementation process. Although the MH proposes to create a pool whereby all existing insurance schemes and the new established one will be joined and expenditures will be made from there, Price Waterhouse, considering the political obstacles that might arise, proposes to keep all the existing schemes as they are but add the new scheme. The proposal of the MH is the ultimate aim of their proposal, however, at a later stage. These resources will be passed to the regional health authorities and spent from their budget.

It was accepted from the outset that implementation of this option will not be easy as a number of radical changes are needed to fulfil its requirements. The need for a management information system becomes

prominent as the new independent provider organizations would need to have accurate information to charge the full costs of the services provided. Besides, the opting out process, similar to the reforms in the British NHS, would take a long time and be realized gradually as the capabilities of the individual providers in management would need to be improved first. The implementation of the intermediate strategy is planned to be completed over a seven 7 year period.

The proposals of these two initiatives, the National Health Policy Document and the Mater Plan Study, although they intersect in certain areas like universal health insurance scheme, differ in other aspects. The Master Plan Study does not take a PHC stance as is the case in the MH's policies. For the Master Plan, PHC is explicitly a layer in the health care system although there are some elements included, as will be discussed later, they do not go far beyond the first level of care. Nevertheless, both initiatives attempt at increasing the role of the private sector either by introducing the family practitioner scheme as in the case of the MH or by opting out of hospitals from the public sector as in the case of the SPO. The MH's stance, however restricted, is much closer to the PHC approach in general.

This chapter has elaborated the health policies in Turkey, discussed the successes and failures of existing policies and presented the new policy initiatives in order to provide a basis for the further discussions on PHC

and related issues. After this general introduction of the system and its dynamics, the following Chapters will concentrate on PHC and its implementation in Turkey.

CHAPTER IV. THE PRIMARY HEALTH CARE APPROACH: A UNIVERSAL CONSENSUS?

In the preceding two chapters an attempt was made to introduce the Turkish health sector in terms of health status, health care delivery system and policies. The following sections in this chapter will conceptualize the theoretical base of the PHC approach to elucidate the concept before discussing its implementation in Turkey. To this end, the main aims of this Chapter are: first, to outline the developments before the endorsement of the Alma-Ata Declaration by 134 countries in 1978, and to explore the approaches to health and health services with special reference to developing countries in the pre-Alma-Ata period; second, to discuss the PHC Approach as it appeared in the Declaration with its peculiarities and to present different definitions of the concept; and last but not least, to examine the developments after the Declaration.

A. A BRIEF HISTORY OF THE PRE-ALMA-ATA PERIOD

Writing the history of the pre-Alma-Ata period requires going back to the 1850s, when the "Public Health Movement" of the time had started to come to the fore. The contribution of this movement to the improvements of the health status of today's developed countries has been well documented and analyzed (Agbonifo, 1983; Grosse, Harkavy, 1980; McKeown, 1979). PHC, albeit the catch-phrase of the late 1970s and onwards, is said to be rooted in the public health movement of the late 1800s (Fendall, 1985: p.30). Lemuel Shattuck's report about the health status of the population of Massachusetts, in 1850, has been given as an

early example of the PHC approach as we discuss it today (Evans, et al., 1981: p.1117). In that report, Shattuck, after analyzing the health status of the people, recommended a set of activities embodying elements such as immunization, child health, housing, environmental sanitation, community oriented health workforce, community participation and some others that comprise the essential elements of the PHC approach. It is not the aim here to elaborate the movement in detail, but to elucidate the fact that PHC is not a new phenomenon that appeared all of a sudden in 1978.

In order to present the developments before the Alma-Ata Declaration there are two important aspects to be considered: first the health problems of especially the developing world, and second, quite closely attached to the first, concepts of development and the impact of colonialism on the development of the Third World's health systems.

a. Health Conditions in Developing Countries

The deteriorating conditions of health in developing countries and their reasons, together with attempts to find solutions, have been the main drives behind the PHC movement. Health problems of the developing world, mainly caused by poor sanitation, inadequate housing, infectious diseases and incompetent health services had long been on the agendas of health professionals and international organizations. The gap between the

health indicators of the developed and developing world is evident but the difference among the developing nations is enormous as well.

Low life expectancy at birth in developing countries is mainly attributed to high IMRs caused by diarrhoea, infectious diseases, pneumonia and other preventable diseases whose impact on children is exacerbated by the contribution of malnutrition. Although there have been substantial improvements in the life expectancy figures of developing countries between the period 1940-1970, this improvement lost momentum in the late 1970s mainly due to four reasons: failures associated with vertical programmes like malaria control; adverse effects of economic development and urbanization; failures associated with the provision of modern health care; and, poor utilization of health services and unsuccessful health promotion attempts (World Bank, 1980: pp.18-20).

It has long been recognized that the diseases of the developing world are associated with poverty, poor environmental conditions, lack of clean water and inadequate nutrition (Doyal, Pennel, 1979: p.137; MacPherson, 1982: p.95). According to the estimates of UNICEF, over 1 billion people, a fifth of the whole world population, lack adequate food, clean water, elementary education and basic health care (UNICEF, 1990a: p.3). This figure unequivocally explains the reasons for the high death toll in developing countries. In 1990 it was estimated that 30 per cent of deaths among children under five were caused by acute respiratory diseases, 28

per cent by diarrhoea, 11 per cent by measles, 7 per cent by malaria, 4 per cent by whooping cough and 6 per cent by neo-natal tetanus (UNICEF, 1990a: p.17). Malnutrition, although it may not be recognized as the sole reason for death, is the major contributor to deaths from infectious diseases, diarrhoea and pneumonia. The adult population is also affected by malnutrition that saps their energy and weakens their ability to work and earn a living.

Apart from the aforementioned diseases mainly affecting the child population of the world, diseases that reduce the quality of life like schistosomiasis, malaria, sleeping sickness and others are also widespread in developing countries. However, the existence of this type of a disease pattern does not mean that the developing countries do not suffer from the diseases of the developed world such as cancer and heart diseases. In reality, the existence of both types of disease patterns is stated as the major challenge to the developing nations (Evans, et al., 1981: p.1119; Kleczkowski, et al., 1984a: p.33; Rice, Rasmusson, 1992: p.71).

Problems associated with health resources in developing countries exacerbate the conditions they are suffering today. Apart from the chronic lack of resources, uneven distribution of the available ones poses a great threat to the provision of health services. Health workforce is scarce and inadequate to the country's requirements. Hospitals, mainly situated in urban areas, consume the lion's share of the national health budget. The

existence of a well developed private sector in many countries is a big strain on the public sector as the former usually uses the resources of the latter.

b. Development of Health Services in Developing Countries

A consensus has been reached by all parties that the problems of developing countries, showing the characteristics of the same problems that the now developed countries had a hundred years ago, are rooted in wider issues than simply inadequate health services. The relationship of health to development or underdevelopment has been analyzed by many authors and both the reasons for underdevelopment and its effect on health or vice versa have been explored (Doyal, Pennel, 1987; Gish, 1979; Lachenmann, 1982; MacPherson, 1982).

In this section, first of all the influence of the colonial period on the development of health services in the ex-colonies will be analyzed to make the problems those countries face today clearer and then changes in the concept of "development" over time will be analyzed in order to complete the picture before Alma-Ata, 1978.

Before the penetration of the "Western Medical Care" to distant areas in the World, different medical systems, where both preventive and curative measures were applied, had already existed over centuries. Traditional

medicine, as it is called today, that goes back to hundreds of centuries had played and is still playing an important role in people's lives. Apart from some unknown local traditional practices, the most well known and widely practised ones today are Chinese and Ayurvedic medicine, which, quite ironically, adopt a holistic approach to health that the modern Western medicine has emphasized only recently (Gesler, 1984: p.17). Banerji (1974: p.1333) elaborates the health practices in India going back to the centuries Before Christ and comes to the conclusion that, even after the early period of British rule in India, the Indian system of medicine was superior to the Western system of medicine in terms of the holistic approach it adopted. Hasan (1978: p.20) suggests that had the prevailing traditions in these societies continued in the same manner, these societies would have continued to make progress and their health status indicators would have competed with the developed world.

The changes in developing countries -moving towards Western/Modern type of medical care and ignoring the traditional practices- started when colonial powers introduced their systems to these countries, the strong motive being to provide health services to their natives in colonies (Banerji, 1974: p.1334; Gish, 1979: p.205; MacPherson, 1982: p.102; Hasan, 1978: p.20). As Gish outlines, the system brought by these powers was composed of three major elements: the urban hospital, the rural dispensary and hygiene or public health element. All these three elements were mainly directed towards creating and maintaining a healthy

environment for Europeans and to help economic activities. Gish states that "the administrators and staff of colonial medical institutions saw themselves as providing a needed service, as well as helping to introduce more scientific and orderly method into the health and health care environments of the more "backward" parts of the world. It was generally assumed that the administered people would prosper to the degree they became like those who administered them" (Gish, 1979: p.205).

Independence did not alter the outlook of medical services in these ex-colonies, the only difference being the attempts to expand the aforementioned structure to the majority of the population. However, these attempts, quite contrary to their stated aims, ended up with more resources for curative-urban services directed towards the elite. The system inherited from the colonial powers was adopted without questioning its applicability in their own conditions. Furthermore, the ex-colonies and other developing countries turned their face to the United States as a model for developing their health services and that meant construction of modern hospitals and sophisticated medical care (Roemer, 1986: p.60).

However, this does not mean that nothing has been achieved so far as the rural population is concerned. The rural health centre concept as outlined in King's most quoted book (King, 1966), where he elaborated a model of health care in developing countries in detail with special emphasis on health centres and medical auxiliaries, has been perceived by many

politicians of the Third World as a way of expanding health services to the rural populations. So the Basic Health Services movement, emphasizing rural health centres where maternal and child health care, immunization, environmental sanitation, in sum both preventive and curative activities are undertaken, evolved during the late 1960s. However, as Ebrahim and Ranken state, in most of the areas the services continued to show the characteristics of an institutionalized ambulatory care (Ebrahim, Ranken, 1988: p.5).

Another aspect of health services after independence or during the 1950s was the considerable emphasis made on disease eradication campaigns where vertical organizations to combat specific diseases were established mainly influenced by international organizations such as the WHO. The most notorious one of these vertical campaigns is the Malaria Eradication Campaign of the WHO, launched in the late 1950s, which was declared as a failure later in 1968 (Roemer, 1986: p.61). Banerji (1974: p.1343) discusses the adverse impact of mass campaigns after independence in India and states that their most detrimental contribution to the health of the Indian population was obstructing the way to develop and improve a permanent health system based on real needs of the rural population. The subject of vertical approach to health will be discussed later especially in the SPHC section.

In the international arena, frustration with the so called "trickle down" approach to development was the watershed in international thinking. The dominant view of the early 1950s until the 1970s was the emphasis on economic growth measured mainly by increases in GNP via capital accumulation and investment in productive sectors (Agbonifo, 1983: p.2004; Arndt, 1983: p.1; Christian, et al., 1977: p.64; Gish, 1979: p.208; Grosse, Harkavy, 1980: p.165). Social sectors such as health and education have received little or no attention, especially health services which were often perceived as a "bottomless pit" (Gish, 1979: p.208). It was assumed that the benefits of economic growth would "trickle down" to the population in the form of jobs and other economic opportunities. The concept was dominant until the 1970s when it was realized that the poor people of the world did not benefit from the high levels of economic growth enjoyed by many of the third world countries. Dudley Seers (1969: pp.2-3) criticized this definition of development and suggested three more appropriate measures of development as: improved nutritional status, greater possibilities for employment and increasing equality between groups and social classes within and between countries. Health, heretofore perceived mainly as a consumption good rather than an investment good, came to the fore of the discussions as one of the basic sectors contributing to development via increased productivity of the labour force. However, the interaction between health and development is a complex one. Grosse and Harkavy drew attention to conflicting evidence coming out from research in this area as the findings differ from disease to disease and

place to place (Grosse, Harkavy, 1980: p.166). On the other hand, the major drawback of this approach is its inability to answer the dilemma it poses in terms of the health investments that should be made to the economically inactive population groups, like the children and elderly, who in reality are more in need (Abel-Smith, 1976: p.141; Jackson, Ugalde, 1985: p.22). Besides, the possible negative impact of development on health is another issue of concern. The negative impact of development projects on the environment and health status of the population and agricultural practices have long been discussed (Fendall, 1985: p.320; Elliot, Cole-King, 1981: pp.568-569). For instance, it is well known that irrigation projects have a positive effect of increasing agricultural product but they also have a role in increasing incidence of schistosomiasis. Similar effects can be found in other areas as well.

The major outcome of the "trickle down approach" in the health sector was the construction of "centres of excellence" in developed urban areas, usually attached to a medical school, with the expectation and hope that their services would benefit the whole population. However, they did not produce the expected improvements in the health status of the people; besides they became a burden on the limited health budgets of the poor nations and their cost increases became unbearable (Golladay, 1980: p.27).

After worldwide acceptance of deficiencies in equating development with increases in GNP, the international community turned its face to the "Basic

Needs Approach", an outcome of the involvement of the human factor in economic thinking, that was formally articulated in the International Labour Office's World Employment Conference of 1976 (Grosse, Harkavy, 1980: p.165). The Basic Needs Approach was defined as one "which gives priority to meeting the basic needs defined as fulfilment of certain standards of nutrition (food and water) and the universal provision of health and education services to all the people" (Stewart, 1985: p.1). In the health field the reflection of this new movement emerged as the PHC approach (Berman, 1982: p.1054; Gish, 1982: p.1049-1050), as it was regarded as the representative of the health services/sector component of the basic needs strategy (Gish, 1982: p.1050).

B. DECLARATION OF ALMA-ATA

The attempts on the WHO front, leading to the Declaration of Alma-Ata, started as early as 1951, when the Director General of WHO, in his annual report, criticized the specialized mass campaigns for the eradication of diseases as endless efforts if they are not followed by the establishment of permanent health services. The same tendency continued until the 1960s when the promotion of Basic Health Services started to influence many developing countries. Between 1960-1970 strong emphasis was made both by the WHO and the UNICEF on integrating special programmes with basic health services. The dissatisfaction with the existing health conditions in developing countries became the central focus of debate in the early

1970s. In 1971 WHO and UNICEF decided to carry out a joint study where the aim was to propose "alternative approaches to meeting basic health needs" in developing countries. The research, completed in 1975, reached the conclusion that:

> *"Despite great efforts by governments and international organizations, the basic health needs of vast numbers of the world's people remain unsatisfied...To meet the main health needs of the underprivileged who make about 80 per cent of the population in less developed countries, health services should seek out these people, find what they need and want and protect, treat and educate them. The strategy adopted for this purpose by many developing countries has been modelled on that of the industrialised countries, but as a strategy it has been a failure" (Djukonovic, Mach, 1975: p.7).*

Their recommendations, that virtually resulted in the Declaration of Alma-Ata, were based on the experiences of countries who had achieved a certain level of health status or had a prospect of doing so with limited resources. The study recommended the adoption of PHC that will be a part of the overall development process; that will encourage active participation of all the parties concerned; that will use primary health workers selected by their community; and, that will emphasize preventive measures, health education, maternal and child health, traditional practitioners, appropriate technology and so on and so forth (Djukonovic, Mach, 1975: pp.105-106).

This marked the turning point on the route to Alma-Ata and another study sponsored by WHO, with the same emphasis on community involvement, strengthened the international thinking on how to improve the health status of the underprivileged. Newell (1975), again basing his argument on the experiences of countries or programmes at different levels, concluded that health should be achieved "by the people". Later, Gish (1979), considering the fact that health can not be achieved only "by" the people without the involvement of governments, suggested the term "health with the people" instead. Here it has to be stated that China and its approach to health and health care have played an important role in this new movement of the 1970s. The political issues attached to these achievements will be discussed later, however, it should be noted that the common points in countries that achieved overall development in their health status were integrating health into their development process without separation as experienced in the 1960s, and adopting a community based approach.

There are of course a number of points to be discussed about the applicability of the examples presented in both studies to different settings, and there are also political, economic, social and other factors to be considered before embarking on attempts similar to those examples. However, recommendations that emerged from these two studies formed the Declaration of Alma-Ata and in 1978 the PHC approach was ripe enough to be launched at an international conference sponsored by the

WHO and UNICEF as the key to attaining the global target of Health for All by the year 2000, defined as "the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (WHO/UNICEF, 1978: p.3). The concept of HFA and its meaning was articulated by H. Mahler, the architect of the concept, in detail. He stated that HFA means that: health is reachable by every member of a society and removal of obstacles to health like malnutrition, unhygienic housing, lack of medical personnel to this end; that health is not a means to achieve economic development but rather an end in itself; and HFA is a holistic concept combining the efforts of other sectors such as education, housing, industry, medicine and public health (Mahler, 1981: p.6).

The Conference, that has been acknowledged as "the largest and most authoritative international meeting on health care ever convened" (Golladay, 1980: p.28), was attended by representatives of 134 countries and delegates from 64 United Nation organizations together with specialized agencies and non-governmental organizations. The term PHC was defined as:

> *"the essential health care based on scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and*

> *self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community*" (WHO/UNICEF, 1978: p.3).

In the same document the characteristics of PHC were outlined as follows.

PHC:

> ***(a)*** *reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and based on the application of the relevant results of social, biomedical and health services research and public health experience;*
> ***(b)*** *addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;*
> ***(c)*** *includes at least; education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;*
> ***(d)*** *requires and promotes maximum community and individual self reliance and participation in the planning, organization, operation and control of PHC, making fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate;*
> ***(e)*** *should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all and giving priority to those most in need;*
> ***(f)*** *relies at local and referral levels on health workers including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the*

expressed health needs of the community (WHO/UNICEF, 1978: p.5).

The Declaration has triggered an exchange of views in the international arena, but a consensus has not yet been reached regarding either the meaning of PHC or certain components of it. The following section will discuss these topics.

C. PRIMARY HEALTH CARE: A COMPREHENSIVE APPROACH OR FIRST LEVEL OF CARE?

The Declaration of Alma-Ata, concomitant with a growing literature on the issue, has articulated the PHC concept, its characteristics and main features. Although it has been nearly fifteen years since the Declaration, an explicit definition of PHC has not been reached yet. The Declaration is criticized by some authors on the grounds that it overlooked complex interactions operating in a society (Sidel, Sidel, 1977), and it is seen by some as another attempt of the developed world to impose their solutions, mainly based on medical care, to the health problems of the developing world (Navarro, 1984). Others criticize it on the grounds of being an ambiguous collection of statements open to misunderstandings and misinterpretations (Frenk, et al., 1990: p.678). Despite the existence of such criticisms, the Alma-Ata Declaration and its contribution has been

praised by the majority of the people involved and it has been described as a watershed in health history (Banerji, 1988: p.294).

In spite of the consensus and commitment reached during the endorsement of the Declaration among all country representatives involved, the implementation process so far does not reflect the same enthusiasm. One of the reasons for this, inter alia, could be related to how PHC is perceived and defined by the parties involved.

The narrow definition of the concept regards PHC as essential health services provided at the first level of contact by an auxiliary, a health worker or a general practitioner. This approach to PHC is usually the outcome of associating health with medical care. According to this definition, it is the first level of a referral chain where complex cases are referred to the secondary or tertiary level. Preventive measures like immunization, health education are also carried out at this level. Parker, et al., in their research, where they tried to find a common meaning of primary health care by analyzing the perceptions of different groups including professionals and consumers, reached the following definition, reflecting the narrow definition of PHC: "Primary care provides basic services, including those of an emergency nature, in a holistic fashion. It provides continuing management and coordination of all medical care services with appropriate retention and referral to other levels. It places emphasis when feasible, on the preventive and the preventive-curative

spectrum of health care. Its services are provided equitably in a dignified, personalized and caring manner" (Parker, et al., 1976: p.428).

The practical implementation of this definition takes the form of general practitioners (or other members of the team like health visitors) in the developed world; and health centres, established during the 1960s in the developing world. PHC is associated with services of these centres that are basically responsible for the eight elements of PHC activities outlined in the Alma-Ata Declaration. In the past, these centres have suffered severely from shortages of personnel and other resources, making it almost impossible to undertake the responsibilities they are assigned. This model was criticized mainly because of its negligence of community involvement in decision making and its hierarchical description of relations where the influence of medical practitioners made the involvement of other professionals and auxiliaries almost impossible (Lachenmann, 1982: p.28).

Frenk et al. criticize the Alma-Ata Declaration for the emergence of this narrow definition, as they claim that the Declaration did not clarify the relationships between primary care and prevention or between secondary care and curative medicine. Although the Declaration aimed at promoting all aspects of a nation's health care system, they say, the constant emphasis on the primary level of care, as it is the most underdeveloped one, resulted in the identification of PHC with first level care (Frenk, et al.,1990: p.678).

The broad definition, which lies at the core of this research, is a comprehensive one that does not only involve health but other sectors as well. In this definition, PHC is seen as part of a development process where health care is an essential part of it and community involvement at all levels is a prerequisite for success (Ebrahim, Ranken, 1988: p.7; Heggenhougen, 1984: p.221; Rifkin, Walt, 1986: p.560; MacPherson, 1987: p.76). It is not another layer in the health care delivery system, as perceived in the former, but rather a philosophy and an approach to improving the health status of people. Figure 1 shows the form that a comprehensive health system based on PHC principles takes.

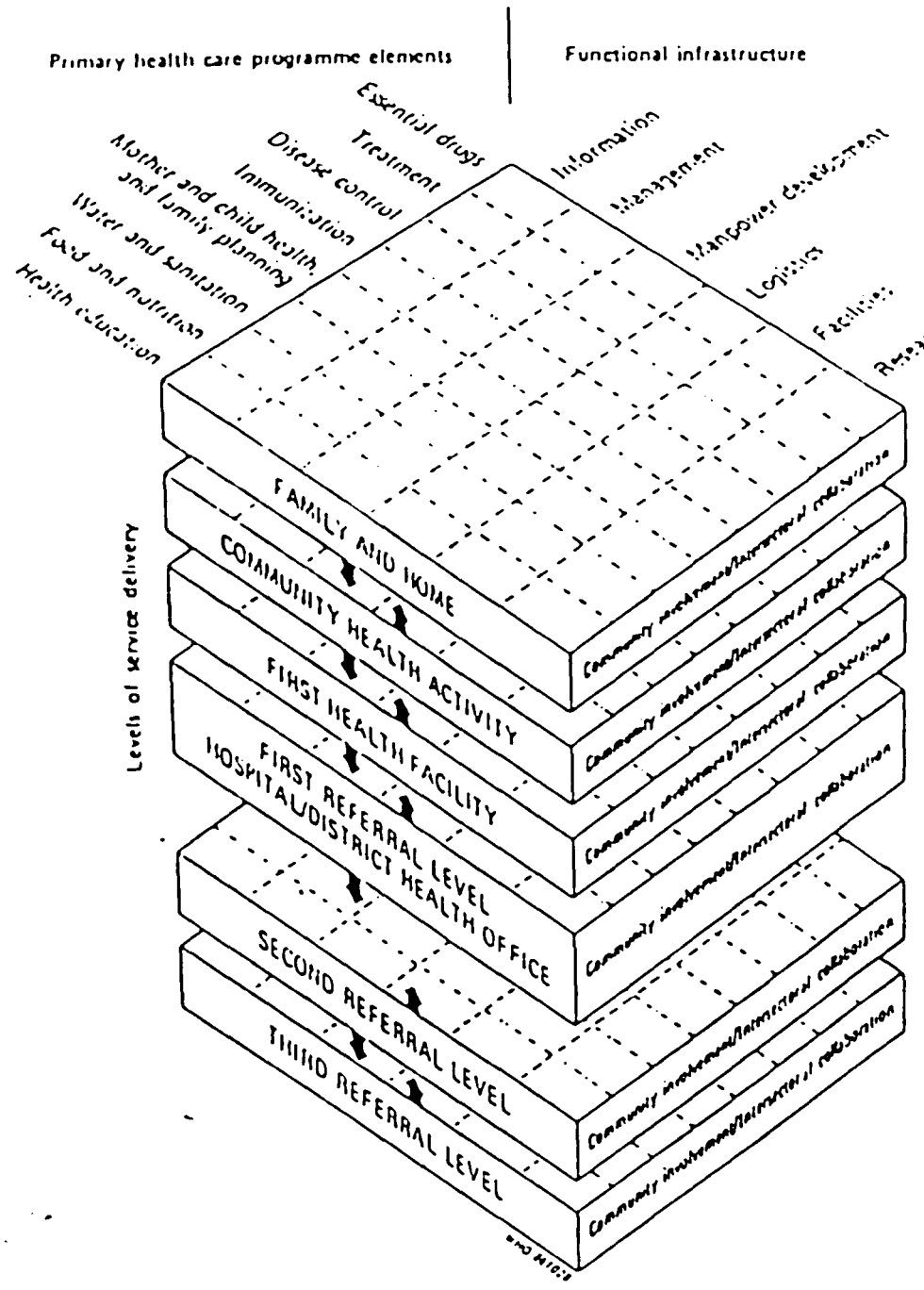
The characteristics of a health system based on PHC have been summarised by Kleczkowski, et al., as follows (1984b: p.7):

A well balanced health system based on PHC should:

-encompass the entire population on a basis of equity and responsible participation;
-include components from the health sector and from other sectors whose interrelated actions contribute to health;
-provide the essential elements of PHC at the first point of contact between individuals and the health system;
-support the provision of PHC at the local level as an important priority;
-provide, at intermediate levels, the skilled and specialized care needed to deal with the more technical health problems requiring referral form the local level, as well as continued training and guidance for communities and community health workers;
-provides, at the central level, planning and managerial skills, highly specialized care, teaching for specialized

staff, the services of such institutions as central laboratories and central logistic and financial support;
-provide coordination throughout the system with referral of problems between levels and among components wherever appropriate.

Figure 1: A Conceptual Model of a Comprehensive Health System Based on the Principles of PHC



Source: WHO, 1987: p.21

Proponents of this broad definition of PHC, emphasize the "bottom-up" characteristics of the approach. "Democratization" of health services, as Banerji calls it (1988: p.295), requires active involvement of the community in all activities. A joint study carried out by WHO and UNICEF on health policy sums up the broad definition of PHC by stating that "far from being just the addition of yet another layer to the health service -at the bottom, in the communities, using community resources- it implies a reordering of priorities that should permeate all levels and sectors concerned with the promotion of health" (WHO/UNICEF, 1981: p.6).

On the other hand, PHC can also be viewed as both an approach and a set of activities. As an approach it implies that improvements in health depend largely on improvements in food, water, sanitation, housing, education and employment. Therefore ministries of health have only partial responsibility in improving the health status of the population. As far as health activities are concerned, these are mainly the responsibility of the health care delivery system, hence, the MH (Vaughan, et al., 1985: p.1).

The aforementioned categorization of PHC definitions as "broad" vs. "narrow" simplifies the discussions around the issue. As the perception of PHC approach itself will generally determine the applications later, it seems appropriate to scrutinize the subject further. Van der Geest et al., proposing a multi-level perspective in analyzing PHC, drew attention to

the fact that PHC means different things to different people having different positions in the political hierarchy. They define PHC from the international organizations', state's, professional health workers', and populations' point of view. International organizations, mainly WHO and UNICEF, perceive PHC as an integration of two approaches: community based health care and basic health services. However, the changes that occurred in the PHC policy of these organizations, especially changes in the policies of the UNICEF that will be discussed later in detail, have both proven the controversy surrounding PHC and made the attempts at definition more complex. State's definition of PHC is under the influence of complex political and social interactions. PHC is a hot political topic which can be used by the state to serve its long and short term objectives. Van der Geest et al. sum up the three particular characteristics of PHC at the national government level as: medical, where the aim is to extend the coverage of medical provision and to improve morbidity and mortality rates; political, where improvements achieved through medical provision are used to increase the political credibility of the government; or, financial, where the government hopes to reduce expenditure for basic health care and to increase its revenue through international aid. According to Van der Geest et al. the view of PHC from the professional health workers' corner is bleak and they have a host of reasons to reject PHC and to refuse involvement in it. These reasons are mainly related to the financial implications of PHC on their career, their education that is not consonant with the requirements of the PHC policy and inadequate

living conditions in rural areas. As far as the fourth level of the multi-level perspective taken by Van der Geest et al. is concerned, i.e. population, the PHC approach even becomes more complex. Here the main emphasis is on the probable differences and even conflicts between the perceived needs of the population and their needs defined by planners and epidemiologists. The authors draw attention to how the "self-reliance" concept can be used to let the governments off the hook and how this can be opposed by the community (Van Der Geest et al., 1990: pp.1026-1030).

In this thesis, the Alma-Ata definition of PHC will be the yardstick in every discussion mainly because all participants, including Turkey, have shown their commitment to and acceptance of this definition, both by endorsing the Declaration and by declaring PHC policies at the national level afterwards. This does not imply that the researcher is not aware of the facts and fallacies inherent in commitments of this type. As Mburu states (1980: p.17), whatever the commitment of a country to this kind of international declarations, in the end, it is free in the implementation process. Especially in such a contentious topic, requiring a major social transformation, as stated in the joint WHO and UNICEF study (WHO/UNICEF, 1981: p.7), it would be naive to expect translation of these commitments into actions wholeheartedly all around the world. As De Kadt states, since the 1970s, the international arena has experienced such declarations over a number of development related areas and special implementation programmes attached to them that ended with frustration

(De Kadt, 1982: p.741). However, since the time of the Declaration, the PHC wave has not yet lost its pace, both in national and international arenas, emphasizing the need for research to elaborate the concept in detail.

Since the Declaration, as a result of the conflicting views stated earlier, PHC, primary medical care and first level of care are sometimes used interchangeably. Frenk et al. (1990: p.678) draw attention to confusing PHC with primary medical care and articulate the two concepts by stating that the former is associated with risk anticipation and the latter is concerned with providing care for uncomplicated conditions. In their interpretation, PHC encompasses primary medical care but not vice versa. Identification of PHC with primary medical care or first level of care, and isolation of it from secondary and tertiary care is the result of the identification of PHC with primitive, low technology and cheap first contact care. The erroneous contention that PHC is a cheap solution for the vast majority of third world countries has long been challenged. There are basically two misconceptions here. First of all PHC is not only an approach for the third world but also an approach valuable for developed countries as well (Kaprio, 1979; Kleczkowski, et al. 1984b). Although the problems these countries face are diverse, their solutions are not so much different as far as the ideological interpretations attached to the PHC approach is concerned. Kleczkowski, et al., in their attempt to show its relevance to developed countries state that in the heavily polluted

contemporary society of the 1990s, people living in developed countries also need policies for "safe" water and policies to promote healthy life styles. (Kleczkowski, et al., 1984b). Townsend and Davidson's most quoted "Black Report" and its continuation, Whitehead's "The Health Divide", proclaiming the existence of inequalities in a developed country is an outstanding evidence of the validity of the approach in the developed world as well (Townsend, Davidson, 1988).

The second and maybe the most important misconception is identifying PHC as a cheap solution. This view has been criticized fiercely and it has been accepted that this type of misconception not only undermines the value of PHC but also affects its implementation process (Fendall, 1985: p.312; Joseph, Russel, 1980: p.142; Segall, 1983: p.1948; WHO/UNICEF, 1981: p.56). Joseph and Russel (1980: p.142), in their attempts to estimate resource requirements for PHC, argue that although their analyses rely on rough estimates and several assumptions, they can safely conclude that even these facts reveal that PHC is an expensive undertaking. Segall (1983: p.1948) as well emphasizes this by drawing attention to the fact that although unit costs of PHC interventions are low, when population coverage is considered the bill to be paid increases dramatically. One of the reasons for this misconception could be the association of PHC with preventive care and regarding it as cheaper than curative care. The myth that prevention is cheaper than cure has been challenged on the grounds that it involves other sectors including housing, agriculture, education etc.

(Klouda, 1983: pp.49-50). On the other hand, considering the comprehensiveness of the approach, that it encompasses all preventive, curative, rehabilitative and promotive activities, the identification of preventive care with PHC is a false assumption. Although the approach emphasizes the importance of preventive care and "prevention is better than cure", it does not discard curative care or any other forms of activities directed towards improving the health status of people. Besides, as has been stated elsewhere, in a world where a reservoir of disease exists, people demand to be cured rather than prevented (Fendall, 1981: p.394; Fendall, 1985: p.309; Gish, 1978: p.51; Vaughan, Walt, 1984: p.110). The crucial point is to establish a balance between the two, rather than reject either the former or the latter. This labelling of PHC as a cheap solution only helps the wrong assumption that PHC is a second class medicine and secondary and tertiary care are first class. This is not true (Joseph, Russel, 1980: p.138; Kleczkowski, et al., 1984b). Concepts inherent in PHC like appropriate technology, community self-reliance, community health workers and essential drugs make it vulnerable to identification with low technology and second class medicine. The main menace of this kind of thinking is the creation of a two tier health system whereby the rich enjoy high-tech sophisticated medical care and the poor are left inadequately supported by any health care.

D. PILLARS OF THE PRIMARY HEALTH CARE APPROACH

The PHC movement gained pace after the Declaration, and many countries around the world proclaimed their commitment to the approach and embarked on programmes. However, fourteen years after the event, the future of PHC seems bleak (Smith, 1982: p.30; Van der Geest, et al., 1990: p.1025). On many occasions, the narrow definition of PHC was adopted and the extension of basic health services, founded earlier, has usually been associated with PHC. Attempts were made to increase the number of health centres and to provide them with health professionals (Kleczkowski, et al., 1984b). Also in many cases small projects or CHW programmes were labelled as PHC (Vaughan, Walt, 1984: p.111). The replicability of these projects in other areas has been discussed and it has been found that application of these projects, usually affected by the local conditions and initiated by local leaders, on a nationwide basis brings some problems (Smith, 1982: p.31). Because of the attractiveness of these projects to donors, as will be discussed in the SPHC approach, and because the financial requirements of these projects are initially met by the donors, governments agree to them without considering their long term implications. Once the donor completes its contribution, these projects usually collapse or are withdrawn as they are not fitted to the general framework of the health delivery system of the country at the outset. So in conclusion it can be said that only eight years away from the year 2000, the achievement of the goal of HFA through PHC has been endangered

severely. This section will mainly focus on the possible reasons for this outcome and the next one will discuss the "SPHC" approach which emerged as a challenge to the original PHC approach declared in Alma-Ata, frequently labelled as "Comprehensive PHC" to distinguish it from the former. In the following part of this section, essential components of the PHC approach that may have an influence on the implementation of the approach will be discussed.

a. Emphasis on Equity

The first feature of the concept, and indeed at the core of the debate where failures are discussed, is its emphasis on equity. As Segall (1983: p. 1947) points out, "PHC implies equality of access to health care of people with equal need and the reference point to this approach is thus equity". The wording "all" in the global aim of "Health for All by the Year 2000" implies an acceptable level of health for all people in the world. The call for social and economic justice has been unequivocally made by the WHO in its 1979 publication of "Formulating Strategies for Health for All by the Year 2000" where it has been stated that "the overall social goal of Health for All has to be broken down into more concrete social policies aimed at improvement of the quality of life and maximum health benefits to all. If the gap between "haves" and "have nots" is to be reduced within and among countries, there will be a need in most countries to formulate and put into effect concrete measures for a more equitable distribution of

resources. In many countries, this will imply the preferential allocation of resources to those in greatest social need as an absolute priority as a step towards attaining total population coverage" (WHO, 1979: p.12). This means that the disadvantaged groups at the moment, namely, the urban poor and rural population will have to be given special consideration to meet their needs so far as the global objective is concerned. However, this is easier said than done as the complex interactions of social, political and economic factors existing in a society affect the implementation to a great extent.

It is widely accepted that there is a huge gap between urban and rural populations in terms of resources allocated and services provided (MacPherson, 1982: p.99; Muhondwa, 1986: p.1247). One outcome of this negligence of the poor and rural population is the undeniable gap between the health status indicators of both groups.

Maldistribution of resources in the developing world, both financial and material, mainly because of the health care systems adopted, has already been acknowledged. The hospital based, curative care and high technology oriented characteristics of the systems adopted were mentioned earlier. These services are mainly concentrated in urban areas where the elites and health professionals enjoy a health service that can compete with its counterparts in the developed world. In reality, the demand for this high-tech organized medicine comes mainly from the better-off members of the

population and the providers of care (Gish, 1990: p.402). However, the adoption of the PHC approach requires a major shift in this prevailing resource allocation pattern. It is not only a matter of increasing the resources allocated to the health sector from the general budget to the MH, but rather a more radical process whereby the resource allocation pattern within the sector needs to be arranged in favour of the PHC policies adopted. As Segall comments, more resources to a maldistributive system can only exacerbate the existing problems (Segall, 1983: p.1948). Moreover, even if other conditions like political will to increase the resources allocated to the sector existed, in this world of recession and low economic growth, it seems impossible to increase the level of resources devoted to the health sector in the foreseeable future (Evans, et al., 1981: p.1122; Amonoo-Lartson, 1984: 200). This implies either shifting resources from other sectors or reallocating the resources within the health sector and in many cases doing both. This is the major challenge to PHC as it requires strong political commitment and change in the socio-political structure of the society (Chen, 1986: p.1264; Gish, 1973: p.411; Mahler, 1981: p.18; Vaughan, Walt 1984: p.109; WHO/UNICEF, 1981: p.61). It has been stated that "it is relatively easy to make a political commitment to PHC at the policy level but it will require political steadfastness to see the process through the stages of implementation, when the pattern of resource allocation is changing" (WHO/UNICEF 1981: p.61). This means shifting resources from hospital based care, enjoyed by the urban population, to the rural population. However this is not as easy as stated

mainly for two reasons. First, because it is almost impossible to move the physical plant already established (Segall, 1983: p.1948) and second, the objection of the urban population and health professionals to such an attempt could hinder the process (Amonoo-Lartson, et al., 1984: p.197; Gish, 1973: p.412; Segall, 1983: p.1948; Vaughan, Walt, 1984: p.108; Walt, Vaughan, 1981: p.12; WHO/UNICEF, 1981: p.61). As the beneficiaries of the status quo, and the most influential group of people that could exert power over resource allocation decisions, their objection could impede attempts to adopt and implement the PHC approach.

The objection or lack of enthusiasm of the professionals may stem from both the type of education they get, where the major emphasis is on hospital based curative services, and from the material benefits of practising medicine in urban areas mainly in the private sector. Decosas while discussing Sierra Leone's attempts to prepare a PHC action plan, draws attention to the importance of gaining the support of the elites and concludes that if one of the elite groups (professional, economic, political or bureaucratic) had committed itself to the plan, the plan might have had a chance of survival. His discussion of the lack of commitment from the medical profession centres around the threat that PHC can pose to private practice which is the major source of income for the majority of doctors and nurses (Decosas, 1990: p.176).

Professionals' attitude is quite important as the key positions in the ministries of health in developing countries are usually held by physicians. These physicians, by virtue of their education, either in their own country or abroad, have a substantial commitment to hospital based health services. Ugalde (1978), draws an example from Iran where the "laissez-faire" values of the American medicine were brought in the 1970s by Iranian doctors trained in America. In another attempt to investigate the influence of medical doctors in developing health policies, Ugalde (1979) concludes that in Columbia where the medical doctors have a firm grip over public health policies, their equation of health with medicine results in strong emphasis on curative care over preventive programmes. The other opposition to reallocation of resources can come from the "elites" who are mainly the bureaucrats, military personnel and politicians.

Under the aforementioned circumstances, it has been stated that as reallocation of existing resources seems almost impossible, the new resources allocated to health care should be directed towards PHC. Nevertheless, as stated earlier, the financial state of the World is not as good as when the Declaration was made. Apart from these financial constraints, the weak position of the MH among other ministries (Vaughan, Walt, 1984: p.113) and still perceiving health sector as a "bottomless pit", imply the fact that the ministry will be deprived of the funds needed. There is ample evidence that in times of austerity measures, the MH's expenditures will be the first to be cut back.

Another factor playing an important part in the equity considerations is the existence of a well developed private sector in many countries. Segall, in his analysis of the effects of the private sector on PHC, classified its effects as economic, ideological and political. Economically, absorption of health care personnel trained at the public expense, inflation of medical costs, higher earnings compared to the government service, government subsidies of private medicine through tax concessions or use of public resources by part time private practitioners are considered to be a drain on the already restricted resources. On the other hand ideologically, its emphasis on clinical care poses a great threat on the adoption and application of the PHC approach. Last but not least, the political effects of the existence of a private medicine occur with the institutionalisation of the medical profession through associations. The medical profession, through their "professional associations", assigned the role of defending the interests of their members, exert power in the political arena and influence the policies adopted, which in many cases reflect the biased tendencies mentioned earlier (Segall, 1983: pp.1951-1954). Apart from these, the existence of a private sector may also preclude the implementation of a national health policy as the government will not have much control over its operation (Vaughan, Walt, 1984: p.110). The considerable amount of money spent in the developing countries as direct household expenditures to the private sector is another issue of concern. Redirection of those already available resources can be an alternative way of raising resources for PHC.

So far resource allocation issues, the importance of political will and the influence of the private medical sector on equity have been discussed and the major issue surrounding this debate has been deliberately left to the end of this section, that is the influence of the regime type in adopting a PHC point of view. As mentioned at the beginning of this chapter, the two publications of the WHO, (Djukonovic, Mach, 1975; Newell, 1975) where examples of PHC practices were presented, have played the major part in translating these ideas into the Declaration of Alma-Ata. However, in these examples only China, Cuba and Tanzania covered the entire society and other examples came from isolated projects implemented in one part of a country for a group of the population. The common characteristic of these countries, that is, the existence of a fundamental shift of wealth and power in the society has been cited as the major reason for their success (De Kadt, 1982: p.747; Rohde, 1983: p.13; Sidel, Sidel, 1977: p.418; Vaughan, Walt, 1984: p.109). Boland and Young (1982: p.234) argue that restrictions on personal freedom in those countries are contradictory for the "Western Democracies", that is why they seem to propose a trade-off between such individual freedoms and improvements in health status. This view has been challenged by others and it has been stated that PHC does not necessarily require a "socialist" regime but rather a political structure that puts emphasis on equity (Bossert, Parker, 1984: p.696).

As stated earlier, China has set an example of a country where a reasonable level of health status has been reached with limited resources, and the experience of this country has been the major motive behind the PHC approach. However, attention has been drawn to the underlying factors in this achievement (Rifkin, 1973; Rifkin, 1978). Rifkin (1973) in her attempt to investigate the relevance of the Chinese experience to other developing nations outlined the factors affecting the Chinese success. She stated that factors like: combining prevention with treatment with more emphasis on the former; mobilizing communities to support preventive activities through mass campaigns; giving priority to the rural areas and decreasing the monopoly of elites on goods and services; putting emphasis on workforce training responsive to the available resources and overall goals of the society; and last but not least, integrating the traditional and Western medical practice have played a major role in achieving the health status level reached by China. She has summed up the criticisms to embarking on such programmes without considering the realities inherent in them by saying "Many either glossed over, or missed completely the fact that barefoot doctors are a political rather than a technical creation in China, a tool to break the power of the medical professionals, give the people a part in providing their own health care, and distribute health resources more equitably " (Rifkin, 1978: p.34).

As a conclusion it could be said that the "equity" aspect of the PHC approach, requiring radical changes in the way society is organized, could

be the main obstacle in the implementation process. Strong political will and commitment is a prerequisite to such a shift from the heretofore dominant values and activities. Gish's comment on this issue summarizes all that has been said when he states that "the major obstacles to more just and efficient health delivery are not the usually cited ones of limited resources and poor communication, or lack of technological knowledge and data, but rather social systems that fail to place high value on the health care needs of rural peasants" (Gish, 1973: p.411).

b. Intersectoral Action

Another important feature of the PHC approach is its emphasis on intersectoral action, stemming from the acceptance that health is not affected by the activities of the MH alone but by the practices of other ministries and sectors as well. It has been unequivocally stated in the Declaration that "PHC, in addition to the health sector, involves all related sectors and aspects of national and community development, in particular, agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors" (WHO/UNICEF, 1978: p.4). Possible benefits that can be derived from intersectoral collaboration have been stated as: sharing information, generating new ideas, increased political support and more efficient use of commonly needed resources (WHO, 1984a: p.35).

Nevertheless, the concept of intersectoral action is not immune from problems as well. These problems may arise because of not being aware of the health repercussions of certain activities of other sectors, conflicts between other sector experts and mainly because of working in a different cultural environment with diverse tasks (WHO, 1984a: p.35). Albeit reference is usually made to the importance of an integrated approach to development, involving economic, social and cultural sectors, the practice has, in many cases, been the opposite and health has usually been considered as the responsibility of the health sector alone, associated with the activities of the MH (Ebrahim, Ranken, 1988: p.131). The contribution of other sectors' activities to health has been outlined in detail elsewhere (Bekele, 1978).

National health councils, mainly advisory bodies, composed of members representing diverse organizations and professions are recommended by the WHO to ensure the linkage between health and other sectors (WHO, 1979: p.24). These councils can be enlarged to districts and communities to achieve intersectoral action at all levels. However, the difficulties these councils are facing, in terms of establishing mechanisms for cooperation, have been described (Vaughan, Walt, 1984: p.111). Lachenmann proposes two different forms that intersectoral action can take at the lowest level. First, including other sectors' activities (agricultural extension, community development, literacy campaigns) in joint actions of relevance to health, and second, transferring health care functions to other institutions such as

schools, cooperatives and firms. It is also recognized that at the peripheral level community workers can act as agents integrating activities of all sectors (Lachenmann, 1982: p.39).

In practice, intersectoral action has usually failed mainly because of the conflicts among certain government departments. Governmental division is an important element in achieving intersectoral collaboration. Rigid hierarchical division and lack of flexibility among governmental departments can be an obstacle. Yamamoto (1986: p.1232) considers this as the major reason for failure in achieving intersectoral action in Japan. Solutions to the problems faced by intersectoral cooperation activities were worked out by Kleczkowski et al. (1984b). They came up with conclusions like identifying areas of intersectoral cooperation and determining each sector's contribution to the goals, developing coordinating mechanisms at all levels; perceiving health and PHC as integral parts of socioeconomic development; passing legislation supporting intersectoral action; supporting community participation that will encourage intersectoral approach at the community level; recognizing the need to deal with health hazards caused by development activities. Although there are problems at the centre, in terms of intersectoral action, the coordination at the peripheral level is said to be better on many occasions (Vaughan, Walt, 1984: p.111).

c. Community Participation

Community participation, labelled by some as the "heart" of the PHC approach (Ahmed, 1978), is one of the essential pillars, and maybe the one that is most difficult to achieve. The definition of the concept in the Declaration emphasizes the importance of full participation of individuals and families in the community and spirit of self reliance and self determination (WHO/UNICEF, 1978). Community participation in practice can take many forms of which CHWs and community financing are the most popular ones. As stated earlier, after the Declaration, many countries have embarked on CHW programmes as a reflection of their commitment to the PHC approach and in many cases the approach has been associated with the CHW schemes. Chapter VI will analyze the concept of community participation and its implementation in Turkey in detail.

d. Decentralization

A natural consequence of an approach emphasizing community participation and self determination is decentralization of some functions and power from the centre to the periphery. This indicates the fact that decentralization is another important aspect of PHC. As far as analyzing the Turkish implementation of the PHC approach is concerned,

decentralization plays a significant part. That is why the subject will be discussed later in chapter VII.

e. Appropriate Health Technology

In the PHC document of the WHO and UNICEF (1978: p.59), appropriate health technology is mentioned as an important concept for the success of PHC. It is stated that "the time has come for all levels of the health system to review critically their methods, techniques, equipment and drugs, with the aim of using only those technologies that have proved their worth and can be afforded. For PHC this is vital because there has been a tendency to concentrate on medical technologies that are more appropriate for hospital use than for front-line care. The scope and purpose of PHC, and the technical capacity of those who provide it, make it more important than ever to have appropriate technology available" (WHO/UNICEF, 1978: p. 39). The term has been defined as "methods, procedures, techniques and equipment that are scientifically valid, adapted to local needs and acceptable to those who use them and to those for whom they are used, and that can be maintained and utilized with resources the community or country can afford" (WHO, 1984b: pp.28-29). Mahler (1981: pp.9-10) fiercely opposes the use of present sophisticated and costly technology where, in many cases, its merits have not been explored, and favours a shift towards developing a kind of technology that is technically sound, culturally acceptable and financially feasible.

However this is easier said than acted upon, especially when the professional, commercial and political repercussions of such an approach are considered. One reflection of this approach is the "Essential Drugs List" of the WHO, prepared with the aim of controlling the escalating drug expenditures and securing the availability of these drugs at all levels.

f. Integration with Traditional Practitioners

As stated earlier, before the influence of the Western medicine had started, there used to be other medical systems operating in different parts of the world that are named at the moment as "traditional medicine". For a substantial number of people, this type of medicine is still the only available or accessible one (Bichmann, 1979: p.176; Chiwuzie, et al., 1987: p.240; Hoff, 1992: p.183; Phillips, 1990: p.73). Medical pluralism, i.e. "the existence and use of a wide range of sources of medical care, traditional and modern, static and evolving" (Phillips, 1990: p.75) is a fact in many countries and is also increasingly recognized in the developed world in the form of alternative medicine.

The recognition of traditional medicine and its encouragement by the WHO started after the mid 1970s with a series of publications. However, the reaction of the world has not been a unanimous one, accepting the reality of traditional medicine and trying to integrate it with the existing health care system. Traditional medicine, as stated earlier, is a fact of life

and impossible to jettison completely from people's lives. In many societies it is closely intertwined with scientific medicine. Bibeau's (1985: p.938) example from China, where people used both scientific and traditional medicine in combatting a cholera epidemic, shows that combination. However, the attempts to combine traditional medicine with Western did not prove to be successful even in China. Bibeau (1985: p.940) attributes this to the structural impossibility of making a synthesis of the two medical systems.

Countries' way of looking at traditional medicine practices and their legal arrangements vary considerably. Stepan (quoted in Phillips, 1990: p.85), establishes four categories of legal regulation as far as traditional medicine is concerned. These are: exclusive (monopolistic) systems, where traditional medicine is recognized as unlawful and where some form of sanctions are taken to prevent its practice; tolerant systems, where various forms of traditional medicine are legally tolerated to some extent albeit only activities based on modern practices are recognized; inclusive systems, where practices other than modern medicine are accepted as legal and their practitioners are allowed to perform with certain standards; integrated systems, where two or more systems are integrated with a single system. The last category is the one favoured by the WHO, as it has been stated that "...traditional medical practitioners are often part of the local community, culture and tradition and continue to have high social standing in many places, exerting considerable influence on local health practices.

With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community...It is therefore worthwhile exploring the possibilities of engaging them in PHC and of training them accordingly" (WHO/UNICEF, 1978: p.63). After the Declaration, projects integrating traditional birth attendants to the system had commenced and in many cases they were used as CHWs. This may be because of the possibility and ease of teaching ordinary obstetric care (Bichmann, 1979: p.178).

As other concepts inherent in the PHC approach, integration of traditional and Western medicine is not easy. One of the important reasons for this is the domination of the medical profession and their attitude towards traditional healers. The open mindedness of the medical profession to the practices of their traditional counterparts is an important element in attempts at integration (Bibeau, 1985: p.941; Bichmann, 1979: p.178). Furthermore, confining the integration practices to rural areas, mainly to bridge the gap resulting from lack of modern medicine in those areas, is not acceptable (Bibeau, 1985: p.941). Integration should occur in all areas where they exist together whether it be in rural or urban areas.

The aforementioned pillars of the PHC approach reflect the need for radical changes in the existing structure of the societies. The slow progress or lack of progress towards HFA in many countries, or emergence of other

approaches as will be discussed in the next section, can be attributed to difficulties in achieving such reforms.

E. EMERGENCE OF SELECTIVE PHC: A CHALLENGE TO THE ALMA-ATA DECLARATION

The challenge to PHC, as defined in Alma-Ata, emerged very quickly with the publication of a contentious article by Walsh and Warren (1980), coining the concept of "Selective Primary Health Care".

Although the debate started with the publication of the article, the concept is not new, and indeed, it is another version of vertical programmes and disease specific interventions. Before moving any further it seems essential to distinguish between the vertical and horizontal approaches that have been on the agenda for so long. Gonzales (quoted in Mills, 1983: p.1972) defines the terms "horizontal" and "vertical" as follows:

> *The "horizontal" approach seeks to tackle the overall health problems on a wide front and on a long term basis through the creation of a system of permanent institutions commonly known as "general health services". The "vertical approach" calls for the solution of a given problem through the application of specific measures through single purpose machinery.*

As stated earlier, vertical programmes, in the form of mass campaigns like malaria or smallpox eradication, were the popular ways of intervention to health problems in the 1950s. The PHC approach could be viewed as a response to disease oriented, technology centred vertical interventions that are proven to be unsuccessful by the experience in the past. However, the adherence to an integrated horizontal approach did not last long as it was challenged quickly by SPHC.

Walsh and Warren (1980: p.145) justify their adherence to selective strategies on the grounds of the amount of resources required to attain HFA through PHC. The authors argue that although HFA and PHC have laudable objectives, the number of personnel required and the cost of achieving it are enormous and beyond the capacities of many developing countries, and so why the attainment of the global goal in the near future is unlikely. The selective strategy involves attacking diseases in developing countries on the basis of morbidity and mortality that they cause and the cost effectiveness of the interventions required. After prioritizing diseases based on their prevalence, morbidity and mortality, the cost effectiveness of the available interventions were considered and the authors came up with four interventions that prove to be the best solutions to tackle the health problems of the developing countries, viz. immunization, oral rehydration, breast feeding and use of anti-malarial drugs. However, the authors have emphasized, as appears in the title of the article, that this

approach is an "interim" strategy until the resources required by the PHC approach are obtained.

After the publication of the article by Walsh and Warren, other articles, supporting these views, have started to appear concomitant with a number of conferences, usually founded by the Rockefeller Foundation and some international organizations including the WHO. A consensus report produced after one of these conferences, organized by the Rockefeller Foundation in collaboration with the WHO, indicated the first signs of reconciliation between the two approaches (quoted in Warren, 1988: p.892):

> *"Primary Health Care should respond to all of the health needs of the community, but priority should be given to those interventions that will rapidly reduce mortality and morbidity at the least possible cost. The strengthening of an infrastructure capable of responding to the priority problems offers a particular challenge for bringing us closer to the goal Health for All".*

At the same time, views supporting selective strategies started to appear in journals (Boland, Young, 1982; Evans, et al., 1981). The breakthrough for SPHC came when UNICEF, the co-sponsor of the Alma-Ata Conference, proclaimed "Child Survival Development Revolution". This movement, that basically advocated selective strategies to improve health, attracted the attention of many developing countries and international

organizations. GOBI, the acronym for growth monitoring, oral rehydration, breast feeding and immunization, emerged as the strategy to be adopted. Later, UNICEF added three F's meaning family planning, female literacy and food production and declared that these were the strategies to avert unnecessary deaths among infants and to improve the health status of a population. The executive director of UNICEF has stated that "growth monitoring charts, packets of oral rehydration salts and vaccines are low-cost, life saving, growth protecting technologies which can enable parents to protect their children against the worst effects of poverty" (Grant, 1984: p.3).

UNICEF adopted "social marketing" techniques to "sell" this approach to governments, to make it known by people, and to motivate people to use techniques such as breast feeding and family planning. Social marketing is criticized on the grounds of implying an obstacle to community participation. One of the prominent opponents of SPHC views social marketing attempts as a means to "browbeat people into accepting whatever is handed down to them by manipulators from abroad" (Banerji, 1988: p.294). Wisner draws attention to the fact that social marketing focuses on products rather than processes. He suggests that such a one way communication endangers the future of participatory programmes as ministries are influenced by the immediate solutions that social marketing offers (Wisner, 1988: p.946). On the other hand, Vittachi challenges this view and states that it is a strategy to stimulate and generate demand that

is unseen or unexpressed thus far and that is why it is not a top-down strategy (Vittachi, 1984: p.19).

Immunization, inter alia, became the most attractive intervention on the basis of cost effectiveness and efficacy. The Expanded Programme on Immunization (EPI) had long been adhered to by the WHO during the late 1970s and has been seen as a "building block" for PHC (WHO, 1985a: p.93). The WHO worked in collaboration with UNICEF in implementing the programme since the early days of its proclamation and they still strive for the same end hand in hand. It has been stated that between 1985 and 1987, seventy seven countries, of which 90 per cent were developing ones, showed their intention to immunize 90 per cent of their population by 1990). Despite these commitments, this objective has been stated as unrealistic (Phillips, 1990: p.231) and 1988 figures show that reaching the target is almost impossible even in the foreseeable future (UNICEF, 1990a: p.2). Furthermore, the destiny of those children who are immunized but fall into the trap of abject poverty is an important question to be addressed. Sustaining the immunization levels that are reached through campaigns is difficult unless an infrastructure that will undertake the surveillance task has been developed. For instance one of the most vulnerable part of a vaccination campaign is keeping the cold chain intact (Cheyne, 1982: p.436) which requires a constant observation of the vaccine chain. Without achieving this, an effective immunization campaign is impossible.

The second intervention strategy favoured by international agencies is oral rehydration. As stated earlier, diarrhoea is a major cause of deaths among children in developing countries. Apart from its indirect effects on health, by inducing malnutrition and making the child more susceptible to other diseases such as measles, it can cause deaths directly because of dehydration. Oral rehydration salts or oral rehydration therapy has become the major course of action to decrease the deaths occurring because of dehydration. However, oral rehydration packages provide palliative solutions as they do not affect the causes of diarrhoea, and utilization requires intensive education campaigns.

Growth monitoring activities are carried out through growth charts with the aim of drawing attention to children at risk who are behind the normal growth expectations for a specific age. However, there are doubts about its feasibility. Rifkin and Walt (1986: p.563) emphasize the fact that the technique by itself does not mean much unless it is supported by a basic infrastructure and its benefits are recognized by mothers and health workers.

UNICEF was not alone in its attempts to promote GOBI-FFF. WHO, USAID, Red Cross, World Bank and other international agencies and foundations like Rockefeller and Ford have given their full support for immunization, oral rehydration and other programmes. Unger and Killingsworth (1986) provide a host of reasons for the attraction of

international agencies to SPHC interventions. Among them the most quoted is the immediate and observable outcomes such programmes can offer (Unger, Killingsworth, 1986: p.1061). Immunization campaigns, whose results can be relatively easily calculated in terms of costs and number of deaths averted, appeal to both the international donor agencies and governments. Especially when a life time of a government, usually five years, is concerned, visible results in terms of gaining political support are quite important and selective strategies offer this advantage.

Thus far the views of the proponents of SPHC have been outlined; however, the other camp's views need to be elaborated as well. The criticisms directed towards SPHC can be classified as: its evaluation method of interventions, its technology orientation, its neglect of the importance of building permanent health structures, its unawareness of the underlying factors of the poor health in developing countries.

Methodological considerations centre around the issues of lack of information in developing countries when deciding upon the diseases to intervene, appropriateness of cost-effectiveness analysis in such decisions and the shortcomings of the projects selected to support the proponents' arguments.

The problem of obtaining reliable epidemiological data in developing countries is well known. The critiques of the SPHC approach state that

the data requirements to prioritize the diseases to be tackled are enormous and by no means can be met in the foreseeable future (Unger, Killingsworth, 1986: p.1004). They question the validity of the approach based on false assumptions from the start.

As far as the methodology adopted is concerned, the second critique centres around the acceptability of the cost effectiveness criterion in these circumstances. First of all, the decisions regarding health are of value laden characteristics and not as simple as bringing two equations together. For instance, the approach's emphasis of childhood conditions and negligence of adult health problems is challenged on the grounds that those adults' health is indispensable for a community to survive (Berman, 1982: p.1057; Unger, Killingsworth, 1980: p.1004). Furthermore, the limitations of cost effectiveness analysis in choosing from alternative health interventions has been discussed in detail (Berman, 1982: pp. 1055-1056; Unger, Killingsworth, 1980: pp.1009-1010). Generally the critiques drew attention to the fact that cost effectiveness is useful only if the alternative health interventions have single outcomes.

The third criticism about the methodology adopted emerges from the questioning of the reliability of the projects used in the paper. At the point of evaluating and selecting medical interventions, the authors relied on reported results from different projects all around the world and estimated the cost and effectiveness in terms of number of deaths averted

for a model area in Africa. Gish states that the isolated nature of these projects, often carried out by external agencies on the one hand, and basing arguments on the chosen model African area and generalizing this to the whole third world consisted of diverse countries on the other, undermine the reliability of the study (Gish, 1982: p.1052). On their subsequent papers written to answer the criticisms of Gish (1982) and Berman (1982), Walsh and Warren (Walsh, 1982; Warren, 1982) praised the achievements of the Haiti project using a selective approach (Berggren, et al., 1981). Banerji (1988), in his attempt to delineate the flaws in the selective strategies, criticizes the project fiercely and elaborates the shortcomings of this project.

Another reason for the rejection of SPHC approach is its technology orientation, i.e. "magic bullet" approach to health. This is an outcome of the definition of health as different from the WHO's comprehensive definition and narrowing it down to "absence of disease" (Phillips, 1990: p.163). Banerji (1988,1990) argues that the approach (and in this case, the immunization aspect of it) is another attempt of the developed world to perpetuate its social and economic control over the third world countries. This type of criticism stems from the very basic perception inherent in the comprehensive PHC approach, that, it is essentially a part of the development process and health programmes are only part of the factors influential in improvements in the health status of a population. Rifkin and Walt (1986: p.560) identify this as the most important distinction

between the two approaches, as they state that PHC is essentially concerned with the processes of health development, whereas SPHC concentrates on identifying and transferring effective technologies to reduce disease. As long as other underlying factors of poor health such as poverty are not tackled, interventions adopted by SPHC can not be a solution. Averting deaths from measles by immunization does not ensure that those children will not die or suffer from other diseases that could have been ameliorated by adopting the comprehensive PHC approach. For instance, the Kasongo project in Zaire concluded that although the death toll of children dying from measles has declined through immunization, the same drop did not occur in the overall mortality rate as almost the same number of children continued to die from other causes (Kasongo Project Team, 1981). While criticizing the technological orientation of the agencies in the 1980s, Wisner draws attention to substituting technology for social transformation, accuses selectivists of emphasizing means as ends and asks the question: "are we really supposed to believe that oral rehydration therapy is an acceptable substitute for the clean water which would prevent diarrhoea to which parents and children have a right?" (Wisner, 1988: p.965).

The last group of criticisms mainly concentrate on the importance of building permanent health infrastructures. Vertical programmes fall short of this objective causing waste of already scarce resources. For instance, vertical programmes in the past, like malaria eradication programmes, had

developed outside the health system and were not integrated with it. The outcomes of this programme have been its enormous cost to the communities in terms of the resources allocated, and its inability to combat malaria, as an increase in the malaria cases has been experienced once the programme's actions are stopped after the first phase of success. Koch-weser and Yanhower (1991: p.13) in their interpretations of the reasons of child mortality declines in Nicaragua state that the main reason for the decline, which started after the mid-1970s, was strengthening of the infrastructure designed to provide primary care including improved nutrition as neither oral rehydration therapy nor EPI were operating then.

Reactions to SPHC were summarised and adverse affects of the SPHC approach were publicized in the aftermath of two international meetings, in 1985, in Antwerp (Banerji, 1988) and in 1986, in Haikko (Segall, Vienonen, 1987). Both meetings, attended by academicians and health professionals, criticized SPHC basically on the aforementioned grounds and required total rejection of the approach that denotes a u-turn and called for a collective action to promote and implement PHC as declared in Alma-Ata.

Is SPHC totally different from PHC? Opponents of the SPHC argue that it is totally different and in many cases in contradiction with the philosophy of PHC (Banerji, 1988: p.296; Banerji, 1990: p.508; Newell, 1988: p.906; Rifkin, Walt, 1986: p.565) and call it as the "counter revolution" (Newell,

1988), "a thinly disguised euphemism for vertical programmes" (Fendall, 1985: p.311) or "old wine in new bottles" (Gish, 1982). The major criticism in this sense comes from the top-down, community ignorant characteristics of the SPHC approach. Newell goes further by saying that in a system where all SPHC measures are applied, if they are not consonant with the society's priorities, with the way of life of the population then it is accepted as a failure. On the contrary, a PHC system where people take part in choosing priorities and making decisions can be regarded as successful even if diseases that are targeted by SPHC continue to occur (Newell, 1988: p.905). Rifkin and Walt argue that these two approaches are different because of different stances they have taken. They state that, first of all, the SPHC supporters' contention that the outcomes of interventions can be controlled by the providers challenge the other group's belief that outcomes of medical interventions lie in the hands of users influenced mainly by social, political and economic conditions. Another major distinction between these two approaches is related to the duration of expected health improvements. It has been stated that the supporters of PHC believe real improvements in health will occur after a long period of time as changes in social, economic and political factors are required. On the other hand, SPHC advocates expect immediate results as their trust in technology urges them to think that regardless of the society, technology can change health (Rifkin, Walt, 1986: p.565).

Despite the criticisms outlined above, some argue that the polarization of SPHC and PHC is artificial and discuss that in real life the differences are not so apparent (Taylor, Jolly, 1988: pp.972-973). They emphasize that campaign approaches are inherent in the Alma-Ata document as it has been stated there that national programmes may start with a limited number of activities because of resource constraints and others can be added in the course of time (WHO/UNICEF, 1978: p.74). Newell, a prominent critic of SPHC, joins them in this respect and argues that, it is the Declaration of Alma-Ata which is to blame for the emergence of SPHC approach. He states that: "at Alma-Ata, almost inevitably, the emphasis moved from what is wrong and why to what can health services do and how can success be measured. Lists started to appear of health status problems which needed to be dealt with and they included the expected, including maternal and child mortality, water and sanitation, health education, fertility and the communicable diseases...The risk of such an activity is that when you start with *any* list, the entire reasoning starts to change and the list becomes the objective" (Newell, 1988: p.904). Taylor and Jolly (1988: pp.972-973) also criticize other critiques of SPHC such as vertical vs. horizontal programmes, top-down vs. bottom-up approaches; planned vs. participatory approaches and technological magic bullet approaches vs. building organizational structures and conclude that it is not an "either...or" question but what is needed is a balance between these sometimes contrasting approaches and only in this way HFA can become a reality. This approach of balancing both has also been

advocated by Vittachi where he proposed that a bit of both will match the real world conditions (Vittachi, 1985: p.27). Lipkin, after welcoming the debate as it can make choices more rational, in his commentary article to Gish (1982) and Berman's (1982) criticism on the SPHC, accuses them of making their arguments on the basis of the assumptions they create rather than Walsh and Warren's. He advocates the selective approach and argues that the criticisms should be towards their data and choices rather than their approach to the problems (Lipkin, 1982: p.1062).

Can SPHC and PHC be reconciled? To the opponents of the Selective approach, these two can never be reconciled as they imply different, and in many cases opposite things (Rifkin, Walt, 1986: p.565). Some argue that adoption of a selective approach would only help to slow down the process of implementing the PHC approach (Wisner, 1988: p.968). On the other hand, proponents of the selective approach answer these criticisms by putting the emphasis on their perception that SPHC is a small and interim part of the broad concept of PHC (Walsh, 1982). In their view, both concepts are reconcilable (Warren, 1988: p.895). Selective strategies are considered as temporary measures that need to be taken while the development process and implementation of the PHC approach proceeds (Warren, 1988: p.891).

In this Chapter, an attempt has been made to discuss PHC, its development, meaning, pillars and the challenges to it purely on a

theoretical basis. The next Chapter, however, will concentrate on the Turkish case and will analyze the Turkish policies adopted, in the past and present, from a PHC point of view.

CHAPTER V. PRIMARY HEALTH CARE IN TURKEY

This chapter aims at analyzing the PHC approach in the Turkish context. The discussion will be restricted to the national policy level, and the commitment of the Turkish government to the Alma Ata Declaration will be analyzed in terms of the policies adopted and proclaimed both implicitly and explicitly. Albeit the researcher is aware of the fact that policies adopted and commitments made at the national level do not mean much unless they are translated into actions, the implementation process is not of concern here. However, reference will be made to certain policies and their implementation where appropriate. To this end, policy documents produced by the government and the MH will be the main sources of reference in analyzing the Turkish perspective in PHC. Furthermore, the interviews conducted among the key health policy makers will be the most crucial material in discussing the past, present and future of PHC.

Before moving further, it seems appropriate to define the term "health policy", keeping in mind the existing huge body of literature about the subject. Lee and Mills, in their attempt to define the term, distinguish between two approaches (Lee, Mills, 1982: p.28). In the first, health policy is defined as "authoritative statements of intent, probably adopted by governments on behalf of the public with the aim of altering for the better health and welfare of the population". The second approach, contrary to the former, recognizes the implementation process and different actors involved both at the centre and periphery. From this point of view, health

policy is "what health agencies actually do rather than what governments would like them to do" (Lee, Mills, 1982: p.28). The nature of this Study allows exploration of the first definition, although the implementation process and its significance is appreciated, and, as stated earlier, will be referred to where appropriate. On the other hand, the issue of inaction of governments, i.e. their choice of not making a certain policy is also of concern (Dye, 1978; Leichter, 1979).

The interaction of national policies, strategies and plans and their inseparability have been pointed out by the WHO where each term has been defined as follows:

> "*A national health policy is an expression of goals for improving the health situation, the priorities among these goals, and main directions for attaining them. A national strategy which should be based on the national health policy, includes the broad lines of action required in all sectors involved to give effect to that policy. A national plan of action is a broad intersectoral master plan for attaining the national health goals through implementation of the strategy. It indicates what has to be done, who has to do it, during what time of frame, and with what resources*" (WHO, 1979: p.14).

These three form a continuum whereby the entry point for a country will depend on the development of the country's health system and main priorities. It is not possible to follow this sequence strictly in the real world (WHO, 1981a: p.18). Policies are proclaimed in government

publications in the form of legislation, plans, programmes and budgets. As stated by Kleczkowski et al., "to become effective, commitment to PHC must be translated into clear statements of government intent supported by government legislation" (Kleczkowski, et al., 1984b: p.12). Some of these pieces of legislation and the Turkish health system were analyzed in the previous chapters; here they will be scrutinized further with the aim of exploring the prospects for PHC in Turkey.

The Turkish Republic was founded after the collapse of the Ottoman Empire in 1923. The country has never been colonized, and attempts at dividing the country after the First World War were defeated with the Independence War. The outlook of the country at that time was gloomy for all aspects of life, including health. If Turkey has never been colonized, how did she get involved with Western medicine and how did the health care delivery system develop? The answer lies in the desire to become Westernized in all aspects of life. The founder of the Republic, Atatürk, saw westernization as a solution to overcome all the problems of the society. The cultural revolution that Turkey underwent during the late 1920s and 1930s, where radical changes like turning to Latin script, adopting secular policies, and changes regarding the legal structure of the country took place, were remarkable in that they reflected the adherence to the West and the desire to become a part of the "developed" world. Although there was no special reference to health and the health sector during these radical changes, establishment of the MH as one of the first

ministries indicates the importance attached to the issue. Information about that period in terms of improvements in the health status of the populace is very limited. A report prepared by the International Bank for Reconstruction and Development in collaboration with the Turkish government, in 1951, praises the achievements made in three decades (International Bank for Development and Reconstruction, 1951: p.178). The achievements made are expressed as the expansion of hospital facilities, increase in the number of physicians, nurses and hospitals and the attacks made on diseases like malaria, tuberculosis and trachoma. However, the report draws attention to the uneven distribution of resources favouring big cities, especially İstanbul. The Report states that, in 1951, seventy per cent of all hospital beds were concentrated in Istanbul concomitant with the large proportion of doctors staying in the same city. The bias towards curative services and inadequate attention given to public health measures together with the uneven distribution of resources biased towards developed urban areas, are comparable to the experiences of the colonized countries after independence. The only difference is the fact that, although Turkey has never been colonized, she followed the steps of the Western medical system willingly and established a health system similar to that of the colonized countries. This adherence to Western medicine can be seen from the following quotation extracted from the Parliamentary debates that took place recently where it was stated that:

> *"Turkey, having chosen a democratic model of administration, based on a parliamentary system, with liberal economic policies and implementations as a yardstick, can not choose another system but a Western type of health system"* (Türkiye Büyük Millet Meclisi, 1987: p.373).

The developments in health services in Turkey followed the same pattern of developments in the world. Disease eradication campaigns of the 1950s and health centres or socialization of health services in the 1960s were all consonant with the changing approaches towards health and health services. The acceptance of the responsibility of the state for people's physical and psychological well-being and for the provision of medical care, in the 1961 constitution, and the perception of health as a right prompted the evolution of socialized medicine that reflected the characteristics of the Basic Health Services movement explained earlier in Chapter IV. After the beginning of the 1960s, the country experienced the rapid development of health centres.

The HFA goal and the Alma Ata Declaration, even though Turkey was one of the signatories of the Declaration, did not generate particular attention until the late 1980s. The phrase "HFA by the Year 2000" was first used in 1983 by an MP in Parliament during the budget discussions of the MH. His main emphasis was on family planning and on the importance of family planning activities in achieving HFA. This was his only remark about HFA (Türkiye Büyük Millet Meclisi, 1983: p.431). The second mention of the phrase, again in the Parliament, was in 1984

(Türkiye Büyük Millet Meclisi, 1984: p.326). In 1987, the document proclaiming the European regional targets for HFA (WHO, 1985b) was translated into Turkish. However, the discussions of HFA policies and PHC started intensively after 1989, twelve years after the Declaration. In 1989, it was stated by an MP in the Parliament that the WHO had started a movement towards HFA by the year 2000 and to achieve this objective, he added, both the governments and individuals had responsibilities to undertake which should be shared by both parties on equal terms. Another comment made by the same MP was the claim that the objectives of the HFA movement were the same as the ones stated in the Constitution, Plans and Programmes (Türkiye Büyük Millet Meclisi, 1989: p.229). Parallel to the late mention of the HFA goal, the Alma-Ata Declaration was also not referred to in the Parliament until 1989. In 1989, an MP, referring to Alma-Ata on the subject of improving accessibility to the people, stated that health centres were established to enhance the accessibility and availability of health services to people, which was the essential requirement of the Alma-Ata Declaration (Türkiye Büyük Millet Meclisi, 1989: p.204). The same issue was raised in 1990 and 1991 budget discussions, however the connection with HFA and PHC was stated first in 1991 where it was said that the key to achieve HFA is PHC (Türkiye Büyük Millet Meclisi, 1990: p.541; Türkiye Büyük Millet Meclisi, 1991: p.239). As stated earlier in the Major Policy Documents section of the Chapter III, the appearance of the PHC policy on the health agenda was accelerated with the preparation and publication of the policy document

"HFA by the Year 2000. The Turkish National Health Policy". This indicates that Turkey, although twelve years after the Declaration, has chosen the determination of national health policy as the entry point of her experience with PHC (Sağlık Bakanlığı, 1990a).

A. DEFINITION OF PRIMARY HEALTH CARE IN THE TURKISH CONTEXT

Before discussing the definition of PHC in the Turkish context, one particular point about the confusion of terminology should be made. In Turkey, browsing through the documents and conversations with people involved in the field, reveal the fact that there is a confusion among terms such as PHC, basic health services, preventive services and socialization. The Turkish version of the PHC concept, "*Temel Sağlık Hizmetleri*", refers directly to socialization, and the Directorate in the Ministry under this name deals only with the socialized health services. Basic health services, which is the nearest translation of the Turkish version, does not imply PHC. This shows that, as experienced during the interviews, there is a need to distinguish these terms when referring to Alma-Ata and PHC. On the other hand, as will be discussed in the next paragraphs, identification of PHC with socialized health services reflects the adoption of the "narrow definition" of PHC. Activities of the health houses and health centres, with the responsibility of the eight tasks determined at Alma-Ata, are considered as the implementation of PHC. So, from the outset it could be

said that, Turkey falls into the group where implementing PHC approach means expanding the existing basic health services system, without considering the essential prerequisites of the approach.

How do the Turkish policy-makers define PHC? During the interviews their perception of the concept was asked directly or indirectly. Apart from a direct question, "How do you define PHC?", some other questions related to the issue were also asked. As mentioned earlier, PHC is usually associated with the first level of contact and/or socialized health services. Only one interviewee made the connection with PHC and the development process and seemed to have a broader perception of PHC. The SPO experts appeared to be the most ignorant and the Minister's advisors appeared as the most knowledgeable. Politicians, on the other hand, associated PHC mainly with preventive and socialized services, except one. The most striking example came from the SPO where a health expert bluntly stated that she had never heard of Alma-Ata and HFA. However, this was an extreme example and on the whole the interviewees had some perception of PHC and Alma-Ata.

The association of Alma-Ata with socialization is a common perception. For instance one of the ministerial advisors has stated that:

> *"On paper, Alma-Ata is just like the copy of our Act of the Socialization of Health Services. I mean in terms of principles. There are not any differences between the Alma-*

Ata Declaration and our system brought by this Act. However, Alma-Ata urges the implementation of these principles, it requires action and requires the allocation of resources based on these principles. That does not unfortunately happen in Turkey".

Similarly, a deputy director of the Directorate of PHC in the MH emphasized this association. He stated that:

"*The Alma Ata Declaration is what the socialized system is all about. Look, the Declaration was made towards the end of the 1970s, but our Act was passed in 1961. This shows what a broad vision those people had then.*"

The majority of the respondents associated PHC with first level care where health services are provided through health centres and health houses. For instance, the founder of the socialized system stated that:

"*PHC and health centre services are the same. It is the translation of the same phrase although I must admit it is not a good translation. I refer to it as the first level of care. In our country primary care level is the health centre but it can take another form in other countries. For instance private surgeries are also considered as PHC level. The Act of Socialization of Health Services was passed 18 years before the Alma-Ata. The ideas that were brought by the Act are superior to the Declaration. The most important difference comes from the fact that in the socialized health services, both the primary and secondary care are integrated whereas this is not the case in Alma-Ata*".

This claim is not correct. The Declaration, as discussed earlier is not only about the first level of care. The emphasis is on that level as it is the most crucial level of a country's health system based on PHC principles and as it is the closest level to the community itself, parallel with the bottom-up approach adopted by the Declaration. The shape of a country's health system based on PHC principles was presented in Figure 1 in the previous chapter. That figure, based on the broad definition, encompasses all levels existing in a health system.

A prominent advocate of the socialized system and an active member of the Turkish Medical Association referred to the eight tasks determined in Alma-Ata as the main responsibilities of PHC. He stated that:

"We define PHC as it is defined in the Declaration of Alma-Ata. The approach has been elaborated one by one in the fifth article of the Declaration. However, we have to underline two points in there. The Declaration lists eight tasks as PHC services. Each country would shape this concept according to its traditions, culture and capabilities. However, there it has been stated that this can not be less than those eight tasks. I would like to emphasize the wording "at least" stated in this fifth article. Socialization is more comprehensive than the Declaration in this sense. I was the Chairman of the commission responsible for determining these tasks where we came up with a long list embodying tasks such as preventive services, including both services like immunization, health education, family planning and early diagnosis that are directly related to the people, and, services like safe water, housing, food hygiene, food control etc. that are directed to the environment; first aid services; emergency services; ambulatory care; patient referral and follow-up;

administrative services; judicial medical services and first, second and third level of curative services. As you can see these are broader than the ones established in Alma-Ata. Whether we have been able to carry out all these tasks is of course another question".

The possible negative outcome of the list of tasks mentioned in Alma-Ata was discussed in the previous chapter, where Newell (1988: p.904) drew attention to the fact that providing such lists would shift the attention from what was wrong and why to what can the health services do. The above mentioned quotation reflects this outcome very clearly as the respondent, without referring to the basic tenets of the approach emphasizes the tasks to be undertaken. He is not alone as in other cases where the definition of PHC was asked the interviewees unanimously referred to these tasks to be undertaken. Some of the answers are below:

"When talking about the PHC level we should consider preventive health care covering immunization, safe water, housing, nutrition, oral rehydration etc. Apart from this we include the curative services that will be provided by a doctor at the first level of contact. Of course one of the most important elements of the PHC level is health education. If these are provided, both the aim of reducing the infant mortality rate and increasing the life expectancy at birth will be achieved. There is a classical definition of PHC. They are the services that are appropriate for the country's conditions, that are going to prevent the most prevalent diseases in the area, that are close to the population including preventive and first level of health services" [a ministerial advisor].

"PHC is the basic health care, I mean the basic element of health. I perceive it as taking the necessary precautions in order to prevent people from becoming ill" [Former Director of Curative Services in the MH].

"The PHC concept includes preventive services plus some other elements. When we say PHC services, it is clear now. Family planning, early diagnosis of diseases, immunization, personal hygiene, health education are the components of this. When we look at these we can see that although the components such as immunization, health education personal hygiene are included in the preventive health care services, there are some others such as treatment of major illnesses, accidents that are not embodied by the preventive health services concept" [a ministerial advisor].

As stated earlier, the group most ignorant about the concept appeared to be the SPO health experts. That was surprising especially when the Sixth Development Plan emphasizing "preventive services and PHC services will be strengthened" is concerned (Devlet Planlama Teşkilatı, 1989a: p.289). One of the experts, as stated earlier, mentioned that she had never heard of Alma-Ata and when her definition of PHC as stated in plans was questioned she replied:

"It is the preventive services like immunization, environmental health, mental health etc. (So does that mean that you equate PHC with preventive services?) Yes, that is right. (How about the socialization model? Is there any relationship between this model and PHC?) Well, I do not know actually, I have never thought about it. But as the health centres and health houses have some responsibilities relating to preventive health

care, I think that might be true. I mean there may be a relation. To be honest, I do not know these areas very well".

On the other hand, another health expert's definition went along the conventional lines:

"When we say PHC we mean preventive plus minimum curative services. We can also add minimum follow-up after treatment as well".

As stated earlier, among all interviewees, only one made the connection with the development process. A former health minister and a prominent member of the then opposition party, who became the Secretary of State for the family and women's affairs in 1992 with the new coalition government, defined PHC as follows:

"I do not define PHC as medical services directed to individuals with special emphasis on preventive medicine. PHC includes elements such as good housing, safe water, sanitation, sewerage systems, nutrition, basic education by which the community reaches a decent level of social and economic development. Plus, all the precautions that will be taken to prevent diseases such as immunization, maternal and child health care etc."

The outsider's view of the Turkish version of the PHC approach is not different from what has been outlined so far. For instance, a WHO

consultant's answer to the question "How do you think PHC is understood by the policy-makers in Turkey?" is as follows:

> *"It is basically perceived as socialized health services which mainly reflects the approach adopted during the Basic Health Services movement. As you know PHC is a broader concept which in fact is quite closely related to other broader concepts such as economy etc. I must add here that you have the tendency to have a vertical programme whenever a problem exists. You can see this from the organizational chart of the Ministry. PHC is also a vertical programme in the chart which is not the case in reality, I mean which should not be the case. This is a problem. Maybe it is because of lack of publication in this area and you know that many people have difficulties in reaching literature in other languages".*

All the above quotations, revealing the perceptions about the PHC approach, indicate a number of things. First of all, it is clear that in Turkish policy makers' mind PHC is associated directly with Socialization and services provided by the health houses and health centres. Second, preventive care, basic health services and socialization are used interchangeably without considering the differences inherent in them. Third, PHC is equated with "services" as a reflection of the medical approach to health and no reference has been made to other essential components of the approach.

An analysis of the Parliamentary debates in order to explore the definition of PHC adopted by the politicians reveals that only three MPs during the

1961-1991 period have offered definitions much closer to the broader definition of PHC. The following quotations reflect their views:

> *"PHC, emphasizing preventive health care, while proposing the collaboration of curative care, adopting community participation and intersectoral action as main principles is the linchpin of our health policy. Consonant with this approach, the number of health houses and health centres has increased dramatically since we took office" (Türkiye Büyük Millet Meclisi, 1987: p. 774).*

> *"PHC constitutes the first level of the broad health services chain to which individuals and families refer first when needed which is close to people's home and work place. To put this another way, health is the basic element of economic and social development and community participation and intersectoral action are the pillars of it" (Türkiye Büyük Millet Meclisi, 1989: p.232).*

> *"Unfortunately, health services in Turkey are equated with curative health care and a large share of the MH's budget is allocated to this type of services. The repercussions of this negligence of preventive services will be an increase in diseases prevalent in the society. Increasing number of diseases will result in more money allocated to curative services. To break this vicious circle we need to develop a system based on PHC. However, PHC should not be confused with preventive health services. Apart from preventive health services, PHC includes first level of care and control of some endemic diseases. PHC constitutes the essential part of a country's health system and in general sense it is the essential part of social and economic development" (Türkiye Büyük Millet Meclisi, 1990: p.531).*

The rhetoric in Parliamentary discussions is the emphasis made on preventive services over and over again, justified by its cheapness

compared with curative services. In the previous chapter it has already been argued that this is not an "either...or" situation but a complex one requiring integration rather than preferring one over the other. The following three quotations, from the 1960s, 1970s and 1980s, are chosen to show that the perception of preventive care has not changed over time and they are good representatives of all discussions made on the issue:

> *"Preventive services have always been given secondary place in all budget discussions. In a developing country like us, suffering from a number of contagious diseases, this should have been the reverse. Preventing people from getting ill is always cheaper than curing them. That is why the ministry should consider its stance against preventive services again" (Türkiye Büyük Millet Meclisi, 1964: p.842).*

> *"In certain periods, the government had given priority to preventive services and allocated more resources and in some other times it had done the reverse. There are basically two reasons for that. Plans and programmes usually consider basic needs whereas in the implementation process people lean towards meeting emergency needs. Of course both for rural and urban areas the main problem is preventive services. However, because of scarcity of resources and other reasons we prefer meeting immediate needs, and as a result of this curative services expand all the time. In my opinion, the other reason is related to the fact that outcomes of preventive services are sometimes invisible and require a long time to occur. On the contrary, the outcomes of curative services are visible and can be achieved in a short time. That is why, quite naturally, people tend to favour curative services and demand accordingly. On the other hand, preventive services are cheap and development in this area will automatically decrease the curative service expenditures" (Türkiye Büyük Millet Meclisi, 1972: p.45).*

> *"Being healthy is a basic human right and to sustain this right is the responsibility of the MH on behalf of the government. The primary task of the MH is to prevent people from getting diseases and later treat them if they are ill. There is a big difference between the expenditures made to prevent diseases and expenditures made to cure. The crucial point is to decrease the number of diseases rather than to cure them. Preventive services should be the primary goal where curative services take a complementary stance" (Türkiye Büyük Millet Meclisi, 1991: p:212).*

The majority of the interviewees' views on preventive services are not so different from the aforementioned MPs' in Parliament. Some of them are quoted below:

> *"What are our priorities? Curative care or preventive care? Of course it should be preventive care because it is cheaper. Prevention is always cheaper than cure" [A former health minister].*

> *"We, in the development plans, suggest that preventive services should be given the priority. However, this does not mean that we are not going to consider curative services. We also have to consider curative services as well. This is what actually happens. When we analyze the developments, we see that although we say that preventive services will be given the priority; in reality, curative services always take the priority. This is very expensive. However, an important question "have we reached a satisfactory point as far as the curative services are concerned?" should be considered as well. We have not reached that satisfactory level yet. Because of this and because of the political decisions taken without considering the overall services, we unfortunately allocate resources in favour of curative services" [SPO health expert].*

> *"The resources of the country are very scarce and curative care is not successful all the time and very expensive. I mean fixing a breakdown is more difficult and complex than taking necessary precautions to prevent its happening. That is why when allocating resources we have to develop an environment in which that kind of failures would not occur at all. I mean prevention. Nonetheless this does not mean that we will leave the other area and people who need care will be left to their faith" [SPO health sector expert].*

The association of PHC with preventive care or considering preventive care as a cheap solution are not peculiar to Turkish policy-makers. As stated earlier these misconceptions, quite widely held worldwide, undermine the value of PHC and strengthen the contention that PHC is a second class medicine.

B. PILLARS OF PRIMARY HEALTH CARE: DO THEY EXIST IN TURKEY?

a. Resource Allocation and Equity Considerations

As PHC is a part of the development process and as it has strong relationships with the economic state of the country and issues like income distribution, unemployment etc. there is a need to elaborate the Turkish case briefly. The Turkish economy, with its $1210 GNP per capita as of 1987 (World Bank, 1989a: p.164), has undergone a radical transformation process since 1980 where a closed economy with severe setbacks has been transformed to an open economy based on liberal economic policies. The

outcomes of these policies are yet to be seen, however; high inflation rate, high unemployment rate and unjust income distribution, together with an ever increasing foreign debt (55 million dollars at the end of 1988 [OECD, 1990: p.7]), do not provide an optimistic picture for the near future, especially for those at low income levels.

The income distribution profile of Turkey can be obtained from two pieces of research carried out by the SPO in 1973 and the State Institute of Statistics (SIS) in 1987. Comparison of the results of these studies shows that there have not been major changes or improvements in the income distribution over time. Table 10 shows the results of the two surveys.

Table 10: Percentage Share of Household Income

Household Percentages	Income Share (Percentage)	
	1973 SPO	1987 SIS
First 20 per cent	3.5	4.0
Second 20 per cent	8.0	7.0
Third 20 per cent	12.5	13.0
Fourth 20 per cent	19.5	21.0
Fifth 20 per cent	56.5	55.0

Source: Devlet Planlama Teşkilatı, 1990b: p.342.

The average annual rate of inflation, a burden especially on middle and low income groups, has increased from 20.7 per cent in 1965 to 37.4 in the 1980-1987 period (World Bank, 1989a: p.164). The rate has more than doubled in 1988, compared to 1987, to 68 per cent (OECD, 1990: p.21). The 1992 estimate for the inflation rate is around 80 per cent (Cumhuriyet Gazetesi, 1991).

Unemployment, another negative contributor to the health of the people has been a problem since the 1980s. 1987 figures show that the unemployment rate is 9.5 per cent (OECD, 1990: p.21). However, the absence of unemployment benefit in the social security system hinders attempts to discover the real rate. For instance, elsewhere the rate is claimed to be 23 per cent for the same year (Dedeoğlu, 1990: p.388).

This brief presentation of the economic situation of Turkey represents the burden put on lower income groups of the population and its repercussions on health are well known. It is impossible to talk about ameliorating health inequalities without tackling the broader economic inequalities. The fundamental prerequisite of PHC, political will, once again comes to the fore as the most important aspect of implementation. Although closely related to the subject, inequalities in general are not of concern here. That is why the following paragraphs will focus on health inequalities to show how one of the pillars of PHC, equity, is pursued.

Health services in Turkey have always been considered as the responsibility of the State starting from the enactment of the Public Health Act of 1930 and this policy has been strengthened in the last two Constitutions and other acts like Socialization. As stated earlier, the main drive behind the Socialization Act was the acceptance of health as a basic human right consonant with the International Human Rights Declaration. The main aim of this Act and the organization model it proposed was to provide health services on the basis of equity. So it can be said that the equity consideration in policies started long before the Alma-Ata Declaration. However, what has been achieved since then is another question to be answered.

Inequalities in health status among regions have already been mentioned in Chapter II, Tables 2 and 3, where differences in terms of IMR were outlined. Inequalities in workforce distribution were also summarised in Table 9 of the same chapter. The available evidence suggests a bias in favour of the West over the Eastern part of the country; however, lack of a sound information system, as in many other issues, obstructs the picture. What is known is the fact that there is a serious inequality problem in Turkey requiring adjustments in resource allocation patterns. Apart from regional considerations, the type of services to which resources are allocated should be considered as well. Although the rhetoric claims the reverse, resources are allocated in favour of curative services as Table 6, the breakdown of the MH's budget, has shown. One important point to be

considered here is the structure of the Turkish health care delivery system as outlined earlier. The providers other than the MH are mainly involved in curative services with little room, if any, for preventive services. On the macro analysis, if their budgets and the private sector expenditures are considered, the bias towards curative care will be more evident. This bias has been addressed by one of the ministerial advisors as follows:

> *"If we analyze objectively we would see that 95 per cent of our problems can be solved at the PHC level. So if I have 100 units of currency in my pocket I have to allocate 95 units of this to PHC services and the remaining 5 units of this to other clinical services. Nevertheless the opposite is the case in Turkey. We spend 5 per cent of our budget to 95 per cent of the problems and spend 95 per cent of the budget to the problems having a proportion of 5 per cent among the total".*

The interviewees unanimously accepted that hospital services consume more of the resources although the reverse should have been the case. For instance, the founder of the Socialization Act articulated this issue on a historical basis as follows:

> *"There is a problem of allocating more to the hospital services. At the time of Refik Saydam [10] the main aim of the health policy was to combat infectious diseases and to this end, approximately 2.5-3.0 per cent of the budget was allocated to the health sector. However, during that time hospitals were not financed by the MH but through*

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[10] Health Minister (1921-1937)

provincial administrations and local governments. I mean at the time of Refik Saydam, approximately 3 per cent of the budget was allocated to preventive services. The only hospitals owned by the MH were the five prototype hospitals built as an example at that time. However, in 1925 all the local government and other hospitals were transferred to the Ministry. There was an increase of around 4 per cent in the budget allocated to the Ministry at first but then this figure was again dropped to 2.5 per cent. This of course had a negative effect on preventive services. As the doctors, the politicians and the public are keen on improving the hospital services and hospitals, the money allocated to the ministry is directed mainly to the hospitals".

As stated by the WHO "it is at the budget level that governments' general statements of intent are usually translated into specific terms and the budget is therefore of special importance as a basis for indicators of commitment" (WHO, 1981b: p.19). That is why before moving any further the Turkish budgeting process has to be elaborated. The MH prepares its own budget, based mainly on previous years' expenses and calculation of the need for areas of improvement, on new programmes and on the budget forms filled in by the periphery showing their requests for the next term, before the deadline determined by the Ministry of Finance. The Ministry of Finance, considering the draft budget and consulting the SPO, first to assure the compatibility of the MH proposals with Plans and Programmes and second, to learn their investment requirements, makes the fine tuning of the budget, harmonizes it with the resources and then sends the document to the Parliamentary sub-commission. The budget is discussed there with a number of politicians from all political parties

having members in the Parliament and the MH, the Ministry of Finance and SPO officials. After taking its final form, the budget is sent to the General Assembly for ratification and after that the process is completed and the MH is left alone with what remains after negotiations. Each department in the ministry has its own budget and the director of the department has responsibility for justifying expenditures. Political interests and preferences play a significant role in this process. The problems relating to the budgeting process were enunciated by the interviewees in the MH as they are the people who face day to day problems in this area. One of the ministerial advisors, involved in all aspects of this process, mentioned his concern about the issue as follows:

"We do not, unfortunately, have a systemized method in the resource allocation process. I mean we do not determine the needs of a certain area and then allocate resources according to some criteria developed before. The resource allocation process in the health sector is affected severely by political pressures. For example, if you go to the North of the country, in some provinces you will see a health centre in every 5 kilometres. If you inquire you will discover that the MP of that province had once worked in the MH or something else. When decisions are made in the Ministry, the decisions are made in favour of the MPs that demand most. When allocating resources we do not determine the needs, problems and solutions and the money required to meet these needs and then spend the money according to priority areas. That is why resource allocation decisions are influenced by political decisions very severely. However, we should not name the person as an MP. It could be anyone who is politically powerful. You can see the outcomes of this situation very easily. For instance, we need investments for PHC services but we build hospitals instead. We need

alcohol, cotton or a basic X-Ray machine in a hospital but we buy a tomography machine. What we do is to go for the luxurious goods and spend unnecessarily".

As stated earlier, the vertical structure of the MH means each department will have its own budget. The existence of departments like Maternal and Child Health, whose responsibility falls in the area of PHC and the existence of a PHC department as a separate entity does not permit the rational use of resources. On the other hand, the centralised character of the budgeting process, where the periphery has almost no say in allocation of resources, does not comply with the bottom-up characteristics of PHC. The omission of the "need" concept from the budgetary process creates problems as stated by one of the ministerial advisors:

"*There are many weaknesses in the budgeting techniques. The budgets are not prepared by the periphery and then sent to the centre but prepared by the centre and sent to the periphery. So, as a result, first the money is not spent in real need areas and second, it is spent on unnecessary things*".

Basing the new budget on the previous year's spending, the incremental approach (Bloom, 1988: p.60), has both strengths and drawbacks. Its main strength has been stated as recognizing the need to sustain existing services; however, its weakness in anticipating the need for change and inflexibility, together with having no incentive for rational spending, make this type of budgeting inappropriate for PHC (Bloom, 1988: p.60; Mills,

Gilson, 1988: p.120). These drawbacks are put forward by one of the Deputy Directors of the Directorate of PHC department as follows:

> *"We prepare the budget of the periphery mainly on the basis of their previous expenditures, plus the inflation rate and new requirements and send it to them saying "do whatever you can do with this amount of money". However, this does not mean that they can spend this money in the areas they really need. These resources are allocated to certain areas and should only be spent on them. For instance, if you, as the centre, have decided that they should spend x amount of money to buy stationary even if they do not need that amount of stationary they have to buy, as they can not spend that money on other items they need. In fact, if they do not spend that money, that means their next year's budget will be less than this year's".*

The same issue was also raised by one of the ministerial advisors showing, the inflexibility of the current system:

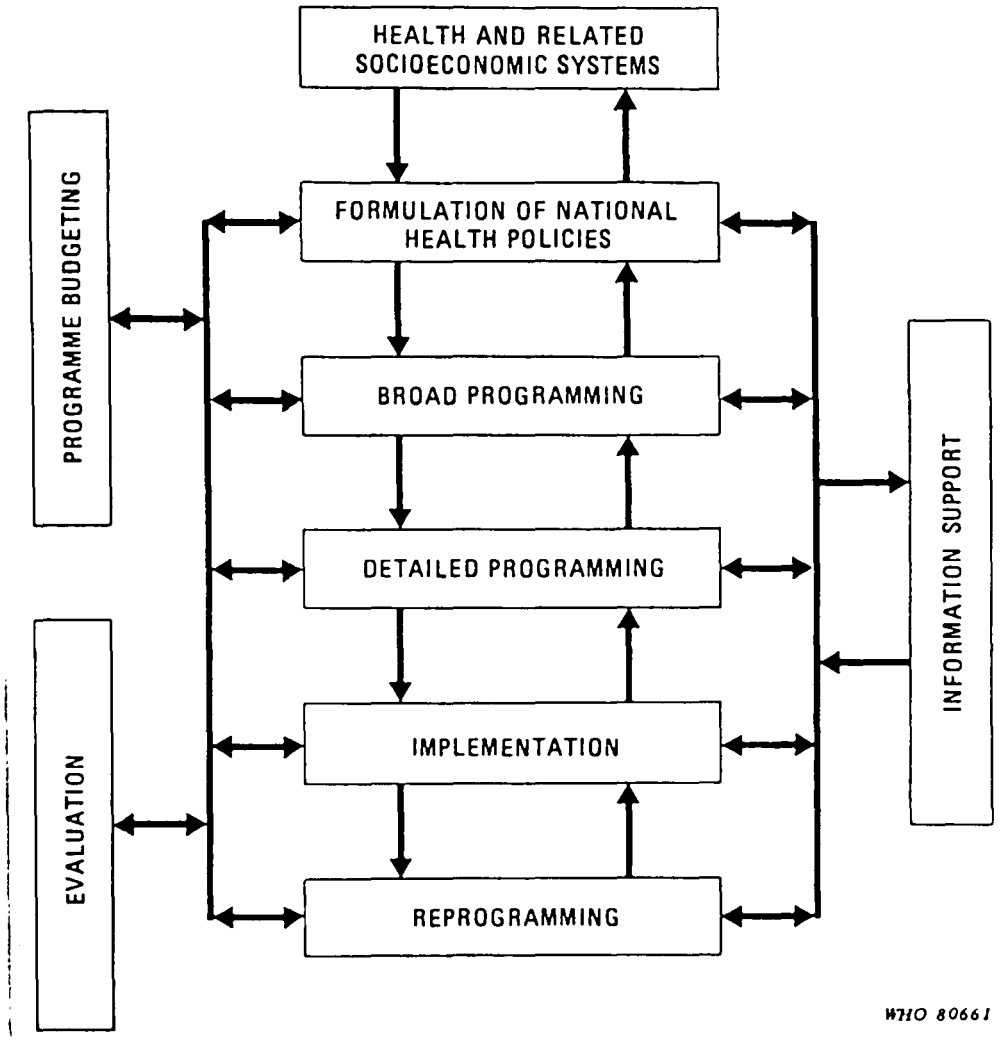
> *"I worked as a provincial health administrator and experienced all the difficulties that administrators face today. For instance, there were times that I needed money to buy petrol for our vehicles but the centre sent me money to buy durable materials such as desks, chairs etc. I can not use this money to buy petrol even if I do not need any desks or chairs. I have to spend the money for the things that the centre wants me to buy, not for the things I desperately need".*

With this type of budgeting, it is impossible to reallocate resources within the MH, as required by the PHC approach. The maldistribution of

resources and the contribution of this tendency inherent in the incremental approach would only increase the existing maldistribution as described in the previous chapter (Segall, 1983: p.1948). Apart from the process by which budgets are prepared, there are problems with the type of budget itself in many developing countries, including Turkey. The resources are allocated according to the headings consonant with the hierarchical division in the Ministry and later the budget is broken down to sub-headings according to the expenditure items like, salaries, transport, stationary etc. This type of budgeting does not allow to see the distribution of resources in accordance with defined needs and priorities (Segall, 1983: p.1950).

WHO recommends programme budgeting as part of the managerial process for national health development (Figure 2) developed to enunciate the process required for PHC (WHO, 1981a). Programme budgeting was defined in a subsequent publication as: "programming by objectives and budgeting by programmes". The two aims of programme budgeting were stated as follows; "(i) to help decision makers choose priorities and the best health strategies by advising them about available resources and the cost and effects of different courses of action; (ii) to translate the financial requirements of health programmes into the budgets of the institutions and field agencies who will implement the programmes" (WHO, 1984c: p.13). Turkey, with no intention of changing its budgeting and resource allocation process in the foreseeable future, has to reconsider her commitment to PHC.

Figure 2: The Managerial Process for National Health Development



Source: WHO, 1984c: p.7

Another issue of concern in terms of equity is the fragmented structure of the Turkish health system both in terms of organization and financing as outlined earlier. The existence of other organizations providing health services to their employees causes inequalities in two ways. First of all, the employees of these organizations are more privileged than the rest of the population as they have easy access to an organized health care system. Second, the bias of these organizations towards curative, hospital based clinical medicine at the expense of preventive services impedes the

implementation of the PHC approach. The philosophical damage made to the whole system is far worse as these policies help in strengthening curative services.

As far as the financing mechanism is concerned, when discussing the financing mechanism of Turkey, it has been shown that there is a large group with no financial security and another group enjoying the benefits of social security or free services as in the case of government employees. Ironically, the former group is either unemployed or in a low income group, representing those most in need of both services and financial back-up. The financial requirements of the latter group are either met by taxes or insurance premiums. The equity problems associated with social insurance systems in countries with high unemployment rates and rural agricultural population were discussed in Chapter II, that is why they will not be tackled here. However the case of taxes needs to be mentioned. The tax system of a country could also be an important contributor to existing inequalities. In countries where the tax revenues are based on indirect taxes, the poor, by paying their taxes through consumption may also subsidize the rich. Tax collection is a major problem in Turkey, as people refrain from paying their taxes by using loopholes in the Legislation. As stated by one of the interviewees during the interview "not paying tax is a national sport in Turkey".

The last but not least point to be addressed in this section is the involvement of the private sector and its possible influence on equity and resource allocation. As has been outlined in the previous chapter, the existence of a well developed private sector poses intractable problems to the public services and overall health system on economic, ideological and political grounds. As stated earlier, although the share of private hospital beds is very small (4 per cent), the private practitioners, usually part time government employees, constitute the bulk of the private sector in Turkey. Roemer (1991: p.391) states that, in 1984, 41.6 percent of the total physicians were in full time private practice. However, a substantial number of the remaining also practise privately after their official duty hours. Roemer concludes that over half of the time of Turkish doctors is devoted to private medical practice. The recent recommendations to improve the health services in Turkey have been in favour of extending the involvement of the private sector. For instance, the World Bank, involved in a health project covering 6 million people, with the aim of gradually enlarging the project to the whole population, promotes the expansion of private sector involvement and inception of user charges consonant with its worldwide well known views (World bank, 1990). By the same token, the National Health Policy Paper, by proposing the concept of private "family practitioners", also promotes the private practice without considering the possible adverse effects of the private sector on PHC (Sağlık Bakanlığı, 1990a: p.31). The document, by suggesting the use of private consultants' surgeries as the second level of care moves one

step further in providing incentives for the enlargement of the private sector in Turkey. The Document claims that the Turkish people culturally and traditionally have a tendency to use the private sector. The evidence for this claim comes from analysis of the structure of outpatient treatments where nearly half occur in the private sector. However, the Document does not raise the question whether this is because the people are forced to refer to the private sector in an environment where state services are poor and where part-time practitioners enforce them to do so, or it is really inherent in the cultural background. As Kleczkowski et al. state (1984a: p.22), in countries where public sector health services are relatively weak, there is a tendency for a strong private sector. Accordingly, this might be the reason for the current high utilization of the private sector in Turkey rather than a cultural tendency.

All the evidence put forward in this section suggests that, Turkey, although an egalitarian society on paper, marked with her Constitution, does not show her political commitment and will to move towards an equitable society in reality. Equity, the most important and contentious pillar of the PHC approach and a move towards a health system based on equity seems to be one of the main obstacles on the road to PHC as declared in Alma-Ata. On the other hand, the following sections will also discuss other aspects of the PHC approach, which, mainly share the same destiny with the equity objective.

b. Intersectoral Action in Turkey

Intersectoral action, an essential component of PHC, has long been on the agenda of the Turkish policy makers. In the first Five Year Development Plan it was stated that "necessary precautions will be taken to improve coordination between the MH and other organizations in areas such as improving environmental conditions, health education, family planning and nutrition" (Devlet Planlama Teşkilatı, 1963 :p.413). The same intention was made in the second plan as well where it was stated that "coordination will be provided among the organizations dealing with the improvements in environmental conditions to prevent infectious diseases, immunization campaigns and production of vaccines" (Devlet Planlama Teşkilatı, 1967: p.223). However, the concept is not referred to after the Second Development Plan for one reason or another. On the other hand, the analysis of Parliamentary discussions reveals that intersectoral action has been the subject of discussions since 1963, maybe earlier as well, and has continued until now. The early discussions of the topic centred around socialization, as the problems faced then were attributed mainly to insufficient infrastructure. For instance in 1965 it was stated that:

> *"In the Eastern part of the country, it is impossible to use the health centres in winter for about 6-8 months. They do not have roads. For socialization to succeed the infrastructure of the socialized areas should be complete. Unfortunately the issue is left to the MH alone. This needs to be changed and*

participation of the Ministry of Village Works, Ministry of Agriculture, Ministry of Education, Ministry of Interior and others where appropriate should be provided" (Türkiye Büyük Millet Meclisi, 1965: p.480).

After the 1980s, consonant with the changing overt attitude towards socialization, intersectoral action began to be associated with preventive services rather than socialization and it has been reiterated that intersectoral action is a prerequisite to improved preventive services.

There is only one example in the Turkish health scene where intersectoral action was achieved for a limited period of time, during the EPI campaign of 1985. Nonetheless after the completion of the campaign, other sectors withdrew their support and the MH is once again left alone in its struggle for achieving better health status for the people.

During the interviews, the interviewees, after praising intersectoral action unanimously and pointing out that this has not been achieved in Turkey, listed a host of reasons for difficulties in its implementation. Their comments are important because as prominent members of the State hierarchy their day to day experiences and activities reveal the real reasons why different organizations can not come together and act in harmony. Some attribute this to cultural influences and accuse the Turkish culture of being inappropriate for intersectoral action. For instance the chairman of the Turkish Medical Association has stated that:

> *"Intersectoral action does not exist. In our culture we are not used to that sort of collaborative action. We are highly individualistic".*

This is a too strong claim and needs to be analyzed by behaviourial scientists but people who believe in this claim are not few in numbers. There are others who accuse the administrative system of the country. The WHO consultant working in Turkey summed up the views of these people when he stated that:

> *"I have to mention the geographical inequalities. In the Eastern region the literacy rate is lower, income level is lower, sanitation and hygienic conditions are worse, housing is a problem etc. You can enlarge this list. So considering the intersectoral relationship between health and other sectors we can say that unless the general development level of these areas are improved than it will be quite optimistic to expect improvements in health status. As you know this intersectoral action is particularly a problem in countries especially where the administrative structure is highly centralised and where there is small room for manoeuvre at the periphery that is only enough to carry out day to day activities".*

This view, more logical than the former, is true but whether a "centralised structure" is in the "culture" of the Turkish people is another question that should be addressed. The practical problems faced by intersectoral action attempts were outlined by one of the ministerial advisors unequivocally as follows:

"My personal belief is that, if some concepts are emphasized frequently, this shows that there is a need in this area. There are two concepts that can not be implemented very easily in Turkey. One is community participation and the other is intersectoral action. It is almost impossible to have intersectoral action in Turkey. I know this very well as being a participant in many issues requiring intersectoral action. I believe intersectoral action is more important than community participation. I find community participation a bit unrealistic but intersectoral action is not like that. It is very realistic but it is the one which is the most difficult, almost impossible to achieve. We have lots of problems in our country. If you decide to establish a committee comprising of different people coming from different ministries, you will have to face many problems. For instance, let's suppose that you are going to establish a committee that consists of the undersecretaries of the MH, Ministry of Education, Ministry of Labour, Ministry of Defense and Ministry of Finance. It will be impossible for you to select the chairman of this committee. Why? Let's say that the subject of the committee is only health. So the chairman of the committee should be the undersecretary of the MH. However, as the Ministry of Defense, Ministry of Finance and Ministry of Education are higher in status as far as the Ministerial hierarchy is concerned, it will be impossible for them to attend a committee chaired by the undersecretary of the MH. This is a simple example that there are many problems even before making decisions. What will be done to solve this problem is to lower the level of the committee members to the director of departments for example. However, their power is also decreased by this process so that they can not decide on important issues. The most successful attempt of intersectoral action was the immunization campaign in 1985 but this was ordered and supported by the President and the Prime Minister. As the order came from that level, intersectoral action was achieved. You can not expect their commitment to all activities you are planning to undertake."

This claim corresponds with the problem discussed in the intersectoral action section of the previous chapter. As stated earlier, rigid hierarchical division in the State's organization and conflicts among governmental departments are among the main causes of lack of intersectoral action. The most striking example of this conflict in Turkey is the one between the MH and SPO, two major organizations in terms of health policy making and implementation.

The MH, in the past, until the preparation of the National Health Policy Document, has never been involved so intensively in the policy-making process. The plans and objectives were prepared by the SPO and execution of these plans was left to the MH. However, after 1987, especially after the preparation and enactment of the Basic Act of Health Services, and establishment of the committee for National Health Policy paper, the MH started to have an active role in the policy-making process. At that time there was a conflict between the MH and SPO over the issue of preparing a master plan, which in the end, as stated earlier, was contracted out to a foreign consultancy firm by the SPO. This conflict between the two organizations was revealed during the interviews by the members of the both organizations. For instance, a health sector specialist in the SPO surprisingly stated that he has not read the "National Health Policy" document produced by the MH saying quite arrogantly:

"I have not read what is written there although I was among the ones that set up that commission and around the names of a hundred people were given to the MH by the SPO. This is not the report of the MH but of that commission. I have not analyzed what is in there, however they have nothing different from what we are saying in our plans. Moreover the master plan study that we are carrying out now may have some differences in nuances but the whole picture is the same".

The following quotation extracted from the interview made in the MH with one of the ministerial advisors, who is also the mastermind of the recent policies, reveals how the SPO is viewed by the other side:

"I think the process of planning in Turkey as a whole is a useless one. The methodology they use is very vague. For instance, they set up sub-committees and call people from related areas like academicians, bureaucrats, doctors, etc. These people generally discuss the matters that have already been discussed elsewhere and they come out with very general policy statements like we see in our plans. So it is totally a time consuming process. The policies, as they are named, reflect general desires like "health status will be improved". How? When? By whom? These are never answered in the plans. Another important problem attached to this issue is the people who are in the process. They are not planners in real sense. Those people who are in the committee could be experts in their own areas but I doubt if they ever had any planning experience. This is also true for the health sector department in the SPO. People working there have no education and background in the health sector. They are not from the field and in addition they do not know anything about planning. Actually there is one person there who carries out all the tasks and who does not know anything about health and health planning. I am sorry to say but this is the reality."

The communication problem between the two organizations is realized by outsiders as well. For example an expert in UNICEF who works with a number of ministries and the SPO in undertaking UNICEF's projects stated as follows:

> *"I know that there is something wrong between the two organizations. For instance there are some people in the MH who have never heard about the Master Plan although they occupy top positions in the organizational hierarchy. Besides, although this Plan is contracted out by the SPO and they are the responsible organization, half of the staff have never heard about the subject. I guess there are some serious communication problems somewhere".*

Another conflict area that hinders attempts at intersectoral action stems from the organizational structure of the MH. As seen from the Appendix 4, the Ministry itself has been organized with strict organizational hierarchy causing conflicts between departments and obstructing intersectoral action even within the MH. For instance, one of the deputy directors of the Directorate of PHC complained about this situation as follows:

> *"Unfortunately we do not have communication between departments within the MH. We all act as independent departments, although our tasks on many occasions intersect. I do not know what is going on in the Maternal and Child Health Department or Tuberculosis Department and by the same token they do not know what I am doing".*

The same issue has been raised by the Price Waterhouse Report as well. It has been stated that the two departments in the MH, namely the Directorate of PHC and the Directorate of Maternal and Child Health, perceive the problems and ways of provision of services in different ways (Devlet Planlama Teşkilatı, 1990a: p.161). On the other hand, it has to be stated here that the Ministry of Education also has a department responsible for the health of the children at school age. They provide these services through 74 health centres staffed with 310 doctors, 100 dentists and 520 nurses. This organization mainly screens school children periodically and also provides first level care to teachers and their dependents. This also reflects another example of the fragmented structure of the country's health system even on particular issues.

Creation of a new department within the Ministry solely responsible for PHC, whose director has equal power with other directors, as in the case of Turkey, has been accepted as a positive step by the WHO. However, attention has also been drawn to the fact that the existence of such a department would also cause coordination problems with other divisions and also other divisions would presume that PHC is outside their responsibility (WHO, 1984a: p.25).

One of the recommendations of the WHO for improving intersectoral action, National Health Councils, has been adopted by the National Health Policy Document to develop and sustain such activities. The paper

suggested establishment of councils at every level. The High Coordination Council for National Health Policy, established as the highest level of council proposed, aims at observing the planning and coordination of National Health Policy and making necessary changes in the direction of policy whenever needed. The Council members constitute the high ranking political and bureaucratic figures of the country and leaders of interests groups. The Council is chaired by the Prime Minister.

The second level in this hierarchy is The Directorate of National Health Policy Coordination Council, established within the MH and attached directly to the Undersecretary. The Directorate, consisting of ten different working groups each having a particular responsibility, is mainly designed to execute the plans and to find reasons for any departure from the plans. While performing its task, the Directorate is required to develop and sustain strong relationships with other public organizations. The interim reports prepared three times a year by the Directorate and the final report are planned for use in the WHO's HFA committees.

The Document recommends the establishment of Councils at the periphery as well. The National Health Policy Provincial Coordination Council, aimed at coordinating, evaluating and directing the activities at the provincial level consists of agents of the central organizations at the periphery. It is the peripheral replica of the High Coordination Council for National Health Policy. The second level at the periphery is the

National Health Policy District Council, established at the district level and members of this council are the representatives of the provincial organizations at the district level. At the community level, National Health Policy Health Centre Councils will be established mainly with the aim of determining the demands of the community and improving methods to create community participation. The activities of voluntary organizations within the province will be coordinated to National Health Policy by Associations.

The proposal of the Document coincides with the recommendations of WHO and encompasses all segments both in the state hierarchy and community that are required to ensure intersectoral action. However, how these councils will work or will they share the same destiny with the similar councils recommended by the Socialization Act and similar questions is yet to be answered. The reality is lack of intersectoral action at the present time.

c. Traditional Practitioners

As far as traditional practitioners are concerned, Turkey falls into the category of exclusive (monopolistic) systems where these practices are strictly outlawed. Traditional practice was forbidden in Turkey as early as 1928 by an Act arranging the duties and responsibilities of health professionals (Act No 1219). Articles 25, 41, 54, 61 and 67 of this Act

preclude treating patients without a diploma and the punishment ranges from imprisonment to a fine (Köroğlu, 1987). The timing of the Act is quite interesting, especially when the severe shortage of any kind of trained personnel at that time is considered, and when traditional practitioners were the only options for the majority of the population. The real motive behind this restriction is not clearly known but there may be multiple influences such as a strong lobby of medical professionals and adherence to Western medicine.

Exclusion of this group of healers from the system and considering their practices as a criminal offence have two serious repercussions. First of all they have to practise underground and the quacks and charlatans among them cannot be controlled; second, research about their activities and their place in society becomes impossible as neither the healer nor the patient would be willing to come forward and participate from fear of being punished. At the moment what is known about traditional healers does not go beyond some of their wrongdoings publicized in newspapers about cases resulting in the death or disabling of the patient. This portrayal strengthens the stance taken by the medical profession which holds a firm belief that any kind of medical intervention, however simple, has to be undertaken by a medical doctor and fuels the hatred towards them.

The only research done on this subject, albeit with some severe restrictions, was in 1968 as part of a health workforce study (Taylor, et al.,

1968). The research has categorized the traditional practitioners performing in Turkey viz. needleman, traditional birth attendants, bone setters, circumcisers, blood-letters, lead pourers, tooth-pullers, umbilicus setters, coccyx pullers, religious teachers and mystic healers (Taylor, et al., 1968: pp.179-180). Among these, the most prominent are: the needleman, who usually derives his health knowledge from military service where he works with a doctor or in hospital and they diagnose, prescribe drugs and give injections; the traditional birth attendant who acquires her knowledge in delivery through experience or relationships; the bone setter who usually learns his skills from his/her family and reduces dislocations, sets fractures and gives advice; and the circumcisers. Mystic healers, religious teachers and lead pourers are involved in supernatural healing.

As stated earlier, the illegal character of the practice does not allow a clear picture to emerge about the number of traditional healers and where and how they work. The aforementioned survey, in 1968, found that in a rural health centre serving about ten villages and a population of 7000-10000, there will be at least one traditional birth attendant in each village; one needleman per village; at least four bone setters for the area; one circumciser; one tooth puller and possibly one mystic or religious healer for the area (Taylor, et al., 1968: p.189). The only recent figure that can help to show the extent of these practices comes from the Hacettepe University's survey mentioned earlier, where it was found that in 1983, 65.8 per cent of deliveries in the Eastern part of the country were carried and

delivered by traditional midwives and neighbours and relatives (22.2 per cent by traditional midwives, 43.6 per cent by neighbours) (Hacettepe University, 1987: p.76).

These figures show the potential for integrating these healers with the existing system. However, the State prefers to ignore them which results in losing both a potentially useful workforce and control over their practices. In Taylor et al.'s research, the researchers, considering the cultural attitudes of villages and their attitude towards health professionals together with the influence of traditional healers in the society, recommended the use of traditional birth attendants in the National Family Planning Programme and integration of others into the system by one way or another after a certain training process.

Integration of traditional healers in the foreseeable future seems impossible in Turkey. First of all there is a need to amend the related articles of the Act. So long as there is commitment and will, this will not be a serious problem. But the main problem is the acceptance of the healers by the medical profession, especially doctors who hold the power in the health sector. As will be discussed later in the CHW section, involvement of any kind of practitioners in the field, even other professionals like nurses, is not welcomed by doctors. The National Health Policy Document, supposed to be establishing the fundamentals of the

implementation of the PHC approach in Turkey, does not mention traditional healers and CHWs.

d. Appropriate Technology

Appropriate technology is a concept that has never been mentioned in any documents analyzed, except one, and has never been an issue on the agenda. The only document referring to appropriate technology is the National Health Policy Document.

It is stated in the Document that, in Turkey, some dental and sterilizing equipment has been manufactured. The remaining high tech equipment is imported from abroad. The Document identifies three areas of concern as far as medical technology is concerned viz. manipulation of the production in the country, appropriate importation policy and maintenance and calibration of the existing equipment. It is stated that production within the country should be diverted to equipment that is needed for PHC. A special emphasis is given to orthopaedic equipment. The amount of money spent to import equipment from abroad has been mentioned as 40 million American Dollars of which the biggest share is made by public organizations without any regulations and expert advice on their efficiency and efficacy. The third area of concern is the problem of broken equipment and maintenance. Lack of expertise in maintaining sophisticated equipment is the major problem as an abundance of

equipment stay idle just because of ignorance. The Document urges collaboration with the universities and other organizations to overcome this problem (Sağlık Bakanlığı, 1990a: pp.23-24).

As can be seen, the aforementioned issues, although relevant, do not cover what is meant by the approach. For instance, lack of the community aspect inherent in the definition of appropriate health technology is a major drawback. Technically sound, culturally acceptable and financially feasible technology is the prerequisite of appropriate technology. None of these have ever been questioned or considered in the Turkish context at all.

C. SELECTIVE PRIMARY HEALTH CARE IN TURKEY

The signs of the vertical approach to solving health problems were initially seen in the first comprehensive health act of the young Turkish Republic: the Public Health Act of 1930. As stated earlier, there, a special consideration was given to diseases like tuberculosis and malaria as they were the major diseases responsible for the high death toll then. Although, at the beginning, all activities in combatting these diseases were carried out under one Directorate in the Ministerial hierarchy, later these were separated and new directorates within the ministry were established with their own personnel and peripheral organization. Malaria was separated first in 1946 followed by tuberculosis in 1963 (Sağlık ve Sosyal

Yardım Bakanlığı, 1973: pp.53-54). Apart from these, the Directorate of Family Planning and the Directorate of Maternal and Child Health were built into the ministerial organization in 1965. As can be seen from the organizational chart of the MH (Appendix 4) all these vertical structures have survived until now and there seems no prospect of change in the near future. This issue was raised in the interviews as well. The WHO consultant working in Turkey mentioned his concern about this type of organizational structure as follows:

> "*You have many vertical programmes like tuberculosis control or malaria control or maternal and child health etc. These operate independently of the socialized services and I think this situation is the main obstacle you have in implementing the PHC approach*".

The integration of these organizations at the periphery has been recommended by the National Health Policy Document when proposing Public Health Centres at the district level as one of the new proposals of the new organization model. Accordingly, those Public Health Centres will embody all the vertical programmes performing in the periphery and carry out the functions of these programmes in a more integrated manner. However, the future of these proposals is yet to be seen (Sağlık Bakanlığı, 1990a: p.30).

On the other hand, the views of the Ministerial staff on this issue are particularly important as they, in their day to day activities, come face to

face with problems caused by this structure. For instance, a deputy director of the Directorate of the PHC department said that:

> *"I want to emphasize the Maternal and Child Health Department first. As you know, one of the major responsibilities of the health houses or health centres is to provide maternal and child health to the community. If it is so, why do we have another department in the Ministry having the same responsibility? They have their own personnel and premises. They carry out immunization, pre-natal and ante-natal checks, family planning etc. and these are also a part of our responsibilities. I do not have any control over their personnel or activities whatsoever. Let's look at the Tuberculosis and Malaria Control Departments. They similarly have their own organization and personnel which we, as a department, have no control over. Why? These services can be provided by our health centres. (Question: Why do you think these departments are not integrated to your department?) I think it is mainly because of political reasons. Nobody wants to lose power. But in the end we suffer from that as duplication of services occurs very frequently".*

Another member of the ministerial staff, one of the Ministerial advisors, who, quite ironically, also held the Director position in the Directorate of Tuberculosis Control Department at the time of the interview, complained about the vertical organization structure and stated the reasons for difficulties in integrating these services as follows:

> *"I am one of the strong proponents of horizontal programmes, in fact, I am the one in the MH fighting for this concept. When socialization was planned in 1961,*

although it was a horizontal programme, these vertical programmes were kept as well. I asked the founder of socialization the reason for this and he replied that the heads of these programmes and departments were so powerful that it was impossible to abolish them. Of course these programmes had many success stories. At those times there were vertical programmes in Europe as well. They were able to adapt themselves to new developments very quickly but we were late. Recently, I attempted to integrate the vertical programme of which I am the director to the health centres with no success. Even the smallest attempts have failed. For instance, I tried to delegate the responsibility of BCG immunization to health centres that are at the moment carried out in tuberculosis dispensaries. The uproar of the people involved was so strong that I had to abandon my plans immediately".

Vertical programmes have always been praised in Parliamentary discussions and no proposition for their integration was made during the 1963-1992 period. On the contrary, their achievements have been considered as a monument to the successes of the MH. In 1987 Parliamentary discussions, an MP even proposed a return to these programmes where he commented that:

"Malaria and Tuberculosis that have long been off the agenda of the MH, after the successes of the previous attempts, have started to show their face again. You have been trying to solve these problems with an integrated model, this is impossible. Although tuberculosis is a social disease and the MH can not fight it alone, there are certain courses of action that can be taken to control its spread and these can not be fulfilled with the integrated system. We have to turn to the methods in the past with which we almost

eradicated tuberculosis" (Türkiye Büyük Millet Meclisi, 1987: p.769).

Apart from the vertical structure mentioned above, the most recent involvement of Turkey in SPHC should be given special consideration. As a member of the UN and as a partner of international organizations like UNICEF and WHO, Turkey has been an ardent supporter and contributor to international developments and movements. UNICEF and WHO have bureaus in the Capital, and in fact, Turkey hosts the only bureau of the WHO in the European Region. The EPI of 1985 is the latest example of Turkish involvement in international movements and of course a reflection of the SPHC approach. The major aims of this campaign were stated as:

> *"to show that a large country with high IMR and barely average EPI coverage could inexpensively vaccinate at least 80 per cent of its children -despite barriers of weather, terrain and population dispersion; to demonstrate that the dynamics of preparing for and carrying out an immunization campaign would give the way for a permanent system of high immunization coverage; and to show that a radically accelerated take off in immunization could lift and rejuvenate the whole of a country's delivery system, throwing open the way for solid advances in other PHC and child survival areas*". (UNICEF, 1986: p.iii).

Although the campaign was welcomed by the majority of the people in the area, there were also conflicting opinions regarding the appropriateness of such attempts. The proponents of the campaign based their arguments on the prospective positive effects of social mobilization inherent in such

campaigns and on solving the problems arising from routine immunization activities; and they perceived the campaign as the sole way to increase the immunization coverage to 80 per cent. On the other hand, the opponents emphasized the artificiality of the success rates achieved during these campaigns which will not be maintained by routine services afterwards and argued its demoralizing effect both on the public and health services (Bertan, Reid, 1985: p.267). During the interviews one of the ministerial advisors stated his reservation about immunization campaigns as follows:

> *"My personal belief is that, immunization is not a service that could be provided by campaigns. You can not have an immunization campaign. However, it was successful in terms of improving the consciousness of people and health personnel. At best the concept of immunization was placed in people's minds"*.

On the other hand, a former health minister has opposed the campaign on other grounds:

> *"We decided to carry out a country-wide immunization programme but in the end we used this as a means of propaganda by converting it to a campaign. I was always against the idea of having a campaign. This is one of the basic roles of the State. Turkey, as a country, has already passed the stage of tackling these sort of problems by campaigns. UNICEF had made a dramatic mistake here by announcing this programme as a campaign. No one has the right to show us as a Middle Eastern country with these sort of initiatives"*.

The immunization campaign was launched on 11 September 1985 by the President of the country, reflecting the commitment from the highest level of the State, and a high level of intersectoral action was achieved where almost all facilities of the State were mobilized towards the aim of high immunization coverage. The rapid assessment of the campaign undertaken by UNICEF has shown that the Campaign prevented 1.3 million cases of measles, 873 000 cases of pertussis and 9000 cases of polio and 22 500 deaths from these diseases (UNICEF, 1986: p.iv). The campaign has been shown as an example of success in the international arena and was praised as an example of the appropriateness of selective strategies (Walsh, 1988: p.901). Whatever the achievement, the coverage rates after the immunization campaign declined dramatically, proving the doubts of the sceptics, mainly because of the withdrawal of intersectoral action (Table 11).

This table indicates a decline in immunization coverage rates especially immediately after the campaign, in 1986, and in 1989. Although the target coverage rate for all vaccines was stated as 95 per cent in the joint Report of the Government of Turkey, UNICEF/US AID/WHO team (Report, 1988: p.22), the actual figures as outlined above show considerable deviation from this aim. One of the ministerial advisors put this fact and reasons frankly as follows:

Table 11: Immunization Percentage of the Programmed Target Population (Children Under 1)

Vaccine	1985	1986	1987	1988	1989
DPT1	91	67	74	89	50
DPT2	82	49	71	82	48
DPT3	66	45	71	76	48
Measles	94	34	50	66	42
OPV1	90	53	71	90	50
OPV2	81	45	71	83	48
OPV3	66	34	50	77	48

Source: Sağlık Bakanlığı, 1989: p.50.

> *"The rate of immunization during this campaign reached 85 per cent but after the end of the campaign we realized that this rate fell down to 40 per cent again. That is why this is something that can not be dealt with campaigns. Letting people know about immunization or informing people about the benefits can be achieved through campaigns but providing the service is not a matter of campaign. What have we done throughout this process? We used all the facilities of both public and private organizations to reach the furthest village in the country but once the campaign ended, all the vehicles and support from other organizations together with the international support were withdrawn and we were left alone".*

On the other hand, the Price Waterhouse study draws attention to the fact that the immunization rate in Turkey could be overestimated. They give an example from Mardin (an underdeveloped South Eastern Province)

where of the 26 000 deliveries made, only 7200 have been recorded and state that the immunization rate calculated according to recorded deliveries would not reflect the real rates (Devlet Planlama Teşkilatı, 1990a: p.158). That is why the actual immunization rate could be much lower.

The First Health Screening Campaign of 1989 is another example of the selective approach adopted. The Campaign was again launched by the President of the country with the aims of improving health consciousness of people, emphasizing the need for early diagnosis, improving intersectoral action, detecting the pneumonia cases and treating them free of charge, combatting diarrhoeal diseases, detecting malaria cases, immunizing children and pregnant women and so on (Saglik Bakanligi, 1990: pp.3-4). The main target population of the Campaign was children at school age and to this end, 59.43 per cent of school children were screened against ophthalmological diseases, ear, nose,throat problems, tuberculosis and some other diseases considered to be a problem. The Campaign, widely accepted as a showpiece or political propaganda of the then government was fiercely opposed by the Turkish Medical Association (Turk Tabipleri Birligi Merkez Konseyi, 1990) but the doctors were forced by the MH to take part in the Campaign. In the document, introducing the preliminary results of the Campaign, it is stated that the basic aim underlying the Campaign was the achievement of HFA by the year 2000 (Saglik Bakanligi, 1990c: p.45). However, the Campaign, criticized by all

quarters stopped after the change in government and there are no intentions at present to continue.

The destiny of the EPI and Health Screening campaigns, justifies the arguments made against SPHC and is consonant with the critiques mentioned in the previous chapter. However, there is not any sign of abandoning this approach at the moment as other selective interventions like oral rehydration therapy continue to be on the agenda. SPHC provides politicians and administrators quick, visible outcomes and helps them to get public support and can be used as an important material for election campaigns, as it was the case in Turkey. Professional support is evident as well, as there is no threat to either the elite or the professionals and no change in the status quo is expected in terms of organization and finance. These reasons suffice for adopting a selective approach in Turkey, as in any other countries, together with the influence of the World Bank and UNICEF.

D. RECENT POLICIES: A WAY FORWARD?

As stated earlier, in the last five years, the Turkish health policy scene has experienced remarkable changes starting from the Basic Act of Health Services to preparation of the Turkish National Health Policy Document, all reflecting the direction that Turkey is planning to take to get ready for the year 2000. In this section, the compatibility of these changes with the

PHC approach and their possible effects on attaining the Global Goal will be discussed.

Chronologically, the Basic Act of Health Services marks the beginning of an era where the health services started to occupy the then government's agenda. The Act, aimed at determining the basic principles of health services in Turkey, as stated earlier, does not bring much so far as PHC is concerned. As a thorough analysis will show, apart from the articles 3(b) and 3(j), where the priority that will be given to preventive services in the former and emphasis on the education of the public on matters like family planning, maternal and child health, nutrition and environment in the latter are mentioned, the Act does not refer to PHC but brings regulations about hospitals and their personnel and a universal health insurance scheme. When the debates over the Act which took place in the Parliament are analyzed one could see the tendency mentioned above more clearly among its supporters. For instance, one of the debaters, a member of the ruling party, while declaring his party's opinions about the Act claims that:

> *"With this Act our people will find the opportunity to be treated in hospitals with the latest technology; will be treated by doctors very well educated about the latest developments in medicine; will not need to leave his/her village or district to find a decent health service as there will be a doctor all over the country; will find the caring relationship in private practices and latest technology in abroad in his/her own health centre or hospital; will be able to find the prescribed*

> *medicines with the right amount at the right time; in sum with this Act our people will have a health system that will compete with the systems in the developed world*" (Türkiye Büyük Millet Meclisi, 1987: p.373).

The institutionalized stance taken by the Act, omitting the community participation, intersectoral action and other prerequisites of the PHC approach and equating health with medical care provided in hospitals, does not suggest a serious political will behind PHC.

The second attempt, in the series of attempts directed to make changes in health policy, came in 1989 with the preparation of the Turkish National Health Policy Document, mentioned frequently in previous chapters. The Master Plan Study, undertaken by the SPO started at the same time as well.

As stated earlier briefly in Chapter III., the general policies adopted by the National Health Policy Document were viz: decreasing inequalities in health, community participation and health eduction, a system based on PHC and intersectoral collaboration. The Document, after putting these basic principles, elaborated other issues like management, financing and the workforce.

The major drawbacks of the current management process were stated as: lack of a sound resource allocation process based on cost effectiveness and

cost efficiency; adoption of a short term problem solving approach rather than a comprehensive long term one directed towards predetermined goals and objectives; and, overcentralization of power. As far as the financing of the health services is concerned, the Document proposes the following as the main changes to be embarked on in order to achieve HFA 2000: inception of a universal health insurance scheme; unification of the planning activities under one organization and determination of health expenditures and cost analysis. The third issue tackled in detail in the Document is the health workforce. Inequalities in the distribution of the health workforce; problems related to the quality of the workforce and the compatibility of these qualifications with the requirements of a system based on PHC have been stated as the main issues to be considered. The MH has no say at the moment in workforce planning as this is undertaken by the Ministry of Education through the Higher Education Council. The Document proposes an alteration in this process where the MH would have direct responsibility.

After outlining the main problem areas, the Turkish model for PHC has been delineated in the Document. The proposed model keeps the health houses with their classical duties but proposes to assign a health technician to each of them together with the already existing midwives. Health centres, having a team consisting of a practitioner, health technician, nurse and midwife, are restricted to rural areas only. Their major tasks and responsibilities do not differ from the Act of Socialization but the only

difference is their restriction to rural areas. The first change in the proposed model of National Health Policy appears at the district level where "Public Health Centres" embodying the health centres, tuberculosis dispensaries, maternal and child health care units are proposed. These centres will have the responsibilities of health education, emergency care, combating infectious diseases, maternal and child health, family planning activities, immunization, environmental health, laboratory and radiology services and compiling data. According to the policy paper, each district in the country will have at least one of these centres and more than one where needed. These centres will not be responsible for first level of care in principle, except emergency services, but they will act mainly as logistic supporters of health centres and private practitioners. In brief it could be said that these centres will be responsible more for environmental issues than for individualized care. This brings out the second new proposal in the National Health Policy Document, i.e. family practitioners. Accordingly, first level care will be provided by family practitioners who will work in their private surgeries under a "per capita" payment system. The payment will come from the patients' social security organization. Family practitioners will be responsible for first level care, follow up of patients after they receive second or third level care, preventive services, periodical examinations and emergency care (Sağlık Bakanlığı, 1990a: pp.29-31).

The major change brought by the National Health Policy Document as far as the second and third levels of care are concerned is the decentralization

of these levels of care to local administrations. The difficulties associated with the centralized structure of the MH are stated and it is also stated that the MH should not act as a provider organization and those hospitals should be left under the control of local authorities. This will establish a system whereby community participation and local management will be improved.

A special emphasis is given to the lack of hospital planning which as a consequence leads to inefficient use of already scarce resources. The aim is to take necessary administrative and legal precautions for the active involvement of the MH in planning. There are other statements as far as the hospitals are concerned relating to issues such as using the unutilized capacity effectively, rational management of resources and training hospital managers; however, the main change in the second and third level of care is the proposal of decentralization.

In the referral system brought by the Document, the family practitioners will act as "gate-keepers" and the patients will not be able to by-pass this level and refer directly to the hospitals. It is stated that 90 per cent of first level of outpatient care is being given by secondary and tertiary level institutions although there is a referral system brought by the socialization model in theory. Family practitioners will also be permitted to refer their patients to the private surgeries of consultants as a second level of care (Sağlık Bakanlığı, 1990a: pp.31-33).

Here an important point about a claim made by the Document should be made. At the very beginning of the Document, where the general policies were formed, after praising the need for a system based on PHC, it is stated that "Turkey does not need to make major changes in her legal and physical infrastructure to establish a system based on Alma-Ata principles" (Sağlık Bakanlığı, 1990a: p.12). This claim was put forward as a question to the mastermind and author of the Document during the interview where he replied that:

> *"Yes we do not need major changes. Look at the physical infrastructure of the country. We have 3500 health centres of which 2400 of these are situated in villages. As far as the villages are concerned we have a sufficient number of health centres. So we do not need to build extra buildings. In the family practitioner scheme that we bring, the doctor works in his/her private office which already exists. So, in sum, in order to provide PHC services as understood in Alma-Ata we do not need to build new buildings and offices. With minor changes or provision of some extra equipment we will solve the problem here. Let us consider the legal aspect of the question. There are no important legal obstacles at the moment to having a decentralized system. However, there is a lack of administrative commitment. I mean this issue does not require major legal changes. What is required is to have a system in which budgeting, health education etc. is starting from the bottom not from the top".*

There are certain points to be tackled in this statement. First of all it is obvious that "physical infrastructure" for PHC implies only health houses and health centres or private surgeries. Other parts of the infrastructure

like safe water, appropriate roads, electricity, sewerage systems and others that are required for a healthy environment inherent in PHC are not considered. It has been stated that 47 per cent of the rural population did not have access to safe water in 1985-1987 (UNICEF, 1990a: p.81). There are serious problems of transportation in the Eastern part of the country where either road connections to the centre do not exist or the existing ones are closed with snow during winter. It is impossible to talk about sewerage systems in Turkey even in developed big cities. All these imply a major need of change in the physical infrastructure in order to adopt a system with the spirit of Alma-Ata, contrary to what is claimed in the document and by the interviewee. As far as health legislation is concerned, there needs to be a radical change as well. Decentralization and bottom-up approach require radical legal changes in a country where the whole system of administration is overcentralised. It is true that once there is political will and commitment these changes may occur with less pain; however, at the moment claiming that there are not physical and legal obstacles is an oversimplification of the current situation.

This document is very important as being the first example of its kind where policies for HFA based on PHC are mentioned for the first time in the history of Turkish health policy. However, the document at the moment stays as a blueprint because of the change of government after the general election in October 1991. The new government advocates preventive care to decrease the health problems of the country and

adheres to improvements in the socialization programme to strengthen the first level of care and to decrease the number of patients referring to hospitals. The most interesting point made in the government programme relates to preparing a "national health policy" that will not change with governments (Başbakanlık Basımevi, 1991: p.50). This statement brings the question about the position of the previous National Health Policy Document which had the same objective. As stated earlier, "lack of a national health policy" has been the motto of Turkish policy makers since the 1960s. This issue is raised by the majority of the interviewees as well. Some of the quotations are as follows:

> *"We do not have a nationally determined health policy. Actually I regard not having a policy as our main policy. I do not know if this is correct or not but I mention this in order to emphasize that we should not give priority to our political preferences on health matters. One party can come to power this year and another party can come next year but this should not be an important change as far as health is concerned. When featuring national health policy, I meant that we should have a policy or a set of policies that will not be affected by the changes in governments. Let us have the general points determined, and of course some fine tuning can be made by each government without spoiling this general picture. For instance, one of the governments can emphasize extending the services to the rural areas and can make its plan accordingly and another could come and claim that the rural areas had enough investment and can declare that it is going to give priority to the services in urban areas. However, that general picture should be determined with the contribution of all parties"* [a former health minister].

"There are many national policies in Turkey. For example the foreign policy of Turkey has never changed with the changing governments. Our policy towards Greece has never changed whether we have a conservative or social democrat government. Similarly the national defence policy has never changed as well. We have to determine the general policy. What should the objectives of the national health policy be? It should be a policy towards solving the problems affecting the health of the people. For instance, suppose that we are in Ankara and we want to go to Istanbul. One government could decide to go by train and the other could decide to go by bus. These are the political decisions of governments. In our health policy we have to decide where to go. We have to decide nationally on this issue, then of course every government would take its initiative in deciding the roads to this ultimate aim. Now we have adopted the universal health insurance model in the financing of the services. I am personally not interested in the ways of financing be it from the insurance premiums or from the general budget. What I am interested in is the strengthening of the PHC services, establishing a family practitioner scheme, increasing the immunization rate to 100 per cent etc. After shaping the general principles one government could come and say that these services are going to be financed through insurance premiums and the other government could claim that they are going to be financed from the general budget. When saying national health policy, this should not be perceived as restricting the political decisions of the governments" [A ministerial advisor].

"Turkey has not had a continuous health policy since 1961. Although socialization was introduced in 1961, this system has always been impeded and it always suffered from changes conflicting even within itself. So this means that the first problem is not having a health policy that is consonant with the needs of the country. Turkey has never had a period in which a long term policy was followed without being affected by changes of government. This was expected to

happen when socialization was introduced to the system in 1961 without any success" [A former health minister].

There seems to be a conflict with the real situation and claims made by the interviewees and in other documents like Parliamentary discussions, as the general direction of the Turkish health policy and objectives have always been mentioned in the Five Year Development Plans. In all six development plans prepared thus far, improving health status of the population through preventive services and considering curative care activities as complementary; increasing the efficiency and effectiveness of the health services; providing equitable, accessible, efficient and effective health services to all population regardless of geographical areas; and other health polices have been reiterated as national health policies of the country. In the last plan, as mentioned earlier, these attempts have gone beyond being mere policy intentions to concrete objectives. However, the isolation of the SPO from the MH and political arena emerges once again. On the other hand, the claim that the recent National Health Policy Document was prepared in order to have a policy that will not be affected by government changes has proven to be false as the new government has already mentioned that it will "prepare a national health policy that will not change with the government changes!". The frequent government and minister changes and discarding the previous government's activities together with changing all top civil servants are national problems in

Turkey. This has mainly been outlined by outsiders in the health arena during the interviews such as:

> *"One of the reasons for the conflict between organizations and also not having a sound national policy is the high turnover rates among the staff at the centre. I have been working in the UNICEF for four years and this is the fifth health minister that I have to work with, second undersecretary and numerous Directors. The same is true for other ministries like the Ministry of Education as well. With every new minister, all the directors and other high ranking officers change as well. Even if they do not change, some other problems emerge and inevitably a waiting period follows. That waiting period is the most serious problem as far as our programmes are concerned. There is also a six month waiting period when there is the expectation that the minister is going to change in the near future"* [UNICEF consultant].

> *"The technical team and also the politicians, the Minister of Health are changing very rapidly. This is not a good thing for continuity. Even several Directorate Generals change very frequently. They usually do not have the same ideas that their predecessors had"* [Representative of WHO].

The aforementioned claim that the new government has made about developing a "National Health Policy" indicates that the same problem will apply for developing that policy as well; for every new government will come with the aim of doing that as their major contribution. However, there has not been any concrete attempt to initiate that process since the new government took office and besides, the government programme

stating that: PHC will be strengthened, family practitioner services will be improved, an effective referral system will be developed, family planning services will be given special consideration and universal health insurance will be introduced gradually, does not reflect a major shift from their predecessors (Başbakanlık Basımevi, 1991: p.52).

The second document that will be analyzed here is the Master Plan Study that coincided with the preparation of the National Health Policy Document. As stated earlier, this study concluded with the adoption of an option whereby the provision of health services is separated from purchasing and finance with an emphasis on a more decentralized system and a universal health insurance scheme. The detailed analysis of the Price Waterhouse Report reveals that the report defines PHC as nothing more than the first level of care, that is, services provided by the socialized health services. Intersectoral action, community participation and equitable distribution of resources were stated in the Report as the three principles of PHC as declared in Alma-Ata. Community participation is taken as the promotion of public acceptance of medical interventions. Equitable distribution of resources, that the resources should be allocated based on need, is described as a vague concept. The key component of PHC is stated as a family doctor or a general practitioner (Devlet Planlama Teşkilatı, 1990a: pp.194-196). The Study's verdict about PHC in Turkey is that the services provided are not sufficient both in terms of quality and quantity. The reasons for this are attributed to lack of

continuing financial investment, failure to implement an effective organization and management structure with appropriate powers and responsibilities at the Provincial level and below, and problems related to the workforce (Devlet Planlama Teşkilatı, 1990a: p.204).

At this point, another project carried out by the World Bank with the aims of improving the health status of ten selected provinces of the country, by improving access to basic health services; enhancing efficiency and improving finance prospects for the sector; and strengthening the MH's management capacity should also be mentioned (World Bank, 1989b: p.i). The project, costing 146.3 million American Dollars, of which 75 million comes from a loan provided by the World Bank, is the recent outcome of the Bank's involvement in the Turkish health sector with Health Sector Review Report of 1986 (World Bank, 1986) and Health Financing Report in Turkey (World Bank, 1990). It has been envisaged that by the end of the project high quality basic health services will be provided by the health posts, health centres and district hospitals. Briefly it could be said that the project is about improving the system brought by the socialized services; however, there are some other components like improving the information network and management capabilities of the centre. After the attainment of these aims in 10 selected provinces, the ultimate aim is stated as to expand the model to the whole country encompassing the whole population. No reference has been made in the project proposal to the principles of Alma-Ata. The project, as in Price Waterhouse, takes the

stance that considers the first level of care as one of the ingredients of the whole health delivery system that should be strengthened to avoid unnecessary flows of patients to the secondary and tertiary care. The project will be implemented by a unit established in the MH.

The whole picture outlined so far where, SPO prepares the Master Plan on the one hand and the MH introduces the National Health Policy activities on the other, where at the same time the World Bank is involved in another project, characterizes the fragmented structure of the sector that is even reflected at the national policy-making level. On the other hand, some other projects of UNICEF as well operate contributing the sophisticated outlook of the health sector.

What this Chapter suggests is that implementation of the PHC approach, in its broadest version, is a formidable challenge in Turkey. Especially, as far as the medical approach adopted in solving health problems and the narrow definition of PHC are concerned, this challenge becomes more eminent. The next two chapters will enunciate the two major prerequisites of the PHC approach and will elaborate the difficulties associated with implementing PHC further.

CHAPTER VI. COMMUNITY PARTICIPATION

A. COMMUNITY PARTICIPATION IN THEORY

a. Definition of the Concept

Community participation, one of the prerequisites of the PHC approach, is also a concept evolved over time long before the Declaration of Alma-Ata. Rifkin dates the emergence of the concept back to the Public Health Movement of the 19th century in Europe (Rifkin, 1985: p.xiii). However, the community participation concept, as understood today, came to the fore with the community development approach that emerged after the Second World War. The widely cited definition of community development was coined by the British Colonial Office in the 1948 Cambridge summer conference on African administration as:

> " *a movement designed to promote living for the whole community with the active participation, and if possible on the initiative of the community but if this initiative is not coming spontaneously, by the use of techniques arousing and stimulating it in order to secure its active and enthusiastic response to the movement*" (Colonial Office, 1958: p.2).

Concomitant with the adoption of the approach by international agencies and the United Nations, community development programmes started to be developed and implemented around the world, the most famous and ambitious one being launched in India in 1952. These programmes also involved the health sector in their wide scope, however, those initiatives

were restricted to health education only. Nevertheless, the community development initiatives failed one by one over time and by the end of the 1960s the approach as a whole was regarded as inappropriate. Some of the reasons for this outcome, that are relevant to community participation in PHC, will be discussed later.

The PHC approach, its definition and requirements put a great emphasis on community participation. The definition of PHC in the Declaration of Alma-Ata embodied terms such as "self reliance" and "self determination", and full participation of the community was considered as one of the prerequisites of the approach. Participation of people, either individually or collectively, in the planning and implementation process was considered both as a right and a duty (WHO/UNICEF, 1978: p.3) and to demonstrate the emphasis given, it was proclaimed that "no declaration about PHC by a national government or an international organization appears to be complete without reference to community participation" (WHO/UNICEF, 1981: p.33).

After Alma-Ata, community participation in health, considered as the heart of the PHC approach (Ahmed, 1978), gained pace and a large body of literature and research have developed. The WHO, in all its attempts to promote PHC, emphasized community participation as an indicator of the seriousness of political commitment (WHO, 1981b: p.20); a social,

economic and technical necessity (WHO, 1979: p.17); and a prerequisite to achieve coverage and effectiveness (WHO, 1988: p.46).

Community participation as a concept has a number of shortcomings. First of all, it can mean different things in different settings to different people, that is to say, a consensus as to the definition of the concept has not been reached yet (Brehms, 1983: p.13; Rifkin, 1986: p.241). Rifkin (1986: p.241), after analyzing more than 200 community participation cases, concluded that even different planners in the same project had different perceptions and definitions of community participation, showing the impossibility of reaching a universally acceptable definition. One important point that needs to be clarified here is related to the deeper issues inherent in the participatory approach itself like democracy, representation and equity. However, these discussions go beyond the scope of the thesis and they will not be dealt with here.

Oakley's list of three interpretations of participation gives an insight to how participation can be perceived differently:

> "*Participation means...in its broadest sense to sensitize people and thus to increase the receptivity and ability of rural people to respond to development programmes, as well as to encourage local initiatives*"
>
> "*With regard to development...participation includes people's involvement in the decision-making process, implementing programmes...their sharing in the benefits of development*

programmes and their involvement on efforts to evaluate such programmes"

"*Participation involves...organized efforts to increase control over resources and regulative institutions in given social situations on the part of groups and movements of the hitherto excluded from such control*" (Oakley, 1989: p.9).

WHO defines community participation as:

"*the process by which individuals and families assume responsibility for their own health and welfare and for those of the community and develop the capacity to their and community's development...This enables them to become agents of their own development instead of passive beneficiaries of development aid*" (WHO/UNICEF, 1978: p.50).

Here it needs to mentioned that, the WHO, after the Alma-Ata Declaration has opted for the term "involvement" instead of participation on the grounds that the former implies "a deeper and more personal identification of members of the community with PHC" (WHO, 1984b: p.11). Madan opposes the wording "involvement" and argues that the term reflects some ambiguity as involvement may be voluntary, through education and persuasion or through pressure and coercion which is not desirable in democratic societies (Madan, 1987: p.617). However, the aim here is not to delve into the philosophical arguments about participation versus involvement but to stress the existence of this terminology

difference. That is why the term participation will be used throughout the thesis interchangeably with involvement.

The major determinant in defining participation is whether it is seen as a means or as an end in itself. The former approach suggests that participation is not the objective in itself but a means that can be used to reach a certain objective. For instance, it has been concluded that the main drive behind adopting participatory approaches by the World Bank or some other bilateral or multilateral organizations, is the desire to achieve efficiency objectives (Bamberger, 1988: p.6). Participation in this sense is limited to comment and advice rather than direct involvement (Oakley, 1989: p.10). Mobilization of community resources is one of the major drives behind this type of participation. On the other hand, participation as an end, emphasizes the process of participation itself and empowerment of people is the main drive behind it. Unlike the former, participation in this sense is a dynamic everlasting process that continues after the completion of a programme (Oakley, 1989: p.18). WHO takes a conciliatory approach and combines the two views where it has been stated that "community involvement is more than a means of supporting PHC, it is seen as a parallel end in itself, since adequate PHC can not exist without sufficient community involvement" (Vuori, Hastings: p.6).

Community participation is elucidated by Rifkin (1985) more explicitly by analyzing it from different perspectives. She elaborates the concept from

medical, health planning and community development perspectives and defines how community participation is perceived, who participates and how it occurs from the point of view of each approach. The medical approach, perceiving health as the absence of disease, suggests that the community's role should be responding to the directions by the medical profession. On the other hand, the health planning approach considers that health is a result of delivery of health services. The community is viewed here not merely as a recipient of services provided by professionals, as in the former, but as a participant in the process of producing good health. The community development approach, based on community wants rather than policy-makers' needs, is a bottom up approach to planning where communities are involved in initiating, planning and implementation process of the programmes (Rifkin, 1985: pp. 2-24). Rifkin's argument is useful both for answering the questions like who participates, why do we need participation and how participation occurs more clearly and also for analyzing the available examples of community participation in different settings more systematically.

Thus far, the problem of having a universal definition of community participation has been emphasized and the existence of different perspectives and different ways of looking at the issue have been stated. Although these drawbacks exist, the following definition by Oakley serves the aim of this thesis:

> *"Community involvement [in health development] is a process by which partnership is established between the government and local communities in the planning, implementation and utilization of health activities in order to benefit from increased self reliance and social control over the infrastructure and technology of PHC"* (Oakley, 1989: p.13).

b. The Rationale for Community Participation

Why do we need participation? What is the rationale for involving people in one way or another in the decision-making, implementation and evaluation process? Attempts have been made to answer these questions and the common points reached are as follows:

Point 1: Community Needs Will be Met and Understood Properly

It is believed that the involvement of the community in the decision-making process will result in an environment whereby people's needs are better represented in the decisions reached. It has long been argued that communities know their needs best and their involvement at this stage would facilitate the acceptance of the project and the feeling of responsibility for the continuation and maintenance of what has been made (Bamberger, 1988: p.9; Oakley, 1989: p.6; Rifkin, 1990: p.11). However, this "felt need" concept poses some problems in practice. First of all, the perceptions of the community in terms of their needs and solutions do not necessarily match with what is really needed. As Foster states (1982: p.191), healthy children may be the felt need of the community but

environmental conditions and sanitary measures that would improve the health status of their children may not be on their agenda. Second, as White states (1982: p.27), rich communities who hold the power and who are closer to the centre may reflect their needs better than the less organized, poor communities. Third, an inevitable conflict would arise if the community's needs and wants do not match with the projects that the governments plan to undertake. Last but not least, the reflected needs of the community do not necessarily represent the whole community, especially when the power distribution within the communities is considered. Local politicians and elites as dominant groups within the community could exert power to select the projects they wanted (White, 1982: p.27). However, these shortcomings do not overtake the possible benefits that could be gained from adopting a participatory approach. The minimum advantage that could arise will at least be the use of local technology and information about climate and geographical conditions of the area. Elsewhere, many examples of project failures where this sort of information was lacking have been given (Bamberger, 1988: p.9).

Point 2: Community Participation Will Mobilize the Resources Within the Community

Communities are usually seen as a source of untapped resources (Rifkin, 1985: p.44; Rifkin, 1990: p.11; WHO, 1984a: p.39). Especially in health services, where chronic scarcity of resources is a well known fact,

mobilization of these resources is vital to undertake the projects and programmes that will be implemented. These resources can be in the form of money, materials and labour. Community participation is a prerequisite for such mobilization and this participation will also ensure the maintenance and acceptability of the project (Bamberger, 1991: p.282). Community participation in this case is provided by community financing and CHWs which will be discussed later in this chapter in more detail as both are important aspects of the PHC approach.

Point 3: Community Participation is a Right and Duty

Involvement in decisions affecting their lives is a right and duty that every community is entitled to exercise. It has been accepted that this would increase self-esteem and create a sense of responsibility on the part of community which would in the end lead to better use of services (Hollnsteiner, 1980: p.44; Oakley, 1989: p.5; Rifkin, 1990: p.11). Self-reliance and self-determination, as appeared in the definition of the PHC approach, can only be achieved through involving the community in the decision-making process and enhancing group solidarity. On the other hand, the right to express views and share responsibility in the decisions are accepted as significant features of a modern society (Hollnsteiner, 1980: p.44).

Point 4: Community Participation can Decrease the Cost of Providing Services

Community participation is also seen as a cost effective way of providing health services (Brehms, 1983: p.13; Cernea, 1984: p.41; Oakley, 1989: p.5; Paul, 1987: p.20; White, 1982: p.23). From the government's point of view, contributions of the people would release resources for other projects that would help to extend the coverage of services to other people in different geographical areas. This extension of coverage of health services can help to lower the overall costs (Oakley, 1989: p.50). However, the question that should be asked here is "who benefits from these decreased costs and released resources?" The practice in the end could result in the poor subsidizing the rich (White, 1982: p.23).

Point 5: Community Participation Increases People's Consciousness

It is argued that community participation can make people politically conscious so that they can make their voice heard. The term "conscientization", widely used in community participation and development literature, was coined by Paolo Freire, a Brazilian educator, to emphasize the importance of increasing people's awareness of their environment, living conditions and reasons underlying their poverty. Conscientization was defined by Milwood (quoted in Rifkin, 1985: p.30) as "an awakening of consciousness, the development of a critical awareness

of a person's identity and situation, a reawakening of the capacity to analyze the causes and consequences of one's own situation and to act logically and reflectively to transform that reality". However, this process may not be wanted by the government, as increased awareness of the people at the lower strata of the community and demands from them may not comply with the government's plans. That is why community participation attempts in some instances may be obstructed or diverted by the government itself (White, 1982: p.33).

The aforementioned points could be expanded and a long list could be reached. However, these are the main arguments for participation and their repercussions imply controversial outcomes that in the end shape the way participation is perceived and practised. On the other hand, participation also involves costs. These are documented, mainly in World Bank publications, as possible delays in initiating the projects as a result of negotiations with the beneficiaries; increases in managerial and administrative staff required; changes in the direction of the project as well organized communities can exert power to add new perspectives to the project; and the likely frustration and dissatisfaction of the community due to delays in the project (Bamberger, 1988: pp.10-11).

C. COMMUNITY PARTICIPATION: ISSUES AND CONSTRAINTS

An important question to be asked in attempts to elucidate the issues surrounding the community participation concept is the question of "who participates?" This question first of all, inevitably, leads to another one: "what is a community?" This concept itself suffers from ambiguity as various definitions of the term exists. The Alma-Ata Declaration defines community as "...people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social and cultural characteristics as well as interests and aspirations including health" (WHO/UNICEF, 1978: p.49). On the other hand, an earlier WHO/UNICEF publication defined community as "a group of people who can be identified as living with and having a sense of belonging to a geographical area. Depending upon the settlement pattern and population density, a community may consist of a village or town, a part of a village or town, or several non-contiguous settlements" (WHO/UNICEF, 1977: p.9). The latter does not take into account the web of relations existing in every community but restricts itself to geographical division, whereas, the former, more correctly, emphasizes the fact that communities have cultural, economic and social characteristics which in the end create the sense of community. White also stresses that a community does not mean just the inhabitants of a locality but does involve some form of organization (White, 1982: p: 19). The same issue has been raised by Madan (1987: p.616) where he stated that to speak of

a "community" there must be both a homogeneity of values and interests and a considerable degree of physical togetherness.

The fundamental point that should be made here is the fact that the question of who participates is a political one (Rifkin, 1985: p.43). The politics of community participation will be discussed at the end of this section; that is why here it would suffice to say that in real life the power holders in a community are the elites that benefit from the status quo. As discussed earlier in attempts to define PHC, these powerful groups, who also control the resources available in a society, are the real decision-makers. Their economic power, education and information base, compared with the populace in the lower strata of the society, form the essence of the power they possess.

Another question to be asked with regard to participation is the question of "how?" As stated earlier, the aim here is not to delve into the arguments about "participation" , "democracy", "representation" etc. That is why the above question will be analyzed in terms of participation in programmes with a health services component. Rifkin (1986: p.247) identifies five levels of participation where the breadth of participation extends from the narrowest level, i.e. participating in the benefits of the programme, to the broadest, i.e. participating in planning of the programmes. All these levels can be summarized as follows:

1. **People participate in benefits of the programme.** In this type of participation, passive participation in reality, people are basically recipients of services and education provided by planners and agencies. Their only contribution may be attending a clinic or paying a small fee for the services provided.

2. **People participate in activities of the programmes.** Community participation at this level involves the community members' contributions in terms of money, labour and material. It can be considered as an active form of participation compared to the above; however, community members do not have any say in the selection of activities or services to be provided. These activities are undertaken by planners or professionals. Here, a distinction between contribution and participation should be made as this issue will be raised again when discussing the Turkish experience with community participation. A community's contribution to a programme takes the form of giving money, labour or materials with the aim of bridging the gap between the programmes' objectives and resources. In this case, the participants play a passive role without any involvement in decision-making. As will be discussed later in the community financing section of this chapter, the repercussions of this may be letting the governments "off the hook" or subsidizing of the rich by the poor. As Rifkin states (1985: p.47), with contributions, people inevitably become the subjects but not the objects of a community health programme.

3. People participate in implementing health programmes. At this level, the community may run drug purchasing schemes, antenatal clinics and/or choose the site of the clinic. Here they will inevitably have some managerial responsibilities as to the decisions that should be taken. However, their decisions do not go beyond this point, that is, they are not involved in the selection of the activities to be undertaken. These decisions are made by planners who also play an advisory role to the community.

4. People participate in monitoring and evaluation of programmes. At this level, people are involved in evaluating the programme outcomes and help planners in finding out if the programmes' objectives have been achieved or not and if not why not. Their involvement is restricted to measuring objectives and monitoring activities; however, the development of programme objectives will remain in the hands of planners.

5. People participate in planning programmes. This type of participation, covering all the aforementioned ones with active involvement in decision-making, is the most comprehensive level of community participation. Here, the community, usually through their leaders and key members decide on what health programmes should be undertaken and then asks professionals, agencies or the government to provide expert knowledge and resources. However, according to Muhondwa (1986: p.1252), the nature of activities in health services does not allow this type of participation and

requires the involvement of an outsider agency in order to initiate such programmes. This feature implies that community participation in health programmes will inevitably be of the consultative type. However, this consultation could mean that the community will be involved in choosing methods to be applied and judging the acceptability of these methods by the community.

These five levels can be analyzed in terms of the different approaches to community participation that Rifkin made and stated earlier: medical approach, health planning approach and community development approach. If it is regarded as a continuum, at the one extreme, the medical approach to community participation restricts participation to its minimum level. Here the community is expected to respond to a set of plans prepared by the professionals without being actively involved. At the other extreme end of the continuum, the community development approach to community participation stresses that community participation should start with awareness building and all the community members, especially the less privileged should be actively involved in the process of learning to change the existing systems of health care and controlling health policies that affect their daily lives. On the other hand, the health planning approach, that is at the middle point of this continuum tries to conciliate the two extremes by considering community participation as a problem of both awareness and logistics (Rifkin, 1985: p.47).

Apart from presenting the levels of participation, a full answer to the question of "how" also requires a reference to the mechanisms that activate participation. Agudelo (1985: p.376), calling these mechanisms "co-agents", summarizes how community participation takes place. These "agents" are CHWs, health committees, community organizations such as community boards, neighbourhood committees, cooperatives and the community as a whole participating through health activities supported by the majority of community members. The extent and efficiency of these mechanisms would largely depend on how community participation is perceived in general. The approach adopted would determine the characteristics and activities of these "agents".

Thus far the concept of community participation and issues surrounding it have been discussed and an attempt has been made to delineate the concept by asking questions like "why", "who" and "how". The next discussion in this section will be about clarifying the obstacles to community participation that might illuminate the reasons for not having a nationwide successful community participation programme yet.

It has already been stated earlier that PHC is intertwined with politics and a country's political, economic and social structure play a salient role in the way it is implemented. Community participation is not immune from this as well. Social stratification and the existence of social classes with varying degrees of power and different interests are facts of community life. This

stratification has an important influence on community participation practices. In Ugalde's words "the degree of success of any form of community participation is inversely correlated to the degree of social stratification of the society" (Ugalde, 1985: p.49).

The commitment of the government to community participation is the major determinant of how participation occurs. This commitment varies with the ideology of the government and its enthusiasm towards the betterment of the underprivileged sections of the populace. Rifkin states that (1985: p.45) in socialist countries, where the stress is on equal distribution of resources and collective action, reaching a community consensus and activity may be much easier than in non-socialist nations where individual incentive is the norm. By the same token, De Kadt draws attention to different definitions of community participation by governments of varied ideological stance. He states that the view of a government which is not interested in eliminating socio-economic inequalities and which is keen to preserve the existing power relations will be quite different from that of committed to social justice and empowerment of the underprivileged (De Kadt, 1982: p.749). The same conclusion has been reached in the comprehensive analysis of community participation by the special issue of Contact (1980: p.119) where it has been stated that developing community participation programmes is very difficult in countries where the government feels threatened by the active involvement of people. Apart from governments, the elites and

professionals, who are in a better position than others and who usually control the bulk of the resources, have interests which are also major obstacles to community participation attempts. Hollnsteiner (1980: p.43) draws attention to the fact that, albeit the elites may advocate community participation, in practice they allow the community to be involved only after the major decisions are made. Therefore, community participation after this stage is all about following the predetermined paths regardless of communities' real wants.

Why are governments and elites unwilling to involve communities? The answer to this question may vary and at any time either one or all the answers may be appropriate. First and foremost, community participation may, and is expected to, increase communities' awareness and consciousness (the process of conscientization discussed earlier) that could in the end threaten the status quo. According to Morgan, effective participation inevitably reaches this point. He gives an example from Costa Rica where as a result of participation, promoted by the U.S. government and international agencies, people understood that the major reasons behind their health problems were inequitable land tenure and unemployment that were tolerated by their government. This, coupled with some other reasons, ended with the abandonment of participation efforts (Morgan, 1990: p.216). Second, the contention of elites, especially professionals, that they know best how to make decisions on behalf of communities is another reason for their reluctance to promote community

participation activities. Especially in the case of developing countries, where a high proportion of the community is either illiterate or have only basic education, this tendency can be seen more clearly (Hollnsteiner, 1980: p.45). As Reidy and Kitching state, community participation requires professionals to lay aside their values and be open to learn from and listen to people who are less educated than themselves (Reidy, Kitching, 1986: p.426). Another reason for the reluctance of professionals to advocate community participation could be the fact that their status in the community could also be threatened once the community becomes aware of the real reasons of their poor health and of the limited answers that the professionals can provide (Brownlea, 1987: p.610). However, as Hollnsteiner states, professionals are not necessarily the only group to blame for this apathy of the community. As the communities are used to plans and programmes prepared for them and implemented by some other people, inevitably they may not have the courage or enthusiasm to take the initiative even if the elites or professionals are willing to implement some sort of community participation (Hollnsteiner, 1980: p.45). The reason for this apathy of the community could also be closely associated with poverty. Experience so far suggests that, especially in the case of poverty, individual and family concerns come before community goals (Foster, 1982: p.190; Rifkin, 1986: p.244).

The last point to be mentioned here is about professionals' role in a community. Rifkin tries to answer the question "what is expected from

professionals and what are their roles in a community?" from the three approaches' perspective she proposes (Rifkin, 1985: pp.48-52). From the medical approach's point of view, the professional is the key element in the community health programmes. Concomitant with the view that the objective of community participation is to improve medical services, s/he expects community participation to improve the utilization of services. To this end, s/he decides on what is best for the community at large and plans and puts these plans into practice. So the professional in this case is the planner, manager, problem-solver, consultant, clinician, leader, teacher, evaluator, therefore everything for the health system. The health planning approach, on the other hand, perceives the role of the professional as a component rather than a key to a community health programme. This approach encourages a team relationship involving people from various disciplines and community members. The professional in this case is the member of a team, using his/her time to treat complicated cases, supervision, etc. The third approach, community development approach, perceives the professional as a resource for community health programmes. It claims that when services to the community are defined by the professionals rather than the community, the community is not truly served. Here, the roles of the professionals are defined by the community and they are seen as a resource where the health process begins with the people themselves.

As far as the resistance of the elites to community participation is concerned, bureaucrats may also resist community participation because of the requirement for decentralization of authority and power to lower levels of the social strata. This would threaten their powerful status in the country as a whole.

The aforementioned issues are salient obstacles to community participation. However, apart from these political and ideological issues there are other things to be considered as well, albeit some of them are intertwined with the issues raised above. First of all, community participation requires a strong political commitment (Ahmed, 1978: pp.83-85; Oakley, 1989: p.17; UNICEF, 1982: p.124; Vuori, Hastings: p.13) to enable the implementation on a national scale rather than on a small field project basis. Second, the community should have the ability to organize itself. The structure and power of local governments are very important here. Community participation can only be developed on the basis of some form of local organization, representing all interest groups in the community, having a formal and legitimate character. Third, it should be kept in mind that it is not possible to have community participation through health service activities alone. Earlier attempts at community participation, focusing mainly on the delivery of health services, have failed for three important reasons. First of all most lay people identify health services with curative services that they get when they are ill and this is not a priority on their long list of priorities like food, shelter and clothing.

Second, most lay people do not see any chance of involvement as they have no experience in health services. Third, planners and agencies have a tendency to present problems to the community and show health services as a solution, leaving little scope for the development of active participation. That is why community participation in health services requires a holistic approach to community development (Rifkin, 1986: p.242). The last but not least requirement of having a nationwide successful community participation example is the constitutional and legal support (Oakley, 1984: p.17). Without this support, community participation attempts will not go further than a blueprint.

All the discussion above once again elucidates the complex interactions inherent in the PHC approach. Community participation, proclaimed as a prerequisite for PHC in the Alma-Ata Declaration, has lost its pace since the late 1980s and has never gone far beyond sporadic projects of CHWs and community financing schemes. As Vaughan and Walt state, so far the implementation process has resulted in an enormous gap between the mechanisms for participation and the ideal concept of participation (Vaughan, Walt, 1984: p.111).

D. COMMUNITY PARTICIPATION IN PRACTICE

a. Community Health Workers

CHWs, another contentious topic inherent in the PHC approach, have always been at the core of debates about community participation. Their roles, the way they are paid, the way they perform in the community and their training methods have always either been praised by their proponents or attacked by their opponents. However, the experience so far seems to be more on the side of the sceptics. As in community participation, a countrywide CHW programme is yet to be seen. Thus far, positive reports have usually come from small scale projects generally funded by outside agencies.

In the Alma-Ata Declaration it was stated that PHC is provided by the CHWs at the first level of contact between individuals and the health care system. It was also claimed that CHWs are the most realistic solution for most of the developing countries as they require a short term training and live within the community (WHO/UNICEF, 1978: pp.62-63).

The ambiguity surrounding the definition of community participation also exists for CHWs, and the definition itself has changed over time with the experience gained from the programmes. WHO defined CHWs as:

> "*Trained health workers who live within the community and work with other health and development workers as a team...In many societies these workers come from and are chosen by the community in which they work. In some countries they work as volunteers; normally those that work part-time or full-time are rewarded in cash or in kind by the community and formal health services*" (WHO, 1984b: p.12).

The above definition reflects the expectations from the CHWs and communities at the initial period of the inception of the concept. It was thought then that the community would support the CHW if they selected them, if they were residents in the area and if they were from the community. However, experience thus far has shown that it is not usually the community who has a say in their selection and performance but community leaders and health professionals (Walt, 1990: p.23). So the definition was later modified as follows:

> "*Generally local inhabitants given a limited amount of training to provide specific basic health and nutrition services to the members of their surrounding communities. They are expected to stay in their home village or neighbourhood and usually only work part-time as health workers. They may be volunteers or receive salary. They are generally not, however, civil servants or professional employees of the Ministry of Health*" (Berman, et al., 1987: p.442).

As can be seen, this definition omitted the selection of CHWs by the community as a result of the lessons derived from past experiences. The best way to elucidate the concept further may be by asking questions as

was done in the community participation section like "what are their roles in the community"? and "how are they paid"?

The answer to the first question about the role of the CHW, is yet again a political one and these issues will be discussed later in the politics of CHWs. However, Walt's argument about the role of the CHWs is the most appropriate one to serve the aim of answering the above question (Walt, 1990: pp.37-51). Walt states that CHWs are expected to play three major roles: CHWs as mini doctors; CHWs as extra pair of hands; and CHWs as educators. So far as the first role is concerned, this is mainly a result of the CHWs' own identification with doctors. Although, CHWs in some projects are given the responsibility to inject or supply drugs, considering the short formal training period, this identification might prove to be dangerous. As a result of this, the CHW might eschew his/her preventive and environmental tasks and perform exclusively curative services. On the other hand, it is usually argued that as it is the curative services that a community puts value on and gives the first priority, in order to gain credibility from the community, curative services should be one of the essential ingredients of his/her list of tasks.

The CHW, as an extra pair of hands, is usually attached to a health facility where s/he is expected to help the activities undertaken, which usually means helping mainly the nurses or midwives. This extra pair of hands is very attractive to nurses, especially in very crowded health facilities, as this

would mean the freeing of the nurse from routine tasks. On the other hand, it might be attractive to the CHW as well, as s/he gains more status by working together with professionals. However, considering one of the main reasons behind the creation of such a workforce, that is to bridge the gap between the community and health professionals at the health care facility, which requires the constant presence of the CHW in the community, and also considering the fact that in reality it is not the most needy who uses the health facilities, this type of role does not actually comply with what is expected from CHWs.

The last role that might be expected from a CHW is the role of an educator with the aim of changing the behaviour of the community so far as certain habits and traditions are concerned. However, sceptics argue that this transformation of behaviour will not occur easily, especially as it is not coming from a skilled professional health worker. On the other hand, if the community expects him to carry out this role, and if the community is involved in determining the tasks of the CHW then this acceptance is expected to come naturally. The issue of the community's involvement in decisions concerning CHWs was raised by Skeet as well. He stated that the tasks of the CHWs, usually associated with the eight essential tasks proclaimed in Alma-Ata, are generally determined by the MH without any involvement of the community. According to him, this, coupled with the level of education they have, the type and duration of their training, their means of transport and the health needs and size of

the communities they are expected to serve inevitably lead to failures (Skeet, 1984: p.293). CHWs in this role are also expected to develop or speed up the conscientization process mentioned earlier. The CHW adopting this role becomes a key agent in increasing the awareness of his/her community as to the reasons for and solutions to their problems. However, this role may not be regarded as appropriate by governments that want to perpetuate the status quo. There are a number of examples of this kind where CHW programmes were abandoned, or, in extreme cases, the CHWs suffered from atrocities towards them (Heggenhougen, 1984: p.219).

i. Successes and Failures of the CHW Schemes

After the Declaration, the World experienced a boom in CHW projects mainly because implementing the PHC approach became synonymous with introducing CHW schemes (Vaughan, Walt, 1984: p.111) and these schemes were the easiest ways of showing the commitment of the MH (Walt, 1988: p.16). Nevertheless, these programmes usually showed the characteristics of "vertical" programmes, without any integration with the country's health system and with minimal, or no interest from health professionals (Walt, 1988: p.2). This isolation of CHW programmes is considered very dangerous and in fact it has been claimed that in such an environment these programmes would be harmful (Skeet, 1984: p.295).

One of the assumptions made, at the time when CHWs were proposed, was that the community would finance these workers or they would work voluntarily. It was assumed that as, in theory, the community would be involved in every aspect of these programmes, they would be more than willing to contribute to the maintenance of the programme. However, this assumption turned out to be false mainly for two reasons. First of all, as stated earlier, experience showed that villagers had little or no say at all during the inception and implementation of the programme. In many cases, the elite, mainly the leader of the community or health professionals, had the major say in determining who was going to work as a CHW and what tasks they would perform. In many countries the CHWs were selected by health professionals or government without consulting the community. Walt, et al. (1989: p.602), give the example from Sri Lanka where in a programme based on volunteers, 80 per cent of the people in the community did not even know how the volunteers were selected. This fact was considered as one of the major contributors to the failure of the programmes (De La Paz, 1989: p.36; Hasan, 1981: p.59).

The second factor that led to the failure of the aforementioned assumption is related to poverty and unemployment. It is well known that people living in developing countries are generally poor and the unemployment rate is high. In such an environment, first of all, it is unrealistic to expect someone to work on a voluntary basis as involvement with these activities would mean sacrificing productive hours. The hope that voluntary work

would lead to employment status in the future can influence the drive behind volunteering. This was one of the main reasons put forward by volunteers in Sri Lanka (Walt, et al., 1989: p.603). On the other hand, the expectation that finance for these workers would come from the community is also mistaken as those communities are also poor. Even if they are willing to support and even if they are involved in the decision making process they might not have the means to do so. Walt draws attention to these two facts where she claims that a national programme relying on volunteers is likely to fail and there is not an example of a CHW programme where community financing is sustained (Walt, 1988: p.2). This view was supported earlier by De Zoysa and Cole-King as well (1983: p.126). These experiences led to the conclusion that the CHWs should be paid in one way or another by the government. However, this raised further questions over the status of the CHWs. If they are paid by the government, does that mean that they will be civil servants and another type of health professional? If the answer is yes, or if CHWs identify themselves with these groups, the most salient rationale behind having CHWs will be severely damaged: to bridge the gap between the community and the professionals. On the other hand, it has been argued that payment of CHWs by the government makes the CHW an extension of the formal health services which could facilitate the supervision and management of these workers. However, it has also been agreed that the financial requirements of such a scheme would be huge and many countries in the world could not undertake them (De Zoysa, Cole-King,

1983: p.128). There are examples of CHW programmes where the CHWs are given salaries from the government but the numbers trained have been lower than anticipated because of the financial burden. There are also examples of volunteer programmes where a large number of CHWs are trained but the turnover rates were high (Walt, et al., 1989: p.599).

The best way to answer these questions or solve the problem of "who pays?" might be by taking a middle way of sharing the burden between the community and the government. Excluding the government altogether does not seem to be a realistic way of thinking (De Zoysa, Cole-King, 1983: p.129; Nughoro, 1981: p.62).

Another important problem facing the CHWs is the attitude of health professionals. In programmes where the role of the CHW is not delineated in detail and the professionals have doubts as to their functions, they could ignore the CHWs or even put obstacles before them. The support of the professional is essential as the CHWs need continuous, on the spot training. The professional vs. CHW conflict can jeopardize the success of the programme. This is mainly related to unclarified roles of the CHWs. Although there are extreme views like regarding doctors as auxiliaries and CHWs as the key members of the health team (Werner, 1981: p.51), the rational solution is to balance their expected roles and see them as complementary to each other rather than as rivals. Apart from doctors, the attitudes of nurses as health professionals are also of great

importance. Walt draws attention to the fact that although it is often the nurses who train and supervise CHWs, their involvement in the planning stage of CHW schemes is restricted. This, according to Walt, is the main reason why these programmes are not usually welcomed by them. The repercussions of such conflicts and misperceptions of the role of the CHW have been the acceptance of CHWs as an extra pair of hands and in many cases they are kept in health centres to carry out some tasks like weighing children, recording, etc. which otherwise would have been done by nurses.

In order to have a successful and working CHW programme, the linkage between the CHW and the closest health unit is of great importance. The health unit, whatever it is named, has the responsibility of backing, training and evaluating the performance of the CHWs. Besides, patients who will need further attention will be referred to this unit by the CHW. If the linkage is weak, the programme will inevitably fail. Cook (1981: p.57), in his criticism of Werner, emphasizes this point and argues that unless there are well equipped referral centres and national teaching hospitals, the whole structure will collapse.

The last problem area regarding the CHW schemes that will be discussed here relates to their training. The training period, although it varies substantially from country to country, is very short and the skills acquired are quite restricted. The major drawback here is the expectation that they will be useful with the amount of training they have in remote rural areas

where the referral system is weak and support services as well as supervision and evaluation are not enough. Apart from the duration, the content of their training is also very important. Although it has been stated that their training will be concentrated on community health problems, in reality an individualistic approach has been taken with emphasis on areas such as breast feeding, diarrhoea etc. As a result of this approach, they do not usually have the ability and skills to meet the demands coming from their community for instance for curing certain illnesses or bringing about solutions to environmental problems. One of the main reasons for this lack of connection between the community's needs and the curricula of CHWs could be the exclusion of the community from the process of determining the curricula. In the end, the CHWs are not taught what the community wants but what the health professionals want them to do. Skeet (1984: p.294) draws attention to this point and states that in many countries curricula are unrelated to the requirements of the job to be performed and the training period is theoretical and inadequately supervised.

The aforementioned problems faced by the CHW programmes and their solutions are, in reality, intertwined with political issues like other aspects of PHC. The answers to the questions raised and problems incurred are political. The crucial question to be addressed before answering what is expected from CHWs is the question "are they changing agents or are they only another type of workforce used to extend the existing health

services?" In the literature this issue is argued extensively (Cowdhury, 1981; Martin, 1981; Rifkin, 1978; Samba, 1981; Stark, 1981; Walt, 1990).

The earliest programmes of CHWs were created generally by health professionals with the aim of extending existing health services to communities that otherwise do not have access. In those projects, in Walt's terms, they were just another pair of hands (Walt, 1990: p.20-21) helping the professionals in carrying out their activities. This view has been challenged by those who perceive CHWs as changing agents of the community. Werner (1981: p.46-54), an ardent supporter of this view, states that in circumstances where the CHW is taught adequate skills, encouraged to think and to take initiative, supervised and supported at every level, s/he will use his/her full energy in serving the community and get his/her people's confidence. S/He, in this case, will act as a role model for his/her community and others and become a change agent with the role of awakening his people. However, Werner stresses that this kind of CHW would be perceived as dangerous by the oppressive regimes that are not keen on changing the status quo. After analyzing a number of projects in Latin America, Werner came to the conclusion that there existed two kinds of regimes in these examples: community supportive and community oppressive. The supportive programmes, usually on small scale non-governmental projects, were the ones that encourage self-initiative, decision making and self-reliance. On the contrary, the community oppressive programmes were of an authoritarian nature, encouraging

greater dependency of the community on higher levels of the society. He found that national programmes were usually of this character and the politico-economic structure of the country had a great influence to this end.

Cowdhury (1981: p.55) in support of Werner's argument, states that good health workers will inevitably become political figures which in the end would give them an uncertain future, as they might become targets of the power holder groups in the community. Samba (1981: p.64) also gives his support to the arguments put forward by Werner and presents CHW as the best person to initiate, sustain and control the inevitable revolution. However, these claims have been bitterly criticized by Cook (1981: pp.57-58) where he proposed a balanced view between professionals and CHWs.

In discussing the politics of CHWs, special consideration should be given to the politics of barefoot doctors in China as their successes in the late 1970s inspired the developments that ended up with the Alma-Ata Declaration. According to Skeet (1984: p.292), the successes of CHWs are exaggerated on two grounds. First of all, when the Western World became aware of the Chinese health system, China was a closed community. That is why the experts in the area were fed only by the information provided by China and they did not base their arguments on objective research. This resulted in hearing only the successes of the barefoot doctors. Second, at that time both international organizations and policy makers

were seeking a solution for the health problems of the world. So the timing in this sense was perfect. Rifkin's argument regarding barefoot doctors gives insight into why the same achievements have not occurred in other countries or in other projects. She draws attention to the fact that barefoot doctors in China were a political creation established to break the power of the medical professionals, to change the way the health resources are distributed and to encourage people to take part in developing their own health care. Rifkin states that in countries where those incentives are lacking, which is usually the case, it is naive to expect the same achievements from these health workers (Rifkin, 1978: p.34). At this point, the policy shift made by China after the Declaration, regarding barefoot doctors has to be pointed out. The most important change that emerged was the opportunity that was given to barefoot doctors to become "rural doctors" upon their success in certification tests which make them another type in the professional strata. On the other hand, as New states (1986: p.151), concomitant with the recent policy trends in China towards institutionalized, Western oriented, high-tech medicine, reversing the tendency during the cultural revolution, the country in the future might not be cited as a successful example of PHC.

The political functions of CHWs are elaborated by Stark (1985: pp.270-274) where she classified three functions for CHWs in a society: the cooling out function, the spying function and the political function. She argues that CHWs can be used by governments as cooling-out agents

where struggle for change in the government or regime takes place and also they can be used as a carrot in areas where these movements have not yet started. On the other hand, the CHW can act as a spy of the government to inform of unrest in the community or possible actions that would take place. The CHW as a political figure is in a dangerous position as they may become the target of the government or the elite for their attempts to help the conscientization process of their communities.

In conclusion it can be said that, generally because of the aforementioned reasons, the enthusiasm for CHW schemes has cooled. One of the drawbacks to be mentioned here is the lack of evaluation studies that measure the effects of CHW programmes on the community. The development of such analysis would help to outline the benefits from CHW schemes, if any, and encourage their improvements. What does the future hold for CHWs? This question is very well answered by Walt (1988: p.18) where she summarized the outlook. She stated that first of all, the world has entered a stage where austerity measures are taken by all governments and the hopes that the developed countries would share some of the financial burden of implementing PHC have failed. So all countries face a period of economic and financial crisis and as is very well known, health services are the first to suffer in such times. Second, the extent to which CHWs could help to improve health status is not clear mainly because of the lack of evaluation studies mentioned earlier. This shortcoming strengthens the views of the sceptics. Third, CHWs can not

play political roles in non-democratic countries. Fourth, the support of health professionals to CHWs is the most important requirement of such programmes. The medical approach adopted by many health professionals is an important obstacle to overcome.

b. Community Financing

It has long been argued that the desire to ease resource constraints lies at the heart of the motivation to improve community participation (WHO/UNICEF, 1981: p.41). This desire leads to another contentious topic of PHC and community participation, namely, community financing. Here the discussions will take place first around the definition and second its feasibility.

Stinson, after reviewing more than a hundred projects, financed by the community, defined community financing as "contributions by beneficiary individuals and groups to support part of the costs of public health care services" (Stinson, 1982: p.13). However, Abel-Smith and Dua (1988: p.96) criticized this definition because of the confusion it created in people's minds about participation of the community with the financing of health services through general taxation, formal national security schemes or through private household spending. They drew attention to the fact that communities are composed of people living together with common interests to involve in community action and for this reason, they state

that, individual household payments for drugs and treatment (unless these are a part of the community financing programme) and contributions through general taxation or social security schemes should be excluded from the definition of community financing. Their definition of community financing includes the following types of contributions (Abel-Smith, Dua, 1986: p.97).

1. Paying at full or preferential rates for health facilities organized through community efforts. These include the fees charged for personal services determined and approved by the community rather than by market forces. The running of pharmacies or drug banks selling essential drugs to the community falls into this category.

2. Paying for socially organized voluntary community insurance schemes. This category involves prepayments for services or health card schemes.

3. The giving of gifts in cash, labour or kind. This is indeed one of the m most common ways of community financing. These contributions are especially used in special campaigns mainly for one-off construction activities.

4. Paying for the creation and utilization of community capitalization schemes for the promotion of health care.

To Abel-Smith and Dua, even if financing for projects comes from other sources, either governmental or international, as long as one or more of the above mentioned types of community financing is also involved, the project can be regarded as community financed. This definition, more clear than Stinson's seems to be the most appropriate definition put forward for community financing.

The arguments for and against community financing are fiercer than its definition. These arguments are based on two schools of thought, one considering that community financing is the only way of tackling the problem of lack of funds and the other arguing that the poor, who are the least able to finance, are left with a burden that they can not overcome (Stinson, 1984: p.123). The former group base their argument on the contention that communities have untapped resources. It is a well known fact that in most developing nations, household expenditure in the private sector is huge, usually surpassing the amount spent by the MH. In an environment where the health sector suffers from chronic lack of funds, this argument gains support especially from governments and international organizations. On the other hand, the proponents also argue that community financing improves self reliance and is a key to community participation (Cernea, 1984: p.42; Stinson, 1984: p.123). To them, this on its own is enough to support and promote community financing. In Abel-Smith and Dua's words it is the "tangible demonstration of community participation" (Abel-Smith, Dua, 1988: p.96). However, here White's

discussion needs to be mentioned where she stated that solely requiring communities to give support in terms of cash or labour does not mean community participation, unless the community itself takes part in making the decisions to some degree. In projects where an outside agency is totally in control of the whole process one can not speak of participation (White, 1982: p.119).

The opponents, however, base their argument on equity considerations. They insist that community financing, by putting the burden on the least able to pay, namely the urban and rural poor, does nothing but contribute to the already existing inequities in a society (Abel-Smith, Dua, 1988: p.96; Stinson, 1984:p .123). Attention is especially drawn to countries where a group of people, namely elites and the urban population, enjoy free government services (Brehms, 1983: p.15; Stinson, 1984: p.123). Another issue of concern here is the taxation structure of the country (Abel-Smith, Dua, 1988: p.101). In developing countries where taxation is usually of a regressive character, i.e. puts the burden more on the poor and rural population, this segment of the population could already be financing the free services provided for the elites. Ugalde considers this subsidization of urban and rich by the rural and poor from another angle and states that the contribution of rural people through community financing, be it in the form of labour or cash, can free some capital that would be used for the benefit of affluent sections of the population in the form of airports, highways etc. To him, this is one of the main reasons for promotion of

community financing by international agencies (Ugalde, 1985: p.43). In this case, community financing will only exacerbate the inequalities inherent in the system. Vaughan and Walt indicate this fact and state that there is already evidence that rural communities have started to ask the reason why they are required to pay for services that their counterparts in urban settings enjoy freely (Vaughan, Walt, 1984: p.111).

The above discussion brings in the fact that any programme of community financing requires substantial government support whereby the part financed by the community plays a supplementary role (Manzoor, 1978: p.85; Stinson, 1984: p.125). That is to say community financing is not a mechanism to "let governments off the hook" (WHO, 1984a: p.39).

The most common forms of community financing are voluntary labour and direct personal payments (Brehms, 1983: p.22; Abel-Smith, Dua, 1988: p.96; Stinson, 1986: p.123). However, it is very difficult to have sustained contributions in terms of voluntary labour (Abel-Smith, Dua, 1988: p.96). On the other hand, direct payments, apart from their negative repercussions on equity as described above, can deter people from using the services when needed (Stinson, 1984: p.124). Apart from possible adverse effects of community financing, however, there are some positive outcomes as well. For instance, community financing can promote an increase in the general concern for health and health related issues and

also can increase utilization rates of the facilities to which communities have contributed (Abel-Smith, Dua, 1988: p.105).

Whatever the advantages and disadvantages of community financing, the point that is the linchpin of any community financing programme or attempt is the fact that it is not a strategy to decrease the resources devoted by the government. Unless it is seen as a supplementary financing scheme, the attempts of community financing and community participation through it are bound to fail. The most important point to remember is the real aim of community financing: to promote community's involvement in all aspects of their lives and improve their control over activities regarding them. Community financing is not an end in itself i.e. to increase the resources available, but rather a means to reach a decent way of living for all aspects of life.

E. COMMUNITY PARTICIPATION IN TURKEY

Before analyzing community participation in the PHC context, and before discussing the community participation issues in terms of CHWs and community financing, it is essential to consider the history and practice of the community development movement in Turkey. The concept first appeared in the Turkish development literature in the First Five Year Development Plan, where the jargon was changed to "village development", emphasizing the need to start development initiatives from

the village level as 70 per cent of the population lived in rural areas (Devlet Planlama Teşkilatı, 1963: p.406). In the First and Second Development Plans there have been mentions of community development and to this end a study group to formulate this strategy was established. However, with the establishment of the Ministry of Village Works in 1964, these activities were delegated to the ministry and later in 1968 the responsibility to coordinate these activities was left to the Ministry of Interior. Sporadic attempts at community development projects, mainly aimed at mobilizing resources within the community stayed as local initiatives (Aytaç, 1989a: pp.47-48). As a conclusion it can be said that community development initiatives, as in many other countries did not find ground at the national level. The projects, initiated usually by the governor of the project or the district were considered as a means to bridge the gap in resources. The basic tenets of the community development approach like "multipurpose village level workers" (Foster, 1982: p.188) were never implemented. Those initiatives were confined to building a village/district school or health centre but a broad vision of community development/community participation was never adopted.

As far as the health sector is concerned, the first initiative in terms of community participation dates back to the Socialization Act where in the Article 23 it was stated that:

> *"In order to establish and sustain the relationship between the public and the socialized health services, health committees should be organized in health centres and provinces. Their activities and responsibilities will be determined by governmental decrees."*(Koroğlu, 1987: p.220).

This decree was prepared by the MH in 1969. According to that, the main aim of establishing these committees was to establish and sustain a good relationship between the socialized health services and the public which would enable the health centres to provide the services required and would also motivate the material and psychological support of the community.

According to the decree, the committee was comprised of the following members: doctor of the health centre, mayor, village leaders, head teachers of the schools, religious leaders of the communities, and a person from the community chosen by the village elders. The provincial health committee did not include that community representative but the committee was enlarged by covering some more civil servants. The responsibilities of these committees were: to determine the demands of the community; to determine the factors preventing people from utilizing the facilities and to find solutions to these problems; to determine possible ways of motivating the support and help of the people; to determine the environmental problems causing damage to the health of the area; to provide the support of the community in combating infectious diseases and maternal and child health; to provide help for the poor; to organize and plan health education

activities; to support and coordinate related areas or departments for community development services.

The above mentioned committee approach to participation has never fulfilled the expected aims. In reality the composition of these committees did not involve the community members but mainly civil servants and professionals. At the province level, there was not even one representative of the community. One of the ministerial advisors mentioned the reason for failure as follows:

> *"When you look at the Act of Socialization, you can see that this participation issue has taken place in this Act even in the 1960s. Health committees for every village involving the doctor of the health centre, village leader, religious leader of the community were proposed by this Act with the responsibilities for determining the needs of the population, the services expected from them etc. However, these aims were never fulfilled. There were some mistakes in establishing these committees. For example, they did not include the highest administrative authority[11] of the area in these committees. You can not expect it to work without him".*

This comment is both correct and wrong at the same time. Correct, because in the highly centralized administrative structure of the country it is almost impossible to do anything without having the consent of this level.

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[11]Here,he is referring to the governor of province or district. This administrative structure and its effects on PHC as a whole will be discussed in the next chapter.

On the other hand, the comment is wrong as far as the aims of these committees are concerned (at least on paper): to involve community members.

How do the Turkish policy-makers define community participation? They can be mainly divided into two groups: those who perceive community participation as the response of the community to the professionals, who were the majority, and those who perceive participation in a broader context as taking part in decisions. The first group mainly adopted the medical approach that was discussed earlier (Rifkin, 1985: p.47) and restricted the role of the community to the minimum level i.e. responding to what professionals or planners want them to do. The following quotations are representative of this group:

> *"The most important role that the community could play is to accept what is preached and to practise what is required from them. There are very interesting examples that we experienced in Etimesgut*[12]*. For instance, once a doctor went and asked a woman how a four months old child should be fed. She answered like a very well prepared student. However, when the doctor asked her how she was feeding her own children, she denied everything she mentioned just a minute ago and replied that she was feeding him as she learned from her mother"* [Head of the Turkish Medical Association].

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[12]Etimesgutis a district approximately 20 miles from the Capital and is the training area of the Hacettepe University.

"*People should do what has been asked from them. This is especially true when for instance measures related to personal hygiene are taken. People have to follow the instructions of the doctors*" [A former health minister].

"*A social state has some responsibilities that cannot be shifted to another group or person. Health is one of these along with education and defense. Of course health consciousness, education consciousness and defense consciousness should be developed by every individual. I mean a mother should know how to look after her children and she also should be aware of the health services that the state will provide when she needs. That is participation*" [MP, Member of the Health Committee in the Parliament].

"*In the health sector, like in other sectors, the services you provide or you are going to provide should be accepted by the community. You can provide infrastructure, doctor and equipment or you can provide a high quality education programme but if the community is still not allowing the children to drink water when they are suffering from diarrhoea, although you have mentioned the opposite several times, this means the participation of the community is lacking*" [SPO health sector expert].

This perception of community participation coincides with the first, and indeed the narrowest level of Rifkin's classification of levels of participation (Rifkin, 1986: p.247) which considers the people as recipients of the services without any involvement. The main emphasis made by this group is on education of the community in order to raise the awareness or consciousness of people and to accept and practise what has been said.

The second group that perceives community participation as the involvement of the community in decision making and evaluation is the minority. This group of interviewees emphasize the difference between "contribution" and "participation". Examples of this are as follows:

> "*Community participation is, undoubtedly, among the most important factors contributing the problems of a model. However, one should always distinguish between the concepts of "participation" and "contribution". For instance, let us say that a well is going to be built around the health centre. Villagers can contribute by providing material and labour and their role ends when the well is built. This is contribution. On the other hand, participation is taking part in a whole set of administrative activities starting from planning to implementing and evaluation. Even if you finance sufficiently, train the necessary personnel and do everything you can do, without the support and participation of the community none of the models will work properly*" [A member of the Turkish Medical Association].

> "*There are two concepts that are confused frequently: participation and contribution. In Turkey, participation is generally understood as contribution. What I understand from participation stated in Alma-Ata is that, health services are not the services that will be provided to the people by some organizations. Health services are the services that should be provided with the community. These are the services that should be provided according to the needs of the community and with the decisions of the community*" [A ministerial advisor].

These two are the only representatives of the second group defending community participation with a broader perspective. This view has been

challenged by another advisor to the minister who also named community participation as a "romantic attempt". He stated that:

> *"I think the concept of community participation, declared in Alma-Ata and included in the 38 targets for the European Region, is a very vague concept. This ideal has not been achieved in Turkey and I think that the number of countries that could claim that they have achieved this objective is also limited. This concept has been in the literature for a long time. As you know, some concepts become a fashion for a certain period of time until they fade away...There are some ambitious types of participation like participation in administration. In today's environment, it is very difficult to implement community participation apart from participation in the administration of hospitals. You can achieve people's participation in hospital management via hospital boards. So with the privatization of hospitals we will move one step further towards the community participation concept".*

On the other hand, together with these two groups, there was also an example where the interviewee stated that she did not have any knowledge about the issue.

> *"Well, I really do not know issues about Alma-Ata and PHC so I can not define community participation as well. But I could say that the community could participate by paying tax"* [SPO health expert].

These definitions of community participation mainly reveal the fact that although there is not any concrete adherence to community participation in policy initiatives and documents, even if there were, the implementation

would be restricted to educating the community to accept and practise what the planners, professionals or others want them to do or, as will be discussed later, to mobilize the resources of the community.

As far as the parliamentary debates are concerned, there were two phases when the community participation issue was raised. The first phase, between 1964-1966 is characterised by the community development concept where the connection between socialization and community development was made by referring to the former as a prerequisite of the latter. The issue was not tackled between 1960-1989 in any form but in 1989, with the appearance of Alma-Ata in the Parliamentary debates, it was referred to by an MP, though in a very restricted way. He mentioned community participation in the context of maternal and child health services while recommending a more mobile service to the villages and added that community participation as recommended in Alma-Ata could only be achieved by improving this. In 1990 the only appearance of the concept was when an MP referred to community participation as a condition of achieving health aims. However, these restricted examples do not allow us to infer what was actually understood by community participation.

As far as the documents regarding community participation are concerned, three documents need special consideration: The National Health Policy Document (Sağlık Bakanlığı, 1990a); the Master Plan Study (Price

Waterhouse, 1990); and World Bank's Health Project (World Bank, 1989b).

The National Health Policy Document, analyzed in detail in the previous chapters, under the heading of "General Policies", has described community participation and education as a policy initiative to achieve HFA by the Year 2000. The **full** translation of the section is as follows:

> *"Attaining the goal "Health for All by the Year 2000" could be realized with the attempts of every individual in the community. In this endeavour, every individual can do something for himself, for his family and for all human kind. The "Health for All" goal can only be reached with the participation of people who are educated and whose initiatives are directed to this end. That is why, there is a need to develop a "health" concept in people's mind and to make them use their physical and mental abilities to the maximum. To this end, people's education will be a strategy for the implementation of the policy and concrete attempts will be made to obtain community participation"* (Sağlık Bakanlığı, 1990a: pp.12-13).

The above quotation is the only reference made to community participation in the Document. As can be seen, neither a clear definition of community participation nor what the "concrete attempts" will be, have been elucidated. The claim that a "health" concept should be planted into people's mind reflects the perceptions of the interviewees where they emphasized changes of attitudes and behaviour.

The second important policy document is the Master Plan Study of the State Planning Organization. As stated in Chapter V, the recommendations of the Price Waterhouse typified a system whereby PHC is considered as the first level of contact with the community and as the starting point of a referral chain. In the final report of the Study, where the recommendations are detailed both in terms of content and timetable, (Price Waterhouse, 1990), the future state of the proposed primary health care services has also been put forward. In this section, two statements have been made regarding the community participation issue:

> "*Regular contact between the PHC team and the local population, resulting in improved collection of birth and death certificates, immunization records and disease notification*".

> "*Greater public involvement in decision-making about local PHC services*" (Price Waterhouse, 1990: p.65).

How this involvement will be achieved and with what aim are not answered. However, considering the narrow definition of PHC adopted and other recommendations of the Study, one could infer that the community involvement attempts would not go further than simply gathering information and accepting what has been offered by the authorities and professionals. This point is clarified further when the objective and policy framework of PHC is delineated in the same document. Accordingly, the objective of PHC is:

> "*Increased priority for the delivery of health care by primary health care teams, with every member of the population registered with a team.*
>
> *Investment in improved facilities for delivery of primary health care.*
>
> *Improved status, training, remuneration and deployment of PHC doctors*" (Price Waterhouse, 1990: p.119).

As can be seen, the community participation aspect is not involved in any of the above statements. However, the involvement of terms like "effective use of PHC" and "delivery of health care by primary health care teams" clearly shows the stance taken by the Study.

The third document to be mentioned in this context is the World Bank's project paper that sets the objectives of the initiatives of the Bank (World Bank, 1989b). As stated earlier, the project mainly aims at strengthening PHC in selected provinces with the ultimate aim of covering the whole country. Also it was discussed earlier that the project, like the Master Plan Study and National Health Policy Document, adopted the narrow definition of PHC and claimed to strengthen PHC in Turkey by using the already available health centres and health houses more effectively and efficiently. The same tendency of "providing" PHC services to people is also inherent in the project and no reference to community participation has been made whatsoever. The aim of the project has been stated as:

> *"to set up a partly self-sufficient*[13] *public health system capable of providing quality services to an increasing number of patients"* (World Bank, 1989b: p.17).

The medical approach adopted to improve the health status of population is obvious from the above quotation that does not coincide with Alma-Ata in the broader context.

Thus far, an attempt has been made to clarify what community participation means in the Turkish context by analyzing both the interviews and documents. The analysis so far has shown that Turkey has merely adopted a medical approach to her health problems where health services are provided by the medical profession and where community participation enters the arena when their acceptance and utilization of services are needed. Community participation is a means to increase the effectiveness and efficiency of the services provided by the State but not an end in itself. Therefore community participation can be described in the Turkish context as:

> *"the acceptance and utilization of services by the community members provided by health professionals with the aim of increasing their health status".*

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[13]The self-sufficiency concept used here refers to the inception of user charges.

However, to delineate the issue further, the CHW and community financing issues also need to be analyzed in order to reach a more complete picture and to clarify the prospects for PHC in Turkey.

a. Community Health Workers in Turkey: An Option?

Before analyzing the views of the interviewees in terms of CHWs, it has to be mentioned that Turkey has never attempted to establish a workforce of that kind. Indeed, the prohibition of the activities of traditional practitioners by law is a good indicator of the approach adopted in workforce policies. There is no discussion or suggestion about this issue in any of the documents analyzed. As stated earlier, the Parliamentary debates emphasize the status of doctors both in terms of their payment and their social status more than any other professional group. On the other hand, nor do other documents analyzed show significant difference in this tendency, although some consideration is given to nurses and auxiliaries. As far as the Development Plans are concerned, all the plans, with no exception are concerned with the distribution of the workforce and the imbalance between general practitioners and consultants and so on. There is no mentioning of a type of workforce that would correspond with CHWs. On the other hand, nor do the three most recent and prominent policy documents mentioned above refer to CHWs among their options for Turkey.

After this introduction, giving insight into the background of the approach, the analysis of the interviewees' answers to the questions related to CHWs will elucidate the attitudes towards this option further. The interviewees can be divided into two groups as far as this issue is concerned. The first group, where the majority falls, shows an outright disapproval of the issue. They consider health completely under the auspices of doctors and some even react negatively to the involvement of nurses and midwives. The following quotations are from the representatives of this group:

> "*CHWs are not appropriate for any country in the World. Nobody has the right to contract out health. Suppose that you are suffering from a headache and you visit this CHW. What if you have a tumour in your brain that could only be diagnosed by a qualified person? That is why you cannot contract out health services to other people. This is the responsibility of the doctor and s/he is the one who should carry out these services. I personally think that even injections should only be made by doctors. I mean, I am even against the idea that injections can be made by nurses. Today, unfortunately, we do not have a sufficient number of doctors and that is why nurses are allowed to inject. There were people in the rural areas who used to inject people with the drugs prescribed by the doctor for a little amount of money. I banned their practice when I was a minister*[14]. *However, I hear that there are still some people who continue to inject illegally. There must be a strict control mechanism. You can not contract out health services*" [A former health minister].

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[14]Here he is referring to "needleman" mentioned in the traditional practitioners section earlier. However, his claim that he has precluded the activities of these people is wrong because this was already made illegal in the 1930s.

"We cannot accept the idea of minimum health services. I mean you can not support the idea of having people around that have a three or five months course. Because life is invaluable, it is the most precious thing that a person can have. No one, including the State, has the right to leave this precious thing to the hands of an unskilled man. Wherever a socialization chain is built, there must be a doctor in there, even in the remotest area"[(MP, Member of the Parliamentary Health Committee].

"I am personally against the idea of having such a workforce. But you can have an auxiliary like the midwife we have in our health houses" [Deputy Director of the Directorate of PHC].

"If you analyze the development plans you will see that the importance of health education has been stated over and over. Both the education of the public and the education of the personnel are included in this term. When we say education of the public of course we are going to use all the health personnel starting from the midwife to the doctor. These are the principal health personnel. We also have to benefit from the teacher, religious leader or other respected people from the village. However, this benefit should not be in the form of providing curative services as it will cause disputes with the other professionals" [SPO Health Expert].

"It is not acceptable to apply the CHW schemes like, lets say in China. But we can do something else. In Turkey, the person that we name as CHW is the midwife. However, the midwife is not only the person who has the sole responsibility for deliveries and maternal and child health but she also has the responsibility for carrying out PHC activities. She has to be trained accordingly" [A ministerial advisor].

"We already have this in Turkey. Maybe it is not as disciplined as elsewhere but we have it. For example, people who during their military service learn how to inject can return to their community and perform. Maybe this is not consistent with the definition of CHW but we have certain

types of people replacing this concept. For example, there are bone-setters, traditional birth attendants etc. However, CHWs are generally for underdeveloped countries. I personally believe that Turkey, with her potential human resources has gone far beyond a level where she would need to use CHWs. Until now, maybe not in a disciplined manner, people in the community bridged the gap but I think this issue need not be taken as it is in developing countries. It could have been appropriate in the past but not now. We have around 150 health professional schools at the moment. We will solve all our problems related to the quantity of nurses and midwives by the year 2000. For that reason, Turkey has already overcome the major workforce problems" [A ministerial advisor].

The last quotation reflected a confusion between CHWs and traditional practitioners; that is why he was asked to define CHWs. He stated that:

"When the public sector, for some reason, can not educate health professionals, the gap should be bridged by someone. The CHW is a person to bridge this gap after having some sort of training, either short or long term. It could also be spontaneous as we have at the moment".

According to this definition, the basic drive behind introducing CHWs to the system is workforce shortages rather than improving community participation. His reply becomes more important when his position as one of the masterminds of the National Health Policy Document for the year 2000 and his prominence in adopting recent proposals and developments are considered.

The second group of interviewees, that constitute the minority, had a more positive approach towards CHWs. Some of them showed their approval by defining the possible areas where they might work, albeit not necessarily consistent with the idea of Alma-Ata, or by emphasizing their likely contribution. The following extracts are from this group:

> *"When you assign a doctor or a nurse, they usually leave the post within two months of their assignments. On the paper and on the statistics of the MH they are there but it is not the case. They watch out for every opportunity to leave the place. Then you think that the only person who is not going to leave the area is the one who actually is from the area. The health worker concept is still not acceptable in Turkey mainly because of the attitudes of doctors. To them, nobody should practise anything that is under their responsibility. This was the reaction of the doctors in the MH when we proposed a kind of CHW. Alright, we do not say that someone is going to do some of the work done by doctors but let someone be in the community having the responsibility for providing information to the midwife and the health centre. That person will be identified with the community and he will also know how many houses are there in the village, how many deliveries, pregnancies, abortions have occurred and some other issues. When a midwife visits the village, she will immediately see that woman, these should preferably be women, and ask about the pregnancies etc. In this way, the midwife will complete two days' work in half a day. When the trust of people is increased, then people will identify themselves with the services and begin to ask questions about the reasons for their ill-health or deaths. Within the boundaries of being a voluntary scheme and being restricted only to gathering information, this scheme may be welcomed by everybody, including the MH"* [UNICEF Representative].

> *"If you do not have enough doctors and nurses, and if you still insist on providing the service only by professionals, this*

is a serious mistake. However, do not forget that when you start using nonprofessionals in the health sector, their assistance on some occasions might be more harmful than useful. These people should be well educated and they must work in collaboration with the professionals. In Turkey, it is impossible to appoint a nurse or a midwife to every village. The solution to this problem is to train people from the community that are chosen by the community itself and let them perform under the responsibility of the team. However, at the moment this scheme is not feasible as our health centres are not working adequately" [Chairman of the Turkish Medical Association].

"*CHWs can be an appropriate way of solving some problems but the question of necessity should also be addressed. I do not believe that it is necessary for Turkey to take such an option. Why? Because these programmes are appropriate for the countries suffering from severe staff shortages. However, we can create a type of health worker as we did in Cubuk*[15] *some time ago. We required every village to choose a man and a woman living in their community and we requested them to provide information about births, deaths, migration, diseases occurring in their area. We can open a health house in every village, so these people worked as our antennas or ears in their communities. It really worked very well*" [A member of the Turkish Medical Association].

The recommendations for CHWs in these quotations are restricted to information gathering in the community which puts the CHW in the place of "epidemiological intelligence agent" (Fendal, 1984: p.301). The UNICEF proposal that is also based on voluntary work inevitably would fail if it were ever incepted. The issue of CHW schemes based on

[15]Cubuk is a district approximately 60 kilometres north of Ankara and is a training area for the Hacettepe University.

voluntary work was discussed earlier and it was stated that in the past those attempts failed mainly because of lack of support from the community. Considering the fact that the CHW as proposed in Turkey would not be helpful to the community in one way or another but gather information for the government, why would the community be willing to pay for him is a question to be answered. All the quotations made so far are consistent with the perceptions of community participation made earlier and with the non-existence of discussions about CHW schemes in Turkey. The adopted medical approach to health does not allow policy makers to consider such endeavours even if they adhere to the HFA policy on paper.

b. Community Financing in Turkey

As stated earlier in this section, community participation attempts, if there are any, are restricted to sporadic community financing endeavours. However, these attempts, besides being on an ad hoc basis mostly depending on the community leaders' enthusiasm, have not gone far beyond providing materials or labour. There have never been any attempt at establishing drug schemes or other financing schemes where the community in one way or another accepts some managerial responsibility. Contributions in terms of material and labour have been more intensive in the education sector than health. The most recent example of this is the "Build Your Own School" campaign launched towards the end of the

1980s. However, although this campaign has mobilized some resources, it lost pace after a period of time. The most cited province with regards to this campaign is Tokat (a province in Central Anatolia) which also was declared as a pilot project area by the SPO. It has been stated that although the State could build only 300 classrooms in 60 years, with the "Build Your Own School" campaign 3000 new classrooms and teacher houses were built just in 3 years. The whole cost of the project was 18 billion Turkish Liras of which 5 billion came from the State and the rest from the community. By the same token, in the same province, 176 health houses were built with a total cost of 2.5 billion Turkish Liras where 500 million of this came from State resources (Devlet Planlama Teskilati, 1989b: pp.3-4). However, the personnel and equipment needs of these health houses and teacher needs of the schools were of concern as there are examples in other provinces where after building a health house or school their activities were delayed because of staff and material shortages. Varlık, draws attention to this fact and states that there is an urgent need for midwives and nurses in the houses built with contributions from the community (Varlık, 1989: p.38).

As stated earlier, some interviewees differentiated the term "participation" and "contribution" and classified community financing under the contribution heading. There was a consensus among the interviewees about the applicability of community financing, although some, considering it as the financing of health services on a broader scale, did mention their

concern and stressed the duties of the State, referring to the Constitution. One of the major common points mentioned was the altruistic characteristics of Turkish people. For instance:

> "*Turkey is very lucky as far as this concept is concerned. The public tries to undertake everything that the State can not. But the public should be persuaded. There was a campaign of "Build Your Own School" and as we know hundreds of schools were built by the public. The Turkish people are ready to contribute. If they trust you and if they really believe that you are going to use that contribution for their benefit, then they do not hesitate for a minute. But you have to direct them to the right way*" [A ministerial advisor].

> "*Once the people are made to believe in the services that are going to be provided and once they believe in the benefits of these services, you can ask them to contribute to the financing of these services. I think once this is achieved, because of our cultural characteristics, people will contribute voluntarily and with great enthusiasm even before you ask. These contributions will especially be of great value in areas where the services provided at the moment are lower than the national average*" [SPO Health Expert].

On the other hand, there was one exception to this view where one of the advisors to the Minister denied the feasibility of this concept on the grounds of the long term habits developed by the Turkish people. He stated that:

> "*It is very difficult to implement this concept in Turkey, although this has been achieved even in countries having fewer resources than we have. There are long term habits. Health services have been accepted as free services until this*

time. The situation is the same in the education sector. The money allocated from the budget to education is also very limited, they need a vast amount of resources. Turkish society is used to getting public services free of charge. Even people having enough money do not want to contribute to this kind of services. It is simply because of habits. No problems arise in areas where people are used to paying".

As far as the documents are concerned, apart from a mention of the low costs achieved in building health houses where the community has undertaken the responsibility of financing in 1975 Parliamentary debates, this issue has never been raised in the Parliament. Also apart from the Second Development Plan where it was stated that the contribution of people will be encouraged to build health houses, there was not any reference to the issue in the Plans either. As a concluding remark, especially by referring to the absence of this issue on the agenda of recent policy initiatives, be it from the MH, SPO or the World Bank project, it could be said that community financing shares the same destiny with CHWs and with community participation as a whole and has no ground for development in the foreseeable future.

What is the prospect for community participation in Turkey? This question has been answered unequivocally both by the documents analyzed and interviews made. At present there is no intention to move towards an environment where communities are involved in the decision-making, planning, implementation and evaluation process. The only reference

made to community participation is in terms of improved acceptance of what has been proposed or declared by outsiders, be it professionals, the government or the international agencies. Does that coincide with the WHO's claim that a declaration of commitment to PHC without a reference to community participation is an incomplete commitment (WHO/UNICEF, 1983: p.33)? Does that refer to the self-reliance and self-determination concepts pronounced at Alma-Ata? The answers to these questions are negative. The issue of community participation did not even generate lip service from the government and did not occupy any part of the health agenda. This fact provides a straightforward answer to the main question about the prospect for community participation in Turkey and indeed, to the prospect for PHC as well. The next Chapter will elaborate the impossibility of achieving community participation further when analyzing the issues of decentralization: a major pillar of the PHC approach in general and a prerequisite of a community based approach in particular.

CHAPTER VII. DECENTRALIZATION

Decentralization, as a concept, has been on the international agenda since the early 1950s with varying degrees of impetus. The concept was introduced to countries under colonial rule during the mid-1950s and early 1960s with the establishment of local governments. However, after their independence, mainly with the drive to develop and secure national unity, these countries opted for a more centralized system[16]. The issue has come to the fore again in the 1970s and 1980s mainly because of the frustration with the trickle down approach to development described earlier in Chapter IV. The emphasis on economic growth in the 1960s resulted in a greater emphasis on central planning, and particularly with the insistence of international agencies, many developing countries adopted a centralized approach to development. However, the demise of the "trickle down" effect in the early 1970s brought decentralization on to the agenda of developing countries and a number of them embarked on decentralization programmes (countries like Sudan, Sri Lanka, Papua New Guinea, Tanzania are the most cited ones in the literature) (Conyers, 1984: p.188; Mills, 1990: p.13; Rondinelli, Cheema, 1983: pp.10-14). This history of decentralization has been likened to movements of a pendulum where an attempt at decentralization has been followed by a period of centralization (Conyers, 1983: p.98; Mawhood, 1983:p .8). However, Conyers argues that the recent attempts, because they have distinctive characteristics and because the governments and international agencies are

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[16]A detailed history of decentralization in colonial Africa can be found in Kasfir (1983). Cheema and Rondinelli (1983) also provides an extensive coverage of decentralization practices in Asia, Africa and Latin America.

more enthusiastic towards decentralization, may result in permanent changes (Conyers, 1983: p.98).

The PHC approach, with its special emphasis on community participation and issues like "self-reliance" and "intersectoral action" favours a decentralized administrative system. In the joint WHO/UNICEF document (1978: p.52) it was stated that:

> "...*The importance of decentralization to intermediate levels, such as provincial or district levels, now has to be stressed. These levels are near enough to communities to respond sensitively to their practical problems and needs; they are equally near to the central administrative level to translate government policies into practice. The intermediate levels serve as important pivots for coordinated development*".

This proposal of a decentralized administrative system has also been advocated in subsequent publications of the WHO (WHO, 1979; WHO, 1981b; WHO, 1984a). Because it constitutes an essential part of the PHC approach and because it is an important component for clarifying the Turkish case, this chapter will analyze the concept in depth. This first section will concentrate on the general issues about decentralization while in the second section an attempt will be made to delineate the Turkish situation.

A. DEFINITION AND FORMS OF DECENTRALIZATION

a. Definition

Decentralization, as with other topics discussed so far, is a contentious topic. When the other complicated issues around the PHC approach are taken into account, there is no doubt that explanation of decentralization for PHC is an enormous task. This issue of complexity seems to be the common point agreed upon by the authors involved in the area of public administration in general and health administration in particular (Conyers, 1984: p.186; Conyers, 1986: p.88; Mills, 1990: p.15; Sills, et al., 1986: p.84; Vaughan, 1990: p.139; Wolfers, et al., 1982: p.4). A considerable amount of literature about decentralization has developed over time and attempts have been made to elucidate the concept by drawing from experiences of countries that have embarked on such programmes.

The most cited definition of the concept is provided by Rondinelli as follows:

> "*Decentralization is the transfer or delegation of legal and political authority to plan, make decisions and manage public functions from the central government and its agencies to field organizations of those agencies, subordinate units of government, semi-autonomous public corporations, areawide or regional developmental authorities, functional authorities, autonomous local governments, or nongovernmental organizations*" (Rondinelli, 1981: p.137).

It can be simply defined as "distributing authority and power horizontally rather than hierarchically" (Kasfir, 1983:p .23). Here two points need special consideration. First of all, decentralization and centralization are not opposite ends of a continuum where the existence of one discards the other. Decentralization and centralization, as examples from different countries reflect, can and should exist together at any time in a country. Some functions of the state can be strictly centralized while others are being decentralized to other levels. Indeed some areas like national security and international relations inevitably require a centralized approach (Montgomery, 1983: p.232). This point emphasizes the fact that one cannot talk about pure decentralization or pure centralization but rather talk about the degree of decentralization. The second point to be mentioned is the difficulty in defining a form of decentralization and attempting to fit a country's practices to one or other form as a variety of forms of decentralization can also exist in the same country at the same time. That is why the following discussion about forms of decentralization should be considered as an attempt to simplify the issue rather than a clear-cut classification.

b. Forms of Decentralization

In the literature, there are three classifications developed to elucidate the concept of decentralization. The first one distinguishes between areal and functional decentralization. Functional decentralization involves

decentralization of authority to perform a particular function to specialized organizations acting either nationally or locally. This function can be health care, education or others. On the other hand, areal or geographical decentralization involves the decentralization of responsibilities for public functions to local organizations having well defined local boundaries (Mills, 1990: p.16; Rondinelli, 1981: p.137).

The second classification, derived mainly from the experiences of countries involved in decentralization, identifies four types viz. deconcentration, delegation, devolution and privatization. These will be analyzed in turn.

i) Deconcentration

Deconcentration, as it involves handing over of administrative rather that political authority and as it corresponds to redistribution of administrative responsibilities within the central government, is considered as the least extensive form of decentralization (Mills, 1990: p.16; Rondinelli, 1981: p.137; Rondinelli, Cheema, 1983: p.18). It is sometimes called as a mere shift of "workload" from the centre to the periphery (Rondinelli, 1981: p.137) or sometimes it can be seen as a device to strengthen central power rather than the local autonomy (Mawhood, 1983: p.3; Mills, 1990: p.17).

Deconcentration can take two forms: field administration and local administration. In the former, more autonomy is exercised by the field

staff who are government officials and employees of a central ministry (Rondinelli, 1981: p.137). Coordination between different ministries at the periphery can be obtained by a committee (Mills, 1990: p.17). In the second form of decentralization, i.e. local administration, a government officer, usually accountable to the ministry of interior or ministry of local government, acts as the key person responsible for all government actions in his/her area. All the field staff and administrative units act as the agents of their ministry at the centre and are responsible directly to the above mentioned person (can be named as governor, district officer etc) in their day-to-day activities. As far as the MH is concerned, this type of decentralization requires establishment of a local division staffed by people appointed by the centre to undertake the predetermined activities (Mills, 1990: p.17).

Whichever form is adopted, as has been mentioned earlier, deconcentration is not perceived as an extensive form of decentralization. However, as Rondinelli and Cheema argue (1983: p.19), in countries where all the powers are extensively centralized, even this form of decentralization can have a considerable impact at the periphery and achieve at least the aim of bringing government closer to people.

ii) Delegation

This form of decentralization is more comprehensive than the former. Here, the authority to plan and execute these plans for specific activities or a number of activities within geographical boundaries, is transferred to an organization that is not directly supervised by a higher administrative unit. These organizations, usually named as parastatal organizations, are semi-autonomous and are outside the central government structure. Although the ultimate responsibility lies with the central government, these organizations have broad authorities to carry out the functions assigned to them. This form of decentralization was mainly a response to the requirements of lending agencies like the World Bank mainly with the aims of avoiding the drawbacks of public administration in the third world during the 1950s and 1960s and of improving efficiency and cost control (Mills, 1990: pp.21-22; Rondinelli, 1981: p.138; Rondinelli, Cheema, 1983: p.20). One of the main drives behind delegation attempts was to divorce important functions from inefficient bureaucracies and to encourage the efficiency increasing practices, exercised mainly by the private sector, for public goods and services (Rondinelli, et al., 1984: p.15).

In the health field, this type of decentralization has been practised mainly in two areas, in teaching hospitals and social insurance organizations. In both cases, the MH delegates its responsibilities, although retaining some power of control over their activities, to the board of management of

teaching hospitals or social insurance organization (Mills, 1990: p.22). The defects of the latter form of organization were discussed earlier.

iii) Devolution

Devolution implies creation of authorities that are independent of central government with a set of responsibilities. These authorities are usually described as local government or local authorities. According to Rondinelli and Cheema (1983: p.22) devolution has five fundamental characteristics to be considered. First of all, local governments are autonomous and independent from the direct control of the government even if there is an element of some control. Second, they have clearly determined and legally accepted geographical boundaries within which they perform and undertake the functions under their responsibility. Third, and maybe the most important, they have a corporate cooperative status and power to raise their own revenue. Fourth, the communities' perception is different from other forms of organization as they see local governments both as bodies to satisfy their needs and bodies in which they can exercise some influence. Fifth, the relationship between the central and local government is established on a reciprocal basis as both levels interact independently. Devolution is mainly a phenomenon of Western democracies although there have been many attempts by developing countries to establish local governments compatible with the above mentioned framework. Papua

New Guinea, Sudan and Nigeria are the most cited examples in the literature.

As far as health services are concerned, two issues need to be given special consideration. First of all the local governments' tax base, especially in the developing countries, where collection of these taxes is a permanent problem, might not be adequate to meet the requirements of health services that make heavy demands on recurrent expenditure. This is the main reason for exempting health services ownership and/or financing from the responsibilities of local authorities in many countries. Although this problem can be solved by allocations made from central government to meet these expenditures, this might end with the loss of autonomy by local government. Second, devolution may hinder the attempts to establish a hierarchy of health services and to set up a regional or national structure. Although there are examples where this problem has been solved to a great extent in countries like Norway and Sweden, there is a requirement for heavy state involvement in health services financing (Mills, 1990: p.21).

iv) Privatization

Privatization, perceived as the most extreme form of decentralization (Hambleton, Hoggett, 1984: p.4; Mills, 1990: p.22; Rondinelli, Cheema, 1983: p.24), is actually the phenomenon of the last decade. The concept

itself generates a large amount of literature and a wide variety of discussions about privatization in health services are available which are beyond the scope of this thesis. Privatization is defined by Mills (1990: p.22) as "the transfer of government functions to voluntary organizations or to private profit-making or non-profit-making enterprises with a variable degree of government regulation". With the strong emphasis on liberal economic policies and on free market principles, many developing countries, together with their developed counterparts, have embarked on privatization programmes both in health and other sectors. This tendency supports the claim made by Conyers (1983: p.98) earlier where she compared the decentralization attempts to movements of a pendulum and also claimed that recent attempts at decentralization are more organized and intensive than earlier attempts and they might be successful. The experience so far suggests that, especially with the recent movement towards privatization, the decentralization movement seems to be here to stay.

The above mentioned four forms of decentralization belong to a widely used classification of decentralization attempts. The third type of classification emphasizes what the decentralization policies intend to achieve and three forms of decentralization emerge: political, administrative and geographical decentralization (WHO/UNICEF, 1981: pp.28-31; Wolfers, 1982: pp.4-5). Political decentralization refers to handing over the political power to pass laws or to make policy decisions

in general to elected bodies at the regional or local level. This form of decentralization facilitates community participation and also makes the local authorities more responsive to their community. Administrative decentralization, on the other hand, implies giving power to local representatives of ministries, to a single administrator or to a coordinating committee to implement government programmes. The last form of decentralization, refers to the relocation of certain ministries or departments to a peripheral centre without making any shifts in the decision-making powers.

Although the forms of decentralization in the above discussion can be seen as clear-cut classifications, in reality, it is impossible to find a country where only one form of decentralization is exercised. As accepted by the experts in the area and as the country examples reveal, more than one type of decentralization can exist at the same time in the same country (Conyers, 1983: p.97; Rondinelli, 1983a: p.189; Vaughan, 1990: p.140).

B. DECENTRALIZATION: ISSUES AND CONSTRAINTS

As stated earlier, one can talk about the degree of decentralization rather than centralization versus decentralization at opposite poles (Mills, et al, 1987: p.2). There are a number of factors that affect this degree and form of decentralization exercised. The first factor to determine this degree is the size of the country (Mills,1990: p.27; Mills, et al., 1987: p.16).

The second factor affecting the degree of decentralization, and maybe the most important, is the financial strength of the organization to which the authority and power are decentralized. Naturally, the greater the reliance on central funds, the smaller the amount of autonomy that can be exercised. If the local authority is given the freedom to collect its own taxes and to raise revenue, the general tax structure of developing countries, discussed earlier, poses a problem. In an environment where it is difficult to raise the yield of the land and property taxes, local governments will be left with following choices: raising revenue through indirect taxes that put the burden on the poor, taxes like vehicle, head and entertainment; or heavy involvement by the central government. The last option will inevitably result in restrictions on the autonomy of local government (Mills, 1990: pp.32-33; Mills, et al., 1987: p.20; Rondinelli, 1983b: pp.11-113; Rondinelli, et al., 1984: p.43). The country experiences in Sudan, Latin America and North Africa provide evidence for the adverse effects of lack of adequate resources (Rondinelli, et al., 1984: pp.66-68).

The culture and values of the country are also important elements in the degree and form of decentralization (Rondinelli, et al., 1984: p.50; WHO, 1984: p.34). These elements include both the behaviour and attitudes of government officials to ordinary citizens and also people's perception of authority as well. There are examples where decentralization attempts have failed because of the patronizing attitude of central government

officials to the people at large. It has been stated that this kind of attitude has been developed during the colonial period where people were seen as the servants of the state not vice versa (Rondinelli, 1983b: pp.106-108; Rondinelli, et al., 1984: p.52). This paternalistic approach does not facilitate decentralization attempts. On the other hand, people's attitudes towards authority and power is also an important factor. Some cultures seem to be more sympathetic or used to the centralized administrative structure than others. The existence of this element in decentralization is emphasized by the WHO (1984a: p.34) where it has been stated that because of the culturally inherited hierarchical structure of some societies, be it in the political system, formal organizations or even in the family, it might be difficult to adopt a decentralized approach. In this case, the WHO recommends incremental changes instead of radical attempts. One other factor affecting the apathy of people to participate in the implementation of decentralization can be the distrust built between the government officials and themselves upon a long historical base (Rondinelli, 1983b: pp.108-109).

Another significant factor involved in the decision to decentralize and the degree of decentralization is certainly the degree of political and administrative commitment and support. Different country experiences show that in many cases, the failures of decentralization programmes were attributable to the weak commitment of leaders, both national and local, and civil servants. For instance, in Tanzania and Sudan, although the

national leaders supported both the ideas of decentralization and participation, the initiatives gained little support from the bureaucracy (Rondinelli, et al., 1984: p.47). There are two main drives behind this reaction. First of all, bureaucrats do not look sympathetically on the idea of delegating the power and financial resources they have at their disposal. Second, civil servants, or the centre in general, is usually sceptical about the capabilities of the periphery. They regard the technical and practical knowledge of the periphery as insufficient for the job that is delegated to them. This belief has a certain validity as the centre attracts the most skilled and informed people (Rondinelli, 1983b: p.102; Rondinelli, et al.,1984: p.63; Smith, 1985: p.190). However, Leonard challenges this belief where he questions the type of capacity required. He states that the periphery could be poor in some areas but there must also be some areas where they can perform better. The problem, according to him, is to identify these areas and adopt a strategy whereby the positive elements are used to the maximum and the negative sides are strengthened to meet the requirements (Leonard, 1983: p.274). Another group of people that is likely to undermine the decentralization attempts, and indeed have done so, is the elites in the country. In Africa, the resistance of bureaucracy and elites was one of the most salient problems faced during decentralization attempts (Rondinelli, 1983b: p.95).

The aforementioned factors, with others, have been and are going to be influential either implicitly or explicitly on the degree and form of decentralization.

The experience with decentralization so far suggests that these attempts overall did not meet expectations, albeit the evaluation process has not been successful (Rondinelli, et al., 1984). Despite this fact, decentralization has been and is being promoted both nationally and internationally. What is the reason for this? What are the main drives behind delegating power and authority to lower levels? What benefits are expected from decentralization? The attempts to answer these questions have resulted in some common conclusions which will be presented in this section.

The first, and maybe the most cited, reason for decentralization is related to meeting local needs more accurately as local people, to whom the power to make decisions is delegated, are supposed to know the needs and requirements of the area best (Conyers, 1981: p.114; Ebrahim, Ranken, 1988: p.56; Oakley, 1989: p.31; Rondinelli, 1981: p.135; Smith, 1983: p.28; Vaughan, 1990: p.142; WHO, 1984a: p.31).

The second reason for decentralization, or benefit that could be derived, is the assumption that local residents and/or local civil servants, who make and execute decisions will be more willing to commit themselves to the

programmes where they have an active involvement (Conyers, 1981: p.114).

Third, decentralization is expected to decrease the bureaucratic content at the local level as the need for the approval of headquarters for every initiative will be decreased. This could also help to decrease the time needed to reach decisions and implement them (Conyers, 1981: p.114; Mills, 1990: p. 38; Rondinelli, 1981: p.135; Vaughan, 1990: p.142). The needs of the public will be met without delay and the government will be more responsive thus improving the quality and the quantity of services provided (Rondinelli, et al., 1984: p.5).

Fourth, decentralization is expected to encourage local initiative and develop the abilities of the local level (Conyers, 1981: p.114; Ebrahim, Ranken, 1988: p.49; Rondinelli, 1981: p.135; WHO, 1984: p.31).

Fifth, decentralization can facilitate intersectoral collaboration at the local level whereby activities of different government departments can be coordinated more effectively (Mills, 1990: p.38; Rondinelli, 1981: p.136; Vaughan, 1990: p.142).

Finally, perhaps the most important contribution of decentralization in terms of PHC approach, is to facilitate community participation in decision-making (Mills, 1990: p.38; Rondinelli, 1981: p.136; Rondinelli, et

al., 1984: p.6; Smith, 1985: p.5). This element has been pronounced as one of the main drives behind the decentralization attempts by Zambia, Tanzania and Papua New Guinea (Conyers, 1981: p.113). Apart from these envisaged benefits, Rondinelli, et al. (1984: p.27) suggest that decentralization is promoted by governments to increase political stability and to serve dominant community interests, and according to them, to this end deviations from objectives made at the beginning like increasing management efficiency can be tolerated.

The above mentioned are the potential benefits expected from decentralization; however, as it has been stated elsewhere (Rondinelli, 1981: p.136), the actual scene is quite different from these expectations as decentralization policies in developing countries so far have been disappointing. There have been important gaps between the rhetoric and implementation. Although there are few evaluation studies regarding the achievements of decentralization policies, the very few conducted indicate that there are serious problems in implementation of these policies (Rondinelli ,et al., 1984: p.30; Smith, 1985: p.188). There is strong evidence that in a number of examples, decentralization attempts, ironically, resulted in more centralization mainly because the bodies to which the power and authority were delegated were not given adequate resources (Rondinelli, 1984: pp.31-41; Smith, 1985: p.189). However, this does not mean that decentralization attempts so far have not achieved anything. These achievements from country experiences are: the access of

people to government resources has improved; decentralization has had a positive impact on participation in some places; there have been improvements in the administrative and technical capacities of local organizations; new organizations at the periphery have been established; regional and local planning have become important elements in national development strategy (Rondinelli, et al., 1984: p.46).

The decision regarding the type and degree of decentralization is a difficult one. What should be decentralized and to what extent is a political issue (Stewart, 1984: p.43). It is not practical, nor desirable to talk of absolute decentralization in many areas involving the PHC approach. Especially after the admission of PHC as a national policy, the centre will need to retain some power in certain areas to control the compatibility of local initiatives with the PHC approach. The most vulnerable area in this sense is resource allocation. As has been discussed earlier, the PHC approach implies radical shifts in the way the resources are allocated in order to meet the "equity" element that lies at the heart of the approach. To achieve this, the MH will need to control the amount of resources going to each region with the aim of bridging the gap among regions in terms of resources at their disposal. On the other hand, to maintain the compatibility of resource spending patterns with the PHC approach, the ministry might also need to have some control over the type of the services to which the resources are devoted. If they are left alone, some regions might consider hospital based curative services as a priority with no change

for the services to the disadvantaged. Briefly, it has been stated that, apart from the above mentioned functions, broader policy-making and planning, norm and standard setting, evaluation, workforce development, health services research, specialized health care institutions and international relations also need to be dealt with by the MH. However, after setting the national plans and programmes most other functions can be worked out by the periphery (Kleczkowski, et al., 1984a: p.66; WHO, 1984a: p.32). So far as the "bottom-up" approach inherent in PHC together with requirements like community participation and intersectoral action are concerned, decentralization becomes an important ingredient in implementing the PHC approach (Walt, Vaughan, 1986: p.46). The possible responsibilities of a MH in a decentralized administrative system are summarized by Vaughan (1990: p.144). The district level is perceived as the level at which decentralization can occur most effectively as far as the MH is concerned provided that they are given adequate financial resources and skilled staff (Vaughan, et al, 1985: p.9).

However, it should be taken into account that decentralization policies in the MH can in reality bring an extra burden on the centre. The centre, in this case the MH, will need to improve its capacity to plan, programme and evaluate. On the other hand, the support requirements at the periphery could be enormous, depending on the type of the skilled workforce they have (Vaughan, 1990: p.143). Another important point to be considered as regards the organization of the MH is the existence of

vertical programmes. The WHO emphasizes the incompatibility of vertical programmes with decentralization policies unless they operate in a completely independent manner (WHO, 1984a: p.31). The same issue is raised by Vaughan (1990: p.143) where he emphasized the lack of or poor communication among vertical programmes at the centre.

In sum it could be said that the experience so far has proven that unrealistic, badly planned decentralization attempts, without considering the complex web of elements discussed above are bound to fail and may be bound to result in more centralization. To achieve successful results, incremental changes that do not push the capacities and also perceptions of both the central and local levels would be the best strategy (Rondinelli, 1983b: p.118; Rondinelli, et al., 1984: p.70). While doing that, the fact that decentralization is not a panacea for problems of underdevelopment nor a short-cut to betterment of people's lives should be kept in mind (Conyers, 1981: p.115; Rondinelli, et al., 1984: p.4). Another fact to be considered is that decentralization is best suitable for politically, economically and socially stable countries and not an option to be considered during crisis or chaos (Rondinelli, et al., 1984: p.71; Smith, 1985: p.199).

C. THE TURKISH ADMINISTRATIVE SYSTEM: A CENTRALIZED OR A DECENTRALIZED STATE?

a. The Turkish Administrative System

The Turkish administrative system and legislation have been influenced largely by the French system, especially as far as the administrative division and local administration are concerned. It has been claimed that the current system is a carbon copy of the French system and the problems that the country faces today are mainly derived from the fact that, while adopting the French approach, the necessary changes required by the country's special conditions were not considered and the system was imported without making necessary alterations to meet Turkish needs (Hamamcı, 1989: p.139).

Administratively, Turkey has been divided into 7 regions and 72 provinces that constitute the highest division in the administrative hierarchy. The provinces are then further divided into districts *(Kaza or Ilçe)* and villages *(Köy)* according to their population and geographical location.

The governor of a province, assigned by the centre upon the proposal of the Ministry of Interior and approved by the Cabinet and the President, is the key person in the provincial administration. S/He has enormous power and responsibilities as being the representative of the President, the

government and each ministry within the boundaries of his/her province. Each ministry also has its own organization in the province headed by a director assigned from the centre who is hierarchically below the governor. These directors (e.g. director of health, director of education etc.) are the natural members of the Provincial Administration Committee *(İl İdare Kurulu)*, that is mainly an advisory body on issues related to the administration of the province with responsibility for helping the governor while performing his/her job (Türkiye ve Ortadoğu Amme İdaresi Enstitüsü, 1988: p.504).

The same type of organization is seen at the district level as well. *Kaymakam* (head of the district), assigned by the Ministry of Interior, is the representative of the central government at the district level. There is also a representative of each ministry at the district level and they constitute the "District Administration Committee" having the same responsibilities as its provincial counterpart.

The smallest unit in the Turkish administration is the village, having a population of fewer than 2000 people (Türkiye ve Ortadoğu Amme İdaresi Enstitüsü, 1988: p.519). The head of the village, *muhtar*, and the Committee of Village Elders are elected by village people every five years.

b. The Turkish Local Administration

The 1982 Constitution, where three forms of bodies were introduced, is the legal base for Turkish local administration: Provincial Local Administration *(PLA) (İl Özel İdaresi)*, municipalities *(Belediye)* and village administration.

The PLA was formed and assigned a wide range of duties mainly to compensate for the weakened power of the centre at the beginning of the foundation of the Republic to provide services like education, agriculture, health, environment etc. Each province has one organization of this kind and they are sometimes referred to as half way between municipalities and the centre as they operate within the boundary of the province whereas municipalities are limited by their boundaries (Eryılmaz, 1989: p.95). After the 1950s, the strengthening of the central authority, and establishment of new ministries and organizations at the centre such as the Ministry of Village Work, State Water Works etc., which also have established their own peripheral organizations, resulted in overlapping of responsibilities among these organizations and the PLA. On the other hand, the position of municipalities, both financially and organizationally has also improved and brought discussions about the validity of the PLA (Eryılmaz, 1989: p.95). That is why new legislation about these organizations stated that as the responsibilities of the PLA organizations and the central organizations overlap, the former should undertake their

responsibilities according to the priorities determined by the cabinet. This restriction is mainly contradictory with the widely held belief that the needs and priorities of the people are best determined locally rather than centrally. The issue was raised by Atalay et al and Varcan as well (Atalay, et al, 1989: p.59; Varcan, 1989: p.167). The governor, as the chairman, is the ultimate authority that decides on the activities of these organizations. Although there are two committees, *il genel meclisi* and *il daimi encümeni*, whose members are elected in the local elections, the approval of the Governor is the key element in their activities.

The PLA has the right to generate its own resources through some activities such as producing goods and services, collecting local taxes, renting its own properties etc. and is also allocated money from the centre. Its functions fall under the headings of health and social assistance, city planning, education, agriculture and economic activities that obviously indicate the overlapping responsibilities with the central ministries and their provincial organizations. The intensity of these activities is restricted to and determined by the strength of the organization measured by the resources at its disposal. Inevitably, provinces with a powerful PLA, which are generally already rich ones, offer better services than their counterparts in poor areas. This adds to the already existing inequalities among regions. Meanwhile, powerful governors and local politicians may be more effective in borrowing money from banks and this again could create equity considerations.

The second level in the Turkish local administrative structure is local government (municipalities) established with the Local Government Act of 1930 (Act No. 1580). By law, local governments are formed in areas having more than 2000 population with the proposal of the Committee of Village Elders and the approval of the governor, provincial general committee (*il genel meclisi*), and the President respectively (Türkiye ve Orta Doğu Amme İdaresi Enstitüsü, 1988: p.512). Local governments have three major organs, namely the Mayor, Local Council and a committee named ***Belediye Encümeni***, all elected in local elections. As with the PLAs, local governments are also assigned a variety of tasks ranging from health to education. As far as health issues are concerned, local governments are mainly given the responsibilities of working together with central government to combat infectious diseases, undertake health checks especially of food and drink, houses, factories, milk houses, public toilets and sewerage systems, to clean public places and collect refuse, to combat air pollution and to construct and manage health institutions.

The third level in Turkish local administration is the village level. As stated earlier, the village head (*Muhtar*) and Committee of Village Elders are the main administrative bodies. *Muhtar* is the head of this committee where the village teacher and religious leader *(İmam)* are the natural members. The main tasks of this committee are to determine the priorities of the village, to organize activities that will require common action, to determine the requirements of collaborative work *(imece)*, to control

village expenditure and to punish villagers who do not comply with the requirements of the Committee. The village has its own budget, prepared by the *muhtar* and the elderly committee and approved by the governor. *İmece* (a tradition that finds it roots in the Ottoman Empire) is mainly collaborative work whereby the villagers put their physical labour towards works for the benefit of the whole village. There is also a tax *(Salma)* collected from the villagers according to the income level of the family. The amount of money that should be collected is not sufficient to undertake any task, let alone major initiatives. Apparently there is a need to change these limits and these also should be adjustable with inflation. The reason for not adjusting this amount until now is stated mainly as political (Aytaç, 1989b: p.253). The Committee of Village Elders has a number of responsibilities related to health, social assistance, education, agriculture etc. The health related tasks generally comprise a number of environmental health measures such as provision of safe water, controlling wells and cleaning (Karabilgin, 1988: pp.355-356).

D. DECENTRALIZATION IN TURKEY

In the earlier sections of this chapter, the point that one can only talk about the degree of decentralization rather than decentralization and centralization as concepts at opposite poles was made clear. That is why, the answer to the question whether Turkey is a centralized or a decentralized state is not a straightforward yes or no. However, as the

general presentation of the Turkish administrative system clearly reveals, it could be concluded that if there is a continuum with centralization and decentralization at opposite ends, Turkey stands at a point closer to centralization rather than decentralization. This point was accepted unanimously by the interviewees. On the other hand, there are also elements of decentralization that fall into the forms of decentralization made earlier. As will be discussed here, one can conclude that in Turkey all forms of decentralization categorized earlier exist to a varying degree.

As far as the first classification is concerned, Turkey practises both functional and geographical decentralization. However, although functions at the centre are decentralized to peripheral units, the administrative division, with its clearly determined boundaries drawn by the size of the population and geographical location, epitomize geographical decentralization more than functional. On the other hand, the Turkish administrative structure can also be analyzed by the second category and as will be seen, it can be claimed that all four forms of decentralization exist in the system.

The first form to be mentioned is deconcentration. As mentioned earlier, deconcentration itself can be divided into two: field administration and local administration. In this case Turkish practice falls into the latter rather than the former. As stated earlier, the governor of the province, assigned by the Ministry of Interior is the ultimate power within the

boundaries of the province. Other ministries and central units also have provincial organizations and their own staff headed by a person assigned by the centre. As far as the MH is concerned, as Appendix 5 reveals, the peripheral organization is headed by the Provincial Health Director, a doctor assigned by the MH with the consent of the governor. All the MH facilities are attached to this peripheral organization and they are staffed and equipped by the centre. All the activities or new initiatives of the peripheral unit need to be approved by the governor first and then must be sent to the MH and other related organizations at the centre be it the SPO, other ministries etc. This strict hierarchy causes problems at the periphery, some of them mentioned earlier when issues like budgeting, resource allocation and community participation were discussed. The matter was also tackled by the majority of the interviewees as well. Some of the examples are as follows:

> *"Would you believe that which vaccine is going to be shot and when, in any part of Turkey, is determined by the centre. They send two people from the centre to plan and organize this activity. When I was the provincial health director of Erzurum*[17] *I asked several times both the minister and his undersecretary why they were paying a salary to the provincial health director if they were going to send people from the centre to carry out the work that the Director is supposed to do. Unfortunately, this is how the system works. For instance, if a doctor wants to do something in the health sector, he asks the Provincial Health Director and the director himself refers the same question to the related Director*

[17].A Province in the Eastern part of the country.

General in the MH and, in many cases, instead of answering the question by himself, the Director General asks the minister. So, briefly, we can say that the same centralized structure is the case both in the Ministry and in the Province and this is the underlying factor in failures" [A member of the Turkish Medical Association].

"*You have a very centralized administrative structure. No one can imagine that community participation can take place in such an environment. That is, I think, the main obstacle. If one wants to achieve something and improve community participation, a great deal of power should be transferred to the periphery. How far Turkey is from that I do not know but at the moment decentralization is not the case*" [WHO Consultant].

"*I can simply state that the administrative structure that we have simply cripples the whole sector. One of the essential principles of the administration of health services is decentralization. At the moment, a provincial health director can not transfer doctors from one health centre to another or spend the money allocated from the centre according to its needs. The drawbacks of this centralized structure do not only affect the health sector but all the other sectors as well. Although it has been mentioned and is repeatedly mentioned that this structure will be abandoned, it has not been achieved yet and there is no prospect of doing so in the foreseeable future*" [A ministerial advisor].

The second form of decentralization described earlier, delegation, does also exist in Turkey in general and in the health sector in particular. Both the SIO and University hospitals, where the Ministry exercises little control over their activities, have been delegated responsibilities that normally fall into the MH's functions. On the other hand, as mentioned earlier when

describing the Turkish health system, the existence of other ministries and organizations providing health services to their beneficiaries also reflects a delegation of responsibilities, as far as the MH is concerned. This type of decentralization, as exercised in Turkey, poses intractable problems for policy-making, planning, financing and other related activities in the health sector that were outlined in detail in the preceding chapters.

The third form of decentralization, devolution, is exercised in Turkey through municipalities and provincial local organizations that also have some health related responsibilities. These responsibilities mainly fall into the public health area and often overlap with each other and with other organizations' responsibilities. As stated earlier, provincial local organizations raise their own revenues through economic activities within the boundaries of the province and they are also allocated resources from the centre. Municipalities, on the other hand, can levy taxes, an ability which has been strengthened since 1983 with recent developments in the Turkish political and administrative environment. However, a substantial amount of their resources still comes from the centre which seriously restricts their autonomy. As Heper states (1985a: p.24), since the foundation of the Republic, local governments have mainly been a tool, at the disposal of the centre. Financial constraints and reliance on the centre have been put forward as the major problems regarding local governments in Turkey (Heper, 1985b: p.102; Keles, 1986: p.55). One of the

recommendations to overcome this problem has been stated as restricting their duties (Heper, 1985b: p.102).

Last but not least, privatization, described as the most extreme form of decentralization, is also a phenomenon that entered Turkey with the liberalization policies of the 1980s. The health sector has also been affected by liberalization policies as well. The enactment of the Basic Act of Health Services, discussed in detail earlier, is one of the attempts to move towards more private sector involvement. The claim that the ultimate aim of this Act is to privatize the sector has been made in Parliamentary discussions of the Act (Resmi Gazete, 1987: p.7,9). Other reforms or reform proposals like family practitioners, increased user charges, universal health insurance also reflect the desire to reorganize the public/private mix of the sector in favour of the latter. However, as has been discussed in Chapter IV, increasing involvement of private sector in health services has some adverse effects for implementation of the PHC approach. In this case, moving towards a privatized system may be seen as contradictory to the pronounced commitment of the MH to achieve HFA by the year 2000 through PHC.

As can be seen from the above presentation, Turkey is among the countries in which more than one form of decentralization exists, however, contrary to this existence, the State apparatus remains highly centralized and although the rhetoric praises the advantages of a decentralized system,

the practice does not go beyond giving lip service. One reason for this has been given as the cultural and traditional values of the country. Traditionally, Turkey can be classified as a paternalistic country where the state/government is the ultimate power above the people. In other words, the State is not seen as the servant of the people but vice versa. This paternalistic approach prevails in every walk of life including family relations. This inevitably can be one of the explanations for having a centralized system. This factor has been mentioned by some of the interviewees as well:

> "*Unfortunately we have inherited an administrative system from the Ottoman Empire that is highly autocratic and highly centralized. The highest administrative authority says the last word and it is always his decision that is taken, not the community's*" [Head of the Turkish Medical Association].

> "*I think this centralized structure is in our culture. I mean, we are not very much used to the idea of taking the initiative*" [Former Health Minister].

> "*Maybe this administrative weakness is a tradition inherited from the Ottoman Empire. A person is always asked why he did something but he is never asked why he did not do something. The bureaucrats, then, found the solution in not doing anything, in not taking the initiative*" [A member of the Turkish Medical Association].

> "*This is something that we have inherited from the Ottoman Empire. As a community, we are used to being under the authority of one person and to apply the decisions made by*

him. We are simply not used to making our own decisions" [A ministerial advisor].

This issue is closely related to the culture and we should always consider this. There are many advantages of being centralized as well. You can plan on a country-wide basis, you can control everywhere at the same time and allocate resources according to this. However, there are also some disadvantages such as a lot of formalities, bureaucracy, not involving the community etc. But one should take into account the centralization habit starting from the Ottoman Empire. It is not easy to change this at once. First of all, the conscience of democracy should be placed in people's mind, otherwise decentralization attempts will inevitably fail. For example, if you decentralize some issues many hospitals would attempt to buy computerized tomography although it is not economic to buy it. This would result in misuse of scarce resources. Or people could intervene in health professional's decisions instead of contributing. We are experiencing this in the form of political intervention at the moment. As I told you before, this issue is closely related to the cultural background of the country. That is why we should not move fast towards decentralization. It may be a fashion or it may well be implemented in other countries especially in developed ones but we have to adapt it to our own circumstances" [A ministerial advisor].

As can be seen, whatever the reason is, Turkey, has to reconsider her administrative structure and should find ways to move towards a more decentralized system that would enable the communities to participate and that would meet local needs properly. Is there a prospect for decentralization in Turkey? In order to answer the question with regard to the health sector, two major documents that may play a major part in

reshaping the sector in the future need special attention: the National Health Policy Document and the Master Plan Study.

The National Health Policy Document, while analyzing the administrative process in the health sector, pinpoints the highly centralized approach as one of the major drawbacks of the system. It has been stated that:

> "*Decision-makers at every level of administration, instead of using their initiatives, leave the decisions to upper levels in the hierarchy, be it the Director Generals, the Undersecretary or even the Minister. In the end, these people face problems that should have been solved earlier. At the moment, the assignment of doctors to their posts and budgetary allocations of provinces are made from the centre. First steps in moving towards a more decentralized system could be by leaving the provinces alone in developing their own personnel policies and by delegating them the responsibility of making their own budgets. However, a preparation period is essential in abandoning the traditional structure*" (Sağlık Bakanlığı, 1990a: p.17).

Apart from these two functions, the proposals regarding the delegation of hospitals to PLAs are also signs of a tendency towards decentralization (Sağlık Bakanlığı, 1990a: p.31). However as stated elsewhere (Gish, 1978: p.62), it should be kept in mind that without rearranging overall government activities, it would be very difficult to implement decentralization in only one aspect of a whole range of activities that are interlocked on many occasions.

As far as the proposals of Price Waterhouse are concerned, there, the tendency to decentralize the system is more explicit as a detailed account of the proposed system has been given. The creation of Provincial Health Authorities is a major attempt at a decentralized system. These authorities will have a wide range of responsibilities, such as identifying health care needs in the population and the resources available; preparing plans consonant with those needs; preparing health promotion and preventive services; being a budget holder to finance health care; purchasing primary and secondary health services for the insured population; controlling the registration of the population for PHC; monitoring and evaluating service outcomes and effectiveness (State Planning Organization, 1990: p.23). However, the report, considering the weaknesses regarding the managerial capability at the provincial level both due to skilled staff shortages and lack of management information systems, emphasizes that the decentralization process should not be embarked on until these drawbacks are eliminated. The report, also, by drawing attention to the feelings shared by the majority of the policy makers that decentralization to the provincial level is too radical, proposes the creation of a regional tier of authority either temporarily or permanently like in the British NHS to carry out functions such as resource allocation, planning, research, monitoring and evaluation (Price Waterhouse, 1990: p.24).

All these recent developments indicate the will to decentralize a system presently over-centralized. However, the fact that these proposals are yet

to be implemented and, although two years have passed since their emergence, no concrete attempt has been made to implement what has been proposed, do not indicate that at present decentralization is a reality rather than rhetoric. The reality is, on the contrary, Turkey, as a country claiming to implement the Alma-Ata principles, is far away from meeting one of the basic requirements of the Approach that is closely linked with other prerequisites of PHC such as community participation.

CHAPTER VIII. CONCLUSION

From the outset, the research was restricted to the national health policy-making level and the main aim was to analyze Turkish health policy from a PHC perspective. The broad interpretation of PHC has been considered as the basic criterion in evaluating the policies and their implementation so far, against the principles declared in Alma-Ata. The analysis of documents and interviews made with the key policy-makers articulated the Turkish approach to PHC unequivocally and provided some evidence for the prospects for PHC in Turkey. In this concluding Chapter, an attempt will be made to discuss this evidence and its repercussions as far as the future of PHC in Turkey is concerned.

The first finding of the study is related to the claim made at the outset that the PHC approach is an appropriate option for Turkey. This claim is verified by the facts that Turkey's health status indicators are not promising; that inequalities in general and health inequalities in particular are the major causes of the problems among different segments of the populace; that the current health care delivery system is far from meeting the needs of the population; that the approach towards health and related issues needs to be changed; that the health sector is isolated from other sectors and health is seen only as the responsibility of the MH; that intersectoral action is nonexistent in a matter that desperately needs the involvement of other sectors; that a top-down approach in every walk of life is the norm; that resource allocation problems require immediate attention. These facts call for a change of approach towards health in

general. The PHC approach presented in detail throughout the study, offers a number of alternative ways of tackling these problems. In this case, it can be suggested that a PHC point of view among the health professionals in general and health policy-makers in particular could enable the country to overcome at least some of the problems in the near future.

As stated in earlier chapters, the influence of the PHC approach in Turkey emerged with the National Health Policy Document (Saglik Bakanligi, 1990a). It has also become clear in recent years that the PHC approach has, whenever needed, been used as a scapegoat for a number of policies adopted which claim that the ultimate aim is to achieve HFA through PHC. However, not all the policies developed to this end, although they claim to be so, are in accordance with what was declared in Alma-Ata.

From the outset, an attempt has been made to elaborate the claim that the Turkish version of PHC differs from the Approach in a number of ways. In order to avoid duplications, not all the aspects will be dealt with here in detail, however, a number of issues will be raised again to reach a conclusion. Although the study has involved the period starting from the 1960s, this chapter will concentrate mainly on the new proposals and the current situation as the "prospect" will largely be dependent on these initiatives.

Although the Document suggested that "Turkey does not have to make radical changes in her legal and physical infrastructure to create a system

within the spirit of Alma-Ata" (Saglik Bakanligi, 1990a: p.12), the recommendations made later were in conflict with this claim. The proposals of the Document, not necessarily consonant with PHC, also require some radical shifts at the overall policy level in general and in the health policy field in particular. Two possible reasons could be proposed for explaining the incentives behind this claim. First of all, the policy-makers involved in the preparation of the Document did really believe that no radical change was needed mainly because of their narrow perception of PHC. Second, the claim was made deliberately in order not to generate reaction from different parties with different interests. The interviews with the masterminds of the document, however, revealed that, in reality, the former was the case. As the discussions in the preceding chapters and these concluding remarks will reveal, this claim represents an underestimation of the changes required if the intentions are to be translated into practice.

An important finding of this study is the domination of the medical approach in solving the health problems of the country. The medical approach, that equates health with the absence of disease and considers medical intervention as the only way of achieving health, can be observed both in the attitudes of the interviewees and also in the documents analyzed. Health is unequivocally seen as an outcome of medical services and doctors are the main actors who can achieve and sustain better health. Another important indicator of the adoption of this approach is the

explicit adherence to vertical programmes or SPHC interventions. Although the EPI campaign of 1985 has unequivocally shown that this type of intervention can only provide palliative solutions, the lessons so far do not seem to have been learnt. What is also revealed is the inadequacy of the training of the health personnel, especially doctors, as far as the realities of the country are concerned. Leaving aside the enormous problems caused by dramatic increases in the number of doctors trained, the content of their education is also an important issue to be considered. This education has a prominent role in perpetuating the medical approach that has developed over time. When the fact that key positions in the MH and other organizations related to health are occupied by doctors is considered, the significance of the education process increases. This medical stance affects the definition of PHC as well as the prerequisites of a system based on the PHC approach. The identification of PHC with primary medical care services or first level of contact may be seen as the end result of such a stance. Other evidence supporting this view comes from the way in which concepts related to PHC are regarded. For instance, as far as community participation is concerned, the medical view is obvious. The interviewees' perceptions about community participation and CHWs, the National Health Policy Document's short sighted view of community participation and the blind eye turned to these concepts by other policies and legislation all support the suggestion made above.

Concomitant with the aforementioned approach, both the interviews and documents illustrate that the PHC approach is perceived in its narrowest form. PHC is not more than another layer in the health care system concentrated more on preventive services as they are cheap and easy to provide. This perception inevitably identifies PHC with cheap and low technology medicine. As was argued earlier in Chapter IV the contention that PHC is a cheap solution underestimates the real costs that are involved in adopting such an approach and lowers its value. Another finding in this respect is the association of socialized health services with the Alma-Ata Declaration. There is a wide consensus among policy-makers that Alma-Ata is a carbon copy of the Socialization Act. As stated earlier, the socialized health services, a reflection of the Basic Health Services Approach in the 1960s, are only a copy of Alma-Ata if a narrow view is adopted. The interviews and documents also revealed that there was a considerable amount of confusion over the concepts such as socialization, basic health services, PHC and preventive care. All these concepts, albeit they vary in principles or nuances, are used interchangeably. Although the interviewees unanimously accepted that preventive services should be given priority and although this request is reiterated in the documents time and again, the argument is based on the wrong assumption that preventive care should come first as it is the cheapest solution. The outcomes of such perceptions are evident: PHC, or health in general, is isolated from the development process and health is perceived solely as the responsibility of the MH; PHC does not

generate the attention it deserves as curative services are more prestigious than preventive services in the eye of both professionals and public; and last but not least, the prerequisites of a system based on PHC are overlooked.

In an approach emphasizing equity, resource allocation issues come to the fore as one of the most important issues to be tackled. In Turkey, as elsewhere, the problems related to resources ranging from maldistribution to fragmentation, utilization to allocation, pose intractable problems in the health sector. Without any doubt, the resources allocated to the health sector are extremely scarce; however, the fragmented structure of the system also adversely affects both the calculation of these resources and the assessment of the way they are used. The resources are inappropriately allocated favouring urban to rural, curative to preventive and better off to worse off. In reality there is not an established system whereby resources are allocated according to some criteria. In the absence of such criteria, the allocation process inevitably relies on ad hoc arrangements, strongly influenced by political preferences, without considering the real needs of population groups. None of the policy initiatives, either in the past or at the present time, have aimed at improving a resource allocation method that would reduce the political influences to a minimum, bridge the gap between the haves and have nots and base the resource allocation process on some objective criteria. The implementation of such criteria would inevitably require a shift from the

resources devoted to the urban areas and better off members of the society to the rural and worse off members. This is a substantial challenge to meet.

Apart from the lack of a sound resource allocation mechanism, lack of information on how the available resources are utilized or spent also poses problems in terms of planning and projecting future needs. The heavy involvement of the private sector and presence of a high proportion of private out-of-pocket payments exacerbate the problems stated above. Not only are these expenditures almost entirely made towards curative services but also the private sector drains public resources at the expense of those who need them most. As far as allocation of the resources is concerned, the highly fragmented nature of the system and the presence of providers other than the MH also play a prominent part in the problems caused. As stated earlier, these organizations are purely oriented towards curative services with little or no involvement in preventive measures. This fact indicates that although it is evident from the allocation pattern within the MH that curative services take the lion's share in terms of resources, in reality when other provider organizations are considered the situation worsens. Another point to be mentioned as far as resource allocation is concerned is the budgeting process that is utterly inconsistent with the requirements of the PHC approach. The Ministry, in contrast with the claim that no change is needed for a system based on PHC principles, has to consider the budgeting process and should adopt a

system whereby the needs of the periphery and indeed of the centre are met properly.

As far as resource allocation is concerned, it could be concluded that there is a consensus among the policy-makers and others involved in the field that there is an enormous gap among regions and different groups in the social strata. However, tackling those problems requires steadfastness and determination on the part of the parties involved. Political will is the first requirement for such a movement. Nonetheless, even if the political will existed, there would still be some problems that would need to be dealt with before embarking on radical changes. One and maybe the most important of these is the lack of a sound information system in the country. Allocating resources according to need, however defined, requires clear information about the disease structure of the society at large. As Kleczkowski et al. state (1984a: p.85), the three essential categories of information that are needed for decision-making on health systems are information on health needs, on health resources and on utilization of various types of care. As testified by recent studies such as the Master Plan Study, neither of these exist in Turkey at the present time. Gathering this information inevitably requires some sort of coordination among different parties providing services. Besides, even with such information, the influence of the MH on the utilization of those resources that are out of its control is questionable if a unified system is not achieved. In these circumstances, as has been experienced during the EPI campaign of 1985,

medical interventions, however appropriate they might be, are bound to fail and result in the wastage of the already scarce resources. On the other hand, more involvement of the private sector as proposed in the recent policy reforms, also will have some adverse effects on resource allocation and utilization issues. As stated elsewhere (Segall, 1983: p.1948), the resource considerations of PHC require the involvement of the entire health sector be it the private or social security component of it. However, at the moment all these issues seem to be overlooked by policy-makers.

The inequalities in resource allocation also prevail in all aspects of life. The inequalities in the general economic outlook, worsening each year with high inflation and unemployment rates, exacerbate the burden on poorer sections of the society. As stressed throughout the Study, health is a crucial part of the development process and PHC is an approach that adopts a broader perspective considering integration with the development process as a prerequisite for improved health. The removal of inequalities is a priority problem; however, the issue is more easily described than acted upon. Political, ideological and practical factors interacting within a complex web of relations are the major determinants in dealing with the inequality problem.

The new proposals, especially the inception of a Universal Health Insurance Scheme can be regarded as a positive move towards reducing

inequalities between the better off and worse off members of the society. The current financing structure, both very fragmented and in favour of people who work in organized sectors, is one of the major contributors to the inequalities. With this regard, the inception of the scheme may, from one angle, be seen as an instrument to ameliorate this weakness within society. However, it should be noted that the achievement of this aim requires substantial improvements in the provision side of the services. Otherwise the poor will, inevitably, end up by subsidizing the rich.

Whatever the repercussions of introducing such a scheme, the proposals in general do not paint a bright picture for the future of PHC. The first major drawback is the increasing reliance on the private sector in the provision of services. The proposals go as far as privatizing public sector hospitals. The possible negative influence of the private sector on PHC has been discussed throughout the Study. The MH, although subscribing to PHC, supports the increasing involvement of the private sector by introducing the family practitioner scheme mentioned earlier. As the narrow definition of PHC is adopted, it is thought that the first level of care, or PHC in their terms, if provided by private practitioners will be more effective and efficient but the possible negative effects of the private sector on PHC are overlooked. On the other hand, medical professionals enjoying the benefits of the private sector would oppose the adoption of a broad view of PHC as they would perceive it as a threat to their position. In a country where over half of the practitioners are involved in

the private sector, it is already difficult to pursue these policies and more involvement of the private sector may endanger the situation further. Besides, if the major tenets of the new system, such as the payment method of the family practitioners, their referral patterns and so on are not organized and planned properly at the outset, the system will inevitably collapse in the future.

The prerequisite of ameliorating existing inequalities is not the only principle lacking in the Turkish version of PHC. The ban on traditional healers, lack of intersectoral action, minor interest in appropriate technology and others, that are also representative of the medical stance adopted, also make the perceptions of the policy-makers about PHC crystal clear. However, the study has concentrated more on two principles of PHC: community participation and decentralization as they illustrate the Turkish case unequivocally. In tandem with the narrow understanding of PHC, community participation as well is taken in its least effective form. The National Health Policy Document and the Master Plan Study, together with the interviews, manifest this tendency beyond any doubt. The documents analyzed and the interviews made reveal the fact that community participation has been taken as enhancing people's cooperation with the proposals of professionals. Health education has been identified as the major strategy to this end. On the other hand, it should be kept in mind that even if it were regarded as a contributory factor to the health of the populace, with the current administrative structure and organization

of health services it would be almost impossible to achieve it without making radical changes in those aspects. Turkey, an over-centralized country by any standard, as discussed in the previous chapter, has to consider this aspect before any attempt can be made. Central planning, although it has been losing importance since the adoption of liberal policies in the 1980s, is an obstacle to community participation. The National Health Policy Document, the first example of a health policy document where community participation has at least been regarded as a policy, adopts the narrowest form that community participation could take. It is even dubious whether this form can be considered as community participation. However, considering the medical approach adopted by the policy-makers, this view of community participation is not in conflict in itself. According to the PHC approach, community participation is a wider and more complex concept than simply increasing people's acceptance of what the doctor has ordered! Nevertheless, considering the medical stance adopted in health issues, stated earlier, this perception of community participation is not an unexpected outcome.

The CHW aspect of community participation or PHC seems to be impossible to introduce under the aforementioned conditions. The explicit opposition towards this kind, and indeed in some cases any type of health workers, makes it impossible even to open the issue to discussion. The curricula of the medical schools help to perpetuate those beliefs that disregard any personnel other than doctors. On the other hand, the

community financing aspect of community participation seems to be welcomed. However, community financing that is seen as an end in itself but not as a means to improve community participation would only help to let the government off the hook which was not the intention in the Alma-Ata Declaration.

As stated earlier, the concept of decentralization that lies at the heart of the definition of PHC with its special emphasis on the "bottom-up" approach is also a cause for concern for Turkey. A country where a centralized approach is taken in all aspects of life needs to change her stance in order to meet the requirements of the PHC approach. Even the basic requirements of the Approach can not be met with the current administrative structure of the country. Although the rhetoric claims the reverse, in practice no attempt has been made to alter the current situation. Such an attempt, however, should be made with full precaution as without the initial help and active involvement of the centre, existing regional inequalities may be exacerbated.

An important point to be tackled in these concluding remarks relates to one of the prerequisites of the PHC approach: intersectoral action. The study revealed that intersectoral action, apart from a short period during the EPI campaign, has never existed in Turkey and also the prospect of its achievement is precarious. One of the major reasons for failures in the socialization process has been the lack of intersectoral action among

different providers within the health sector and among other sectors. Although in the Document it is stated that the Turkish social and administrative structure is appropriate for intersectoral action, the study revealed that, in reality, the reverse is the case. The fragmented structure of the health sector requires intersectoral action more desperately than anything else. However, this has not been achieved among the different departments of the MH, and different organizations, be it on the policy-making side or provision and financing side within the health sector, let alone among various sectors like education, housing, agriculture etc. The inter-organizational conflicts are more evident between the SPO and MH, two principal organizations that identify health policies in the State apparatus. Both the interviews and the documents analyzed showed that these two organizations consider themselves rivals rather than partners. From another perspective, the existence of two separate organizations in the health policy-making field itself creates a problem. Different policy documents produced by these organizations, as seen in the case of the National Health Policy Document of the MH and the Master Plan Study of the SPO, proposing different systems with diverse interests, contribute to the already existing conflict. Apart from this conflict there are also undeniably contradictory ideas and images between the MH and other organizations such as the SIO or the Ministry of Finance. Two examples, one in the past and one recently, confirm this claim unequivocally. As stated earlier, one of the main reasons for failure in the socialization policy was attributable to the negative stance taken by the Ministry of Finance.

On the other hand, recently, the inception of a Universal Health Insurance Scheme was fiercely opposed by the SIO. The rigid hierarchical division and departmentalization within the State hierarchy and the problems that are caused by such a division were discussed earlier. These reveal the difficulty of pursuing a health policy that is agreed by all parties wholeheartedly. Although the proposal by the Document to establish Committees at every level to improve coordination and encourage intersectoral action among different sectors can be seen as a positive move towards this aim, the fact that no attempt has been made since the preparation of the Document and the previous experience with the socialized system raise doubts about the impact of these Committees.

As a conclusion, it can be said that one cannot expect a concerted action with the public and private sectors in a country where this action can not even be achieved among the public organizations. In this case, health will inevitably be considered as the responsibility of the MH alone for a long time to come and that will hinder the actions towards HFA.

The position of the PHC department within the MH needs to be elaborated in more detail. There are a couple of points to be made regarding this issue. First of all, at the present time, PHC is yet another vertical programme within the organizational framework of the Ministry. Although in principle the Director General of the PHC department has the same power as other Directors, the lack of coordination among other

departments seems to undermine the power and influence exerted by the department. On the other hand, this departmental division as a whole is not in accordance with the broad definition of PHC. Departmentalization results in the involvement of the PHC department mainly with preventive services and in this case, isolation from the curative services and other departments becomes inevitable. As shown in the Figure 1, a health system based on PHC principles embodies not only the primary level of care but all levels of health care. That is why the MH's organization chart should be reviewed and radical changes should be made if the aim is really to adopt a system based on the spirit of the Alma-Ata. One solution could be, as Vaughan et al. suggest (1985:p.6) creating a senior post, such as undersecretary, that will have both administrative and political authority and that can have a direct influence on other departments' decisions where these are not in accordance with PHC. In this case all departmental functions within the ministry will be coordinated with the PHC department's activities and resource allocation decisions will be more realistic. However, when the power structure and the dynamics in the MH is taken into account, this option is not an easy and a desirable one from the point of view of the department heads and it challenges the claim of the document that Turkey does not need to make radical changes. On the contrary, the country does need radical changes starting from the MH itself. In an environment where concerted action towards PHC cannot be achieved even within the MH, expectation of improving intersectoral action seems likely to remain as a utopia.

Another point, and indeed closely related to the above mentioned one, is the misperception that PHC is mainly the activities of the health house and health centres. This perception is rooted in the narrow definition adopted that defines PHC as the first level of contact with people and basically involving preventive services. This belief in turn entails that the PHC department is only involved with the services of these centres and the establishment of new ones. It is impossible to achieve either the former reorganization proposal suggested or to enlarge the scope of the responsibilities of the department without making changes in the beliefs and attitudes of the parties involved. The first step to this end could be the delineation of the reasons underlying these perceptions. Some reasons inferred from the interviews and documents can be offered. First of all, Turkey, having applied for a full membership status to the EC, although this application has been frozen at present, sees herself as a prospective member of the Community and member countries constitute a model to be adopted; the American influence cannot be denied as well. Second, as far as the WHO's regional division is concerned, Turkey is in the European region. These two factors play an important role in the policies adopted. As stated earlier, PHC in the developed world is perceived as a first level of care generally provided by a general practitioner or a PHC team. Although this perception in these countries may also play a negative part in attempts at reducing inequalities, the health status level reached by those countries may justify the policies adopted. On the other hand, these countries owe their high level of health status not only to the PHC

approach they adopted but to earlier movements in the 19th century. The recent policy initiative in Turkey that aimed at increasing the number of doctors trained to reach the European population per doctor ratios; the preparation of the National Health Policy Document in accordance with the requirements of the European regional policies; and the similarity of the proposals with its counterpart document for the Region, substantiate the evidence available for the claims made above. As a consequence of this, and with the help of the WHO, the majority of the overseas consultants came from Europe, mainly from Britain. Not surprisingly these consultants carried their beliefs and perceptions of PHC to Turkey and influenced the policy-makers. One another example of this tendency is the move towards privatization of health services in tandem with developments especially in the British National Health Service (NHS). As stated elsewhere (Tatar, 1992), the reorganization attempts of Turkey coincided with the shake-ups in the NHS in 1990. The inception of concepts like internal-market, opted-out hospitals and managed competition to the NHS and their reflection in the reorganization process cannot simply be explained by the term coincidence. However, the heavy involvement of the British consultants at that time through organizations like the WHO and Price Waterhouse may help to explain the reason behind these similarities. One exception to the British case may be the fact that although in the country where these terms originated policy-makers and politicians deliberately avoided the use of terms such as privatization, in Turkey they are used openly and in many cases loosely.

Both the Master Plan Study and the National Health Policy Document have shown that Turkey has never turned to other developing countries and their initiatives. Policy-makers are not interested in what is going on in other developing countries and their achievements. Sri Lanka, China, Thailand and Kerala State are too far away to look at and analyze as an example. Although in the National Health Policy Document, international collaboration was one of the proposals and exchange of views and opinions with other countries was suggested as one of the general policies towards HFA (Saglik Bakanligi, 1990a: p.13), in reality, this collaboration has always been restricted to developed and industrialized nations with no attempt to look at the developing world.

Another point to be mentioned in relation to the underlying factors behind the common perception of PHC, maybe the most important of all is the fact that Turkey lacks trained personnel who will propose policies that are relevant to the country's conditions or who will interpret and discuss proposals offered by outsiders. The apathy of academia in relation to these issues on the one hand, and lack of publications on this issue and on discussions not only about PHC but about health and related issues in general on the other, undermine the development of new approaches as well. As a natural consequence of this, neither the discussions surrounding the health issue nor debates about PHC have been made anywhere in the health policy field. This lack of debates on health related issues result in exceptionally narrow based policy discussions. Professionals' and experts'

involvement in these areas is very limited which does not allow any improvement to broaden the knowledge base in health issues in general. In such an environment, debates on Alma-Ata and PHC do not come to the fore from different perspectives and contribution of experts from all areas are restricted. Without an improvement in this area, addition of new perspectives to the health field seems impossible and also the prospect for PHC seems bleak.

All the aforementioned conclusions derived from the research reveal that achieving the goal of HFA by the year 2000 is a formidable task in Turkey as in any other country in the world. Although there are crucial steps to be taken starting from the resource allocation pattern to intersectoral action, from community participation to decentralization, and this list can be enlarged, the first prerequisite to initiate such a transformation is to open up debates about PHC and HFA within the country. The research revealed that the PHC approach in Turkey has been regarded in its narrowest form and is unlikely to make any improvements in the health status of the populace. As stated above, the policy-makers' vision about health in general and PHC in particular needs to be broadened if HFA is to be achieved through PHC as enunciated in the Alma-Ata Declaration. Training and involving personnel other than doctors on these issues might help to open a debate on these areas which could be a useful strategy in the long run. However, it should be noted that in an environment where appointment of any personnel other than doctors to ministerial positions

is opposed fiercely, this process could take a long time and could become a formidable task.

Throughout the thesis, while analyzing the approach itself and discussing certain prerequisites of it, it has been made clear that PHC is a contentious Approach and HFA by the year 2000 is an ambitious goal. The philosophy behind the PHC approach and its peculiar characteristics, together with its intertwined relationship with politics make the Approach vulnerable to a number of factors that are inherent in every society. These points were made clear in related chapters, that is why it is not the aim here to reiterate these issues again but the aim is to recall that the findings reached in this study are not peculiar to Turkey alone. Nevertheless, although there is strong evidence that HFA cannot be achieved within the time span, as De Kadt suggests, "it is [still] worth striving with vigour for the closest approximation of the Health for All by the Year 2000 goal" (De Kadt, 1982: p.741). As a last word it could be said that De Kadt's determination is also relevant to Turkey. This research has analyzed PHC only from the national policy-making level, however, more research both at this level, and more importantly at the periphery should be carried out in order to complement the findings of this study. The practice in the periphery and the implications of these national policies together with the dynamics at this level will provide invaluable information both on the goal and on how these policies are pursued.

In view of all the evidence presented in this study, it could be concluded that unless PHC is seen as a part of the development process and unless the socio-economic and political scene is changed, efforts to achieve HFA through PHC will not stand a high chance of success. However, there are things that the health sector in general and the MH in particular can achieve. As stated elsewhere evolution is possible as well as revolution (Newell, 1988). However, the first step to be taken should be towards better understanding of PHC and related issues.

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APPENDIX 1: THE LIST OF INTERVIEWEES

Three SPO health sector specialists

Two Ministerial Advisors

Three members of the Parliamentary sub-commission on health

Three foreign consultants

Deputy Director of the Directorate of PHC in the MH

Former Director of the Directorate of Curative Services in the MH

Chairman of the Turkish Medical Association

Undersecretary of the MH

A member of the Turkish Medical Association

APPENDIX 2: INTERVIEW FORMAT[18]

1. Could you summarize the most important problems related to health in the country?

Supplementary Questions

a. Could you evaluate the health status level of the population and the most important problems attached to it?

b. Do you think that the current financing mechanism of the sector is appropriate?

c. Do you think that the current fragmented structure of the health sector has a role in the problems of the sector?

d. What are the problems associated with the health workforce?

e. How would you evaluate the current resource allocation pattern?

2. In the Sixth Five Year Development Plan it has been stated that "the aims are to increase the life expectancy rate to 68 and to decrease the IMR to 50 per 1000" How do you think these aims could be reached?

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[18]As stated also in the text, this format should be treated as a basic format. During the interviews, due to the nature of the research, some questions were omitted and some new ones were added according to the flow of the interview.

3. In the Sixth Five Year Development Plan there has been a statement saying that "PHC services are going to be strengthened". How do you define PHC?

4. In the Declaration of Alma-Ata, PHC was defined as "...essential health care made universally acceptable to individuals and families in the communities by means acceptable to them, through their full participation and at a cost that the community can afford". What is your understanding of "full participation" stated in the Declaration?

5. Do you think that communities can participate by financing the system?

Supplementary questions:

a. Are there any examples of this kind of participation in Turkey?

b. What can be the possible shortcomings of such an endeavour?

6. Do you think that participation can take place by introducing CHW schemes?

Supplementary questions:

a. How would you define a CHW?

b. What should their responsibilities be?

c. How should they be trained?

d. How should they be paid?

7. On the whole, what are the political and practical problems attached to the community participation issue?

8. Do you think that the current administrative structure is appropriate for the community participation issue?

Supplementary questions:

a. What are the current drawbacks of the administrative structure of the country for the health sector?

b. Do you support the idea that a more decentralized system is better for the provision of health services?

c. What can the benefits from a decentralized system be?

d. What can be the political and practical problems attached to the issue?

9. What are the achievements towards HFA by the year 2000 been so far in Turkey?

Supplementary questions:

a. Have you ever heard about the HFA issue?

b. Is it relevant to Turkey's conditions?

c. How far do you think Turkey is away from the objective?

10. How would you evaluate the existence and relations of the SPO and MH?

Supplementary questions:

a. What are the limitations of planning in Turkey?

b. Do you think that current development plans, the way they are prepared are sufficient to provide the expected outcomes from planning?

11. What do you think has been done so far towards the implementation of the PHC approach?

Supplementary questions:

a. Has there been any change in the resource allocation patterns?

b. Has there been any examples of intersectoral action?

APPENDIX 3: Number of Patients Accepted to Hospitals by Selected Diseases. (List A of 150 Causes)

Diseases	Discharged	Died	TOTAL
Typhoid	3650	35	3685
Paratyphoid & Salmonella	3936	32	3968
Enteritis & diarrhoeal dis.	86842	1891	88773
Whooping cough	647	5	652
Tetanus	872	211	1083
Measles	615	8	623
Infectious Hepatitis	16111	362	16473
Pneumonia	68128	2854	70982

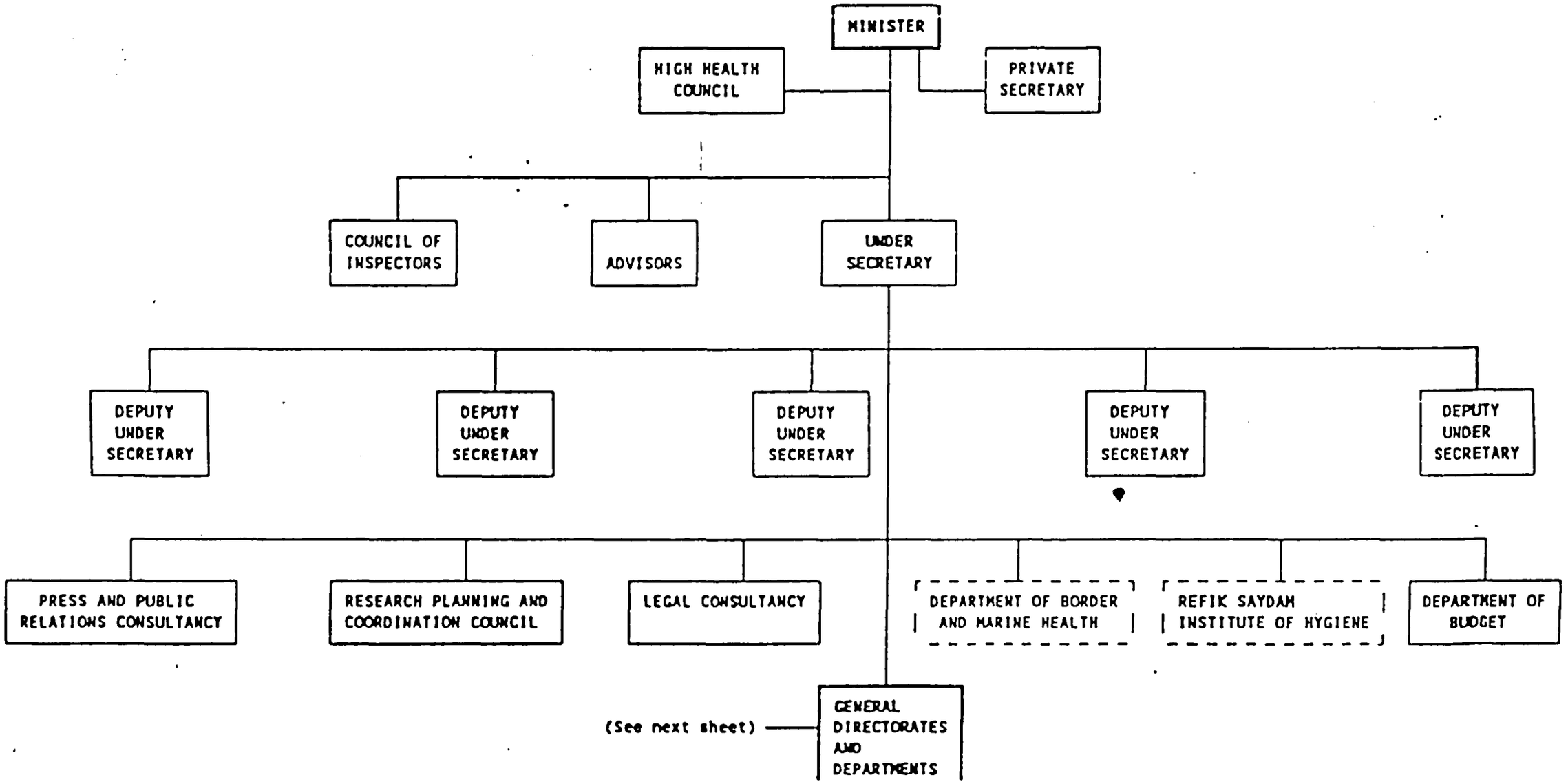
Source: Sağlık Bakanlığı, 1988. pp.76-82

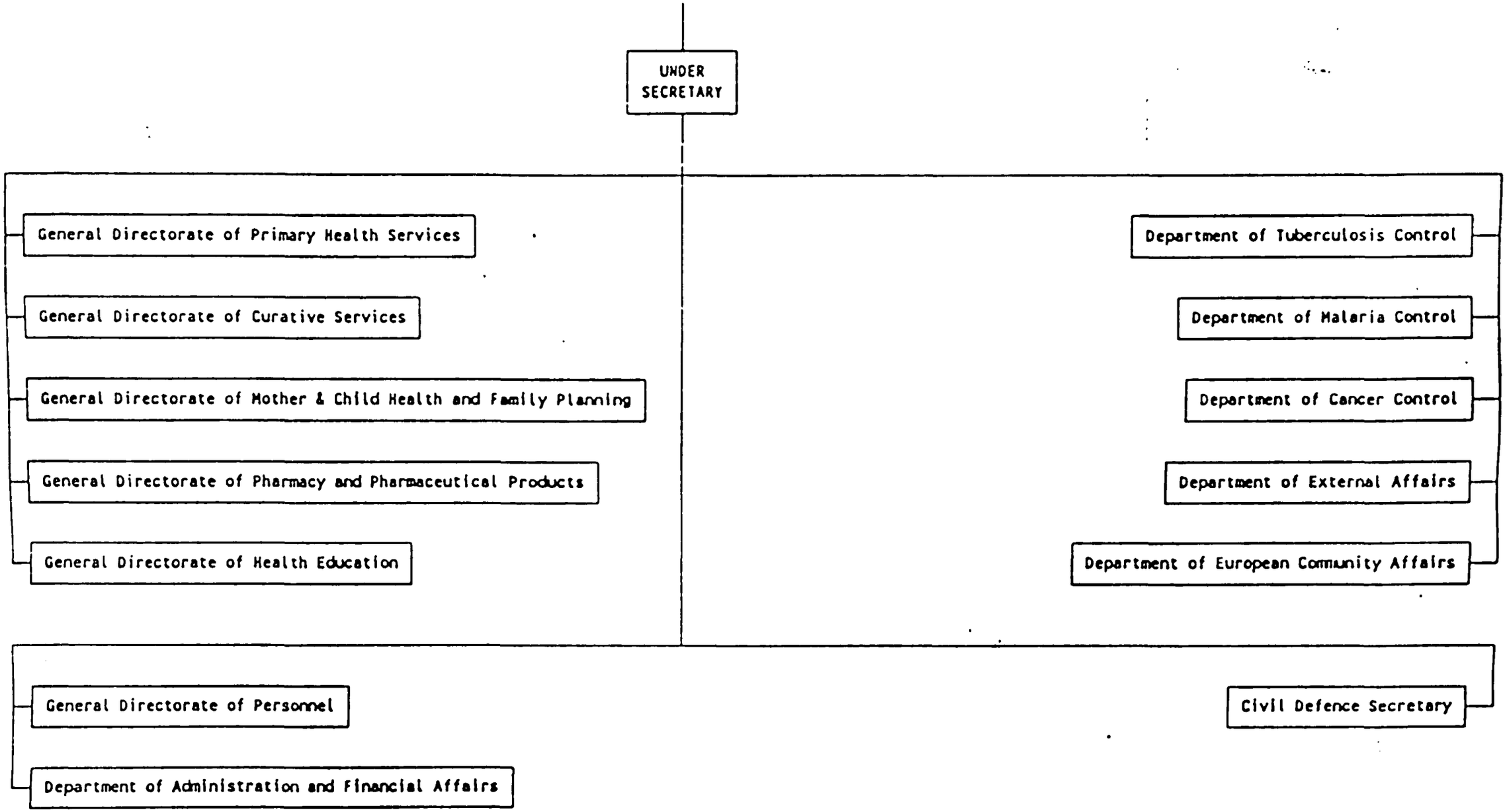
Distribution of Selected Notified Infectious Diseases

DISEASES	NOTIFIED CASES			
	1983	1984	1985	1986
Whooping Cough	5706	3145	2678	1048
Dyptheria	301	155	145	36
Dysentery	1704	2159	2169	3052
Measles	31315	30666	14695	2218
Malaria	66681	55020	47311	37889
Typhoid Fever	1491	1825	2052	3657
Tuberculosis	28634	27729	30960	31029
Hepatitis	21023	32828	25379	27925

Source: Ministry of Health, 1987. pp.153-154

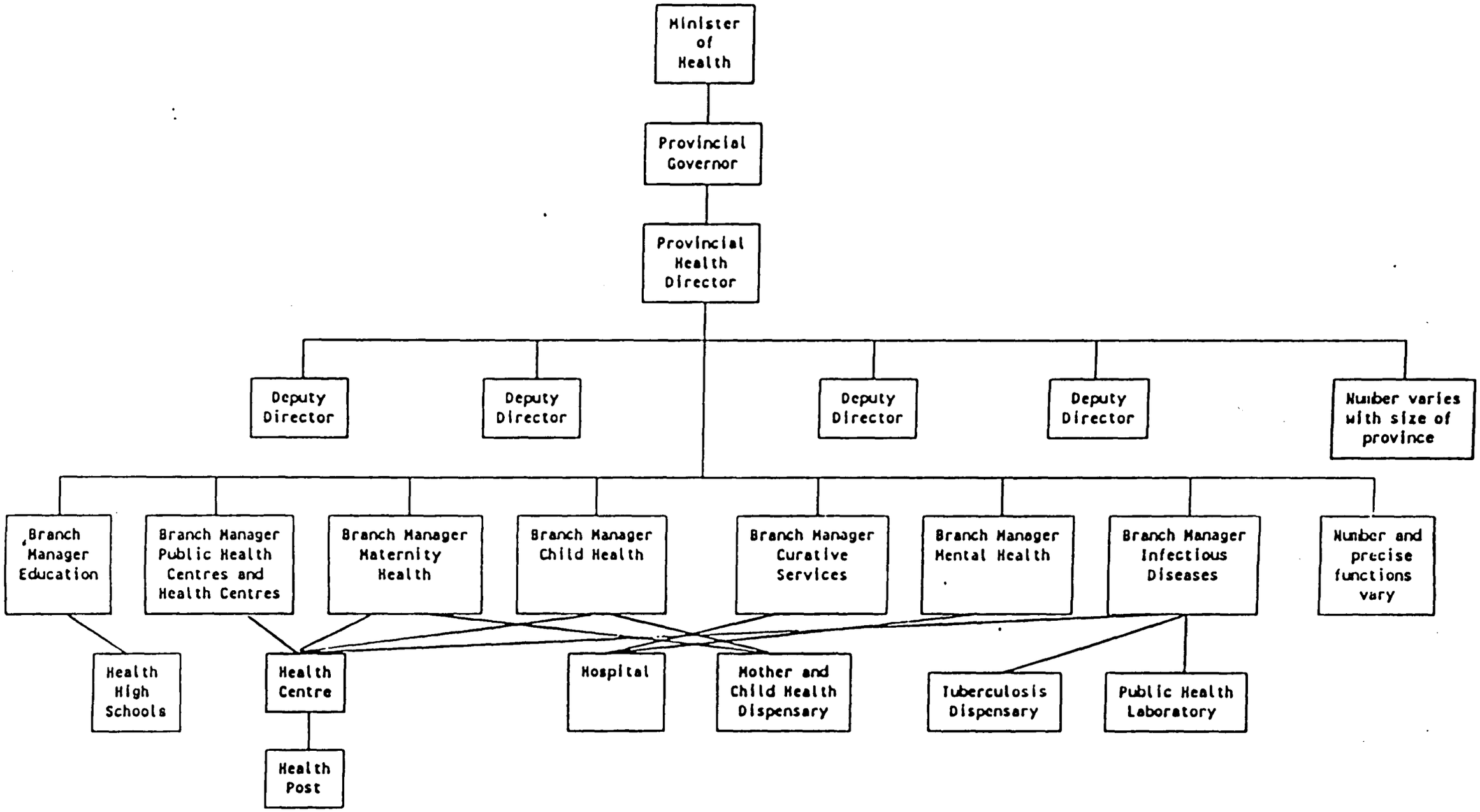
APPENDIX 4. The Organisation Chart of the Ministry of Health (Centre)





Source: Devlet Planlama Teşkilati, 1990a: pp.69-70.

APPENDIX 5: The Organisation Chart of the Ministry of Health (Periphery)



Source: Devlet Planlama Teskilati, 1990a: pp.68.