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Primary health care in Turkey: a passing fashion?

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The Alma-Ata Declaration has long been regarded as a watershed in the health policy arena. The global goal of the World Health Organization, 'Health for All by the Year 2000' through primary health care, has attracted many countries both in the developed and the developing world and commitments to this end have been made at every level. However, albeit this consensus on the paper, a common and explicit definition of the concept has not been reached yet. This paper aims at discussing various definitions of primary health care that emerged after the Declaration and also presenting a case study from Turkey, a country that advocates primary health care in her recent health policy reform attempts. After setting the conceptual framework for discussion the Turkish case is presented by using research carried out among Turkish policy-makers at different levels of the State apparatus. It has been concluded that application of primary health care principles as defined in the broad definition of the concept requires major changes or rather shake-ups in Turkey. These areas are outlined briefly at the end of the paper.

The Alma-Ata Declaration (WHO/UNICEF 1978) has long been referred to as a watershed in the health policy arena. The global goal of the World Health Organization (WHO), 'Health for All by the Year 2000' through Primary Health Care (PHC), has attracted many countries both in the developed and the developing world, and commitments to this end have been made at every level. The Conference in Alma-Ata, acknowledged as 'the largest and most authoritative international meeting on health care ever convened' (Golladay 1980: p. 28), was a turning point, marking a shift in the heretofore dominant views about health and health care systems (WHO/UNICEF 1978).

Considering the developments so far, however, the goal is still distant, with the year 2000 only three years away. Although everyone at Alma-Ata seemed to reach a consensus as to the meaning of PHC, the requirements of the approach and solutions to be applied, in practice no such consensus has yet been reached. The Declaration and subsequent publications of the WHO have attempted to clarify the ambiguity surrounding both the PHC approach and its prerequisites. This has triggered fierce debate worldwide over the meaning of the concept and its practice. This article discusses the various definitions of PHC that emerged after the Declaration and presents a case study from Turkey, a country that has advocated PHC in its recent health policy reform attempts.

PHC: a comprehensive approach or first level of care?

As stated above, since 1978, various definitions of PHC have emerged and it can be claimed that an explicit definition of the concept has yet to be reached. It is not the aim here to delve into the political, ideological or other reasons attached to this issue, but to present these definitions that will guide the discussions in the following sections.

The reaction among academia to the Declaration has been a diverse one. For instance, it has been criticized by some on the grounds that it overlooked complex interactions in society (Sidel and Sidel 1978). Others have perceived it as another attempt by the developed world to impose its solutions, mainly based on medical care, on to the health problems of the developing world (Navarro 1984). Others criticized it as an ambitious collection of statements open to misunderstandings and misinterpretations (Frenk et al. 1990: p. 678). In spite of such criticisms, the Alma-Ata Declaration and its contributions have been praised by others and it has been described as a watershed in health history (Banerji 1988: p. 294). These

diverse views lead inevitably to different interpretations. These interpretations can be divided into narrow vs. broad definition or interpretation of PHC.

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 such as immunization and health education are also carried out at this level.

The implementation of this definition takes the form of general practitioners (often helped by a team of paramedics such as health visitors) in the developed world, and health centres, established during the 1960s, in the developing world. These centres are basically responsible for the eight elements of PHC activities outlined in the Alma-Ata Declaration. The Declaration itself has been criticized for the emergence of this narrow definition. For instance, Frenk et al. (1990: p. 678) argue that although the Declaration aimed at promoting all aspects of a national health system, the constant emphasis on the primary level of care, as it is the most underdeveloped one, and lack of clarification of relationships between primary care and prevention or between secondary care and curative medicine, have together resulted in the identification of PHC with first level care.

Concomitant with the narrow definition of the approach, PHC is frequently confused with primary medical care and the first level of care. This confusion and isolation of PHC from secondary and tertiary care results from the identification of PHC with primitive, low technology and cheap first contact care. All these claims have long been challenged by academia, but some still think along these lines. Concepts in PHC like appropriate technology, community self-reliance, community health workers and essential drugs make the approach 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 care.

Conversely, the broad definition of PHC is a comprehensive one that involves not only health but other sectors too. In this definition, PHC is seen as part of the development process where health care is an essential part of it and community involvement at all levels is a prerequisite for success (Ebrahim and Ranken 1988: p. 7; Heggenhougen 1984: 221; MacPherson 1987: 76; Rifkin and Walt 1986: 560). It is not another layer in the health care delivery system, as perceived in the narrow definition, but rather a philosophy and an approach to improving the health status of people. Proponents of this broad definition of PHC emphasize the bottom-up characteristics of the approach. 'Democratization of health services', as Banerji calls it (1988: 295), requires the 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).

Thus far, some of the confusion around the PHC concept has been presented, with an emphasis on its definition as this will be important in understanding the PHC policies presented later. Although after the Declaration both individual countries and international agencies have initiated PHC programmes in different settings, action so far does not reflect the enthusiasm of 1978. It would be naive to suggest this is the result of different definitions or perceptions of the concept alone. Ideological, political, economic, social and other factors that play a part in the implementation process have been analyzed in the literature in detail. In the end, the definition of the concept itself is ideologically driven. However, as mentioned earlier, these issues are out of the scope of this article. In the following, a case study from a developing country, Turkey, is presented to illustrate how PHC is perceived and how this perception affects national policies.

Turkey: basic health indicators

Since the late 1980s, Turkey has been undergoing a radical reform process in the health sector, concomitant with the changing political, social and economic environment. Not surprisingly, this process can be identified with the Thatcherite policies that had an impact not only in Britain but in many other developed and developing countries. The involvement of international agencies such as the World Bank and International Monetary Fund, together with other

multi- and bi-lateral donors has been strong and a new momentum has been gained in all sectors including health.

As a developing country with approximately US$ 1966 GNP per capita in 1992 (Sağlık Bakanlığı 1992: 13), Turkey reflects the characteristics of the majority of the developing world in terms of the levels of health reached. Basic health indicators such as infant mortality rate (52.6 in 1993), under-five child mortality rate (60.9 in 1993) and maternal mortality rate (134 in 1992) provide undeniable evidence for this claim (Sağlık Bakanlığı ve diğerleri 1994: 87).

Not surprisingly, the high death toll among youngsters can be attributed to infectious and preventable diseases. It has been estimated that, in Turkey, 35% of rural and 25% of urban infant deaths are from pneumonia (UNICEF 1990). Diarrhoea, accounting for 30 000 deaths annually (Sağlık Bakanlığı 1990), is another major factor in the high infant and under-five mortality rates. Malnutrition is a significant contributing factor to deaths from other causes such as pneumonia, diarrhoea and measles.

As in many other countries, lack of information hinders the development of a fully reliable picture from morbidity statistics. However, the general epidemiological outlook of the country has been outlined as (Devlet Planlama Teşkilatı 1990: 56):

1. Perinatal and infectious diseases during infancy;
2. Infectious diseases together with malnutrition in 1–5 year age group;
3. Accidents and other causes in adolescence;
4. Heart diseases and accidents in 25–44 year age group.;
5. Heart diseases and circulatory diseases caused by smoking and cancers in 45–64 year age group.

The organization and financing model of the health care system helps to perpetuate the current poor health status of the country, if not to exacerbate it. In the following, a brief presentation of the system in terms of both organization and finance will be given before discussion of the reforms.

The health care system: organization and finance

Organization

As far as the organization of the health sector is concerned, its 'fragmented' structure seems to be its most important characteristic. The Ministry of Health (MoH), with the constitutional responsibility for improving the health status of the population since the Republic's foundation, is the major governmental body responsible for both making policies and providing health services, and is the major provider of such services. Other public sector organizations have the same aim of improving the health status of their beneficiaries. These are mainly the Social Insurance Organization, Ministry of Defence, Universities, State Economic Enterprises, other ministries and municipalities.

The MoH provides health services through a referral chain composed of health houses, health centres and hospitals. The aim of this system, consonant with the principles of the Basic Health Services Movement of the time it was introduced, was stated as to provide health services to the whole population regardless of their locality and to improve equity (Socialization Act of 1961). However, lack of political commitment, resources, intersectoral action and monetary incentives for professionals have all played significant roles in the failure of the system. Although both the opponents and proponents of the system agree on its failure (though explained from different perspectives), the Act and the attached model are still in force and today there are 11 868 health houses and 4557 health centres across the country (Sağlık Bakanlığı 1995), the majority of them suffering from severe staff and equipment shortages. The referral system does not work and this places great strain on hospitals from the intensive demand of bypassers. The MoH operates 51.5% of all hospital beds (Sağlık Bakanlığı 1995: 38).

For preventive care, health houses and centres are the major units for preventive services provision. Vertical programmes such as tuberculosis control and malaria control are among the main preventive activities of the MoH. Preventive and curative care for mothers and children is provided by the Department of Maternal and Child Health Services in the Ministry through its dispensaries scattered around the country (268 in 1994). The involvement of international agencies should be mentioned here as well; Turkey has strong links with organizations such as UNICEF, WHO, ILO etc. The EPI programme of 1985, that was declared as a success story (Walsh 1988), was the outcome of such links.

As stated earlier, the MoH is not the only organization providing health services. The Social Insurance Organization provides mainly curative services to its

beneficiaries through a network of hospitals and dispensaries, and has a prominent place in the Turkish health sector. The organization has chosen to provide health services directly, through operating its own facilities. In 1994, 16.9% of hospital beds were owned by the organization (Sağlık Bakanlığı 1995:38). Its main sources of finance are health premiums collected both from employers and employees. The presence of a separate organization for the working class carries with it all the associated problems as discussed in the literature (Midgley 1986; Roemer 1971; Zschock 1982).

Some other ministries, such as the Ministry of Defence, Education, Transportation etc., some State Economic Enterprises and some Municipalities also have their own facilities and provide health services to their employees and their dependants, or to the public in general as in the case of municipalities. University hospitals, which provide tertiary care to the public, have a share of 12.8% of hospital beds (Sağlık Bakanlığı 1995: 38).

The private sector as a whole must not be ignored. Although there are doubts about the reliability of the relevant data, the private sector in Turkey, which is mainly composed of part-time practitioners, has a substantial share in health care. Physicians working in the public sector are allowed to work in their private surgeries in the afternoons. Past attempts to ban such part-time practice failed due mainly to the strong lobbying of physicians. The share of the private sector in terms of hospital beds is a mere 3.5%, though in recent years there have been some important developments in this area.

The above-mentioned fragmented structure poses intractable problems to the health care system in Turkey. Lack of coordination among the various service providers contributes to the existing inequalities in terms of health status and the inefficient use of already scarce resources. In many areas, due especially to duplication of services, facilities are run below capacity while in other areas people suffer from lack of resources. As a consequence of this fragmented structure it is almost impossible to formulate and implement country-wide health policies. One particular example of this was experienced during the first years of the health reforms when the Social Insurance Organization fiercely opposed the pooling of all resources under a general health insurance scheme.

Finance

Financing of the health sector is also a cause for concern in Turkey. Turkey allocates 3.2% of GNP to the health sector (World Bank 1990: 49), of which 1.7% comes from public sources and 1.4% from private, and suffers from severe resource shortages. These figures must be treated tentatively as, like in almost all other developing countries, lack of accurate and reliable data is a significant problem in Turkey. The same fragmented structure operates in the financing of the health sector as does in the provision of services. The population can be divided into two main groups: people whose health expenditures are covered by one of the schemes operating in the sector and people with no coverage whatsoever. The former group is divided into a further five groups according to the scheme to which they are attached:

1) civil servants and their dependants, who enjoy free health services mainly from the MoH and university facilities. Their expenses are paid from their department's budgetary allowance for this purpose. Since 1983, civil servants must pay 20% of the prescription charge.

2) members of the State Insurance Organization, who use health services provided by the organization's facilities and financed by their own contributions.

3) retired civil servants and their dependants, who are covered by the Government Employees Retirement Fund (GERF) which contracts out services to the MoH facilities and university hospitals. The Fund is financed by the contributions of the active civil servants and the State.

4) people covered by the latest fund established to provide social security to 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. As in GERF, the organization buys health care services from other public sector organizations.

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

The second major group, i.e. people who have no coverage for health expenditure, formed approximately 40% of the population in 1993. These people, mainly the rural population and the urban poor, have to pay their expenditures directly out of their

pockets unless they can produce proof of their inability to pay, in which case the services are provided free of charge. The World Bank estimates that around 10% of the population do not have sufficient means to pay for their health expenditure and need to be subsidized by the State (World Bank 1990: 18).

The Turkish health care system faces serious problems in the provision of decent and equitable health services to the population. Realization and acceptance of this fact, together with international developments, have inevitably resulted in a reform process, as in many other countries, whereby the whole structure of the health system is reorganized. In the next section these reform proposals will be presented briefly.

The Turkish health reform proposals: a way forward?

The year 1990 was a watershed in the Turkish health policy-making environment. As a result of the discussions commenced in the late 1980s and the influence of the international organizations, the Health for All proposals and PHC approach have come to the fore on the agendas of the health policy-makers. A reform process that claimed to be a reflection of these global policies started with the publication of the first ever comprehensive policy document of the MoH: 'Health for All by the Year 2000. The National Health Policy' (Sağlık Bakanlığı 1990). This document outlined general policies and strategies for implementation. The general policies adopted by the document were: decreasing inequalities in health, community participation, health education, a system based on the PHC approach and intersectoral collaboration.

This draft document provided the principles for the ultimate 'National Health Policy Document' of 1993 which was produced after two years of long discussion, debates and negotiations (The Ministry of Health, 1993) – hereafter referred to as the Document. The proposals of this Document and legal arrangements still await ratification from the Parliament to become legally enforceable.

The analysis of the reforms can be undertaken in two parts: organization and finance. In financing, the schemes mentioned earlier are preserved with the addition that a new scheme to cover people outside the existing ones will be established: The General Health Insurance Scheme (GHIS). As involvement in the scheme is compulsory, the whole population will have financial coverage for health services when it is introduced.

The reforms are based on the purchaser-provider split. The MoH will no longer provide health services but will formulate policies and monitor and evaluate their implementation. Before analyzing how the system would work, it is essential to present the proposed organization model. Health houses and health centres will be retained in rural areas and will act as the first level of care for the rural population. In cities, however, a family practitioner scheme will be established to provide this level of care. These practitioners, working either alone or within groups, will be paid by capitation and provide services similar to GPs in the British National Health Service (NHS). In the long run, if these proposals are implemented, this area will grow as a distinct speciality within general medicine, as in the UK. However, for the time being new medical school graduates and consultants working in private surgeries will be the main source of this new type of practitioner. The family practitioner will act as a gatekeeper.

The main emphasis of the reforms is on 'decentralization' in the health sector. The Turkish administrative system in general, and health sector in particular, reflect a highly centralized structure which has long been regarded as one of the malaises of the current situation. With the new proposals, Provincial Health Directorates (that act in the provinces as the agents of the MoH in the current system) will be given responsibility for 'buying services' for the people in their defined area. The finances, from various sources outlined earlier, will be pooled in each Directorate and services will be bought by these authorities for the patient. Hospitals in the system will take the form of 'self-governing trusts' as in the British NHS. However, the Turkish reforms go one step further and state that the ultimate aim is to privatize hospitals. Provincial Health Directorates will buy services from family practitioners on a per capita basis and hospital services will be bought via block contracts. The essence of the reforms is the family practitioners and hospitals competing among themselves for the resources of the Provincial Health Directorate (internal market).

Turkish commitment to the Alma-Ata Declaration

By signing the original document in 1978, Turkey declared unequivocally its commitment to the PHC

approach. However, until 1990 this commitment had generated little attention in health policy quarters. The first draft document of 1990, mentioned earlier, re-emphasized the Turkish commitment to the PHC approach by stating that 'the aim is to achieve Health for All by the Year 2000 and this can only be achieved through PHC as declared in Alma-Ata'. Thus the primary aim of the reforms was to create a health system based on the principles of Health for All by the Year 2000 and PHC.

This link between PHC and health care reforms could clearly be seen in the Document of 1993 which was prepared in line with the 38 targets of the WHO Regional Office for Europe. The Document addressed the targets, principles and strategies on issues such as health information systems, health technology, environmental health, life style and provision of health services. PHC has been placed under the heading of 'provision of health services' together with hospitals, human resources, pharmaceuticals and health financing. Target 16 of the Document reads:

> 'A strong PHC service will be established by the year 2000'.

The principles that such a system will be based on are:

- PHC services accessible to everyone will be established;
- Services should be easily accessible, high quality and with minimum formalities;
- Services should be integrated;
- PHC services should be provided under public control;
- People should have the opportunity to choose their physician.
- Services should be organized in such a way as to solve the priority health problems of the country.

As can be seen, PHC has been identified with the first level of care, i.e. services provided by health centres or family practitioners. This tendency to equate first level care with PHC, i.e. the narrow definition of the concept, became more prominent during a study carried out to delineate the perceptions of policy-makers on PHC and related issues (Tatar 1993). In the following, the main findings of this research are presented.

A case study

The aims of the research were threefold: to analyze Turkish health policy since the 1960s from the PHC perspective, with the aim of exploring the Turkish response to Alma-Ata; to explore the perceptions of Turkish health policy-makers about PHC and related issues; and in light of these, to discuss the prospects for PHC in Turkey. In order to achieve these aims, a qualitative approach was adopted in which document analysis and semi-structured interviews conducted with health policy-makers constituted the backbone of the research methodology.

The document analysis covered mainly the period from the 1920s to the present time. Health policy documents were scrutinized thoroughly to determine the health policy trends in Turkey with special emphasis on PHC policies.

The aim of the second method, semi-structured interviews with health policy-makers at the national level, was to find out the perceptions of policy-makers on PHC and related issues. The interviews were 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. During the interviewee selection process 'information rich cases' were targeted (purposeful sampling instead of random sampling). In the following some of the conclusions of the research are given with the aim of shedding light on how PHC is perceived among Turkish policy-makers and the prospects for PHC in Turkey.

As far as the definition of PHC is concerned the research revealed that the concept of PHC was directly associated with first level of care and 'socialized' health services mentioned earlier. Health houses and centres established by the Act of Socialization in 1961 were regarded as the main points of contact in the health sector. The 'preventive' aspect of these services, and the belief that prevention is better and cheaper than cure, associated PHC with cheap, low technology medicine that should be provided to the rural population and the poor. The association of PHC with preventive care or considering preventive care as a cheap solution are not peculiar to Turkish health policy-makers. These misconceptions, unfortunately, undermine the value of PHC and strengthen the contention that PHC is a second class medicine.

The narrow perception of the PHC approach can be more clearly understood when the pillars of the approach, such as equity, intersectoral action, community participation and decentralization are taken into account. These issues were raised by the interviewer to unfold the perceptions about PHC. The

following is a summary of the results of these interviews.

The pillars of PHC: Turkish policy-makers' views

Health for All and the PHC approach unequivocally emphasize the concept of equity and no political commitment to Health for All and PHC can be considered as complete without attempts to decrease existing inequalities. It is well known that it is impossible to talk about ameliorating health inequalities without tackling the broader economic inequalities. Although closely related to the subject (and the authors are aware of the fact that in a country where the annual inflation rate is expressed in three digits and with over 10% unemployment, health cannot be isolated from these broader concepts), inequalities in general will not be considered here. So far as health inequalities are concerned, there is enough evidence to suggest that gross inequalities exist in terms of health status between regions and between urban and rural populations. As in other developing countries, due to the lack of a sound information system it is very difficult to reach precise figures, but the available data show the discrepancies quite clearly. For instance, in a recent study (Sağlık Bakanlığı ve diğerleri 1994: 87) it was found that the infant mortality rate (IMR) in urban areas was 44 whereas it was 65.4 in rural areas. Similarly, the IMR of West Turkey was 42.7, rising to 60 in the Eastern parts. This indicator alone illustrates the significant inequalities existing among regions in Turkey.

In an approach emphasizing equity, resource allocation issues are among the most important 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. The resources allocated to the health sector might well be extremely scarce; but the fragmented structure of the system adversely affects the assessment of the way they are used. The resources are inappropriately allocated favouring urban over rural, curative over preventive and better off over worse off. In reality there is no established system whereby resources are allocated according to some criteria, and in the absence of such criteria, the allocation process inevitably relies on ad hoc arrangements, strongly influenced by political preferences, with little consideration of the real needs of population groups. None of the policy initiatives, either in the past or at present, have aimed at developing a re-source allocation method that would reduce political influences to a minimum, bridge the gap between haves and have nots, and base the resource allocation process on some objective criteria. The implementation of such criteria would inevitably require a shift in resources away from the urban areas and better-off members of society to the rural and worse-off members. This is a substantial challenge to be met.

The financing mechanism of the sector presented earlier should also be given consideration while discussing equity. It has already 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 the low income groups, and thus represents those most in need of both services and financial back-up. The recently proposed general health insurance scheme for those people without coverage seems to be a way forward towards bridging the gap between haves and have nots. However, if all the population is not covered under the same scheme, with the same rules, these inequalities are likely to persist even when the proposed system is established.

The second pillar of PHC, namely intersectoral action, has long been on the agendas of Turkish health policy-makers. Analysis of documents such as the Development Plans, parliamentary minutes and documents of the MoH reveals that 'intersectoral action' and its importance have been emphasized frequently. However, the concept has been left as a rhetoric. The interviewees, after accepting that intersectoral action is a difficult strategy to implement, have attributed this fact to Turkish traditions, the administrative system of the country and the organizational structure of the MoH. It is almost unanimously stated that in a country where intersectoral action could not be achieved among the departments of the MoH, it is a fantasy to talk about intersectoral action among different organizations of the State.

The third pillar of PHC, community participation, declared as the heart of PHC (Ahmed 1978), deserves a particular mention. The Declaration of Alma-Ata, by embodying terms such as self-reliance and self-determination, acknowledged community participation as a prerequisite of the PHC 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: 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: 35). The WHO, in all its attempts to promote PHC, has emphasized community participation as an indicator of the seriousness of political commitment (WHO 1981: 20); a social, economic and technical necessity (WHO 1979: 17); and a prerequisite to achieve coverage and effectiveness (WHO 1988: 46).

Community participation in the Turkish context has been analyzed in detail elsewhere (Tatar 1996). It suffices here to say that, as with other aspects of the approach, the policy-makers view community participation in its narrowest sense as the response of the community to the professionals, i.e. responding to what professionals, planners, want them to do. The main emphasis made by this group was on education of the community in order to raise the awareness or consciousness of people with the aim that they will accept and practice what has been introduced. The definition given by the policy-makers revealed that although there was no concrete adherence to community participation in policy initiatives and documents, even if there were, the implementation would have been restricted to educating the community to accept and practice what others wanted them to do. The same tendency could be observed in the major health documents of the country as well.

So far as the two interconnected issues of community participation are concerned, namely community health workers (CHWs) and community financing, there was an outright rejection of the former. The small group of interviewees that seemed to be sympathetic to CHWs restricted their role to gathering information about the community, consistent with what Fendall defined as an 'epidemiological intelligence agent' (Fendall 1984: 301).

However, the policy-makers' views about the issue of community financing were more positive and it was unanimously accepted that community financing is the most applicable form of community participation in health services. These views, of course, do not comply with WHO's claims that a declaration of commitment to PHC without a reference to community participation is an incomplete one (WHO/UNICEF 1983: 33).

So far as the prerequisites of the PHC approach are concerned, decentralization, lying at the heart of the definition of the PHC approach, needs special emphasis. Turkey is very much centralized with even the simplest administrative decisions being taken at the centre. This issue has been reiterated in the policy documents and by the interviewees to be among the most important malaises of the system. The recent reforms, if implemented, will bring a decentralized perspective to the health sector with Provincial Health Directorates that will be delegated substantial power and with the creation of autonomous and privatized hospitals. Target 15 of the Document claims that a decentralized health care system will be established by the year 2000, in line with the proposed reforms. However, decentralizing one sector's activities will not achieve the stated aims unless all other sectors are decentralized as well. The country needs major reform of the whole administrative structure but this is easier said than done.

The above discussion on the PHC perspective of the reforms does not mean that the reform attempts in the Turkish health sector are totally without point. This process has brought several positive points to the Turkish health policy environment. First of all, these attempts have created an environment whereby 'health' has been elevated to a higher level on the agendas of all related people and institutions. The debates that were organized to involve representatives of all segments of the health related community kept the topic hot for a long time and urged people to raise their opinion. This was quite a new approach adopted by the reformers. Second, the proposals and the suggested system brought new concepts such as decentralization, managed competition, internal market and so on to the Turkish health professionals' terminology. Third, in tandem with the authors' belief that, under current circumstances, any system coherent in itself will be better than the existing one, these proposals, meeting this coherency criterion to a great extent, would bring a better system for the Turkish people.

Conclusion

This article, having two clear aims of discussing the different definitions of PHC and presenting Turkey as a case study, has deliberately waived deeper practical, ideological and philosophical arguments about the concept and has concentrated more on the pure definition and the way it is perceived in Turkey. However, as stated, the authors are aware of the fact

that both the definition and implementation of PHC are deeply rooted in these arguments.

Bearing these points in mind, as a conclusion it can be said that PHC in Turkey is perceived differently from its broad definition. The aforementioned research revealed certain aspects of the Turkish case. It is clear that in Turkish health policy-makers' minds PHC is associated directly with the services provided by health houses and health centres or with the recent proposals for family practitioners. The narrow definition of PHC dominated the views of health policy-makers, and the reflection of this perception and the medical approach adopted can be seen in the recent reforms. As a consequence of this medical approach to health, PHC is equated with 'medical services' and no reference has been made to other essential components of the approach.

As far as the pillars of the PHC approach are concerned, issues such as intersectoral action, community participation, decentralization and others are perceived distinctly from the Alma-Ata Declaration or perceived correctly but not implemented. Intersectoral action, for instance, is praised both in the documents and by the interviewees but in practice it is paid lip service more frequently than other pillars. For community participation, CHWs and community financing, the prevailing medical approach to health influences these concepts adversely and restricts community participation to its simplest level. In general, this medical approach seems to be the main menace to PHC in its broadest sense. However, considering that key positions in the MoH and other health related organizations are occupied by doctors educated under the influence of this approach, it would be unrealistic to expect a change in this environment in the foreseeable future. A change, if desirable, could be initiated by the involvement of social scientists in this area which are now almost non-existent.

It can be concluded that there is a great need for more information and discussion about the approach and related issues. The favourable environment created since the late 1980s has never existed in the past. The reform process, outlined earlier, has created an atmosphere where a wide range of organizations and people in the field can discuss the proposals openly. This type of policy-making process is quite new in Turkey and the environment is ready for the discussion of issues related to health. The MoH and academia should seize this opportunity to create a health care system.

It should be stated here that although a long time has passed since the preparation and referral of the reform proposals to Parliament, they still await ratification to be implemented. The unstable political environment and radical, even controversial proposals can be stated as the main reasons underlying this delay. Nevertheless, there are positive signs that the proposals will be ratified soon. As a concluding remark it could be stated that if PHC is still judged to be a viable approach, it should be discussed thoroughly. Only in this way will the answer to the question posed in the title of this article be negative, emphasizing that PHC is not a fashion but a lasting passion in the Turkish health sector.

References

Ahmed M. 1978. Community participation: the heart of Primary Health Care. *Assignment Children* **42:** 80–100.

Banerji D. 1988. Hidden menace in the universal child immunization. *International Journal of Health Services* **18**(2): 293–9.

Devlet Planlama Teşkilati. 1990. Sağlık Sektörü Master Plan Etüdü. Ankara.

Ebrahem GJ, Ranken JP. 1988. *Primary Health Care. Reorienting Organizational Study.* London: MacMillan Publishers Limited.

Fendall R. 1984. We expect too much from community health workers. *World Health Forum* **5:** 300–3.

Frenk J et al. 1990. First contact, simplified technology or risk anticipation? Defining primary health care. *Academic Medicine* **65**(11): 676–81.

Golladay F. 1980. *Health Problems in Developing Countries.* Washington: World Bank Staff Working Papers No. 412.

Heggenhougen HK. 1984. Will primary health care efforts be allowed to succeed? *Social Science and Medicine* **19**(3): 217–24.

MacPherson S. 1987. *Five Hundred Million Children.* Sussex: Wheatsheaf Books.

Midgley I. 1986. The advocacy of social insurance is questionable. *Health Planning and Financing* **7:** 18–21.

Ministry of Health. 1993. National Health Policy. Ankara.

Navarro V. 1984. A critique of the ideological and political position of the Brandt Report and the Alma-Ata Declaration. *International Journal of Health Services* **14**(2): 159–72.

Rifkin S. 1985. *Health Planning and Community Participation.* London: Croom Helm.

Rifkin S, Walt G. 1986. Why health improves: defining the issues concerning comprehensive primary health care and selective primary health care. *Social Science and Medicine* **23**(6): 559–66.

Roemer MI. 1971. Social security for medical care: is it justified in developing countries. *International Journal of Health Services* **1**(4): 354–61.

Sağlık Bakanlığı. 1990. *2000 Yılında Herkese Sağlık*. Türk Milli Sağlık Politikası. Ankara.

Sağlık Bakanlığı. 1992. Sağlık İstatistikleri. Ankara.

Sağlık Bakanlığı. 1995. *Özet* Sağlık İstatistikleri. Ankara.

Sağlık Bakanlığı ve diğerleri. 1994. *Türkiye Nüfus ve* Sağlık Araştırması. Ankara.
Sidel VW, Sidel R. 1977. Primary health care in relation to socio-political structure. *Social Science and Medicine* **11:** 415–19.
Tatar M. 1993. Health for All by the Year 2000 and Primary Health Care: The Turkish Case. Nottingham: unpublished PhD thesis, Nottingham University.
Tatar M. 1996. Community participation in health care: the Turkish case. *Social Science and Medicine* **42**(11): 1493–500.
UNICEF. 1990. *The State of the World's Children 1990.* Oxford: Oxford University Press.
Walsh J. 1988. Selectivity within PHC. *Social Science and Medicine* **26**(9): 899–902.
WHO. 1979. *Formulating Strategies for HFA by the Year 2000.* Geneva: World Health Organization.
WHO. 1981. *Development of Indicators for Monitoring Progress Towards HFA by the Year 2000.* Geneva: World Health Organization.
WHO. 1988. *From Alma-Ata to the Year 2000. Reflections at the Midpoint.* Geneva: World Health Organization.
WHO/UNICEF. 1981. *National Decision-Making for Primary Health Care.* Geneva: World Health Organization.
WHO/UNICEF. 1978. *Alma-Ata 1978. Primary Health Care.* Geneva: World Health Organization.
World Bank. 1990. *Issues and Options in Health Financing in Turkey.* Washington DC.
Zschock DK. 1982. General review of problems of medical care delivery under social security in developing countries. *International Social Security Review* **35**(1): 3–15.

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