WOMEN AND HEALTH INSURANCE: THE SITUATION OF WOMEN AS DEPENDANTS IN TURKEY

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Abstract

Not only biological conditions and medical services but also gender, income, social support arrangements, education, employment, working conditions, culture have important influence on health status. Still another determinant of health status is gender blindness in carrying out research studies on health. Gender sensitive approach is needed to get unbiased knowledge. This helps to attain equity in health in the long run by implementing appropriate measures. In this study, the position of women regarding inequalities in access to health services is conceptualised. Health problems as well as social and cultural constraints which are specific for women are aimed to be investigated and means for inquiring these issues are proposed. The problems arising from the health insurance system are outlined and through questionnaire form of "Women and Health Module" the determination of the complete system regarding use of health insurance is suggested. The information obtained after the implementation of the module will be useful in the establishment of relationship between socio-economic characteristics of persons and use of health services. A specific reference of the study will be use of health services through health insurance system.

Keywords*: Health status, Health insurance, Dependence, Health equity, Dual records method, Women and health module.*

Résumé

Non seulement les facteurs biologiques et les services médicaux, mais aussi le sexe, le revenu, les systèmes de solidarité, l'éducation, l'emploi, les conditions de travail et la culture ont une grande influence sur la santé. Il y a un autre élément qui n'est pas sans effet, c'est l'absence de prise en compte de la problématique du genre dans les recherches en matière de santé. Une approche qui intègre les rapports sociaux entre les sexes est indispensable pour produire des connaissances non biaisées. À long terme, par la mise en œuvre de mesures appropriées, elle permet d'atteindre l'égalité des sexes dans le domaine de la santé. Dans cette étude, les auteurs conceptualisent la situation des femmes en matière d'inégalités d'accès aux services de santé. L'objectif est d'examiner les problèmes de santé et les contraintes sociales et culturelles qui touchent particulièrement les femmes, et de proposer des voies d'analyse. Les auteurs présentent les problèmes liés au système d'assurance maladie et, au moyen du questionnaire du « module femmes et santé », proposent une description d'ensemble du système et de la manière dont il est utilisé. L'information recueillie après la mise en œuvre du module « femmes et santé » servira à établir les relations entre les caractéristiques socio-économiques des personnes et le recours aux services de santé. Le thème central de cette étude est le recours aux soins de santé par le biais du système d'assurance maladie.

Mots-clés *: État de santé, Assurance maladie, Dépendance, Égalité en matière de santé, Méthode de double collecte, Module "femmes et santé".*

1. Introduction[1]

There is a need for comprehensive understanding of women's health status which has been neglected for long time in Turkey. A specific module on women's health is aimed to be launched to fill this gap in the Turkish Population Survey which will be held in 2001. There are mainly four steps in exploring a research topic regardless of being qualitative or quantitative. Data collection, analysis, interpretation and the utilization of the attained information are consecutive steps in empirical investigations (Hentschel, 1997). This paper is concerned with

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the first step in this scheme, data collection. Perceived or self-rated health status, rather than long-standing health conditions will be basis for the evaluation of health. Hopefully, the other three steps will be used to reach a complete review and analysis of the research study after the completion of field work of the survey.

In the second section obstacles preventing the attainment of equity in health are emphasized. Generally, gender is omitted in health studies. There is a considerable literature discussing how inclusion of gender in research studies works as an initial stage in ending inequality between women and men. It is stated that neglect of gender works as an impediment for the attainment of women's health profile without bias. Moss (this volume) argued that improvement in vital statistics and disease statistics is indispensable for the attainment of progress in women's health. The third section gives a brief history of health insurance system in Turkey regarding the way through which persons are covered by the system. The differences between women and men in employment status, sectoral distribution of employment, coverage by health insurance scheme are emphasized in this section. It gives reasons for women's dependency on men in utilizing health services. The fourth section introduces population and health surveys implemented so far in Turkey and their implication for women's health. This section contains some suggestions to improve conventional population and health surveys. The fifth section introduces a technique as an alternative to conventional survey, dual records method. It is based on the matching of informations coming from civil registration and a survey. The sixth section is on a specific module set forth in the main part of population and health survey, Women and Health Module. The module aims to shed light upon issues on women's health which have not been explored so far in Turkey. The last section briefly concludes the study by enumerating the expected output.

2. The need for mainstreaming gender in health system

Gender is a social and cultural category determining roles and responsibilities associated with both sexes. Hence it does not relate to the determination of biological differences. It concerns the understanding of differentiation in thinking and act between women and men and in perception by others which results from the way society is con-

structed (WHO, 1998). Generally women are dominated by their partners or in-laws in such a way that they are restricted in their behaviours regarding their expenditure, nourishment, use of health services (Moss, this volume). Women's desire to access into health services is affected from place of settlement, perceived health status, presence of health insurance, the mean by which insurance is attained and the degree of bureaucracy in the delivery of services. Once women decide to have health services, age, education, women's standing in public life and at household level affect the diagnosis and treatment they get from health institution. It is essential to carry out research to understand the ways in which gender exposes men and women to different environments and how they react to such differences (Östlin *et al.*, 2000).

Attainment of a reasonably healthy and prosperous life necessitates to lead a life with a degree of economic independence. The distribution of endowments and liabilities such as work, time, money within the family reflects the relative economic resources that women and men command. Women's higher economic dependence makes them more vulnerable than men to poverty. It is stated by Östlin *et al.* (2000) that equity in health can only be achieved through the fair distribution of resources, benefits and responsibilities between women and men. Equity in health requires more than a mere establishment of well being in society. Traditional measurement of poverty at family or household level fails to recognize poverty of some women who are economically dependent on men (Lister, 1994). It is stated by Arber (1991) that consumption measures rather than occupation may indicate better the class position of women since they create differentiation in women's everyday lives. It is further argued by Moss (this volume) that:

> "The epidemiologists and demographers who write about the impact of socioeconomic position, poverty or income inequality and health have often failed to consider the processes within households and in women's daily lives that may actually shape their health or the health of men."

Although the extent differs, "feminisation of poverty" prevails in all societies. Poverty determines women's access to education as well as the type of occupations open for persons, quality of health care and the safety of environment. Moreover, women's secondary position in society makes development of mental health difficult for them. Struggles against inequalities starting from early childhood affect their psychology negatively (Doyal, 1998). Poverty, isolation from outside world, low education, dependence on others, patriarchal oppression

and violence increase the risk of psychiatric morbidity in women (UN, 1998).

Brocas *et al.* (1990) underlined the importance of persons' access to social security benefits in their own right as individual. The establishment of a system in which individuals are treated equally is emphasized. In this way it is possible to guarantee the protection of individuals in an environment where family break-ups are widespread. The reliance on husband's pension for income in later life has proved to be inadequate and risky for women due to increase in lone parenthood and divorce rate (Ginn and Arber, 1994). Although women have to meet many different responsibilities both in house and outside, paid employment out of the home brings about self-esteem, financial and social support for women.

There is marked difference between women and men with respect to health issues. Women live longer than men of same or comparable society. Improvement in living standards, economic development and social change contributes to women's biological advantage and the gap between life expectancy for women and men widens (UNDP, 1995). On the other hand, greater longevity of women does not guarantee a healthier life for them. Not only biological factors but also social ones contribute to differences between women and men. Garcia-Moreno (1997) stated that contrary to their relative positions in longevity, level of illness and disability are higher for women. She cited three main factors contributing to their disadvantageous position as: (1) those associated with their greater longevity, (2) the reasons associated with women's reproductive capacity, (3) the higher incidence for women of symptoms of mental distress.

There is need for the assessment of different needs of persons in development, implementation, monitoring and evaluation of health care services. One of the aspects of this issue is the integration of gender perspective into the health policies for the achievement of women's coverage in the health system.

Conventional health services for women focus mainly on reproductive functions and ignore other health needs of women. Moreover, traditional health care relates only to child health, further neglecting the needs of women (Paolissio and Leslie, 1995).

The Platform for Action emphasizes a holistic and life-cycle approach to women's health in the implementation of five strategic ob-

jectives.[2] Mainstreaming a gender perspective into health studies requires the development of a comprehensive women's health profile. Only in this way, the picture of women's health position not only in demography and reproductive health but also with regard to socio-economic status, overall health status, life style, environment, health care services, health service use, sexuality may be attained (UN, 1998).

3. Gender inequality in access to health services in Turkey

As in many other countries, main objectives of health services in Turkey are connected with the general health status of population. Women are on the scene as long as their health problems are related with their reproductive functions. Pronatalist population policy was implemented between 1923-1960 and antinatalist population policy put into force after 1960. The shift in population policy is manifested in the population planning law of 1965 (HIPS, 1999). However, there has not been any important change in the evaluation of women's health until 1990 and women's health has been equated with mother and child health. A new trend began after 1990 and private institutions specialised in women's health have started to operate.

The most important reason behind inequality between women and men in accessing health services is the fact that the health insurance system in operation does not fit to the conditions in Turkey and there are problems arising from misfunctioning. A person may be covered together with his/her dependants by compulsory health insurance under the umbrella of social security only if he/she has an income generating activity in the formal sector. Individual's mother, father, partner (usually wife) and children may benefit from health insurance as dependants if they are not covered in their own right.

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2. Five strategic objectives designed under the "Women and Health" section of the Platform for Action are as follows:
- Increase women's access throughout the life-cycle to appropriate, affordable and quality health care, information and related services;
- Strengthen preventive programs that promote women's health;
- Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues;
- Promote research and disseminate information on women's health;
- Increase resources and monitor follow-up for women's health.

In the history of social security in Turkey, firstly, public sector employees were covered by health insurance. Health insurance scheme covered only a limited number of employees in 1930 and it was extended to include all employees working in the public sector in 1946. At the same time, the system was reviewed and expanded to cover wage earners working in private, non-agricultural sectors and their dependants under compulsory insurance scheme. Lastly, employees in agriculture, employers and self-employed persons were covered by compulsory insurance in 1971. However, the majority of employed women who are working as unpaid family workers (75% of total women employment in 1990) are still out of the system.

13.2% of women in urban areas of settlement and 46.6% of women in rural areas of settlement are employed in 1999 (SIS, 1999). Approximately half of the women are working in the informal sector in urban places and thus are not covered by social security scheme. Moreover 72.2% of total employed women are working in agriculture and 87.5% of them are unpaid family workers. For this reason, only a few employed women are covered by social insurance in their own right. Women, most of the time, remain out of social security coverage since the system of social security does not function properly even for employed persons working in the formal sector due to ignorance, lack of consciousness regarding its importance.

Although their main objectives, methods, samples used differ, percentages of population covered by health insurance are similar according to 1993 Demographic and Health Survey and 1994 Income Distribution Survey. 51.8% of women aged between 15-49 and 58.2% of men who are husbands of aforementioned women are covered by health insurance according to 1993 Demographic and Health Survey. The corresponding figures are 55.3% and 53.6% for women and men aged 15 years and over respectively according to 1994 Income Distribution Survey. 1998 Demographic and Health Survey results reveal that a slight increase has been observed for both women and men with regard to health insurance coverage: 57.2% of women and 61.7% of men are covered by health insurance in 1998 (Table 1).

Women working in agriculture constitute 76.4% of women according to the 1994 Income Distribution Survey. The share of women in industry and services in total women's employment are 9.7% and 13.9% respectively. The situation is quite different for men: 34.6% of employed men work in agriculture and 17.7% of them are employed in industry. Share of men employed in services sector among total em-

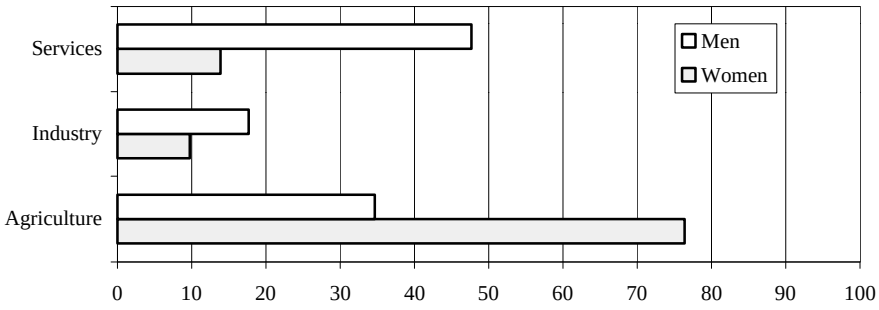
industry. Share of men employed in services sector among total employed men is 47.7% (Figure 1).

Table 1
Population covered by health insurance (%)

	1993 [a]	1994 [b]	1998 [a]
Women	51.8	55.3	57.2
Men	58.2	53.6	61.7

a. HIPS, 1993 and 1998; calculated for married women aged between 15-49 and their husbands.
b. SIS, 1994; calculated for women and men aged 15 years and over.

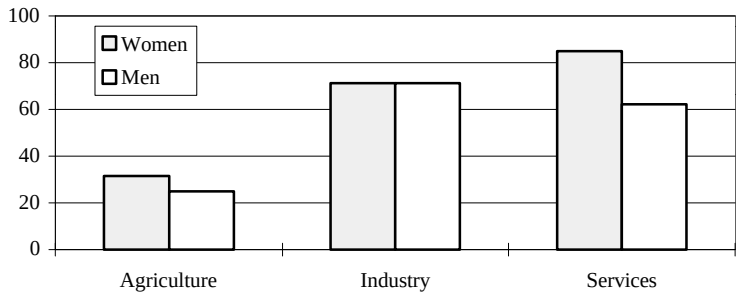
Figure 1
Distribution of employment by sector (%)
(Population of 15 years and over)



Source: SIS, 1994.

The percentage of women covered by health insurance is lowest for agriculture while it is highest for services sector. Only 31.7% of women in agriculture are covered by health insurance. Coverage by health insurance is 71.0% and 84.9% for women employed in industry and services sectors respectively. 25.1% of men employed in agriculture are within health insurance system. The corresponding figures are 71.2% and 62.1% for men employed in industry and services sectors respectively (Figure 2).

Figure 2
Coverage of health insurance by sector (%)
(Population of 15 years and over)



Source: SIS, 1994.

Figure 3 demonstrates the possibilities for being covered by health insurance scheme for women who are either not working or working but not covered by health insurance. Women may remain covered by health insurance throughout their lifetime provided that their fathers/ mothers and husbands are covered. 45.3% of married women who are employed as compared to 55.1% of married women who are not employed are covered under the umbrella of health insurance in 1993. Among married women who are covered by health insurance, more than nine tenth of women who are not employed and more than half of women who are employed are insured through their husband in 1993. The corresponding figures are 95.4% and 53.2% for married women who are not employed and who are employed respectively in 1998. While 49.7% of unmarried working women are insured in their own right, 50.3% of them are insured through their mother or father in 1998. Women who are not economically active are covered by health insurance scheme only if their mother or father have health insurance (Table 2).

However, access into health services as dependants of persons is by no means a privilege. It is a result of a system which places the person who is employed to the center. The reasons behind the construction of a family in which women generally remain out of labour force are ignored for most of the time. Dependency, if not in health insurance, in other areas of life continues to prevail even for women who

are employed. Nowadays, system allows women to have voluntary social security. However, according to the 1998 Turkish Demographic and Health Survey, 80% of women do not have personal income and among those who have personal income, only 49% decide autonomously how to use their income. These obstacles prevent women from having voluntary social security (HIPS, 1999).

Figure 3
The conditions to access into health services
for women who are not working or working without health insurance

	BIRTH	MARRIAGE	DEATH OF HUSBAND
FATHER/ MOTHER AND HUSBAND **HAVE** H.I.	WOMAN **HAS** H.I. THROUGH HER FATH./MOTH.	WOMAN **HAS** H.I. THROUGH HER HUSB.	WOMAN **HAS** H.I. THROUGH HER HUSB. / WOMAN **HAS** H.I. THROUGH HER FATH./MOTH. / DIVORCE
FATHER/ MOTHER **HAVE**, HUSBAND **DOES NOT HAVE** H.I.	WOMAN **HAS** H.I. THROUGH HER FATH./MOTH.	WOMAN **DOES NOT HAVE** H.I.	WOMAN **HAS** H.I. THROUGH HER FATH./MOTH. / WOMAN **HAS** H.I. THROUGH HER FATH./MOTH. / DIVORCE
FATHER/ MOTHER **DO NOT HAVE**, HUSBAND **HAS** H.I.	WOMAN **DOES NOT HAVE** H.I.	WOMAN **HAS** H.I. THROUGH HER HUSB.	WOMAN **HAS** H.I. THROUGH HER HUSB. / WOMAN **DOES NOT HAVE** H.I. / DIVORCE
FATHER/ MOTHER AND HUSBAND **DO NOT HAVE** H.I.	WOMAN **DOES NOT HAVE** H.I.	WOMAN **DOES NOT HAVE** H.I.	WOMAN **DOES NOT HAVE** H.I. / WOMAN **DOES NOT HAVE** H.I. / DIVORCE

H.I. : Health insurance.

Table 2
Percentage of women covered by health insurance by source of insurance

Health insurance scheme coverage	1993		1998			
	Married		Married		Never married	
	Em-ployed	Not employed	Em-ployed	Not employed	Em-ployed	Not employed
Covered:	45.3	55.1	57.7	56.9	58.5	57.6
- in their own right	*44.1*	-	*43.6*	-	*49.7*	-
- through their husband	*52.9*	*95.2*	*53.2*	*95.4*	-	-
- through their mother/father	*2.2*	*3.6*	*3.2*	*4.6*	*50.3*	*100.0*
- but source is unknown	*0.8*	*1.3*	-	-	-	-
Not covered	54.7	44.9	42.3	43.1	41.5	42.4

Source: HIPS, 1993 and 1998.

4. Women's place in research on population and health in Turkey

Antinatalist population policies were put into force in 1960 in Turkey. After this change in population policy, population and health surveys have been carried out every five years regularly since 1963. These surveys collected information mainly on fertility, family planning, infant and child morbidity, infant and child mortality. Health status of women and use of health services by women are questioned only when these are directly related with children's health. Furthermore, reproductive health of women has never been studied as a separate subject. Women Module which covers information on women's status in connection with child care and child health added to main body of the Demographic and Health Surveys of 1993 and 1998. It may be said that women are not visible in population and health surveys for themselves and women's health is not emphasized for issues other than women's reproductive roles.

Conventional approach in designing a research on health lacks insight into biological and social differences between women and men. Gender sensitive research design is required for the attainment of gender differentials which is indispensable for research and policy formulation. Absence of a complete vital registration system is one of the

main reasons behind the failure in provision of complete picture of women's health status. However, this is compounded by either gender blindness or by complicated social issues which is reflected in women's health problems. Hence, there is need for the improvement of vital statistics in such a way that differences between women and men in morbidity and causes of mortality as well as in the use of health services can be acquired. Ignoring biological differences between women and men and assuming that they differ only in their reproductive systems result in mistakes. Collecting information on health status of women with gender awareness requires more than merely disaggregating the data by sex. Apart from biomedical and epidemiological data, socioeconomic data too is needed. Collection of qualitative data is important for attaining data on socioeconomic factors that affect women's health. Inequalities in health status between women and men and women's unequal treatment in health care need to be questioned in detail.

5. Implementation of dual records method in Turkey

Dual Records System which is an extension of the direct matching technique uses two independent steps to collect data on vital events: one is the civil registration and the other is a survey. Information from two sources is then matched. The use of this technique to evaluate registration coverage brings about considerable improvements in the long run (UN, 1999).

Until now, mainly two studies which employed the Dual Records Method implemented in Turkey. The first was carried out in 1966-1967 and the second one was carried out in 1974-1975.

Two independent methods were used to collect the data of "Vital Statistics from the Turkish Demographic Survey" implemented in the 1966-1967 period. The first employed a local resident-registrar who made regular monthly visits to each household in his assigned area and reported to the Central Office the demographic changes which have occurred in the household during the past month. The second method employed a staff supervisor who independently called on each of these same households every six months. The two reports were matched and all mismatches were field or letter verified (MHSW, 1970).

The second survey which made use of dual records method between 1974-1975 has not been as successful as the first one. The prob-

lems faced in the field were connected with inadequacy of instructions given to interviewers, inappropriate weather conditions for an extensive research (SIS, 1975).

6. Women and Health Module

6.1. The rationale for implementation of Women and Health Module within the framework of Turkish Population and Health Survey

Although low coverage of persons by compulsory health insurance is a problem by itself, more important problem is the difficulty in assessing the mean by which persons utilize health services. The system in Turkey which enables persons to be insured through other persons forms a complicated situation. It is not known whether a person is insured in his (her) own right or through other persons. The situation is more serious for women since use of health services through others' health insurance as dependants is more common among women. The health insurance system in Turkey requires radical changes. The present system is neither efficient nor equality promoting. A system in which every person is insured in their own right is required. The establishment of such a system is necessary to prevent evasion in paying premiums which is observed in current system. A rational and equality based approach is needed for both (1) the purpose of increasing the quality of health services with awareness of different needs of women and men in health services and (2) the attainment of a more egalitarian system in which health is realised not as a privilege but as a basic human right and persons are insured individually for themselves.

Use of dual records method serves as an initial stage towards improvement of health statistics which is a prerequisite for elimination of ambiguity with regard to the functioning of current health insurance scheme. The Women and Health Module which is designed within the main body of Turkish Population Survey aims to attain a complete and intersectoral picture (i.e. interaction of health with education, labour force participation, marital status, family background and other socio-economic, cultural, physical conditions) of women with reference to health. Then whole data collected through survey will be compared and matched with data acquired through civil registration.

6.2. The implementation of Women and Health Module

The pilot study of Turkish Population Survey making use of dual records method will take place in 2001. The design of the study in general and questionnaire for the main module is not complete for the time being. Women and Health Module has set out to be designed in compliance with the principles of main study. Main module of the Turkish Population Survey aims to collect data on birth, death and migration of household members. General health status and diseases are also considered to be covered under the main module. Women and Health Module is intended to be applied on women aged 15 years and over and aims to attain information on issues which are not reached through main module.

In the design of questions related with women's health, questions concerning women's status in general are contained in the module, for they have important effect on women's health. The main themes under Women and Health Module are:

– general information on women such as (1) age; (2) place of settlement in childhood; (3) employment status and health insurance coverage of women's mother and father; (4) blood relationship between mother and father; (5) behavioral characteristics of mother and father as perceived by women; (6) educational attainment;
– the beginning, termination and number of marriages;
– fertility practices;
– health problems associated with reproductive life;
– general information pertaining to child(ren);
– decision making process in family;
– level of responsibility sharing at household level;
– degree of women's freedom of movement;
– presence and degree of violence against women;
– labour force participation, social security, presence and type of health insurance and source of health insurance (persons through whom women get insurance);
– the decision regarding the use of health services, the institution for getting medical assistance and attitude of health personnel;
– general health, chronic diseases and inquiry with regard to menopause;
– mental health.

Implementation of the module will enable to assess coverage of women by health insurance, the source of insurance. Moreover, a considerable insight into the conditions for utilizing health services, institutions which women use to get medical assistance and into the manner health personnel adopts towards female patients will be attained. Survey results will also shed light upon issues concerning reproductive health which is not investigated in detail before such as physical as well as mental illness experienced by women through and after their pregnancies, the termination of pregnancy (with live birth, still birth, miscarriage), menopause and illness connected with it. General health and chronic diseases will also be inquired with a different perspective. Limits on physical movement, the degree of stress, chronic physical and mental diseases, use of medicine and early elderliness[3] will be explored for the establishment of relationship between women's physical and mental well-being and educational, social, cultural characteristics in advance.

7. Conclusion

The decision towards implementation of dual records method by using a gender sensitive approach is an important step for the overall improvement in vital registration. In the context of Women and Health Module, attainment of a complete picture of women's status is aimed.

The module will enable:

– determination of persons covered by health insurance through “third persons” who are not entitled to be covered by health insurance on their own right;

– understanding of structural, social, cultural, educational barriers in front of women which prevent them from accessing available health services;

– evaluation for women's level of mobility and independence in deciding on their personal concerns;

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3. Early elderliness refers to a situation in which women marry young, give birth and become mother in-law at their early ages. This is observed generally in rural areas and slum regions of urban areas. Women may have some degree of authority over other household members only after being mother in-law and marriage of child is considered as a border line between youth and elderliness for women in those communities. The module contains some questions on early elderliness for some diseases are considered to prevail due to elderliness.

– gaining insight into biological as well as mental differences between women and men and creating awareness for differentiation of needs in health services between women and men.

After determination of persons through whom other persons are insured, feedback regarding characteristics of persons (a) having health insurance in their own right and having dependants as user of the same right, (b) having health insurance through other persons' health insurance will be attained. Use of the information will facilitate the establishment of persons' overall profile with reference to presence and source of health insurance.

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