

TURKEY

Turkey (population 68.8 million) is located largely in south western Asia, and in south eastern Europe west of the Bosphorus. Turkey covers an area of 780,580 square kilometres; bordering the Black Sea between Bulgaria and Georgia, and bordering the Aegean and Mediterranean Sea between Greece and Syria. Land boundaries border Bulgaria and Greece to the west; Georgia, Armenia and Iran to the north and east; Iraq and Syria to the south.



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According to the United Nations human development index (HDI), Turkey is ranked 88/177 countries worldwide (value 0.751)¹. This places Turkey in the group of countries with medium human development.

PALLIATIVE CARE SERVICE PROVISION

Turkey is an area where supportive care with hospice/ palliative care is linked to the development of other services, particularly within hospital based oncology units. We have taken the view that where a service is in the process of development from (largely) physical care to a broader form of holistic care it should be included in the review.

Current services

There are no specialist palliative care services in Turkey. Medical oncology units and departments of algology (pain) at major hospitals in the country provide pain control and symptom relief.² Oncologists and pain specialists in 7 hospitals report actively working to establish the concepts of palliative care (Table 1).

Table 1 Palliation in Turkey 2005 (hospitals with some active development of palliative care concepts)

<i>Adult Services</i>								
	<i>Freestanding unit</i>	<i>Hospital unit</i>	<i>Hospital support team</i>		<i>Home care</i>	<i>Day care</i>	<i>Clinic/ Drop-in centre</i>	<i>Grand Total</i>
Başkent University Hospital, Ankara		1						1
Gazi University Hospital, Ankara		1						1
Gulhane Military Academy, Ankara		1						1
Hacettepe University Hospital, Ankara		1						1
Istanbul University Medical Faculty		1						1
Marmara University Medical Faculty, Istanbul		1						1
Pamukkale University Medical Faculty, Denizli		1						1
Total		7						7

Development of palliative care tends to be focused around cancer patients in oncology units and ‘algology’ (pain) departments and centres. The majority of cancer patients are treated in university hospitals that support units with pain specialists and medical oncologists.³ Pain centres and departments also offer palliation for patients at the end of life with other illnesses. Some specialist cancer state hospitals such as the *Dr Ahmet Andicen Oncology Hospital* and *Demetevler Oncology Hospital* will provide pain relief and symptom management. No information, however, is currently available about the development of palliative care services in the state hospital system or the development of training in the 57 medical schools around the country.⁴ There are around 30 specialist ‘pain centres’ and 20 medical faculties with departments of algology in Turkey.⁵ There are no reported activities for paediatric palliative care.

Individual physicians (and their colleagues) have reported active involvement in developing the concepts of palliative care within departments and units in three main areas of the country; in Ankara, a pain specialist at *Hacettepe University Hospital*, three oncologists, one at *Başkent University Hospital*, one in the *Gulhane Military Academy, (GATA)* and one at *Gazi University Hospital* ; in Istanbul, a pain specialist at the *Istanbul University Medical Faculty* and two oncologists at the *Marmara University Medical Faculty* ; there is one pulmonary specialist developing concepts of palliative care at the *Pamukkale University Medical School, Denizli*. Medical and nursing professionals have also expressed interest in palliative care at *Ankara University Faculty of Medicine*.

Başkent University Hospital Faculty of Medicine

Başkent University, founded in 1993 through the cooperation of the Turkish Organ Transplant and Burns Treatment Foundation, (established in 1980), and the Hasberal Education Foundation, runs a large university hospital in Ankara with several other sites around the country. A broad spectrum of up-to-date diagnosis and treatment in all fields of medicine is provided including oncology and algology. Medical Oncologist, Professor Özgür Özyilkan, chair of the Medical Oncology Department is encouraging palliative care approaches in his unit.⁶ Professor Özyilkan is also a founder member of the Turkish Oncology Group.⁷

Gulhane Military Academy (GATA)

Medical Oncologist, Dr Seref Komurçu is providing palliation in the 33 bed oncology unit at GATA, a large (1500 bed) military hospital in Ankara. The oncology unit has a staff of 7 physicians and 18 nurses. They treat around 1200 patients annually with around 100 inpatients every year requiring palliation at the end of life. Dr Komurçu explains that at GATA:

‘We don’t have a separate unit for palliative care, but we need it. I’m mostly involved in palliative care, and I’m preparing some project to set up a separate unit, but it’s not easy. We need a separate floor and some other personnel, so I think it will take some time, a couple of years maybe. I do palliative care in that department and we follow the terminal patient also in the department. End of life care is done in the inpatient situation and most of the patients stay at home at their end of life period, and some patients prefer to stay at hospital in their terminal phase, and we apply terminal sedation sometimes. We don’t have a home care program: our insurance on each level doesn’t cover the home care program. But some new regulations are being [developed] and

maybe after this year the general insurances will cover home care treatment.’⁸

Hacettepe University School of Medicine, Ankara

Pain specialist and surgeon Dr Osman Abbasoglu, is involved in encouraging a palliative care approach in the Department of Anaesthesiology. The department offers a ‘pain relief service with one assistant professor in charge.’ Dr Abbasoglu explains that he works with adults, seeing around 400 patients each year, ‘about 80 % are inpatients, 15 % day care, 5 -10 % home-based.’ Patients are referred to the department for palliative pain relief by other physicians, ‘more than half have cancer, about 25 % chronic diseases like COPD.’^{9 10} The physicians can call on a social worker to support a patient if they perceive a need. There are plans to build an inpatient hospice unit at the Hacettepe.

Gazi University Hospital, Ankara

Medical oncologist Dr Deniz Yamac, based at the 20 bed oncology unit specialises in head, neck and breast cancer. Whilst she offers pain relief and symptom control, she is also actively developing palliative care training for doctors, nurses and students, but says that at this time there are no funds to develop the service in the way she hopes, for example, by employing a psychologist or setting up home care support. Working as part of a 6 doctor team, Dr Yamac sees up to 100 patients a week, around 10 of whom need end of life palliative care.

Marmara University Medical School Hospital, Istanbul

With 350 beds, Marmara Hospital’s services include a 14 bed oncology out patient unit,¹¹ where medical oncologists Dr Perran Fulden Yumuk and Dr Nazim Turdal are actively developing the principles of palliative care. They are part of a team including 3 medical oncologists, 2 medical fellows, 7 nurses, a psychologist, a pharmacist, a data manager and 2 secretaries. They see around 1000 new cancer patients a year. They write: ‘We are also following our patients who need palliative care and try to give them support for their pain management, nutritional status, etc. We try to be with our patients and relatives from the beginning of their disease till the end with all our team.’¹²

Istanbul University Faculty of Medicine,

Pain specialist and Chairman of the Department of Algology, Professor Serdar Erdine has developed pain relief, known in Turkey as ‘algology’ as a specialty.^{13 14} In his 14 bed unit they see around 3000 patients each year referred from other departments for pain relief. Around 1000 are cancer patients, most at the end of life. The remainder are patients with chronic pain from other illnesses. He follows the WHO ‘analgesic ladder’ when prescribing.¹⁵ His aim is to support patients to have sufficient pain relief at the end of life so they can be cared for at home.¹⁶

Pamukkale University Hospital Medical School, Denizli

Pulmonary specialist Dr Sevin Baser is keen to develop training for department staff, medical and nursing students in the concepts of palliative care. His enthusiasm follows his own specialist palliative care training in the US. The hospital sees a high number of patients with late stage lung cancer who need palliation. There is no medical oncologist and as yet, no dedicated palliative care.¹⁷

Reimbursement and funding for services

Services currently providing palliation are largely based in university hospitals, which are government funded. Patients in university hospitals either have to pay for treatment and medication themselves privately or their costs may be partially (or completely) covered either through one of three government health insurance schemes, or by the Green Card scheme, or by private insurance.

Free inpatient treatment and medication in university hospitals is available for people on low incomes if they have been issued a government Green Card. Outpatient prescribed medication has to be paid for by the patient, who may be covered by their health insurance. End of life medical support accessible in Ministry of Health hospitals is free for inpatients, if they are insured or have a Green Card. There are a few home care services run by private health companies who also offer palliative care, but these are not reimbursable by government insurance plans.¹⁸

The health system is highly complex in Turkey with access to government health insurance schemes dependent on location and also whether the patient is, or has been, a government employee. More government funded services are found in the three largest cities. Where government funded provision exists there are more likely to be free or subsidised primary care and inpatient services.¹⁹

There are no reports of charitable palliative care agencies (NGOs). In 2003, one cancer NGO, the Association of Patients with Cancer, was reportedly able to offer some financial help for cancer patients in need.²⁰

Opioid availability and consumption

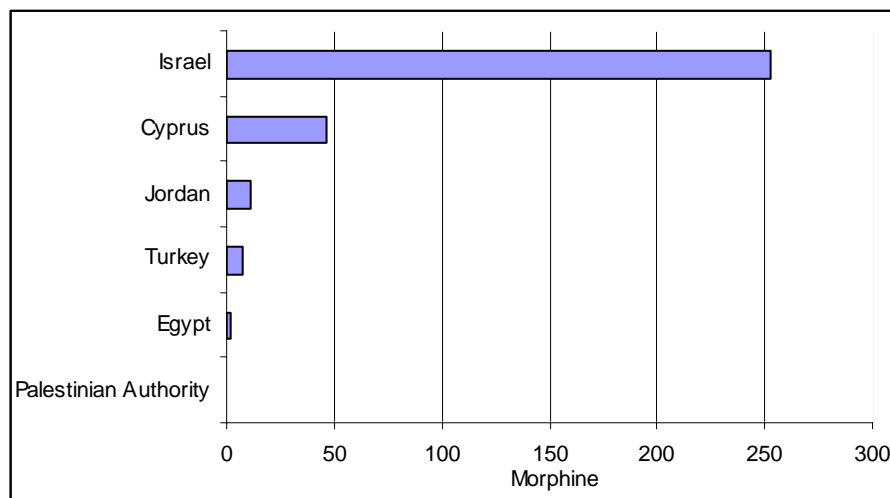
The International Narcotics Control Board^{21 22} has published the following figures for the consumption of narcotic drugs in Turkey during 2002: codeine 1117 kg (down from 1784 kg in 1999); morphine 16 kg (down from 22 kg in 1999); pethidine 132 kg (up from 121 kg in 1999).²³

For the years 2000-2002, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)²⁴ in Turkey was 7. This compares with other countries in the Middle East region as follows: Cyprus 46; Egypt 2; Israel 253; Jordan 11. The Palestinian Authority reported no morphine consumption during 2000-2002 (Table 2).

Opioid preparations are available for patients at the end of life. Turkey has a colour coded prescription system; red prescription sheets for opioids, green for sedatives and opioid derivatives like Tramadol. White prescription sheets are used for all other drugs. There is a dosage limit of no higher than 400mg morphine in any one dose. Supply is limited to no more than 10 ampoules of morphine per prescription, no more than 24 tablets of codeine 40mg, and no more than 3 packs of drugs over 7-10 days.²⁵

Deniz Yamac, Medical Oncologist at Gazi Hospital explains that they use a full range of medications including MST, morphine; oral, injectable, and pumps as IV infusion, Fentanyl [transdermal patches], Sevredol and Oxycodone. The Department of Algology at Gazi uses intrathecal injections but the unit do not use subcutaneous infusions.²⁶

Table 2 Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2000-2002: the six MECC²⁷ member countries in the Middle East region.



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2004. Statistics for 2002*. New York: United Nations, 2004.

Dr Seref Komurçu, Medical Oncologist at Gulhane Military Academy reports that in addition to oral opioids they use epidural catheter in some patients.²⁸

Professor Serdar Erdine explains that although they can prescribe Fentanyl patches, slow release oral morphine and tramadol: ‘short acting opioids are not available, like methadone.’ In his algology department in the Medical Faculty of Istanbul he reports:

‘We implant [morphine] pumps (intrathecal, epidural) for cancer. In our centre [since the mid 1990s] we have performed more than 1000 [insertions of pumps] for cancer. Plus, we do all types of nerve blocks. In a year we see 1000 patients with cancer, but we do only 100 [nerve blocks] for cancer. We obey the rules of the WHO step system. Not much use of the subcutaneous infusion because we see patients before the end of life, [although] the oncology departments are aware of our pain department and refer patients, and usually they are at a very late stage when diagnosed.’²⁹

Prof Erdine has seen a change since the transdermal patches became available in Turkey. Before patches were available he saw more patients for pain relief at an earlier stage in their treatment, but now the oncology department only refer patients to the pain department who, for example, are no longer having their pain relieved by the patches.

National and professional organisations

The *Turkish Oncology Group (TOG)* was established in 1989. The Group works to encourage education about cancer and has several different sections which focus on different cancers. In the late 1990s the Group initiated a section on palliative care training and development. In October 2004 the Group dedicated a conference to the continuing development of palliative care in Turkey. The conference was co-sponsored and supported by MASCC (Multinational Association of Supportive Care in Cancer)³⁰ and co-chaired by Dr Eoin Tiernan with Dr Declan Welsh, and TOG president, Dr Dincer Firat. As representative of MASCC, Dr Eoin Tiernan explains:

‘This key conference coincided with the un-veiling of architectural plans for Turkey’s first hospice unit, to be opened in Ankara. Though home care, hospice and palliative care are not yet well developed in Turkey, the high attendance and obvious support from prominent members of the Oncology community in Turkey for the meeting gave ample evidence of the clear determination of TOG to advance both palliative and supportive care issues. The very-well organised programme covered a wide range of topics in supportive care, including both physical and psychological symptom management, with a distinguished faculty of speakers. Dr Matti Aapro, President of MASCC, also contributed to the programme presenting updates on current approaches to anaemia and emesis. One of the main purposes of the meeting was to explore the challenges in organising and developing home care and hospice programmes in Turkey. In keeping with this, international perspectives on home care and hospice development were presented by Dr Declan Walsh (US), Dr Eoin Tiernan (Ireland), and Julia Anne Walsh (US). Perspectives on organization of home care and hospice in Turkey were presented by a number of professionals working in innovative programmes in Turkey, and the sessions were followed by lively debate and discussion, with a representative from the Ministry of Health contributing. The meeting was also supported by Ms. Guldal Aksit, a Turkish government minister, who made a formal address pledging government support for this very important initiative.’³¹

Palliative care coverage

Supportive care with pain relief is being developed mainly in university hospitals in Ankara and Istanbul – the two largest cities in the more populated western area of Turkey.³²

Education and training

There are a number of medical oncologists and pain specialists involved in developing palliative care education and training within existing hospital oncology and pain units.

Gazi University Hospital, Ankara

Dr Deniz Yamac, who was introduced to the concepts of palliative care whilst completing training in oncology at Arkansas Cancer Institute, US, has been running short sessions and day workshops from her oncology unit since 2000. These are designed for other medical faculty members and resident physicians. There is a separate programme for medical students. In 2005, Dr Yamac is starting to set up workshops for nurses in the oncology unit. She is also involved in a project - starting in 2005, funded by private health insurance - to train nurses in home care for cancer patients.³³

Istanbul University Faculty of Medicine

Professor Serdar Erdine is actively involved in public and professional education promoting the principles of palliative care and pain relief using opioids. Using his 25 years of experience and extensive knowledge of pain relief, he explains that he and other colleagues are trying to alleviate people’s fears of cancer by raising public awareness, through TV and articles in journals and newspapers, of the effectiveness of

opioids in relieving cancer pain. He is also organising a campaign to educate physicians about the safety and efficacy of using opioids.

Gulhane Military Academy,(GATA), Ankara

Dr Seref Komurçu, who trained as a fellow in palliative care at the Cleveland Clinic, US, is now teaching palliative care to colleagues in his oncology unit.

Palliative care workforce capacity

As of 2005, there are no specialist palliative care health professionals in Turkey. Some individual medical oncologists and pain specialists are active in promoting the training of colleagues (doctors, nurses, psychologists, medical and nursing students) in the concepts of palliative care in their departments.

HISTORY AND DEVELOPMENT OF PALLIATIVE CARE

Narrative history of palliative care

Since the mid 1990s there has been a growing awareness for the need to develop a palliative care service in Turkey that would include not only pain relief and symptom control but also the psychosocial needs of the patient, and their families, at the end of life. Traditionally, Turkish people have tended to die at home cared for by their family. In less populated rural areas home is still the commonest place of death. Studies conducted in the late 1990s and early 2000s revealed a radical shift in the place of death for Turkish people, particularly those who have migrated to urban areas where 75% of the population now live.^{34 35} With this change in socio-economic patterns fewer women are available to care for relatives in the home. Over 60% of urban deaths are now in hospitals, although, according to one national survey of people's attitudes to dying in hospice or hospital, 47% of the 200 adults questioned would prefer to care for their dying relative at home. Conversely, for themselves, 54% would prefer to die in hospital as they hoped to have better care.³⁶

Political events, particularly in the 1990s, inadvertently raised awareness of the need to address adequate provision of care at the end of life, when separatist insurgency led to people fleeing from rural to urban areas (chiefly in regions such as Diyarbakir and Adana in the south-eastern Turkey). This caused an enormous burden for local hospitals that were unprepared for such a large increase in their patient populations and most significantly, the consequent increase in the need for narcotic drugs for patients at the end of life.³⁷

Given this socio economic and cultural background the concepts of palliative care have, however, proved slow to disseminate, in contrast to the development of improved methods of pain relief.³⁸ Professor Serdar Erdine, Chair of the Department of Algology at Istanbul Hospital Faculty of Medicine, explains that although: 'the real palliative care services are very weak here, pain management is very well developed and is going to be a specialty very soon.'³⁹

Several pain specialists and oncologists have recognised the need for specialist palliative care services since the mid 1990s, and a number have sought palliative medicine training overseas and returned to encourage training and development within their own units and faculty departments. There are, however, no national guidelines or government financed support for palliative care services. (Although a

cancer control policy is being prepared and there is now a public health policy for AIDS).⁴⁰ Most of the interested oncologists and pain specialists are working in relatively few university hospitals (there are a total of 50 government supported university hospitals in the country and 668 government funded Ministry of Health hospitals). In 2003, Professor Yasemin Oguz, of the Unit of Deontology (Medical Ethics) in the Faculty of Medicine at Ankara University co-authored a paper with colleagues in which they report that end of life care services continue to be markedly inadequate. In particular, she and her colleagues highlight the lack of nursing or financial support for families who have to care for their older, terminally ill relatives at home, which increases the likelihood of hospital admission. Oguz et al. note the issues around using opioids, points reiterated by Serdar Erdine in 2005, and suggests that too often the end of life is likely to be painful and lonely in hospital:

‘Narcotics are often available to meet the needs of dying patients with chronic pain. Many private pharmacies shun the bureaucracy and the potential liability that goes with dispensing “green” prescriptions (for addictive or abusable drugs) and “red” prescriptions (for narcotics). The difficulty in finding a healthcare professional to come to the home to dispense, administer, monitor, or instruct in the proper use of opiates encumbers or entirely obstructs home care with narcotics. Under-treated pain and the lack of a means to secure access to opiates lead people to seek overloaded hospital-based clinics or avoidable and costly inpatient treatment. Hospitals and their staff are not organised or trained to provide palliative care.’ Of 7 university hospitals and 9 state hospitals in the three largest cities: ‘no hospital had a policy on end of life care, pain management or DNR (do not resuscitate) orders. Dying patients are often placed in what healthcare professionals informally call “agonal rooms”. These are often in less noticed areas of the hospitals ... The dying person is often alone in an institution from which he or she or relatives sought help.’⁴¹

A needs assessment was due to be conducted by Professor Oguz in 2004 because as she describes, a major problem in meeting the palliative care needs of patients and educating healthcare professionals lies in the lack of data:

‘As the director of the needs assessment project for palliative care in Turkey I may say that our main problem is the lack of national data on the subject. Without essential data it is not possible to convince the Turkish Ministry of Health and National Health Insurance Organizations about the importance of the subject. Palliative care and end of life issues are a kind of no man’s land in Turkey. Although many healthcare professionals encounter the problems and are aware of the need, they do not see the subject as their business. There are financial and legal restrictions. Our initial objective is to establish a continuous communication between interested professionals and patient advocacy groups. There are a couple of non-governmental organizations which may support the efforts. One of them is the Association of Patients with Cancer. Their main concern is financial problems of cancer patients. Another important group is the Turkish Oncology Group (TOG) which is not a formal association, but a collection of interested professionals. It has a subgroup named Education, Research and Supportive Treatments.’⁴²

Unfortunately, the palliative care needs assessment described here has been delayed for lack of funds.⁴³ Although, these economic difficulties are reported to act to slow the development of hospice home care there are some recent initiatives, driven by

members of the TOG. For example, medical oncologists Dr Perran Fulden Yumuk and Dr Nazim Turdal at the *Marmara University Medical School Hospital* in Istanbul report:

‘We are planning to build a hospice and one fellow is being educated in USA for this purpose and she will finish her fellowship in 3 years. At this time there are no university or government based hospice programs in Istanbul. Most of the time patients are admitted to hospitals for palliative support, which is usually unnecessary use of beds, etc. This is why we decided to build a hospice in Istanbul.’⁴⁴

There are also plans to build an inpatient hospice at the Hacettepe Hospital in Ankara, with construction due to start in 2005. This is a project initiated and encouraged by Professor Dincar Firat, President of the Turkish Oncology Group.⁴⁵ Members of the *Turkish Oncology Group* (TOG) have also been active in encouraging the development of palliative care training. As part of this initiative to raise awareness and address the need for palliative care, the TOG organised a conference in Istanbul during October 2004, dedicated to developing home-based palliative care programmes. Dr Seref Komurçu reported:

‘After that meeting we invited some people from government and from insurance companies, so they learned something about home-care programmes and the need for the programmes. So I believe that meeting helped a lot, and there were some discussions about the new regulations on home care, and I think three weeks ago regulations were done. The government asks our Society about home care: how it can be controlled and to what standard. We gave some opinions, and the government also took some other ideas from some other organizations.’⁴⁶

Although, the Turkish Oncology Group have supported the concept of palliative medicine for medical oncologists and other interested healthcare professionals, professional oncology nursing organisations are not yet involved in developing specialist palliative care training.⁴⁷

In June 2004, Turkey joined the *Middle East Cancer Consortium (MECC)*. MECC, funded by the National Cancer Institute, Bethesda, USA, is involved in helping its 6 member countries to develop a standardised cancer registry as part of its goal to raise cancer awareness and reduce the burden of cancer in the region.⁴⁸ MECC organises and offers free places at its seminars and conferences for its member countries’ healthcare professionals. From February 2004, MECC has been supporting initiatives to assess palliative care provision, needs and training.

Life/oral histories

Dr Seref Komurçu - *Medical Oncologist, Gulhane Military Academy*: interviewed by Amanda Bingley – 18 April 2005 – Duration of interview: 35 minutes

Seref Komurçu talks about his education as a fellow in the US at the Cleveland Clinic and in the palliative care department. Since his return 8 years ago, he has been developing and teaching palliative care in his oncology unit.

Dr Deniz Yamac - *Associate Professor of Internal Medicine and Medical Oncology, Gazi University Hospital*: interviewed by Amanda Bingley, 6 July 2005 – duration of interview 45 minutes.

Deniz Yamac, who specialises in breast cancer, head and neck cancer, talks about her growing interest in palliative care since 1995, when she trained in Medical Oncology at Arkansas Cancer Institute, USA. She explains that after some years in oncology she realised she had to know about palliative care and set about studying on her own. She offers palliation to her own patients at the end of life, and advises colleagues about palliation for their patients. She is actively developing palliative care training in the oncology unit, and with medical students in the university medical school. She is taking part in a project to train general nurses in home care.

Professor Serdar Erdine - *Chair of Algology, Istanbul University Faculty of Medicine*: interviewed by Amanda Bingley, 11 July 2005 – duration of interview 36 minutes

Serdar Erdine talks about his work developing pain management and seeing a pain or algology specialty recognised. He also describes the current attitudes towards palliation in Turkey, and his campaign to raise public awareness of the efficacy of cancer pain relief; to alleviate fears of opioids; and to educate physicians in opioid use.

PUBLIC HEALTH CONTEXT

Population

Turkey's population of around 68.8 million is made up of multi-ethnic groups: the largest of which is Kurdish.

The population is predominantly young. In 2003, an estimated 10 % were <4 years old; only 2.3 % were > 65 years old.⁴⁹ There has been a marked migration from rural to urban centres. In 1960, 70% of the population lived in rural areas and 30% in urban areas. By 2000, only 25% were living in rural areas and 75% were in urban areas, the majority migrating from eastern areas to western areas into the three largest cities, Istanbul, Ankara and Izmir.⁵⁰

Religious groups include: Muslim 99.8% (mostly Sunni), other 0.2% (mostly Christians and Jews).⁵¹

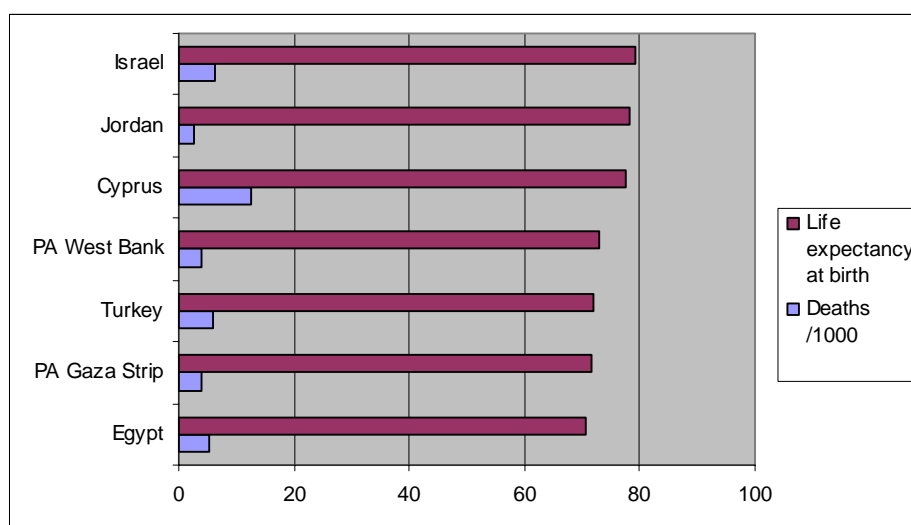
Epidemiology

In Turkey the WHO World Health Report (2003) indicates an adult mortality⁵² rate per 1000 population of 177 for males and 112 for females. (crude death rate 5.95 deaths/1,000 population and life expectancy at birth (total population) 72.08 years (2004 est.)⁵³ (Table 3).

Life expectancy for males is 67.9; for females 72.2. Healthy life expectancy is 61.2 for males; 62.8 for females.⁵⁴

Circulatory disease is the primary cause of death. In 2003, circulatory disease accounted for 48% of all registered deaths (26% deaths in men and 23% deaths in women).⁵⁵

Table 3 Country death rates and life expectancy at birth (total population)*



Cancer (neoplasm) is the second commonest registered cause of death. In 2003, cancer accounted for an estimated 13% of all registered deaths (8% deaths in men and 5% deaths in women).⁵⁶ The first cancer registry in Turkey to follow international guidelines, the Izmir Cancer Registry, was established in 1992, and records cancer incidence in the Izmir region of the country.⁵⁷ Published figures relate to the Izmir region of Turkey in 1994, with an estimated population of around 3.2 million. Cancers of the tracheii, bronchus and lungs were the commonest in men (61.6% annual incidence). Breast cancer was the commonest in women (24.4% annual incidence).⁵⁸

There are no UNAIDS figures for the prevalence of HIV/AIDS in Turkey⁵⁹. Estimates from the CIA World Factbook suggest a very low rate of less than 0.1% (2001 est.) (Table 4).

Table 4 Country HIV and AIDS estimates, end 2003*

Adult (15-49) HIV prevalence rate	...
Adults (15-49) living with HIV	...
Adults and children (0-49) living with HIV	...
Women (15-49) living with HIV	...
AIDS deaths (adults and children) in 2003	...

Source: 2004 Report of the global AIDS epidemic

** No estimates have been made where sufficient data for the last six years was not available*

In 2004, the Turkish State Statistics Institute reported a total of 197 HIV/AIDS cases (as of end 2003).⁶⁰

Tuberculosis is a greater problem than HIV/AIDS with an estimated 18,000 people undergoing treatment each year. The State Institute for Statistics reports:

‘In the past, prevention used to be the main part of tuberculosis control activities in Turkey, but at the present, successful case detection and treatment have become major components of tuberculosis control program. Therefore, besides anti-tuberculosis drugs, diagnosis has also been provided free of charge to patients. Today, tuberculosis control services are provided by 244 dispensaries of which belong to the Ministry of Health, 31 dispensaries of which belong to voluntary organizations, 22 Chest Diseases Hospitals and 11 mobile tuberculosis group. These units are controlling approximately 2.5 million persons each year and providing health care for 18,000 patients.’⁶¹

Health care system

In 2003, Turkey’s total per capita expenditure on health care was Intl \$294 (5 % of GDP).⁶² Among the six MECC countries of Middle East, this figure falls within a spending range of Intl \$1839 in Israel (8.7 % of GDP) and Intl \$153 in Egypt (3.9 % of GDP). At 3.9 % the smallest spending as a percentage of GDP is in Egypt (Tables 7 and 8). There are no available figures for the Palestinian Authority.

The WHO overall health system performance score places Turkey 70/191 countries. This composite measure of overall health system attainment⁶³ is based on a country’s goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

Tables 5 and 6: Total health expenditure (Intl \$) per capita and as a percentage of GDP: Six MECC countries of the Middle East, 2003

Table 5 Health expenditure (Intl \$) per capita: MECC countries		Table 6 Health expenditure (Intl \$) as a percentage of GDP: MECC countries	
Country	Per capita	Country	% GDP
Israel	1839	Israel	8.7
Cyprus	941	Cyprus	8.1
Jordan	412	Jordan	9.5
Turkey	294	Turkey	5
Egypt	153	Egypt	3.9
Palestinian Authority	No figures*	Palestinian Authority	2.4*

Source WHO World Health Report 2003 **Source Palestinian Central Bureau Statistics*

Turkey has a complex, partly-nationalized health care system established in 1961, and a well-established private sector. As Savas et al. explain:

‘Turkey’s health care system is at once centralised and fragmented. Health care is provided by public, quasi-public, private and philanthropic organisations but relations among them are not well structured or regulated. Health care is financed by the government (through the Ministry of Finance), social security institutions (the Social Insurance Organisation (SSK), the Social Insurance Agency of Merchants, Artisans and the Self-employed (Bag-

Kur) and the Government Employees' Retirement Fund (GERF) and [private] out-of-pocket payments.⁶⁴

The government public provision includes: Ministry of Health hospitals, health clinics and specific health centres (family, maternal and child health, tuberculosis dispensaries); Ministry of Defence military hospitals; and Higher Education Council funded university hospitals.⁶⁵ Philanthropic organisations include the Red Crescent which provides aid in natural and war-related disasters, as well as support in dispensaries. A variety of philanthropic non governmental organisations (NGOs) known as collectively as the 'Foundations' offer help to people with illnesses such as diabetes, cancer and AIDS, but as yet, not for palliative care.

People can access free services (including inpatient medication, but excluding outpatient prescriptions) in all Ministry of Health institutions and when referred in university hospitals if they have a 'low income' Green Card. The municipalities of the 3 largest cities run their own hospitals and offer free home care for the poor, which includes care at the end of life.⁶⁶

People without a Green Card cover their medical costs either through one of the three social security government schemes (SSK, Bag-Kur, GERF) or they have private health insurance. The State Planning Organisation estimates suggest around 83% population have health cover, with 87% of the population covered by some kind of insurance cover, either directly or as a dependent. The actual figures are thought to be lower. Over half the population contribute to one of the social security schemes: (34 million to the most flexible and comprehensive scheme at SSK). There are continuing concerns that a substantial proportion of the population are not covered by insurance, or that some schemes offer inadequate provision.⁶⁷ The lack of adequate provision is especially problematic for people at the end of life; some government insurance schemes do not cover outpatient medications, which mean many people have to go into hospital if they or their families cannot afford the costs of medication when at home. Conversely, private provision at the end of life is not always available. For example, many private nursing homes will not admit patients who are known to be in the terminal stage of their illness.⁶⁸

Political economy

GDP of Turkey⁶⁹ per capita is Intl \$5,830. This falls within the range of \$21,223 (Israel) and \$600 (Palestinian Authority Gaza Strip) in the 6 MECC countries of the Middle East (Table 7).

Table 7: GDP per capita (Intl \$): 6 MECC countries of the Middle East, 2001

Country	GDP per capita (Int \$)
Israel	21,223
Cyprus	11,588
Turkey	5,830
Jordan	4,348
Egypt	3,901
Palestinian Authority West Bank*	**800
Palestinian Authority Gaza Strip*	600

Source WHO (2001) *CIA World Factbook (2003est.)**(2002est.)

Modern Turkey was founded in 1923 from the Turkish remnants of the defeated Ottoman Empire by national hero Mustafa Kemal, who was later honoured with the title Atatürk, or "Father of the Turks." Under his leadership, the country adopted wide-ranging social, legal, and political reforms. After a period of largely one-party rule, an experiment with multi-party politics led to the 1950 election victory of the opposition Democratic Party and the peaceful transfer of power. Since then, Turkish political parties have multiplied, but democracy has been fractured by periods of instability and intermittent military coups (1960, 1971, 1980), which in each case eventually resulted in a return of political power to civilians. In 1997, the military again helped engineer the ouster - popularly dubbed a "post-modern coup" - of the then Islamic-oriented government. Turkey intervened militarily on Cyprus in 1974 to prevent a Greek takeover of the island and has since acted as patron state to the "Turkish Republic of Northern Cyprus," which only Turkey recognizes. A separatist insurgency begun in 1984 by the Kurdistan Workers' Party (PKK) - now known as the People's Congress of Kurdistan or Kongra-Gel (KGK) - has dominated the Turkish military's attention and claimed more than 30,000 lives, but since the capture of the group's leader in 1999, the insurgents have withdrawn from Turkey, mainly to northern Iraq. Turkey joined the UN in 1945 and in 1952 it became a member of NATO. In 1964, Turkey became an associate member of the European Community and is currently undertaking substantial legal and economic reforms in pursuit of full membership in the European Union.⁷⁰

ETHICAL ISSUES

There are three key ethical issues relating to palliative and end of life care in Turkey: difficulties around disclosure of prognosis, that arise because the Turkish people tend to avoid openly discussing diagnosis and the progress of their illness; problems of communication with patients at the end of life and acceptance by the medical professionals; and fears about use of opioids, that can lead to low usage and potentially increased suffering at the end of life.

In terms of issues around disclosure of diagnosis and problems of communication there is a strong ethos in Turkey of keeping a diagnosis from the patient, largely because a cancer diagnosis, in particular, is still regarded as a death sentence. Also, Turkish culture has tended towards a 'paternalistic attitude' in the physician.⁷¹ There are signs that physicians' and public attitudes are changing, along with changes in legal responsibility towards patient's rights and autonomy; and that these changes are essential in order to encourage a greater openness.^{72 73 74} Medical oncologist, Deniz Yamac explains:

'Turkey is a little different from Europe, people know about end of life but they don't say it, about half can talk about it, about cancer, but some don't want [to hear] the name of cancer. You can act according to the patient which is in front of you. You must feel it, you must have the information before you and be open. I ask my patients, "what do you know about your disease, your illness, what do you need?" So I can see my way how to act, how to talk, but I don't think that all Turkish doctors [who] are concerned with cancer know that, so I do the workshops in communication. Not to know – how to tell. They [the patients] should know; it's their life. I try to tell it but not to break their heart. They must know their future. But doctors run away in order to prevent themselves from hurting. Doctors are afraid of palliative care and [often] don't want to be involved.'⁷⁵

Yasemin Oguz et al. suggest that an important ethical issue is a lack of acceptance of the end of life by healthcare professionals, which requires the creation of a 'treatment philosophy' that acknowledges and provides for the needs of people at the end of life:

'To create this new treatment philosophy, Turkish physicians will have to accept death and dying patients as a natural life process for which medicine in its caring and comforting role has an important role.'⁷⁶

There are ethical concerns about the continuing widespread fear of opioids, a fear which pervades the perceptions and practice of the public at the end of life and the healthcare professionals who care for them. The problem about the practice of euthanasia and assisted suicide of people suffering severe under-treated pain has fuelled considerable debate in medical ethics since the mid 1970s.⁷⁷ The point is made that improved training would result in better pain management and thus mean less suffering and consequently less call for euthanasia and assisted suicide.⁷⁸ For example, in 2003, Turkish oncologists at Akdeniz University Hospital demonstrated a significant improvement in quality of life for cancer patients who were receiving opioids.⁷⁹ There is a strong ethical dimension to the national campaign conducted by Serdar Erdine to educate both the public and healthcare professionals about the efficacy of appropriate opioid usage in alleviating cancer pain.⁸⁰

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