

**Health reform and new politics of health care in Turkey**

**Volkan Yılmaz**

**Submitted in accordance with the requirements for the degree of**

**Doctor of Philosophy**

**The University of Leeds**

**School of Politics and International Studies**

**December 2014**

The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

© 2014 The University of Leeds and Volkan Yılmaz

The right of Volkan Yılmaz to be identified as Author of this work has been asserted by him in accordance with the Copyright, Designs and Patents Act 1988.



## Acknowledgements

It is a pleasant duty to express my sincere gratitude to my thesis supervisors, Dr. Charles Dannreuther and Dr. Jelke Boesten, in reaching this rewarding moment in my academic life. Their intellectual insight, collegiality and congeniality supported me throughout this study, which I will never forget.

I would like to express my appreciation to Prof. Ray Bush and Prof. Gordon Crawford for their valuable and constructive suggestions during the upgrade process. I would also like to extend my thanks to Dr. Zülküf Aydın for his whole-hearted and encouraging engagement with my project in my first year at the University of Leeds.

I owe intellectual debt of gratitude to Prof. Çağlar Keyder and Prof. Ayşe Buğra, co-founders of Boğaziçi University Social Policy Forum, who inspired a considerable number of students including myself to work on social policies in Turkey. I would like to extend my thanks to Dr. Burcu Yakut-Çakar and Dr. Ayşen Candaş for making issues of social policies and social rights interesting for me. I am thankful for Prof. Belgin Tekçe, Dr. Asena Günal and Dr. Tuba Ağartan for expanding the boundaries of social sciences in Turkey to include health care issues. This thesis would not be possible without their earlier works and the inspiration they gave me.

The completion of this project could not have been accomplished without the support of Prof. Nurhan Yentürk, the founder of the Civil Society Studies Centre at İstanbul Bilgi University. Yentürk has always been a role model for me with her never-ending academic productivity and generous support for young academics. I would like to extend my thanks to my colleagues at the Civil Society Studies Centre at İstanbul Bilgi University for their kindness and cooperation.

I wish to thank my dearest sister Asuman Ünivar and dearest friends for being there: Nilay Şentürk, Mehmet Baki Deniz, Burcu Oy, Zeynep Akça, Pınar Gümüş, Sinan Eden, Sezen Yalçın, İpek Göçmen and special thanks to my thesis-mate Ezgi Şeref for sharing the moment.

My dear mother Seyhan Yanık, who would not be able to see the completion of this project, has always been a great model of character, strength and resilience for me over the course of my life.

I am grateful to the University of Leeds for granting me a generous graduate scholarship and the British Institute in Ankara for granting me a research scholarship. Without these opportunities, I would not be able to complete this project.

Finally, I would like to thank Megan Dold who did her best to edit this thesis.

## **Abstract**

The health care system in Turkey has undergone a transformation process since the Health Transformation Programme (HTP) launched in 2003 and significantly increased marketization in health care provision. This study asks the following questions: What political dynamics enabled the introduction of health care reform in Turkey? What kind of political conflicts did the reform generate? How and to whose benefit have these conflicts been resolved? As a historically grounded, single country case study, this study draws on 33 in-depth interviews conducted with major political actors who were involved in the HTP. This study concludes that the reform under consideration was a product of two factors: the World Bank's pro-market approach to health reforms that became internalised in the health care bureaucracy in Turkey after the mid-1980s, and the controlled populism of the Justice and Development Party (the AK Party). With the introduction of the HTP, the power distribution upon which Turkey's health care system is based has been changing in three ways. First, the Turkish Medical Association (TTB) lost its leverage in health care policies. Excluded from the reform process, the only success of the TTB was using judicial activism to block the government's attempts to introduce a full time work requirement for medical doctors. Second, the reform gave birth to the emergence of a new political actor in health care politics, namely private health care provider organisations. Private health care provider organisations, which avoided confrontational discourse in their relations with the government due to the financial dependency of the sector on the state, succeeded in altering the legal and administrative limits that the reform put on their opportunities for capital accumulation. Finally, the transformation of the AK Party from a catchall party to a cartel party that undermines the electoral competition in Turkey might put the representation of the citizens' interests on health care policies at risk.

# Table of Contents

Acknowledgements .....	3
Abstract .....	5
Table of Contents .....	6
List of Tables .....	9
List of Graphs .....	10
List of Abbreviations .....	11
Chapter 1: New Politics of Health Care in Turkey .....	14
1.1. Introduction .....	14
1.2. The contribution and significance of the study .....	18
1.3. Methodology .....	20
1.4. Methods .....	21
1.5. Fieldwork .....	23
1.6. Limitations .....	24
1.7. Ethical considerations .....	25
1.8. The organisation of chapters .....	26
Chapter 2: The Politics of Health Care: A Critical Review of Literature ..	28
2.1. Introduction .....	28
2.2. A short history of health care policy .....	29
2.3. Is health care a commodity? .....	32
2.4. Health care reform under neoliberalism .....	35
2.5. The politics of health care: Different approaches .....	39
2.5.1. The pluralist approach .....	41
2.5.2. The power resources approach .....	43
2.5.3. The institutionalist approach .....	45
2.5.4. The new politics approach .....	48
2.6. Conclusion .....	50
Chapter 3: Health Care and Politics in Turkish History .....	51
3.1. Introduction .....	51
3.2. The history of health care politics in Turkey before the reform .....	52
3.2.1. The history of health care and politics until the end of WW2 ...	53
3.2.2. The history of health care and politics between the end of WW2 and the military coup d'état in 1980 .....	56
3.2.3. The history of health care politics since the military coup d'état in 1980 .....	68
3.3. Turkey's health care system before the reform within a comparative perspective .....	78
3.3.1. Health care finance .....	80
3.3.2. Health care delivery .....	82
3.3.3. The regulation of health care finance and delivery .....	84
3.4. Conclusion .....	84
Chapter 4: The Health Transformation Programme in Turkey within the Context of Health Care Reforms in Other Developing Countries .....	88
4.1. Introduction .....	88

4.2. The main parameters of the Health Transformation Programme in Turkey.....	89
4.2.1. Changes in health care finance.....	90
4.2.2. Changes in health care delivery.....	93
4.2.3. The results of the Health Transformation Programme so far ...	95
4.3. The post-1980s health care reforms in Latin America, Southern Europe and East Asia.....	98
4.3.1. Background.....	98
4.3.2. Health care reforms in Latin America.....	102
4.3.3. Health Care Reforms in Southern Europe.....	105
4.3.4 Health Care Reforms in East Asia and South East Asia.....	109
4.4. Conclusion.....	113
Chapter 5: The Impact of the World Bank on Health Care Reform in Turkey.....	116
5.1. Introduction.....	116
5.2. The World Bank's approach to health care reform in developing countries.....	119
5.3. The History of the partnership between the World Bank and Turkey in health care and its impact on the Health Transformation Programme.....	125
5.4. The partnership of the World Bank and the AK Party government on health care reform.....	127
5.5. The importance of World Bank loans for health care reform in Turkey: Is it overrated?.....	131
5.6. The influence of the World Bank's know-how and policy advice on the reform.....	133
5.7. The reform as a closed process.....	140
5.8. The partnership of the World Bank and the government: Any disagreements?.....	141
5.9. Conclusion.....	145
Chapter 6: The AK Party and the Politics of Health Care in Turkey in the Last Decade.....	150
6.1. Introduction.....	150
6.2. Political Parties and the Society.....	151
6.3. The influence of the AK Party's political ideology on the content of the reform.....	153
6.4. The Health Transformation Programme as a factor in the consolidation of the AK Party rule.....	157
6.5. The Health Transformation Programme and the AK Party's alliance with the poor and the rich.....	162
6.6. Conclusion.....	167
Chapter 7: The Turkish Medical Association as an Actor in the Politics of Health Care.....	169
7.1. Introduction.....	169
7.2. The literature on the role of medical doctors and professional medical organisations in health care reforms.....	170



7.3. A brief political history of the Turkish Medical Association and its power resources within Turkey’s political system.....	173
7.4. The Turkish Medical Association’s opposition to the Health Transformation Programme: Contestations with the AK Party governments.....	181
7.4.1. The clash over the role and function of the Turkish Medical Association.....	183
7.4.2. The clash over the employment status of medical doctors .....	186
7.5. Conclusion.....	195
Chapter 8: Private Health Care Provider Organisations as New Actors in the Politics of Health Care .....	197
8.1. Introduction .....	197
8.2. Literature on the relations between the state and business organisations in health care politics .....	198
8.3. Literature on the relations between the state and business organisations in health care politics in Turkey .....	203
8.4. Private health care providers in Turkey’s health care system: A brief history and the Health Transformation Programme .....	207
8.5. The state of the private sector in health care provision after the reform .....	213
8.6. The birth of new actors in health care politics: private health care provider organisations .....	220
8.7. Private health care provider organisations at work: discourses, demands and strategies.....	225
8.7. Conclusion.....	242
Chapter 9: Conclusion.....	245
Bibliography .....	262
Appendix: List of Interviews .....	311

## **List of Tables**

Table 1. Number of hospitals, in terms of ownership of hospitals, 2002-2011

Table 2. Bed capacity in different hospital types, in terms of ownership of hospitals, 2002-2011

Table 3. Share of bed capacity/total bed capacity for different hospital types, in terms of ownership of hospitals, 2002-2011

Table 4. Distribution of total applications to hospitals by type of health care providers, in terms of ownership of hospitals, 2002-2011

Table 5. Breakdown of the expenditures of the SGK according to different hospital types, 2002-2011

Table 6. Sizes of private hospitals, 2011

Table 7. Foreign direct investment (FDI) in health care, 2006-2011

## **List of Graphs**

Graph 1. Public health expenditures/GDP

## **List of Abbreviations**

American Medical Association, AMA

British Medical Association, BMA

Democratic Left Party, Demokratik Sol Parti, DSP

European Monetary Union, EMU

European Union, EU

Great Britain Pound(s), GBP

Gross domestic product, GDP

Health and Social Services Labourers Union, Sağlık ve Sosyal Hizmet Emekçileri Sendikası, SES

Health Transformation Programme, HTP

International Bank for Reconstruction and Development, IBRD

International Centre for Settlement of Investment Disputes, ICSID

International Development Association, IDA

International Finance Corporation, IFC

International Monetary Fund, IMF

Justice and Development Party, Adalet ve Kalkınma Partisi, AK Party

Justice and Development Party, Adalet ve Kalkınma Partisi, AKP<sup>1</sup>

Justice Party, Adalet Partisi, AP

---

<sup>1</sup> Official abbreviation of the Justice and Development Party is the AK Party. However, abbreviations of political parties in Turkey are generally the combination of the first letters of their official name. As the word “ak” means “white” implying transparency, the Justice and Development Party decided to use the AK Party, rather than the AKP. However, the opponents of the AK Party still use the AKP to refer to the Justice and Development Party.

Kurdistan Workers' Party, PKK

Labour Party of Turkey, Türkiye İşçi Partisi, TİP

Liberation Army of People of Turkey, Türkiye Halk Kurtuluş Ordusu, THKO

Ministry of Health, MoH

Motherland Party, Anavatan Partisi, ANAP

Multilateral Investment Guarantee Agency, MIGA

National Health Service, NHS

Organization for Economic Cooperation and Development, OECD

Private Finance Initiatives, PFI

Private Hospitals and Health Institutions Association, Özel Hastaneler ve Sağlık Kuruluşları Derneği, OHSAD

Progressive Youth Association, İlerici Gençlik Derneği, İGD

Public Private Partnership, PPP

Republican People's Party, Cumhuriyet Halk Partisi, CHP

Revolutionary Health Workers' Union, Devrimci Sağlık İşçileri Sendikası, DEV-SAĞLIK-İŞ

Revolutionary Path Movement, Devrimci Yol Hareketi, DEV-YOL

Revolutionary Youth, Devrimci Gençlik, DEV-GENÇ

Small and medium enterprise(s), SME(s)

Social Democratic Populist Party, Sosyal Demokrat Halkçı Parti, SHP

Social Insurances Institution, Sosyal Sigortalar Kurumu, SSK

Social Security Institution, Sosyal Güvenlik Kurumu, SGK

The Committee of Union and Progress, İttihat ve Terakki Cemiyeti, İTC

The Confederation of Progressive Trade Unions' of Turkey, Devrimci İşçi Sendikaları Konfederasyonu, DİSK

The Confederation of Public Labourers' Union, Kamu Emekçileri Sendikaları Konfederasyonu, KESK

The Confederation of Turkish Trade Unions, Türkiye İşçi Sendikaları Konfederasyonu, TÜRK-İŞ

The General Directorate of Health Project, Sağlık Projesi Genel Koordinatörlüğü, SPGK

The Pension Fund for the Self-Employed, Esnaf, Sanatkarlar ve Diğer Bağımsız Çalışanlar Sigorta Kurumu, BAĞ-KUR

The Public Hospitals Institution of Turkey, Türkiye Kamu Hastaneleri Kurumu, TKHK

The State Planning Organisation, Devlet Planlama Teşkilatı, DPT

The Turkish Confederation of Employer Associations, Türk İşverenleri Sendikaları Konfederasyonu, TİSK

The Union of Chambers of Turkish Engineers and Architects, Türk Mühendis ve Mimar Odaları Birliği, TMMOB

True Path Party, Doğru Yol Partisi, DYP

Turkish Industry and Business Association, Türk Sanayicileri ve İşadamları Derneği, TÜSİAD

Turkish Lira(s), TL

Turkish Medical Association, Türk Tabipleri Birliği, TTB

Virtue Party, Fazilet Partisi, FP

Welfare Party, Refah Partisi, RP

World Bank Group, WBG

World Bank, WB

World Health Organization, WHO

WW2, Second World War

# Chapter 1: New Politics of Health Care in Turkey

## 1.1. Introduction

Turkey's health care system has been through a significant transformation process since the launch of the Health Transformation Programme (HTP) in 2003. While the impact of the reform on different components of Turkey's health care system has been researched (Hazama, 2013; Adiyok, 2012; Ağartan, 2012; Ağartan, 2012; Baris et al., 2011; Yaşar and Uğurluoğlu, 2011; Elveren, 2008; Keyder, 2007; Üstündağ and Yoltar, 2007; Adaman, 2003) the politics of health care which paved the way for the launch of the HTP, and the political contestations and negotiations between different actors during the implementation of this reform process, have not been investigated so far. In order to address this gap in the literature, this thesis examines the politics of health care in Turkey during the launch and implementation of the HTP in the last decade.

In fact, Turkey has not been an outlier in transforming its health care system among other countries. The restructuring of health care systems has been on the agenda of the majority of governments for the last three decades. Contextual factors such as an ageing population and increasing health expenditures have been presented as the main drivers of health care reforms (i.e. Oxley and MacFarlan, 1995). While these factors might create the need for health care reform in a given country context, the mere presence of these factors cannot guarantee the introduction and implementation of reforms.

The study of the American example might support this claim. The 2000 World Health Report of the World Health Organization (WHO) ranked the American health care system 37<sup>th</sup> out of 186 countries. According to the

report, Americans spent the most on their health, yet their health care system ranked 72<sup>nd</sup> in terms of health outcomes and 54-55<sup>th</sup> in fairness in financial contribution (World Health Organization, 2000). As the report clearly demonstrates, the U.S. health care system needed a reform.

However, Skocpol demonstrates that the low performance of the American health care system did not automatically lead to a health care reform. For instance, President Clinton's attempt at comprehensive health care reform was doomed to fail (1997). It took more than a decade for the U.S. to ratify The Patient Protection and Affordable Care Act, better known as ObamaCare (Jacobs and Skocpol, 2010). Even the ratification of this reform did not guarantee its implementation. In *National Federation of Independent Business vs. Sebelius*, the United States Supreme Court upheld the powers of Congress to enact key provisions of the Act, including the compulsory health insurance requirement. As the American experience suggests, the mere existence of factors that require health care reform is not sufficient to start a health care reform process.

In cases where reform does happen, despite similar challenges including but not limited to increasing burden of health care expenditures on the public budget, the literature indicates that these reforms differ from one another in terms of the solutions they bring forward. For instance, Latin American and Southern European countries shared health care systems with similar problems, such as a lack of universal coverage, but they followed dissimilar paths in reforming their health care policies. While Spain and Greece carried out health care reforms aimed at transforming their social-insurance based health care systems into tax-financed health care systems (Petmesidou and Guillén, 2008), Argentina and Chile introduced reforms that altered the main parameters of their formerly social insurance-based health care systems into more private insurance-based systems (Barrientos and Lloyd-Sherlock, 2000). As the abovementioned studies on health care reform in different countries suggest, shared problems do not explain if the reform will be introduced at all, nor what kind of health care reform will follow.



Both cases suggest that contextual and/or structural factors do not suffice to explain the emergence and implementation of health care reforms. What factor then is missing? The missing factor is politics. Whether it is defined as “the authoritative allocation of values (valued things) for a society” (Easton, 1985, p.134) or “the study of the influence and the influential” (Lasswell, 1936, p.295), politics play a significant role in either making health care reforms possible or preventing them from happening. In cases where reform is possible, politics influence the chances of the reform being implemented and shape its content.

Despite the fact that the literature on health care policy and the welfare state seem to be relatively detached from one another, Moran rightly reminds us that health care has been the largest component of the welfare state since the end of Second World War (2000, pp.138-139). Therefore, Moran argues what happens to health care is the key for grasping what happens to the welfare state. However the existence of a strong linkage between health care and the welfare state does not suggest that the health care system is just a subset of the broader welfare system, as its direct link with the industry makes health care a theme that cannot be reduced to the welfare state (Moran, 2000, p.139). Without ignoring the strong linkages between the broader welfare state and health care policy, it should also be noted that like all welfare policies, health care policy has its own historical trajectory and set of policy actors involved (Kasza, 2002, p.282). Therefore, changes in health care policies imply alteration of the welfare state as well, yet these changes might have relatively autonomous dynamics from other changes in welfare policies.

The literature on the politics of health care (i.e. Jacobs and Skocpol, 2010; Klein, 2010; Harrison and McDonald, 2008; Giaimo, 2005; Freeman, 1999; Marmor, 1999; Skocpol, 1997; Navarro, 1994; Immergut, 1992; Alford, 1975) is also detached from the literature on welfare politics (i.e. Korpi and Palme, 2003; Rothstein and Steinmo, 2002; Baldwin, 1999; Pierson, 1996; Skocpol, 1992; Korpi, 1989; Korpi, 1980). However, both literatures approach policy reforms as critical arenas within which various actors

renegotiate political bargains that back welfare systems in general and health care systems in particular.

In line with a worldwide trend, health care reform had been on the political agenda since the late 1970s in Turkey. While significant yet limited changes were made in Turkey's health care system between the late 1970s and 2000s, fundamental health care reform was only introduced in 2003. Before the reform, Turkey's health care system relied upon a combination of social insurance based health care finance and state-led health care provision. However, both the service delivery and health care finance structure had been fragmented and failed to provide universal coverage.

The Justice and Development Party (*Adalet ve Kalkınma Partisi, AK Party*), a conservative neoliberal political party, introduced the HTP after the Party came to power as a single party government in the 2002 general elections. The three main objectives of the HTP are to increase the efficiency and the quality of health care services, to ensure cost-containment in Turkey's health care system, and to achieve universal coverage while abolishing inequalities in access (Ministry of Health of the Republic of Turkey, 2003). In light of objectives that are almost universal blueprints of contemporary health care reforms, a series of legal changes significantly altered the main pillars of the health care system in Turkey, such as financing, provision, and the regulation of health care services (Yaşar, 2011).

Today Turkey spends less than all other Organisation for Economic Cooperation and Development (OECD) members on health care services in proportion to its gross domestic product (GDP) (Organisation for Economic Co-operation and Development, 2012). However, the share of public expenditures in health care in Turkey has been higher than in other middle-income countries (OECD and World Bank, 2008, p.99).

Drawing on this health care reform experience, this research is inspired by the research agenda that Hall and Thelen suggest as follows, "the principal challenge facing analysts (of governmental reform) therefore is to identify the coalitions of social and political actors that provide the

support for a change in regulations or policy regimes and the factors motivating their support” (Hall and Thelen, 2009, p.20). Following the footsteps of the literature on the Varieties of Capitalism, Hall and Thelen argue that institutionalist perspective have the power to explain institutional change, in addition to accounting for institutional inertia (Hall and Thelen, 2009, p.21). For them, distributional concerns lie at the heart of the dynamics that drive institutional change (Hall and Thelen, 2009, p.21).

In light of the research agenda described above, this study asks the following research questions: What political dynamics enabled the introduction of health care reform in Turkey? What kind of politics did health care reform in Turkey generate? What kind of political conflicts arose among different actors over the reform? How and to whose benefit have these conflicts been resolved?

## **1.2. The contribution and significance of the study**

The literature on the politics of health care is skewed towards the economically developed countries of Western Europe and North America (i.e. Klein, 2010; Jacobs and Skocpol, 2010; Ham, 2009; Çalıkoğlu, 2008; Hassenteufel and Palier, 2007; Rothgang et al., 2005; Lister, 2005; Giaimo, 2005; Batley, 2004; Freeman, 1999; Marmor, 1999; Moran, 1999; Giaimo and Manow, 1999; Wessen, 1999; Freeman, 1998; Immergut, 1992; Moran, 1992; Alford, 1975). However, the literature on health care reform in developing countries concentrates on the results of health care reforms on access and coverage while leaving the politics of health care that leads to reform and during the reform process under-researched (i.e. Dannreuther and Gideon, 2008; Petmesidou and Guillén, 2008; Lloyd-Sherlock, 2006; Muntaner et al., 2006; Lloyd-Sherlock, 2005; Homedes and Ugalde, 2005; Guillén and Palier, 2004; Laurell, 2001; Barrientos and Lloyd-Sherlock, 2000; Berman and Bossert, 2000; Schieber and Maeda, 1999; Sen and Koivusalo, 1998; Reich, 1995). The literature on health care reform in

developing countries tends to underestimate the role of domestic political actors (including the government) and the interplay between global and domestic actors, and overestimate the impact of global players on the reforms.

Therefore, the originality of this work derives from the original empirical knowledge it seeks to produce on the politics of health care that paved the way to the introduction and implementation of a specific health care reform in a developing country context. I believe that this study on the politics of health care reform experience in the Turkish context is a significant contribution to the literature, as the literature on this topic has been skewed towards Western European and North American countries.

Indeed, Turkey's recent experience of health care reform attracted immense scholarly attention. Research on the health care reform experience of Turkey has generally focused on the impacts of the reform on access, coverage and the working conditions of medical doctors (i.e. Hazama, 2013; Adiyok, 2012; Çarkoğlu and Kalaycıoğlu, 2012; Ağartan, 2012; Belek, 2012; Demirci, 2012; Barış et al., 2011; Sönmez, 2011; Yaşar, 2011; Yaşar and Uğurluoğlu, 2011; Erus and Aktakke, 2010; Uçku and Elçi, 2010; Teksöz et al., 2009; OECD and World Bank, 2008; Kılıç, 2008; Pala, 2007; Soyer, 2007; Soyer, 2004).

Ağartan has been the only scholar that has examined the politics of current health care reform in Turkey so far (Ağartan, 2008; 2007). Ağartan briefly underlines the significant role of the expert network or the government's change team, which is discussed in detail in the following chapters, in the preparation of Turkey's health care reform. While Ağartan's contribution has been significant, her study suffers from two shortcomings. First, her work does not examine the contestations and negotiations between different political actors over the reform period, with the exception of her emphasis upon the change team. Second, her findings do not cover the period after 2008. Several important dimensions of the health care reform process were not completed by 2008, and quite important political clashes occurred after 2008.

With the objective of addressing this gap in the literature, this study offers a detailed description as well as an analysis of the health care politics throughout the HTP. While this study does not claim the power of generalizability to other country contexts, I believe it has the power to contribute to the broader understanding of the changing political foundations of Turkey's welfare system. Last but not least, this study offers insight into the explanatory power of different approaches in the politics of health care and the politics of social policies in developing country contexts.

### **1.3. Methodology**

This thesis is an example of a historically grounded, qualitative single-country case study. As mentioned in the earlier section, scholarly approaches to the politics of health care and welfare have been informed mainly by the Western European and North American experiences so far. Therefore, the main methodological problem in this study might be to apply these approaches to another geography with a different historical legacy. In order to compensate for this possible dissonance between the case and approaches, the study methodologically draws on the insights from Historical Institutionalism. In his work on the social policy regimes in the developing world, Gough argues that Historical Institutionalism, as “a middle way between teleological or functionalist approaches (both modernisation and Marxist) on the one hand, and post-modern approaches emphasising uniqueness and diversity on the other” (2004, p.240). Using Gough's insight might compensate for the possible dissonance between the case and approaches that were developed from the analysis of cases significantly different from this case under investigation.

Historical Institutionalism perspective suggests that the historical legacy of a given country has a decisive influence upon the contemporary form of its politics as well as prospects for political and policy changes. At its most extreme form, Historical Institutionalism—when accounting for the main political factors that shape reform—generally attributes the

primary agency to the political economic legacy of the country and its institutions (i.e. the argument about ‘veto points’ in Immergut, 1992).

While the focus of Historical Institutionalism is on the influence of history and institutions on policy outcomes and political dynamics, this focus has not led scholars using this approach to disregard the agency of actors to initiate political change. Scholars working within Historical Institutionalism aim to examine how power struggles have been mediated and framed by a particular historical and institutional context, and how these struggles change that context at the same time (i.e. Rothstein and Steinmo, 2002; Hall and Taylor, 1996). Therefore, scholars working within Historical Institutionalism primarily study the interaction between man-made institutional structures and agency, without disregarding how and to what extent the options of the latter have been restricted by the former.

This research employs Historical Institutionalism with the objective of integrating the political and economic legacy and health care system legacy of Turkey into the actor-based analysis of the politics of contemporary health care reform. This thesis takes a more critical stance with respect to purely institutionalist arguments and intends to keep Historical Institutionalism as a way of bringing history and institutions into the final analysis without discrediting the impact of actual political struggles between existing political actors. Following the footsteps of scholars of historically informed qualitative political science, I developed the analysis by creating linkages between the empirical data and the broader socio-cultural, economic and political frameworks (Vromen, 2010, p.264).

#### **1.4. Methods**

This study relies upon qualitative research methods. Qualitative research methods have been selected on the basis of their ability to capture the multi-layered and complex nature of health care reform processes (Caronna, 2010, p.71) and the politics of health care, which includes alterations in the power structure, subjective interpretations of the process

by major actors, and changes to the formal and informal rules that operate in the health service domain.

Qualitative methods in general (Vromen, 2010) and case study research in particular are established approaches in the studies of political processes (Yanow et al., 2010). The benefit of using qualitative methods and the case study method in this research is to integrate both historical insight and the personal reflections of actors involved in the institutions, events, or processes that are under investigation (Vromen, 2010, p.249). The practical benefit of using a case study lies in the possibility of combining different qualitative methods such as in-depth interviews and documentary analysis to understand the intensity of lived human experience (Yanow et al., 2010, p.109).

It is a well-known fact that scholars who generate and use large-scale quantitative data generally contest the validity and reliability of case study results. Flyvbjerg summarises well-known critiques of the case study method under five headings: the limited use of context independent knowledge, the lack of generalizability in case study research, the suitability of case research for generating a hypothesis rather than testing it, the tendency of a case study to verify the hypothesis of the researcher, and the inappropriateness of case study to develop general propositions or theoretical conclusions (2006, p.221).

All of these critiques originate from a positivist take on approaching social and political issues. The majority of scholars who produce case studies using qualitative methods, however, do not share these positivist assumptions. I am convinced that the strength of social sciences lies in its ability to produce context-dependent explanation and rich knowledge (Vromen, 2010, p.257) rather than exploring the 'objective' laws of the society and politics as well as making predictions about the future (Flyvbjerg, 2006, p.223).

The criteria for selecting informants in case study research do not follow the logic of random selection in quantitative methods. In case study research, cases are selected with respect to the researcher's expectation

about what kind of knowledge this particular case can probably generate (Vromen, 2010, p.259; Flyvbjerg, 2006, p.230). In this regard, case study method has always been open to the subjectivity of the researcher. The subjective element in case study research, however, has not been dissimilar to the hidden subjectivity in quantitative research, in which scholars construct categories and variables with which they conduct research and make analysis (Flyvbjerg, 2006, p.235).

This research relies upon in-depth interviews and desk research. Desk research covered the review of literature on politics and health care policies in Turkey. I reviewed all major legislative documents, reports, position papers, and media stories on health care reform. In-depth interviews were conducted with the representatives of main political actors (i.e. the AK Party, the WB, Turkish Medical Association (*Türk Tabipleri Birliği, TTB*) and private health care provider organisations) and state institutions (Social Security Institution (*Sosyal Güvenlik Kurumu, SGK*) and the Ministry of Health (*MoH*)) in order to gain insight to the power struggle on particular junctures and issues. This research did not collect original data from patients. However, findings from public opinion surveys that investigate the abovementioned themes are used instead.

## **1.5. Fieldwork**

I conducted 33 face-to-face in-depth interviews mainly in Ankara and İstanbul. The majority of the interviews were conducted between August 2011 and December 2011. Interviewees were divided into two groups. The first group included members of the reform team, key bureaucrats in the MoH and the SGK, and the WB experts. The second group of interviewees included representatives from different political organisations involved in health care politics. This group was composed of executives from private health care provider organisations, the leading cadre of the TTB and trade unions organised in the domain of health care services and politically engaged experts of health care policies.



Arranging face-to-face interviews with people who hold key positions is not always an easy task. For interviewees who could not be reached, I employed an alternative strategy of organising academic workshops on health care reform in Turkey and inviting key people (with whom the researcher might not succeed in conducting interviews otherwise) to give public speeches at these workshops. In doing so, the researcher organised a workshop<sup>2</sup> and co-organised two panels.<sup>3</sup> This strategy proved to be successful as the author managed to get the accounts of three people holding key positions in the first workshop and an additional three people in the second workshop via their presentations. In addition, the researcher collected additional information by attending conferences and workshops of medical associations and exchanging ideas with medical doctors and activists at those conferences.<sup>4</sup>

## 1.6. Limitations

Two dimensions of health care policies and politics lie beyond the scope of this research: the provision of primary health care services and the regulation of pharmaceutical sector. While primary health care services have been an important part of the HTP, the major impacts of changes in primary health care services will lend itself to empirical research in the long run. Given the fact that the HTP failed to introduce the referral system that would make the health care provision into a unified delivery system, it became possible to focus on secondary and tertiary health care services without analysing the changes in primary health care services. Second, the regulation of the pharmaceutical sector has been left outside the scope of

---

<sup>2</sup> “Transformation of Turkey’s Health System” on November 25, 2011 in Bogazici University, Istanbul. I would like to thank Boğaziçi University Social Policy Forum and Friedrich Ebert Stiftung Istanbul for their support.

<sup>3</sup> “Turkey’s Health Care Reform and Its Critiques,” 7<sup>th</sup> National Congress of Bioethics on October 13, 2012.

<sup>4</sup> Crisis of Capitalism and Health, organised by International Association of Health Policies and Turkish Medical Association, Ankara, October 2011; Transformation and Changes in Health Care, Çukurova Scholars Association, February 2013; National Congress of Turkish Thoracic Society, Antalya, April 2013.

this research because it is the only domain that has not been directly affected by the HTP.

Another source of limitation in this research project may derive from the selection of Ankara, İstanbul, Samsun, İzmir and Adana as the main field sites. All of these cities are metropolitan cities in Turkey. While Ankara was selected as the capital city, all the other cities were selected because they are home to all three types of major actors in health care delivery: public, university and private hospitals. Due to this selection of field sites, conclusions drawn from this research might not include sufficient input from political actors in smaller cities. However, due to the centralised structure of the Turkey's political system, it would not be erroneous to assume that the impact of political actors in smaller cities would be limited.

## **1.7. Ethical considerations**

The Ethics Committee of the University of Leeds reviewed and granted a favourable opinion to this research. Informed consent was taken from all informants through the use of participant consent forms and information about the research was provided in Turkish. This research did not involve informants from vulnerable groups and did not include sensitive issues that might put undue stress upon informants. The researcher used an audio recorder only when the informant agreed. In cases where the informant did not wish the researcher to record the interview, the researcher took extensive notes during and after the interview. The data generated by interviews was anonymised with the method of assigning numbers in line with the chronology of interviews (i.e. Interview no. 30).

This research was conducted in Turkey. However, given that the working language of the research is also the researcher's native language, no translators were used. No inducements were provided to the informants. The main objectives of the research were transparent to the informants. No data was disclosed to the authorities. The researcher did not come across

any situation such as the discovery of any form of a criminal offense and/or the possibility of physical and psychological harm to other people. This research included at least one informant from all organised social actors that represent the reform team, the WB experts, trade unions organised in health care services, the medical profession, and the private hospital sector.

The data generated in this research has been kept secure. The general rules of information security in social science research, which are confidentiality, integrity and availability, were followed. The main data to be secured in this research was the audio recordings of the interviews with state officials, representatives of organised interest groups, and medical doctors. Audio recordings of these interviews were kept in the researcher's space in the university's LUTube, and the researcher's personal external hard drive. Access to audio recordings was restricted to the researcher in LUTube. The University's secure Remote and Mobile Access Service was used to upload the audio recordings immediately after the completion of the interviews. Audio recordings were kept encrypted in the researcher's personal external drive. Audio recordings of interviews will be kept for two years after the completion of the Ph.D. degree. After the completion of the degree, the data will be kept encrypted in the personal external hard drive of the researcher.

## **1.8. The organisation of chapters**

This thesis is organised into nine chapters. Following this introductory chapter, the second chapter reviews the literature on the politics of health care in order to set out the main theoretical framework and key approaches that are used in the analysis. The third chapter describes the historical legacy of Turkey's health care system against the background of Turkish politics, upon which the HTP was introduced. The fourth chapter examines the HTP within the context of health care reforms in selected developing countries. The fifth chapter addresses the role of the WB in Turkey's health care reform in order to understand how and to what extent the global health

reform agenda could make its way into Turkey's health care system. Following this, the sixth chapter investigates the AK Party's impact on health care reform. The seventh chapter examines the role of the TTB during the reform. The eighth chapter investigates the emergence and the role of private health care provider organisations during the reform process. The conclusion chapter offers insight into the political dynamics that made the HTP possible, and the impact of these dynamics upon the content of the reform. The conclusion also analyses how reform changed the power dynamics between different actors by investigating the political conflicts that arose during the health care reform process.

## **Chapter 2: The Politics of Health Care: A Critical Review of Literature**

### **2.1. Introduction**

Health care reform in Turkey has been a platform for critical contestations as well as alliances among different actors including the AK Party, the WB, the TTB and private health care provider organisations. For instance, after the British Medical Journal published the article titled “Healthcare in Turkey: From Laggard to Leader” (Barış et al., 2011), a number of responses appeared in the same journal and painted a pessimistic picture of Turkey’s post-reform health care system (i.e. Civaner, 2011). Such a debate, visible in the British Medical Journal alone, is just one manifestation of the heated political conflicts that have come about since the introduction of the HTP in 2003. The health care reform in Turkey has not been the only one to cause significant conflicts. Both ObamaCare in the U.S. and the reform of the National Health Service (NHS) in Britain generated similar political conflicts that are still present.

How can we understand these political conflicts in health care today? What is at stake and for whom? With the objective of providing a sound approach to examining these questions, this chapter is divided into five major sections and a conclusion. The second section presents the historical foundations of health care policy. The third section presents the main characteristics of modern health care systems before the emergence of a worldwide reform trend in the late 1970s and early 1980s and situates the health care system in Turkey within a comparative framework. The fourth section lays out the debate among contesting scholarly approaches to health care politics. The aim here is to demonstrate the content of the political nature of debates around health care by introducing different theoretical takes on the question of how health care should be treated in today’s societies. Drawing on the theoretical debates with respect to the status of health care in contemporary societies, the fifth section discusses the context

within which health care reforms have come to the political agenda in different countries after 1970s. The main objective of the fifth section is to set the political economic scene within which the health care reforms emerged and to introduce the main concepts that have been widely used in explaining the reform-led changes in health care systems. Last but not least, the sixth section reviews different approaches to the study of politics of health care in particular and the politics of welfare in general.

## **2.2. A short history of health care policy**

Public health measures are considered to be the first form of health care policy. Modern states initially developed these measures in the 18<sup>th</sup> and 19<sup>th</sup> centuries to combat communicable diseases, which were then the major cause of death in societies during the advent of industrial capitalism (Rosen, 1993).

Three contesting explanations have been provided in the literature to account for the political dynamics that have contributed to the development of public health measures. The first one suggests that public health measures came about in order to ensure the well being of labourers, as they were considered to be an important infrastructure of capitalist production (Navarro, 1976, p.197). The second explanation identifies public health measures with the genesis of a new logic of government, or ‘governmentality’, which centres its power base upon the regulation of the lives of the population at large (Foucault, 1991). The third explanation suggests that public health measures were developed thanks to the political reaction of organised labour against the social costs of capitalism (Leys, 2010, p.5). Leys argues that public health measures emerged “in spite of capitalism as much as because of it” (2010, p.2).

Public health measures introduced after the rise of industrial capitalism proved their effectiveness by increasing life expectancy and eliminating communicable diseases in most countries throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries. In these countries, non-communicable diseases replaced

communicable diseases as the prominent cause of health problems and death. The shift in medical needs of societies from the elimination of communicable diseases to the treatment of non-communicable diseases is commonly referred to as ‘epidemiological transition’ (Leys, 2010, p.2).

In contemporary societies, the role of preventive care has been restricted to a marginal subsector within health care services.<sup>5</sup> Preventive care is commonly associated with primary care services such as ambulatory care, visits to general practitioners, and/or health posts and centres. Health care services today have mainly taken the form of curative health care, which is associated with large hospital complexes, specialists, health technology and medications (Blank and Burau, 2010, p.18).<sup>6</sup> In this context, health care policy refers to the courses of action pursued by the governments with respect to the financing, regulation and provision of public health as well as curative health care services in a given country (Blank and Burau, 2010, p.2).<sup>7</sup>

---

<sup>5</sup> Increasing prioritisation of curative health care services over preventive health care services in last century has been harshly criticised in the literature (i.e. Navarro, 1976, pp.19-20).

<sup>6</sup> This dominance of curative health care in contemporary societies originates from the “therapeutic revolution” in Western medicine. Therapeutic revolution is known as the transformation of the dominant paradigm in medicine due to the genesis of the germ theory of disease, which promotes the idea that “each disease had a well-defined cause and its control could best be achieved by attacking the causative agent or if this was not possible, by focusing treatment on the affected part of the body.” See: DUBOS, R. J. 1987. *Mirage of Health: Utopias, Progress and Biological Change*, New Jersey, Rutgers University Press. Scholars argue that there is both an economic and ideological elective affinity between germ theory of disease and capitalism, which together culminated into the dominance of curative health care. See: NAVARRO, V. 1976. *Social Class, Political Power, and the State: Their Implications in Medicine. Medicine Under Capitalism*. New York and London: Prodist and Croom Helm, DOYAL, L. & PENNELL, I. 1994. *The Political Economy of Health*, London, Pluto Press.

<sup>7</sup> Health care policy could be defined as a subset of health policy. See: WALT, G. 1994. *Health Policy: An Introduction to Process and Power*, Johannesburg: Witwatersrand University Press, London and New Jersey: Zed Books, MORAN, M. 1999. *Governing the Health Care State: A Comparative Study of the United Kingdom, the United States and Germany*, Manchester and New York, Manchester University Press. Health policy is a term that refers to the whole set of policies that directly or indirectly affects the well being of individuals and the environment in which individuals live. In other words, as Blank and Burau put it, health policy could be defined as any policy action that has health implications. See: BLANK, R. H. & BURAU, V. 2010. *Comparative Health Policy*, Hampshire, Palgrave Macmillan, *ibid*. According to this definition, health policy includes wide range of policy domains from urban planning to consumer protection. In line with these broad policy domains that health policy refers to, the literature on health policy addresses relationships between the wellbeing of societies and a wide range of other factors

Widespread production and consumption of curative health services dates back to the emergence of health insurance in 19<sup>th</sup> century Germany, when Chancellor Bismarck introduced pensions and health insurance programmes in order to appease workers who were mobilised by socialist ideas.

After the Second World War, this trend became more popular. The welfare states<sup>8</sup> of Western Europe and some developing countries (including former socialist bloc countries under the Union of Soviet Socialist Republics) played a critical role in giving shape to the health care policies, as we know them today. The consolidation of welfare states affected health care policy in two fundamental ways. First, welfare states had been committed to make curative medicine accessible to society at large. Indeed, all member states of the Organisation for Economic Co-operation and Development (OECD), with the exception of the US, succeeded in providing nearly universal access to almost free health care for their citizens.<sup>9</sup>

Second, welfare states contributed to the creation of an immense health care industry, including the pharmaceutical sector and health technology controlled by the private sector (Moran, 1999, pp.177-178). Welfare states also opened up a pathway for greater employment in the

---

such as environment, demography, and social inequalities. See: WILKINSON, R. & PICKETT, K. 2010. *The Spirit Level: Why Equality is Better for Everyone*, London, Penguin Books.

<sup>8</sup> Welfare state generally refers to the state “which intervenes within the processes of economic reproduction and distribution to reallocate life chances between individuals and/or classes.” See. PIERSON, C. 1991. *Beyond the Welfare State? The New Political Economy of Welfare*, Pennsylvania, The Pennsylvania State University Press.

<sup>9</sup> The level of health care expenditures in countries is in positive correlation with the level of GDP per capita. The higher the country’s GDP per capita, the more it spends on health care. See: WALL, A. 1996. Conclusion. In: WALL, A. (ed.) *Health Care Systems in Liberal Democracies*. London and New York: Routledge, MORAN, M. 1999. *Governing the Health Care State: A Comparative Study of the United Kingdom, the United States and Germany*, Manchester and New York, Manchester University Press, BLANK, R. H. & BURAU, V. 2010. *Comparative Health Policy*, Hampshire, Palgrave Macmillan.

Comparative studies of health expenditures in countries with similar levels of GDP per capita, however, demonstrate that the levels of health care expenditures in these countries display a significant variation, which led to the growth of health care system typologies debate that I will discuss later in this chapter. See: WALL, A. 1996. Conclusion. In: WALL, A. (ed.) *Health Care Systems in Liberal Democracies*. London and New York: Routledge, WENDT, C., FRISINA, L. & ROTHGANG, H. 2009. Healthcare System Types: A Conceptual Framework for Comparison. *Social Policy & Administration*, 43, 70-90.



public sector (Leys, 2010, p.11). Through these mechanisms, welfare states acted as the primary engine behind the dramatic growth in the health care economy after the Second World War (Moran, 1999, pp.2-3), which has now become one of the largest sectors of the global economy.

### **2.3. Is health care a commodity?**

Like in all other cases of institutional change (Hall and Thelen, 2009, p.21), distributional concerns, or the classic “who gets what” question, lie at the heart of health care politics. This section aims to look at the common assumptions that feed into the political debates around health care, and will also introduce different theoretical takes on the question of how health care should be treated in today’s societies.

Although health care remains both a commodity and a right in the majority of countries today, neither notion is complete. Here commodity is defined as a thing that is being bought and sold by means of exchange which satisfies human want one way or another (Marx, 2008, pp.13-50).<sup>10</sup>

Is health care a commodity today? From one perspective, the products of the health industry, including health technologies and pharmaceuticals, have long been global commodities. Rising medical tourism and increasing foreign direct investment in health care services, along with a greater movement of medical doctors across borders, would suggest that health care service provision is also becoming a global commodity. The transnationalisation of health care services accelerated after the ratification of the World Trade Organisation’s General Agreement on Trade in Services (GATS) and other regional conventions (Blank and Burau, 2010, p.8; Sexton, 2003, pp.39-40). More recently, The Transatlantic Trade and Investment Partnership (TTIP) that the European Commission negotiates

---

<sup>10</sup> Things gain meaning due to their use-values for human beings. These things that are of use for human beings start to bear an exchange-value when they stand in relation to each other. Imaginary construct that brings commodities in relation to each other is the idea of market.

with the United States of America poses a threat to the future sustainability of the UK's National Health Service, as it opens up health care market to transnational companies without leaving any room for national governments to put restrictions on the commodification of health care services (Patients4NHS, 2014). In this regard, it could be suggested that the ratification of the TTIP, in case it happens, would increase the commodification of health care delivery.

The establishment of health care as a right refers to the legal codification and implementation of the 'decommodification of health care,' that is the extent to which individuals' access to health care is not dependent upon their market position and "the extent to which a country's provision of health is independent from the market" (Bambra, 2005b, p.33). In fact, health care systems in different countries substantively restrict the commodification of health care by undertaking or regulating the finance, production and consumption of health care services. Taking both perspectives into account, it could be argued that the commodity status of health care is not fully formed, and the idea itself remains highly contested due to high levels of state regulation and/or involvement aimed at restricting the commodification of health care.

The rise of health economics both popularised the use of economics discourse in the health care domain and contributed to the understanding and making of health care as a commodity. Fuchs succinctly summarises universal assumptions of the health economics approach (1996, p.3). According to Fuchs, health economics has three main assumptions: scarcity, substitutability, and heterogeneity. Scarcity here refers to the scarcity of resources. Substitutability refers to the idea that investing in health care has an opportunity cost of not investing in another domain. By heterogeneity, Fuchs emphasises the availability of alternative medical interventions for any health problem (1996, p.4).

Health economics suggests that the uncertainty of demand for health care makes it a candidate for an insurance market (Appleby, 1998, p.39; Ranade, 1998, p.3). For health economists, a tax-financed health care

system that provides free health care at the point of service is doomed to suffer from the problem of moral hazard (Arrow, 1963, pp.961-962). The problem of moral hazard refers to the tendency of individuals to consume a good or a service more than they need to when they are not paying for the service themselves (Appleby, 1998, p.39). From the perspective of health economists, moral hazard becomes much more acute in the case of state-organised health insurance; the system removes all incentives to economise not only for patients, but also for medical doctors. According to health economics, the best model for allocating health care services in a society is market distribution.

Health economics was not left unchallenged (i.e. Mooney, 2009). For instance, Blank and Burau argue that perfect knowledge is not available to the consumer of health care services. Therefore, a consumer makes his/her decisions with limited knowledge and relies mainly on the medical doctor's expertise. Second, the consumer of health care services does not know the value and costs of goods and services that he/she considers purchasing. This lack of price knowledge disempowers him/her as a consumer. Last, consumers may not be able to receive the full value of goods and services that he/she buys due to the unpredictability of the efficacy of medical treatment (Blank and Burau, 2010, pp.107-108). Therefore, Blank and Burau argue that, pure market solutions in health care cannot serve the service recipients. Others claim that the exchange value of health care becomes unaffordable at times when it is urgently needed and when its use value for the service recipient is the greatest (Lister, 2005, p.98; Skocpol, 1997, p.17). These assertions are especially valid, as only the very rich can purchase high-technology health care on the spot (Moran, 2000, p.141). As these assertions suggest, it could be argued that the health economics approach totally ignores distributional questions in health care policy (Evans, 1997, p.463).

Despite these criticisms, the health economics approach has become the dominant paradigm in policy circles since late 1970s. International organisations such as the WB and the OECD popularised the health

economics approach in developing countries (Freeman, 1998, p.398). Part of an international ‘epistemic community,’ health economists have been in charge of preparing most health care reform projects and therefore their assumptions have constituted the bedrock of these projects (Appleby, 1998, p.35). More importantly, health economics engendered ‘policy paradigm’, which is defined as the taken-for-granted “framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing” (Hall, 1993, p.279), that has shaped how different actors perceive health care. In this paradigm, previous terminology on health care policies changes significantly: patients become consumers, managers become necessary actors whose intention is to ensure consumer satisfaction and service efficiency, and medical doctors become unreliable providers whose practice should be closely regulated (Irvine, 2002, pp.31-38). Meanwhile, universalist health care systems in Western Europe, which used to be the vantage point for reform in developing countries and in the US before the rise of neoliberalism, have been undermined ideologically; the US modified market model has emerged as the preferred source of inspiration in health care policy (Moran, 1998, pp.18-19).

## **2.4. Health care reform under neoliberalism**

The increasing popularity of health economics after the early 1970s and the rise of health care reform in the political agenda was not a coincidence. Neoliberalism, a new powerful political project, emerged as a response to the oil crises in early 1970s and the contraction of profit margins worldwide. As a political project, neoliberalism “proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (Harvey, 2005, p.2). Neoliberalism is better understood as “a historically specific, on going,

and internally contradictory process of market-driven socio-spatial transformation, rather than as a fully actualised policy regime, ideological form, or regulatory framework” (Brenner and Theodore, 2002, p.353).

Neoliberalism promotes five key ideas: confidence in the market as the most efficient way of allocating resources; the necessity of establishing a global free trade regime; the desirability of a state as a facilitator rather than as a substitute or alternative to the market; the need to subordinate fiscal to monetary policy to introduce budget discipline; and the necessity to institute flexible labour markets by lowering labour costs and social policy disincentives to market participation (Hay, 2004, pp.507-508). In its early phase, neoliberalism appeared as an overtly ideological project; over time, neoliberalism gradually became a technocratic and seemingly apolitical *modus operandi* (Hay, 2004, pp.511-518).

What does neoliberalism mean for health care? In line with its premise summarised above, the neoliberal project aimed to deepen health care markets where they already existed, and to establish new health care markets where there were none before. It could be argued that neoliberal health care reforms generally rely upon a combination of four dynamics, which are not mutually exclusive, explained below. These dynamics are privatisation, marketization, commercialisation and economisation.

Privatisation refers to a policy direction that promotes more reliance on the private sector and the non-profit sector to an extent, and less on the state in any domain of the economy. Privatisation can appear in three forms. The first one is to reduce the state’s role in producing goods and services and/or state ownership and to transfer this role and ownership to private hands. Second, privatisation can be put into practice by allowing the private sector to increase its shares in the production of goods and services and in the ownership of property vis-à-vis the public sector (Savas, 2000, pp.3-4). The first route for privatisation is politically contentious, especially in welfare domains such as health care policy. Governments can pursue the second route to privatisation as a long-term agenda in order to avoid political conflicts. In addition to these forms of privatisation, public-private

partnerships can also be considered a form of privatisation. Public-private partnerships broadly refer to arrangements between the state and the private sector that delegate formerly public responsibilities to the private sector (Savas, 2000, p.4).

Another common pillar of contemporary health care reforms is marketization. Marketization can be defined as a policy paradigm aimed at redesigning a policy domain in the image of the idea of a market. In the domain of health care, the main objective of marketization is to establish a competition-based health care market in which the demand and supply of services belongs to different parties (Ewert, 2009, pp.23-24). Ideologically, the discourse on marketization of health care services prioritises consumer choice, innovation in health technologies, 'value for money' and diversification of health care services over the provision of equal benefit packages of health care services for all citizens. According to the marketization paradigm, the role of the state should be limited to the regulation of markets.

However, especially in state-dominated health care systems, the retrenchment of the role of state to regulation is not an easy task in the short run. Therefore, the marketization paradigm is generally put into practice through the introduction of 'quasi-markets' in the domains of welfare services. Quasi-markets broadly refer to the policy arrangements in which the state ceases to be a provider and funder of welfare services and starts to purchase these services from a competitive market through mechanisms such as bidding (Le Grand, 1991, p.1257). Quasi-markets are labelled as 'quasi' due to their two distinct features: first, service providers in quasi-markets may include private actors as well as non-profit third sector and public actors who compete with each other for attracting consumer demand. A second feature of quasi-markets is that consumers are not always free individuals who are authorised to make autonomous consumption decisions. They are either represented by a third party actor or a 'sponsor' who purchases services on their behalf or selects services from a pre-determined portfolio of providers (Enthoven, 1993, pp.29-30; Le

Grand, 1991, pp.1259-1260). For example, in line with Enthoven's policy suggestions for the UK (1993), quasi-markets in health care were primarily established in the NHS in 1991 (Ranade, 1994, p.63), to ascertain efficiency and promote consumer choice (Appleby, 1998, p.34).

A third dynamic that neoliberal health care reforms generate is commercialisation. Commercialisation in health care services is defined as "the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them, for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance" (Mackintosh and Koivusalo, 2005, pp.3-4). Mackintosh and Koivusalo suggest that the concept of commercialisation can have a wider meaning that encompasses the processes of privatisation and marketization but is not limited to them. In their approach, the commercialisation of health care services represents the commodification of health care in general.

Neoliberal health care reforms can also lead to economisation. Economisation can be defined as a policy approach that aims to establish efficient distribution of limited resources; however, it does not automatically imply the processes of privatisation, marketization and commercialisation. Economisation emphasises the scarcity of the state's financial resources and other resources to be spent for health care services. On the basis of these assumptions, economisation in the domain of health care generally refers to the introduction of different mechanisms targeting cost-containment and/or better allocation of health care resources. These policies involve the restructuring of public health care services in order to ensure efficiency and value for money (Ewert, 2009, pp.23-24).

The need for cost-containment has made priority setting in health care a critical issue (Blank and Burau, 2010, p.111) and is commonly known as health care rationing. Rationing, which is part of the economisation dynamic, refers to various sets of restrictions on eligibility, delay, deterrence and deflection (Wall, 1996, p.192). While rationing has always

been part of health care systems even before the age of neoliberalism, the distinctiveness of neoliberal-inspired rationing lies in its reliance upon market mechanisms that are considered to be the best form of rationing.

Economisation generally manifested itself in the form of 'New Public Management' (NPM) reforms. The UK was the first country to initiate NPM measures, and this paradigm then spread to other countries (Lane, 2000, p.3). Inspired by strong public sector criticism from the public choice school and the Chicago school of economics, NPM reforms imported management techniques from the private sector into the public sector (Ferlie et al., 1996, p.9). This idea originated from the belief that management tasks in the public and private sectors are similar and therefore best undertaken through the use of private sector managerial expertise (Ranade, 1994, p.90). Some of the best known examples of NPM mechanisms include: total quality management applications, the establishment of autonomous expert bodies in various domains of public policy, decentralised budgeting and management, managerial control and accountability tools, assessment of organisational efficiency based on input-output comparisons, and productivity-linked rewards and financing applications (Harrison, 2004, pp.173-174).

Neoliberal health care reforms generally introduce a combination of the dynamics explained above. However, in light of Brenner and Theodore's conceptualisation of 'actually existing neoliberalism' (2002) it should be noted that these reforms might be subjected to significant modifications as a result of the contestations and negotiations between different political actors in countries undertaking these reforms. Different approaches to the politics of health care are explained below in order to examine these contestations and negotiations over health care reforms.

## **2.5. The politics of health care: Different approaches**

Whether politics is the leading factor for the emergence of modern health care systems and contemporary health care reforms remains a



contested issue. As noted earlier, several factors were important in providing the necessary conditions for the emergence of neoliberal health care reforms, including the budgetary crisis of the modern state; drastic rises in the cost of health care services, and the dramatic increase in demand for health care services. However, studies increasingly demonstrate that the politics constitute at least an important factor that affect the possibilities of the enactment, implementation, and content of health care reforms (i.e. Millar et al., 2013; Bhatia and Coleman, 2003; Chinitz, 1995).

For instance, Baldwin suggests that broader economic dynamics might create a need for the development of social policies that have to perform some social functions. However, he emphasises the fact that social policies generally go beyond this minimal function. In addition, countries formulate different social policies to deal with common social problems (Baldwin, 1999, p.5). Skocpol also agrees with the idea that long-term or structural factors, such as the level of industrialisation or the budgetary crisis of the modern state, might constitute necessary yet insufficient reasons for the emergence of the welfare state and/or different sorts of social policies. While long-term or structural factors might introduce new controversial issues and produce new social groups, Skocpol underlines that they determine neither the patterns of politics nor the policy outcomes (1992, pp.13-14). Korpi's power resources approach also suggests that while industrialisation led to the emergence of organised labour, the political attempts of organised labour were the main factor that led to the creation of welfare states and social policies (Korpi, 1980, pp.296-297).

Therefore, both the genesis and alteration of social policies have a significant political component to them. How are we going to understand this political component? There are as many approaches to the politics of health care as there are to politics in general. For the purpose of this study, I would like to review the most dominant approaches to the politics of health care, as these approaches have inspired seminal works on the issue. The

four major approaches include: the pluralist, the power resources, the institutionalist, and the new politics approach.

### **2.5.1. The pluralist approach**

The pluralist approach to the politics of health care might be considered the application of a classical liberal perspective on health care politics. Schmitter defines pluralism, in direct contrast to corporatism, as follows:

“A system of interest representation in which the constituent units are organized into an unspecified number of multiple, voluntary, competitive, non-hierarchically ordered and self-determined (as to type and scope of interest) categories which are not specially licensed, recognized, subsidized, created or otherwise controlled in leadership selection or interest articulation by the state and which do not exercise monopoly of representational activity within their respective categories” (Schmitter, 1976, p.96).

As the quote above suggests, pluralism understands politics as a marketplace of ideas and actors competing with one another. It could be suggested that the pluralist approach relies upon three general assumptions. First, the pluralist approach presents the political domain and the economic domain as separate and limits the political domain to activities within formal political institutions. Despite the separation of these domains, the pluralist approach suggests that all actors including political actors are self-interested; however, the self-interest of political actors is defined within the limits of politics. Therefore, according to the pluralist approach, politics is mainly interest-group politics. The third assumption of the pluralist approach is that society can be understood as a free marketplace of ideas: individuals can express their preferences in general elections or can organise along with their own interests and lobby those in power.

To exemplify, Chinitz provides an example of the application of pluralist approach in analysis of health care politics in Israel. He suggests that the pluralist democratic system of Israel made the rise of a powerful government possible, which led to a non-incremental change in health care insurance policy of the country in spite of the traditional opposition of the labour federation and the Labour Party (Chinitz, 1995, p.923).

According to the critiques of the pluralist approach, the main problem of this approach lies in its assumption that power is evenly distributed in societies. Nevertheless, political groups have different capacities and these changes the prospects of different political groups to influence the political outcomes (Giaino, 2005, p.196). As Navarro's study indicates, what the majority thinks on a particular topic might not be sufficient to change policies accordingly. Navarro argues that the U.S. has long been an example in which public opinion on health care policy was not in favour of the status quo in health care policies, yet the popular idea did not resonate at the political level (1994, p.173). In addition, as Alford successfully discovers, there might also be 'repressed structural interests,' which refer to the interests of sectors of society that have not been served by a social institution or political mechanism (Alford, 1975, p.15). Therefore, these critiques suggest that the pluralist approach to politics is fallacious in grasping how politics operate within the context of unequal power relations.

Despite the theoretical strength of its critiques, it could be argued that it is not easy for researchers to escape the pluralist approach to politics. Empirical research generally involves investigating visible political conflicts between particular actors. If scholars fail to link these empirical observations to political, economic and historical contexts and positions of political actors in unequal power distribution, then results will most likely echo the pluralist approach. In addition, researchers might also strive to establish links between the political and economic domains in order to escape the naiveté of the pluralist findings.

Last but not the least, the pluralist approach to politics might be suitable for the analysis of small-scale political processes. After the most

powerful actors set the general parameters of a political debate, Walt argues that 'bounded pluralism' might apply to sub-decisions (Walt, 1994, p.202). If applied to health care policies, it could be argued that powerful political actors determine issues of systemic importance in the high politics of health care. High politics of health care here refers to issues that are closely interlinked with wider economic and political decisions. Alternatively, a wide range of groups may have a say and even influence the final decision in low politics of health care (Walt, 1994, p.10). However, Walt adds a word of caution to his promotion of the bounded pluralist approach for issues of low politics of health care; he notes that even the bounded form of pluralism may not be appropriate for countries which are under the total hegemony of market ideology (Walt, 1994, p.203).

### **2.5.2. The power resources approach**

The power resources approach can be regarded as the application of social democratic theory to the studies of welfare politics and policies. Korpi, the pioneering scholar of the power resources approach, suggests that there are basically two power resources in capitalist democracies. The first one derives from control over the means of production; the second one originates from political organisations (1980, p.298). While the power resources approach also represents politics and the economy as separate domains like the pluralist approach does, it identifies the broader system as capitalist, which distinguishes it from the pluralist approach. And unlike the pluralist approach, the power resources approach assumes that power is not evenly distributed in capitalist democracies. For Korpi, the capitalist system is based upon a class structure (1989; 1980). Similar to Korpi, Navarro suggests that interest groups are part of a broader class politics (1994, pp.174-175). The power resources approach proposes that distributive concerns are at the centre of most political processes (Baldwin, 1999, p.1).

According to the power resources approach, social classes can only become political actors through different institutional forms (Korpi, 1989,

p.312). More specifically, Korpi evaluates the scope of a working class organisation based on the proportion of unionised workers in the labour force and the proportion of the constituency supporting political parties on the left end of the spectrum (1980, p.307). Esping-Andersen elaborates this approach by noting that the power of the organised labour always has to be assessed in relation to the contending actors (Esping-Andersen, 1990, p.16).

For Korpi, although the working class is the less powerful party in the economic realm, it might become a bearer of significant power in the political realm, as it is the numerical majority (1989, p.312). As a result, the power of the organised labour might infuse state intervention into distributive issues to the benefit of its members (Korpi, 1980, p.298). In other words, left parties and trade unions might institute social rights by assuming the power of the state, or they might act as powerful political alternatives that push governments to adopt (at least partly) their social agendas (Korpi, 1989, p.316). As the power resources approach assumes that the state is a relatively autonomous entity, organised labour can grab state power through democratic means and use it for their own interests. Once organised labour start to use the legislative power to introduce welfare policies, the introduction of these policies might further strengthen organised labour in return (Esping-Andersen, 1990, p.16).

Critics of the power resources approach include representatives of the institutionalist school (Skocpol, 1992; 1980; Immergut, 1992) and scholars who argue that Christian democracy, not Social democracy, has been decisive in the establishment of welfare states in most countries (Manow and Kersbergen, 2009; Van Kersbergen, 1995).

Main criticisms of the power resources approach are as follows. The first is that the power resources approach imposes one form of political organisations (left parties and trade unions) upon the politics of welfare while disregarding all other forms of political organisations. However, the significant influence of trade unions and left parties on the development of welfare states is due to the particular historical experience of some countries, leaving a significant group of others as outliers to the norm. The

second criticism questions the portrayal of welfare politics as a class struggle between two broad categories of classes, namely the working class and the bourgeoisie. For instance, many scholars underline the importance of the middle class in the development of welfare states (Baldwin, 1999, p.9) and in the transformation of health care systems (Leys, 2010, p.19; Evans, 1997, p.453). Skocpol also notes the significance of cross-class coalitions for various social policies (1992, p.25).

In another criticism, Van Kersbergen questions the empirical validity of the power resources approach. He suggests that religiously motivated political actors, specifically Christian democratic parties, played a key role in the creation of welfare states and policies in European countries. He draws attention to the fact that Christian democratic parties were the major actors in the development of social policies in these countries. Van Kersbergen takes this claim one step further and argues that the content of the Christian democratic parties' ideologies created a distinctive welfare state regime (1995, pp.239-240). Additionally, political coalitions established by Christian Democratic parties also influenced the social policy developments (Manow and Kersbergen, 2009, p.28). More generally, Manow and Van Kersbergen suggest that the state/church conflict as well as the conflict between different sects of Christianity had an immense effect on the development of social policies (2009, p.4).

### **2.5.3. The institutionalist approach**

The institutionalist approach asserts that institutions frame politics by defining the terms within which political conflicts take place (Rothstein and Steinmo, 2002; Hall and Taylor, 1996; Immergut, 1992, p.243). Institutionalism has several variants, including sociological, historical, rational and ideational. Here I would like to focus especially on historical and ideational versions, as they are well-established approaches to the study of welfare politics.

Institutionalist arguments on welfare state development and reform can differ. While some literature points to the key role of political institutions in framing politics, others give political institutions a stronger agency. Immergut, who exemplified the latter trend, argues that institutional setting in a given country context has much more influence on the policy outcome than the initial ideas and organisational strengths of political actors involved in the process (1992, p.xiii). This institutional context refers to: what extent executive body can act independently from the legislature, the courts, or the electorate (Immergut, 1992, p.26); what is politically feasible (Immergut, 1992 p.xiii); where 'veto points' in the political system lie (Immergut, 1992, p.7); and which actors are excluded from the political process (Immergut, 1992, p.21). For Immergut, the political system determines "whether politics is best understood as 'interest-group' politics, 'professional' politics, 'bureaucratic' politics, or 'class' politics" (1992, p.xiv). Therefore, in the eyes of the institutionalists, institutions generally have more power than social groups in affecting the political processes.

Skocpol declares, "the degrees of success in achieving political goals - including the enactment of social legislation- depend on the relative opportunities that existing political institutions offer to the group or movement in question (and simultaneously deny to its opponents and competitors)" (Skocpol, 1992, p.54). In Skocpol's words, "states and parties have their own structures and histories, which in turn have their own impact upon society" (1980). In practice, this contention implies that institutions shape the demands of both the capital and the labour. They do not have any *a priori* demands (Skocpol, 1992, pp.25-30).

For institutionalists, institutions may affect political processes and policy outcomes by reproducing themselves; in other words, 'institutional inertia' affects policy outcomes. In this regard, the state bureaucracy is one of the most crucial yet most neglected political actors involved in the politics of welfare. For instance, Asiskovitch proposes that all democracies allocate power to the bureaucracy (Asiskovitch, 2010, p.548). In addition, relatively

specialised policy communities within a bureaucracy may also emerge as important actors (Walt, 1994, p.86). However, Asiskovitch notes that the power of bureaucracies vary according to the political importance of the issue at hand: if the issue might affect the electoral prospects of the government, then the power of the bureaucracy over that issue is limited (Asiskovitch, 2010, p.550). Moreover, the leverage of the bureaucracy vis-à-vis elected governments varies according to the institutional structure in a particular country. As evidenced in the case of the U.S., the impact of the expert-run Central Budget Office on the design of health care reform was greater than that of the contending different political factions at the time (Skocpol, 1997, p.67).

Another strand of the institutionalist approach called sociological institutionalism, draws attention to the norms and values produced and sustained by institutions. Sociological institutionalism suggests that institutions create and sustain legitimacy by establishing the prevalent norms and values. Freeman, one of the strongest advocates for this approach, suggests that health care systems are essentially cultural systems. For Freeman, the legitimacy of health care systems is in “their ability to reproduce the cultural norms on which they depend” (1999, p.93).

Finally, ideational institutionalism is one of the dominant approaches in understanding health care politics. Béland argues that taking ideas seriously in researching policy change and health care politics can escape institutionalism from accounting mainly for the absence of change or the presence of limited change. It can do so by linking the politics of ideas with the mobilisation of political actors without underestimating the impact of unequal power distribution and the limits that existing policy structures on policy change (Béland, 2010, p.626). In their study on Canadian and German health care systems, for instance, Bhatia and Coleman exemplify the explanatory power of the ideational institutionalism in the domain of health care politics (for a similar case study see Millar et al., 2013). They argue that the presence of challenging discourse and the consensus among different political actors over that discourse contributed to the emergence



of significant policy change in Germany, the absence of which left Canada with minor policy changes (Bhatia and Coleman, 2003, p.717).

The main benefit of the institutionalist approach is that it allows room for understanding different configurations of politics in different geographies. Bringing history and culture into the analysis, the institutionalist approach draws the scholars' attention to the importance of the contextualisation of the subject matter.

#### **2.5.4. The new politics approach**

The new politics approach, which is part of the institutionalist tradition, emerged as a reaction to the once popular arguments that claimed welfare states have been in demise since the late 1970s (i.e. Clayton, 1998, p.1131). Against this claim, the new politics approach claims that the nature of welfare politics changed after the establishment of welfare states (Pierson, 1996). Despite the erosion of the political power of organised labour over time, Pierson underlines the fact that the welfare programmes still survived (1996, p.175).

The resilience of the pre-established welfare programmes in the context of a disempowered labour force can be explained in two ways. First, power sharing in modern democracies has made radical reforms harder. Given that welfare programmes signify the new status quo, the conservative attitude of democratic institutions guarantees the resiliency of these programmes. Second, major welfare policies created their own beneficiary groups (Pierson, 1993, p.628), to punish politicians who might undermine the programme (Pierson, 1996, pp.174-175).

Therefore, in contrast to the power resources approach, Pierson suggests that class-based political organisations do not play a key role in the politics of welfare today. He adds, "Today's policymakers operate in an environment fundamentally shaped by policies inherited from the past, rather than suggesting that current politics will echo the conflicts of a previous era" (Pierson, 1996, p.179). In practice, the new politics approach

generally accounts for sustained levels of public spending for welfare programmes and public support for the welfare state.

One could make use of Pierson's distinction between welfare programmes whose sole constituency is organised labour and welfare programmes whose constituency is not limited to this group (Pierson, 1996, p.175). In this categorisation, health care services fall into the second category. In Baldwin's words, "although they intersect and often coincide, the actors who do battle over welfare policy and social classes in the more general sense are, in fact, two distinct entities" (Baldwin, 1999, p.11). The distinction that the new politics approach draws between these welfare recipients (i.e. members of a social health insurance fund for white-collar workers) and social classes (i.e. the working class) might have important political implications. In addition, beneficiaries of specific welfare programmes vary in their particular features. For instance, while income level might be the main criterion in determining who would be most affected from the reform of an income maintenance programme, changes in health insurance legislation might have the most influence individuals with genetic diseases.

Neoliberal health care reforms that make citizens' access to health care services more difficult are highly unlikely as they result in the electoral failure of the governments. According to the new politics approach, governments can only introduce neoliberal health care reforms if they are in a position to absorb the negative electoral consequences (Pierson, 1996, p.176) or if they face a serious budgetary crisis (Pierson, 1996, p.177). Otherwise, they will not be able to introduce a neoliberal health care reform.

Nevertheless, in its current form, the new politics approach seems to offer a rather conservative understanding of welfare politics. Skocpol's contribution might lend this approach a different spin from the conservative attitude. Skocpol agrees with the idea that previous policies affect the creation and type of new policies. In addition, she argues, "We must make social policies the starting points as well as the end points of analysis: As politics creates policies, policies also remake politics" (Skocpol, 1992, p.58).

## **2.6. Conclusion**

This chapter demonstrates the importance of politics as a factor contributing to policy change in the domain of health care. This chapter laid out the main parameters of the political conflict within the realm of health care policies today. As demonstrated earlier in this chapter, this political conflict centres upon the commodity status of health care services, as well as distributive concerns about health care finance and delivery. The chapter also discussed the main characteristics of neoliberalism as the political economic model that led to the proliferation of health care reforms from the late 1970s until today, and the particular form of solutions that neoliberalism proposed in the health care policy realm. The chapter also outlined the major approaches to examining health care politics: the pluralist, the power resources, the institutionalist, and the new politics approach.

Insights from all these approaches are used –where appropriate- in the analysis of the empirical data that this study collected. While generally drawing upon the insights of historical and ideational versions of institutionalism, I agree with Béland’s suggestion stated as follows: “Overall, rather than rely exclusively on monocausal models, the analysis of policy change could study the relationship between ideas and institutions while taking into consideration the role of specific actors and the changing social and economic circumstances they face” (Béland, 2010, p.627). The following chapter presents the historical, political and economic legacies of Turkish politics and the historical foundations and main tenets of Turkey’s health care system.

## **Chapter 3: Health Care and Politics in Turkish History**

### **3.1. Introduction**

There seems to be an implicit consensus in the health care politics literature that domestic politics have shaped health care reforms in advanced capitalist societies in Western Europe and North America, while international influences have been decisive in framing reforms in other parts of the world (Immergut, 1992; Giaimo, 2005; Giaimo and Manow, 1999; Harrison and McDonald, 2008; Jacobs and Skocpol, 2010; Navarro, 1994). Apart from a small number of exceptions—i.e. Moran’s study (2000, p.152) on the health care state in Western Europe and North America, which demonstrates the United States’ impact on health care reforms in other advanced capitalist countries—the literature generally conforms to this disputable assumption.

Without underestimating the global power inequalities between countries, corporate powers, and international organisations, it is argued here that this assumption renders nearly invisible the impact of three factors—inherited political and economic institutions, the political history of a country, and the role of domestic politics—on health care reforms in a developing country context. In fact, scholars suggest that health care reforms always arose as products of domestic politics (Blank and Burau, 2010, p.2; Moran, 1999, p.17).

Scholars employing the Historical Institutional perspective argue that all public policy reforms interact with inherited political and economic institutions in the context in which they are carried out (Ellison, 2006, p.1; Brenner and Theodore, 2002, p.351). In other words, national political contestations over specific public policy reforms do not occur in a vacuum. On the contrary, the historical institutional context frames, inspires, and provides health care reforms, and all other reforms, a meaningful platform.

In light of these insights, I would like to bring the history of the health care system and the politics of health care into the discussion on health care reform in Turkey. This chapter provides an overview of the historical development of Turkey's health care system by linking this to the history of Turkish politics. In doing so, the main objective here is to provide a historical and institutional background to the political contestations over contemporary health care reform in Turkey.

In addition to this introduction, the chapter has three sections. In the next section, the chapter outlines the history of the development of the health care system and the politics of health care in Turkey. The third section reviews the main tenets of Turkey's health care system before the reform and locates it within a comparative framework. Lastly, the conclusion links the politics of health care in Turkey from the establishment of the Republic of Turkey in early 20<sup>th</sup> century until the rise of the AK Party and the launch of the HTP and the main parameters of health care system development in Turkey.

### **3.2. The history of health care politics in Turkey before the reform**

This section gives an overview of the major developments in the Turkish health care system's history while locating these developments within the history of Turkish politics. Özbek, suggests that this history can be split on the basis of critical developments and general trends into three stages: the first period (1850s —1940s) the second period (1940s—1980s) and the third period (1980s—present). Following Özbek's periodisation, this section is organised into three parts. The first part explains the development of the health care system until the end of the Second World War (WW2). The second part examines the developments in the domain of health care between the end of WW2 and the military coup d'état in 1980. The final part investigates the history of the health care system

development and the politics of health care from the military coup d'état in 1980 until the AK Party's rise to power in the 2002 general elections.

### **3.2.1. The history of health care and politics until the end of WW2**

In order to understand the development of social policies in Turkey, Özbek argues that scholars should look to the late Ottoman period. Özbek suggests that the rise of the modern state and the state's engagement with public health did not start with the birth of the Turkish Republic, but rather during the late Ottoman era (2006, p.19). Indeed, historical research validates this claim in the domain of health care. For instance, Aydın reports that the Ottoman state began to employ medical doctors as state officials in order to serve the public during the late 19<sup>th</sup> century and early 20<sup>th</sup> century (2002, pp.11-25). The medical doctors were known as the fatherland's physicians (*memleket tabibi*) or the government's physicians (*hükümet tabibi*) at the time. The late Ottoman era signified the birth of modern statecraft and modern social policies in the Balkans and in Anatolia.

The political history of the late Ottoman era suggests that the medical profession played an important role in popularising the Western ideals of a secular nation state. These medical doctors were graduates of the Ottoman medical schools. The first modern medical education within the boundaries of the Ottoman Empire dates back to the establishment of the Military Medical School (*Tıbhane-i Amire*) in the first half of the 19<sup>th</sup> century, which later became known as the first modern School of Medicine (*Mekteb-i Tıbbiye-i Adliye-i Şahane*).

Medical school graduates formed a well-organised sector of society. In fact, the first medical association was founded in the second half of the 19<sup>th</sup> century. Medical doctors organised in ways beyond just professional medical societies; students and graduates of the School of Medicine were among the founders of the Committee of Union and Progress (*İttihat ve Terakki Cemiyeti*, or *İTC*). The İTC was considered to be the political

organisation responsible for the establishment of the Turkish Republic, and medical doctors were commonly in the higher ranks (i.e. *Dr. Nazım Bey*). Given their historic role in the establishment of the Republic of Turkey in the early 20<sup>th</sup> century and the elective affinity between their secular educational backgrounds and the official ideology at the time, doctors gained elite status within the social and political hierarchy in the Republic.

Therefore, the medical doctors who once constituted the opposition in the late Ottoman era became part of the governing bloc in the early Republican period. Founded in 1923, the Republic was run by the Republican People's Party (*Cumhuriyet Halk Partisi, or CHP*) with its charismatic leader and founding father of the Republic, Mustafa Kemal Atatürk. The CHP ruled as a single-party government until the transition to a multiparty system in the early 1950s.

While being part of the governing bloc would have empowered doctors politically, it hardly protected their professional autonomy from the state. A Law on the Practice of Medicine ratified in the early days of the Republic established provincial medical chambers (Medical chambers were known as *Etibba Odaları* in Turkish at the time) (The Republic of Turkey, 1928). In other words, the executive body founded the professional medical organisations. As part of this, the first medical chamber, the Istanbul provincial medical chamber, was established in 1929. It could be argued that the establishment of provincial medical chambers by law implied a corporatist tendency in the political structure of the Republic. State dominance over professional bodies might be considered a reflection of the Ottoman-Turkish polity's 'bureaucratic centralist' character (Heper, 1991, p.12).

One of the defining features of the origin of social policies in the period until the end of WW2, according to Özbek, is that the policies emerged in the context of limited industrialisation and the absence of a politically and socially significant social category: the industrial workers. For Özbek, in the first period of this history, the state mainly introduced social assistance measures and was involved in pro-natalist policies (2006, pp.20-21).

One of the critical developments in the first period was the promulgation of the Public Health Law. With this law, the state openly declared that it assumed responsibility for protecting the health of its population against communicable diseases (The Republic of Turkey, 1930). Günal notes that this was a necessary step at the time, as communicable diseases such as malaria, tuberculosis, trachoma, syphilis and leprosy were prevalent among the citizenry in the early days of the Republic (2008, p.22).

In the first period, the state only financed preventive health services and left curative health care services to resource-deficit municipalities. Financing curative health care services therefore constituted the most significant problem at the time. Although social insurance and taxation had both been mentioned as possible sources of health care finance during the National Economy Congress in 1923 (Talas, 1992, pp.94-95), the state did not assume any responsibility for initiating the establishment of public insurance funds until the end of WW2.

While the state did not establish modern social security measures in this period, some scholars emphasise that it did pioneer significant legislative developments that began to regulate the labour market. One such example was the establishment of health insurance funds and provision of health care services in the mining sector, which employed the largest portion of industrial workers in the country at the time. The Turkish Parliament passed legislation to regulate the working conditions of coal mine workers in Zonguldak and the Ereğli basin (The Republic of Turkey, 1921). This law required the owners of coalmines to contribute to their workers' health insurance funds and provide free health care services. Talas argues that this legislation was the first social policy legislation of the Republic. Unlike Özbek, who dates the emergence of social policies to the late Ottoman era, Talas argues that the legislation symbolised the emergence of a new 'policy paradigm' that portrayed state as the regulating party in relations between workers and employers (1992, p.85-86). Although the state was involved in the labour relations of the mining sector, it did not make financial contributions to the health fund of the workers. The



revenues of the fund were collected from workers and their employers only (Talas, 1992, p.119). The state's non-contribution to the workers' social security funds became the norm in the second period.

In the domain of health care provision, the state during this period lacked sufficient human, technical and institutional capacities to serve the health needs of the general population. As Buğra reports, all international observers declared that human resources and the institutional capacity of Turkey's health care system were insufficient (2008, pp.120-121).

Therefore, in the first period of the history of health care and politics in Turkey, Turkey's institutional capacity for health care finance and delivery was limited. The major development in this period was the state's involvement with public health measures that aimed to protect the population from communicable diseases. In addition, this period demonstrates how medical doctors emerged as a privileged ally of the official ideology. Lastly, in the first period, the basic features of the nascent social security system started to emerge in the mining sector.

### **3.2.2. The history of health care and politics between the end of WW2 and the military coup d'état in 1980**

The end of the WW2 marked the start of the second period in the history of social policies in Turkey. Social policies developed in line with the national developmentalist economic policies. In this regard, it is suggested here that Turkey's welfare system can be categorised as an example of 'protective welfare state', which is defined as a system that makes social rights conditional upon labour market attachment that makes these rights available for only a limited stratum of the society (Rudra, 2007, p.384). Parallel to social policy developments in Western European countries, Turkey began to initiate modern social security measures and invest in the extension of public capacity for providing health care services. According to Özbek, this period marked the strongest developments in the history of social policies in Turkey (2006, pp.22-23).

### ***3.2.2.1 Transition to electoral democracy and its impact on health care politics***

The second period commenced with the introduction of two consecutive National Health Plans. Mr. Refik Saydam, the first Minister of Health for Turkey, introduced the first plan in the late 1940s. The plan called for the extension of preventive health care services, better organisation of health care delivery, and the establishment of health chests or social insurances to finance these services (Aydın, 2002, pp.53-54).

CHP had ruled the country as a single party government since the founding of the Republic in 1923. General elections in 1950 marked Turkey's transition to a multiparty parliamentary democracy. The Democratic Party (*Demokrat Parti, or DP*) gained more than half of the national votes, which led to a peaceful transition of power from the CHP to DP. Later, Mr. Behçet Uz, the DP Minister of Health, launched the Second Health Plan. Similar to Saydam's plan, the major objective of the Second Health Plan was also better organisation of health care services and the extension of health care services to all parts of the country (Aydın, 2002, p.53-54).

Keyder makes it clear that populism only became a powerful political tool and useful discourse after the ruling bloc was divided into two political parties, the CHP and DP (Keyder, 2007b, p.147). Toprak argues that this form of populism, which was blended with nationalism, was based on the idea that the social policies of the state might abolish class differences and create a 'classless' nation (Toprak, 1982, p.350).

In fact, the emergence of the health care service provision as a democratic imperative seemed to yield some fruit in the DP period. Günal suggests that the share of the MoH's budget increased substantially, and public capacity of health care provision also made significant progress (2008, p.23). Günal also notes that the DP government invested in the

development of curative health care services, the institutional capacity of which was quite restricted at the time (2008, p.145).

The governments were also quite active in supporting the making of a national bourgeoisie. Toprak suggests that the state's investment in the creation of the national bourgeoisie dated back to the late Ottoman era (Toprak, 1982, p.348). Boratav argues that the Republic was no different; it had always been committed to nurturing a national bourgeoisie (Boratav, 2010, p.40). However, the state's involvement in the creation of the national bourgeoisie did not resonate in the domain of health care, as health care were not considered to be a lucrative sector at the time. Therefore, health care services emerged and began to grow as part of the public sector.

### ***3.2.2.2 The 1961 Constitution and the socialisation of health care services***

The first military coup d'état in the history of the Republic overthrew the DP government on 27 May 1960 and condemned the former Prime Minister to death. The National Unity Committee (*Milli Birlik Komitesi*) then ruled the country for over a year and ratified the new Constitution of Turkey in 1961 before transferring power to civilians. Professionals, including academics and other leading civil servants, collaborated with the political cadre in the establishment of the new regime. For instance, well-known law professors joined the Constitution Making Committee of the military junta and prepared the new Constitution of the Republic.

Despite the fact that the Constitution was the product of a military junta, many scholars consider it to be the most democratic and progressive constitution of the Republic. Talas, one of the pioneering scholars of social policy in Turkey, argues that the 1961 Constitution was a progressive development as it included clauses guaranteeing the right to union, the right to collective bargaining, and the right to industrial action for the first time in Turkish history (1992, p.70). Similarly, Boratav argues that the

1961 Constitution paved the way for the emergence of populist redistributive policies between 1962 and 1976 (2010, p.123).

Indeed, the 1961 Constitution strengthened the social state components of the Republic and included a special 'right to health' clause that made the state responsible for universal health care provision. In this context, a 15-year long government project titled 'the Socialisation of Health Services Programme' or briefly 'the Socialisation Programme' (The Republic of Turkey, 1961) was launched. Mr. Nusret Fişek, a distinguished professor of public health, was the leading figure during this reform process. The main objective of this Programme was to establish a vertically organised health care delivery system to serve the country as a whole, from the smallest villages to the metropolitan cities. In line with this objective, the Programme aimed to establish public health care service provider institutions on different geographical scales: health posts, health stations and health centres. These would operate within a working referral system and integrate all health care delivery units in the country under the purview of the MoH (Günel, 2008, pp.380-381).

The Programme contributed to the dissemination of primary care services to rural areas as well as socially and economically deprived neighbourhoods. However, the Programme only reached 26 cities in 14 years, which left 41 cities, including three metropolitan areas, out of the programme (Günel, 2008, p.25). The main reasons for this failure were threefold: one, the Programme lacked sustainable financing from the public budget. Two, the Social Insurances Institution (SSK) started organising separate health care services for workers, most of whom were based in cities. Three, the majority of medical doctors were not willing to work in the deprived areas of the country.

In leftist circles, the Socialisation Programme is considered to be one of the most significant historical moments in the Republican history, as the state attempted to strengthen its 'social' part. This Programme was believed to initiate a new policy paradigm aiming at the development of a universalistic national health care system. Indeed, the egalitarian impact

of the Programme extended the scope of primary health care services, which were provided for free at the point of need. In addition, the Socialisation Programme strengthened citizens' perception that health care provision is the responsibility of the state.

However, Günal argues that the Socialisation Programme failed to initiate the establishment of a universalistic national health care system, especially concerning health care finance (2008, p.26). Aydın argued that Nusret Fişek, the pioneer of the Socialisation Programme, supported the idea of health insurance rather than a tax-based health care finance model (2002, p.90). Therefore, Aydın suggests that the Socialisation Programme did not call for the establishment of a full-fledged state health care system (2002, pp.82-83).

### ***3.2.2.3 The developments in the social security***

In the second period of the history of social policies in Turkey, the main parameters of the health care finance were slowly consolidated. The Social Insurance Institution (*Sosyal Sigortalar Kurumu, or SSK*), formerly known as the Workers' Insurances Institution, was founded in 1946 as the first social insurance institution. While the active labour force numbered at around 14.5 million in the early 1950s, the SSK provided insurance coverage to only half a million workers (Buğra, 2008, p.161). Nevertheless, the number of insured workers substantially increased throughout the 1960s. In the meantime, the SSK extended insurance coverage to workers' family members (Buğra, 2008, p.178), which facilitated considerable number of citizens' access to health care services.

Shortly after the SSK was created, the Retirement Fund for Civil Servants (*Emekli Sandığı, or ES*) was established in 1949 (The Republic of Turkey, 1949). However, Turkey's social security system only began to provide insurance coverage for the self-employed, including farmers, in 1971, due to the establishment of the Pension Fund for the Self Employed

(*Esnaf, Sanatkarlar ve Diğer Bağımsız Çalışanlar Sigorta Kurumu, or BAĞ-KUR*) (The Republic of Turkey, 1971).

While the health care finance model in Turkey started to take shape as a social security based model, the structure of the country's labour market put serious restrictions on the model's ability to provide universal coverage. For instance, in 1927, only one-fourth of the population resided in cities. It was only in 1985 that the urban population exceeded the rural population. Therefore, in this period, the social security schemes (especially before the establishment of BAĞ-KUR) failed to reach the large majority of the population working in agriculture.

In order to compensate for this failure to provide universal coverage, the Hospitals Ordinance of 1955 included a special clause to provide free public hospital examinations for civil servants, medical professionals, pregnant women, people with infectious diseases, emergency cases, and people who acquired official documents from local authorities, namely *muhtars*, proving that they were poor (The Republic of Turkey, 1955). Buğra suggests that by dealing with the failure to provide universal coverage in this way, social policies emerged not in the form of formal social rights but rather through reciprocity relations between the people left outside of the formal social security system and governments in Turkey (2008, p.183). This practice was just one example of how informality and patronage relations played a significant role in social policy and other domains such as housing (Buğra, 2008, p. 183).<sup>11</sup>

From another perspective, Günal views these features of the Ordinance as an indication of the hierarchal nature of the social security system in terms of access to health care services. Civil servants were in a favourable position at the top, while those working in the informal sectors and agricultural sector were at the bottom (Günal, 2008, p.185). In addition to these inequalities, the Ordinance also allowed public hospitals to offer

---

<sup>11</sup> The Turkish state adopted a similar policy in the case of housing. As the migration from rural to urban areas gained pace, the state started to let migrants from the rural areas to settle in public lands and construct their houses upon public land rather than developing social housing projects (Buğra, 2008: 183).

private, first class, second class and third class rooms for their patients. Therefore, Günal argues that the objective was not to institute equality in access to health care but rather to facilitate access to services in line with social stratification.

#### ***3.2.2.4 The politics of health care in the second period***

In the second period of the history of social policies, Turkey witnessed the establishment of institutions representing employers, workers and medical doctors. The Chambers of Commerce was established in 1950, and membership was compulsory. The Confederation of Turkish Trade Unions (*Türkiye İşçi Sendikaları Konfederasyonu*, or *TÜRK-İŞ*) was founded in 1951 as the only trade union representing the workers at the time. Both of these institutions were weak in their ability to mobilise constituencies and they remained extensions of state institutions until the late 1960s.

The TTB was founded in 1953 and replaced the provincial medical chambers. (The history of the TTB is discussed in detail in Chapter 7.) The TTB functioned as a corporatist professional body. In its early years, the TTB defended the privilege of medical doctors to open up private clinics without quitting positions in public hospitals. From the end of WW2 until the transfer of power to civilians after the 1960 military coup d'état, it can be argued that neither the TTB nor TÜRK-İŞ had a significant impact in the politics of social policies and health care in particular.

Class-based political divisions in Turkey became visible only after the 1960s. After the ratification of the 1961 Constitution, labour and capital organisations based on voluntary membership began to appear (Buğra, 1997, pp.333-336). In 1961, the Turkish Confederation of Employer Associations (*Türkiye İşveren Sendikaları Konfederasyonu*, or *TİSK*) was founded and became the political voice of the employers. In 1967, the Confederation of Progressive Trade Unions' of Turkey (*Devrimci İşçi Sendikaları Konfederasyonu*, or *DİSK*) was established and became one of the most influential actors of the workers' movement. In the late 1960s, 12

leading businessmen established the Turkish Industrialists' and Businessmen's Association (*Türk Sanayicileri ve İşadamları Derneği*, or *TÜSİAD*) to act autonomously from the state with the objective of influencing political decisions. The TÜSİAD soon appeared to be the strongest representative of the employers.

#### 3.2.2.4.1 The political contestations over the Socialisation Programme

In this period, two key parts of the Socialisation Programme sparked political debates. The first was the government's proposal to require medical doctors to work full-time for public hospitals, which reappeared during the implementation of the HTP, which is discussed in detail in Chapter 7. Ersoy reports that a significant number of medical doctors at the time strongly opposed this full-time work proposal (1998, p.11). Their opposition was mainly motivated by self-interest. The number of medical doctors' private clinics proliferated in İstanbul throughout the 1950s, and the newspapers were filled with private clinic advertisements (Günel, 2008, p.185). Not surprisingly, in the early 1960s medical doctors with their own private clinics resisted working full time for public hospitals, and the strong opposition eventually led to the dismissal of the proposal. Despite the fact that the TTB lacked 'veto power' in the political system, medical doctors' ability to dismiss the full-time work proposal demonstrates their political power at the time.

The second contested part of the Programme was its ambition to unite all public health facilities under the purview of the MoH. Public health facilities included public hospitals (affiliated with the MoH), the SSK hospitals and public university hospitals. Therefore, the MoH's proposal to control all of the public facilities was not welcomed by SSK bureaucrats and university hospital academics. In a meeting organised by the Ministry, the Head of Health Affairs in the SSK Dr. Refik Erer argued that SSK hospitals were established thanks to 'the labour of workers' and thus they should be in charge of their hospitals. Erer concluded that a transfer of SSK hospitals



to the MoH was simply impossible (Ministry of Health and Social Assistance, 1966). Representatives of university hospitals also opposed the proposed transfer of public university hospitals to the MoH. The firm stance that SSK bureaucrats and academics took on this issue might be suggestive of their quest to keep their autonomy, as well as their distrust of the government.

#### 3.2.2.4.2. The power of trade unions and employer organisations in the Social Insurances Institution

Although Turkey's health care system was based upon a social insurance model, its governance model did not resemble the social insurance-based systems of Western Europe that gave trade unions (and sometimes employer organisations as well) exclusive power to administer funds. The Turkish social security system did not allow power sharing between governments and trade unions. In fact, the composition of the executive board of the SSK reflected the bureaucratic dominance over the SSK's decision-making process. According to the constituent legislation of the SSK, five of the seven members of the executive board were state officials (The Republic of Turkey, 1964, 10<sup>th</sup> Article). One member was the representative of the employers, while another was the representative of workers. Therefore, it could be argued that the administration of Turkey's welfare system was corporatist, yet the governance of this system was not based upon a corporatist pact between the state and other social actors. It was rather state-dominated or can be characterised as 'state corporatism' as Schmitter defines it (Schmitter, 1974, pp.103-104)

#### 3.2.2.4.3 The impact of the left on the politics of health care

Keyder suggests that the dissolution of the world system induced by the Great Depression enabled the Turkish bureaucracy to introduce a state-directed national economy model after the end of WW2 (2007b, pp.11-12).

For Yeldan, this model lent itself to the consolidation of the industrial bourgeoisie in the 1960s and 1970s, as the state transferred significant amounts of profits to the Turkish bourgeoisie in this period (2001, p.38).

In general, the late 1960s and 1970s were the most successful years for the left in Turkey, both in terms of electoral success and ability to mobilise public support (Boratav, 2010, p. 221). Even though this period marked the strongest period for Turkey's left, Keyder argues "neither farmers nor workers were politically strong and organised enough to influence directly the outcome of a political contestation" (2007b, p.13). For Keyder, the major influential political actors in Turkish politics were from different groups within the bureaucracy and the nascent bourgeoisie (2007b, p.13). Indeed, Keyder's argument is validated to an extent as the institutional setting empowered the bureaucracy and gave a showpiece role for trade union representatives.

However, the discursive power of the left constituted a strong vantage point for governments to shape their policies. The power of the left also paved the way for the transformation of the CHP into a social democratic party in the early 1970s. The main dynamic of the left mobilisation originated through trade unions and student movements.

The second law on trade unions repealed the first legislation (The Republic of Turkey, 1947), and loosened restrictions on the organisation of trade unions (The Republic of Turkey, 1963). In this context, DİSK was established in 1967 as an alternative to TÜRK-İŞ. Unlike TÜRK-İŞ's bureaucratic structure and consequent failure to mobilise workers' demands, DİSK emerged as the most significant political actor of the workers' movement and was able to organise massive, effective rallies.

In addition to DİSK, a number of university student movements—generally linked to different leftist organisations—were also quite active in setting the political agenda in the country. These youth organisations included but were not limited to the Revolutionary Youth (*Devrimci Gençlik*, or DEV-GENÇ), the Liberation Army of People Party-Front (*Türkiye Halk Kurtuluş Partisi-Cephesi*, or THKP-C), the Revolutionary

Path Movement (*Devrimci Yol Hareketi*, or DEV-YOL), the Liberation Army of People of Turkey (*Türkiye Halk Kurtuluş Ordusu*, or THKO) and the Progressive Youth Association (*İlerici Gençler Derneği*, or İGD).

As previously mentioned, the rise of the left in Turkish politics during the 1960s found a limited space within parliamentary politics due to the judiciary's tendency to close down socialist parties and the left's aversion towards the parliamentary route to socialism. The most significant initiative that the left pursued through parliamentary politics was the establishment of the Labour Party of Turkey (*Türkiye İşçi Partisi*, or TİP). A number of trade unionists and intellectuals founded TİP in 1961. The first electoral success of TİP in Turkey came during the 1965 elections, in which the party received roughly 2.5 per cent of national votes and gained 14 out of 450 seats in the Parliament. TİP's programme did not particularly address health care policies, the absence of which was not an exception in left politics in Turkey in general at the time, but it did declare that the workers' participation in government would make social and economic rights in the Constitution as 'lived realities' rather than mere clauses on paper (The Labour Party of Turkey, 1964). However, the TİP experience was short-lived.

In response to the tense political atmosphere, Mr. Memduh Tağmaç, the Commander of the Turkish Military Forces at the time, said, "Social awakening went beyond the economic development" (Günel, 2014). In response to the increasing mobilisation of the left, the military once again staged a coup and forced the centre-right AP to resign. The new government that followed the AP government was not a military junta, but rather a civilian, technocratic government.

With the general election in 1973, Turkish political life once again started to resemble an electoral democracy. Before the general elections in 1973, CHP went through a discursive change. This discursive change started with the endeavours of Mr. İsmet İnönü, one of the founding fathers of the Republic, to appeal to the newly emerging leftist youth by declaring

that the CHP was located at the 'centre-left' (*ortanın solu*) of the political spectrum.

However, the success of this discursive change could only be possible with the change of the CHP's chairman. Mr. Bülent Ecevit was elected as the new chairman of the CHP in 1972. Unlike İnönü, Ecevit brought different variants of the left under the umbrella of the CHP and succeeded in presenting himself as the child of the people. In addition, CHP's election promises started to resemble the social democratic parties of Western Europe. In the 1973 election campaigns, CHP criticised the centre-right AP for "undermining the social state character of the state" (The Republican People's Party of Turkey, 1973, p.7) and declared that a prospective CHP government would make the "health care system work for citizens" (The Republican People's Party of Turkey, 1973, p.17). In doing so, CHP promised to abolish inequalities between the SSK, ES and BAĞ-KUR (The Republican People's Party of Turkey, 1973, p.133); and establish a new governance mechanism for social insurances that would put premium payers in charge (The Republican People's Party of Turkey, 1973, p.134). CHP won the general elections in 1973. Ecevit's CHP succeeded in maintaining its victory in the 1977 election, which marked the highest share of votes (roughly 41 per cent) by a left party in the history of the Republic.<sup>12</sup>

The rise of Ecevit's CHP to power brought hope for the realisation of the ideal of health care for all. Indeed, Ecevit's CHP tried to take critical steps to consolidate a public health care system. For instance, the CHP government re-introduced the full time work requirement for medical doctors (The Republic of Turkey, 1978). However, CHP government was also short-lived.

Throughout the 1970s, unstable coalition governments ran the country, and armed conflicts between the leftist and the nationalist groups created a serious political instability. In this context, governments were not

---

<sup>12</sup> Later scholars considered around one-third of all voters in Turkey to be traditionally left leaning, and the remaining two thirds traditionally right leaning (Ayata, 1993a, p.32).

in a position to carry out comprehensive and long-term reforms, which led to the deepening of problems in Turkey's health care system.

The only noteworthy political development in the 1970s in health care politics was an ideological shift in the leading cadre of the TTB, which is discussed in detail in Chapter 7. The rising popularity of the left in Turkish politics during the 1960s and 1970s found its echo amongst medical doctors and medical students. Organised socialist groups nominated their representatives in the elections for the General Council of the TTB in 1977 and succeeded in electing Dr. Erdal Atabek to head the TTB. This election implied a historic change in the political positioning of the TTB. Once established as a corporatist professional body, the TTB used to take its legitimacy from the state. The rise to power of socialist medical doctors in the TTB resulted in the recalibration of the source of legitimacy for the medical profession. Socialist medical doctors turned their faces to the people and declared that they would search for legitimacy from the people rather than from the state. As a result, the TTB emerged as the defender of the socialist perspective to health care services.

### **3.2.3. The history of health care politics since the military coup d'état in 1980**

The military coup in 1980 marked the start of the third period in the history of social policies in Turkey within Özbek's periodization. Following the junta, the pro-market Motherland Party (*Anavatan Partisi, or ANAP*) emerged as a single-party government and ruled the country throughout the 1980s. After the fall of the ANAP, the country was ruled by a coalition of social democratic SHP (*Sosyal Demokrat Halkçı Parti, SHP*) and centre-right True Path Party (*Doğru Yol Partisi, DYP*).

While these marginal political developments left footprints on the health care system of Turkey, the general health care policy environment from 1980s up until the introduction of the HTP can be conceptualised as 'policy drift'. Policy drift is defined as "changes in the operation or effect of

policies that occur without significant changes in those policies' structure. The major cause of drift in the social welfare field is a shift in the social context of policies, such as the rise of new or newly intensified social risks with which existing programs are poorly equipped to grapple" (Hacker, 2004, p.246).

### ***3.2.3.1. The Junta: Suppression of the left***

The Military coup on 12 September 1980 was a historic moment in Turkish politics and had a substantial impact on the country's political and economic trajectory. The junta closed down all political parties, trade unions and civil society organisations. A new constitution for the country, once again, was prepared under the purview of the junta. The new Constitution, ratified in a referendum that took place in 1982, clearly instituted an authoritarian regime that introduced serious restrictions on the use of individual and collective rights and freedoms.

One of the major changes that the junta introduced was the alteration of the development strategy from import-substitution industrialisation to export-oriented growth. The junta initiated the integration of Turkish economy into the global economy, which transformed Turkey's economy into an open market economy in the 1990s (Yeldan, 2001, p.25). In line with the export-oriented growth strategy, the junta initiated the privatisation of public sector institutions and increased the role of the private sector in the economy. However, this top-down change in the development strategy of the country was not carried out at the expense of employers. On the contrary, Şenses notes that employer organisations succeeded in promoting their demands under the military rule. For instance, their pre-coup demands in the domains of labour legislation were implemented after the military coup (Şenses, 1993, p.105).

The impact of the 1980 military coup on Turkish political life was deep and devastating. The military junta closed all active political organisations in the country; arrested activists, intellectuals, academics, journalists; and

silenced all forms of political opposition. This devastating impact was skewed towards the left end of the political spectrum. For instance, Heper argues, “The state’s intention was to de-activate, re-organise and then to exclude the present unions from the political sphere. Any gains that unions could make always remained precarious” (1991, p.17). As Buğra stated, the state did not welcome the development of organised capitalist interests as well. However, the state’s attitude towards the organisation of labour was much harsher: the state actively restricted, prohibited and even abolished labour organisations. This became much more evident after the 1980 military coup d’état when “the activities of business organisations flourished, while labour organisations were totally silenced” (Buğra, 1997, p.59). Therefore, the political effect of the 1980 military coup d’état was partially the victory of business interests over labour’s demands.

The military government’s stance towards the TTB was not much different from its stance towards trade unions. As mentioned before, the TTB had already transcended the boundaries of a classical professional body and began to voice a socialist perspective towards health care in the 1970s. The military junta also closed down the General Council of the TTB and sent the head of the organisation to jail. Once the TTB was reopened, the military government attempted to make sure that compulsory membership of medical doctors working for public facilities to the TTB was lifted all together. The base of the General Council of the TTB was moved to Ankara, and the MoH was authorised to monitor the finances and administration of provincial medical chambers. All these changes were directed towards the re-consolidation of state control over the TTB.

### ***3.2.3.2. The Motherland Party period: Attempts to liberalise health care***

In the aftermath of the transfer of power from the military to the civilian government following the 1980 coup d’état, ANAP came to power with an agenda of economic liberalisation. By collaborating with the IMF

and the WB to initiate the Structural Adjustment Programme (SAP), ANAP took steps to increase the role of private entrepreneurs in the provision of health care. Private hospitals, according to the approach of ANAP, would help diminish the pressure on the SSK hospitals and the MoH hospitals. ANAP's agenda for health care policy, however, was not limited to the fostering of private sector in health care provision. Its broader agenda included new public management policies, which manifested itself in the introduction of the Basic Law of Health Services that introduced market mechanisms to public health services (The Republic of Turkey, 1987).

The main objectives of the Basic Law of Health Services were to transform public hospitals into individual health enterprises, to end the lifelong employment guarantee provided for medical doctors in the public sector, to introduce employment contracts and a performance-based payment model for health workers, and to establish a compulsory contribution-based general health insurance system by integrating all schemes under one institution (The Republic of Turkey, 1987). In response, the main centre-left political party of the time, the SHP, filed an appeal to the Constitutional Court with the request to annul particular articles of the law. The Constitutional Court annulled some articles of the law, rendering implementation of the law impossible (The Constitutional Court of Turkey, 1988).

Despite the success of the SHP in stopping the pro-market reform, in-depth analysis of this case provides insight into the different health care service paradigms of the SHP and the majority of the Constitutional Court members. The SHP argued that the Law introduced exchange relationships between patients and public hospitals. The SHP found this unacceptable in a country where access to health care services was defined as a citizenship right. The SHP stated, "Health care, as a right of citizens and duty of the state, cannot become an issue of commercial undertaking" (The Constitutional Court of Turkey, 1988, p.4).

While the Constitutional Court did not rule the proposed transformation of public hospitals into individual health enterprises



unconstitutional; it annulled articles that were on the transfer of power to the government in unification of social security institutions as well as the introduction of performance-based payment for health workers (The Constitutional Court of Turkey, 1988). The detailed ruling demonstrates that the majority of the members of the Constitutional Court seemed to adopt an economically liberal approach to health care. For instance, the Constitutional Court decided that the SHP's claim that the social state has to provide health care services free at the point of service was invalid. Instead, it argued that public bodies could receive payments from citizens according to their income levels (The Constitutional Court of Turkey, 1988).

Despite the fact that the ANAP government could not implement the Basic Law of Health Services, the ANAP legacy left its footprint on health care with the introduction of revolving funds into public hospitals in 1987 (Buğra, 2008, p.213). The introduction of revolving funds into public hospitals symbolised the first step of the marketization of public health care services.

In the meantime, due to the drastic decrease in formal employment opportunities and the outbreak of the armed conflict between the Kurdistan Workers' Party militias (*Partiya Karkerên Kurdistan, or PKK*) and the Turkish army, the number of uninsured citizens began to substantially increase. In that context, while social risks associated with health care policies increased for citizens, no changes were made in the health system until the introduction of the Green Card scheme that will be discussed in the next section, which makes this situation to be best categorised as 'policy drift'.

The second footprint that ANAP had on health care was the promotion of private initiatives in health care delivery. Keyder suggests that private health provision initiatives started to gain visibility in the early 1990s due to the introduction of private sector incentives in the late 1980s (2007a, p.18). Consequently, inpatient bed capacity of private hospitals reached one-tenth of total inpatient bed capacity in Turkey in the middle of 2000s (Keyder, 2007a, p.19). In addition, Günal also notes that the number of

private inpatient institutions increased more than 1.5 times and the number of beds in these institutions almost doubled between 1980s and 1990s (2008, pp.407-408).

The majority of these private inpatient institutions were based in metropolitan cities of Turkey. Their services were mainly focused on specialties like ophthalmology, dental health, obstetrics, gynaecology, microchirurgia, and transplantation. The concentration of these private inpatient institutions in these areas of health care services, which were not advanced in public hospitals at the time, provided these institutions with a clear comparative advantage in the market (Günel, 2008, pp.407-408). However, the dominance of the public sector in most health care services remained intact. In 1990, it was reported that 78 per cent of all hospitals in Turkey were under the administration of the MoH, the SSK and public universities (PriceWaterhouse, 1990, p.66). While the dominance of the public sector in health care delivery persisted, the private sector started to increase its share in health care delivery during the 1990s.

### ***3.2.3.3 The introduction of the Green Card scheme***

In the 1987 general elections, SHP came second with almost one-fourth of the national vote, followed by the DYP, centre-right party that represented a significant portion of the farmers, with roughly 20 per cent of all votes. After the significant fall in ANAP's votes in the 1991 general elections, DYP and SHP formed a coalition government.

SHP was against privatisation in health care services, while DYP generally had a populist take on social policy issues. A major health care policy development in the DYP-SHP coalition government period was the introduction of the Green Card scheme in 1992 (The Republic of Turkey, 1992), which gave an end to the policy drift in health care policies throughout 1980s. The Green Card scheme was essentially a social assistance scheme that gave the very poor access to inpatient services in public hospitals. Buğra suggests that the introduction of the Green Card

scheme represented a step toward the idea of health care services for all (2008, pp.214-215). She argues that the Green Card model symbolises a procedural formalisation to grant the poor access to health care services, especially in comparison to the former model, which required the poor to convince either the local authorities or the chief physician that they were poor in order to access health care services for free (Buğra, 2008, pp.214-215).

#### ***3.2.3.4 The global health reform agenda arrives in Turkey***

In line with international trends, in the early 1990s the Turkish governments were engaged in drafting health care reforms and making attempts to legislate them. Four critical developments during this period contributed to the elevation of health care reform onto the political agenda.

The first of these developments was the commencement of a partnership between Turkish governments and the WB on health care issues in 1990. Throughout the 1990s, the Turkish governments collaborated with the WB on health care issues, and the WB has been one of the key players in Turkey's health care policy. The first WB project on health care started in 1990, and the second project was launched in 1996. A detailed history of the WB-Turkey health care partnership is discussed in the Chapter 5.

The impact of the WB's pro-market discourse on reforms was visible in the criticisms that developed about the existing health care system, as well as how health care reforms were framed in national policy documents. For instance, in a 'National Health Policy' document, the Ministry questioned the centralised structure of health care delivery, the lack of managerial staff in public hospitals, the absence of awareness about costs amongst the staff, and the lack of motivation amongst medical doctors due to the inexistence of performance-based payment mechanisms (The Ministry of Health, 1993, p.51). In the same year, the Draft Law on Health projected the introduction of a basic benefit package for public health

insurance plans and out-of-pocket contributions for the insured (The Republic of Turkey, 1993). In 1997, a Ministry's report titled 'Health Sector Reforms in Turkey' stated that purchaser and provider roles in Turkey's health care system should separate, competition should be established among different service providers, and social insurance should cover the whole population (The Ministry of Health, 1997, p.29).

The second critical development was the publication of a report titled the 'Health Sector Master Plan'. The State Planning Organisation (*Devlet Planlama Teşkilatı, or DPT*) commissioned the preparation of this report to PriceWaterhouse. The report declared that the state was incapable of planning Turkey's diverse health care system (PriceWaterhouse, 1990, pp.4-5). It also stated that the health care system failed to provide equitable access to health care services and to integrate preventive and curative health care services (PriceWaterhouse, 1990, p.34). This report raised awareness among different actors about the chronic problems of Turkey's health care system. It also popularised the discourse of health economics in terms of defining these problems and proposing solutions, thus contributed to the emergence of a new 'policy paradigm'.

The third critical development was the revitalisation of the medical doctors' movement under the umbrella of the TTB at the end of the 1980s. Between 1988 and 1992, thousands of medical doctors marched in the 'White Protests' in order to call for the improvement of their working conditions and the realisation of a universal right to health (Soyer, 2005, pp.189-190). With these protests, the TTB called for the establishment of a public health care system and once again emerged as a significant political actor in the politics of health care.

The fourth critical development that increased the politicians' and bureaucrats' attention to health care policy was the emerging income-expenses imbalance of the social security institutions. In the late 1980s and early 1990s, governments started to make public transfers to these institutions in order to strike a balance between their incomes and expenses. The ES was the first institution to face a budget deficit in 1986,

followed by the BAĞ-KUR in 1989 and finally by the SSK in 1991 (Yılmaz, 2012). Transfers from the public budget to social security institutions reached 1 per cent of GDP in 1994 and this share continued to increase until 2000 (Yılmaz, 2012).

While these deficits emerged partly as a result of governments' use of social security funds for external debt payments and interest-free government borrowing from these funds, the same governments and the mainstream media started to conceptualise these deficits as a 'black hole' for the public budget. The portrayal of the fiscal deficit of social security institutions as 'black hole' can be conceptualised as part of the process of 'the social construction of the need to reform' (Cox, 2001, pp.475-477) of Turkey's health system.

In contrast to the popular discourse that made social security institutions the scapegoat of the public budget imbalance, the Health Insurance Commission of Australia's report on the Turkish health care system concluded that Turkey "as a whole spends less of its national product on health care than other countries of comparable development" (Health Insurance Commission of Australia, 1995, p.3) and the private insurance option "has no major role to play in addressing the fiscal problems in the health care system or dealing with the problems the uninsured have in accessing services (Health Insurance Commission of Australia, 1995, p.7). However, the deficits of the social security institutions were hardly handled within a conceptual framework that the Health Insurance Commission of Australia used at the time, which demonstrates the power imbalances between competing ideas in health care politics.

The presence of these four factors led to a growing consensus that health care reform was needed. However, the introduction of reform did not follow automatically. A major reason for the failure of health care reform at the time was the fact that the country was run by weak coalition governments.

However, the problem of social insurance coverage continued to worsen. As a result of the heightened armed conflict between the Turkish

army and the PKK, nearly a million people (mostly of Kurdish origin) from the South Eastern and Eastern small provinces and villages migrated to the metropolitan cities. Given the limited formal employment opportunities available in metropolitan cities, migrants remained outside of the formal social security system.

In this context, the political Islamist Welfare Party (*Refah Partisi, or RP*) emerged as the new centre of attraction especially amongst the urban poor and in economically deprived regions of Eastern and South Eastern Anatolia. RP's roots originated from the 'National Outlook' (*Milli Görüş*) movement that combined a modest Islamic critique of capitalism with third-world nationalism. In contrast to the mainstream centre-right and centre-left parties at the time, RP appeared as an ideological movement and was able to mobilise significant numbers of committed activists who voluntarily worked for the party's success in elections.

The first significant victory of the RP came in the 1994 municipal elections, when RP received almost 20 per cent of the votes and became the second-runner. In addition, now-President Recep Tayyip Erdoğan was elected as the mayor of the Istanbul Metropolitan Municipality. RP's wave of success continued in the 1995 general elections. In this election, RP got first place, marking the most significant victory of a Political Islamist party in the history of the Republic. However, the Turkish army, infamous for its military coup d'états, forced the RP-DYP coalition government to resign. This event is known as the 28 February 1997 'post-modern coup d'état', which led to the closure of RP by the Constitutional Court.

Following the military coup, the centre-left Ecevit's Democratic Left Party (*Demokratik Sol Parti, or DSP*) came first in general elections in 1999 and formed a broad coalition government with the Nationalist Action Party (*Milliyetçi Hareket Partisi, or MHP*) and ANAP. The coalition government proved to be unsuccessful in dealing with two serious earthquakes, and its economic policies paved the way for the largest economic crisis in the history of the Republic in 2001. Unsurprisingly, these political parties lost most of their votes in the 2002 general elections and did not gain any seats in the

Parliament, due to the fact that they could not meet the 10 per cent national threshold.

A group of politicians separated from the National Outlook movement and its Virtue Party (*Fazilet Partisi, or FP*) –which was founded as the heir to RP- and founded the AK Party in 2001. The AK Party’s general approach to social policies and health care policy in particular will be discussed in detail in Chapter 6. It was in this context that the AK Party came to power as a single party government in the 2002 general elections.

Before the AK Party came to power, the problems in Turkey’s health care system had already been quite visible. A representative survey conducted in six cities in Turkey showed that roughly 42 per cent of respondents stated that they could not apply to health care services in the last 6 months due to financial difficulties (Ministry of Health, 1999). Parallel to this, the first comprehensive study on health expenditures found that Turkey was among the OECD countries making a large amount of out-of-pocket expenditures for health care services. The share of out-of-pocket health expenditures in 2000 constituted roughly 28 per cent of total health expenditures (The Ministry of Health of Turkey, 2004, p.36). In light of this historical and political background, the next section provides an overview of the main tenets of Turkey’s health care system before the reform and locates it within a comparative framework.

### **3.3. Turkey’s health care system before the reform within a comparative perspective**

A health care system could be broadly defined as the whole set of regulations in a given country with respect to the financing, provision and regulation of health care services (Wendt et al., 2009, p.77). In the literature, the health care systems approach inspired health care system typologies. These typologies enable scholars to compare and contrast different national health care systems as well as evaluate whether the direction of changes in different national health care systems diverge or

converge (i.e. Blank and Burau, 2010; Wendt et al., 2009; Hassenteufel and Palier, 2007; Bambra, 2005a; Wall, 1996; Moran, 1992).

While health care systems approach is useful in explaining the major characteristics of national health care policies, it has to be used with caution due to its tendency to underestimate the internal contradictions of national health care policies. Freeman argues that health care policies generally do not constitute a conflict-free system, as each country's health care policies are based upon institutions that are superimposed on one another. These coexisting institutions might be complementary as well as in conflict (Freeman, 1999, p.89). In response, scholars call for an approach that pays enough attention to conflicts as well as tensions within the health care domain (Blank and Burau, 2010, p.224; Kasza, 2002). As discussed before in detail, Turkey's health care system is also composed of different institutions and programmes not necessarily designed to fit into a single health care system.

Bearing these words of caution about health care systems approach in mind, I would like to first situate Turkey's health care system within a health care systems typology. Among various health care systems typologies (i.e Hassenteufel and Palier, 2007; Burau and Blank, 2006; Bambra, 2005a; Rothgang et al., 2005; Wall, 1996), I would like to use Wendt et al.'s typology (2009). As the most comprehensive and up-to-date typology, it has the power to explain the diversity of contemporary health care systems.

For Wendt et al., there are three main ideal-types of health care systems: state health care systems, societal health care systems, and private health care systems (2009, p.81). The defining characteristic of the state health care systems is that the state undertakes financing, provision and regulation activities. In societal health care systems, societal actors, mostly in the form of independent autonomous social organisations (i.e. trade unions), are in charge of all three main pillars of the health care system. Lastly, in private health care systems, private actors control all the pillars of health care systems. On the basis of these three main ideal-types,



they devised 27 combinations of health care systems with different forms of control over different pillars of the health care system. According to Wendt et al.'s typology, Turkey's health care system before the introduction of the HTP most resembled the state health care systems, as the state had been the dominant power in the financing, provision and regulation of health care services.

### **3.3.1. Health care finance**

The financing of health care services is one of the fundamental subsectors of health care systems. By financing, scholars refer to the mechanisms through which the total amount of financial resources allocated to health care services are collected, and how the conditions of access to health care services are determined (Blank and Burau, 2010, p. 220).

The four main sources of health care service funding identified in the literature are general taxation, social insurance, private insurance, and direct payments by the user (Blank and Burau, 2010, p.13; Normand, 1997, p.205). The health care systems of most countries rely on a combination of these sources. For instance, the health care system in the U.S. is primarily funded by private insurance schemes, but involves public funding to ascertain the access of special groups, such as children, the disabled, the poor and/or the elderly (via Medicaid and Medicare) to health care services.

Nevertheless, one funding source is usually dominant in a health care system (Normand, 1997, p.205). This dominant funding source gives the system its general characteristic and has equity implications in terms of access to health care. The financing of health care services is also considered to be “a pointer to power” (Blank and Burau, 2010, p.63) in a given health care system. The main institutional funder of the system tends to have more power over the system as a whole.

Similar to most developing countries (Barrientos and Lloyd-Sherlock, 2000, p.417), Turkey's health care system relied upon a social health

insurance model of financing. As discussed earlier in this chapter, Turkey's welfare system resembled Rudra's protective welfare system, social insurances in Turkey were first founded to provide protection for state officials and urban formal sector workers after the Second World War. Indeed, Turkey's health care system before the reform had three public insurance schemes, which combined retirement pensions with health insurance and constituted the main source of health care finance. As listed before, these insurances were as follows: SSK, ES and BAĞ-KUR.

The state in Turkey did not make financial contributions to these social insurance funds. In other words, these insurance funds were mainly financed out of employers' and employees' contributions. Despite the fact that employees and employers financed these insurance funds, the two groups were not in charge of the administration of these funds. Instead, as mentioned before, the majority of the members of these funds' executive boards were government employees. In this setting, governments could even use these funds arbitrarily for purposes other than paying retirement pensions and/or health expenditures (i.e. paying the government's debts to the International Monetary Fund (IMF)).

The size of the formal sector determines the scope for the development of social health insurance (Normand, 1997, p.216). Similar to other developing countries (Lloyd-Sherlock, 2006, p.355; Barrientos and Lloyd-Sherlock, 2000, p.417), the limited scope of the formal sector in Turkey decreased the ability of the social health insurance model to provide universal coverage. In line with the developmentalist aspirations of the period between the end of World War II and the beginning of the 1980s, the number of social insurance outsiders was expected to disappear as industrial development gained pace and created a high volume of formal jobs (Buğra and Keyder, 2006, p.17; Lloyd-Sherlock, 2006, p.365). After these expectations proved to be wrong during the transformation of the global economy from the 1970s, the Turkish government developed a separate non-contributory scheme –the Green Card scheme– for the uninsured, financed out of the public budget (Buğra, 2008, p.215). Such a

move was in line with trends in other developing countries (Barrientos and Lloyd-Sherlock, 2000, p.417).

In Turkey's health care system before the reform, the number of citizens with private health insurance remained quite low. In 2000, approximately 0.4 per cent of the population had private health insurance coverage (Turkish Industrialists' and Businessmen's Association, 2005). Therefore, the private sector did not have any significant power in the health care finance.

However, out-of-pocket payments constituted a significant share in health care finance before the introduction of the HTP. In 2000, out-of-pocket payments constituted 27.7 per cent of total health expenditures in Turkey (The Ministry of Health of Turkey, 2004, p.33). Out-of-pocket payments included both formal and informal payments. To exemplify, formal payments were made to purchase medications and to pay for compulsory "donations" to the SSK hospitals (Yeni Şafak, 2000). Another example of out-of-pocket payments was informal payments made during patients' visits to the private clinic of a medical doctor, with the expectation of getting timely and quality health care services in public hospitals in return. Due to the coexistence of formal social security alongside high levels of informality, scholars identified Turkey's previous social security system as an "eclectic system" (Buğra and Candaş, 2011, p.516).

### **3.3.2. Health care delivery**

The provision of health care services is another significant subsector of health care systems, which refers to the rules and regulations with respect to the institutional means through which health care services are delivered in a given country context. Health care systems in countries rely on different forms of health care service delivery. With the exception of data on hospitals beds in public and private sectors, in-depth information on the role of the state in health care provision is still not available for different

countries (Rothgang et al., 2005, p.196) thus preventing international comparison.

There are three different forms of ownership of health facilities.<sup>13</sup> Health care services may be delivered through public facilities, private facilities, and/or non-profit facilities. There is a relationship between the dominant type of health care finance and the ownership of health care facilities. For instance, health care systems funded out of tax revenues rely heavily on public hospitals as the main providers of health care services, while social health insurance based systems depend both on public and private hospitals (Blank and Burau, 2010, p.82-83). In health care systems funded primarily by private health insurance, the private sector is generally the largest health care provider. In line with contemporary health reforms, midway solutions, which combine non-profit ownership with a level of state guarantee such as hospital trusts in the UK and health maintenance organisations in the US have developed.

Turkey's health care system before the introduction of the HTP relied upon public provision of health care services. However, the public sector was divided into different institutions, the largest number of which was owned by the MoH, the SSK and public universities respectively. The number of private sector hospitals including foreigners' and minority foundations' hospitals constituted a negligible portion of health care provision in the country (The Ministry of Health of Turkey, 2004, p.7-8).

As discussed earlier in this chapter, medical doctors in the public sector had the right to open up and operate private clinics with outpatient services without quitting their positions in the public sector. This made private clinics an important component of Turkey's health care system.

---

<sup>13</sup> Different rules and regulations may apply to the provision of primary and secondary health care services in a particular country. To exemplify, the NHS treats general practitioners as individual entrepreneurs and works with them on a contractual basis. GPs in the UK are involved in the delivery of primary care services and are permitted to establish private practices while remaining as employees of a health authority or hospital trust. See: ROTHGANG, H., CACACE, M., GRIMMEISEN, S. & WENDT, C. 2005. The Changing Role of the State in Healthcare Systems. *European Review*, 13, 187-212.

### **3.3.3. The regulation of health care finance and delivery**

The last important component of the health care system is the regulation of health care services. The regulation of health care services refers to the course of the governance of health care delivery and health care finance (Wendt et al., 2009, p.77). Wendt et al. argue that this dimension can only be analysed in qualitative terms, as it requires the examination of different actors' engagement in regulatory practices with respect to diverse subsectors of health care systems.

As the state was the dominant party in the financing and provision of health care services, the regulation mainly took place within the public administration. Indeed, neither professional organisations nor trade unions had any institutionalised regulatory power over health care services in Turkey's health care system.

Despite the fact that Turkey's health care system closely resembled state health care systems as defined in Wendt et al.'s health care system typology, it also relied upon a significant amount of out-of-pocket payments in health care finance and private provision of health care services in the form of private practice of medical doctors. Given the importance of these components, it could be argued that the state's regulatory capacity was limited, as it failed to control the informality enmeshed into the formal health care system.

## **3.4. Conclusion**

This chapter introduced the main parameters of the development of the health care system in Turkey with references to significant moments within the politics of health care. Starting from the late 19<sup>th</sup> century,

Turkey's health care system was consolidated as a result of a collection of policy efforts in the domains of health care finance and delivery.

The state integrated the members of the medical community into its nation-making endeavour as state officials with elite status. In this context, the medical community served as one of the 'Westerniser' political forces in the history of late Ottoman and early Republican periods and contributed to the nation-making endeavour.

Parallel to welfare state developments in other parts of the world after the end of the Second World War, Turkey started to pursue more programmes to consolidate its health care system. In the domain of health care delivery, the geographical extension of primary health care services had been the major concern of governments until 1980s. In the domain of health care finance, governments initiated the establishment of occupational-status based social health insurance plans. Advances in health care finance increased the demand for and scope of secondary and tertiary health care services.

However, it could be concluded that the historical development of Turkey's health care system can hardly be explained with the power resources approach. In Keyder's words, "neither farmers nor workers were politically strong and organised enough to influence directly the outcome of a political contestation" (Keyder, 2007b, p.3). Parallel to the pluralist approach, the major dynamic behind the birth of Turkey's health care system in the 1950s was the transition to electoral democracy, as the ruling bloc was divided into two political parties. In order to secure their re-election chances, a series of governments made advances in the domain of health care policies and cumulatively paved the way to the emergence of Turkey's health care system as described in this chapter. However, as the analysis of Turkey's political history suggests, the reduction of politics into electoral politics was not inartificial. In contrast, for the most part the political system left almost no possibilities for class politics. Electoral politics remained the only possibility for citizens to influence policy making.

The relatively liberal constitution of 1961 provided a restricted window of opportunity for different political actors to emerge as autonomous actors. Parallel to the rise of social movements worldwide around 1968, the DİSK and TTB emerged as powerful actors defending social rights of citizens, including the right to health care. Despite the fact that the main parameters of Turkey's health care system resembled the corporatist welfare regimes in Western Europe, this corporatist character did not exist in the governance side. In other words, the political system of Turkey did not permit trade unions and professional organisations to take part in the administration of social security funds or health care delivery, which limited the impact of both DİSK and TTB on health care policy outcomes. However, here it is argued that the left might have had an influence on the development of social policies in general and health care system in particular, as a bundle of actors created a moral discursive vantage point for public discussions on social welfare issues.

The concept of policy drift can best describe the situation of Turkey's health care system throughout 1980s. The introduction of the Green Card scheme was the only change in health care policies throughout 1990s, which could not give an end to the failure of Turkey's health care system to provide universal coverage. Meanwhile, the Political Islamist National Outlook movement benefited from the policy drift and recruited the outsiders to the formal social security system into its ranks.

The WB's engagement with Turkey's health care system during 1990s seemed to have an immense impact on the framing of these problems and the solutions, which is discussed in Chapter 4 and 5 in detail. A number of governments in collaboration with the WB came up with similar health care reform proposals throughout the 1990s. Due to the short-lived weak coalition governments, none of these proposals could be realised.

In case the governments attempted to introduce policy changes in health care, it met with opposition from the left. Even though the left did not enjoy any 'veto power' within the system, it used all possible political resources to stop these reform projects. While the SHP filed an appeal to

the Constitutional Court, the TTB mobilised medical doctors against the proposed reforms. As a result, it was only in 2003 that the single party government of the AK Party could initiate a comprehensive health care reform. The next chapter explains the main parameters of this reform while situating it within similar reform projects worldwide.



# **Chapter 4: The Health Transformation Programme in Turkey within the Context of Health Care Reforms in Other Developing Countries**

## **4.1. Introduction**

Reforming Turkey's health care system had been on the agenda of governments since the 1990s in Turkey. As mentioned in the previous chapter, the changing character of Turkey's health care reform projects coincided with the establishment of the partnership between the WB and Turkish government in 1990. Indeed, Turkey was not an exception to global wave of health care reform. The WB had been promoting pro-market health care reforms in the developing countries of Latin America and the transition countries of Eastern Europe and Central Asia since the late 1980s. In addition to the WB, the IMF was also active in promoting pro-market health care reforms and enforcing the developing country governments to spend less on health care services as part of the Stabilisation Programmes. During this time, advanced capitalist countries were not immune to health care reforms either. Due to rising health care costs and changes in the power dynamics in favour of the pro-market political actors, many Western European countries also introduced pro-market health care reforms.

Despite the fact that the post-1980s health care reforms generally shared a strong marketization dynamic, as discussed in Chapter 2, it would be erroneous to portray these reforms as carbon copies of one another. While the marketization tendency is evident in most reforms, health care reforms took unique shapes in different national settings due to diverse political dynamics.

In this context, the major objective of this chapter is to describe the HTP and to situate it within the context of post-1980s health care reforms in developing countries. In doing so, this chapter demonstrates the

similarities as well as differences between the HTP in Turkey and other health care reforms.

This chapter has four main sections. After this introductory section, the second section describes the main parameters of the HTP. The third section provides an overview of the post-1980s health care reforms in developing country contexts with a special focus on Latin America, Southern Europe and East Asia. The concluding section discusses the similarities as well as differences between the HTP and reforms that were carried out in Latin American, Southern European and East Asian countries.

#### **4.2. The main parameters of the Health Transformation Programme in Turkey**

The AK Party government came to power in the 2002 general elections and launched the HTP in 2003. The reform paved the way for the restructuring of health care finance, health care provision, and regulation of health care services in Turkey.

The MoH declared that the HTP had eight components: 1) transform the MoH into a planning and a monitoring body; 2) unify the public health insurance schemes under the umbrella of general health insurance; 3) facilitate access to health care services, which included the introduction of the family physicians model, the introduction of the referral chain, and the establishment of health enterprises; 4) increase the motivation of human resources in health care; 5) establish educational institutions to support the new model; 6) introduce quality measures for the health care sector; 7) support the rational use of medications; and 8) establish a health information system (Ministry of Health of the Republic of Turkey, 2003, pp.26-36). For the purpose of this study, I will discuss below the abovementioned components of the HTP in relation to the changes they made in the domains of health care finance and delivery.

#### 4.2.1. Changes in health care finance

The HTP aimed to establish a compulsory general health insurance model for all. Compulsory general health insurance was put into practice in 2008 (The Republic of Turkey, 2006). With this change, three public health insurance schemes and the Green Card scheme were united under the umbrella of the general health insurance. The SGK was established to replace previous institutions that used to be in charge of health care finance for different occupational groups, namely the ES, BAĞ-KUR and SSK. In doing so, the reform also equalised the benefit packages of all three social insurance schemes and the Green Card scheme.

The general health insurance model kept the social insurance based financing model of Turkey's health care system intact. It did not change the residual tax-financed component that had financed the non-contributory scheme, namely the Green Card. Different from the previous model; all citizens are now obliged to contribute to the public health insurance fund regardless of their employment status. The only exception to this rule is the exemption given to those living under the official Green Card eligibility income threshold.<sup>14</sup> Unlike the previous health care finance model, the state began to contribute an amount equal to 25 per cent of all premiums collected monthly to the public health insurance fund.

The new financing model not only consolidated the social insurance based financing model of Turkey's health care system, but also introduced additional sources of health care finance. These sources include contributory payments for all hospital visits and medications, additional payments for private hospital visits (which began to serve citizens with

---

<sup>14</sup> Income eligibility criterion for a Green Card is below the officially defined poverty threshold. For the period between 1 June – 31 December 2012, income ranges and premium levels apply to these ranges of monthly incomes per person in a family: 1) No premium to be paid for people living under less than one third of minimum wage (313,50 TL=app. 135 €), 2) 37,62 TL (app. 16 €) premium to be paid for people living on monthly incomes between one third of minimum wage (313,50 TL=app. 135 €) and minimum wage (940,50 TL=app. 405 €), 3) 112,86 TL (app. 49 €) premium to be paid for people living on monthly incomes between minimum wage (940,50 TL=app. 405 €) and two minimum wages (1881 TL=app. 810 €), 4) 225,72 TL (app. 97 €) premium to be paid for people living on monthly incomes above two minimum wages (1881 TL=app. 810 €).

public health insurance after the reform) and optional supplementary private health insurance.

Patients are obliged to make contributory flat rate payments, named contributory payments, when accessing outpatient health care services and medications.<sup>15</sup>The amount of payment is calculated on the basis of the number of hospital visits and the number of prescribed medications. The rate of payment only differs according to the hospital type, i.e. a public university hospital, or a public education and research hospital. Patients are exempt from making contributory payments when they visit primary health care services. In addition, patients with defined health conditions (i.e. an emergency situation or metastatic cancer) are exempt from making contributory payments.

In the early days of the reform, the government argued that contributory payments were introduced in order to promote rational use of hospitals and medications. Therefore, contributory payments are presented as part of economisation dynamic inherent in the HTP. Nevertheless, a study on the rate changes of contributory payments points to an increase throughout the reform process (Turkish Medical Association, 2011a). Indeed, these increases resulted in the tripling of the total revenue collected from contributory payments from 2009 to 2010 (Medimagazin, 2011a). Finally, I argued elsewhere that the increasing trend in the rate of contributory payments over time suggests that these payments might become an important source of health care finance, might go beyond the objectives of economisation and contribute to marketization of health care services (Yılmaz, 2013).

The second new component of health care finance was the introduction of additional payments for private hospital visits. As discussed in the next subsection, the HTP integrated a significant number of private hospitals

---

<sup>15</sup> Up-to-date rates of contributory payments at the time this article was drafted were as follows: 1) 5 TL (= app. 2,15 €) for each outpatient visit to a public hospital, 2) 12 TL (= app. 5,17 €) for each outpatient visit to a private hospital that offers services to the publicly insured, 3) 3 TL (= app. 1,29 €) for each prescription including up to three items of medication, 4) Additional 1 TL (=app. 0,43 €) for each item of medication over three.

into the system as service providers for the publicly insured. However, citizens can only get access to private hospital services if they are able and willing to make additional payments to top up their public health insurance plan. The SGK determines the maximum amount of additional payment that a private hospital can charge. Additional payments imply marketization of health care services.

Similar to the level of contributory payments, the maximum rate of additional payments also demonstrates an increasing trend, which signifies increasing marketization of health care services over time. The maximum amount of additional payment in 2012 was 90 per cent of prices, as determined by the SGK for private hospital services (Habertürk, 2012), which then rose up to 200 per cent over a year (NTVMSNBC, 2013a). In addition, the rate of additional payments differs according to where a private hospital stands in the Ministry's quality rankings. Since the reform, the rate of additional payments has become one of the main areas of controversy between the SGK (or the government in a Turkish context) and private hospitals, which is discussed in detail in Chapter 8.

Lastly, the HTP introduced a basic benefit package for public health insurance. After the reform, the SGK became responsible for defining the basic benefit package of public health insurance. SGK annually issues the type, amount and duration of diagnostic services, medications and treatment services that are financed out of the public health insurance fund.

These developments in the domain of health care finance seem to encourage the purchase of private health insurance plans. Indeed, the number of citizens with private health insurance increased from roughly 850,000 in 2004 (Insurance Association of Turkey, 2012) to approximately 2,800,000 in 2013 (Insurance Association of Turkey, 2014). Despite the fact that the total share of citizens with private health insurance has still not exceeded 2 per cent of the total population, the increase in private health insurance uptake is still noteworthy.

In addition, the HTP also introduced supplementary (private) health insurance. The main aim of this new private health insurance component is to top up the public health insurance by offering financial protection for additional payments in private hospitals that offer services to the publicly insured (Mapfre Genel Sigorta, 2012). Despite the slow pace of development in this area so far, one of the leading health insurance firms expects to reach five million consumers in five years time (Mapfre Genel Sigorta, 2012).

#### **4.2.2. Changes in health care delivery**

Before the reform, different types of public hospitals, such as the MoH hospitals, the SSK hospitals, and public university hospitals, dominated the health care delivery in Turkey's health care system. Two major components of the HTP sought to restructure health care delivery in Turkey and create a quasi-market in health care provision. While the first of these components was the transformation of the MoH into a planning and monitoring body, the second one aimed to establish health enterprises.

These individual health enterprises include both public and private hospitals. Public hospitals are transformed into health enterprises, named Public Hospital Unions (*Kamu Hastane Birlikleri*), that have both financial and administrative autonomy from the central state organisations (Ministry of Health of the Republic of Turkey, 2003, p.31). In the new health care delivery structure, all health care providers will be able to offer services to the publicly insured as long as they comply with the MoH quality requirements and sign a contract with the SGK (Ministry of Health of the Republic of Turkey, 2003, p.31). The new model will lead public hospitals to adopt private sector tools in hospital management and payment mechanisms for health workers (i.e. performance-based model of payments). In this new model, the MoH will cease to function as a health care provider. It will instead act as a monitoring body in the health care delivery market (Ministry of Health of the Republic of Turkey, 2003, p.27).

The first step that the government took in this direction was to transfer the SSK hospitals to the MoH (The Republic of Turkey, 2005). It then restructured the MoH to fit into its new overseer and monitoring role and granted administrative and partial financial autonomy to public hospitals (The Republic of Turkey, 2011a). In line with these legislative changes, Public Hospital Unions were established to bring together geographically close public hospitals and grant them financial and administrative autonomy.

Finally, the government began to establish new public hospitals with a new financing mechanism, one that resembled the Private Finance Initiatives (PFI) in the UK (The Republic of Turkey, 2013). The establishment of Public Hospital Unions and the introduction of Private Finance Initiatives as the new resource for the construction of public hospitals can be understood with the concept of ‘institutional layering’, which refers to “the grafting of new elements onto an otherwise stable institutional framework. Such amendments . . . can alter the overall trajectory of an institution’s development” (Thelen, 2004, p.35). In other words, the injection of private sector management techniques into public health delivery institutions and the introduction of public-private partnership model in establishing new hospitals might transform the overall trajectory of public health delivery system in near future.

Another major step that the government took was to allow the SGK to purchase services from private hospitals for its insurees, which implied the launch of the quasi-market model in health care delivery. Prior to the reform, public hospitals were free to purchase diagnostic and maintenance services from private providers. In addition, the ES also used to purchase services from private hospitals, though this was limited in scope. However, with the implementation of the HTP, the state began to purchase health care services on a much larger scale than in the earlier periods. As a result, both the share of private sector investments to the health care sector and the share of expenditures from the SGK to private hospitals increased drastically during the reform (Sönmez, 2011, pp.60-71).

As mentioned in the earlier chapter, private clinics used to function as an important component of the health care delivery structure in Turkey before the reform. With the launch of the HTP, the government's insistence to introduce a full-time work requirement for medical doctors and to exclude private clinics from the public health insurance plan led to a decline in the number of private clinics (Kaban, 2010).

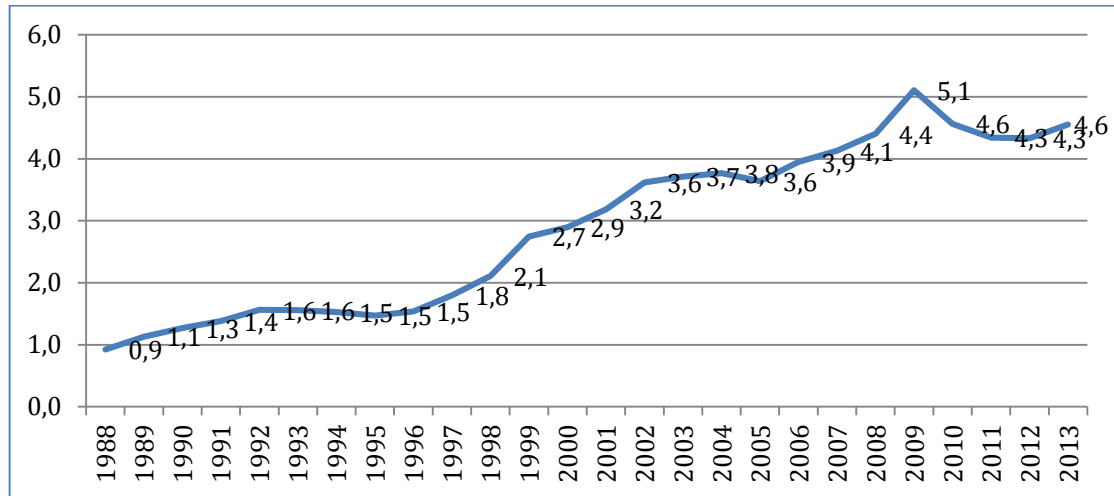
Another significant development occurred in the provision of medications. Before the HTP, the SSK beneficiaries and Green Card holders could not easily access medications. While the SSK beneficiaries had been obliged to use the pharmacies owned by the SSK, Green Card beneficiaries did not have the right to free medications. The main problem for the SSK beneficiaries was the small number of the SSK pharmacies and consequent limitations to getting necessary medications on time. The only mechanism through which Green Card beneficiaries could access medications was to apply for a social assistance scheme, a laborious and lengthy application process. With the launch of the HTP, the beneficiaries of the SSK began to access medications through all privately owned pharmacies, which mostly solved the access problems of this group. As discussed in the earlier subsection, the reform granted equal benefit packages for Green Card users, including access to medications through privately owned pharmacies, which implied a clear improvement in Green Card beneficiaries' access to health care.

#### **4.2.3. The results of the Health Transformation Programme so far**

One of the results of the HTP was an increase in public health expenditures and the share of public health expenditures in GDP. Graph 1 shown below indicates this increase.



Graph 1. Public health expenditures/GDP



Sources: Calculated by the author using data from the ES, BAĞKUR and SSK for the years between 1988 and 2004, the SGK for 2005, the General Directorate of Public Accounts for the years between 2006 and 2013.

As the Graph 1 indicates, despite the policy drift –with the exception of the introduction of the Green Card scheme- between 1988 and 2002, the share of public health expenditures in GDP raised from 0.9 per cent in 1988 to 3.6 per cent in 2002. After the introduction of the HTP in 2003, increase in the share of public health expenditures in GDP continued. The share of public health expenditures in GDP raised from 3.7 per cent in 2003 to 4.6 per cent in 2013.<sup>16</sup> This increase might be explained with different components of the reform stated as follows: the equalisation of benefit packages for all public insurees including the beneficiaries of Green Card scheme, the increase in the number of Green Card beneficiaries and the introduction of public transfers for services of private hospitals to public insurees.

A survey reveals that the general public perceives the short-term impact of the contemporary health reform as largely positive. The rate of highly and very highly satisfied citizens increased from 40 per cent in 2003 to roughly 75 per cent in 2013 (Turkish Statistical Institute, 2014, p.78).

<sup>16</sup> Highest share of public health expenditures in GDP in 2008 is due to the shrinkage of the GDP by 4.8 per cent during the economic crisis.

This drastic increase in citizens' satisfaction can be partly attributed to the increased ease of access: it was reported that per capita hospital visits rose from 2 in 2002 to 5.1 in 2012 (Ministry of Health of the Republic of Turkey, 2013, p.91). In addition, the state began to pay the premiums of more people, as evidenced by the rising numbers of Green Card users. The number of people under the income eligibility threshold whose premiums were paid by the state increased from less than 7 million in the early 2000s (Social Security Institution of Turkey, 2010) to nearly 12.5 million by April 2014 (Social Security Institution of Turkey, 2014). In addition, the equalisation of benefit packages might have contributed to an increase in the rate of public satisfaction with health care services. After the reform, the public expenditures for health care have become more fairly distributed among different occupational status groups (Teksöz et al., 2009). As a result of these developments, Alkan interpreted the AK Party's consecutive victories in general elections as a result of the government's success in reforming health care (2011).

In the literature, scholars seem to disagree on the impact of the reform on three fronts: access to health care, the working conditions of health workers, and the future sustainability of health care system. Some scholars argue that the reform had a positive impact on citizens' access to health care services by easing citizens' access to health care services and abolishing the former occupational status-based inequalities in access to health care (i.e. Barış et al., 2011; Karadeniz, 2009; Teksöz et al., 2009; Ağartan, 2008; Ağartan, 2007; Keyder, 2007).

In response, others suggest that the reform's pro-market components pose significant obstacles against the consolidation of an egalitarian health care system (i.e. Yılmaz, 2013; Ağartan, 2012; Etiler and Urhan, 2011; Turkish Medical Association, 2011b; Yaşar, 2011; Yaşar and Uğurluoğlu, 2011; Sönmez, 2011; Civaner, 2011; Uçku and Elçi, 2010; Üstündağ and Yoltar, 2007; Pala, 2007).

In sum, it might be claimed that the short-term impact of the reform on citizens' access to health care services was largely positive. However,

there is no consensus in the literature over the long-term impacts of the reform on the sustainability of Turkey's health care system, its ability to provide free health care services for all, and the provision of health care services on the basis of equal citizenship status.

### **4.3. The post-1980s health care reforms in Latin America, Southern Europe and East Asia**

The main aim of this section is to review the post-1980s health care reforms with a special emphasis on developing country contexts. This section will also analyse the similarities and differences between these reforms and the HTP. The first subsection provides an overview of the political, economic and demographic background of post-1980 health care reforms debates worldwide. The second subsection examines post-1980 health care reforms in three regions, namely Latin America, Southern Europe, East Asia and South Asia. Countries from these three regions were selected primarily due to the similarities they share with Turkey in terms of welfare systems (Buğra and Keyder, 2006, p.212) and/or political economic context (i.e. Eder, 1993).

#### **4.3.1. Background**

Before the consolidation of the Washington Consensus, health care reforms in developing countries aimed to extend the scope of, and facilitate, access to health care services. A combination of anti-colonial sentiment, positive international political atmosphere crowned by the Alma Ata Declaration of 1978, and the ideals of socialism and social democracy, made "health for all" the common political developing country discourse on health care policies, even if governments did not always put "health for all" into practice.

Unlike most advanced capitalist countries, developing countries could not provide universal coverage for all citizens before the early 1980s. The

majority of health care systems in high and middle-income developing countries traditionally rely on a social insurance system for civil servants and other formal sector employees (Barrientos and Lloyd-Sherlock, 2000, p.417). In line with the developmentalist objectives of the post-WW2 period, it was expected that health insurance would gradually cover all citizens.

Since the late 1970s and early 1980s, health care reforms have become part of the political agenda both in developing countries and advanced capitalist countries. In advanced capitalist countries, several reasons accounted for the rise of health care reforms in the political agenda, including: ageing populations and chronic diseases which led to a rise in health care expenditures, an increase in demand for health care services, intensive use of health technologies such as computerised axial tomography (CAT) scanners, magnetic resonance imaging (MRI) and positron emission tomography (PET) (Wessen, 1999, p.386; Abel-Smith and Mossialos, 1994, p.90), and the need to contain increasing health care expenditures accordingly (Blank and Burau, 2010, pp.96-97). Indeed, scholars note that the increasing rate of health care costs exceeded the rate of economic growth in advanced capitalist countries (Blank and Burau, 2010, p.19).

Regarding the factors that led to significant increases in health care expenditures, Moran suggests that Western European governments made a conscious political choice to prioritise protecting the global competitiveness of their health industries over the sustainability of the provision of free health service for all (1998: p.26).

Going back to the discussion on cost-containment, it is important to ask the following question: Do pro-market health care reforms decrease health care spending? The evidence indicates the answer to the question if the proposed pro-market solutions serve the cost-containment objective is open to debate. State health care systems seem to better accommodate health care costs (Abel-Smith and Mossialos, 1994, p.125). Societal health care systems seem to be weaker than state health care systems in containing costs, yet they fared better than private health care systems (Blank and Burau, 2010, p.76). As the case of the U.S. demonstrates, greater

private sector involvement in health care services tends to result in reduced government ability to control health costs (Blank and Burau, 2010, p.107).

How has the US private health care system emerged as the vantage point for health care reforms in Western Europe and elsewhere? While the US health care system has been a laggard in terms of its failure to both provide universal coverage and contain health care expenditures, it nevertheless become a vantage point for health care reforms. The strength of the US position within the global health care market makes it a reference point for health care reforms, even though the UK has one of the best performing health care systems in terms of cost containment and universal coverage (Moran, 1999, p.18).

If pro-market health care reforms do not support cost-containment, what makes them acceptable for democratic societies? Some sectors of Western European societies find pro-market health care reforms appealing due to various reasons. Scholars suggest that upper and upper middle classes in particular have been unsatisfied by the restricted choice and relatively low quality of health care services of state health care systems. This discontent has not been unfounded, as rationing mechanisms led to problems such as long waiting times and delays, especially in access to specialty health care services (Leys, 2010, p.19; Moran, 2000, p.150; Ranade, 1994, p.43). Moran emphasises that even though state health care systems perform well in controlling the system and providing access to all free at the point of service, they are more likely to be insensitive to consumer demand and inefficiencies (1998, p.19). As a result, neoliberal discourse of health care reforms has become a voice for high-income groups' demands for better health care in these countries (Moran, 1998, p.30). Finally, in line with the expectations of ideational institutionalism, it could be suggested that the fact that pro-market health care reforms lack evidence does not seem to weaken their popularity. The power of neoliberalism manifested itself in the recognition of the basic premises of health economics among policy makers, which empowered the pro-market policy frame in health care policies.

In the aftermath of the fall of Keynesianism and the consolidation of the Washington Consensus, the political atmosphere that favoured the establishment of state health care systems in the developing world started to disappear. The WB emerged as the key institution in global health care policy, and its role is discussed in detail in Chapter 5. The WB's first report on financing health services in developing countries was published in 1987 (World Bank, 1987). The report promoted pro-market health care reforms and contributed substantially to the increasing political urgency attached to health care reform in developing countries. The WB's approach was clearly pro-market in health care delivery but pushed the state's financier role to remain intact (World Bank, 1993, p.65). In this period, managers and economists became part of health care policy debates, challenging the dominance of the medical profession in the political realm in developing countries (Walt and Gilson, 1994, p.357).

Therefore, the post-1980s health care reforms in developing countries emerged as products of both a pro-market dominant discourse and a new set of actors in the health care domain. Structural Adjustment Programmes (SAPs) and Stabilisation Programmes that laid the basic tenets of the economies of developing countries and public sector transformation in these countries became part of the political context within which health care reforms gained primacy. In this context, pro-market health care reforms sometimes were introduced as part of the conditionalities attached to loans provided by international donor organisations at the time of economic crises (Hall, 2003, p.87).

However, it would be erroneous to conclude that health care systems are simply converging to private health care systems. In contrast, Rothgang et al. suggests that there is a relative retreat of the state from health care financing, while the differences between health care system types remains relatively stable over time (2005, pp.194-196).

Research on some country cases point to a reverse dynamic in private health care systems. For instance, the U.S. government recently managed to introduce a health care reform to increase the regulatory power of the

state over the health insurance market with the objective of ensuring access to health care services especially for seniors, the sick and middle-class Americans (Jacobs and Skocpol, 2010, p.122). Therefore, evidence supports the claim made in Chapter 2 that health care reforms all around the world are ongoing political processes, the pace and scope of which vary according to the political and economic dynamics in different national contexts. The study of individual cases of health care reforms shows that all these processes are political processes that are open to unprecedented outcomes.

One should note that stark differences exist between advanced capitalist countries and developing countries with respect to the political economic context within which the post-1980 health care reforms arrive. Developing countries differ from advanced capitalist countries in terms of financial resources they can allocate to health care services. Schieber and Maeda looked at the WB statistics on health care to show that developing countries—home to 84 per cent of the world population—account for only 11 per cent of all health care spending in the world (1999, p.194). Even though more money poured into health care does not necessarily translate into better health outcomes, the considerable disparity between health care expenditures of developing countries and advanced capitalist countries might well indicate the inequality of health care infrastructures and health outcomes between these two groups of countries.

Against this background, the selected country cases below indicate that the political trajectories of post-1980 health care reforms in the developing world have been diverse with respect to the content of these reforms as well as the changes they brought on.

#### **4.3.2. Health care reforms in Latin America**

Most post-1980 health care reforms in Latin America were introduced as part of the SAPs during economic crises. Apart from a small number of exceptions, such as the Venezuelan health care reform in 1999 (Muntaner

et al., 2006, p.804), the majority of Latin American health care reforms had strong pro-market components.

Most Latin American countries and Turkey shared social insurance-based health care systems that failed to provide coverage for those outside the formal labour market. While Turkey's health care reform did not start during an economic crisis, as was the case in most Latin American reforms, it still shares a pro-market approach with Latin American reforms. Therefore, an analysis of three Latin American experiences of post 1980 health care reforms might shed light to the discussions on Turkish health care reform. With this objective, we examine three reform experiences: in El Salvador, Chile and Argentina.

#### ***4.3.2.1. Health care reform in El Salvador***

El Salvador witnessed health care reform during its public sector restructuring after the 1980 economic crisis and 1992 peace agreement. The WB was seen as the most critical international partner of the El Salvadorian government during the reform process (Homedes et al., 2000, pp.66-67). The government established the Health Reform Group, which led the reform process without consultation with trade unions, peasants' organisations, professional organisations and the MoH (Homedes et al., 2000, p.75). The reform resulted in decentralised health care services, a limited role for the public sector in health care, new user fees for health care services, and a basic benefit package that merely included primary health care services (Homedes et al., 2000, pp.71-73).

#### ***4.3.2.2. Health care reform in Chile***

Chilean health care traditionally relied on a centralised public health care system funded by a set of social health insurance schemes (Barrientos, 2000, pp.95-96). Similar to the El Salvadorian experience, the first set of post-1980 health care reforms in Chile came into place as part of the SAP.



In addition, the country was also under the rule of the military dictatorship that overthrew Salvador Allende's government in Chile. The dictatorship introduced private health insurance and extended its coverage to blue-collar workers in the late 1970s and early 1980s (Barrientos, 2000, p.96). However, until the end of the 1990s, private health insurance covered just over a quarter of the citizenry, which included mostly low-risk individuals and high-income earners (Barrientos, 2000, p.94). In addition, the military dictatorship separated health care finance and provision from each another (Barrientos, 2000, p.96).

Chile's transition to electoral democracy after 1989 brought the centre-left to power and strengthened the public component of its health care system. A second set of Chilean health care reforms, titled The Plan AUGE, attempted to reverse the marketization process initiated by the Pinochet dictatorship and established a universal health insurance for all, one which would eliminate differences in benefit packages among different sectors of society. However, this reform did not ensure equal access to health care for the majority of women. The reform also failed to eradicate income-based inequalities in access to health care services (Dannreuther and Gideon, 2008). After the reform, the public component of the Chilean health care system functioned as a 'provider of last resort' (Barrientos, 2000, p.94). The resulting health care system rendered a strong stratification both in citizens' access to health care services and their affiliation to health insurances (Barrientos, 2000, p.111).

#### ***4.3.2.3. Health care reform in Argentina***

During the 1990s, the government carried out a comprehensive health care reform in collaboration with the WB. Before the reform, the Argentinian health care system had been built upon a tripartite structure: the publicly funded sector, social insurance funds, and private health care (Lloyd-Sherlock, 2005, p.1895). The publicly funded sector suffered from underfunding, while small-sized social insurance funds were weak vis-à-vis

health care providers due to the lack of state regulation (Lloyd-Sherlock, 2005, p.1895). Throughout the 1990s, the private sector component grew (Lloyd-Sherlock, 2005, p.1895).

Similar to the experience of most other Latin American countries, health care reform was initiated at a time when the Argentinean economy was under the impact of the SAP in the 1990s. One of the key components of the Argentinean health care reform was the introduction of a competitive market in health insurance, which gave citizens the option to exit from the social health insurance scheme and switch to the private health insurance (Lloyd-Sherlock, 2005, p.1897). Secondly, the reform transformed public hospitals into health enterprises with their own management authorities, with the exception of keeping the provincial administrations' authority over the hospital staff (Lloyd-Sherlock, 2005, p.1898).

#### **4.3.3. Health Care Reforms in Southern Europe**

Southern European countries, namely Greece, Italy, Spain and Portugal, historically share similar traits with Turkey in terms of their political economic structures, social insurance based financing of health care, and the legacy of authoritarian rule. Scholars generally classify Turkey's welfare system as reminiscent of the Southern European welfare regime type (Buğra and Keyder, 2006, p.212). However, it is important to note that Günal rightly suggested that Southern European countries took a different route in terms of their health care systems after the end of the 1970s. While Turkey mostly chose to consolidate its social insurance based financing model, Southern European countries switched to a national health services model (Günal, 2008, pp.13-14).

Although Southern European countries and Turkey took different historical paths toward health care reform, it might still be useful to examine the reforms to see if different political dynamics in Southern Europe resulted in a switch to a national health services model.

Before discussing individual cases, I would like to note the difference between the political economic context within which national health care systems are embedded in Southern European countries and Britain and Scandinavian countries. First of all, Southern European countries had societal health care systems before the reforms, and these systems were then transformed into state health care systems. In contrast, Britain and Scandinavian countries established their health care systems as state health care systems from the very start (Petmesidou and Guillén, 2008, p.107). Second, Britain and Scandinavian countries set up their national health care services at times of steady economic growth and prosperity, while Southern European countries established national health care services during periods of economic austerity (Petmesidou and Guillén, 2008, p.107). Similar to Latin American countries that were obliged to undertake SAPs under the influence of the WB and the IMF, Southern European countries were required to meet the Maastricht criteria in order to join the preparations of the European Monetary Union (EMU) (Petmesidou and Guillén, 2008, p.107).

As a result, and in line with historical institutionalist predictions, Moran suggests that national health care services in Southern European countries do not function like the systems of Northern European countries (2000, p.154). Co-payments increasingly became the biggest source of health care finance, while universal coverage remained more as an ideal than reality (Moran, 2000, p.154). According to Moran, the partial failure of the national health care service model in Southern Europe was due to the fact that Southern European health care reforms were undertaken at a time of fiscal austerity. Lastly, Moran draws attention to the role of the political culture in these countries, which resulted in corruption and the prevalence of private practice of medical doctors (Moran, 2000, p.155). Against this background, health care reforms in Greece and Italy are discussed in detail below.

#### ***4.3.3.1. Health Care Reform in Greece***

After the fall of the military junta in the middle of the 1970s, the New Democracy Party of Karamanlis won the general elections in Greece. However, it was not until 1981 that the Pan Hellenic Socialist Movement (PASOK) initiated health care reform and established a national health service in Greece (Kondilis et al., 2011, pp.32-33). As part of the reform, the establishment of new private health facilities was banned. This reform led to an increase in public health facilities for health care delivery (Kondilis et al., 2011, p.33).

However, reformers could not unite social security funds due to strong opposition by trade unions (Kondilis et al., 2011, p.33). As a result, while almost two-thirds of total health expenditures were funded through general taxation in Spain and Italy, only around 20 per cent of total health expenditures was financed through general taxation in Greece in 2004 (Petmesidou and Guillén, 2008, p.111). Petmesidou and Guillen suggest that the main reason for Greece's failure to unite separate social security funds was the 'statist-clientelistic' political culture and consequent polarised political structure (2008, p.110).

After the fall of the Social Democrats, the Conservative government lifted the ban on the establishment of private health facilities, introduced co-payment and user charges, subsidised private health insurances, abolished the employment security for medical doctors (Kondilis et al., 2011, p.34), and permitted medical doctors working for public hospitals to engage in private practice (Petmesidou and Guillén, 2008, p.110).

As mentioned earlier, the European Union's (EU) Maastricht criteria, coupled with preparations for the transition to a monetary union in Europe, undermined the power of the Greek government over the public budget during the reform process (Kondilis et al., 2011, p.34). As a result, the consolidation of national health care services model could not be a policy priority. Alternatively, the government became concerned with cost-containment in health care services, which then resulted in the further

marketization of health care services (Kondilis et al., 2011, pp.34-35). Therefore, despite the introduction of the NHS model, Tountas et al. suggest that the role of the private sector increased over time (2005, p.168). They argue that the main reason for the increased private sector presence in health care was due to the public sector's failure to provide quality services while citizens' disposable income increased, thereby fostering 'passive privatisation' (Tountas et al., 2005, p.169).

The private hospitals sector witnessed mergers and acquisitions between the late 1990s and early 2000s. This process led to the establishment of an oligopolistic market in private health care provision dominated by three multinationals (Kondilis et al., 2011, p.37). In his study of the concentration of private hospitals sector, Boutsoli also reports that the private hospitals sector has become an oligopolistic market, as it became increasingly concentrated over time and only a few companies today control the market (2007, p.223). The current Greek health care system, which has low satisfaction rates among the public, resembles a mixed health care system that is composed of different forms of financing and delivery structures (Kondilis et al., 2011, pp.40-41).

#### ***4.3.3.1. Health Care Reform in Italy***

The Italian government introduced health care reform to transform the country's health care system into a national health service in 1978. The major aim of this reform was to establish tax-based financing, free access to services for all, and public provision of services (Donatini et al., 2001, p.91). However, the reform could not be fully implemented, and private health care providers flourished due to limited public capacity for delivering health care services. In addition, costly co-payments created an obstacle for patients wishing to access health care services during the 1980s and early 1990s (Donatini et al., 2001, p.92).

In response, the Italian government initiated a new reform project in the early 1990s. In line with the British NHS reform, the main objectives of

this reform were to create an internal market for health care delivery and to decentralise health care services (Donatini et al., 2001, p.92). Nevertheless, these changes did not work in tandem with one other due to the lack of regulatory capacity in regional authorities.

In 1999, the Italian health care system once again witnessed health care reform. This time, the reform strengthened the regulatory role of the state but left the administration of health care delivery to the autonomous regions (Donatini et al., 2001, p.93). The reform authorised autonomous regions to permit the establishment of new health care facilities, which increased state power over the private providers (Donatini et al., 2001, p.99).

In the Italian case, the reform ended the dual practice of medical doctors until 1998 (Donatini et al., 2001, p.100). Alternatively, public hospitals reserved 6 to 12 per cent of beds for private patients of medical doctors, provided that these doctors pay a specific amount of their extra income to the hospital (Donatini et al., 2001, p.100).

#### **4.3.4 Health Care Reforms in East Asia and South East Asia**

The social policies of East Asian and South East Asian countries have been traditionally enmeshed with outward-oriented developmentalist aspirations, which are categorised as ‘productive welfare systems’ (Rudra, 2007). East Asian and South East Asian countries also witnessed a welfare system transformation after the 1980s. Since the literature on political economy has compared Malaysia and South Korea with Turkey (i.e. Eder, 1993) health care reforms in both countries are briefly discussed below.

##### ***4.3.4.1. Health Care Reform in Malaysia***

The Malaysian health care system was traditionally a state health care system (Ramesh, 2009, p.73). While the Malaysian government included health care in its privatisation plan in 1983 (Ramesh, 2009, p.75),

the government did not put this objective into practice for fear that it might hamper its re-election chances (Ramesh, 2009, p.75).

Alternatively, the Malaysian government pursued an alternative strategy that encouraged the private health sector to develop without undertaking direct privatisation (Leng and Barraclough, 2007, p.21). As the national income of Malaysia rose dramatically in the 1990s and 2000s, private hospitals flourished, proving the success of the government's 'passive privatisation' strategy (Leng and Barraclough, 2007, p.24). For example, the share of private hospital beds in total hospital beds increased from 5 per cent in 1980 to 25 per cent in 2002 (Leng and Barraclough, 2007, p.9). In this new setting, roughly less than half of the medical doctors work for the private sector, while more than half are hired by the public sector (Ramesh, 2009, p.75). In accordance with the concept of 'policy drift', the Malaysian case indicates that unimplemented reform or a passive attitude by the government does not merely mean stability in health care system. On the contrary, this inactivity can permit active change by other actors on the ground.

Malaysia relies upon various forms of health care finance tools, including government transfers, user charges, out-of-pocket payments, and a tiny proportion of social security funds and private health insurance funds (Ramesh, 2009, p.76). Government transfers to health care accounted for little more than half of total health care expenditures in 1998 and in 2002 (Ramesh, 2009, p.77).

Ramesh reports that the Malaysian government has been concerned with the containment of health care costs since the mid 1980s (2009, p.79). The government plans to transform the country's health care finance model from a tax-based model to a social insurance-based. However, Ramesh suggests that the government has still been unsuccessful in reaching these objectives due to possible electoral backlash (2009, p.79).

#### ***4.3.4.2. Health Care Reform in South Korea***

South Korea, similar to Turkey, has one of the lowest levels of social expenditures among other members of the OECD. In his book on the South Korean social policy, Woo argues that the main reason for low social expenditures was due to the state's primary political objectives, which were commitment to economic development and national competitiveness in the international economy. These objectives left social policy development off the political agenda. In order to strengthen its developmentalist strategy, Woo suggests that the South Korean state worked with the owners of large companies and created a cooperative labour force using company-level trade unions (2004, p.135). In fact, the Korean Tripartite Commission, which is composed of government, business and labour representatives, functioned as a corporatist governance body in South Korea. In this setting, company-level welfare provision increased in scope, yet the development of a universalistic welfare state remained limited (Woo, 2004, p.135).

Woo explains that the South Korean health care system began to develop during the economic boom of the 1960s and 1970s under the authoritarian regime. This system provided health care coverage mainly for those working in the largest companies. However, the Medical Aid Programme, similar to the Green Card scheme in Turkey, was introduced in 1977 as a tax-financed welfare programme to provide free health care services for those living under the officially determined poverty threshold (Chun et al., 2009, p.26).

According to Woo, health insurances for the general population appeared only after the relative democratisation of the country in the late 1980s (2004, p.130). For instance, in the late 1980s, health insurance schemes for the self-employed became available (Chun et al., 2009, p.141). According to Woo, the largest increase in health insurance coverage came about after the financial crises of 1997 and 1998 in order to reinstitute legitimacy of the state at the time (2004, p.130). Kwon also suggests that the democratisation of Korean politics and the financial crises of 1997 and



1998 made the developmentalist Korean state a more inclusive one in the domain of health care (2005, p.494).

In 1998, the South Korean government, a single party government of the now centre-left Democratic United Party, launched its plan to unite health insurances. As trade unionism was confined to the company-level, the largest trade union of the country, the Federation of Korean Trade Unions, opposed any proposal to unify social insurances and establish a national health service (Woo, 2004, p.134). The largest business organisation also opposed the unification proposal and suggested instead the extensive use of private health insurance (Woo, 2004, p.109).

Despite strong opposition to the proposed reform, the Democratic United Party's centre-left government legislated the reform, and the Constitutional Court ruled the unification of health insurance funds as constitutional (Woo, 2004, p.109). As a result, the National Medical Insurance Corporation was established in 1998 to merge 227 social insurance funds under the umbrella of one corporation (Chun et al., 2009, p.142).

Despite the ruling, the Grand National Party, the major conservative party of South Korea, and the Federation of Korean Trade Unions continued to work against the actual unification of social insurance funds. Indeed, Woo suggests that the fate of the financial unification of health insurance funds was still unclear in 2002. The anti-unification camp managed to convince the government to delay the financial merger until the end of the 2002 general elections (Chun et al., 2009, p.144). Woo argues that the political division between the Federation of Korean Trade Unions, who were against the unification, and the Korean Confederation of Trade Unions, who were for the unification, decreased the chance of full-fledged unification of health insurance being realised (2004, p.120). Finally, after the electoral victory of the centre-left Democratic United Party in the 2002 presidential elections, the financial merger could be implemented in 2003 (Chun et al., 2009, pp.144-145).

After the mid 2000s, the Medical Aid Programme began to be perceived as a significant burden on the public budget (Kwon, 2007). As a result, the South Korean government introduced cost-sharing for outpatient care services with a ceiling on user chargers and limited access of the beneficiaries of Medical Aid Programme to certain health care providers (Kwon, 2007). Kwon reports that progressive civic groups opposed these changes to the Medical Aid Programme yet failed to stop the reform (2007).

#### **4.4. Conclusion**

This concluding section explores the similarities and differences between the HTP in Turkey and reforms in Latin American, Southern European and East Asian countries. In doing so, the section offers insight into the specificities of the HTP in Turkey within a comparative perspective. Last but not the least, the section shows that significant actors have to be taken into account when examining the politics of health care in developing countries.

The first conclusion that might be drawn from this discussion is that while there seems to be a general trend for marketization in different health care reforms, there is no single route for developing countries to restructure their health care systems. Even if two countries seem to take a similar path (i.e. providing more room for private health insurance schemes), if and how this path is implemented on the ground depends on various political factors.

However, it can be safely argued that the dominant global ‘policy paradigm’ of pro-market health care reforms for developing country governments has been by and large the same. International organisations, especially the WB, have been at the forefront of promoting this discourse through various means, which will be discussed in detail in next chapter.

The HTP has both similarities and differences with health care reforms in the selected countries of Latin America, Southern Europe and East Asia. The main tenets of the reform in Turkey, including the purchaser-provider split, the social insurance funds merger, user chargers

to outpatient services, and a greater role for the private sector in health care delivery, are common in most of the health care reforms discussed above. Similar to the Latin American health care reforms carried out in collaboration with the WB, Turkey's health care reform has been an almost secretive political process that included government officials and the WB experts but excluded other actors such as trade union and the TTB representatives, the point that is elaborated in the next chapter.

As far as the outcomes of the abovementioned reforms are concerned, passive privatisation seems to be a general trend rather than sale of public health care institutions to the private sector. Turkey is not an exception to this trend. As is the case of Greece, changes in health care delivery market have been leading to a greater concentration in the health care delivery market in Turkey. Similar to the Malaysian experience, a rise in national income seems to strengthen the use of private health care facilities in the Turkish case. During the post-1980 health care reforms, hardly any of the developing country cases were investing in public health care facilities. Therefore, it could be argued that the rise of private actors in health care delivery emerged as common trend in the aftermath of post-1980 health care reforms in developing countries.

A major difference between the HTP and reforms in other selected developing countries is the continued dominant role of the Turkish state in health care finance. For instance, unlike the reform in Argentina, the Turkish health care reform did not include an exit option from compulsory social health insurance. This might be partly explained on the basis of the contextual differences within which reforms were introduced in these two countries. While health care reform in Argentina was introduced at times of austerity, Turkish health care reform came into place during steady economic growth. The second difference might be the limited power of political actors beyond the government in Turkey. Unlike South Korea, consultative bodies like the Tripartite Commission do not exist in Turkey's political system. For instance, while the power of trade unions and other actors delayed the implementation of health care reform in South Korea

and blocked reform in Greece, no political actors have succeeded in delaying or blocking the reform of a single-party government in Turkey.

The selected case studies suggest that there are important political factors that have to be taken into account when understanding the politics of health care during health care reform processes. These actors include the role of international organisations, governments and their power within the country's political system, and the role of trade unions and business organisations. The subsequent chapters examine the role of these actors in the politics of health care in Turkey.

There are also general lessons to be learnt from these case studies. For instance, if a country is under the rule of a working electoral democracy, governments seem to care about their electoral prospects while carrying out health care reforms, which hamper any governmental attempts to pursue direct privatisation. Therefore, when governing parties have competitors, they might choose not to pursue direct privatisation but rather undertake passive privatisation. In addition, trade unions in developing countries can act either to protect their members' relatively privileged positions within health care systems or to establish broader alliances to push for the establishment of universalist health care system for all.

Last but not the least, these cases suggest that significant political clashes might well occur after the reform is enacted. These clashes might even block the implementation of the reform, give it a new shape, or make a significant amendment to it. Therefore, as discussed in Chapter 2, a general tendency in the literature to examine the political processes that result in the enactment of reforms, but neglect the political processes after the primary legislative victory of the proponents of the reform, might not be well grounded. Political negotiations and conflicts over the reform do not come to an end once the primary reform decision is made. In line with this insight, the remaining chapters focus on post-legislative politics in Turkey's health care system as well.

## **Chapter 5: The Impact of the World Bank on Health Care Reform in Turkey**

### **5.1. Introduction**

Domestic political dynamics (within the limits of global economic dynamics) are often used to contextualise the emergence of health care reforms in Western European and North American advanced capitalist countries (Jacobs and Skocpol; 2010; and Klein, 2010; Ewert, 2009; Ham, 2009; Harrison and McDonald, 2008; Giaimo, 2005; Lister, 2005; Salter, 2004; Moran, 1999; Freeman, 1999; Freeman, 1998; Moran, 1998; Abel-Smith and Mossialos, 1994; Walt, 1994; Navarro, 1994; Ranade, 1994; Immergut, 1992; Moran, 1992). In contrast, the role of international organisations is particularly emphasised when looking at health care reforms in developing countries (Sen and Koivusalo, 1998; Berman and Bossert, 2000; Armada et al., 2001; Homedes and Ugalde, 2005; Lloyd-Sherlock, 2006; Ağartan, 2007; Ağartan, 2008).

Before the establishment of the Washington Consensus, the WHO was the most important international actor driving the global health care policy agenda. In the late 1970s, the WB replaced the WHO as the new key global development actor and began directing considerable amounts of financial resources to the reform of health care systems in developing countries.

The World Bank Group (WBG) institutions, which were primarily established during the Bretton Woods Conference in 1944 to assist the reconstruction of Europe after the Second World War, changed shape as the neoliberal political agenda took off first in the U.S. and the U.K. and then spread to other countries. As the voting structure of the WB allowed advanced capitalist states to dominate over the Bank's policy choices (Armada et al., 2001, p.732), political changes especially in the U.S. and the U.K. proved to be influential in reshaping the policy priorities of the WB alongside the Washington Consensus. In this process, the WB emerged as

one of the largest global development actors and pioneers of pro-market health care reforms in developing countries.

Starting in the late 1970s, the WB increased the scope of its funds in the domain of health care services, which exceeded the total budget of all health-related UN organisations by the 1990s. In addition to its financial resources, the WB also established an international ‘epistemic community’, as Freeman suggests (Freeman, 1998, p.398) that began to claim expertise in reforming health care systems especially in developing countries.

With these changes, the WB started to get involved in the domestic policies of its aid recipient countries, including in the restructuring of public administration, and in the domains of social policy and health care policy (Laurell and Arellano, 1996, p.2). The WB began to act as a vantage point for health care reforms in developing countries (Walt, 1994, p.127; Walt, 1998, p.434; Buse and Gwin, 1998; Homedes and Ugalde, 2005, p.94).

The WB, a member of the WBG, is comprised of two institutions: the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA). In addition to the WB, the International Finance Corporation (IFC), which is also a member organisation of the WBG alongside the Multilateral Investment Guarantee Agency (MIGA) and International Centre for Settlement of Investment Disputes (ICSID), has also been quite influential in the health care domain in developing countries. The IFC is “the world’s largest multilateral investor in the private health sector in emerging markets” (International Finance Corporation, 2012b) that works to support the growth of the private sector in health care.

After the release of two WB reports titled ‘Financing Health Services in Developing Countries: An Agenda for Reform’ (World Bank, 1987) and ‘Investing in Health’ (World Bank, 1993), the mandate of the WB over the global health care policy agenda and the discourse of health care reform was consolidated. In this period, Turkey became one of the WB’s target countries. The Turkish governments started to collaborate with the World Bank both in order to determine the shortcomings of Turkey’s health care

system and to formulate possible solutions to help to overcome these shortcomings.

Against this background, this chapter addresses the question of how and to what extent the WB has been influential in the health care reform process in Turkey. With the objective of providing an answer to this question, this chapter examines the interaction between the WB and the AK Party governments in the domain of health care policy, and the historical as well as on-going institutional ties established between the WB and Turkish governments that feed into the contemporary partnership between these two actors. In doing so, this chapter draws on the content analysis of WB documents, as well as interviews conducted with WB experts who took part in the partnership with the Turkish government in the HTP and the members of the government's reform team.

This chapter is organised into nine sections. After this introduction section, the second section discusses the WB's approach to health care policies and health care reforms in developing countries. This section explores whether the WB has a blueprint in health care reforms or not, and if it does, what are the main components. The third section provides an overview of the history of the partnership between the WB and Turkey in health care. The fourth section describes the partnership between the WB and the AK Party government during the preparation and implementation of the HTP. The fifth section examines the effectiveness of the WB loans in providing the WB with political leverage to further its policy advices in the Turkish case. The sixth section investigates the influence of the WB's know-how and policy advices on the reform under consideration. The seventh section analyses the WB experts' insights about the design of the reform process. The eighth section examines the conflicts between the WB and Turkish government throughout the reform process and discusses if and how these conflicts have been solved. The ninth and last section summarises the impact of the WB on Turkey's health care reform.

## **5.2. The World Bank's approach to health care reform in developing countries**

This section explores the following questions: Does the WB have a blueprint in health care reforms? If it does, what are the main parameters of its blueprint?

One way of exploring these questions is to examine the WB's official documents on health care reforms. The World Development Report titled 'Investing in Health' can be considered the foundation of the WB's approach to health care reform in developing countries. In this report, as Laurell and Arellano succinctly state, the WB presented health care both "as an end in itself and as a means to foster development" (1996, p.2). This dual portrayal of health care can be argued to echo the contemporary nature of the health care domain both as a matter of human rights and as a global and national market commodity, which is discussed in detail in Chapter 2.

Despite the fact that the WB describes health care both as a public good and as a profitable sector, scholars argue that the WB's health care reform proposals in practice aim to foster health care as a profitable sector only to disregard its public good character. Laurell and López Arellano argue that the WB report gives priority to health care as a means to foster development (1996, p.2) rather than as a human right to be instituted. As the WB's proposals are centred upon the idea of health care as a means to development (implying economic development only), scholars identify the WB's approach to health care with neoliberalism (Laurell and Arellano, 1996, p.11; Armada et al., 2001, p.735), which here implies a political project that aims to increase the commodification of goods and services formerly out of the market relations.

It could be argued that the WB backs up its contemporary health care reform blueprint with three arguments. These are: 1) the state does not have enough money for universal health care; 2) the public financing and provision of health care services are bound to be inefficient; and 3) instituting equity in access to health care services is not possible.



Inspired by the NPM approach, the WB comes up with a set of policy tools that it promotes as a panacea to the ills of health care systems in developing countries. This set of policy tools includes the consolidation of individual based forms of health care finance (i.e. user charges, compulsory public health insurance and private health insurance) at the expense of tax-based financing models. It also includes the introduction of purchaser-provider split in the domain of health care and the promotion of the private sector involvement in health care finance and delivery (Collins et al., 1999, pp.69-70).

Nevertheless, the WB experts do not agree with the claim that the WB has an ideological health care reform blueprint. One of my informants, holding an important position in the WB headquarters, argued:

“We do not have a reform blueprint for countries. ... It is better to think of it as a loose jacket. It is shaped according to the political economy of each country.” (Interview no. 25)

As the informant stated above, the WB offers ‘loose jacket’ guidelines to developing country governments rather than a reform blueprint. In his understanding, the WB does not impose the specifics of health care reform but rather provides governments with a general perspective on health policy issues and equips them with up-to-date evidence.

However, not all WB experts agree with this statement. Another informant working for the WB office based in Ankara took one step forward to criticise the WB’s blueprint tendency in its health care reform proposals for developing countries:

“We tend to be blueprint. We go to every country and say the same things. Hospital autonomy, purchaser-provider split... Reality is that every country has to contextualize these reforms” (Interview no. 22).

As the interviewee suggests above, the ‘loose jacket’ of the WB has a specific colour. This colour has been already identified in this chapter before through an analysis of the WB discourse on health care systems and its

proposals for developing countries. The WB, according to this informant, has to be more responsive towards varied political and economic factors at play in different countries. However, she does not question the portrayal of the WB's health care reform blueprint as beyond politics. For her, the problem is not about the jacket itself, but the way the WB wants developing countries to wear it.

Where does this 'loose jacket' of health care reform come from? When I asked this question to my informants affiliated with the WB, they all unequivocally referred to scientific evidence. For instance, one suggested,

“There are some principles that science proved to us such as the provider-purchaser split. Science teaches us so. We use evidence-based policy approach” (Interview no. 25).

Another informant from the WB office in Turkey argued:

“Co-payments, everybody has recognised that even in health insurance systems, basic economics which tells you if you don't ask people to pay something, there is the moral hazard issue” (Interview no. 21).

For WB experts, it therefore seems that the main parameters of the 'loose jacket' approach to health care reform originate from scientific evidence. By scientific evidence, they mainly refer to the discipline of health economics. Having expertise on different health care reforms, therefore, may bestow a sense of authority on the WB experts to present their knowledge as universal truth. In this sense, the WB's policy proposals appear as the manifestation of this universal truth. Different alternatives are deemed political or ideologically driven and therefore lack empirical support.

The validity of the WB's general claims is contested in the literature. With respect to the first claim about the lack of public resources for universal health care, scholars argue that the WB fails to analyse the distribution of expenditures, including health expenditures in government budgets, and does not consider alternative solutions that may increase

public social and health expenditures (Laurell and Arellano, 1996, p.9). In regards to the second claim on the inefficiency of public health care service provision; scholars argue that the WB disregards the negative impacts of the SAPs on the efficiency and effectiveness of public financing and delivery of health care services (Laurell and Arellano, 1996, p.10). With respect to the WB's last claim on the inequitable nature of public financing and delivery of health care, scholars emphasise that this problem might well be eliminated by introducing universal public health insurance to replace the formerly inequitable access requirements, rather than allowing more private sector involvement in financing and provision (Laurell and Arellano, 1996, p.10). Nevertheless, the WB disregards the aforementioned alternatives. Therefore, scholars argue that the all-encompassing discourse of the WB on health care actually leaves out any alternative solutions without a valid scientific base (Laurell, 2001; Laurell and Arellano, 1996).

While the pro-market character of the WB's health care reform blueprint has not changed, its approach to role of the state in the health care sector has not remained constant over time. In the early days of the Washington Consensus, the WB called for a 'minimal' state. Later the WB replaced the 'minimal' state ideal with the ideal of the 'effective' state (Archer, 1994, p.13). This discursive change, consolidated in 1990s, became known as 'the governance agenda'.

Some scholars viewed this change in the WB's approach as a sign of a movement to give a larger role to the state in public policies (Archer, 1994, p.13). Nevertheless, not all scholars have attributed a similar significance to this change. In response to Archer, Crawford argued that the WB approach in its revised form continues to subordinate the role of the state to the market (Crawford, 2006, p.115). In the WB's approach, good governance is nothing but pro-market governance (Crawford, 2006, p.120). On the one hand, Crawford rightly emphasises the continuity in the WB's approach to favour the private sector over the public sector in the provision of public services. On the other hand, it could be argued that Archer's emphasis on the difference between the two discourses of the WB signifies

a noteworthy alteration of the WB's policy tools. Therefore, this change in the WB's paradigm might imply that the WB may continue favouring the marketization of health care services, while ensuring that the state monitors and regulates this marketization process.

But why did the WB feel the need to give the state a larger role in existing health care markets? Laurell and López Arellano provide us with an elaborate understanding of the reasons why the WB has made this discursive change. For them, the WB approach to health care reform faces a dilemma. The WB's dilemma resembles the foundational contradiction of the modern capitalist state: promoting capital accumulation while regulating class conflict (Laurell and Arellano, 1996, p.3). While the scholars' analogy is insightful, it also needs further elaboration. In fact, the WB differs from the modern capitalist state in its institutional setup, accountability structures, and ideological makeup.

One of the most striking differences between the WB and democratic capitalist states is that the WB's activities have no popular democratic control. Therefore, unlike democratic capitalist welfare states, it could be argued that the WB's solution to the dilemma between the promotion of capital accumulation and the regulation of class conflict (or soothing the masses through the provision of social policies) is prone to favour the former objective than the latter one. Nevertheless, the lack of popular democratic control in the WB does not necessarily imply that it is totally exempt from the need to establish legitimacy for its pro-market reforms; it has to work with democratically elected governments in most developing countries in order to introduce pro-market health care reforms.

Another difference between the WB and a modern capitalist state might be the level of responsiveness to capitalist interest groups. While the former is expected to think primarily in terms of global markets and serve the global capitalist interests (i.e. multinational companies), the latter is expected to consider the needs of the national market and at least take more into account the interests of the national (or smaller) capitalist interests.

The WB's health care reform proposals in developing countries seem to support the abovementioned analysis. The WB encourages developing country governments to promote a larger role for the private sector in the financing and delivery of healthcare services. The WB also targets public expenditures to provide low-cost services to the bottom income quintiles (Laurell and Arellano, 1996, p.3). While the former proposal might be regarded as the WB's primary objective to foster more private sector participation in the provision of public services, the second proposal might be considered the WB's quest for public legitimacy in its pro-market health care reforms.

It is argued here that the WB's approach to health care reforms in developing countries forms a coherent paradigm that might well be considered a blueprint. In fact, this blueprint suits well with the WB's general pro-market approach to reforms in other public policy domains. The WB's blueprint is established on the following ideals: to encourage more private sector participation in financing and service delivery, to promote efficiency through market or market-like structures in health care, and to restrict the role of the state to the establishment and regulation of these markets or market-like structures.

As the WB informants suggested, the WB tries to be responsive to the political economic differences between countries. However, this responsiveness is quite limited, as it only implies 'contextualising' the WB's blueprint in different institutional environments in order to create legitimacy, rather than considering other alternatives.

Finally, it could be argued that the WB's approach to health care reforms has been fine-tuned over time. In its current form, the WB calls for the strong presence of the state with a stewardship role in the health care market. The WB has adopted a more responsive and flexible approach to national political economic differences while working with developing country governments and recommends public guarantee for the very poor's access to basic health care services.

### **5.3. The History of the partnership between the World Bank and Turkey in health care and its impact on the Health Transformation Programme**

This section presents a brief history of the partnership between the WB and the Turkish governments in the realm of health care policies. The WB's relationship with Turkish governments tightened in the aftermath of the coup d'état in 1980. As mentioned in Chapter 3, the 1980 coup d'état was not only important because it suspended democratic rule in the country, but it also paved the way for liberalisation of the Turkish economy and alteration of the country's main development strategy from import substitution industrialisation to export oriented growth. As Turkey's economy transformed, the WB and the IMF began to get directly involved in economic policy making processes (Yalman, 2009; p.251).

The WB has been involved in various policy domains in Turkey. For instance, the WB had 27 on-going projects in Turkey in 2012. The sectoral distribution of these projects ranged from secondary education to renewable energy and energy efficiency (World Bank, 2012c). The WB's multi-sector engagement with Turkey may have provided the WB with higher leverage vis-à-vis Turkish governments, equipping it with the necessary know-how about the modus operandi of Turkey's public administration.

As of the late 2000s, WB loans to Turkey constituted an important amount of all WB loans. According to the WB data, Turkey is the largest borrower country in Europe and the Central Asia region, and ranks third among all borrower countries in terms of the size of loan agreements that exceeded 1.5\$ billion during the last three years (World Bank, 2008, p.20). Turkey has also been a member of another important member institution of the WBG, the IFC, since 1956. As of 2010, Turkey ranks fifth among all countries benefiting from the IFC operations (International Finance Corporation, 2012a).

The engagement of the WB with Turkey's health care system dates back to the late 1980s. The WB's primary engagement started with the launch of the First Health Project in 1990, which provided the Turkish

government with \$75 million funds. As part of this project, the government was expected to extend the geographical access to healthcare services especially in eight underserved provinces, to enhance the efficiency of health care delivery, to improve the financial sustainability of the health care system, and to support the management capacity in the MoH (World Bank, 2004, p.27).

The Second Health Project came in 1994. As part of the second project, \$130 million loan was released in 1995. Similar to the objectives of the first project, the second project aimed to extend access to essential health care services, this time in 23 Eastern underserved provinces, and to strengthen the management capacity of the MoH (World Bank, 2004, p.27).

Following the second project, the WB and the Turkish government initiated The Primary Health Care Services Project in 1997. This project included a \$14 million loan to the government with the aim of developing a family physician model for Turkey, applying this model nationwide, establishing an effective referral system, and developing the economic analysis capacity in the MoH (World Bank, 2004, p.27). This project, however, was not implemented due to the inability of the unstable coalition governments to make necessary legislative amendments in the Turkish Parliament.

Finally, the last and fourth collaboration between the WB and the Turkish government, which will be discussed in detail in the next section, came in the early 2000s. Although none of the former three partnerships between the WB and Turkish governments produced satisfactory outcomes, the experience provided the WB with strong know-how in working with Turkish governments and bureaucracy. Second, these partnerships helped the WB to promote its approach to health care within the MoH. For instance, Ministry officials who attended the WB's trainings on health care policy learned how to approach these issues from the health economics perspective and became part of the WB's epistemic communities on health care policy issues. Moreover, the WB succeeded in institutionalising its discourse within the Ministry in the form of a directorate, namely the

General Directorate of Health Project (*Sağlık Projesi Genel Koordinatörlüğü, or SPGK*). Indeed, some Directorate officials served in key posts during the introduction of the HTP of the AK Party government.

Therefore, it could be argued that the partnerships between the WB and Turkish governments throughout the 1990s laid the foundation for the introduction of pro-market health care reform in Turkey. This argument is elaborated in 6<sup>th</sup> section of this chapter by demonstrating the adoption of the WB's 'policy paradigm' on health care policies in policy documents of Turkish public administration.

#### **5.4. The partnership of the World Bank and the AK Party government on health care reform**

In 2003, the WB released a policy note identifying the main public policy areas that needed to be reformed in Turkey. The note clearly prioritised health care policy as it called for “fundamental and systemic changes” in Turkey’s health care system that would include separating financing and provision of healthcare, improving resource mobilisation and allocation, enhancing access to health care services, increasing the utilisation of health care services in accordance with the needs of the population, improving efficiency in production and delivery of health care services, and enhancing clinical effectiveness of the health care services (World Bank, 2003a, pp.31-32). In the same policy note, the WB also declared its readiness and enthusiasm to support a new health reform project in Turkey and expressed its willingness to provide both policy advice and loan to the government and bureaucracy (World Bank, 2003a, p.33).

The AK Party government launched its Urgent Action Plan to initiate a comprehensive health care reform. This Plan declared that the government would take policy actions, including: the restructuring of the MoH, granting administrative and financial autonomy to public hospitals, unifying all hospitals under the umbrella of the MoH, splitting purchaser and provider function in health care, the introduction of universal



compulsory social health insurance, and provision of incentives to private sector initiatives in health care (The Republic of Turkey, 2003, pp.99-101). Given the similarities between the components of the government's reform plan and the WB's proposals, it could be argued that the AK Party and the WB were in consensus over the main parameters of the forthcoming health care reform.

The actual collaboration between the AK Party government and the WB started with the launch of the Health Transition Project in 2004. The government and the WB designed the Health Transition Project to support the implementation of the government's HTP. The Health Transition Project had two phases. In the first phase, initiated in 2004, the WB's objective was the following:

“to assist the government to strengthen the institutional environment for the implementation of the Health Transformation Programme that will improve system stewardship, streamline financing and service delivery, and build the institutional capacity to extend health insurance coverage to the whole population in a fiscally sustainable manner” (World Bank, 2004, pp.ii).

Completed by 2007, the first phase of the project included the release of a roughly \$61 million loan (World Bank, 2003b, p.11). While previous WB projects in health care in Turkey invested the majority of loans into building infrastructure and purchasing equipment (World Bank, 2004, p.6), most of this project's budget was allocated to training and consultancy services (World Bank, 2003b, pp.10-11).

The second phase of the project, called the Health Transformation and Social Security Reform Project, came into effect in 2009 and was completed by 2013. The main objectives of this project was to improve the effectiveness of the SGK and the MoH in developing and implementing reforms on provider payments and health care systems performance, and piloting output-based financing for non-communicable diseases prevention and control (World Bank, 2009, p.iv). With this project, the WB supplied approximately \$75 million (World Bank, 2009: iv). Most of the project

budget was dedicated to capacity building in the MoH to claim a stewardship role and retreat from its dominant role in the health care delivery (World Bank, 2009, p.v).

In addition to the Health Transition Project and the Health Transformation and Social Security Reform Project, the WB financially supported the government through the First and Second Programmatic Public Sector Development Policy Loans and First and Second Restoring Equitable Growth and Employment Development Policy Loans. Implemented between 2004 and 2011, these four projects did not exclusively address health care policies, but each had strong health components. Indeed, one of the four programme development objectives specifically addressed health care reform. This objective is stated as follows:

“Reforming substantially the country’s social protection system, which covers social security, universal health insurance and social assistance to address growing deficits in the social security system, to make structural and administrative improvements in the provision of social security benefits and social assistance, and to support universal access to health services while increasing the efficiency of their provision” (World Bank, 2012, p.viii).

The WB loans for these four consecutive projects ranged from \$400 million to \$1.3 billion (World Bank, 2012, p.i). The share of loans directed to health care reforms ranged from 11 per cent to 25 per cent (World Bank, 2012, pp.v-vi).

The WB published the three-year country partnership strategy document for Turkey between 2008 and 2011, which set the priorities of partnership for the WB. The Bank presented its main domains of interest in Turkey as 1) improved competitiveness and employment; 2) equitable human and social development; and 3) efficient provision of high-quality public services (World Bank, 2008, p.i). Under the pillar of equitable human and social development, the WB once again affirmed that its priority to make the health care system more effective (World Bank, 2008, p.ii).

In the three-year country partnership strategy document, the main objectives of the WB in health care were presented as improving the cost-effectiveness of healthcare services and increasing the responsiveness of these services to the needs of the population (World Bank, 2008, p.32). In order to achieve these general objectives, the WB declared that it would continue providing financial support in the form of lending, technical assistance, just-in-time policy notes, monitoring and evaluation of the impacts of on-going healthcare reform, and training in the form of health care reform flagship programmes for policy makers and practitioners (World Bank, 2008, p.32).

In addition to the WB's engagement through the partnerships with the government, the WBG was engaged with Turkey's health sector through the IFC. Unlike the WB, which primarily collaborates with governments, the IFC works directly with the private sector. Following the release of the HTP in 2003, the IFC identified Turkey as a "high priority country in the health sector" (Albawaba Business, 2003).

In line with the prioritisation of Turkey in the investments in the health sector, the IFC released an 11\$ million loan for the MESA group with the objective of supporting the construction and launch of a private hospital in the capital city of Ankara (Albawaba Business, 2003). Another notable project of the IFC was its support for Acibadem Healthcare Group with a \$20 million loan (International Finance Corporation, 2007) that was then followed by another corporate loan of up to 40\$ million in 2006 (Joseph, 2006). Lastly, the IFC provided Yapı Kredi Leasing with 25\$ million in 2010 which has been used to provide financial support for small and medium enterprises (SME) in the health sector to access higher levels of health technology (International Finance Corporation, 2011). The total amount of IFC loans to private sector institutions in health care exceeded the total amount of the WB loans to the government in the Health Transition Project.

The WBG declared the IFC's commitment to support higher levels of private sector provision in health care services. As stated in the WB's Country Partnership Strategy for Turkey, the IFC, in collaboration with

domestic banks, would lend its support specifically to companies that aim to become national health care service providers; expand their domestic or foreign operations; establish specialised centres of excellence, and/or have smaller hospitals and clinics (World Bank, 2008, p.32).

First of all, the continuous support of the WB to the HTP suggests that the WB and the government had been in agreement on the main parameters of the reform project. Second, the main objectives of the WB are in accordance with the WB's health care reform blueprint for developing countries, which was described earlier in this chapter. Third, the WB focuses its endeavours on the institutional establishment of a pro-market health care system. The WB uses two major tools to influence the preparation and implementation of health care reform in its partnership with the AKParty government. These tools are loans and evidence-based policy advice.

### **5.5. The importance of World Bank loans for health care reform in Turkey: Is it overrated?**

As discussed above, the WB uses different instruments to initiate, support or influence reforms in developing countries, including Turkey. Loan agreements are one of the most commonly used instruments of the WB.

For some scholars, continuous WB loans directed to the restructuring of health care services in Turkey provide sufficient empirical data to argue that the HTP has been a top-down WB project (i.e. Savaş, 2012, pp.18-37). Indeed, similar arguments were made for health care reforms supported by the WB in other developing countries (i.e. Armada et al., 2001, p.731).

Nevertheless, both the reform team and the WB team members argue against the claim that the WB has been decisive throughout the reform process as a result of its partial financier role. For instance, one of the informants, who worked as a member of the health care reform team in

Turkey, pointed out the limitations of the WB's power due to the scope of financial resources it provided during the reform process. He said,

“If you especially look at the World Bank's loan agreements in social sectors, these are not huge amounts of money. Indeed, these are quite symbolic amounts of money within overall budgets of countries. This is at least valid for Turkey. Maybe this is not so in Uganda. From this angle, the World Bank's impositions in social sectors cannot be effective in countries like Turkey.” (Interview no. 22)

As this quotation suggests, members of the reform team trusted the financial resources of Turkish state, explaining their financial and intellectual autonomy from the WB on the basis of the economic strength of the country. The WB report on the politics of health care reform in Turkey also supports this informant's claim. The report suggests that the WB loan for healthcare reform could not sufficiently provide the Bank with significant leverage, since its amount was small compared to other loans that the government was managing at the time (Rossetti, 2004, p.24).

Similarly, an informant who worked as a team leader on one of the WB health projects argued,

“The AK Party did not come to the World Bank for money. Indeed, total amount of loan lent was around 0,5 per cent of total health budget. The AK Party wanted to benefit from the World Bank know-how. It wanted to use the World Bank for legitimacy. If the reform would go well, than it would be the AK Party's reform. If it would not, then it would be the World Bank's. In addition, it was useful to have a small yet a flexible budget. Therefore, we might list three reasons: technical advice, legitimacy and flexible money” (Interview no. 25)

As the informant suggested, acquiring loans was not the main motive of the AK Party government when approaching the WB to collaborate on the health care reform. Apart from the critiques of the reform, neither the WB experts nor the members of the reform team suggested that the WB loans provided the WB with a strong decision making capacity with respect to the content of the reform.

In fact, the relative autonomy of the AK Party government from the WB and the low level of importance attributed to the loan components of the WB partnership throughout the reform process might be due to contextual economic factors. With respect to the economic situation of the recipient country, an economic crisis seems to be an important contextual factor that has serious implications in determining the terms of the relationship between the recipient country and the WB. As country cases demonstrated in Chapter 4, scholars suggested that developing country governments had the lowest capacity to negotiate with the WB in adverse macroeconomic contexts and complied with the WB's policy proposals in order to access loans and international aid (Laurell and Arellano, 1996, p.13; Batley, 2004, pp.54-55). In contrast to Latin American reform experiences, the latest WB and Turkish government health care reform partnership was established at a time of steady economic growth of the Turkish economy. According to the WB data, Turkey's economy has been booming with over 5 per cent economic growth especially between 2003 and 2007, which might have increased the control of the Turkish government vis-à-vis the World Bank over the specifics of the reform project.

### **5.6. The influence of the World Bank's know-how and policy advice on the reform**

Despite the emphasis given to WB loans when explaining the impact of the WB on health care reform in Turkey, the effectiveness of other WB tools, such as know-how support and policy advice, have been generally overlooked. In fact, in the case of Turkey, the WB has been active in researching the health care sector, promoting health care reform ideas, and providing strategic political advice to the government in order to make the reform politically feasible in Turkey.

The WB was the pioneering institution producing knowledge on the problems of the health care system of Turkey before the reform. In fact, one of the informants, who formerly worked for the SPGK and then became part

of the reform team during the preparation and implementation of the HTP, argued that there was a consensus over the general parameters of the health care reform even before the AK Party came to power. He said,

“In the beginning of 2000s, a programme called Health Transformation Programme came to the agenda. In fact, this was a new version of health care reforms. ... In that period (before 2003), technical preparations of related ministries had been already there. Undersecretaries of the Ministry of Finance, Ministry of Labour and Social Security, State Planning Organisation, Treasury and Ministry of Health already prepared letters of agreement. As of 2003, general philosophy of these prior agreements was kept intact and took the name of Health Transformation Programme (Interview no. 32).

As a member of the reform team and a former official of the General Directorate of Health Project, this informant’s perception of continuity between former reform projects and the current one has to be taken into consideration in order to understand the extent to which the earlier partnership between the WB and government shaped the major parameters of the reform. Earlier input of the WB into this consensus is explored later.

This statement, however, might also imply that the AK Party’s input, coupled with contestations between the AK Party and the WB throughout the preparation and implementation of the HTP, did not make a significant change in the content of the reform. The validity of this claim is discussed in detail in the next chapter on the AK Party’s impact on the HTP.

One of the moments when the World Bank contributed to ‘the social construction of the need to reform’, in Cox’s terms (2001, pp.475-477), was the release of its report on Turkey’s health care system in 2003 (World Bank, 2003b). This study has been quite influential in setting the main parameters of the political debates on Turkey’s health care system and then constituted a vantage point for the AK Party government’s HTP (World Bank, 2010, p.ix).

In this study, the WB called for “fundamental and systemic changes” in Turkey’s health care system (World Bank, 2003b, p.iii). Additionally, the WB listed the fundamental and systemic changes to be made, which

included the introduction of compulsory universal social health insurance with optional supplementary private health insurance; the development of an essential health care services package; better targeted public spending; the reorganisation of public hospitals by granting them financial and administrative autonomy; the transformation of the role of the MoH from a health care service provider to a stewardship body that oversees and guides the provision of health care services; and the transformation of the role of the SSK from being both financier as well as the provider of health care services to a purely social insurance body (World Bank, 2003b, pp.iv-vi). In fact, as discussed in the earlier chapter, the HTP covers almost all of the abovementioned WB proposals.

Some political actors interpreted the similarity of the WB proposals and the government's health care reform as evidence of the fact that the reform is the replication of a WB blueprint. One of the informants, who was the head of the TTB, suggested,

“Before I compared two documents, I thought this claim (the claim that the reform is a replication of the World Bank blueprint) was quite inspired by our standard left perspectives. ... Despite the fact that this might sound like a slogan, I think the discourse that suggests this reform is a World Bank project is the manifestation of reality” (Interview no. 14).

Another informant, who is the head of one of the leading trade unions in the health sector, also made a similar comment on the reform. She argued, “This programme in health care is totally a World Bank programme. In fact, it is a word-for-word translation. The AKP is the direct subcontractor of the World Bank” (Interview no. 31). Both the TTB and this trade union in health sector opposed the HTP. Therefore, proving that the reform is a replication of the WB is important to them, as they think this would undermine the legitimacy of the reform in the eyes of the general public. For these actors, the WB symbolises the interests of the transnational capitalist class and the advanced capitalist countries, especially the United States. They argue that this blueprint reform,



implemented by the AK Party, furthers the interests of these actors rather than the interests of the citizens of Turkey.

In response, one member of the reform team contests this perception that HTP is merely a replication of the WB blueprint. He stated,

“I would really want that (directly implementing an available World Bank model in Turkey). If only somebody could bring in an already implemented experience and we could be inspired by it and come up with a health care system by adopting it to Turkey. I would really want that, as a person involved in this process. But we did not have that chance. ... In the last instance, we know the sector, we know the country, and we know the world. We started with needs, the needs of the citizens and the needs of the sector. ... I can safely argue that this model is authentic to Turkey” (Interview no. 8).

In contrast to the anti-reform camp’s critic of the blueprint reform, as seen above, this informant stressed the fact that the government’s reform team has been decisive in preparing Turkey’s health care reform and the resulting reform has been unique to Turkey. He emphasised both the competency of the reform team and their responsiveness to both citizenry and sector interests. Another informant, who was also a member of the government’s reform team, also argued against the claim that the HTP was the carbon copy of the WB’s blueprint.

“This is a perception that I always contest, a perception that the WB and the IMF imposed this. Indeed, the advances in health care finance in the world had reflections in Turkey. But other than perceiving this as an imposition of the World Bank and IMF, because it is not true, I think it is possible to perceive this as the accumulation of experiences and institutional memory in Turkey that was enriched by the WB’s consultancy support” (Interview no. 32).

This informant agreed with the previous one, who was also a member of the reform team, that the WB and the IMF did not impose the reform on Turkey. However, he acknowledged that the history of health care reform attempts and the preparations made throughout the 1990s provided significant inputs for the HTP. Unlike the informant who presented the

reform as a fully authentic reform of Turkey, this informant acknowledged the importance of international input. For instance, he suggested that the international policy trends in health care finance, which he conceptualised as “advances”, also resonated in this reform. Similar to the way WB experts presented policy trends as up-to-date scientific evidence, this informant also portrayed international policy trends in health care beyond politics and scientific.

The WB experts also claimed that while the main parameters of the HTP included the WB proposals for health care reform in Turkey, it does not necessarily imply that the reform is a WB imposed one. Indeed, one of my informants who worked in the WB as a policy expert stated in his public speech:

“The starting point of all partnerships (between the World Bank and governments) is, as I said, the development program of the countries. The World Bank does not come and tell the governments to do something for them. It does not work like this. Here the public sector is decisive.” (Public Speech no. 4)

Indeed, the Five Year Development Plans, prepared mainly by bureaucrats with the input of a selected group of academics, before the introduction of HTP included policy priorities as follows:

- Five Year Development Plan for 1985-1989: The establishment of a universal health insurance (The State Planning Organisation of Turkey, 1984: p.2), increasing service efficiency in health facilities, supporting the establishment of new private health facilities, allowing private health facilities to freely determine prices for their services, the prevention of Social Insurance Institution’s establishment of new health facilities (The State Planning Organisation of Turkey, 1984, p.152)
- Five Year Development Plan for 1990-1995: Provision of incentives to integrate private health providers into the public health care delivery system (The State Planning Organisation of Turkey, 1989, p.291), diversification of sources of health care finance, the introduction of universal health insurance (The State Planning Organisation of Turkey, 1989, p.357).

- Five Year Development Plan for 1996-2000: Establishing a purchaser-provider split in health care, transformation of the MoH into a stewardship body and limiting its role in health care provision, granting administrative and financial autonomy to public hospitals, (The State Planning Organisation of Turkey, 1995, p.46) and provision of incentives to the private sector in order to increase its presence in health care domain (The State Planning Organisation of Turkey, 1995, p.48).
- Five Year Development Plan for 2001-2005: Provision of incentives to private health insurance companies (The State Planning Organisation of Turkey, 2000, p.225), establishing a purchaser-provider split in health care, increasing the efficiency of management of public hospitals (The State Planning Organisation of Turkey, 2000, p.223)

One should not disregard the historical origins of these ideas in Turkish policy circles and the role of the WB in generating these ideas. The WB promoted a new pro-market discourse in health care since the late 1970s. As discussed earlier in this chapter, the WB had a significant role in the restructuring of the Turkish economy after the 1980 military coup d'état alongside with the policy trends of the Washington Consensus. Therefore, it could be argued that the WB historically contributed to the emergence of pro-market ideas in health care and contributed to the birth of its local allies since 1980s. In other words, the WB set the 'policy paradigm', within which policymakers operated in Turkey in the domain of health care since 1980s.

Against this background, during the preparation and implementation of the HTP, WB experts and the government's reform team were in general agreement on the main parameters of the reform and worked together as a large team. One of the informants, who worked as the project leader of the WB, stated the uniqueness of the Turkish case compared to health care reform experiences in other countries,

“Every single person in the MoH knows what the programme is about. In some other countries, ... people know when it happens. ... Wealth of our discussion with MoH here, level of discussion is impressive. It is actually technical. You cannot underestimate the power of that.

Everything is understood, taken and thought through.” (Interview no. 21)

While this quotation reveals that the WB carried out top-down reform projects in countries where even state officials did not “know what the programme was about” before it was implemented, it also demonstrates state officials in Turkey were more competent in the eyes of the WB experts than most other countries about the general philosophy as well as the details of the reform project. This competency might well be attributed to the earlier partnership between the WB and the governments that made health care bureaucrats part of the WB’s epistemic community.

One of my informants, a former member of the government’s reform team, supported the WB team leader’s suggestion that the government’s reform team was comfortable about their competencies:

“We should not overestimate the WB. I attended the WB’s trainings. But please do not understand this like this. We do listen. But why should we look down on our people? Why should we look down on our politicians? We do listen. We can listen to anyone. Am I a wally? Can’t I analyse what has been said there? Am I not aware of my country’s reality?” (Public speech no. 5)

As the quotation suggests, the members of the reform team do not feel challenged by the WB’s role in the preparation and implementation of the reform. For this informant, the power lay in the hands of the government’s reform team and the government rather than the WB experts. Therefore, they were free to attend the WB trainings and assess the applicability of this information on the Turkish case. However, he seemed to underestimate how his approach to health care reform came into being as a result of a historical process.

In sum, the WB was decisive in setting the terms of the health care reform, as a result of its historical role. During the introduction and implementation of the HTP, the influential role of the WB was policy consultancy. In the end, the government’s confident reform team

contextualised the WB's health care reform blueprint. In other words, the major impact of the WB in the HTP was its constitutive role in the emergence of the 'policy paradigm' within policymakers operated throughout the preparation and implementation of the HTP.

### **5.7. The reform as a closed process**

During the introduction and implementation of the HTP, the government did not allow any other domestic actors to influence the preparation and implementation of the reform. An informant, who also worked as the project leader of the WB, acknowledged this fact as follows:

“The way you do business here is very different. You would never go to a big public meeting and talk about such things. You would do that through your one-to-one relationship” (Interview no. 22).

As the informant stated above, she had to adapt to the local *modus operandi*. This *modus operandi* in Turkey consists of the acknowledged power of the executive over legislative, respect for the government's ability to exclude all political actors from the reform process, and the exercise of caution about the AK Party government's tendency to stop working with international organisations in case they publicly announce the problems they see in the reform projects. Therefore, the informant adopted the accepted way of “doing business here” and kept criticisms for private meetings with the Turkish politicians and high-level bureaucrats. For her, the secretive form of policy formation and the strong leadership was the main reason behind the success of HTP. She stated,

“Health Transformation Project happened only because it had the support of the prime minister and a very strong minister of health” (Interview no. 22).

As the quotation above suggests, the informant, who worked as the WB team leader in health care projects in Turkey, argued that the strong

power of the executive in the Turkish political system and the willingness of the government to carry out the reform brought success to health care reform. This might also serve as evidence that the WB prefers a strong executive to a democratically vibrant political atmosphere, the latter of which could slow down the reform process.

A similar perspective could be seen in the criticisms raised in the OECD and the WB's report, which portrayed even the institutional checks and balances in the Turkish political system as obstacles for the introduction of a comprehensive health care reform before 2003. The report suggests,

“Governance arrangements in the health sector were fragmented and considerable power ultimately belonged with the Constitutional Court and Grand National Assembly” (OECD and World Bank, 2008, p.38).

As stated in the report, the power of the Constitutional Court and Turkish Parliament hindered the prospects of the introduction of reform projects of the MoH before 2003, and slowed down the implementation as discussed in Chapter 7. For the WB, reform success is possible with a strong government.

### **5.8. The partnership of the World Bank and the government: Any disagreements?**

Following the completion of the Health Transition Project, the WB confidently stated that the government's HTP was a good practice (World Bank, 2009, p.26). Turkey's HTP was awarded one of 12 projects that 'improved the lives of people in Europe and Central Asia' in 2010. OECD and the WB report also presented the reform as a success story:

“The Health Transformation Programme in many ways reflects “good practice” in the development and implementation of a major health sector reform including UHI coverage in an OECD country. Strong government commitment and leadership along with major financing

reforms aided by strong economic growth have been complemented by sequential delivery system reforms. While it is too early to evaluate the impacts of the HTP on all aspects of health status, financial protection, and consumer satisfaction, the preliminary indications from the available data suggest that there has been important progress in all three areas. Turkey is closing the performance gap with other OECD countries and, on a number of measures including overall costs, performs well in relation to other comparable upper middle-income countries. There may be much that other countries can learn from the recent health reforms in Turkey” (OECD and World Bank, 2008, pp.128-129).

As the quotation from the report suggests above, despite the lack of empirical evidence on the ‘impact’ of the reform, the WB and OECD began to present the HTP as a best practice that could be replicated in other developing countries. Both the interviews with the WB experts and the report quoted above demonstrate that the partnership between the WB and Turkish government had been a close and relatively problem-free one.

However, there have also been disagreements and contestations between the WB and Turkish government during the implementation of the HTP. The same report provides an outline of the areas upon which the WB and Turkish government seemed to disagree. According to the report, the government could not complete the restructuring of the MoH to transform the Ministry into a stewardship body, nor could it strengthen the capacity of the SGK to implement incentive-based payment systems in purchasing services from health care providers or transfer regulatory functions to quasi-public institutions until the end of the Phase I of the HTP (OECD and World Bank, 2008, p.110).

In fact, one of the informants, who was part of the reform team acknowledged the tension between the WB team and the government on decisions concerning the public presence in health care provision, as mentioned in the OECD and WB report. He stated,

“At times, we will take measures as part of this Programme that the WB might not accept. Indeed, we have been doing it already. Let me give you an example. In the WB’s tailor-made projects for developing

countries, nationalisation of hospitals does not have any place. In contrast, there is the decentralisation of hospitals. They might even include the privatisation of hospitals. In Health Transformation Programme, nowhere you can find any prospect of the privatisation of public hospitals. In fact, Social Insurance Institutions were nationalised” (Interview no. 20).

In the quotation above, the informant claimed that the reform has been swimming against the WB sponsored health care reforms current, especially in regards to the role of the state in health care provision. While the WB encourages developing countries to decentralise and even privatise health care delivery, the informant argued that the Turkish reform nationalised the Social Insurance Institution (SSK) hospitals and did not set forth any privatisation agenda. Despite the questionable validity of the informant’s claim that is challenged in discussion on the establishment of Public Hospital Unions and the introduction of PFI in public hospital constructions in Chapter 4, it could still be argued that the government did not radically decrease the role of the state in health care provision.

While this member of the reform team presented the changes in the health care delivery structure as a radical divergence from the blueprint, one of the former WB team leaders did not perceive this as a significant point of contestation between the Bank and the government. She argued,

“Some of the analytical advice (that is written in the WB report) were not taken by the government initially. ... This is normal for us by the way. Because our objective is to advise the government based on available evidence. ... In all countries, health reforms are guided by political economy decisions. ... Even though you provide the best technical advice, there is no guarantee that any government will move on all directions. They have to evaluate the political situation” (Interview no. 22).

As is seen in the quotation above, one of the former WB team leaders suggested that their responsibility has been to support the government with the best policy advice according to the WB’s criteria. However, whether or not the government takes the advice is the decision of the government. The



government decision might originate from the fact that it does not agree with the WB on a specific policy issue or it might derive from the fact that the government thinks that the moment is not right to implement that specific policy advice due to political reasons. In addition, as discussed in Chapter 4, no democratic developing country government could pursue direct privatisation policies in the domain of health care delivery, as it might hamper their chances of re-election.

In fact, it could be argued that the government's steps in health care delivery disprove the former member of the reform team who argued that the Government's health care reform would not lead to decentralisation and privatisation. As discussed in Chapter 4, the government restructured the Ministry to fit into its new overseer and monitoring role, granted administrative and partially financial autonomy to public hospitals, and established a quasi-autonomous public body, the Public Hospitals Institution of Turkey (*Türkiye Kamu Hastaneleri Kurumu, or TKHK*) to coordinate health care delivery (The Republic of Turkey, 2011a). In line with these legislative changes, the Public Hospitals Unions were established to bring together geographically close public hospitals and grant them financial and administrative autonomy. The TKHK is responsible for overseeing and monitoring the activities of Public Hospitals Unions.

On the one hand, the government's further steps to decentralise health care delivery structure, transfer the Ministry's powers to a quasi-autonomous public body, and establish Public Hospitals Unions as health care enterprises, might be interpreted as evidence of the government's perfect agreement with the WB's policy advice. Therefore, this might prove the former head of the WB team leader, who claimed that the government was not taking necessary steps to decentralise and privatise the public hospitals at the time due to the unfavourable political atmosphere. It could be argued that once the government had the chance to go further, it did not hesitate to do it.

On the other hand, the alterations of the health care delivery structure and the governance of this structure do not fully comply with the WB

blueprint. The TKHK is still affiliated with the MoH. In addition, the TKHK is legally responsible for complying with the Ministry's policies and targets. It could be argued that the political mandate of the government over the health care delivery structure has not been challenged even after the 2011 changes. From the WB's perspective, the political mandate of the government on health care delivery might distort market dynamics. However, the government might have an interest in keeping the public presence in health care provision in order to use that to set up its own cadre in public hospitals, to appease the public with better provision and/or to suppress the prices of private hospitals services. Therefore, despite the overall agreement between the WB and the government on the main tenets of the reform, the government's other political interests and concerns as well as its interaction with private health care provider organisations –that is discussed in detail in Chapter 8- might result in changes in the original reform programme.

## **5.9. Conclusion**

This chapter explored how and to what extent the WB has been influential in the preparation and implementation of the AK Party government's HTP.

The impact of the WB on the reform has taken two different paths. First, here it is argued that the growing dominance of the WB over the global health care reform agenda since the late 1970s and the engagement of the WB with Turkey's health care system since the late 1980s accordingly popularised the pro-market health care reform paradigm among Turkish policy circles that paved the way for the emergence of the contemporary health care reform in Turkey. As shown in interview excerpts, this history paved the way to the fact that both WB officials as well as members of the reform team see the WB's approach to health care issues as scientifically proven and evidence-based rather than political. This common belief strengthened the perception of the pro-market approach in health care

reforms as beyond politics and empowered the pro-market approach with significant discursive power.

Concurrent to the proliferation of the health economics discourse worldwide, the WB came up with pro-market health care reform suggestions for developing countries. While the core of this approach has been sustained, its components have changed over time. Earlier WB projects on health care reform in developing countries, especially in Latin American countries, as discussed in Chapter 4, had a sharp and sudden privatisation agenda. Later on, the WB adopted a more balanced approach to health care reforms to give significant regulatory powers to the state in the establishment and running of market health care systems.

The partnership between Turkish governments and the WB resulted in the institutionalisation of pro-market health care reform discourse within Turkey's MoH, which then manifested itself in the establishment of the General Directorate of Health Project. In addition, this partnership helped Turkish state officials become part of the WB sponsored international epistemic community on health care reforms. Throughout the 1990s, a number of governments attempted to introduce pro-market health care reforms in collaboration with the WB. However, all these attempts failed mainly due to the weak coalition governments. Despite the failure of these reform projects, the collaboration of the WB and the MoH resulted in the consolidation of a bureaucratic consensus over the need for a pro-market reform in Turkey's health care system. This consensus seemed to be consolidated before the AK Party came to power. Therefore, as of the 2000s, the pro-market approach towards health care reform appeared almost as a non-alien approach in health care policy circles in Turkey. The TTB, trade unions, and other left leaning organisations were the only actors who refused to adapt to this new discourse.

In fact, the AK Party's health care reform proposal bore close resemblance to the WB's suggestions for reform in Turkey's health care system and its reform blueprint. Nevertheless, here it is argued that this was not due to the WB's imposition of the reform on the AK Party

government, as the absence of an economic crisis and the political strength the AK Party gained over time increased the leverage of the AK Party government vis-à-vis the WB.

Indeed, the members of the government's reform team did not accept criticisms that the reform was a top-down WB reform blueprint. Alternatively, they argued that they had the power and competency to design the reform in line with the needs of Turkish citizens and the health care sector in Turkey (disregarding any possible conflict between these two set of needs). However, here it is argued that the same faith that they shared with WB experts on scientific evidence and the discipline of health economics, coupled with the fact that there was no alternative but pro-market reform, made the WB and the government partnership a problem-free one.

The analysis in this chapter makes it clear that the AK Party government chose to work with the WB not because it was in need of the WB loans, but because it preferred benefiting from the WB's know-how and expertise on health care reforms. In practice, the WB provided relatively insignificant amount of loans (0.5 per cent of the total public expenditures spent on health care) to the government. More importantly, the WB supported the government's reform team with their know-how and expertise on health care reforms. The result was a success story not only for the Turkish government but also for the WB. The WB appreciated the Turkish reform experience and started to promote it as one of the best practices in health care.

The WB experts presented strong commitment to the government in implementing the reform as the recipe for the success in Turkish health care reform. However, they did not question the design of the reform process as a closed one that did not allow democratic participation of significant stakeholders.

Despite the fact that the WB and the AK Party government have been in agreement upon the general parameters of the reform, it has become clearer that their final destinations might not overlap. While the WB's final

destination is a market health care system, the government has been hesitant towards retreating from the financing and provision of health care services. Even though the government took steps in increasing the financial and administrative autonomy of public hospitals and introduced strong private sector management methods into the modus operandi of these hospitals, it did not transfer the MoH's control and even dominance over health care provision. This discrepancy between the WB's and the government's final destinations might spring from the fact that their primary political interests are different. Unlike the WB, the government has to secure its electoral success and might not want to lose its political mandate over the health care provision, which are discussed in Chapter 6 and Chapter 8 respectively.

In conclusion, this chapter suggests that the WB's influence on the health care reform in Turkey could be better understood if the WB is perceived both an institution that predated the rise of the AK Party and as an actor that collaborated with the AK Party government. While the structural role of the WB originates from its long-lasting ideological investment in the domain of health care, its influence as an actor over health care reforms is subject to change due to contextual factors. The strength of the WB's ideological dominance in the domain of health care has a clear implication for the main tenets of the health care reform. Nevertheless, domestic political actors have the power to alter these main tenets by introducing different policy formulations and manipulate the negative impacts of the reform by employing different strategies, such as changing the timing of different parts of the reform.

Globally dominant ideas did matter in shaping the content of health care reform in Turkey. However, the Turkish case suggests that these ideas make inroads to the national policy setting not always through the direct imposition of the WB with loans and its conditionalities at times of austerity. They can also be effective through the establishment of an ideological consensus over how to approach health care policy, with the help of long-lasting investments of the WB on knowledge production and policy

advice and the rise of neoliberal political actors to power at the national level.

## Chapter 6: The AK Party and the Politics of Health Care in Turkey in the Last Decade

### 6.1. Introduction

This chapter focuses on the role of the AK Party throughout the health care reform process in Turkey between 2003 and 2013. The role of the AK Party in forming the consecutive single-party governments that introduced and implemented the HTP might *prima facie* seem obvious for readers. However, there are still important questions to explore in understanding how and to what extent the AK Party exerted its influence on the content of the reform, tackled the political conflicts throughout the reform process, made the reform politically possible, and benefited politically from the outcomes of the reform. While the alliances and contestations of the AK Party governments with other political actors throughout the HTP are discussed in other chapters, this chapter explores the role of the HTP in the AK Party's electoral successes and its organisational change over time.

In light of these questions, the chapter is organised into five main sections in addition to this introductory part. The first section discusses the literature on the relations between the society and political parties. The second section explores the influence of the AK Party's political ideology on the content of the reform. The third section examines how the HTP became a factor in the consolidation of the AK Party rule. The fourth section concentrates on how the AK Party formulated its discourse with respect to the reform and to what extent it successfully appealed to its social base and even expanded it. In the concluding section, the AK Party's discursive and practical strategies in making the HTP possible are discussed to provide a holistic account of its role.

This chapter suggests that the HTP has been a product of the AK Party's alliance with those who were formerly left out or marginalised in Turkey's health care system, as well as the emerging group of health care entrepreneurs who owe their allegiance to the state-sponsored capital

accumulation in the provision of health care services. Therefore, with respect to the future trajectory of Turkey's health care system, conflicting political claims exist within the AK Party and among the new terrain of health care politics in Turkey.

## **6.2. Political Parties and the Society**

For the purposes of this thesis, the literature on the relations between political parties and the society is explored. In Chapter 2, four different perspectives, namely the pluralist, the power resources, the institutionalist and the new politics approaches, to the politics of health care are introduced. Amongst these perspectives, especially first two perspectives suggest that political parties represent pre-defined interests of different social groups.

According to the pluralist approach, political parties are portrayed as “brokers” between civil society and the decision-making authorities (i.e. Truman, 1951). From another perspective, the power resources approach assumes that political parties represent class interests, and social democratic/social parties might represent working class interests in a capitalist democracy (i.e. Korpi, 1980).

Alternatively, Kirchheimer, in his thesis on the emergence of ‘catchall parties’, suggests that political parties might not be representing the pre-defined sectors of the society with pre-defined interests (Krouwel, 1996, p.30). For Kirchheimer, catchall parties are those parties, the appeal of which is to all social classes (Krouwel, 1996, p.30). While factors resulting in the emergence of ‘catchall parties’ are diverse, one of these factors is the increasing attraction of voters to the personality of the leaders of political parties, rather than their ideological stances (Krouwel, 1996, p.30). Kirchheimer explains the emergence of ‘catchall parties’ and their rise to power as an end product of a broader political transformation. Main tenets of the new political atmosphere include the following: the erosion of parliamentary democracy, the formation of a state-party cartel, the



personalization of electoral appeal and the undermining of separation of powers (Krouwel, 1996, p.31).

Kirchheimer's conceptualization of catchall parties might be useful in understanding the AK Party phenomenon in the politics of Turkey in the last decade. As discussed in Chapter 3, military interventions into democratic politics in Turkey put pressure on the rise of class politics throughout 1970s, which made populism in electoral politics the only way of doing formal politics concerning solving social and economic problems of the citizenry. Although the earlier works on the AK Party that are discussed shortly in detail in this chapter are helpful in understanding the original class basis of the party and the political movement that gave birth to it, they fail to explain the latest form that the AK Party took. In its earlier form in the beginning of 2000s, the AK Party resembled Kirchheimer's 'catchall party' especially in the sense that it appeals to all social classes at the same time, which was then transformed into a state-party cartel.

Adding to Kirchheimer's analysis of the transformation of political parties, Katz and Mair argue that the distancing of political parties from the civil society and the convergence of political parties with the state give birth to a new form of political party, which is 'the cartel party' (1995, p.14). The 'cartel party' is characterized by its interpenetration with the state and its ability to prevent the possibility of the success of external and internal dissent undermining its unity and authority (Katz and Mair, 1995, pp.17-23). Later Blyth and Katz suggest that major political parties in advanced capitalist societies have been transformed into 'cartel parties' for two reasons: the limits of 'catchall parties', and the limits that globalisation has imposed upon political systems (2005, p.40).

The concept of 'the cartel party' is helpful in understanding the current form that the AK Party took in Turkey's political system. Turkey's political system is prone to paving the way to the emergence of a cartel party. This is mainly due to three factors. First factor is that the political party funding structure is based upon a model that favours the political parties that gain more votes than 10 per cent national threshold in elections. Larger the

share of votes the party gets in general elections, more financial resources it gets from the public budget in the upcoming elections. Secondly, Turkey's electoral system is clearly majoritarian. Thirdly, checks and balances in Turkey's political system are weak to prevent the interpenetration of state and the governing party. As discussed in this chapter later on, the AK Party's successive electoral victories, coupled with the lack of necessary checks and balances in Turkey's political system to prevent the centralisation of power, paved the way to the transformation of this party into a cartel party.

### **6.3. The influence of the AK Party's political ideology on the content of the reform**

The AK Party was established 15 months before it came to power in the 2002 general elections. However, the leading cadre of the AK Party was not a newcomer to parliamentary politics. As discussed in Chapter 3, the leading cadre of the AK Party separated from the major Political Islamist movement, called the National Outlook Movement, whose political parties had been closed down due to their allegedly anti-secular activities. In response, the AK Party presented itself as a "conservative democratic" political party that aimed to bring together different streams of centrist and rightist politics. Coşar and Özman argued that the leading cadres of the AK Party invented the label of conservative democracy in order to avoid being seen as a religious fundamentalist political party that would pose a threat against Turkish political regime (2004, p.65).

The AK Party's portrayal of itself as a centrist political party resonated in the academic conceptualisation of the party's political stance. For instance, Özbudun defined the AK Party as "a moderate conservative democratic party" (2006, p.543). While acknowledging the historical link between Political Islam and the AK Party, Özbudun suggested that the AK Party had less in common with the political parties that represented Political Islam (i.e. The RP) and more in common with the mainstream

centre-right parties. The AK Party succeeded in rebuilding the former Motherland Party's centrist coalition that brought together almost all components of the right and even a small segment of the centre-left (Özbudun, 2006, p.546). In line with Özbudun, İnsel portrayed the AK Party not as the heir of Political Islam but as a pragmatic middle-class party within which the elements of the National Outlook movement would eventually become marginal (2003, pp.300-301).

Both the AK Party's programme and the public statements of its leading cadre have been eclectic with respect to their approach towards social policies and health care policies in particular. On the one hand, the AK Party clearly adopted a pro-market approach to its major economic policies. Distinguishing itself from the National Outlook Movement's Islamist "third-worldism", the AK Party clearly aligned its economic policies with neoliberalism. In the party programme, the AK Party declares, "it is in favour of working market economy with all its rules and institutions" (Justice and Development Party, 2014). The AK Party's neoliberal approach also manifested itself in its approach to health care policy, as evidenced in Erdoğan's public statement: "I do insist on this; free markets have to be formed in health, as there are free markets for all other things in the world" (Hürriyet, 2006).

On the other hand, the AK Party inherited the National Outlook Movement's discursive and organisational expertise in appealing to and mobilising the urban poor, a group that had long been left out of the political agenda of centrist parties from the right and the left of the spectrum. The inheritance of the AK Party from the Political Islam of 1990s found its echo in the party programme and the public statements of the leading cadre, as both promised to expand public services, including health care services for all citizens of Turkey, especially for those who had been either left out or marginalised. For instance, one of the seven main components of the AK Party's party programme is dedicated to social policies. Among other areas such as education services and social services, the programme lists health care policies under the heading of social policies and suggests that the AK

Party acknowledges the responsibility of the social state to offer health care services to its citizens (Justice and Development Party, 2014).

Therefore, from its establishment, the AK Party's ideological stance has been "a synthesis between the neoliberal context ... and traditional-conservative values" (Coşar and Özman, 2004, p.67). The AK Party utilised a traditional-conservative political discourse to communicate its populist agenda with the general public, which has been based on the use of social policies including health care policies for electoral success. In other words, the AK Party simultaneously pursued neoliberal economic policies and populist social policies. One of my informants, who worked within the health care reform team of the AK Party, suggested,

"Three consecutive AK Party governments pursued liberal economic policies. But, they also pursued serious social policies in education and health. In fact, these two sets of policies are in conflict with one another. We have to see this. ... This brought success. ... If health will be governed with the same liberal logic, then the risk of private sector becoming dominant might become real. That is why this has to become state policy" (Interview no.20).

As evidenced in the quotation above, my informant, who was part of the AK Party's health care reform team, acknowledged a difference in the perspectives that inform the government's economic and social policies. From his perspective, the coexistence of both logics in the discourse and practices of the AK Party secured the government's political success. Similarly, my other informant from the Revolutionary Health Workers' Union (*Devrimci Sağlık İşçileri Sendikası, DEV-SAĞLIK-İŞ*), who was critical of the government's health care reform, stated,

"In order to prevent social opposition to these policies (neoliberal economic policies), the AKP developed social policies to neutralise poverty. In this sense, it had a special mission" (Interview no.31).

Therefore, it could be argued that representatives from both the pro-reform and anti-reform camps acknowledged the politically successful

nature of the AK Party's two-tiered policy agenda, which included implementing neoliberal economic policies while pursuing social policies. As my informant who worked as a member of the AK Party's health care reform team suggested, "Health care was key in the AKP's quest for power. The AKP used health care to influence people" (Interview no.8).

As Öniş succinctly explained, the AK Party arguably was able to realise both of its main objectives, namely securing economic growth and mobilising formal and informal redistributive mechanisms (2012, p.137). Öniş suggested that the international political and economic environment also enabled the AK Party's ability to realise both of these seemingly irreconcilable political objectives, which he conceptualises as 'controlled populism' (2012, p.137).

However, the AK Party not only compensated its economic policies with social policies; it also introduced pro-market social policies, as it is argued in the case of the HTP in Chapter 4. The HTP includes both pro-market and redistributive measures. Each set of measures has been creating conflicting dynamics within Turkey's health care system. On the one hand, the HTP actively supported the increasing role of the private sector in the provision of health care services and envisaged to introduce supplementary private health insurance to top up the public health insurance. On the other hand, the HTP established a general public health insurance scheme to cover all citizens without recognising an opt-out option for those who might prefer purchasing private health insurance only. The HTP also made specific health care services, such as emergency services and cancer care in public and private hospitals, free for all citizens. In doing so, I argue that the AK Party's synthesis of neoliberalism with populism also manifested itself in the HTP and made the reform process conducive to political conflicts within the AK Party and among different actors of health care politics.

#### **6.4. The Health Transformation Programme as a factor in the consolidation of the AK Party rule**

The AK Party was established by a group of politicians who had resigned from the Political Islamist FP a little more than a year before the 2002 general election. Following the economic crisis in 2001, the AK Party came first in the 2002 general elections. As a result of the 10 per cent national threshold, the AK Party could take the majority of seats in the Parliament, which made it possible to form a single-party government. One of the most important results of the general elections in 2002 was the historical failure of the traditionally powerful political parties in the centre-right and centre-left (Çarkoğlu, 2002, p.131; Coşar and Özman, 2004, p.57). The AK Party's electoral victory in 2002 marked a turning point for Turkish politics, as the Party succeeded in consolidating and then expanding its constituency without leaving any chance for the formation of another centre-right political party over the next decade.

Before the AK Party's rise to power in the 2002 general elections, Çarkoğlu defined the main characteristics of the Turkish party system as "the apparent lack of continuity, together with ever-increasing fractionalization and volatility of electoral support" (2002, p.123). Then he suggested, "The AK Party became the first political party in Turkish electoral history to gather behind it a uniform nationwide swing in its favour" (Çarkoğlu, 2002, p.139). After more than a decade of the AK Party rule, the AK Party managed to increase its share of votes in three consecutive general and local elections. At last, the AK Party received more than 45 per cent of the votes in the March 2014 municipal elections. One of the distinctive characteristics of the AK Party has been its appeal to the Kurdish electorate both in the Western provinces and in the Kurdish-populated Eastern provinces of Turkey.

Given the AK Party's electoral victories in the last decade, it is not still possible to argue that the electoral support of the AK Party has been volatile. However, the AK Party's success in consolidating its constituency

can hardly be explained on the basis of its ability to keep its primary political coalition with well-known centre-right politicians intact.

Despite the heterogeneity of the AK Party's parliamentary group, which included former members of centrist parties as well as former social democrats in its first term, Erdoğan's power over the Party consolidated slowly in its following two terms. Erdoğan's mandate over the AK Party proved to be strong especially after the political conflict on December 17<sup>th</sup>, 2013 between the Gülen movement, which supported the Party since its establishment, and the AK Party's Erdoğan-headed core cadre. Only 9 MPs resigned from the Party, which had 326 seats in the Turkish Parliament, after the rising political conflict between the Gülen movement and Erdoğan-led AK Party (Al Jazeera Turk, 2014a).

How could a political party dominated by a group of Political Islamists become the representative of the centre-right and secure the majority of the votes in three consecutive elections in a political context that was defined with the volatility of electoral support? Academics have provided various reasons in explaining the electoral success of the AK Party, which includes the economic growth delivered during its rule, its debatable ability to articulate democracy and Islam, and its willingness to introduce the peace process with the Kurdish. Here I argue that the HTP, which created mainly positive outcomes for the majority of citizens between 2003 and 2013, has also contributed significantly to the electoral success of the AK Party.

Pioneering scholars who worked on issue salience suggest that the public is generally concerned about specific policy developments in determining which political party they will cast their vote for (i.e. RePass, 1971, p.400). Belanger and Meguid add to this claim that the political party or candidate's ownership of the issue might affect voting behaviour only if the issue under question is salient in the eyes of the general public (2008, p.489). Despite the fact that no studies are available on the issue salience of health care reform in Turkey so far, it might be suggested that the prevalent problems of the pre-reform health care system of Turkey could make the health care reform a salient issue for the general public

throughout 2000s. Health care reform had been an important part of the AK Party's promises to its constituency in the 2002 general election campaign (Ağartan, 2008). Therefore, it could be claimed that the election campaigns of the AK Party demonstrated that the party claims strong ownership of the health care reform.

Three sets of evidence might substantiate the claim that the introduction of the HTP contributed to the electoral success of the AK Party in general elections that took place 2007 and 2011. First, according to the Turkish Statistical Institute survey findings, 39.5 per cent of the population stated that they were satisfied with public health care services in 2003, and this figure increased to 74.7 in 2013 (2014). Therefore, it could be suggested that this dramatic rise in the percentage of the population that was satisfied with public health care services might have affected the voting behaviour.

Second, the success of the health care reform has remained part of the AK Party's election campaign, even 10 years after the launch of the reform. For example, before the municipal elections in 2014, Deputy Prime Minister Mr. Bülent Arınç declared health care services as the most popular policy of the AK Party government (Anadolu Ajansı, 2014). More recently, in the AK Party rally that took place in the city of Yozgat before the March 2014 municipal elections, Erdoğan's address to the public mentioned the positive outcomes of the health care reform (Sorgun, 2014).

Third, public opinion surveys indicate that the general public assesses the AK Party's performance in health care as the most successful among all other policy domains. For example, the International Republican Institute's report indicates that the respondents ranked the government's performance in the improvement of the health care system as 6.26 on a 0 to 10 scale (10 refers to the best performance), which made the improvement of the health care system as the best performance of the government among different policy domains in the eyes of the general public (The International Republican Institute, 2011, p.8). In the same survey, 4 per cent of the respondents suggested that the improvement of the health care system



would be the most important issue that they would consider in the next elections (The International Republican Institute, 2011, p.9).

Given the evidence stated above, I argue that the AK Party's success in introducing and implementing the HTP contributed to its successive electoral victories. The AK Party, which first emerged as a by-product of a far-right Political Islamist National Outlook Movement, managed to establish itself as a catch-all party using formal and informal redistributive mechanisms, the most important of which has been the easing of access to health care services. As the improvements in health care services affect the society as a whole, the AK Party's popularity could make its way to almost all provinces in Turkey.

Nevertheless, the claim that the AK Party's social policies contributed to its electoral success might seem incompatible with the *zeitgeist* in the age of neoliberal globalisation. However, both the specific features of the development of the welfare state in Turkey and the political atmosphere that the AK Party had to work within created a rather different national context than scholars portrayed. While Turkey's welfare system was established concurrent with Western European trends in the post-WW2 period, it was insufficient in providing social protection for all mainly due to the lack of universal coverage and the absence of social assistance and services components (Buğra and Keyder, 2006, p.212). As a result, the level of social expenditures in Turkey remained limited throughout the 1980s and 1990s when compared to its counterparts (Buğra and Adar, 2007). Therefore, while the limits of neoliberal globalisation also apply to Turkey, there still was room for Turkish governments to increase the share of public expenditures in the total public budget by changing the internal composition of the public budget. Even after seven years of AK Party rule that eased citizens' access to health care services and introduced cash transfers for disabled people and their relatives, the share of public social expenditures in Turkey's GDP did not increase drastically. According to the OECD Social Expenditure Database, the share of public social expenditures in Turkey's GDP was 12.8 in 2009, whereas the OECD average was 22.

Another factor that might explain why and how the AK Party could initiate a health care reform that put a new burden on public budget is the political context within which the Party had to work. After the AK Party's rise to power in the 2002 general elections, it still had to create its political legitimacy among the general public and high-level bureaucrats due to its historical affiliation with Political Islam. Given the fact that all successive parties of the Political Islam were shut down before, the AK Party's leading cadre had to be politically cautious in order not to face a similar end. In fact, the first public statement of Erdoğan after the AK Party victory included his Party's commitment to the EU accession process, allegiance to the economic program of Turkey with the IMF, and respect for non-conservatives' lifestyles (Hürriyet, 2002).

In addition, despite the victory of the AK Party in forming a single-party government in the 2002 general elections, more than 50 per cent of the votes were not represented in the Parliament mainly due to the 10 per cent national election threshold. In other words, as Sayarı suggested, "the Turkish electoral system –proportional representation with multimember districts under d'Hondt formula and a 10 per cent national threshold that parties must pass to qualify for seats- had a strong mechanical effect in translating votes into seats: the AKP won nearly two-thirds of the seats with about one-third of the vote" (2007, p.200). Therefore, it can be safely argued that while the AK Party's first electoral victory brought it to power, its status as a single-party government did not come with strong political legitimacy (Çarkoğlu, 2002, p.152).

What is more striking about the AK Party's electoral success was its ability to increase its share of votes in the 2007 and 2011 general elections, which provided the Party with the political legitimacy it did not enjoy in its first term. I think, among other factors, the introduction of health care reform was *sine qua non* for the AK Party to become politically legitimate, at least for some sectors of society who did not vote for the AK Party in the 2002 general elections.

## **6.5. The Health Transformation Programme and the AK Party's alliance with the poor and the rich**

The AK Party's constituency started to increase from around 35 per cent of all voters in the 2002 general elections to approximately 50 per cent in the 2011 general elections. The AK Party also expanded organisationally. As of 2013, according to the data of the Supreme Court of Appeals Prosecutor's Office, the AK Party had the largest membership base with around 7.5 million registered members (out of around 50 million citizens above the age of 18); whereas the main opposition CHP had around 1 million in 2013 (Hürriyet, 2013b).

Understanding the AK Party's social basis and its growth has been among the main paradoxes studied by social scientists in Turkey in the last decade. In order to understand the AK Party's social basis, it is important to note that the Party inherited a significant portion of the Political Islam votes, as the FP, which the leading cadre of the AK Party had resigned from, had around 15 per cent in the 1999 general election. Despite the fact that the new Political Islamist party that was established after the closure of the FP also ran for the 2002 elections, it could only received around 2.5 per cent of the votes. Therefore, one can safely argue that around half of the AK Party's votes in the 2002 general elections came from the Political Islamist constituency.

Given that the AK Party became heir to the throne of the previously existing Political Islamist parties, it would be beneficial to briefly discuss the core constituencies of these parties. Ayata suggested that the traditional petty bourgeoisie, consisting of artisans and shopkeepers, could be considered the core of the Political Islamist constituency (1993b, p.57). However, this group that Ayata describes constitutes far less than a significant proportion of the AK Party voters.

The Nationalist Outlook movement gained pace throughout the 1990s as a result of its successful alliance with the urban poor. In the middle of the 1990s, the RP won the municipalities in key cities such as Ankara and

Istanbul. The Party worked hard, both before and after the municipal elections, to organise and support the urban poor through the use of party and municipality resources in the age of Turkey's welfare system's crisis (Akıncı, 1999, pp.76-78). The RP's endeavours to reach out to the urban poor through its "just order" ideology, i.e. offering social services to the urban poor and showing sympathy towards the everyday problems of the urban poor throughout the 1990s, strengthened its popularity (Ayata, 1996, p.52). Gülalp also links the popularisation of Political Islam among the urban poor as a response to the lack of formal social safety nets in the age of a neoliberal transformation of Turkey's economy after the military coup d'état in 1980 (2001, p.441). As discussed in Chapter 3, the National Outlook movement benefited from the policy drift in social policies throughout 1980s and 1990s.

In addition to its strong links with the urban poor, the National Outlook movement also organised part of the business community throughout the 1990s. For instance, the Independent Industrialists' and Businessmen's Association (MUSİAD), which is known for its political affinity with Political Islam, was established in 1990. According to Ayata, the Islamist bourgeoisie "grew as a result of the conscious efforts of Islamists in the ANAP governments who provided the Islamist bourgeoisie access to credit from official sources. They were also given preferential treatment in receiving government contracts" (1993b, p.58). While the Islamist bourgeoisie did not constitute the strongest faction within the Turkish bourgeoisie at the time, its financial support for the Political Islamist parties proved to be important especially in assisting the urban poor in the age of the welfare system crisis.

As a result of the strengthening of Political Islam, thanks to the alliance it created with the urban poor and the support it took from the Islamist bourgeoisie, the social base of Political Islam in Turkey became "a vertical bloc comprising segments of different socio-economic classes" including the capitalists in the peripheral cities, the professional middle class and workers who could not get integrated into the formal employment

(Gülalp, 2001, pp.444-445). In other words, the National Outlook movement already gained the capacity of forming a 'catch-all party' in 1990s.

The AK Party inherited this organisational capacity from the earlier Political Islamist parties that brought together the rich and the poor. Özbudun describes the core constituency of the AK Party as “the rural population, artisans and small traders, urban slum-dwellers, and the rapidly rising Islamist bourgeoisie” (2006, p.547). For Insel, the AK Party emerged to represent “the new middle class,” the core of which is comprised of “small and mid range enterprisers who live mostly in midsize cities and some of whom are employer and employee simultaneously, and the young executives who have received university education, especially in technical fields” (2003, p.297) and “a good portion of the working class” (2003, p.299). Finally, Sayari describes the main alliance upon which the AK Party rested as follows, “Backed financially by the country’s growing Islamist business sector, the AKP did particularly well among the urban poor in major Turkish cities” (2007, p.202).

In line with this political legacy described above, here it is argued that the AK Party’s health care reform was designed to cater both to the Islamist bourgeoisie and the urban poor at the same time. The AK Party’s election declaration included a section on health care, which promised citizens to abolish inequalities between different public health insurance schemes and expand the coverage of public health insurance to include all citizens (Justice and Development Party, 2002, p.83). The promise of the AK Party appealed to the grievances of those who had been either left without any public health insurance or who could have access to inpatient services only due to the limitations imposed on the Green Card scheme. In addition to this, the AK Party promised the private investors that it would allow them to take part in health care provision (Justice and Development Party, 2002, p.83).

The former Minister of Health’s public statements remain as evidence of the AK Party’s pro-poor discourse throughout the reform process. For instance, Minister Akdağ suggested that no hospitals would be allowed to

take patients hostage in return for their debts to the hospitals (Milliyet, 2002). Similarly, Akdağ stated that AK Party is in favour of the poor and the middle class, so its health care reform is pro-poor (Demirkaya, 2010).

In relation to the inability of Turkey's welfare system to provide a safety net for all, Buğra argued that the relations between state and citizens have been bifurcated (2008, p.261). As explained in Chapter 3, while Turkey's welfare system succeeded in offering a safety net for a considerable segment of the society through formal employment and social rights attached to the employment status, it failed to universalise this safety net for others who could not take up formal employment opportunities. Therefore, these two broad social groups have dissimilar experiences with the state and the welfare system in Turkey. Buğra argued that the AK Party government employed a polarising discourse, one that presented the outsiders' interests as opposed to those who were benefiting from the formal social security system (2008, p.263) especially state officials. Election results as well as a drastic increase in citizens' rate of satisfaction with health care services indicate that the AK Party's promise for the urban poor appealed to the grievances of this social group.

Yoltar and Üstündağ substantiated Buğra's argument in the domain of health care services. According to their qualitative study, the majority of society, especially Green Card beneficiaries and the members of the SSK, had been disillusioned with public health services before the AK Party came to power, while civil servants were generally satisfied with the public health services (2007). Therefore, the AK Party's promises in the domain of health care were not ungrounded sociologically.

One of my informants, a specialist medical doctor who had worked in a public hospital and a member of the Association for Human Health and Education, explained how the poor felt "empowered" in the hospital setting after the AK Party's health care reform:

"As the AKP created the perception that the lower class feels more integrated into the system... They did this in health. For instance we

tell people in emergency services that if there are urgent cases, other people will be denied services. This is something normal. ... But they respond to us that we are now in the government, you have to examine us, you can't deny services to us..." (Interview no.17)

As the quotation suggests, the poor seem to feel empowered by the AK Party; they viewed the AK Party as the guarantor for access to health care service even at times when they might be procedurally denied.

It could also be argued that the AK Party could easily hold sway over the general public thanks to the positive public perception of its leading cadre. Since its establishment, the AK Party created a public perception of the members of its leading cadre, and especially its leader Mr. Recep Tayyip Erdoğan, as "the children of the people" (İnsel, 2003, p.299). Erdoğan, who served as the mayor of the Istanbul Metropolitan Municipality, had been jailed after he read a poem with religious references to politics in a public meeting. Before the establishment of the AK Party, the imprisonment of Erdoğan created a public uproar, which strengthened Erdoğan's public image as a "child of the people" who was subjected to undue treatment by the bureaucratic elite.

The use of religious discourse has always been one of the key strategies of the political elite in dealing with socio-economic problems in Turkish political history (Heper and Keyman, 1998, p.259). Therefore, while the AK Party was not the pioneer of this political strategy, it might be considered one of its virtuosos.

How could the AK Party reconcile the demands of the rich and of the poor in health care reform? It should be noted that the AK Party used a specific way to integrate the urban poor into the health care system without harming the interests of the middle and small-sized entrepreneurs, who traditionally tended to favour the Political Islamist parties. Buğra suggested that the AK Party's approach to the working poor should be understood with reference to its alliance with SMEs (2008, p.250). Given that the majority of working poor are informally employed, their employers consist mainly of SMEs. The AK Party, rather than pursuing a health care

finance strategy that would bring responsibility to the employers of SMEs to contribute to the public health care fund as it does for the formal sector, did not feel the need to break the path dependency in health care finance model intact in Turkey's health care system. Subjecting all those out of the formal labour market to means-testing procedures, the AK Party treated the working poor no different from those out of the labour market, and made those individuals responsible for contributing to the public social insurance fund.

The AK Party's health care reform also strengthened its alliance with the Islamist bourgeoisie by opening up new areas of capital accumulation for this group, which is discussed in Chapter 8. This strategy of using public tenders and other public tools to open up new areas of capital accumulation for allied businessmen is not peculiar to the AK Party. As Heper and Keyman stated, "the process of capital accumulation through contracts with the state was the beginning of the formation of vertical links between the state and the society" (1998, p.261). Çarkoğlu also suggested that rent creation and patronage distribution lay at the centre of party politics in Turkey (2002, p.139). As Buğra and Savaşkan evidenced, the AK Party also utilised this strategy by using legislative and administrative mechanisms "to support capital accumulation by newly emerging businesspeople" (2012, p.33). Listing the AK Party-allied businessmen invested in health care, Buğra and Savaşkan successfully demonstrated that the health care sector has been part of this government's selective support for capital accumulation (2012, p.36).

## **6.6. Conclusion**

In this chapter, it is argued that the AK Party's successful synthesis of neoliberalism and populism with a conservative discourse manifested itself in the framing of the HTP in two ways. First, the AK Party succeeded in creating satisfaction among the poor with health care reform while implementing neoliberal economic policies, which strengthened the alliance



it had inherited from the previous Political Islamist parties with the urban poor. Second, the AK Party managed to use the health care reform process as a new contour of capital accumulation for its allied businessmen by integrating the private sector into the provision of health care services.

However, the future of the political alliance backing the reform under consideration is bleak. This is mainly due to the incompatibility of pursuing both strategies in the medium term. While health care entrepreneurs aim to increase out-of-pocket payments to top up public health insurance in accessing private health care services, citizens are against the rising out-of-pocket payments. Therefore, the very political strategy of the AK Party, which made health care reform a success story in the first place, might create hard-to-solve dilemmas in near future.

## Chapter 7: The Turkish Medical Association as an Actor in the Politics of Health Care

### 7.1. Introduction

This chapter explores the role of the TTB as an actor in the politics of health care in Turkey during the launch and implementation of the HTP in 2003.

This chapter is organised into five sections including this introductory one. In the second section, the main arguments stemming from the literature on the role of medical doctors and their professional organisations in health care reforms are reviewed. Following this review, the third section introduces the brief political history of the TTB and situates this organisation within Turkey's political system. The fourth section examines the origins and modes of contestations between the TTB and the government. The last section provides an analysis of the role of the TTB as an actor in the politics of health care in light of the literature on the role of medical doctors and their professional organisations in health care reforms.

This chapter suggests that the role of the TTB during the launch and implementation of the HTP does not fully conform to existing claims in the literature. As a professional medical organisation, the TTB could not escape from its role as an interest-based organisation promoting the rights of medical doctors in different moments during the health care reform. The main contestation between the AK Party government and the TTB has been the control over medical doctors' labour. In addition, following the ideological change in the leading cadre of the TTB in 1970s, the TTB attempts to push the limits of working for the interest of medical doctors and works for transcending *prima facie* the conflict between the medical doctors' rights and citizens' right to health care in its political discourse. This endeavour of the TTB supports the emphasis that ideational institutionalism puts on the role and importance of ideas in welfare politics.

## **7.2. The literature on the role of medical doctors and professional medical organisations in health care reforms**

The literature on the politics of health care acknowledges medical doctors and their professional organisations as pivotal actors in health care reforms. It might be argued that the power of medical doctors in the politics of health care originates from the moral authority of the medical profession and medical doctors' exclusive expertise. For instance, Hyde argues that the power and influence of the American Medical Association (AMA) originates from the professionalism of the medical community, its monopoly over the medical practice, its power of coercion in the form of medical ethics (1954, pp.948-949). In addition, he suggests that the political power of the AMA can be attributed to the higher social status of medical doctors in American society, its mastery over political tactics as an organised professional group, the increased activity of medical doctors in politics, its established relations with the administrative bodies (Hyde, 1954, pp.954-958). For some scholars, this moral authority and expertise gives medical doctors a significant power over health care reform decisions (Normand, 1997, p.223, Blank and Bureau, 2010, p.4).

The literature on professional medical organisations demonstrates the interplay between health care policies and professional politics. In his seminal book on the case of British Medical Association (BMA), Eckstein suggests that the development of public health policies was closely correlated with the politicization of the BMA, which stayed away from politics and concentrated its activities mainly on the regulation of the medical profession before (1960, p.42). The ratification of the National Health Service Act in 1946, which made the state as the main employer in health care services, led to the expansion of the membership base of the BMA to include the majority of medical doctors in Britain (Eckstein, 1960, p.44). Despite the fact that the BMA opposed the establishment of the NHS and appeared as the chief enemy of the Ministry of Health before 1946, the establishment of the NHS then empowered the BMA organisationally and

financially, transformed the BMA into a corporatist body that started cooperating with Ministry of Health later on (Eckstein, 1960, p. 48). In addition, Eckstein's study also indicates differences in the professional institutional context within which professional medical organisations operate do matter in determining their power vis-à-vis other political actors. For instance, Eckstein notes that the BMA does not enjoy the monopoly over professional politics, as the AMA does, due to the presence of the Royal Colleges. As a result, the Ministry of Health had the power to play the Royal Colleges off against the BMA in some cases (1960, p.48).

In the literature, there is a tendency to explain the political discourses and acts of medical doctors and their professional medical organisations in a uniform way. For instance, Navarro suggests that the impact of medical doctors on health care policy should be understood on the basis of their class positions in the society. According to Navarro, as most medical doctors in the U.S. belong to the upper middle classes (1976, p.206), he expects them to act according to their class interests in political controversies over health care. Similarly, Moran suggests that the major objective of medical associations has been to “control over entry to, and competition within, the market, while at the same time allowing the profession to control its own affairs” (2000, 144). Parallel to Moran's insight, Eckstein argues that the BMA's prior opposition to the establishment of the NHS was a result of its general distrust of the entry of non-medical organisations into the domain of health care, more than a result of its ideological stance (1964, p. 130).

The power of medical associations over health care reforms is debated in the literature. While some scholars argue that the success of a particular health care policy requires at least tacit support of the medical community (Normand, 1997, p.223, Blank and Burau, 2010, p.4), others suggest that the power of medical doctors should not be overestimated, as it has been proved to be fragile when it conflicts with stronger business interests or organised public interest in general (Arrow, 2001, p.1201).

It should also be noted that the power of medical associations might vary according to the different dimensions of health care politics. In this

respect, Moran's functional categorisation of the politics of health care might be helpful. Moran places the politics of health care into three categories: politics of consumption of health care; politics of production of health care; and politics of medical profession (1999, p.5). Moran suggests that the politics of consumption receives the largest attention from the general public due to its collective form of financing and access (1999, pp.5-6) especially in state and societal type health care systems. Governments are also highly involved in politics of consumption for two reasons. First, they are in control of the largest portion of health care expenditures (Moran, 1999, p.175). Second, the politics of consumption of health care may have an influence upon the electoral fortunes of governing and oppositional political parties (Moran, 1999, p.7). Political struggles over the consumption of health care have been carried out at the national level (Moran, 1999, pp.177-178). Unlike the politics of consumption, a significant volume of contemporary politics of production are organised at the international level (Moran, 1999, pp.177-178). Lastly, professional politics generally take place between the organised medical profession and governments at the national level (Moran, 1999, pp.177-178). Therefore, medical associations might enjoy greater power over the politics of the production of health care and professional politics, and to a limited extent over the politics of the consumption of health care.

Other scholars note that power is not evenly distributed within the medical community. In a study on the AMA, Hyde suggests that urban practitioners and specialists, whose incomes are above the average income of medical doctors, are in a better position to devote time and energy into health care politics (1954, p.947). In a study on the BMA, Eckstein argues that the BMA has largely been a general practitioners' association, which has an impact on the political positions it takes during conflicts (1960, p.50).

Another line of thought, which is discussed in detail in Chapter 2, is institutionalism. Institutionalism mainly suggests that the power of medical associations depends on the political system within which they are embedded. Immergut, in her analysis of health care reforms in Switzerland,

France and Sweden, found out that while medical associations in all three countries opposed the governments' efforts to introduce national health policies, the policy outcomes were all different (1992, p.xxi). Therefore, Immergut argues that the power of medical associations derives not from their internal power resources but from the political system that enables or disables them to influence the policy outcomes. In her words, "the political impact of a particular group is contingent on strategic opportunities stemming from the logic of political decision processes" (Immergut, 1992, p.11).

In addition to Immergut's insight, it might also be claimed that the level of organisation among the medical community, the internal coherency of the medical association, and the strategic tactics of the medical association might also have an impact on the extent to which medical associations influence the policy outcomes.

While these accounts provide insights for the students of health care politics, here it is argued that the role of the medical community and medical association in concrete health care reforms could be better understood by situating the medical community and the association within the historical and political context of the country under consideration.

### **7.3. A brief political history of the Turkish Medical Association and its power resources within Turkey's political system**

The emergence of the medical community in Turkey dates back to the Late Ottoman period when the first Western-type medical schools were established in the early 19<sup>th</sup> century. The graduates of the first medical schools, who then became defenders of modern ideologies, had a significant impact on the Late Ottoman politics and on the politics in the early Republican Period. In the early Republican period, medical doctors played a key role in establishing legitimacy for the new regime and were considered the bearers of the official Kemalist ideology.

As explained in Chapter 3, the TTB was established in 1953 by law (The Republic of Turkey, 1953) and was officially designed as a corporatist professional organisation expected to support the health care policies of the government, serve the medical community, and act as an advisory body for the government and the MoH in particular. Schmitter defines corporatism as follows:

“A system of interest representation in which the constituent units are organized into a limited number of singular, compulsory, non-competitive, hierarchically ordered and functionally differentiated categories, recognised or licensed (if not created) by the state and granted a deliberate representational monopoly within their respective categories in exchange for observing certain controls on their selection of leaders and articulation of demands and support.” (Schmitter, 1974, pp.93-94).

Parallel to Schmitter’s definition, lawmakers designed the TTB as a corporatist body that would represent the medical community at the policy level, while not offering it much power over policy outcomes. However, the transformation of the TTB into a *de facto* non-governmental organisation as well as a locus of leftist opposition proves that actual discourses and practices of organisations might push the predetermined limits imposed on them.

In the 1970s, young medical doctors sympathising with leftist views started to gain the upper hand within the executive board of the TTB, which resulted in the transformation of the TTB from a corporatist professional body into a dissenting civil society organisation composed of medical doctors who had a say on matters not limited to health care issues. While the military coup d’état in 1980 suppressed all forms of civil society organisations including the TTB, the Association was one of the pioneering organisations within Turkey’s civil society that succeeded in revitalising itself in late 1980s.

Today, the TTB is a public corporate entity that works under the purview of the MoH. However, in practice, the TTB works independently

from the MoH and acts more like a non-governmental organisation. As the former head of the TTB argued, governments have acknowledged the Association as an opposing force since the second half of the 1970s (Interview no.9). The former head of the TTB explained the current state of the Association as follows:

“Concerning the foundation law of the TTB, we are not fully a non-governmental organisation. We are founded by the law. We have a legal link with the Ministry of Health in one way or another. That is why the Ministry of Health always wanted the TTB to be its backyard” (Interview no.14).

However, as the TTB’s ability to oppose the government’s health care reform proposals discussed in this chapter indicates, the agency of the TTB’s leadership managed to restrict the influence of the Ministry on the TTB and transformed the TTB de facto into a civil society organisation. In the words of the former head of the TTB:

“The Ministry of Health wants to monitor the TTB. They also have legal basis. But we are against the monitoring of the Ministry. We defend the position that professional organisation should be independent. We think this is the only way we can protect the values of the medical profession” (Interview no.9).

As the quote above indicates, the agency of the TTB’s leading cadre is decisive in keeping the organisation an independent professional organisation capable of promoting and protecting “the values of the medical profession” vis-à-vis governments and the bureaucracy.

The TTB today has chambers of medicine in 65 cities across Turkey. Membership is compulsory only for medical doctors working independently. Given the fact that the overwhelming majority of medical doctors work either for public or private hospitals, it could be argued that non-compulsory membership to the TTB undermines its representative power. Despite the lack of compulsory membership, however, the TTB states that its



membership base covers around 80 per cent of all practicing medical doctors in 2006 (Turkish Medical Association, 2014).

Unlike most of its counterparts in other countries, the TTB does not accept sponsorship from private companies operating within the health sector. The former head of the Association explains the rationale behind this decision as follows:

“We, as the TTB, are an organisation that can define its own position when we get into a political conflict. Membership fees constitute the largest portion of the Association’s total revenue. We reject the sponsorship proposals from the pharmaceutical sector. We know that pharmaceutical industry can make the Association rich. We are aware of that. But then we will lose the ability to develop our own political position in line with our values” (Interview no.9).

As is seen in the quote above, “values of the medical profession” have a central place in the TTB’s political discourse. The TTB bases its legitimacy upon the universal values of the medical profession, which are defined on the basis of international human rights conventions, the Hippocratic Oath, and medical ethics. In fact, earlier studies on other medical associations indicate that the use of ethics in opposing political reforms is not limited to the case of TTB. For instance, Hyde argues that the AMA substantiated its opposition to the state’s attempts to control medical practice by referring to the ethical values of the opposition. For Hyde, in doing so, the AMA failed to address economic issues in the domain of health care politics realistically (1954, p.976).

The representatives of the AK Party government, and especially the Minister of Health at the time, constantly accused the TTB of being “too political” on health care issues and trespassing the boundaries of acting as a professional organisation. For instance, the Minister of Health at the time, Mr. Recep Akdağ, explained the major cause of contestation between the government and the TTB as follows:

“We are not in a struggle with the TTB as a professional organisation. There is an ideological battle. They are struggling with us on ideological grounds” (Medimagazin, 2011b).

As the quote above suggests, on the one hand, the Minister acknowledges the political character of the TTB as a professional organisation. On the other hand, the Minister of Health does not consider an ideological battle with a professional organisation as legitimate. He continues to explain:

“In this professional organisation, my invaluable friends represent 100 to 200 thousand people. I am representing 74 million people. I am sorry but I am not going to let any person, any professional organisation to stamp on the national will” (Medimagazin, 2011b).

Akdağ draws attention to the broader legitimacy of the government vis-à-vis the TTB, a legitimacy that originates from electoral victory and the greater representative power of the government. Therefore, any political opposition of the TTB against the government, according to Akdağ, is acceptable. This is because it implies an opposition against “the national will”, which is presented as almost sacred and clearly indivisible especially after the AK Party’s transformation into a ‘cartel party’ as it is claimed in Chapter 6.

The former head of the TTB explains how two different bases for legitimacy clash during conflicts between the government and the TTB:

“The Minister takes a position against the TTB’s proposals as follows. He argues that they take their legitimacy from the populace. But he says, you only do what your colleagues want you to do. He says, you are not a political party. He asks us to establish a political party and run in forthcoming elections. But we cannot seek recognition of universal values from the public. Of course the government determines health care policies. But it is also a right to dissent these policies. It should be possible to develop criticisms on the basis of medical ethos” (Interview no.9).

In practice, it could be argued that the TTB has been an outlier in the global scene of medical associations in terms of its overtly left-leaning political position that aims to reconcile the interests of medical professionals and patients and introduce an egalitarian public health care system funded by general taxation.

In addition to its reference to “universal values of the medical practice”, the TTB suggests a paradigm that reconciles the medical doctors’ rights with citizens’ rights to health care. For instance, the former head of the TTB suggests,

“Our objective is to protect medical practice and its values for the good of the society. For us, there is no distinction between the rights of medical doctors and the rights of the patients. For us, there is only the right to health care” (Interview no.9).

The holistic approach to the right to health care explained by the interviewee above is grounded in Marxian class analysis that the leading cadre of the TTB internalised since 1970s. He argued,

“In the end, medical doctors are workers. They have a special form of labour, but it is a form of labour. Medical doctors are increasingly becoming part of the majority that does not have anything to sell but their labour power. ... Class conflict underlies the contestations in the domain of health care.” (Interview no.9).

In light of the values and the basis of legitimacy stated above, the TTB has also been active in health care politics, including the politics of production and consumption. While the TTB does not have a veto point concerning health care decisions, it has developed two main strategies in order to influence policy outcomes. The first of these strategies is legal activism. As the former head of the TTB stated, “Legal activism is at the forefront of the TTB’s opposition strategies, as getting a result is faster. We use all legitimate means” (Interview no.9). Once the government introduces a change in health care policies that is not compatible with the TTB’s

political position, the TTB opens a case against the change either in the Supreme Court or in the Constitutional Court.

The second of the TTB's main strategy is to organise press conferences and labour strikes of medical doctors, generally in collaboration with other health workers including nurses and caregivers. The success of these strategies is not guaranteed by the political system and depends on the particular case. As the former head of the TTB states, the TTB keeps its distance from interest-based lobbying strategies:

“We do not use lobbying strategies, using the word lobbying in a pejorative way. We do consult with other stakeholders, but we keep our distance. We do not have ‘go-getter’ skills. What we rather do is the following: preparing opinions, publications, press releases, labour strikes...” (Interview no.9).

In fact, the TTB used judicial activism to annul critical changes in the health care reform through organised labour strikes and street protests against the reform,<sup>17</sup> especially during the Day of Medicine, which has been celebrated in Turkey on every March 14<sup>th</sup> and is accepted as the anniversary of the launch of modern medicine teaching in the early 19<sup>th</sup> century.

From another perspective, the health care reform team perceived the TTB's rejection of lobbying strategies and pursuit of a hardliner position with respect to health care reform as “uncooperative” (Interview no.20).

Politically speaking, the TTB has been acting in alliance with other left-leaning professional organisations, trade unions, and non-governmental organisations. My interviewee explained the rationale behind this alliance as follows:

“The TTB is part of the broader labour struggle. It prioritises values. We do not prioritise medical doctors, we defend health workers as a whole” (Interview no.9).

---

<sup>17</sup> i.e. Labour strike on 5 November 2003, protest on 24 December 2003, protest on 10-11 March 2004, protest on 13 March 2011.

The allied organisations of the TTB include but are not limited to the Turkish Nurses Association, the Health and Social Services Labourers Union (*Sağlık ve Sosyal Hizmet Emekçileri Sendikası, SES*), the Union of Chambers of Turkish Engineers and Architects (*Türk Mühendis ve Mimar Odaları Birliği, TMMOB*), and the Revolutionary Health Workers Union (*Devrimci Sağlık İşçileri Sendikası, DEV SAĞLIK-İŞ*). In addition, the TTB has been the leading organisation that informs and shapes the opinion of other allied organisations on health care issues. It could be argued that allied organisations of the TTB are all political parties on the left -including today's main opposition party (CHP)- and organisations that place themselves on the left of the political spectrum.

The TTB holds general elections for its executive board. Despite the fact that the Active Democratic Group (*Etkin Demokratik Grup*) of left-leaning medical doctors has ruled the Association since 1970s, politics within the TTB have been vibrant. There are strong alternative groups seeking to come to power within the Association. These alternative groups include but are not limited to Turkey's Platform for Medical Doctors (*Türkiye Hekim Platformu*), Rights of Medical Doctors Group (*Hekim Hakları Grubu*) and Medical Doctors' Union of Forces (*Hekim Güçbirliği*).

As confirmed by the former head of the TTB, a major fault line between the three largest groups in the TTB echoes the broader political fault lines in the country (Interview no.14). Turkey's Platform for Medical Doctors is Turkish nationalist; Rights of Medical Doctors Group is neo-liberal conservative; and Medical Doctors' Union of Forces is Kemalist nationalist. To exemplify, Medical Doctors' Union of Forces calls for medical doctors to join the ranks of their union with these statements:

“Distinguished colleagues, ... we have been unified and struggling against trivialisation of all of our medical doctors and their labours and the enslavement of them; we have been and are defending our national values, Mustafa Kemal Atatürk and revolutions of the Republic that are under threat...” (Hekim Güçbirliği, 2012b).

One of the major critiques raised by the Medical Doctors' Union of Forces against the Active Democratic Group is that the TTB prepared posters in minority languages in Turkey (Kurdish and Armenian) under the administration of the Active Democratic Group (Güzelant, 2012).

Interestingly, the socialists—represented by the Active Democratic Group within the TTB—are clearly a minority group in Turkish politics that managed to remain in power in the TTB. In response to my question about how the socialists managed to remain in power in the Association, the former head of the Association gave the following answer:

“Concerning medical doctors’ rights, people who are ideologically close to the government lately established relationships that were aside from TTB. They negotiated with the Ministry. They tried to improve the situation at the time. They worked to initiate some positive steps. None of them succeeded. Therefore, they had to deal with this: they don’t have a problem with privatisation but those defend medical doctors’ rights are us, those against privatisation” (Interview no.14).

As the quote above suggests, one could argue that the legitimacy of the leading cadre of the TTB originates from its know-how on legal and street activism. However, this legitimacy has always been elusive, as there is tension between the values of the leading cadre and the membership base of the TTB.

#### **7.4. The Turkish Medical Association’s opposition to the Health Transformation Programme: Contestations with the AK Party governments**

As discussed in an earlier section, the TTB bases its political discourse of the critique of health care reform on universal values of the medical profession and a Marxian class analysis that sees medical doctors as part of the working class. In this respect, the TTB rejects the bifurcation of “the right to health” between the rights of medical doctors and the rights of citizens. Instead, it aims to unify the struggles of medical doctors’ rights

and the citizens' rights to health care. For the TTB, this can only be possible in a fully socialised national health care system that provides free and universal access to all citizens.

The AK Party's HTP has a rather different approach to health care that aims to transform the health care domain into a quasi-market model. In this model, different actors will operate in a self-interested fashion. The conflict among the self-interested behaviours of different actors is expected to provide the optimal distribution of resources. In order to guarantee the optimal distribution of resources within the health sector, the state has the responsibility to regulate the behaviours of all actors, including medical doctors, health care providers, patients, and health insurance providers.

Throughout the reform process, the ideal of a fully socialised national health care system that provides free and universal access to all citizens remained a vantage point for the TTB in its critique of Turkey's new health care system represented by the HTP. Nevertheless, it should be also noted that the underlying conflict between the TTB and the AK Party governments is not limited to their opposing views with respect to reform in health care system. As a secularist organisation supportive of the rights of the Kurdish minority, and part of a pro labour rights alliance with professional organisations, trade unions, and civil society organisations, the TTB has been overtly critical of the AK Party's neo-liberal economic policies and its conservative outlook. In fact, the TTB was an active participant of Gezi Park protests in 2013. For instance, the TTB expressed their solidarity with the 69 detained members of the Confederation of Public Labourers' Union (KESK). In the public statement on the detainment of KESK members issued by the TTB with DİSK and TMMOB, these three organisations define the 'new regime' of Turkey established by the AK Party government with three concepts: "pro-market, reactionist, pro-dependency" (Turkish Medical Association et al., 2012).

In this respect, it could be argued that the relationship between the TTB and the AK Party started from almost irreconcilable political standpoints in a polarised political atmosphere like Turkey. In fact, this

conflict became visible in a number of events, including but not limited to the Gezi Park protests. Therefore, it could be argued that the conflict between the two actors over the HTP was also a manifestation of a deeper conflict between anti-communists vs. socialists, the right vs. the left, conservatives vs. seculars, and pro-market vs. pro-state.

Against this background, in line with the scope of this study, here the conflict between the TTB and the AK Party government is explored with a special emphasis on health care issues. The TTB's criticisms of the reform included the following five main pillars: the reform results in the privatisation of health care services; the reform is the replica of neoliberal health care reforms that have been imposed by the WB on developing countries; the reform leads to the deterioration of working conditions for medical doctors and other health workers; the reform leads to an increase of violence against health workers; and the reform results in the dissolution of teamwork among medical doctors and other health workers by introducing performance-based payments and increasing subcontracting within the sector (Turkish Medical Association, 2011b).

#### **7.4.1. The clash over the role and function of the Turkish Medical Association**

Despite the fact that the TTB does not enjoy an institutionalised 'veto power' in the Turkish political system, the single-party government takes it seriously because the TTB plays a moral leadership role with the power to shape the popular perception of the health care reform. This is evident in the Minister of Health's public statements that openly address the criticisms raised by the TTB. To exemplify, in response to the TTB's criticism of the reform resulting in privatisation of health care services, the Minister of Health felt the need to declare that the AK Party is not a neoliberal party but rather a proponent of social justice and care for the public and individuals (Medimagazin, 2011b).



While the HTP is based upon an understanding of the health care market that brings together different actors with their own self-interests, this understanding that applies to the market itself seems not to apply to health care politics. In other words, the government does not allow the TTB to push the limits of an interest organisation of medical doctors.

However, the TTB's leading cadre incorporates and even prioritises voicing of criticisms against health care reforms on the basis of the universal values of the medical profession in its mission. TTB representatives suggested that the following phrase of the founding law of the TTB provides them a legitimate ground to develop and voice criticisms against the health care reform under consideration: "to secure the progress of medical profession in favour of public and individual interest" (The Republic of Turkey, 1953).

It should also be noted that while it is a professional organisation without any real representative power with respect to the general public, the TTB also has an implicit claim to define "the public interest" even better than the government. The TTB's claim might be explained on the basis of medical doctors' perception of themselves as disinterested and highly educated people working for the good of the society and never against the society.

The ability of the TTB to assess the outcomes of the reform on behalf of the general public was challenged by the members of the reform team. According to a member of the reform team, despite the positive outcomes of the reform becoming evident in time, medical doctors working in public universities and those serving in the central authority and metropolitan branches of the TTB failed to change their opposing views, mainly because they have limited contact with the public (Interview no.20).

The government felt the need to take a step to exclude all political activities out of the allowed scope of the TTB's activities. By issuing a statutory decree, the government removed the phrase "to secure the progress of medical profession in favour of public and individual interest" from the foundational law of the TTB (The Republic of Turkey, 2011a). With

this change, the duties of the TTB as described in its foundational law (The Republic of Turkey, 1953) were limited to the catering for the solidarity among the members of medical profession and pursuing the interests of medical doctors. While the government representatives have been accusing the TTB of pursuing the private interests of medical doctors at the expense of the general public interest, this change affirms that the government prefers the TTB to act merely as an interest organisation without claiming a broader responsibility to reconcile the interests of the medical professionals with the general public.

The TTB's opposition to the above-mentioned change found echo among the ranks of the main opposition party, namely the CHP. Two well-known members of the parliament, Ms. Emine Ülker Tarhan and Mr. Muharrem İnce, mobilised more than a hundred MPs to open a case against the statutory decree removing the phrase "to secure the progress of medical profession in favour of public and individual interest" from the foundational law of the TTB in the Constitutional Court. The petition included the following phrases:

"The statutory decree under consideration annuls the clause of 'securing the progress of medical profession in favour of public and individual interest', which is the reflection of the responsibility that is given to professional organisations by the 135<sup>th</sup> Clause of the Constitution. The statutory decree aims at annulling the right and the authority given to the organisation by the 135<sup>th</sup> Clause of the Constitution.

...

In addition, the statutory decree aims at undermining the functions of Turkish Medical Association by removing the clause of 'securing the progress of medical profession in favour of public and individual interest'. It is aimed at suppressing the pressure group character of professional organisations that do not comply with the policies of the Ministry of Health. Rather than adopting an approach that recognizes and protects the independent institutional identity, aiming at changing the role and the character of professional organisations is against the democratic, social and constitutional qualities of the state" (2013, p.67).

Finally, the Constitutional Court decided to annul the above-mentioned change in 2013 (Turkish Medical Association, 2013). In the reasoned decision, the Constitutional Court declared,

“The Turkish Medical Association is a professional organisation with public institution status established in line with the 135<sup>th</sup> Clause of the Constitution. It is not possible to make amendments in the statuses of professional organisations with public status within the scope of this Empowering Law no. 6223 (for the Council of Ministers to issue statutory decree)” (The Constitutional Court of Turkey, 2013, p.151).

As stated in the decision, the Constitutional Court acknowledged that the legitimacy of the TTB originates from the Constitution. Therefore, a simple majority in the legislative body does not have the power to amend the roles and functions of the TTB. This decision could be interpreted as the legal recognition of the TTB’s official position, which claims to represent the universal values of the medical profession—values that may not necessarily reflect the popular will. In addition, the decision can also be read as the reinstatement of checks and balance mechanisms that restrict the power of the executive vis-à-vis professional organisations and their political activities.

#### **7.4.2. The clash over the employment status of medical doctors**

The second key issue that sparked a conflict between the TTB and the AK Party governments was the employment conditions of medical doctors. Since the military coup d’état in 1980, Turkey’s medical doctors had been enjoying the privilege that no other civil servants had. Medical doctors gained the right to work for their own private clinics or private health institutions without quitting their jobs in the public sector. Therefore, medical doctors enjoyed the privilege of being civil servants as well as self-employed workers at the same time. The ‘dual commitment’ of medical doctors to public hospitals and their private clinics opened up the health

care system to informality. Before the implementation of the HTP, it was a common practice for patients to pay a visit to medical doctor's private clinic in order to receive better treatment in public hospitals. Therefore, as discussed in Chapter 4, Turkey's health care system before the HTP could hardly be classified as fully decommodified, as informal out-of-pocket payments constituted a significant expenditure for many households.

The clash of the government and medical doctors over the employment conditions of medical doctors started just after the AK Party came to power. Mr. Akdağ, the Minister of Health of the time, made the following statement in the Congress of the TTB in 2003: "Medical doctors should keep away from patients' wallets from now on" (Tıp Dünyası, 2003). It could be argued that the government accused medical doctors of blocking citizens' access to health care services before the reform, thereby legitimising the HTP with anti-medical doctor discourse. One of my informants, who is a professor of public health, explained how the government gained the upper hand vis-à-vis TTB during the debates on full time work law using the deficiencies of the previous health care system:

"The government acted as if all guilt is on the medical doctor, as if there was no connection between the fact of medical doctors being caught up in these kinds of business and market mechanisms. Then the government threw this mess up to medical doctors and the TTB. As a solution, it proposed, it would unlink the private sector and the public sector by introducing full time work requirement for medical doctors" (Interview no.13).

In the aftermath of the 2007 general elections, the AK Party government brought full time work for medical doctors to the agenda. It is important to note that full time work requirement came to the agenda in a context within which the HTP excluded private clinics of medical doctors from health care providers offering services to the insurees of the SGK. The exclusion of private clinics from the new health care system was not a necessity. As the head of the Right to Health Association stated, "they could integrate private clinics into the new system. The new model permitted this

integration” (Interview no.15). However, the government’s choice was in favour of the promotion of the establishment of large-scale private hospitals and their integration into the system. One of my informants, a professor of public health, examined the introduction of full time work requirement for medical doctors in light of changes occurring in the health care delivery market. He argued,

“Full time work, in its current meaning, is a regulation that encourages the intensification of capital to the benefit of large corporations. It is the manifestation of a will that legally lays the ground for this intensification. Small enterprises were being ruled out with a political intervention” (Interview no.13).

The TTB has been traditionally in favour of “full time work regulation” for all medical doctors, which mainly referred to full time work in the public sector. However, referring to the line of thought that the quote above suggests, the TTB strongly opposed the government’s attempt to introduce a full time work requirement for medical doctors. In order to explain its new position, the TTB made a distinction between “real full time work proposals” and “fake full time work proposals” and argued that it supports the former and not the latter (2012). The TTB calls for a full time work that allows medical doctors to earn a salary that corresponds to their labour spent and education attained. The former head of the TTB also explained his position on the introduction of the full time work requirement:

“From my perspective, the full time work principle is a rightful principle. In a public system, private clinics and public service should not go together. However, if you implement full time work in a marketized privatized system like this, you cannot meet the expected efficiency. I am against the full time practice proposed by the Ministry, but I am for a rightful implementation of the full time work” (Interview no.14).

In parallel to the former head’s position, the TTB suggested that the level of medical doctors’ salary should eliminate the need for medical doctors to top their salaries up with extra work and this level should be

reflected in retirement pensions. The TTB released a draft law proposal on full time work (Turkish Medical Association, 2011c), and declared that it was open to negotiation with the MoH for the implementation of “real full time work” (Turkish Medical Association, 2012).

Studying the TTB’s arguments against the introduction of a full time work requirement for medical doctors as part of the HTP and looking at how the government responded to the TTB’s opposition is critical to understanding the limits of the TTB’s political position to defend the right to health care without separating the rights of medical doctors from the rights of patients. Understanding the complexity of the TTB’s position with respect to the introduction of the full time work requirement and the responses it has given might be telling when examining to what extent it is possible for the TTB to keep a distance from interest-based professionalism in an increasingly marketized health environment and an institutional history within which medical doctors with private clinics played key roles.

The government announced the draft law that included the introduction of a full time work requirement for medical doctors in 2008. The draft law included clauses prohibiting all medical doctors working for public and university hospitals to work outside these premises, and for all medical doctors with private clinics to work at the same time for private hospitals that have contracts with the SGK.

In response, the TTB released a report on the draft law. The report suggested that the full time work requirement that the government proposed was different from the full time work proposal of the TTB. While the TTB was in favour of full time work in public hospitals, it was so within a public health care system. However, the new health care system of Turkey is increasingly dependent upon private health care providers. Therefore, this attempt to regulate the medical doctors’ labour and employment status is not justified and is aimed at strengthening the control of private sector health care providers over medical doctors. This form of a full time work requirement, according to the TTB’s report, will eventually result in the depreciation of the cost of medical doctors’ labour (Turkish Medical

Association, 2008). The TTB used three slogans in this report: ‘No to the depreciation of medical doctors’ labour!’, ‘You cannot have full time work with a merchant’s logic!’, and ‘So-called full time work of the MoH: Flexible work, indeed!’ (Turkish Medical Association, 2008). In addition, the former head of the TTB explained why they expect depreciation of the salaries of medical doctors in the near future as follows,

“In a pro-market system I have mentioned before, full time work requirement inevitably leads to the weakening of the negotiation power of medical doctors. ... You increase the private sector, you want medical doctors to work there, you don’t provide them union rights, you don’t make contract a precondition while the TTB is fighting for it” (Interview no.14).

In response, the Minister of Health drew the attention of the public to the high revenues of a minority of medical doctors running private clinics. The Minister stated: “All this uproar is because of 1,200 professors. They insistently want to earn more” (Yalçın, 2009). As mentioned before, this statement could also be read as evidence that the government presented medical doctors as “penny pinchers” in the eyes of the general public in order to create legitimacy for the health care reform.

A senior economist from the WB supported the Minister in analysing the opposition of medical doctors to the introduction of full time work requirement:

“Those who oppose the reform are the pro-status quo camp. These were the medical doctors who benefited from the old system. These were civil servants working in public universities, teaching and using the bed capacity of university hospitals and had their own private clinics. Specialist academic group... I even received hate messages from this group” (Interview no.25)

Signifying a success for the pro-reform camp composed of the government and the WB, the government passed the law in 2010 (The Republic of Turkey, 2010). The law aimed to give an end to this historical

privilege of medical doctors, which caused a political uproar from the medical doctors' side.

In response, the TTB, in collaboration with MPs from the CHP, applied to the Constitutional Court in order to annul the implementation of the law. The Constitutional Court annulled the articles of the law that prohibit the private practice of professors of medicine as well as put a time limit for other medical doctors to decide which institution they want to work for full time (The Constitutional Court of Turkey, 2010). The Court based its decision on the violation of procedure.<sup>18</sup> Despite the decision of the Constitutional Court, the MoH issued a statement announcing that medical doctors working for public hospitals cannot open up private clinics after the time limit determined in the law. The TTB applied to the Council of State to annul the ruling of the MoH and won the case (CNN Türk, 2010). The Council of State declared that all medical doctors have the right to open up private clinics. In response, the MoH contested the earlier decision of the Council of State. In its new decision, the Council of State accepted the objection of the Ministry and decided that medical doctors with the exception of professors of medicine in universities cannot open up private clinics (Sabah, 2011c).

Then the Council of Ministers once again issued a statutory decree that introduced the full time work requirement for all medical doctors in 2011 (The Republic of Turkey, 2011b). Following the promulgation of this statutory decree, 1,157 medical doctors resigned from the public sector and 246 medical doctors retired (Medimagazin, 2012). The Constitutional Court once again annulled the statutory decree (The Constitutional Court of Turkey, 2012) on the basis of the violation of procedure. In response, the TTB announced that the government should respect the decision of the Constitutional Court and respect the professional autonomy of medical

---

<sup>18</sup> In Turkey's political system, The Parliament is authorised to promulgate an Empowering Act that permits The Council of Ministers to pass a statutory decree that has the power of law. In this case, the Constitutional Court decided that the Empowering Act did not authorise the Council of Ministers to make regulations on the labour market for medical doctors.



doctors (Turkish Medical Association, 2012). In a press release published after the Constitutional Court annulled the law on full time work in 2012, the TTB made the statement below:

“The insistence of the AKP government on “full time work law” is neither for the good of medical doctors or patients, it is a regulation for the good of private hospital bosses. Aim is not to encourage medical doctors to provide better services in public facilities or patients to easily access health care services, but to cheapen the labour of the medical doctor” (Turkish Medical Association, 2012).

However, the government did not lose its determination to regulate the labour market for medical doctors. Instead of issuing a statutory decree, it introduced a new law, which prohibited those working for public sector providers, including universities, to run private clinics, while allowing them to work additionally for private hospitals under certain regulations (The Republic of Turkey, 2014a). By allowing medical doctors working in public universities to work additionally for the private sector providers but prohibiting them to work for their private clinics, it could be argued that the government made a conscious political choice in the reconfiguration of the health care delivery structure at the expense of private clinics. This decision is also in line with the prior decision of the government to exclude private clinics from the SGK’s health care providers’ portfolio. The circular that followed the law set a new time limit for medical doctors to make their decisions within three months (The Republic of Turkey, 2014b). The TTB met with the President of the Republic and the Head of the Constitutional Court and shared their criticisms on the new law (Mayda, 2014, Öngel, 2014). In response to the application of MPs from the CHP, the Constitutional Court decided to stop the execution of the time limit, after which university professors would be prohibited to run their private clinics without leaving their positions in the universities (The Constitutional Court of Turkey, 2014). Finally, the Constitutional Court decided to decline the CHP’s application in the end of 2014 (CNN Türk, 2014), which could be regarded as the end of the conflict over the introduction of full time work

requirement for medical doctors including those working in public universities.

As the brief history of the conflict between the TTB and the AK Party government suggests, the introduction of a full time work requirement has been the key issue. It could be argued that the TTB's priority to oppose the full time work requirement was the result of the TTB's defence of the self-interests of clinic-owner medical doctors. In fact, clinic-owner medical doctors can be regarded as a special interest group within the community of medical doctors.

Not all medical specialties are suited to opening up and profitably running a private clinic. As the former head of the TTB suggested, clinic-owner medical doctors are generally obstetricians, organ transplantation specialists, haematologists and oncologists. He added, "They are a group that earns quite high levels of incomes and does not pay much taxes. Their number does not exceed 1000-2000" (Interview no.14). The total number of specialist medical doctors in Turkey in 2010 was 63,563 (The Ministry of Health of Turkey, 2011). If the higher estimation of the informant is accepted, clinic-owner medical doctors constitute only 3 per cent of all specialists in the country. The former head of the TTB openly expressed the hardship to convince clinic-owner medical doctors to work for a salary either in the public or in the private sector. He stated,

"The TTB conducted a survey on full time work. Clinic-owner medical doctors abstained from proposing a certain level of salary that could convince them to work full time for the public sector. I asked is it 10 thousand Turkish Liras (app. 5500 Euros), 15 thousand Turkish Liras (app. 8250 Euros), 20 thousand Turkish Liras (app. 11000 Euros), they answered me arguing if I want them to starve. Therefore it is impossible to satisfy this group as their expectations are that high" (Interview no.14).

As the quotation above suggests, the leading cadre of the TTB has been aware of the fact that clinic-owner medical doctors constitute a privileged

minority within the medical community and are not prone to support the TTB's ideal type public health care system.

However, here I argue that the political opposition of the TTB is a synthesis of the reflection of clinic-owner medical doctors' self-interest and an expression of the leading cadre's opposition to the growing importance of private sector health care providers. It could be argued that the broad scope of the conflict originates from the issue at hand, which is the question of the ownership of medical doctors' labour in a marketized health care sector. While the government attempts to tie medical doctors' labour either to the public or private sector providers without leaving room for medical doctors to run their private clinics, the TTB defends medical doctors' right to work independently, which in practice only serves a minority of medical doctors.

Indeed, the depreciation of medical doctors' salaries and the labefaction of the position of medical doctors in health care delivery have been taking place. For instance, a hospital manager of a nationwide hospital chain argued:

“People now come to X Hospital. They used to go a specific medical doctor before. They used to visit a specific medical doctor in public hospital. ... Now they directly come for our name. Recognition of our brand is more important than the recognition of medical doctors now” (Interview no.3).

This statement proves that the full time work requirement for medical doctors might have contributed to the marginalisation of medical doctors in health care delivery and the proletarianisation of medical doctors. In addition, as the former head of the TTB suggested, after the introduction of cost containment measures in 2008 by the SGK, private health care providers decreased the salaries of medical doctors (Interview no.9).

Despite the proved appropriateness of the TTB's criticisms of the introduction of the full time work requirement, it should also be stated that this conflict left the TTB in a defensive position and reduced its political stance to the defence of the rights of medical doctors only in the eyes of the

general public. Given the fact that the government framed the introduction of the full time work requirement for medical doctors as the only way to decrease unjustified informal out-of-pocket payments, the defensive position of the TTB has been perceived as the defence of the previous status quo that patients suffered. One of my informants, who is a politically active professor of public health, criticised from within the stance of the TTB during public debates on full time work for medical doctors by claiming,

“The TTB should not oppose the loss of the privileges of clinic-owner medical doctors, rather it should popularise ‘full public’ rather than full time work in its current meaning. ... The TTB chose to explain itself to medical doctors only, and did not explain itself to the general public” (Interview no.13).

As the criticism above suggests, the TTB seems to fail in popularising the rationale behind its opposition against the introduction of the full time work requirement to the general public.

## **7.5. Conclusion**

The literature on the role of medical associations in health care politics has a tendency to assume that professional medical associations are organisations that only aim to represent the interests of medical doctors, which are considered similar across countries (i.e. Moran, 2000). However, the case of the TTB explained in this chapter challenges these assumptions. Despite the fact that protecting and promoting the interests of medical doctors is part and parcel of the TTB, the TTB’s self-description, its political stance with respect to health care issues, and its political discourse transcends the ideal-type medical association that the literature suggests. Drawing on a particular historical experience and situated within a specific health care as well as political system, the TTB aspires to promote a holistic approach to the right to health and works for the establishment of universal public health care system.

Second, the literature that examines the possible influence of medical associations in health care reform processes by focusing on the opportunities that a given political system provides to these associations (i.e. Immergut, 1992) is insufficient in understanding the influence of the TTB during the HTP. While the lack of the TTB's 'veto point' in the political system limits its opportunities to influence the reform process, the TTB successfully challenged the government by using judicial activism, especially in the case of the introduction of full time work requirement for medical doctors. Therefore, here it is claimed that the Turkish case demonstrates that both the political stance and the influence of medical associations are rather context-specific, historically grounded and open to the influence of the agency of the actors under consideration.

The TTB's endeavour to act both as a professional organisation and a dissenting civil society organisation aiming to establish a universal public health care system for all has its practical limits. These limits include the limited opportunities the TTB has in its ability to appeal to the general public, especially when compared to the government, and the responsibility that the leading cadre of the TTB has towards its constituency. Given these limits and within an increasingly marketized health care arena, it is expected that the TTB might face difficulties in reconciling the rights of the medical doctors with citizens' right to health care in its political strategies, as it did during the conflict over full time work proposal.

# **Chapter 8: Private Health Care Provider Organisations as New Actors in the Politics of Health Care**

## **8.1. Introduction**

Until this chapter, I analysed the health care politics that led to the emergence of the HTP and the impact of the political actors that existed before the reform on the HTP. However, in line with Skocpol's emphasis on the importance of 'policy feedback', "as politics creates policies, policies also remake politics" (1992, p.58). In this regard, this chapter explores how the HTP has changed the health care politics scene in Turkey by paving the way for the privatisation of health care provision. The inclusion of private hospitals into public health insurance plan, which can be conceptualised as policy layering, led to the emergence of new strong political actors, namely the private health care provider organisations. In doing so, this chapter examines the following: the emergence and the role of private health care provider organisations as actors in the politics of health care in Turkey, the discourse they employ in influencing the reform, the content of their demands and concerns about the reform, and the strategies they use to reach out the members of the government and health care bureaucracy.

This chapter is organised into eight sections, including this introductory one. The second section reviews the literature on the relations between the state and business organisations with a special focus on studies conducted within the field of health care politics. The third section provides the review of the literature on state-business relations in case of Turkey. The fourth section sets background on the role of private health care providers in Turkey's health care system before the launch of the HTP, and also explains the new direction that Turkey's health care system has taken with the reform. The fifth section offers an empirical analysis of the impact of the reform on health care provision. Against this background, the sixth section explores the newly emerging actors of health care politics, namely private health care provider organisations. The seventh section examines

the discourse and strategies that private health care provider organisations used in order to influence the future direction of Turkey's health care system. The last section, in light of the literature, provides an analysis of the impact of the HTP on the landscape of health care politics in Turkey, and how the new actors arising from the Programme influence the reform itself.

Here it is argued that the privatisation of health care provision, which resulted from the implementation of the HTP, drastically changed the health care politics scene. While governments and the TTB dominated the health care politics scene up until the 1980s, and the WB became another major actor at the end of the 1980s, the HTP led to the creation of additional strong political actors: private health care provider groups and their business associations. The Private Hospitals and Health Institutions Association (*Özel Hastaneler ve Sağlık Kuruluşları Derneği, OHSAD*), established as a voluntary business organisation one year after the launch of the reform, emerged as the pioneering actor representing the private health care providers in health care politics. The OHSAD consolidated sectoral interests and also began to function as a pressure group to push the government to increase the role of the private sector in health care provision. It is argued that the relations between the OHSAD and the government can be better understood within the peculiar political and historical context of state-business relations in Turkey.

## **8.2. Literature on the relations between the state and business organisations in health care politics**

In response to the liberal perspective that naturalises free markets, Polanyi suggested, "The road to the free market was opened and kept open by an enormous increase in continuous, centrally organised and controlled interventionism" (2001, p.146). As discussed in the following two sections of this chapter, the HTP can be interpreted as the quintessential example of the market-constituting role of the state. The HTP created a new market, a

quasi-market, in health care provision by including private health care providers in the public health insurance plan and by providing incentives for the establishment of private hospitals. As discussed in the fifth and sixth sections of this chapter, the establishment of the market in health care provision and the increasing marketization of health care services had a substantial impact on health care politics, namely by diversifying the political actors in the health care politics landscape and reshuffling the power distribution among these actors.

Against the thesis arguing that economic globalisation leads to the convergence of economic as well as social welfare policies in different countries, the scholars introduced the Varieties of Capitalism (VoC) approach to demonstrate that responses of national economies to globalisation are path-dependent. Scholars suggest,

“The varieties of capitalism approach, for example, has insisted on institutional inertia and path dependency to highlight the continuing difference between liberal market economies and coordinated market economies.” (Hall and Soskice, 2001)

Following the footsteps of the VoC approach, which is discussed earlier in Chapter 2, it is argued here that the Turkey’s pre-existing health care system, political system, and the different actors of health care politics significantly transformed the health care reform blueprint of the WB and paved the way for the HTP as we know it today.

However, the implementation of the reform reshuffled the power dynamics within health care politics and changed the landscape of health care politics. These new actors, understood here as mainly private health care providers and their associations, emerged in health care politics as a result of the marketization dynamic that the reform created. They came with their own stakes and a new discourse. They came into contact with pre-existing actors, negotiated with the health care bureaucracy, the government and others and contested them in order to change the direction of the health care system to favour their own interests. In order to understand the relations between private health provider organisations



and other key players, as well as the influence of these organisations on health care policies, it is crucial to contextualise and historicise these relations.

Bennett notes that the literature on the role of private health care providers in contemporary health care systems in developing countries has been under-researched (1991, p.50). In fact, the literature on the influence of private health care provider organisations on health care reform is not abundant. While the health care reform literature on developing countries successfully addresses the influences of international financial institutions, national governments, health care bureaucracy on reforms leading to marketization of health care services (Batley, 2004; Armada et al., 2001; Berman and Bossert, 2000), international epistemic communities (Freeman, 1999) and 'peer dynamics' between similar countries (Brooks, 2005), it hardly examines private health care provider organisations as possibly important actors in health care reforms in the developing world.

Giaimo and Manow's comparative study of health care reforms in Britain, Germany and the United States (1999) and Giaimo's follow-up study on the same countries (2005) are some of the few studies that have included the relationship between states and the private health care providers in their analysis of health care politics. Following the footsteps of Historical Institutionalism and using the insights of the VoC approach, Giaimo argues:

“The reasons for these different reform outcomes lay in the specific constellation of actors and institutions in the political and health care systems of each country that underpinned the capitalist settlement in health care. Together, they created distinct reform politics in each nation that produced different mixtures of governance instruments and that proved more or less amenable to market solutions. Formal institutions and the balance of political forces in the political arena either granted or denied health care stakeholders entry to the policy process to shape reform and thus affected the capacity of governments to formulate and enact a radical market programme.” (Giaimo, 2005, p.4)

As the quote above suggests, Giaimo successfully contextualises the politics of health care; she invites the students of health care politics to see the diversity of political actors, examine the power dynamics between these actors, and locate them within a political system. While Giaimo comes up with strictly institutionalist conclusions, such as claiming that single-party governments in centralised political systems are free to unilaterally decide the terms of the health care reform (2005, p.195), she also underlines the agency of the interest groups (i.e. organisational characteristics of interest groups and the capacity of interest groups to take collective action) that may challenge the institutional barriers that block their access to decision-making mechanisms (Giaimo, 2005, p.196). Similarly, in Giaimo and Manow's co-authored article, they questioned the static analysis of institutionalism and argued that arguments based on the power of political systems to shape each political actor's influence on policy outcomes (i.e. Immergut, 1992) do not help scholars to examine the exact direction that health care systems take after the reform (Giaimo and Manow, 1999, p.993).

Therefore, their suggestion for students of health care politics is to take the pre-existing institutional context that shapes the politics without underestimating the power of existing actors to make a change. As Giaimo and Manow argues,

“Policy makers have had to anticipate the views of key health care actors in the reform debates and have tailored their reform policies to fit the existing institutional configuration of their given health care system. In addition, sectoral institutions may provide or deny government actors leverage over, and links to, health care providers and payers. These linkages, in turn, affect state capacity to intervene in the health sector, to shape market forces in health care, and to take a leading role in the project of reform” (Giaimo and Manow, 1999, pp.993-994).

As the quote above suggests, non-state actors might have an influence on state capacity to introduce and implement specific reforms. Therefore, it can be suggested that the merit of Giaimo and Manow's perspective lies in

its ability to relativize the power of policy makers and situate them within a set of other political actors.

Despite its emphasis on the multiplicity of political actors in health care politics, Giaimo's approach does not call for analysis based upon a pluralist understanding of politics. While politics create markets, as Polanyi suggested, markets also shape politics. When an actor gains economic power in the health care market, his or her economic power can translate into political power in health care politics. Giaimo argues that it is crucial to examine the inter-linkages between the health sector and health care politics in order to understand the power basis of each political actor. In her own words, she explains this inter-linkage between the health sector and health care politics as follows:

“However, the political arena tells only part of the story of health care reform. A full explanation requires that we look also at the health sector itself and its interplay with the political arena. Thus, existing policies and institutional arrangements in the health sector both created and reinforced certain expectations on the part of the public and stakeholders as to the appropriateness of state intervention in the health sector.” (Giaimo, 2005, p.4)

Another of Giaimo's contributions to the study of health care politics is her emphasis on the on-going political conflicts in the post-legislative process of health care reforms and even after the failure of a reform effort (2005, p.196). Giaimo's abovementioned insight is in line with the Historical Institutionalists scholars' emphasis on the impact of policies on politics, or 'the policy feedback' (Pierson, 1993). Taking this insight into consideration is especially important in understanding the role of private health care providers and their associations in health care politics in Turkey, as the creation and influence of these actors came after and as a result of the implementation of the reform.

While political scientists only focus on the legislative victories and failures in investigating the politics during health care reforms, Giaimo underlines the fact that political contestations continue after the promulgation of key legislations, and these contestations can be as powerful

as pre-legislative ones in terms of their impacts on policy outcomes. Jacobs and Skocpol's study on the case of the health care politics during President Obama's health care reform also indicates that the legislative victory in a health care reform is not the finish line for political contestations between different political actors. Instead, a victory can ignite new contestations, which may have the power to fundamentally change the direction of the health care system in the future (Jacobs and Skocpol, 2010, p.7).

### **8.3. Literature on the relations between the state and business organisations in health care politics in Turkey**

In light of the insights in the above-mentioned literature, one has to look closely at the historical and political structures of the state-business relations in Turkey in order to understand the actual contestations and negotiations that have been taking place among private health care providers, their organisations, and the government.

Relations between the state, governments, and business in Turkey are rather complex. Historically, Turkey's bourgeoisie has been a product of the nation-state making process. One of the major objectives of the newly founded Republic of Turkey was to give birth to "the national bourgeoisie" that would replace the non-Muslim and non-Turkish bourgeoisie of the late Ottoman period. Therefore, it could be argued that Turkey's bourgeoisie owes its very existence to the state.

After the establishment of the Republic, the bureaucracy contributed to the emergence of a domestic manufacturing bourgeoisie and allied with it in pursuing import-substituting industrial developmentalist policies (Keyder, 1987, pp.129-137). As the state had the upper hand, the ability of the business community to formulate its interest independent from the state remained restricted. In line with the corporatist ethos of the first three-quarters of the 20<sup>th</sup> century, Heper suggests that all of the business community organisations in Turkey were either directly established by the state or with the support of the state (1991, p.15). The establishment of the

Turkish Union of Chambers and Commodity Exchanges (TOBB) in 1950 by law exemplified this trend.

However, the fact that business organisations were closely associated with and controlled by the state did not mean that the business community did not negotiate its interests. As Heper argues, negotiations between the business community and the state did not operate through institutional channels; “*Individual* members of the private sector often by-passed their interest group associations and attempted establishing *clientele* relations with government officials” (1991, p.17). Therefore, clientelism and particularism had been the main characteristics of the relations between the state, governments, and the business community. While governments supported the capital accumulation of the business community, they never welcomed the participation of business organisations in public policy making processes (Buğra, 1997, p.324) or the use of an interest-based discourse by business organisations (Buğra, 1997, p.355). In response, Buğra argues, while Turkish businessmen perceived the state as the main source of uncertainty in the growth of the private sector, they were also well aware that they owed their acquired social statuses to the state. Therefore, businessmen in Turkey did not call for a ‘free market’ economy but rather always asked the state to closely cooperate with the private sector (Buğra, 1997, p.176).

There were attempts from the business community to formulate its own class interests relatively autonomously from the state by coming together under the umbrella of voluntary organisations. Established in 1961, TİSK was the first voluntary organisation of the business community. However, big industrialists were not content with the representation structure of TİSK, which distributed power in favour of small and medium sized companies like TOBB. As a result, the TÜSİAD was established in 1971. TÜSİAD “is the first example of an explicit interest group that is voluntary” (Esmer, 1991, p.132). Esmer suggests that big industrialists established TÜSİAD because they felt that they were not as powerful as

they deserved in TOBB and TİSK according to their power in the market (1991, p.133).

While TÜSİAD proved to be politically effective in developing a class agenda that could be more confrontational than corporatist business organisations like TOBB, Esmer underlines the fact that the TÜSİAD always sought public legitimacy in its public statements by aiming to reconcile its interests with general social interests (1991, p.133). Similarly, Buğra states that the narratives of Turkish businessmen were almost apologetic with respect to their quest for capital accumulation and even businessmen themselves felt uneasy about the social legitimacy of working for material gains (1997, p.42).

Nevertheless, the birth of TÜSİAD could hardly break the clientelistic relations between individual businessmen and the state. The state continued not to recognise TÜSİAD as an institution of mediation between the state and big business. Instead, the state continued to deal with individual businessmen, which in turn disempowered the legitimacy and representative power of TÜSİAD within the business community (Buğra, 1997, p.349). Buğra and Savaşkan explain the nature of state-business relations in Turkey before 1980 as follows:

“The Turkish business environment was characterised, first and foremost, by the nature of the relations between the government and big business, which were carried outside the frame of organised interest representation. The relations of the latter with the government were characterised by particularism and clientelism, but were also rife with tensions. To the extent that one can see these two parties as partners in development, the dominant partner was surely the one holding the political power” (Buğra and Savaşkan, 2014, p.10).

Yalman questions Buğra and Savaşkan’s claim that those holding the political power had more power than the business community. Alternatively, Yalman suggests that the fact that the state in Turkey always acted in favour of the business community in its economic policies might well prove the strength of the bourgeoisie rather than its relative impotency (2009, p.344). While Yalman’s theoretical argument might be

valid in understanding the relationship between the state and the business in the long term, it is hardly useful in an empirical analysis of interactions between the state and the business community, conflicts within the business community, and the formulation of “business interests” in a specific sector and within a particular historical and political context.

In response, Buğra and Savaşkan come up with a perspective that enables an empirical yet historically grounded analysis of state-business relations and demonstrates how market actors might well define their political interests that transcend their short-term market interests:

“Individual economic gain does not seem to be a sufficient motive to explain the broader scope and underpinnings of the relations among the actors involved. In the Turkish case, these relations were part of a politically guided process of class transformation that reshaped and influenced the configuration of business interests and the interface between economic power and the political influence of the private sector. The interaction was situated in networks that brought business actors together with the government and operated according to a logic that extended beyond economic concerns and, in certain cases, even conflicted with efforts to maximise short-term private economic interests” (Buğra and Savaşkan, 2014, p.77).

As the above quote suggests, Buğra and Savaşkan note that individual economic gain, which is apparently crucial for the sustainability of the business, is not the only motive that drives the business community. However, the inter-linkages between the business community and the state might require the business community to go against its immediate economic gains for achieving a greater goal, which Buğra and Savaşkan conceptualise as “the politically guided process of class transformation” (2014, p.12). Therefore, rather than searching for the dominant partner in state-business relations, scholars suggest investigating “a form of interaction that involves a mutual dependency between the government and the business” (Buğra and Savaşkan, 2014, p.12).

In their analysis of state-business relations in the AK Party period, Buğra and Savaşkan come up with four significant conclusions. First, they argue that particularism is still salient in government-big business

relations (Buğra and Savaşkan, 2014, p.109), which is hardly mediated by business associations (Buğra and Savaşkan, 2014, p.12). Second, voluntary business associations gained more power than before, which should be taken into consideration (Buğra and Savaşkan, 2014, p.109). Third, they suggest “the state might not only form the market, but also the market actors themselves through the processes of politically supported capital accumulation and business development” (Buğra and Savaşkan, 2014, p.170). In other words, the state has a significant role in giving birth to the market actors and distributing power within the market. Fourth, scholars underline that the provision of health care services had been one of the sectors where the state created markets and gave birth to new market actors (Buğra and Savaşkan, 2014, p.92).

In light of this review, this chapter investigates the following: how and to what extent the objective of increasing private sector involvement in health care provision could be put into practice with the HTP in Turkey, how this process changed the political landscape in the domain of health care, what kind of political conflicts have risen during the implementation of this measure, and how and to what extent have these political conflicts been solved (or not solved).

#### **8.4. Private health care providers in Turkey’s health care system: A brief history and the Health Transformation Programme**

Before the reform was launched in 2003, health care provision in Turkey had been dominated by public hospitals and public health centres. Yet as discussed in Chapter 3, public facilities failed to provide sufficient services for the size of the population. Furthermore, the geographical distribution of these services had been unbalanced, and primary health care services did not function as the first stop for patients.

Along with the domination of the public sector in health care provision, private clinics of medical doctors also played an important role in the



structure of health care provision before the reform. As discussed in Chapter 3 and Chapter 7, medical doctors had the privilege to open their own private clinics and work for their clinics alongside their duties in public hospitals. In a health care system that failed to provide sufficient services for all and offered relatively low salaries for medical doctors, the presence of dual practice opened up the system to informality. People willing to cut in the waiting line visited the private clinics of medical doctors before and during their treatments in public hospitals and sometimes made table payments to medical doctors before undergoing an operation. Given the eclectic structure of health care provision before the reform, Turkey's health care provision structure could be categorised as a publicly dominated one that had strong informally commodified elements in it.

In the early days of the Republic of Turkey, private hospitals were established and operated by minorities and foreigners, which constituted a marginal element of health care delivery. The promulgation of the Private Hospitals Act provided them a legal status and introduced the regulations they had to comply with (The Republic of Turkey, 1933). During the 1960s and 1970s, the private sector in health care provision was comprised of private clinics of medical doctors and small sized laboratory and radiology services (Temel, 2003, p.4). In the aftermath of the military coup in 1980, which oppressed political opposition to the liberalisation of Turkish economy, the Turkish economy began marching towards liberalisation and an externally oriented growth strategy.

As discussed in Chapter 3, the change in the country's macroeconomic policy was reflected in the domain of social policies, which manifested itself in the commencement of a political agenda promoting more private sector involvement in education and health care services. In line with the global wave of health care reform described in Chapter 4 and Chapter 5, governments started to adopt a new language within which health services began to be called a "health sector" after the 1980s (Ersoy, 1998). In fact, governments introduced economic incentives for the private sector to invest in health care provision (Günel, 2008). This policy started to bring results

in the late 1980s and early 1990s with the rise of the share of private sector presence, first in outpatient and then in inpatient services (Temel, 2003, p.4; Belek et al., p.1998). At a time of low levels of public investment in health care, the share of the private sector in the total volume of investment to health care services exceeded that of the public sector in the early 1990s (Soyer, 2005).

Despite the emergence of private hospitals in the 1980s, it should be noted that the scope of private health care provision remained quite limited up until the implementation of the HTP. Private hospitals established between the 1980s and the early 2000s were based in metropolitan cities and primarily served prosperous citizens; private health insurance coverage did not exceed one per cent of the total population.

One of my interviewees, who established a medium-sized private hospital in the early 1990s and still runs it, succinctly summarised the state of private hospitals before the mid-2000s:

“There was almost no connection between private hospitals and the public sector before 2000. We were generally catering those not covered by public social security or having money. I am talking about the structure in Istanbul. There was really a very powerless structure in Anatolia (Author’s note: Anatolia here refers to Turkey except Istanbul)” (Interview no.24).

Against this background, the HTP symbolised a new era for the private sector in the provision of health care services. First of all, as discussed in Chapter 6, the Urgent Action Plan of the first AK Party government declared that one of the government’s main objectives in health care was to provide incentives for the private sector to invest in health care (The Republic of Turkey, 2003, p.11). Despite the vague expression in the Urgent Action Plan, the HTP explicitly stated that the Programme will deliver “competition in service provision” and the MoH will be restructured in order to take up planning and controlling responsibilities (Ministry of Health of the Republic of Turkey, 2003, pp.26-27). Similarly, the WB project, which aimed to support the success of the Programme, set the transformation of

the MoH from a provider body to a controlling and planning agency as the first indicator of success of the project (World Bank, 2010, iii). Finally, as noted in Chapter 6, Prime Minister Erdoğan openly declared, “Free markets should also be established in health care” (Hürriyet, 2006). Indeed, as Ağartan suggested, the market direction of the HTP has been most visible in the provision dimension of the Programme (Ağartan, 2012, p.465).

Second, as discussed in Chapter 4, the government began to use the Public Private Partnerships model in the construction and operation of public hospitals (The Republic of Turkey, 2005).<sup>19</sup> With the objective of finding an alternative way of financing the extension of health care services rather than increasing the public expenditures in a short period of time, the government seeks private investment in health care provision through the introduction of Public Private Partnerships (PPP) in the establishment of large hospital complexes, namely “city hospitals” (*şehir hastaneleri*). In return for the private companies’ investments in the construction of the hospital complexes, the government offers these companies the right to contractually operate all non-medical services for 49 years. Construction companies expressed interest in these projects. Given that the implementation of PPPs in the construction of large public hospital complexes had been recently initiated, this chapter does not examine the case of PPPs in the construction of large public hospital complexes and the operation of non-medical services in these complexes by the private sector.

---

<sup>19</sup> In Turkey, PPPs have been increasingly used after 1980s in different sectors ranging from the construction of highways to the production and distribution of electricity. Earlier forms of PPPs in Turkey had been in line with the Build-Operate Model and the Build-Operate-Transfer Model. In the aftermath of the promulgation of the memorandum allowing public hospitals to purchase non-medical services from the market by the Ministry of Health in 1985, the first use of PPPs in Turkey’s health care sector has been in the procurement of non-medical services in public hospitals including catering, maintenance, security etc. Following this, PPPs have been extended to the diagnostic services in public hospitals. In the form of a Setup-Transfer-Operate model, private investors have been allowed to set up diagnostic machinery (i.e. computed tomography (CT), magnetic resonance (MR)) in public hospitals and operate the diagnostic services for a specific period of time, later transfer the ownership of the machine to the hospital. Please look at TEKİN, P. Ş. 2012. Public-private partnerships and the health care sector. *Turkish Review*, 2, 48-55.

The government decided to integrate private hospitals<sup>20</sup> into the public health insurance plan in 2005, which could be considered the next step after the purchaser and provider functions were split in the health care system. Before the reform, for instance, the SSK used to function as an insurance body for blue-collar workers, and also owned and operated hospitals serving this constituency. Once all public hospitals had been transferred to the MoH with the objective of giving them financial and administrative autonomy in the future, the government began to implement one of the key objectives of the HTP: fostering competition in the provision of health care services.

The integration of private hospitals into the public health insurance plan works in the following way. The SGK annually sets fees for services to be provided by private hospitals in the form of Health Implementation Statements. If interested, private hospitals sign Service Procurement Agreements with the SGK. Once annual agreements are set between private hospitals and the Institution, every citizen of Turkey (who does not have any premium debts to the Institution) has the choice to receive health care services from private hospitals. As mentioned before, there is no working referral system in Turkey's health care system. Therefore, citizens are not required to apply first for general practitioners (or family

---

<sup>20</sup> Foundation university hospitals constitute a grey area in the study of the role of private hospitals in Turkey's health care system. In the Turkish higher education system, it is legally prohibited to establish private universities, thus private university hospitals. Alternatively, the Turkish higher education system allows the establishment of foundation universities and foundation university hospitals. In theory, both these universities and their hospitals are not allowed to work for profit. The legal status of foundation universities and their hospitals is vague since it renders some privileges to foundation hospitals that public institutions have without authorising them with all privileges of the public institutions. On the one hand, hospitals by foundation universities are not under the direct control of the state but instead are administered by the private foundation's board of trustees. On the other hand, these institutions, which are affiliated with the Higher Education Council, enjoy privileges that public institutions traditionally enjoy. From the perspective of the patients, however, hospitals of foundation universities are private hospitals because they charge additional payments like private hospitals. Therefore, for the purpose of this study, hospitals of foundation universities might be considered a form of private hospitals. However, in the official data, hospitals of foundation universities are categorised under the category of "university hospitals" as public university hospitals are categorised. Due to this problem, the official categorisation is used in the data presented in the following section.

physicians, as they have been called in Turkey's health care system since the reform). In addition, no other restriction has been imposed upon citizens in choosing the hospital they want to apply (i.e. geographical restriction).

However, citizens may be required to make additional payments to top up their public health insurance if they apply to private hospitals. Private hospitals are legally authorised to charge the patients in order to subsidise their own services. Two factors influence the rate of additional payments. The first of these factors is that the SGK determines the cap of additional payments. However, this cap varies according to where the specific hospital stands in a ranking by the MoH on the quality of health care services provided. Therefore, one has to make additional payment to access private hospitals, but has to make larger payments in order to access better quality private hospitals. As a result, I argued elsewhere that the introduction of additional payments and the inclusion of private hospitals into the public health insurance plan strengthened income-based inequalities in access to health care services (Yılmaz, 2013).

Similar to the integration of private hospitals into the public health insurance system, the HTP also aimed to turn the MoH into a stewardship agency rather than a provider of health care services. With the transfer of all publicly owned health facilities to the MoH,<sup>21</sup> the Ministry became the owner of the overwhelming majority of public health care providers in the country, the only exception being public university hospitals. However, transforming the MoH into a stewardship agency and granting financial and administrative autonomy to public hospitals could not happen as easily as the integration of private hospitals into the system. Finally, as the new legal changes were enacted, the transformation of the Ministry's role from

---

<sup>21</sup> Despite the dominance of the insurance-based social security system in Turkey, social security institutions (Social Insurances Institution for blue collar workers, Retirement Fund for civil servants and the Pension Fund for the Self-Employed for farmers and the self-employed) did not enjoy financial and administrative autonomy in practice. Despite the resistance of trade unions against the transfer of health facilities owned by these pension and health insurance funds as a part of the Health Transformation Programme, the government could make the transfer possible without receiving much criticism from the general constituency.

provision to stewardship began, and “public hospital unions” were established (The Republic of Turkey, 2011).<sup>22</sup>

### **8.5. The state of the private sector in health care provision after the reform**

Turkey’s new health care system, as described in the previous section, redrew the boundaries of the private sector in the delivery of health care services in Turkey. In addition to the inclusion of private hospitals into the public health insurance plan, government incentives for the establishment of private hospitals continued. The IFC also financially supported selected large hospital chains from the beginning of the reform process (International Finance Corporation, 2012; International Finance Corporation, 2007; Joseph, 2006; Albawaba, 2003), which increased the presence of private hospitals in health care provision. Before discussing the politics of the integration of private hospitals into public health insurance, this section demonstrates how and to what extent the role of the private sector in health care delivery has changed in the last decade of health reform.

The HTP clearly led to an increase in the number of private hospitals and the share of private hospitals out of all hospitals in the country. Table 1 shown below evidences this.

---

<sup>22</sup> According to the new configuration, all public hospitals are transformed into autonomous “public hospital unions” in order to foster competition between private hospitals and public hospital unions as well as among these unions. The TKHK was founded as a new department of the Ministry of Health in charge of establishing new public hospitals and administering the health care services in public hospitals. While this configuration did not provide full autonomy of public hospitals, as the head institution is still directly part of the Ministry, this step could be examined as the first step in experimenting with autonomy of public hospitals. The main difference between public hospitals and newly established public hospitals unions is in their management structures. While chief medical doctors administered the state hospitals before, managers who were employed on contract for two or three years administer public hospital unions. Unlike life-long positions of medical doctors working for public hospitals, these managers can be fired and replaced by a new manager.

Table 1. Number of hospitals

	2002	2006	2007	2008	2009	2010	2011
<b>Public</b>	774	767	848	847	834	843	840
<b>University</b>	50	56	56	57	59	62	65
<b>Private</b>	271	331	365	400	450	489	503
<b>Other</b>	61	49	48	46	46	45	45
<b>Total</b>	1156	1203	1317	1350	1389	1439	1453

(The Ministry of Health of Turkey, 2012, p.121)

As the table above suggests, the number of private hospitals nearly doubled after the launch of the HTP. While the number of private hospitals drastically increased, the rate of increase of other hospital types did not reach the rate of increase in the number of private hospitals.

Another indicator of the increasing role of the private sector in the provision of health care services is the increasing number of beds in private hospitals. Table 2 shown below designates these figures.

Table 2. Bed capacity in different hospital types

	2002	2006	2007	2008	2009	2010	2011
<b>Public</b>	107394	110819	112037	114428	115443	120180	121297
<b>University</b>	26341	31193	30978	29912	30112	35001	34802
<b>Private</b>	12387	14639	17397	20983	25178	28063	31648
<b>Other</b>	18349	17691	17588	17905	17905	16995	6757
<b>Total</b>	164471	174342	178000	183228	188638	200239	194504

(The Ministry of Health of Turkey, 2012, p.64)

As the table above indicates, bed capacity of private hospitals almost tripled since the start of the health care reform. Similarly, bed capacity of both public and university hospitals increased in this time frame. Yet the rate of increase in the bed capacity of these hospital types remained far below that of private hospitals.

Table 3 shown below demonstrates the changes in the share of the number of beds in different hospital types in proportion to the total number of hospitals beds.

Table 3. Share of bed capacity/total bed capacity for different hospital types

	2002	2006	2007	2008	2009	2010	2011
<b>Public</b>	65,3	63,6	62,9	62,5	61,2	60,0	62,4
<b>University</b>	16,0	17,9	17,4	16,3	16,0	17,5	17,9
<b>Private</b>	7,5	8,4	9,8	11,5	13,3	14,0	16,3
<b>Other</b>	11,2	10,1	9,9	9,8	9,5	8,5	3,5

Calculated by the author using (The Ministry of Health of Turkey, 2012, p.64)

As the table above designates, the largest change in the share of bed capacity occurred in private hospitals. While the share of bed capacity in private hospitals more than doubled since the launch of the health care reform, the share of bed capacity in public hospitals in proportion to the total bed capacity in the country experienced a slight decrease of roughly 3 per cent. University hospitals, which include hospitals of foundation universities, also increased their share of bed capacity in this time period, yet with a small increase of approximately 2 per cent. Table 1, 2 and 3 clearly suggest that privatisation, though not in the form of direct transfer of public hospitals into the private sector, has been increasing in the provision of health care services.

While figures on the number of hospitals, bed capacity and the share of bed capacity are demonstrative of the major trends in health care delivery structure, it is also important to look at the amount of applications that different hospital types receive. Table 4 below indicates this change.

Table 4. Distribution of total applications to hospitals by type of health care providers

	2008	2009	2010	2011
<b>Public sector</b>	67,1	66,3	66,2	65,1
<b>University</b>	6,6	6,8	7,9	8,0
<b>Private sector</b>	26,3	26,9	25,8	27,0

Calculated by the author using (The Ministry of Health of Turkey, 2012, p.64)<sup>23</sup>

As shown in the table above, although some scholars argue that the share of private provision is low overall (Ağartan, 2012, p.467), private hospitals received more than one-fourth of all applications to health institutions in 2011.

As the HTP made the SGK the single payer of health care services and included private hospitals into the public health insurance plan,<sup>24</sup> the

<sup>23</sup> Unfortunately, no data is available for years before 2008. This data has been requested from the Ministry of Health, yet the Ministry did not respond.

<sup>24</sup> For more information, please look at AGARTAN, T. I. 2012. Marketization and universalism: Crafting the right balance in the Turkish health care system. *Current Sociology*, 60, pp.456-471, YILMAZ, V. 2013. Changing Origins of Inequalities in Access to Healthcare in Turkey: From Occupational Status to Income? *New Perspectives on Turkey*,



Institution began to transfer financial resources for all these hospital types in return for the services they provided. It should be noted that the share of expenditures made for health care services has been on the rise since 2002. Table 5 below shows the changes in the breakdown of the SGK's expenditures according to different hospital types.

Table 5. Breakdown of the expenditures of the SGK according to different hospital types

	2002	2006	2009	2010	2011
<b>Public sector</b>	64,2	64,0	51,8	52,1	52,3
<b>University</b>	21,8	15,6	19,1	20,3	19,5
<b>Private sector</b>	14,0	20,4	29,1	27,6	28,2

Figures of 2002 and 2006 were calculated by the author using (Sönmez, 2011, p.60). Figures of 2009, 2010 and 2011 were calculated by the author using (The Social Security Institution of Turkey, 2012).

Table 5 above indicates that the largest increase in the share of funds transferred to different hospital types occurred in private hospitals. While the SGK spent 14 per cent of its total expenditures for health care services in private hospitals in 2002, the share of its expenditures for private hospitals increased to 28.2 per cent in 2011. Despite a more than 10 per cent decline in the share of expenditures made for public hospitals, these expenditures still constitute more than half of the SGK's total expenditures for health care services.

The breakdown of figures of total investment in health care according to the investment of public and private sectors suggests that the private sector has the potential to increase its role in health care delivery in the future. As mentioned before, the share of the private sector in the total volume of investment in health care services exceeded that of the public sector in the early 1990s (Soyer, 2005). The share of private investments in health care provision between 2006 and 2010 roughly constituted two-

---

48, pp.53-75. YILMAZ, V. (2013). "Changing Origins of Inequalities in Access to Healthcare in Turkey: From Occupational Status to Income?" *New Perspectives on Turkey*48: pp.53-75.

thirds of total investments made in health care provision (Sönmez, 2011, pp.71-72).

One should note that private health care providers constitute a heterogeneous group. Three types of variation within private hospitals can be identified. These variations include: private hospitals established before the reform or after the reform, different sizes of private hospitals, and whether private hospitals have a foreign capital component.

First, the HTP encouraged the establishment of new private hospitals. While the private hospital sector established in the pre-reform period was concentrated in metropolitan cities and served only the top quintiles of the income distribution, newly emerging private hospitals substantially increased capacity, spread all over the country, and began to serve middle-income patients. These two hospital groups differ from one another on the basis of the source of their main revenues. While the major source of revenue for most pre-reform private hospitals is out-of-pocket payments of high-income individuals and private health insurance companies (for the list of leading private health insurance companies in Turkey please look at Sönmez, 2011, pp.67-68), the major source of revenue for most private hospitals established after the reform is the public health insurance fund and contributory payments made by public insurees.

Second, there are different sizes of private hospitals in the sector. Table 6 shown below designates the diversity in the sizes of private hospitals on the basis of their bed capacities for the year 2010.

Table 6. Sizes of private hospitals

<b>Bed capacity</b>	<b>No. of hospitals</b>	<b>No. of beds</b>	<b>Share of hospitals</b>	<b>Share of beds</b>
<b>200-600</b>	10	2791	2	9,9
<b>100-199</b>	58	7374	11,8	26,2
<b>50-99</b>	137	9215	28	32,7
<b>0-49</b>	285	8767	58,2	31,1
<b>Total</b>	490	28147	100	100

(Sönmez, 2011, p.75).

As Table 6 above indicates, the private hospital sector is a diverse one in terms of its bed capacities. Private hospitals with capacities up to 49 beds

constitute more than half of the sector in terms of their numbers. However, their bed capacity constitutes approximately 31 per cent of total bed capacity in private hospitals. At the top end of the spectrum, only 10 private hospitals have a bed capacity of more than 200 beds. While the share of hospitals in this cluster stands at only 2 per cent, the share of bed capacity in these hospitals constitutes almost 10 per cent of total bed capacity in private hospitals.

By providing an overview of the different sizes of private hospitals, this table only offers a snapshot of the sector at one point time. News stories (i.e. Doğu, 2010) suggest that there is a concentration tendency in the private hospital sector. This sector has become home to private hospital groups (i.e. Acıbadem Health Group) that have been listed on the Istanbul Stock Exchange (Sönmez, 2011, p.74). Given that the economic rationale of the SGK's current pricing system for private hospitals depends on the logic of gaining from high demand, chain hospitals benefit most from this system, as they have the ability to use economies of scale. If the current pricing system remains intact in the near future, this will further increase pressure upon private hospitals to form hospital chains or join one of the existing ones.

Foreign direct investment in private hospitals sector might result in a variation within the sector. Table 7 below demonstrates the total amount of foreign direct investment in the health care sector as a whole.

Table 7. Foreign direct investment (FDI) in health care

	2006	2007	2008	2009	2010	2011
<b>Total FDI in health care services</b>	265	177	149	106	111	232
<b>Total FDI (million dollars)</b>	17639	19137	14747	6252	6238	15703
<b>Share of FDI in health care</b>	1,5	0,9	1,0	1,7	1,8	1,5

(The Ministry of Economy of Turkey, 2012, p.14)

As the table suggests, the share of foreign direct investment in Turkey's health care sector (both the pharmaceutical and private hospital sector) in total FDI per year oscillated between 0.9 per cent and 1.8 per cent between 2006 and 2011. While 111 million dollars was invested in the health care sector in Turkey in 2010, investment increased to 232 million

dollars in 2011 (The Ministry of Economy of Turkey, 2012, p.4). Despite the fact that this increase is substantial, a breakdown of this investment into different sectors of health care is required to make sensible conclusions about this increase.

Interviewees had conflicting views on the potential of the private hospital sector to attract foreign direct investment. For instance, one of my interviewees, who is a professor of public health, argued:

“It is logical to expect the flow of foreign direct investment to go to the hospital sector in the coming period. If health complexes with thousands of bed capacity (referring to the city hospitals that will be constructed as PPPs) are established as promised by the government, I think it will not be possible for the national capital in Turkey to operate these hospitals by itself, and such a scale in the hospital sector will whet foreign hospital chains’ appetite” (Interview no.13).

In fact, mergers between domestic hospital groups and international health care groups started to occur. For instance, one of the most well known mergers in the health care delivery sector was the International Health Care Holding’s purchase of 75 per cent of Turkey’s Acıbadem Group’s stocks at the end of 2011 (Habertürk, 2011).

An overview of the private hospital sector after a decade of health care reform suggests that the reform clearly resulted in the expansion of the role of the private sector in health care provision. Once a marginal component of the health care delivery structure, private hospitals have reached a significant capacity. This is evident as they receive roughly one-fourth of all applications to health care institutions. In return for their services, the SGK started to transfer more than one-fourth of its total expenditures for health care services to private hospitals.

Given the fact that the level of private investment in health care provision exceeded the level of public investments even before the HTP, it could be argued that this might increase the rate of the already rapidly expanding role of the private sector in Turkey’s health care provision and imply passive privatisation.

Domestic capital has dominated the private hospital sector until today. Due to the SGK's pricing policy, one could observe a concentration tendency in the sector. However, with the exception of small number of mergers between domestic hospital groups and international hospital groups, there is still no significant change in the share of inflow in the health care sector in total FDI.

Finally, the analysis of the impact of the reform on private health care providers made in this section demonstrates that the reform led to the emergence of a new cluster of private health care providers that depend on the revenues from the SGK and contributory payments from public insurees. This dependency relationship between the state and the new business created by the reform seems to echo the insights provided by scholars working on state-business relations in Turkey, which is discussed in the following sections.

## **8.6. The birth of new actors in health care politics: private health care provider organisations**

After the expansion of the private sector's role in the delivery of health care services, private health care providers started to organise. Organisation of private health care providers might be seen as a necessity to negotiate with the government (the Council of Ministers) and the two strong state institutions, namely the SGK and the MoH. In fact, private hospital owners established working groups within national business organisations and founded their sectoral business organisations, which have increasingly become involved in the debates on the developments in the domain of health care policies.

However, channels for institutionalised dialogue with non-governmental stakeholders, including private health care provider organisations, are limited. Even in cases of inclusion of non-governmental stakeholders into specific policy making mechanisms, their representation

remains symbolic. Therefore, the interaction between private health care providers and the government is not an exception to this rule.

Among the organisations of private health care providers, three organisations stand out as key players: the Health Sector Committee of the TÜSİAD, the Health Sector Union of The Union of Chamber and Commodity Exchanges, and the OHSAD.

The Union of Chamber and Commodity Exchanges (TOBB) was founded in 1950 by law. In the corporatist structure of Turkey's political system, TOBB served as the highest representative of the private sector. The Health Sector Union of TOBB was established in 2008. Following the corporatist legacy of TOBB, membership of the Union is composed not only of leading private hospitals in Turkey but also related high-level state officials and representatives of voluntary organisations of private health care providers. In addition, the Health Sector Union of TOBB represents private health care providers with one representative in the Planning of Human Resources in the MoH and the Classification Committee in the Ministry of Labour and Social Security. As explained by one of my interviewees, who served as the head of the Health Sector Union of TOBB, the Union uses all legal channels for lobbying in order to influence the preparation of laws on the health sector. These channels include, but are not limited to, the arrangement of meetings with the bureaucrats from key ministries, sharing their opinions with the members of the Council of Ministers, presenting their views in the Parliamentary Committees, and working with MPs in order to make necessary changes to the upcoming legal regulations in the General Assembly of the Parliament (Interview no.10).

As discussed earlier in this chapter, TÜSİAD is Turkey's most powerful voluntary business association that represents the largest enterprises in Turkey's economy. TÜSİAD has a Commission on Social Policies, under which the Health Sector Committee operates. However, this Committee does not work as a representative body. Instead it functions as an expert group that prepares and publishes reports on health care policies,

including policy recommendations. For instance, the Health Sector Committee published a policy report titled “Charting the Way Forward: Health Care Reform in Turkey” (Turkish Industrialists' and Businessmen's Association, 2005), which argued for the introduction of compulsory public health insurance for the entire population but with an opt-out option for those having incomes above a specified threshold. The report also supported an increase in the role of private health care providers as well as the recognition of greater financial and administrative autonomy for public hospitals (Turkish Industrialists' and Businessmen's Association, 2005, pp.19-35).

In addition to the growing interest in health care and establishment of committees within national business organisations, private hospital owners and hospital managers began to establish their own voluntary sectoral associations (i.e. the Association of Health Managers in Turkey and the Aegean Health Institutions Association) or revitalise other organisations that existed before the reform (i.e. the OHSAD). All of these business organisations can be categorised as interest groups in the classical meaning of the concept.

Among these organisations, the OHSAD has been the most active. The OHSAD is a product of a working group that was initiated in 1991. It was later established as an association in 2004. The Private Hospitals Association, Health Institutions Association, Touristic Regions' Health Institutions Association and South Eastern Anatolia Private Health Business Association joined forces and founded the OHSAD. Today OHSAD represents roughly 80 per cent of the private hospital sector and has been quite active in developing a common position for private health care providers and voicing the demands of the private hospital sector.

The composition of OHSAD's executive board reflects the distribution of power within the private health care provision market.<sup>25</sup> However, mid-

---

<sup>25</sup> The executive board of the OHSAD was composed of, but not limited, to the following persons affiliated with largest hospital chains in the market as of 2014: Fahrettin Koca from Medipol Group, Sema Akgün from Memorial Group, Ahmet Şah Kolan from Kolan Hospitals, Muharrem Usta from Medical Park and Liv Hospitals, Hüseyin Bozkurt from

size hospitals representatives and hospital groups also have places on the executive board, one of which has been serving as the head of the executive board.<sup>26</sup> In line with the distribution of power within the executive board, OHSAD's honorary committee is composed of the pioneers of the private health care provision sector.<sup>27</sup>

OHSAD's decision-making structure gives more power to the largest private health care providers, while still favouring small and medium sized hospitals in comparison to their market shares. In the general assembly of OHSAD, each hospital has a voting weight according to its number of beds. OHSAD's charter declares that hospitals with more than 75 beds will have 7 representatives, hospitals with 50-75 beds will have 5 representatives, hospitals with 20-49 beds will have 3 representatives, hospitals with 10-19 will have 2 representatives, and all other health institutions will have 1 representative in the general assembly. In addition, the charter states that the number of representatives of the hospital groups that own more than one hospital will not increase linearly as the number of hospitals they own goes up. The increase in the number of hospital group representatives will be less than the sum of each hospital's number of representatives if each one is owned by different individuals or companies (Private Hospitals and Health Institutions Association, 2004).

Therefore, while the voting structure of OHSAD favours the large hospital groups compared to that of TOBB, it also restricts the direct translation of the market power of the largest health care providers on the decision-making structure of the OHSAD. Given the tendency of particularism in the relations between government and big business, this

---

Medicana Group, Azmi Ofluoğlu from Universal Group, Erhan Kamışlı from Medline, Nurettin Demirkol from Hisar Hospitals.

<sup>26</sup> The executive board of the OHSAD also included the following representatives of mid-sized hospitals as of 2014: Yusuf Ziya Yıldırım from Konukoğlu Hospital, Reşat Bahat from Bahat Hospitals, Hayreddin Yekeler from Emsey Hospital and Abdurrahman Külünk from Erdem Hospital.

<sup>27</sup> The honorary committee of the OHSAD is composed of but not limited to the following persons: Mehmet Ali Aydınlar from Acıbadem Group, Turgut Aydın from Memorial Group, Cemşid Demiroğlu from Florence Nightingale Group, Doğan Birgül from Doğan Hospital, Hüseyin Uurlu from Avrasya Hospital, Ömer Güzel from Biruni Laboratories and Yusuf Elgörmüş from Medicine Hospital Group.



might create an additional incentive for the largest health care providers to enter into particularistic relations with the government, rather than relying upon OHSAD only.

The analysis of the OHSAD's connections with the health care bureaucracy and the AK Party indicates that the OHSAD includes members who worked for health bureaucracy in the public administration and/or members of the leading cadre of the AK Party both in its executive board and its honorary committee. For instance, Mr. Tahsin Güney, who was a member of the OHSAD's executive board in 2014, served as the former head of the SGK between 2008 and 2009. In addition, Mr. Mehmet Nil Hıdır, who was also a member of the OHSAD's executive board in 2014, worked for the health care bureaucracy as the head of North İzmir Public Hospitals Union and then as the head of the Public Health Department in İzmir. Finally, Mr. Süleyman Soylu, who was the vice president of the AK Party, was also the member of the honorary committee of the OHSAD in 2014.

These connections between the private health care provider association and the health care bureaucracy (and the government to an extent) challenges the distinction made between the business community and the bureaucracy as well as between the business community and the government. While the OHSAD resembles the Health Sector Union of TOBB as it includes bureaucrats as well as politicians in its decision-making structure, it is important to note that members of the OHSAD chose to organise and work under the umbrella of a voluntary organisation rather than remaining within the Health Sector Union of TOBB. However, the rationale behind their preference to work within a voluntary organisation seems not to exclude the members of health care bureaucracy and the members of the government, as OHSAD includes them as well. This selective network, which gives strength as well as leverage to OHSAD, might prove that "the politically guided process of class transformation" (Buğra and Savaşkan, 2014, p.12) is also operating within the health sector.

In fact, given the differences in each organisation's decision-making structures, the OHSAD might not be facing the difficulty that the Health

Sector Union of TOBB faces in formulating its political position. In response to my question of how and to what extent the Health Sector Union of TOBB has been able to accommodate the demands of private hospitals with quite different scales of investment and different clientele, the former head of the Health Sector Union stated:

“I can’t tell you that we are confident on that. After 2002 a significant imbalance emerged in the sector. On the one hand, you have chain hospitals established by important investors. On the other hand, you have small and medium size hospitals. ... I don’t think that it is easy to find a solution that will satisfy all” (Interview no.10).

As the quote above suggests, the former head of the Health Sector Union of TOBB acknowledges the complexity of reconciling the interests of private health care providers, which is diversified in terms of the scale of their investments and the market shares. While the decision making structure of the Health Sector Union of TOBB does not provide an easy solution to this, the dominance of the larger private health care providers in OHSAD eases the task of developing a common sectoral discourse, which would likely be in favour of larger private health care providers. As discussed earlier, the current pricing policy of the SGK already favours chain hospitals as they can benefit from the economies of scale. This policy, as part of the reform, did not only change the distribution of power among different players in the market, but also transforms health care politics by undermining the legitimacy of TOBB among private health care providers and paving the way to the emergence of OHSAD as the strongest actor representing the private sector in health care provision.

### **8.7. Private health care provider organisations at work: discourses, demands and strategies**

This section discusses contestations as well as alliances mainly between the government and private health care provider organisations during the implementation of the HTP.

Increasing the role of the private hospitals in health care delivery in Turkey has never been a popular political promise in Turkish politics. Public opinion has been averse to the retrenchment of the state from the provision of health care services. For instance, in a nationwide survey, researchers found that only 19.1 per cent of the respondents agreed with the following statement: “the government should only provide limited basic health care services” (Çarkoğlu and Kalaycıoğlu, 2012, p.11). In other words, an overwhelming majority of Turkey’s population is in favour of the dominance of the state in health care provision.

As discussed in the earlier chapter, in spite of their limited political power and lack of institutional ‘veto power’, organised labour and the TTB strongly resisted all governmental attempts to increase the role of the private sector in health care provision. In a society that has been overwhelmingly in favour of the public provision of health care services, this opposition has always had the potential to become popular in case the government fails to absorb the public demands. Even after a decade of health reform, none of the opposition parties in the Parliament (CHP, Nationalist Action Party, Peace and Democracy Party) embrace the privatisation of health care services.

These political values, therefore, had a major impact in framing the discourse of the government as well as the private health care provider organisations on health care reform. Neither the government nor private health care provider organisations explicitly called for the privatisation of health care services.

Despite the fact that direct privatisation was not chosen as the main method in the HTP, another form of privatisation occurred during the implementation of the Programme. This form of privatisation, that is passive privatisation, was allowing the private sector to increase its share in the health care delivery. Many scholars also analysed the reform as an attempt to privatise health care services (Belek, 2012; Civaner, 2011; Sönmez, 2011; Soyer, 2007). Among those, Soyer successfully addresses the distinctive feature of privatisation in the Turkish case -which is in line with

the passive privatisation experiences in other developing countries discussed in Chapter 4- that the privatisation of health care services was carried out through the integration of private hospitals into the public health insurance system. In addition, he claims, the state transferred public resources to finance the private sector that increased the pace of privatisation (Soyer, 2007, p.90, 105).

Belek argues that privatisation and marketization trends have become clearer in Turkey's health care system in the aftermath of the implementation of the HTP. In addition, these trends have given way to the oligopolisation of the private health care delivery sector. Taking these developments into account, Belek concludes that the HTP has been in perfect tune with the interests of the bourgeoisie. Indeed, there is also evidence that the bourgeoisie has been in charge of implementing the Programme (Belek, 2012, p.11). As Belek's line of argumentation suggests, this form of analysis has the tendency to treat the private sector in health care delivery as a homogenous group with a clear political prospect of full privatisation of the provision of health care services, and does not differentiate the power resources and interests of the government and the private health care provider organisations (and the World Bank as well). Thus, their analysis has become short of explaining how on some issues alliances could be built between private health care providers and the government, how they can disagree with one another on some other issues and what balance the government would like to strike between public and private health care delivery. It could be argued that this line of analysis has the potential to underestimate the role of politics in making predictions for the future.

In fact, without underestimating the political affinity between the neoliberal AK Party governments and the private health care provider organisations, the following part of this section discusses a diverse set of issues that caused controversies between these actors during the preparation as well as the implementation of the HTP. While two parties

were in agreement on some issues, they were in open contestation with each other on solutions on others.

First, as discussed in Chapter 6, the HTP has been a double-edged sword for the AK Party governments from the beginning. On the one hand, the Programme's positive impacts on citizens' access to health care services clearly became one of the main factors that led to the popularity of the governing party especially among the low-income constituency. On the other hand, the governing party had been keen to foster private sector involvement in health care and make the health care delivery sector one of the main sectors within which it created its allied bourgeoisie. Despite its success in delivering both promises at the same time in the early years of the reform process, pursuing this conflicting political strategy put the governing party in an ambivalent political position. Therefore, in order to understand the future direction of Turkey's health care system, one has to examine the negotiations and contestations between private the health care provider organisations and the government.

The HTP did not come into existence due to long discussions between the government representatives and important stakeholders in the domain of health care. In fact, the Independent Industrialists' and Businessmen's Association's (MÜSİAD), a business organisation that has a political affinity with the AK Party, stated that there has been an "absence of sufficient exchange of ideas with stakeholders... during the reform process" (Müstakil Sanayiciler ve İşadamları Derneği, 2009, p.17). The interview with the former head of the WB team assisting the reform process (Interview no.22) also provides sufficient evidence for this. The HTP was instead a product of a small "change team" (Ağartan, 2008) which adopted the WB blueprint for Turkey's context. The government constituted the team and backed most of its proposals politically. The WB provided financial but more importantly know-how support for the team.

Members of the change team clearly did not have unfavourable attitudes towards the increasing role of the private sector in health care delivery. The content of the resulting reform, the discourse of the change

team, and their professional career paths both before and after the reform provide sufficient support for this thesis. However, they differentiated their positions from the private health care provider organisations during the interviews. They spoke on behalf of the state, felt accountable to the government and presented the direction of the reform in a different way than the private hospitals representatives generally did. For instance, one member of the change team argued:

“One of the important objectives of the Health Transformation Programme was this: Serving the people with all resources in the country regardless of their ownership in health care” (Interview no.20).

As this statement suggests, this member of the change team presented both the public and private hospitals as national resources, which the state could use in order to provide services to its citizens. Another member of the change team made a quite similar statement:

“For citizens, rather than the ownership of health care services providers, it is more important whether service is being provided or not” (Interview no.32).

Both of these statements demonstrate that the portrayal of private hospitals as “national resources,” which might imply a corporatist understanding of the business, was common among the members of the change team. A member of the change team noted that private health care providers that existed before the reform did not share this approach in the early days of the reform:

“We have seen that once groups who defend their commercial interests realized that the political power would implement this reform and the reform was inevitable, they declared themselves as actors of this process. But we have also seen that they were generally not that supportive of what was being done” (Interview no.20).

Here the interviewee says clearly that the Government, in his view, was powerful enough to initiate the reform without the need for consent

from commercial interests. Therefore, he suggested, private health care provider organisations had no chance but to secure a place within the process. In contrast, one of my interviewees, a high-level representative from one of the leading private hospital organisations, argued that they have been willing to collaborate with the government from the beginning. The former head of OHSAD stated,

“We (Author’s note: Private hospitals sector) asked them (Author’s note: The government) to purchase services from us. We constitute a significant capacity. This capacity should not be left idle. We told them to benefit from us and we signed an agreement with public social security in 2005. This agreement was an agreement that the private sector was overzealous about.” (Interview no.24).

Regardless of the willingness of the private hospitals to be integrated into the public insurance system, as the statement above suggests, both the government (and the change team) and the private sector seemed to share the same discourse: private hospitals are no different from public ones, and the state could and should better use these resources in delivering health care services to its citizens. This common discourse seemed to work well in covering possible conflict scenarios and thus in satisfying both parties for a fresh beginning as well as not challenging the public aversion towards privatisation of health care services.

After the SGK started to purchase health care services from private hospitals in 2005, the HTP generally served the private hospital sector well up until 2008. During this period, as noted before in this chapter, more than a hundred new private hospitals were established, and bed capacity of private hospitals nearly doubled. One of my interviewees, who worked in the health care reform team, succinctly summarised the state of the private sector in the *laissez faire* period of the reform:

“The private sector found a significant opportunity here. The Ministry of Health failed to respond timely to this process before 2008. It was not against this process. But it could control the process and it could institute a controlled competition. The Ministry of Health was late to transform the free market atmosphere into a regulated competitive

one. That's why there was an explosion in the numbers of private hospitals at the time" (Interview no.20).

This free market atmosphere in private hospitals sector did not last long. A historic moment that changed the relationship between the state and the private hospital sector occurred in February 2008, when the MoH issued a bylaw that introduced significant limitations on the further expansion of the role of the private sector in health care provision (The Ministry of Health of Turkey, 2008). This bylaw ruled that the private hospital sector would remain the same and would not be able to extend the range of services it provides, hire new health professionals, or establish new private hospitals. In other words, the bylaw only allowed for the establishment of new private hospitals in places specified by the Ministry and obliged already established private hospitals to comply with the central planning of the Ministry. In the bylaw, the MoH defines its planning role as follows:

"In accordance with the mentioned objectives, the Ministry is authorised to plan covering both public and private sector health institutions, health human power working for these institutions, medical service branches of these institutions and the qualifications of these branches, and the distribution of technologically intense medical devices" (The Ministry of Health of Turkey, 2008, Clause 9).

Private hospitals were caught unprepared for this sudden change (Güneş, 2008). It could be argued that the discourse shared by the government and private hospital organisations—which conceptualised private hospitals as "national resources"—broke down with this change. Some private health care provider organisations even applied to the Turkish Competition Authority with the claim that the bylaw created a double standard for private hospitals vis-à-vis public hospitals (Coşkun, 2008). In response to the strict regulation of private hospitals after the promulgation of this bylaw, some scholars criticised the process by coining the term "étatisation of private hospitals" and argued that the MoH



overstepped its boundaries of the stewardship role promised in the health care reform (Aksoy, 2008).

Despite the fact that private health care provider organisations raised harsh criticisms against this bylaw, they failed to make a difference. This is mainly due to two factors. First, the private health care provider organisations did not have the option of turning to the constituency. In a recent nationally representative survey on public trust in institutions, researchers found that public trust in public hospitals was greater than in private hospitals. According to the results, 72.3 per cent of the respondents expressed their trust in public hospitals, 13.9 per cent said they neither trusted nor distrusted public hospitals, and 13.8 per cent expressed distrust in public hospitals. Meanwhile, 45.5 per cent said they trusted private hospitals, 17.7 per cent responded that they neither trusted nor distrusted private hospitals; and 36.8 per cent said they did not trust private hospitals at all (Konsensus Araştırma, 2011). In a political context where private hospitals are not trusted as much as public hospitals and there is no alternative political party supporting the cause of private hospitals, private health care provider organisations had no choice but to keep the dialogue with the government.

The second factor that impeded the capacity of private health care provider organisations to take a politically effective step against the MoH's dominance over health care delivery is that the majority of private hospitals had already become dependent on the SGK—and thus the government in the Turkish context— for their financial sustainability. One of my interviewees, a high-level representative of private hospitals sector, succinctly made this dependency clear in his statement as follows:

“More than 60 per cent of the revenues of private hospitals that signed agreements with the SGK come from the SGK. We have no possibility of living without public social security” (Interview no.24).

The dependency of the majority of private hospitals on the revenues from the SGK forced the private health care provider organisations to

concentrate their efforts on increasing the prices of the services set by the SGK. In this regard, the Health Implementation Statement, which the SGK issues annually and amends from time to time, has become one of the most important regulatory tools in the hands of the government. Almost all of my interviewees from the private hospitals expressed their displeasure with the SGK's pricing of their services. They argued that these levels do not match their costs, especially in metropolitan cities, as they claimed that private hospitals in metropolitan cities generally pay higher rents and better wages for specialist medical doctors.

Despite the fact that representatives of private health care provider organisations met with high-level public officials several times, they failed to increase the level of prices in the Health Implementation Statement. This failure could be explained on the basis of two factors. First, as any increase in the level of prices for services would automatically translate into a burden on the public budget, the interests of the private hospitals sector directly conflicted with that of the government on this issue. Second, the government has quite strong ammunition in his hands, as my interviewee from the WB brilliantly pointed out:

“If there were more private health facilities there to deal with, the government would not be able to avoid working with medical associations or hospital associations. Here they can implement the reforms while avoiding all these people. So it is again the reflections of the specifics of your health sector” (Interview no.22).

As the quote implies, while the private sector is dependent on the government for its revenues, the government is not yet dependent as much on the private sector for delivering health care services. This is mainly because; the government has the power resource of directly controlling more than half of the health care delivery structure. Promulgation of the bylaw in 2008 might be considered as the government's inertia to lose this quite effective power resource. From an institutionalist angle, it might well be argued that the dominance of the public hospitals in health care provision before the reform created a 'lock-in effect' in Turkey's health care system.

The government also took additional steps to protect its dominance in the health care delivery structure. In doing so, the SGK ruled that patients willing to access outpatient services of private hospitals would have to pay 15 TL (roughly 4 GBP (Great Britain Pounds) or app. 5 Euros contributory payments on the spot, while the rate is 8 TL (app. 2 GBP or 3 Euros) for patients willing to use outpatient services of public hospital services (The Social Security Institution of Turkey, 2010, Clause 3.2.1.). In response, one of the private health care provider organisations applied to the Competition Authority. In his own words,

“Patients coming to our hospitals pay 15 Turkish Liras, patients going to public hospitals pay 8 Turkish Liras. We applied to the Competition Authority. ... it replied that it could not intervene into this. Why? It declared that this is public, and you are private. The relationship between public and private sectors is not a horizontal relationship. The rules of competition cannot be applied to this relationship. This is a vertical relationship. Therefore, one cannot talk about competition here” (Interview no.24).

The decision of the Competition Authority could be interpreted as evidence for the argument that the idea of free competition between public and private units in health care delivery services has not become mainstream in the bureaucracy. However, the Council of State made a decision in the opposite direction. The Association of Health Corporations in Turkey prosecuted a suit against the SGK in the Council of State with the claim that the introduction of higher rates of contributory payments for private hospitals was not legal. The Council of State decided to grant a motion for a stay of execution (NTVMSNBC, 2009). In its decision, the Council of State declared that there is no legal basis for the introduction of different levels of contributory payments for public and private hospitals (The Council of State of Turkey, 2009). Despite the fact that this decision was repealed by another circle of the Council of State afterwards and not implemented, the partial success of the private health care provider organisations in legal advocacy efforts might bring results in future cases

and signal a shifting perspective amongst the bureaucracy on competition in the delivery of health care services.

The government also mobilised its discourse on private hospitals as “national resources” and used the dependency of the sector to its benefit when it prohibited private hospitals from charging money from patients for emergency health care services. The SGK pays for the emergency services of private hospital patients with public health insurance use. In fact, this was to the detriment of private hospitals, as they would not serve as many patients and therefore sell services at a higher price than they would receive from the SGK. However, it was not easy for private health care provider organisations to challenge the government’s position on this issue, mainly due to the illegitimacy of such an opposition in the eyes of the general public and financial dependency of private health care providers on the state. As the head of OHSAD suggested in an interview: “Do you think it is possible to go out and tell people that you want to charge emergency health care services?” (Akdağ, 2012).

This exemption was extended to include intensive care services; burn injury treatment services; health care services for new-borns; organ, tissue, stem cell transplantation; cardiovascular surgeries; dialysis; surgeries for congenital anomalies, and oncology services (The Social Security Institution of Turkey, 2010, 3.3.3.).<sup>28</sup> Private health care provider organisations did not publicly express their discontent with these new responsibilities and decided to use them to lift the cap (to be discussed later) on additional payments in other health care services.

Another controversial issue in the relations between the private health care provider organisations and the government was the distribution of specialist doctors into public and private health care providers. As discussed in Chapter 7, the government chose to serve the interests of private health care providers vis-à-vis those of medical doctors. In response, the TTB strongly opposed the government’s attempts to give an end to the private

---

<sup>28</sup> For these specified services that private hospitals provide for free, the SGK makes payments according to the Health Implementation Statement it issues.

practices of medical doctors, which push medical doctors to work for either public or private health care providers. In the context of the shortage of specialist medical doctors, private health care provider organisations have to compete with public health care providers to attract medical doctors. While they succeeded in attracting a significant share of medical doctors to work for the private sector before 2008, the government intervention, which prohibited the further migration of medical doctors from the public sector to the private sector in 2008, restricted the ability of private health care providers to increase their share in the market.

In response to the growing discontent with this restriction among private health care providers and the active advocacy of OHSAD, the government and the OHSAD signed a letter of memorandum in 2011 (Private Hospitals and Health Institutions Association, 2011). The memorandum represented the recognition of the government's sole authority over the employment of medical doctors. However, with this memorandum, the government agreed to provide private hospitals a thousand additional specialist medical doctor positions. Therefore, once again private health care provider organisations failed to challenge the government regulation—this time of the employment of medical doctors—yet succeeded in improving their relative position within the new configuration.

Another governmental regulation is the cap on additional payments that private hospitals are allowed to charge patients (The Social Security Institution of Turkey, 2010). The SGK sets this cap as a percentage of the SGK's prices for services. The cap level varies according to the quality category that each hospital falls under within the classification of the MoH. Since increasing the prices set by the SGK is a strenuous objective that increases the burden on the public budget, private health care provider organisations built their strategies on lifting the cap on additional payments. Two of my interviewees from private health care provider organisations claimed that the rationale for their acceptance of all other

conditions from the government was a hope to lift the cap on additional payments:

“The SGK would pay part of patients’ payments and we would top it up with our prices. ... Because we thought we would top it up by charging people, we didn’t really evaluate whether the prices offered by the public social security for our services were realistic or not. We were free to opt out of the system as well” (Interview no.24).

“If caps would be lifted, then our demand to increase prices in the Health Implementation Statement would cease to exist” (Interview no.10).

The Health Sector Union of the TOBB concentrated its energy on lifting the cap on additional payments that they could charge patients with public health insurance plans, which meant, if successful, the introduction of free markets. While the government did not accept this demand, the Health Sector Union of the TOBB succeeded in increasing the ceiling set for the rate of additional payments from 20 per cent of SGK prices at the time to 100 per cent (Interview no.24). With the interviewee’s words, this process unfolded as follows:

“In the draft law, there was a clause allowing private hospitals sector to charge 20 per cent of prices set in the Health Implementation Statement. Our demand was to remove this clause. Our lobby could succeed in changing the clause, which then allowed the Council of Ministers to have the authority to determine the cap on additional payments to 100 per cent. The final law included this clause. While we were trying to make negotiations about the rate, we learnt that the Ministry of Health was insistent upon the clause that specified the ceiling as 20 per cent. The change of the clause that we pushed forward offended the Ministry. In order to appease the Ministry, the Council of Ministers determined that the level of contributory payments would be 30 per cent” (Interview no.10).

As the quote above suggests, the Health Sector Union of TOBB had the power to challenge the MoH’s proposed rate on the cap on additional payments using its connections with the members of the Council of Ministers. While the original proposal of the Health Sector Union of TOBB

was not accepted, it succeeded in increasing the cap, thus further marketizing health care services.

There is also evidence that implies the failure of the regulative acts of the state on the exchange relationship between patients and private health care providers. There have been many cases where private hospitals in practice charge additional payments from patients with public health insurance that are above the determined level. As this illegal practice has become quite widespread, many newspapers have published stories of how excessive payments have been unlawfully requested from patients who used outpatient services of private hospitals (i.e., Samanyolu, 2012; Sonay, 2012; Tezel, 2009).

In response, different public institutions began to increase their regulative and punitive capacities. For instance, the Court of Accounts imposed a record fine on private hospitals on the basis that the hospitals charged higher amounts of additional payments from patients than the legally permitted amount (Avci, 2012). In addition, the SGK introduced new procedures to obstruct the private hospitals' unlawful charge of higher additional payments from the patients. These procedures include obliging private hospitals to ask their patients to sign a printed agreement indicating that they are aware of the amount of the additional payment in advance and they agreed to pay this amount, which obliged private hospitals to prepare an invoice for the additional payments exceeding a specific amount (100 TL, app. 35 GBP), to give this invoice to the patient, to inform the patient and their relatives once the patient was no longer an emergency case, etc. (The Social Security Institution of Turkey, 2011).

As a result, the representatives of private hospital organisations argued that private hospitals, especially those in metropolitan cities,<sup>29</sup> had no other option but to charge patients more than the permitted amount in order not to go bankrupt (Interview no.10; Interview no.24). Therefore,

---

<sup>29</sup> Interviewees from organisations of private hospitals stated that both rents and salaries of medical doctors are substantially higher in metropolitan cities than middle and small sized cities.

while private health care provider organisations continue to negotiate the rate of the cap on additional payments and the prices set by the SGK with the government, private health care providers searched for informal ways to trespass regulative arrangements. However, state institutions responded to this trend with the introduction of stricter regulative arrangements.

Despite the fact that the SGK did not increase the prices it set for the private health care providers, an increasing application of patients in private hospitals increased the financial burden on the state budget. In this context, the SGK took a further step to discourage people to access private hospitals using their public health insurance. With the new regulation, the Institution declared,

“The Institution may set up procedures and principles regarding the direct use of services of the private health providers on the basis of factors stated as follows: the province that the service is provided, whether the provided service is of vital importance or not, *whether the service may be given in public health care service providers* (author’s emphasis) and the quality of service” (The Social Security Institution of Turkey, 2010, 4.2).

With this regulation, the SGK indicated that it might put restrictions on the use of private health care services when public health care providers offer the same services. This was a significant divergence from the original objective of the HTP, which clearly included fostering competition in health care provision. This regulation of the SGK might be read as a form of ‘institutional inertia’.

The relationship between the private health care provider organisations and the government has become tense since regulations that took place in 2008. In this context, one of the representatives of OHSAD made a controversial statement to the public before they signed the Service Procurement Agreement with the SGK in 2012: “Two thousand would die the next day unless we signed the agreement” (Vatan, 2012).

It could be argued that this statement symbolised the power that private health care providers gained within the health care provision, which manifested itself in the fact that the total number of patients that private



hospitals served in 2011 was more than 3 million people (The Ministry of Health of Turkey, 2012, p.92). However, even during this conflict, the OHSAD representative could not stay away from expressing the private sector allegiance to the state, which he perceives as sine qua non to the sustainable growth of private health care providers. In his own words, he stated, “We established these hospitals by trusting the state’s word. We trust the state’s word” (Vatan, 2012). Therefore, for private health care providers, it is again the state that has the responsibility to save them.

The current direction of health care policies in the domain of health care provision might imply that the alliance established between the government, private health care providers, and patients is in the process of breaking up. The former head of OHSAD also argued that the government has come to a decision point:

“The state has to decide at this point. Will the private sector exist in this sector or not? To what extent will it exist? To what extent will the state allow the private sector? Where will the planning go? ... These questions are all open questions. People’s votes will determine the result. I don’t believe that this has been done as part of a long-term plan” (Interview no.24).

As the quote suggests, the head of OHSAD does not believe that the government has already decided the future direction of Turkey’s health care system. However, the current context requires the government to make a decision on the role of the private sector in health care provision and its limits. Once again the government’s preferred balance of the public and private mix in health care provision would be important in determining the future direction of Turkey’s health care system.

While this question is still valid and the on-going political contestations including those within the AK Party will shape the future direction of Turkey’s health care system, recent developments give a hint. Despite the fact that the government did not increase the prices set by the SGK and offered ad hoc increases in the number of specialist medical doctors that private health care providers can hire, it allowed private health

care providers to shift the financial burden on patients. In 2013, the Council of Ministers increased the cap on additional payments from 90 per cent to 200 per cent (NTVMSNBC, 2013). This change is clearly in line with the demands of private health care provider organisations and has the potential to break the financial dependency of private health care providers on the SGK in the long run.

In response to increase in the cap on additional payments from 90 per cent to 200, OHSAD representatives declared that they were not content with this increase for three reasons. First, the cap was calculated on the basis of prices set by the SGK that had been lower than their expectations. Therefore, an increase in the cap did not substantially improve the financial situation of private health care providers. Second, competition between private health care providers over additional payments is high, which limits the ability of each provider to increase additional payments up to the limit of the cap. Third, the exemption of patients from making additional payments for key services (i.e. oncology services and emergency services) limits the revenues of private hospitals from patients. In response, OHSAD representatives suggested that the government should provide incentives for citizens to buy private health insurance plans (Al Jazeera Turk, 2014b). It could be argued that the OHSAD opened up a new battlefield for further marketization, which this time expanded its boundaries to cover health care finance.

It is important to note that the government had different options to solve this crisis with the private health care providers, including the increase in the prices set by the SGK or providing incentives for patients to choose public health care providers. By choosing this policy, the government appeased the private health care providers and did not openly restrict patients' access to private health care providers using their public health insurance plans. However, in practice, this policy shifted the financial burden on patients and strengthened the marketization of health care services.

## 8.7. Conclusion

This chapter examined the scale of the privatisation of health care provision in Turkey's health care system as a result of the HTP and its impact on the politics of health care. In light of Giaimo and Manow's insights, the chapter focuses on the period that follows the legislation of the original reform and examines the political contestations between different actors as well as the impact of these contestations on the direction that the reform takes as a result.

As discussed before, the role of private health care providers increased substantially in the last decade. From negligible share in the total bed capacity and applications of patients annually, private health care providers started to constitute around 20 per cent of the total hospital bed capacity in the country and receive more than one-fourth of all applications for health care providers annually.

Given the fact that the general population supports the dominance of the public sector in health care provision, the government pursued a passive privatisation policy in line with the trend that started long before it came to power. The main mechanism through which the government fostered the private sector involvement in health care provision was to include private health care services into a public health insurance plan. In line with Polanyi's insights, this process is evidence of how the state creates markets. Drawing on the insights of the literature on state-business relations in Turkey, here it is argued that health care has been selected by the AK Party as one of the sectors through which the Party aimed at creating and strengthening its own business community. Linkages between private health care provider organisations and the government as well as the health care bureaucracy demonstrate the intricate relations between state and business in Turkey's politics.

The privatisation of health care provision led to the emergence of new strong political actors, namely the private health care provider organisations. The emergence of private health care provider organisations

and their integration into health care politics can be understood with the concept of ‘institutional conversion’, which refers to “the adoption of new goals or the incorporation of new groups into the coalitions on which institutions are founded can drive a change in the functions that these institutions serve or the role they perform” (Thelen, 2004, p.36).

As discussed in detail before, the OHSAD and the Health Sector Union of TOBB emerged as the strongest actors representing private health care providers. It is important to note that private health care providers do not constitute a homogenous group. They differ in terms of their sizes and their ability to attract patients with private health insurance plans. However, the government’s health care policy, which favoured big players in the health care provision market, found its echo in the interest representation of private health care providers. In addition to the sustenance of particularistic relations between the government and individual businessman, big players preferred to work for the common demands of the sector under the umbrella of OHSAD, the decision-making structure, as it offered higher weight to big players in comparison to the Health Sector Union of TOBB.

While the OHSAD generally took the lead, both of these organisations focused on three key issues: the prices set by the SGK for private health care services, the cap on additional payments that private health care providers could charge patients, and the distribution of specialist medical doctors between public and private health care providers. In all of these issues, private health care provider organisations lobbied the government and related public institutions to make changes in favour of its constituency. Due to the fact that private health care provider organisations had been dependent upon the state for the overwhelming portion of their revenues and the political impossibility of mobilizing the public in favour of privatisation, these organisations had been modest in their demands and stayed away from direct confrontation with the government.

The government has been committed to increasing the role of private health care providers throughout the implementation of the HTP. While the

conflict of interest between the government and private health care providers has been there and will continue to exist in the near future, the two parties seem to agree on a temporary win-win solution. For instance, private health care provider organisations can persuade the government when their interest is in conflict with that of medical doctors and patients willing to use private hospitals, but they fail to succeed when their interest is in conflict with that of the government. As a result, rather than increasing the prices set by the SGK to be paid for private health care services, the government decided to shift this financial burden to the patients by increasing the cap on additional payments.

On the one hand, it can be claimed that the government serves further marketization of health care services without always serving short-term economic interests of private health care providers. Its ability to act relatively autonomous from the sector originates from its dominance in health care provision, despite the drastic increase in the role of the private sector. Nevertheless, it is not clear if the government can keep its bargaining power vis-à-vis private health care providers intact in the future if the pace of privatisation in health care provision and the oligopolisation tendency in the sector continue. The increase of the private involvement in health care provision and its translation to the politics of health care seems to further strengthen the marketization tendency in Turkey's health care system, which may infiltrate into health care finance in near future.

## Chapter 9: Conclusion

Health care reforms are products of political processes, which can hardly be reduced into automatic responses of national health care systems to economic growth, demographic change, and deficiencies in citizens' access. As discussed in Chapter 1 and substantiated with different cases of health care reforms in developing countries in Chapter 4, both the viability of the reform and its content are dependent upon global and domestic political dynamics.

This study, which can be qualified as a historically grounded single country case study, examined how the HTP in Turkey between 2003 and 2013 reconfigured the distribution of power that formed the basis of Turkey's health care system. In doing so, the study analysed the political dynamics that enabled the introduction and implementation of the reform, the political dynamics that the HTP generated, and the impact of these dynamics on the direction of change that the reform engendered.

At the empirical level, the study examined the interplay between the direction of change in the domain of health care finance and delivery and different political actors' subjective interpretations of the reform, their interests, and their strategies throughout the reform process. In this study, actual political conflicts—such as the struggle over the introduction of the full time work requirement for medical doctors, or the struggle over the cap on additional payments that patients make to private hospitals—between different actors were explored to understand the power relations between these actors and their differential impact upon the reform. Finally, the study makes an analysis of how and to whose benefit these political conflicts were resolved, which demonstrates the direction of change in Turkey's health care system and describes the new distribution of power it rests upon.

This study is inspired by the Historical Institutionalist perspective, which calls for the careful examination of the political system and political culture of the country case under consideration in order to explain

institutional change and changes in the distribution of power upon which this institutional change rests. The use of the Historical Institutional perspective is restricted to taking history and political systems into consideration, rather than relying on a purely institutionalist explanation for the reform (i.e. Immergut, 1992). In addition, ideational institutionalism has been used to account for the role of the subjective interpretations of political actors in their strategies throughout the reform process.

The study focuses on existing political actors in health care politics and investigates their subjective perspectives towards the reform at hand, their strategies to influence the reform to their self-defined benefits, and their interactions with one another. In analysing these three factors, the study draws on different approaches to health care politics, namely pluralism, the power resources approach, the institutionalist approach and the new politics approach.

As discussed in Chapter 2, health care today is both a commodity and a human right. This elusive state of health care makes it a locus of political contestations both at the global and domestic level. From another angle, health care is both a sizeable economic sector and a significant area of social policy. Therefore, it lies at the intersection of economics and politics and is subject to significant influences both from the market actors and states. While welfare states emerging in the aftermath of WW2 initiated ‘the decommodification of health care’ as defined by Bambra (2005), Moran emphasises how these states simultaneously invested in private-run pharmaceutical and health technology sectors and thus contributed to the commodification of health care (1999).

With the fall of Keynesianism in the late 1970s, which had previously formed the basis of the equilibrium for health care services in welfare states, neoliberal perspective slowly established itself as the *modus operandi* of the economy and society of the new age. Starting from the late 1970s, neoliberalism, according to Hay (2004), can be defined as confidence in market distribution, a movement towards a global free trade regime, and

a push for the transformation of the role of the state from market alternative to a market facilitator.

With neoliberalism, political struggles over health care gained pace and took a new shape. In the domain of health care, neoliberalism signifies the extension of the commodification of health care services to health care finance and delivery, thus the privatisation of health care finance and delivery and/or the adoption of private sector management techniques by the public sector.

As explained in Chapter 5, international organisations, especially the WB, and international epistemic communities of health economists (Appleby, 1998) have been the harbingers of neoliberalism in the domain of health care policies. Both of these actors pioneered the translation of health care policy issues into the health economics discourse. The WB took one step further and popularised pro-market ‘policy paradigm’ in health care policies especially among developing countries.

However, as the analysis of different cases of health care reforms in developing countries in Chapter 4 suggests, it is not possible to argue that all developing countries followed the neoliberal route in reforming their health care systems from the late 1970s. Therefore, understanding the political dynamics behind health care reforms requires a careful analysis of domestic political factors, actors and their interaction with global actors and factors. While international influences are important, here it is argued that domestic politics also matter in making health care reform possible and in shaping its direction.

As described in Chapter 3, from the first half of the 20<sup>th</sup> century to the introduction of the HTP in 2003, Turkey’s health care system had developed as a result of two key factors: cumulative governmental attempts to introduce social health insurance schemes, and attempts to establish state capacity for preventive and curative health care service delivery. Separate public health insurance schemes were established for each occupational status group (i.e. private sector workers, state officials, farmers and artisans etc.). As discussed in Chapter 3, the development of a full-fledged



health care system in Turkey was the product of populist attempts by a series of governments in power after the bifurcation of the ruling bloc that established the Republic (Keyder, 2007b, p.147). In other words, social insurance-based financing, coupled with a tax financed non-contributory scheme for the very poor since 1992, was the main financial source of health care. Public sector health care providers, combined with the private clinics of specialists working at the same time for the public hospitals, dominated the provision of health care services. Turkey's health care system before the reform most resembled state health care systems within Wendt et al.'s typology (2009). Pressing issues affecting Turkey's health care system before the reform included the vertical and horizontal expansion of services, the question of outsiders to the social insurance-based system, the problem of medical doctors' dual commitment to public hospitals and their private clinics, and the increasing fiscal deficits of social security institutions.

Turkey's health care system witnessed a series of reform attempts throughout the 1990s, but all failed mainly due to the political instability of governments that were unable to tackle internal and external oppositions to their reform proposals. Therefore, the 'policy drift' is the best concept that defines the state of Turkey's health care system between 1980s and 2000s with the exception of the introduction of the Green Card scheme in 1992. With the AK Party's rise to power as a single-party government in the 2002 general elections, a significant transformation in Turkey's health care system finally began.

In this regard, the first political dynamic that paved the way to the introduction of the HTP was the electoral victory of the AK Party in the 2002 general elections. The AK Party, which came onto the scene less than a year before the 2002 general elections, was an inheritor of the Political Islamist National Outlook movement and aspired to become a 'catchall party' as defined by Kirchheimer (Krouwel, 1996). The AK Party inherited the political alliance that the Political Islamist National Outlook movement built, which included the small and medium-sized conservative entrepreneurs located outside of metropolitan cities and the urban poor

throughout the 1990s. The AK Party, primarily based on this alliance, promised to make health care services accessible for all with a special emphasis on those outside of the formal social security system, i.e. those benefiting or aspiring to benefit from the Green Card scheme. The AK Party successfully appealed to this social group growing in numbers over time, which, according to a concept defined by Alfred (1975), had ‘repressed structural interests’ on health care policies. In return, the AK Party became the most popular political party among the urban poor.

Understanding the state of Turkey’s political system and culture during the introduction and the implementation of the HTP is crucial in deciding which approach or approaches to health care politics might best explain the political dynamics that formed the basis of the reform. Turkey’s political system could be considered a form of ‘state corporatism’ as defined by Schmitter (1974). Both the medical doctor organisations and business organisations were state-created entities that lacked ‘veto points’ in Turkey’s political system, which makes it impossible to understand politics from a pluralist perspective. Their presence in policy-making bodies (i.e. special commissions in the MoH) is merely symbolic. The role of the judiciary is limited to a compliance audit of the legislations. Therefore, electoral politics is the key to acquiring power. The electoral system is majoritarian, both in its structure of representation and political finance, which is amenable to the rise of a ‘cartel party’ as defined by Katz and Mair. Within this system, once a single-party government succeeds at remaining in power, the only check and balance mechanism that might still function is the monitoring of the judiciary.

Historically, major political parties have not been organised along class lines. As Keyder suggests, due to political-economic factors like late industrialisation and the suppression of class-based political actors since the establishment of the Republic, neither farmers nor workers were organised enough to exert a strong influence on mainstream politics (Keyder, 2007b). This scenario makes it impossible to apply the power resources approach. However, this low level of organisation among workers

and farmers does not make class irrelevant in understanding the politics in Turkey. Alternatively, one could investigate how and to what extent catchall parties could integrate different social classes into their hegemonic projects. Van Kersbergen's analysis of the influence of Christian democratic political parties on social policies might be useful in understanding the role of the AK Party in the health care reform under consideration. Finally, while the new politics approach (Pierson, 1996) might explain the continued support of the public for the dominant role of the state in health care provision and delivery, it fails to explain the rationale behind the increase in public spending for health care services in Turkey in the age of neoliberalism.

It might be suggested that available theories on the politics of social policies and health care draw heavily on the empirical cases of advanced capitalist countries, which reduces their ability to explain the politics of social policies and health care in developing countries. The theorisation of the politics of social policies and health care in developing country cases remains in the contours of welfare regime typologies (i.e. Gough, 2004, Rudra, 2007). This underdeveloped theorisation might partially originate from the limited number of empirical studies on the issues under consideration. Therefore, this study might contribute to this body of knowledge, which would pave the way to theorisation attempts in the future.

The second political dynamic that made it possible to both introduce and shape the content of the HTP was the involvement of the WB. The WB's influence on the HTP is two-fold: the influence of the WB on health care policies, which originated from its historical partnership with the governments of Turkey; and the hands on impact of the WB during the preparation and the implementation of the HTP.

As discussed in Chapter 5, the WB became the pioneering international organisation that promoted neoliberal health reforms in developing countries. In practice, the WB offers loans to carry out comprehensive health care reforms and provides empirical information and

know-how on reforming health care systems. While the WB experts who I interviewed disagreed with the idea that the WB has a health care reform blueprint, they acknowledged that the WB offers a 'loose jacket'. This jacket, however, has distinctive components, including the purchaser-provider split in health care systems, the necessity of out-of-pocket contribution of patients, and the transformation of the role of the state from provision to stewardship. Therefore, one could argue that the looseness of the jacket refers mainly to the flexibility on the implementation of these components in different institutional contexts. As shown in the interview data in Chapter 5, the WB experts present their pro-market perspectives in health care policies as scientific, evidence-based and beyond politics, which legitimises the technocratisation of health reform processes in developing countries that is in line with Hay's account for neoliberalism.

The partnership between the WB and the Turkish governments on health care policies started in the 1990s. While this partnership could not initiate a reform process immediately, it is argued here that it had a moulding effect for a pro-market reform in the future. Indeed, the WB's involvement in Turkey's health care system equipped the organisation with the necessary information on health care policies. More importantly, with this partnership the WB succeeded in exporting its approach to the MoH bureaucrats, and some of those officials took part in the AK Party's reform team that prepared the HTP. As shown in Chapter 5, the WB's influence on the bureaucrats' perspective to health care policies manifested itself in the presence of a pro-market approach in the five-year development plans of Turkey since the mid-1980s.

The WB's influence on the HTP was not limited to its success in promoting a pro-market approach among the health care bureaucracy throughout the 1990s. In addition, the WB collaborated with the AK Party government in preparing and implementing the HTP. In fact, as discussed in Chapters 7 and 8, the preparation of the HTP was a closed process that excluded not only the TTB and trade unions organised in health care services, but also the business organisations. The government's reform

team, whose pivotal role was discussed in detail elsewhere (Ağartan, 2007), worked closely with the WB experts throughout the reform. Given their shared perspective on health care policies, which could be partly attributed to the previous integration of these experts into the WB-created epistemic community, they did not disagree on the main framework of the reform.

In some countries, as discussed in Chapter 4, factors such as economic crises, the lack of public resources to carry out a reform, or the absence of know-how made the governments amenable to the influence of the WB in shaping their health reforms. Nevertheless, considering the contemporary outcomes of the reform, here it is argued that the AK Party government took rather hesitant steps to immediately decrease the provider role of the state in health care provision, which is incompatible with the WB's blueprint. In other words, the AK Party government might have prioritised the success of the reform in order to create legitimacy in the eyes of the general public. The AK Party was able to realise this objective thanks to the favourable economic atmosphere. Given the AK Party's ownership of health care reform and the saliency of the issue for the general public, here it is argued that the success of the HTP contributed to the consecutive electoral successes of the AK Party.

In fact, the AK Party's electoral successes are especially noteworthy in a context where electoral support, as Çarkoğlu suggests (2002) has been traditionally considered volatile. As a result of consecutive electoral successes and thanks to the majoritarian character of Turkey's political system that lacks sufficient checks and balances, it could be suggested the AK Party established itself as a cartel party, in the sense that Katz and Mair define the concept (1995), especially after its victory in the constitutional referendum in 2011.

The HTP, which bears similarities with the neoliberal perspective in health care reform, aimed to basically create a quasi-market in health care delivery, introduce the new public management tools to public hospitals, and unify all public health insurance schemes under a single umbrella. On the one hand, the HTP could be considered an investment by the AK Party

in the sustenance of its alliance with the urban poor, as it equalised the benefit package of the non-contributory tax financed Green Card scheme with other contributory public health insurance schemes. On the other hand, the AK Party redefined health as an economic growth sector, especially in the areas of health care delivery and health tourism; created a quasi-market, as Le Grand defines it (1991) in health care provision; and reconfigured the public health institutions according to private sector management techniques, as Ferlie et al. describes elsewhere (1996). Similar to Moran's description of the relationship between Western European welfare states and health care (1999), the HTP eased citizens' access to health care services while creating a commodification dynamic at the same time. To use Öniş's conceptualisation, the increase in the rate of citizens' satisfaction with health care services in this context might symbolise the success of the AK Party's 'controlled populism' (2012), which manifested itself in the HTP in the first decade after the legislation of the reform.

Nevertheless, political contestations between different political actors over the direction of the HTP did not come to an end after the legislation of the reform. The distribution of power in Turkey's political system made it possible for the government to introduce the reform without getting the consent of other domestic actors. However, Skocpol emphasizes the 'policy feedback' as follows: "as politics creates policies, policies also remake politics" (1992, p.58). The changes brought forward by the HTP had an impact on health care politics. For instance, the TTB and the government contested each other on the issue of control over the labour of medical doctors, while the OHSAD and the government were in disagreement about what kind of opportunities should be available to private health care providers for capital accumulation.

The third political dynamic that partially shaped the direction of the HTP was the involvement of the TTB in the reform process as a contending party to the government, and the struggle between the TTB and the government over the control of the labour of medical doctors. As described in Chapter 3 and Chapter 7, TTB occupied a special place in health care

politics originating from their privileged status within the history of the nation-state making process in Turkey, their central position in the practice of medicine, and the corporatist structure that gave the TTB a monopoly over the representation of medical doctors' interests.

While the TTB performed its corporatist function until the end of the 1970s, the democratic takeover of the TTB executive board by a socialist group in 1977 led to its transformation into a non-governmental organisation fighting for a universalistic health care system that would provide free and quality health care for all citizens. The TTB based its political stance upon the universal values of the medical profession, and pursued organisational strategies to secure its autonomy from the private sector as well as from the MoH. While the autonomy of medical associations from the state is not an exception in most advanced capitalist countries, the TTB's funding policy that excludes financial contribution of the private sector can be considered as an exception, given scholars criticise the lack of stringency about the policies of professional medical associations concerning conflict of interests in their relations with the private sector (Rothman et al., 2009, p.1367). In light of its broader understanding of health care politics, the TTB engaged not only in professional politics, but also in the politics of production and consumption throughout the reform process.

As suggested in Chapter 5, the AK Party government, in collaboration with a reform team and the WB, carried out the preparation process of the reform as a closed one. In fact, in the polarised atmosphere in Turkey, the collaboration between the TTB under a left-leaning leading cadre and the AK Party government was unlikely. Given the fact that state corporatism of Turkey did not allow the TTB to have a veto point on health care reform decisions, the TTB did not have any institutional channels to influence the preparation of the reform under consideration. Alternatively, the TTB used the only available checks and balances mechanisms that could have an impact on the decisions of a single-party government: street protests and legal activism. While street protests could arguably serve the consolidation

of the TTB's constituency over common goals, they did not have an observable impact on the reform. However, the TTB's legal activism centred upon stopping the government's plan to introduce the full-time work requirement for all medical doctors -an action that would practically end private clinics of medical doctors, their proletarianisation, and their professional autonomy- proved to be successful for almost a decade. While the TTB's political stance aims to unify the interests of medical doctors and the general public under the broader demand for a universalist public health care system, the political system within which it operates and the marketized health care domain left no room for the TTB to focus its political strategies on the politics of consumption as much as it does on professional politics and the politics of production.

From another angle, the reform also had an impact on professional politics within the TTB. While the TTB was politically in favour of the full time work requirement before the introduction of the HTP, it had to revise its political stance. On the one hand, this revision might be attributed to the fact that the introduction of the full time work requirement would lead to the weakening of medical doctors vis-à-vis the state and the market actors. On the other hand, it could be argued that the leading cadre was squeezed between the expectations of its constituency to act as an interest organisation of medical doctors, and its values centred upon a demand for a universalist public health care system for Turkey. In the end, in this case, here it is argued that the TTB failed to unify the interests of medical doctors and the interests of the general public and prioritised the former over the latter.

The fourth political dynamic that partially shaped the direction of the reform in the post-legislative process was the birth of private health care provider organisations (the OHSAD in particular), their involvement in the reform process as a partner of the government, and the tension between the OHSAD and the government over the limits of capital accumulation in the health care delivery sector. As discussed in Chapter 8, the HTP was both a social policy change and an opening up of a new area for capital



accumulation. The HTP opened up a new area for capital accumulation by including private hospitals into the public health insurance plan and excluding the private clinics of medical doctors; which can be defined as 'policy conversion'. In fact, the most visible market direction of the HTP has been in health care delivery (Ağartan, 2012). As shown in Chapter 8, the share of bed capacity of private hospitals among all hospitals tripled between 2002 and 2011 and private hospitals started to receive one-fourth of all applications to health institutions in 2011.

Following the footsteps of Polanyi's insights (2001) and the application of those insights to the health care domain as presented in Giaimo (2005), it is argued that this partial privatisation of health care delivery, which was a result of state intervention to create a market in this domain, had a significant impact on health care politics by giving rise to new actors in health care politics, namely private health care provider organisations.

The Health Sector Union of the TOBB (the corporatist body) and the OHSAD emerged as the strongest parties aiming to represent private health care providers (voluntary business organisations) in health care policy making. It is argued here that the OHSAD's structure of representation, which offered larger private hospital groups more weight, resulted in the OHSAD's emergence as the strongest and most active representative of the private sector in health care provision. Despite the fact that the private hospital sector is heterogeneous concerning the sizes of private hospitals, the pricing policy of the SGK strengthens the oligopolisation tendency in the sector by favouring larger hospitals that can use economies of scale. This oligopolisation tendency also delegitimises the structure of representation of the Health Sector Union of the TOBB and puts the OHSAD in a more favourable position in the eyes of the larger entrepreneurs. As discussed in Chapter 8, while particularistic relations between business and the government have been influential (Heper, 1991), one should note that this study only examined the interaction between private health care provider organisations and the government. The analysis of the composition of the executive board and the honorary board

of the OHSAD, however, demonstrates the interpenetration of the health care bureaucracy and the business organisation as well as the governing political party and the business organisation.

Both the interest formation of private health care provider organisations and their interaction with the government diverges from the pluralist understanding of health care politics. Historically, the relationship between the state and the business was not conflict-ridden; governments used the state capacity to create a national bourgeoisie that was generally politically allied with the government in power (Buğra, 1997). Against this background, Buğra and Savaşkan suggest that the AK Party followed the historical path of state-business relations in Turkey and initiated a politically guided process of class transformation with health care as a significant component of this project (2014).

As a result of the above-mentioned historical structure, and drawing on the discourses and strategies used by private health care provider organisations throughout the reform process, here it is argued that these organisations did not engage in open conflicts with the government, even in the cases where their economic interests were in conflict with the policies intact. While neither the corporatist Health Sector Union of the TOBB nor the voluntary OHSAD had any veto points over the decision making process, both the government as well as the health care bureaucracy were much more open to listening to their demands.

From 2005 to 2008—after the inclusion of private health care providers into the public health insurance plan, but before the introduction of strict restrictions on private health care delivery sector—the relations between private health care provider organisations and the government were smooth. To exemplify, as discussed in Chapter 8, both private health care providers and the government referred to private hospitals as “national resources”, which were portrayed no differently from public hospitals. However, relations became tense after the government introduced new regulations that gave an end to the uncontrolled growth of private health

care provision and its ability to attract a significant share of specialist medical doctors.

The introduction of strict regulations on the opportunities of capital accumulation in health care delivery resulted in the consolidation of private sector interests and a more active role for the private health care provider organisations to advocate for these interests. The OHSAD has three areas of concentration in its strategy to influence the reform, which are listed as follows: the pricing policy of the SGK, the level of cap on additional payments that private hospitals are allowed to charge the patients, and the number of specialist medical doctors that private hospitals are allowed to hire. Given the fact that public opinion is still in favour of public sector dominance over health care delivery, the OHSAD could not employ a strategy to reach out to the public to put pressure upon the government. Alternatively, the OHSAD chose to express its demands to the health care bureaucracy and the representatives of the government without using a confrontational discourse. While the OHSAD may have used a conciliatory discourse to express its demands due to the mutual dependency of the OHSAD and the government in their shared endeavour for the politically motivated class transformation process, another reason might be the fact that the government still had the upper hand vis-à-vis the private sector in health care delivery due to the dominance of public hospitals.

In fact, over the course of the reform, private health care provider organisations in general and the OHSAD in particular could be considered partially successful in influencing the components of the reform that affected them the most. For instance, private health care provider organisations succeeded in altering the limits that the reform put on their opportunities for capital accumulation to their benefit. Throughout the implementation of the HTP, as shown in Chapter 8, the level of cap on additional payments and the number of available positions for specialist medical doctors in private hospitals significantly increased.

However, private health care provider organisations failed to succeed in realising their demands when the demands were in conflict with the

government's priorities. For instance, despite the persistence of private health care provider organisations to improve the pricing policy of the SGK, neither the pricing policy nor the level of prices changed substantially. It might be argued that the failure of this demand is mainly due to the fact that the realisation of this demand would directly increase the financial burden on the public budget. Alternatively, the government chose to transfer the financial burden originating from the private health care providers' demand for better revenues to patients willing to use private hospitals with their public health insurance. In other words, the government prioritised meeting its targets on public budget over keeping the level of out-of-pocket payments that patients make and the level of income-based inequalities in citizens' access to health care services low. Given that the AK Party has been transforming into a 'cartel party' and there are very few other channels that would allow for representation of the patients' interests in health care policy making, it could be argued that patients' interests, which were before partially represented by political parties in a competitive electoral atmosphere, are now increasingly becoming 'repressed structural interests'.

In conclusion, the HTP was a common product of the controlled populism of the AK Party and the pro-market health care reform approach of the WB, the latter of which was institutionalised in Turkey's health care bureaucracy in the mid-1980s. With the introduction of the HTP, the power distribution upon which Turkey's health care system is based has been changing. While governments had always been the strongest party in health care politics before the reform, medical doctors and their organisation also used to have significant leverage. However, after the reform, private health care provider organisations appeared as actors with considerable leverage and the ability to make changes in the reform. In contrast to the collaboration of the government with private health care provider organisations, the government excluded the TTB from the reform process. Despite the broader aspiration of the TTB's leading cadre to struggle for a universalist public health care system, the changes

introduced by the HTP concerning the control over medical doctors' labour pushed the TTB into the political position of an interest-based organisation. Full time work requirement proposal of the government was the only reform component in which the TTB, in collaboration with the judiciary, succeeded in making changes or delaying changes. Finally, advances in Turkey's health care system always came into being as a result of political parties' attempts to appeal to the public in fierce electoral competition. However, the cartelisation of the AK Party, which HTP's success in the public eye might have contributed to, puts the representation of the citizens' interests on health care policies at risk.

Private actors are not newcomers to the domain of health care. They have been the major global actors in pharmaceuticals and health technology sectors. While private actors in health care delivery were not significant actors in most state and societal health care systems, including Turkey's, they were already strong in private health care systems like the U.S. health care system. A recent general trend, which has manifested in the global wave of reforms leading to the privatisation in health care delivery, strengthens private actors in health care market and politics. This trend, which is also visible in the case of Turkey, brings forward the politics of regulation as the main mode of health care politics in the near future. This suggestion is in compliance with Béland's insight stated as follows: "exploring the changing assumptions of policy makers about the proper public-private mix is only one potential aspect of the ideational analysis of the role of ideas in public-private health care" (Béland, 2010, p.629). Taking a step forward, here it is suggested that political contexts where the control of citizens' and other actors' health care policies is weak (i.e. professional actors, trade unions, etc.) might pave the way to the loss of these actors' say and the strengthening of private sectors' input on health care policies.

For further research, the students of health care politics willing to work on the case of Turkey might consider examining the following issues: the changing political dynamics that the pharmaceutical policy of Turkey has been based on after the rise of the AK Party to power, the

transformation of the medical profession and its impacts on professional politics within the TTB, the transnationalisation trend in the health care delivery market, and the emerging alliances between private health care insurance organisations and private health care provider organisations and possible impacts of these alliances on health care policies.

## Bibliography

ABEL-SMITH, B. & MOSSIALOS, E. 1994. Cost containment and health care reform: A study of the European Union. *Health Policy*, 28, pp.89-132.

ADAMAN, F. 2003. Study on the social protection systems in Turkey. *Entry for the report Study on the Social Protection Systems in the 13 Applicant Countries*. European Commission.

ADAR, S. 2007. Turkey: Reform in social security. *Journal of European Social Policy*, 17, pp.167-168.

ADIYOK, M. 2012. Turkey's healthcare: a bad prognosis. *Turkish Review*, 2, pp.26-31.

AĞARTAN, T. İ. 2007. Turkish health policy in a globalizing world: The case of 'Transformation of Health' Program. *ISA Research Committee 19 Annual Academic Conference*. Florence.

AĞARTAN, T. İ. 2008. *Turkish Health System in Transition: Historical Background and Reform Experience*. Ph.D., State University of New York.

AĞARTAN, T. İ. 2012. Gender and health sector reform: Policies, actions and effects. In: ELVEREN, A. Y. & DEDEOĞLU, S. (eds.) *Gender and Society in Turkey: The Impact of Neo-Liberal Policies, Political Islam and EU Accession*. London and New York: IB Tauris.

AĞARTAN, T. İ. 2012. Marketization and universalism: Crafting the right balance in the Turkish healthcare system. *Current Sociology*, 60, pp.456-471.

AKDAĞ, E. 2012. SGK'lya kaç, özel hastanelere tut! *Aksiyon*, 28.05.2012.

AKINCI, U. 1999. The Welfare Party's municipal track record: Evaluating Islamist municipal activism in Turkey. *The Middle East Journal*, 53, pp.75-94.

AKSOY, B. 2008. Özel hastanelerin devletleşmesi ya da Sağlık Bakanlığı'nın haksız rekabeti (Etatisation of private hospitals or Ministry of Health's unfair competition). *Sağlık Düşüncesi ve Tıp Kültürü Platformu Dergisi (Journal of Health Thoughts and Culture of Medicine)*, p.5.

AL JAZEERA TURK 2014a. AK Partili İşbilen istifa etti (İşbilen resigned from the AK Party). *Al-Jazeera Turk*, 07.02.2014.

AL JAZEERA TURK 2014b. Hastanın şikayeti fark ücreti. *Al Jazeera Turk*, 29.01.2014.

ALBAWABA BUSINESS. 2003. IFC makes first investment in Turkey's health sector. *Albawaba Business*, 22 July 2003.

ALFORD, R. R. 1975. *Health Care Politics: Ideological and Interest Group Barriers to Reform*, Chicago and London, The University of Chicago Press.

ALKAN, H. 2011. AKP'nin sağlık kozu. *BBC Türkçe*, 1 June 2011.

ANADOLU AJANSI 2014. En sevilen icraatımız sağlık hizmetleri (Our favourite policy is health care services). *Anadolu Ajansı*, 07.03.2014.

APPLEBY, J. 1998. Economic perspectives on markets and health care. In: RANADE, W. (ed.) *Markets and Health Care: A Comparative Analysis*. London and New York: Longman, pp.34-53.



ARAT, Y. 1991. Politics and big business: Janus-faced link to the state. *In: HEPER, M. (ed.) Strong State and Economic Interest Groups: The Post-1980 Turkish Experience.* Berlin and New York: Walter de Gruyter, pp.135-147.

ARCHER, M. 1998. Realism and morphogenesis. *In: ARCHER, M., BHASKAR, R., COLLIER, A., LAWSON, T. & NORRIE, A. (eds.) Critical Realism.* London and New York: Routledge, pp.356-382.

ARCHER, R. 1994. Markets and good government. *In: CLAYTON, A. (ed.) Governance, Democracy and Conditionality: What Role for NGOs?* Oxford: Intrac, pp.7-34.

ARMADA, F., MUNTANER, C. & NAVARRO, V. 2001. Health and Social Security Reforms in Latin America: The Convergence of the World Health Organization, the World Bank, and Transnational Corporations. *International Journal of Health Services*, 31, pp.729-768.

ARMADA, F., MUNTANER, C. & NAVARRO, V. 2001. Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations. *International Journal of Health Services*, 31, pp.729-768.

ARROW, K. J. 1963. Uncertainty and the welfare economics of medical care. *The American Economic Review*, 53, pp.941-973.

ARROW, K. J. 2001. Reflections on the reflections. *Journal of Health Politics, Policy and Law*, 26, pp.1197-1203.

ASISKOVITCH, S. 2010. Bureaucratic actors in mature welfare states: The case of Israel. *Policy & Politics*, 38, pp.547-563.

AVCI, Ç. 2012. Sayıştay'dan özel hastanelere 300 milyon liralık ceza şoku!  
(Court of Account's shocking fine of 300 million TL for private hospitals).  
*Zaman*, 14 September 2012.

AYATA, A. 1993a. Ideology, social bases, and organizational structure of the post-1980 political parties. In: ERALP, A., TÜNAY, M. & YEŞİLADA, B. (eds.) *The Political and Socioeconomic Transformation of Turkey*. Westport, Connecticut and London: Praeger, pp.31-51.

AYATA, S. 1993b. The rise of Islamic fundamentalism and its institutional framework. In: ERALP, A., TÜNAY, M. & YEŞİLADA, B. (eds.) *The Political and Socioeconomic Transformation of Turkey*. Westport, Connecticut and London: Praeger, pp.40-56.

AYATA, S. 1996. Patronage, party and state: The politicization of Islam in Turkey. *Middle East Journal*, 50, pp.40-56.

AYDIN, E. 2002. *Türkiye'de Sağlık Teşkilatlanması Tarihi (The History of Health Organisation in Turkey)*, Ankara, Naturel Yayınları.

BALDWIN, P. 1999. *The Politics of Social Solidarity: Class Bases of the European Welfare State 1875-1975*, Cambridge and New York, Cambridge University Press.

BAMBRA, C. 2005a. Health status and the worlds of welfare. *Social Policy & Society*, 5, pp.53-62.

BAMBRA, C. 2005b. Worlds of welfare and the health care discrepancy. *Social Policy & Society*, 4, pp. 31-41.

BARIŞ, E., MOLLAHALİLOĞLU, S. & AYDIN, S. 2011. Healthcare in Turkey: From laggard to leader. *British Medical Journal*, p.342.

BARRIENTOS, A. & LLOYD-SHERLOCK, P. 2000. Reforming health insurance in Argentina and Chile. *Health Policy and Planning*, 15, pp.417-423.

BARRIENTOS, A. 2000. Getting better after neoliberalism: Shifts and challenges of health policy in Chile. *In: LLOYD-SHERLOCK, P. (ed.) Health Care Reform & Poverty*. London: Institute of Latin American Studies, pp.94-111.

BATLEY, R. 2004. The politics of service delivery reform. *Development and Change*, 35, pp.31-56.

BELANGER, E. & MEGUID, B. M. 2008. Issue salience, issue ownership and issue-based vote choice. *Electoral Studies*, 27, pp.477-491.

BELEK, İ. 2012. *Sağlıkta Dönüşüm: Halkın Sağlığına Emperyalist Saldırı (Transformation in Health: Imperialist Attack on People's Health)*, İstanbul, Yazılama Yayınları.

BELEK, İ., ONUROĞULLARI, H., NALÇACI, E. & ARDIÇ, F. 1998. *Sınıfsız Toplum Yolunda Türkiye İçin Sağlık Tezi (Health Thesis for Turkey Marching Towards a Classless Society)*, İstanbul, Sorun Yayınları.

BENNETT, S. 1991. The Mystique of Markets: Public and Private Health Care in Developing Countries. *In: CHAANE, B. (ed.)*. London: London School of Hygiene & Tropical Medicine-Department of Public & Health Policy-Health Policy Unit.

BERMAN, P. A. & BOSSERT, T. J. 2000. Decade of Health Sector Reform in Developing Countries: What Have We Learned? *Data for Decision*

*Making Project-Appraising a Decade of Health Sector Reform in Developing Countries.* Washington D.C.

BÈLAND, D. 2010. Policy change and health care research. *Journal of Health Politics, Policy and Law*, 35, 4, pp.615-641.

BHATIA, V. & COLEMAN, W. D. 2003. Ideas and discourse: Reform and resistance in the Canadian and German health systems. *Canadian Journal of Political Science*, 36, 4, pp.715-739.

BLANK, R. H. & BURAU, V. 2010. *Comparative Health Policy*, Hampshire, Palgrave Macmillan.

BLYTH, M. & KATZ, R. 2005. From catch-all politics to cartelisation: The political economy of the cartel party. *West European Politics*, 28, pp.33-60.

BORATAV, K. 2010. *Türkiye İktisat Tarihi 1908-2007 (Economic History of Turkey 1908-2007)*, Ankara, İmge Kitabevi.

BOUSSIOLI, Z. 2007. Concentration in the Greek private hospital sector: A descriptive analysis. *Health Policy*, 82, pp.212-225.

BRENNER, N. & THEODORE, N. 2002. Cities and the geographies of “actually existing neoliberalism”. *Antipode*, 34, pp.349–79.

BROOKS, S. M. 2005. Interdependent and Domestic Foundations of Policy Change: The Diffusion of Pension Privatization Around the World. *International Studies Quarterly*, 49, pp.273-294.

BUĞRA, A. & ADAR, S. 2007. Türkiye'nin Kamu Sosyal Harcamalarının Karşılaştırmalı bir Analizi (A comparative analysis of Turkey's public

social expenditures). İstanbul: Boğaziçi Üniversitesi Sosyal Politika Forumu.

BUĞRA, A. & CANDAS, A. 2011. Change and continuity under an eclectic social security regime: The Case of Turkey. *Middle Eastern Studies*, 47, pp.515-528.

BUĞRA, A. & KEYDER, Ç. 2006. The Turkish welfare regime in transformation. *Journal of European Social Policy*, 16, pp.211-228.

BUĞRA, A. & SAVAŞKAN, O. 2012. Politics and class: The Turkish business environment in the neoliberal age. *New Perspectives on Turkey*, 46, pp.27-63.

BUĞRA, A. & SAVAŞKAN, O. 2014. *New Capitalism in Turkey: The Relationship between Politics, Religion and Business*, Cheltenham and Northampton, Edward Elgar.

BUĞRA, A. 1997. *Devlet ve İşadamları (State and Businessmen)*, İstanbul, İletişim.

BUĞRA, A. 2008. *Kapitalizm, Yoksulluk ve Türkiye'de Sosyal Politika (Capitalism, Poverty and Social Policy in Turkey)*, İstanbul, İletişim Yayınları.

BUSE, K. & GWIN, C. 1998. The World Bank and global cooperation in health: the case of Bangladesh. *Lancet*, 351, pp.665-669.

CARONNA, C. A. 2010. Why use qualitative methods to study health care organizations? Insights from multi-level case studies. In: BOURGEOULT, I., DINGWALL, R. & VRIES, R. D. (eds.) *The SAGE Handbook of*

*Qualitative Methods in Health Research*. London, California, New Delhi, Singapore: Sage Publications, pp.71-87.

CHINITZ, D. 1995. Israel's health policy breakthrough: The politics of reform and the reform of politics. *Journal of Health Politics, Policy and Law*, 20, 4, pp.909-932.

CHUN, C. B., KIM, S. Y., LEE, J. Y. & LEE, S. Y. 2009. Republic of Korea: Health System Review. *European Observatory on Health Care Systems*.

CIVANER, M. 2011. "Transforming" our health by privatisation-Response to Baris et. al. *British Medical Journal*.

CİZRE, Ü. 1991. Labour: The battered community. In: HEPER, M. (ed.) *Strong State and Economic Interest Groups: The Post-1980 Turkish Experience*. Berlin and New York: Walter de Gruyter, pp.287-301.

CLAYTON, R. & PONTUSSON, J. 1998. Welfare-state retrenchment revisited: Entitlement cuts, public sector restructuring, and inegalitarian trends in advanced capitalist societies. *World Politics*, 51, pp.67-98.

CNN TÜRK 2010. Tam Gün Yasası'nda yeni karar (New decision on Full Time Work Law). *CNN Türk*, 23/07/2010.

COLLINS, C., GREEN, A. & HUNTER, D. 1999. Health sector reform and the interpretation of policy context. *Health Policy*, 47, pp.69-83.

COŞAR, S. & ÖZMAN, A. 2004. Centre-right politics in Turkey after the November 2002 general election: neo-liberalism with a Muslim face. *Contemporary Politics*, 10, pp.57-74.

COŞKUN, N. 2008. Özel hastaneler 'hak' arayacak (Private hospitals will claim their 'rights'). *Milliyet*, 26 December 2008.

COX, R. H. 2001. The social construction of an imperative: Why welfare reform happened in Denmark and the Netherlands but not in Germany. *World Politics*, 53, 3, pp.463-498.

CRAWFORD, G. 2006. The World Bank and good governance: Rethinking the state or consolidating neo-liberalism? In: PALONI, A. & ZANARDI, M. (eds.) *The IMF, World Bank and Policy Reform*. Oxon and New York: Routledge, pp.115-141.

ÇALIKOĞLU, Ş. 2008. *Influence of partisan politics on national health care expenditures from public and private sources of finance in OECD countries*. Doctor of Philosophy, Johns Hopkins University.

ÇARKOĞLU, A. & KALAYCIOĞLU, E. 2012. Türkiye'de Sağlık: Toplumbilimsel bir Değerlendirme (Health in Turkey: A Sociological Analysis). İstanbul: Koç Üniversitesi, Sabancı Üniversitesi.

ÇARKOĞLU, A. 2002. The rise of the new generation pro-Islamists in Turkey: The Justice and Development Party phenomenon in the November 2002 elections in Turkey. *South European Society and Politics*, 7, pp.123-156.

CNN TÜRK. 2014. Anayasa Mahkemesi'nden Tam Gün Kararı (The Constitutional Court's Decision on the Full Time Work), *CNN Türk.com*, 07.11.2014.

DANNREUTHER, C. & GIDEON, J. 2008. Entitled to health? Social protection in Chile's Plan AUGE. *Development and Change*, 39, pp.845-864.

DEMİRÇİ, B. 2012. *Transformation in the Organizational and Financial Set-up of the Health Care System in Turkey: Its Repurcussions and Similarities with the English Model*. Doctor of Philosophy, Middle East Technical University.

DEMİRKAYA, N. 2010. Sağlık Bakanı Recep Akdağ, Başbakan Tayyip Erdoğan sonrasında AK Parti'de olacakları İnternethaber'e anlattı (Minister of Health Recep Akdağ explained to the İnternethaber what will happen in the AK Party after Prime Minister Tayyip Erdoğan). *İnternethaber*, 03.12.2010.

DOĞU, N. 2010. Özel Hastanede El Değiştirme Rüzgarı. *Radikal*, 06.11.2010.

DONATINI, A., D'AMBROSIO, A. R. M. G., SCALZO, A. L., ORZELLA, L., CICHETTI, A. & PROFILI, S. 2001. Health Care Systems in Transition: Italy. *European Observatory on Health Care Systems*.

DOYAL, L. & PENNELL, I. 1994. *The Political Economy of Health*, London, Pluto Press.

DUBOS, R. J. 1987. *Mirage of Health: Utopias, Progress and Biological Change*, New Jersey, Rutgers University Press.

EASTON, D. 1985. Political science in the United States: Past and present. *International Political Science Review*, 6, 1, pp.133-152.

ECKSTEIN, H. 1960. *Pressure Group Politics: The Case of British Medical Association*, London, George Allen & Unwin Ltd.



ECKSTEIN, H. 1964. *The English Health Service: Its Origins, Structure and Achievements*, Cambridge & Massachusetts, Harvard University Press.

EDER, M. 1993. *Crises of Late Industrialization: A Comparative Study of the Automotive Industry in Brazil, South Korea and Turkey*. Ph.D., University of Virginia.

ELLISON, N. 2006. *The Transformation of Welfare States?*, London and New York, Routledge.

ELVEREN, A. 2008. Social security reform in Turkey: A critical perspective. *Review of Radical Political Economics*, 40, pp.212-232.

ENTHOVEN, A. C. 1993. The history and principles of managed competition. *Health Affairs*, 12, pp.24-48.

ERSOY, T. 1998. *Türkiye Tıp Tarihi İçin Materyalist Notlar (Materialist Notes for Turkey's Medical History)*, Istanbul, Sorun Yayınları.

ERUS, B. & AKTAKKE, N. 2010. Impact of healthcare reforms on out-of-pocket health expenditures in Turkey for public insurees. Cairo: Economic Research Forum.

ESMER, Y. 1991. Manufacturing Industries: Giants with Hesitant Voices. In: HEPER, M. (ed.) *Strong State and Economic Interest Groups: The Post-1980 Turkish Experience*. Berlin and New York: Walter de Gruyter.

ESPING-ANDERSEN, G. 1990. *The Three Worlds of Welfare Capitalism*, Cambridge and Princeton, Polity Press and Princeton University Press.

ETILER, N. & URHAN, B. 2011. Working conditions of physicians employed in public institutions in Turkey. *In: LISTER, J. (ed.) Europe's Health for Sale: The Heavy Cost of Privatisation.* Oxfordshire: Libri Publishing, pp.83-93.

EVANS, R. G. 1997. Going for the gold: The redistributive agenda behind market-based health care reform. *Journal of Health Politics, Policy and Law*, 22, pp.427-465.

EWERT, B. 2009. Economization and marketization in the German healthcare system: How do users respond? *German Policy Studies*, 5, pp.21-44.

FERLIE, E., ASHBURNER, L., FITZGERALD, L. & PETTIGREW, A. 1996. *The New Public Management in Action*, Oxford and New York, Oxford University Press.

FLYVBJERG, B. 2006. Five misunderstandings about case-study research. *Qualitative Inquiry*, 12, pp.219-245.

FOUCAULT, M. 1991. Governmentality. *In: G.BURCHELL, C.GORDON & MILLER, P. (eds.) The Foucault Effect: Studies in Governmentality.* Chicago: University of Chicago Press, pp.87-104.

FREEMAN, R. 1998. Competition in context: The politics of health care reform in Europe. *International Journal of Quality in Health Care*, 10, pp.395-401.

FREEMAN, R. 1999. Institutions, states and cultures: Health policy and politics in Europe. *In: CLASEN, J. (ed.) Comparative Social Policy: Concepts, Theories and Methods.* Oxford and Massachusetts, pp.80-94.

- FUCHS, V. R. 1996. Economic, values, and health care reform. *The American Economic Review*, 86, pp.1-24.
- GIAIMO, S. & MANOW, P. 1999. Adapting the welfare state: The case of health care reform in Britain, Germany, and the United States. *Comparative Political Studies*, 32, pp.967-1000.
- GIAIMO, S. 2005. *Markets and Medicine: The Politics of Health Care Reform in Britain, Germany, and the United States*, Ann Arbor, The University of Michigan University Press.
- GLASSMAN, A., REICH, M. R., LASERSON, K. & ROJAS, F. 1999. Political analysis of health reform in the Dominican Republic. *Health Policy and Planning*, 14, pp.115-126.
- GOUGH, I. 2004. Social policy regimes in the developing world. In: KENNETT, P. (ed.) *A Handbook of Comparative Social Policy*. Cheltenham Northampton: Edward Elgar, pp.205-226.
- GUILLÉN, A. M. & PALIER, B. 2004. Introduction: Does Europe matter? Accession to EU and social policy developments in recent and new member states. *Journal of European Social Policy*, 14, pp.203-209.
- GÜLALP, H. 2001. Globalization and Political Islam: The social bases of Turkey's Welfare Party. *International Journal of Middle East Studies*, 33, pp.433-448.
- GÜNAL, A. 2008. *Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context*. Ph.D., Boğaziçi University

GÜNAL, İ. 2014. 12 Mart darbesi ve bilim (12<sup>th</sup> March coup d'état and science). *Sol*, 13.03.2014.

GÜNEŞ, S. 2008. *Özel Sağlık Sektöründe 15 Şubat Depremi* [Online]. Ntvmsnbc.com. Available: <http://arsiv.ntvmsnbc.com/news/436232.asp> [Accessed 29.01 2011].

GÜZELANT, M. 2012. Demokratik katılımcı hekim grubunu açık ve dürüst olmaya davet ediyoruz! (We are asking Democratic participatory medical doctors' group to be open and honest!). İzmir: Hekim Güçbirliği (Medical Doctors' Union of Forces).

HABERTÜRK 2011. Acıbadem devleşiyor (Acıbadem grows in size). *Habertürk Ekonomi*, 14 December 2011.

HABERTÜRK 2012. Özel hastanede farka dikkat! (Pay attention to the additional payments in private hospitals). *Habertürk Ekonomi*, 18 March 2012.

HACKER, S. J. 2004. Privatizing risk without privatizing the welfare state: The hidden politics of social policy retrenchment in the United States. *American Political Science Review*, 98, 2, pp.243-260.

HALL, P. 1993. Policy paradigms, social learning, and the state: The case of economic policy-making in Britain. *Comparative Politics*, 25, 3, pp.275-296.

HALL, D. 2003. Multinational corporations and the pattern of privatisation in healthcare. In: SEN, K. (ed.) *Restructuring Health Services: Changing Contexts & Comparative Perspectives*. London and New York: Zed Books, pp.77-92.

HALL, P. A. & SOSKICE, D. 2001. *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage*, New York, Oxford University Press.

HALL, P. A. & TAYLOR, R. C. 1996. Political science and the three new institutionalisms. *Political Studies*, 44, pp.936-957.

HALL, P. A. & THELEN, K. 2009. Institutional change in varieties of capitalism. *Socio-Economic Review*, 7, pp.7-34.

HAM, C. 2009. *Health Policy in Britain*, Hampshire and New York, Palgrave MacMillan.

HARRISON, M. I. 2004. *Implementing Change in Health Systems*, London, Sage Publications.

HARRISON, S. & MCDONALD, R. 2008. *The Politics of Healthcare in Britain*, Los Angeles, London, New Delhi and Singapore, SAGE Publications.

HARVEY, D. 2005. *A Brief History of Neoliberalism*, Oxford and New York, Oxford University Press.

HASSENTEUFEL, P. & PALIER, B. 2007. Towards neo-Bismarckian health care states? Comparing health insurance reforms in Bismarckian Welfare Systems. *Social Policy & Administration*, 41, pp.574-596.

HAY, C. 2004. The normalizing role of rationalist assumptions in the institutional embedding of neoliberalism. *Economy and Society*, 33, pp.500-527.

HAZAMA, Y. 2013. Health Reform and Service Satisfaction in the Poor: Turkey. Institute of Developing Economies (IDE).

HEALTH INSURANCE COMMISSION OF AUSTRALIA 1995. *Final Health Financing Report: Policy Options Study for Turkiye*. Ankara.

HEKİM GÜÇBİRLİĞİ 2012. *Hekim Güçbirliği (Medical Doctors' Union of Forces)* [Online]. Available: <http://www.hekimgucbirligi.org/> [Accessed 12 July 2012 2012].

HEPER, M. & KEYMAN, E. F. 1998. Double-faced state: Political patronage and the consolidation of democracy in Turkey. *Middle Eastern Studies*, 34, pp.259-277.

HEPER, M. 1991. The state and interest groups with special reference to Turkey. In: HEPER, M. (ed.) *Strong State and Economic Interest Groups: The Post-1980 Turkish Experience*. Berlin and New York: Walter de Gruyter, pp.3-23.

HOMEDES, N. & UGALDE, A. 2005. Why neoliberal health reforms have failed in Latin America. *Health Policy*, 71, pp.83–96.

HOMEDES, N., PAZ-NARVAEZ, A. C., SELVA-SUTTER, E., SOLAS, O. & UGALDE, A. 2000. Health reform: Theory and practice in El Salvador. In: LLOYD-SHERLOCK, P. (ed.) *Health Care Reform & Poverty*. London: Institute of Latin American Studies, pp.57-77.

HÜRRİYET 2002. 6 güvence (6 guarantees). *Hürriyet*, 04.11.2002.

HÜRRİYET 2006. Erdoğan: Sağlıkta da serbest piyasa olmalı (Erdoğan: Free markets should also be established in health care). *Hürriyet*, 17.03.2006.

HÜRRİYET 2006. Erdoğan: Sağlıkta da serbest piyasa olmalı (Erdoğan: Free markets should also be established in health care). *Hürriyet*, 17.03.2006.

HÜRRİYET 2013. AK Parti üye sayısında fark attı (the AK Party outscored other parties on the number of members). *Hürriyet*, 13.02.2014.

HYDE, D.R. 1954. The American Medical Association: Power, purpose, and politics in organized medicine. *Yale Law Journal*, 63, pp.937-1022.

IMMERGUT, E. M. 1992. *Health Politics: Interests and Institutions in Western Europe*, Cambridge, New York and Melbourne, Cambridge University Press.

İNSEL, A. 2003. The AKP and normalizing democracy in Turkey. *The South Atlantic Quarterly*, 102, pp.293-308.

INSURANCE ASSOCIATION OF TURKEY 2012. İstatistikler (Statistics). Türkiye Sigorta Birliği.

INSURANCE ASSOCIATION OF TURKEY 2014. Sağlık İstatistikleri (Health Statistics). Türkiye Sigorta Birliği.

INTERNATIONAL FINANCE CORPORATION. 2007. *Financing Private Healthcare in Turkey: Acibadem Healthcare Group. Reducing Poverty, Improving Lives* [Online]. Available: <http://www.ifc.org/wps/wcm/connect/9522e0004970c18b9f3edf3336b93d75f/Reduce%2BPoverty%2BAcibadem.pdf?MOD=AJPERES>.

INTERNATIONAL FINANCE CORPORATION. 2007. Financing Private Healthcare in Turkey: Acibadem Healthcare Group. *Reducing Poverty, Improving Lives*.

INTERNATIONAL FINANCE CORPORATION. 2012. *IFC in Turkey* [Online]. Available:  
[http://www1.ifc.org/wps/wcm/connect/region\\_\\_ext\\_content/regions/europe+middle+east+and+north+africa/ifc+in+europe+and+central+asia/countries/turkey+country+landing+page](http://www1.ifc.org/wps/wcm/connect/region__ext_content/regions/europe+middle+east+and+north+africa/ifc+in+europe+and+central+asia/countries/turkey+country+landing+page) [Accessed 10 February 2012].

INTERNATIONAL FINANCE CORPORATION. 2012a. Investing in Private Health Care in Emerging Markets. *IFC in Turkey* [Online]. Available:  
[http://www1.ifc.org/wps/wcm/connect/region\\_\\_ext\\_content/regions/europe+middle+east+and+north+africa/ifc+in+europe+and+central+asia/countries/turkey+country+landing+page](http://www1.ifc.org/wps/wcm/connect/region__ext_content/regions/europe+middle+east+and+north+africa/ifc+in+europe+and+central+asia/countries/turkey+country+landing+page) [Accessed 10 February 2012].

INTERNATIONAL FINANCE CORPORATION. 2012b. *IFC in Health – Key Facts* [Online]. Available:  
[http://www1.ifc.org/wps/wcm/connect/Industry\\_EXT\\_Content/IFC\\_External\\_Corporate\\_Site/Industries/Health+and+Education/Health+Sector/KeyFacts/](http://www1.ifc.org/wps/wcm/connect/Industry_EXT_Content/IFC_External_Corporate_Site/Industries/Health+and+Education/Health+Sector/KeyFacts/) [Accessed 10 February 2012].

INTERVIEW NO.3 2011. Recorded face-to-to face indepth interview. *Hospital manager of one branch of a nationwide private hospital chain (05.08.2011)*. Samsun.

INTERVIEW NO. 8 2011. Recorded face-to-to face in-depth interview. Hospital manager of one branch of a nationwide private hospital chain and a former member of healthcare reform team (09.08.2011). Adana.



INTERVIEW NO.9 2011. Unrecorded face-to-face indepth interview- personal interview notes available. *Specialist medical doctor and the head of Turkish Medical Association (13.08.2011)*. Ankara.

INTERVIEW NO.10 2011. Recorded face-to-to face in-depth interview. *Hospital owner and the head of health sector union in the Union of Chamber and Commodity Exchanges in Turkey (13.08.2011)*. Ankara.

INTERVIEW NO.13 2011. Recorded face-to-to face indepth interview. *Professor of public health in a public university (01.10.2011)*. Ankara.

INTERVIEW NO.14 2011. Recorded face-to-to face indepth interview. *Specialist medical doctor and former head of Turkish Medical Association (05.10.2011)*. İstanbul.

INTERVIEW NO.15 2011. Recorded face-to-to face indepth interview. *Specialist medical doctor and the head of Right to Health Movement Association (05.10.2011)*. İstanbul.

INTERVIEW NO.17 2011. Recorded face-to-to face indepth interview. *Assistant specialist medical doctor and an active member of the Association for Human Health and Education (07.10.2011)*. İstanbul.

INTERVIEW NO.20 2011. Recorded face-to-to face in-depth interview. *Professor of medicine, president of a private medical university, a specialist medical doctor and a former member of healthcare reform team (26.10.2011)*. İstanbul.

INTERVIEW NO. 21 2011. Recorded face-to-to face in-depth interview. Senior economist in the World Bank and team leader in World Bank's health sector reform project in Turkey (01.11.2011). Ankara.

INTERVIEW NO. 22 2011. Recorded face-to-to face in-depth interview. Senior economist in the World Bank and former team leader in World Bank's health sector reform project in Turkey (01.11.2011). Ankara.

INTERVIEW NO.24 2011. Recorded face-to-to face in-depth interview. *Specialist medical doctor and head of Private Hospitals and Health Institutions Association (04.11.2011)*. İstanbul.

INTERVIEW NO.25 2011. Unrecorded indepth interview via teleconference-personal interview notes available. *Senior economist, head of health sector in the World Bank headquarters, former team leader in World Bank's health sector reform project in Turkey (10.11.2011)*. via teleconference.

INTERVIEW NO. 31 2011. Recorded face-to-to face in-depth interview. Specialist medical doctor and head of Revolutionary Health Workers Union (29.11.2011). Istanbul.

INTERVIEW NO. 32 2011. Recorded face-to-to face in-depth interview. General director of hospitals affiliated with a public university, former member of World Bank team in health sector reform project, former member of healthcare reform team (30.11.2011). İstanbul.

IRVINE, R. 2002. Fabricating 'health consumers' in health care politics. *In: HENDERSON, S. & PETERSEN, A. (eds.) Consuming Health: The Commodification of Health Care*. London and New York: Routledge, pp.31-46.

JACOBS, L. R. & SKOCPOL, T. 2010. *Health Care Reform and American Politics: What Everyone Needs to Know*, Oxford and New York, Oxford University Press.

JOSEPH, L. 2006. IFC Invests in Turkish Health Care Company. *International Finance Corporation website*, 8 March 2006.

JUSTICE AND DEVELOPMENT PARTY 2002. Seçim Beyannamesi (The Declaration for Elections).

JUSTICE AND DEVELOPMENT PARTY 2014. Parti Programı. Justice and Development Party.

KABAN, Ş. 2010. Sağlık Bakanı Recep Akdağ: 20 bin olan özel muayenehane sayısı 4 bine düştü (Minister of Health Recep Akdağ: Number of private clinics fell from 20 thousand to 4 thousand). *Türkiye*, 9 March 2010.

KARADENİZ, O. 2009. Annual National Report 2009-Pensions, Health and Long-term Care. *Analytical Support on the Socio-Economic Impact of Social Protection Systems*. European Commission DG Employment, Social Affairs and Equal Opportunities.

KASZA, G. J. 2002. The illusion of welfare 'regimes'. *Journal of Social Policy*, 31, pp.271-287.

KATZ, R. S. & MAIR, P. 1995. Changing models of party organization and party democracy: The emergence of cartel party. *Party Politics*, 1, 1, pp.5-28.

KATZNELSON, I. 2008. Rethinking the silences of social and economic policy. In: LEIBFRIED, S. & MAU, S. (eds.) *Welfare States: Construction, Deconstruction, Reconstruction Volume I*. Cheltenham and Northampton: Edward Elgar.

KEYDER, Ç. 1987. *State and Class in Turkey: A Study in Capitalist Development*, London and New York, Verso.

KEYDER, Ç. 2007a. Giriş. In: KEYDER, Ç., ÜSTÜNDAĞ, N., AĞARTAN, T. & YOLTAR, Ç. (eds.) *Avrupa'da ve Türkiye'de Sağlık Politikaları*. İstanbul: İletişim.

KEYDER, Ç. 2007b. *Türkiye'de Devlet ve Sınıflar (State and Class in Turkey)*, İstanbul, İletişim.

KILIÇ, A. 2008. The gender dimension of social policy reform in Turkey: Towards equal citizenship? *Social Policy & Administration*, 42, pp.487-503.

KLEIN, R. 2010. *The New Politics of the NHS: From Creation to Reinvention*, Oxon, Radcliffe Publishing.

KONDILIS, E., SMYRNAKIS, E., GIANNAKOPOULOS, S., ZDOUKOS, T. & BENOS, A. 2011. Privatising the Greek health care system - a story of corporate profits and rising health inequalities. In: LISTER, J. (ed.) *Europe's Health for Sale: The Heavy Cost of Privatisation*. Oxfordshire: Libri Publishing, pp.29-43.

KONSENSUS ARAŞTIRMA 2011. En Güvenilen Kurumlar Araştırması (Survey on the Most Trusted Institutions). Konsensus Araştırma.

KORPI, W. & PALME, J. 2003. New politics and class politics in the context of austerity and globalization: Welfare state regress in 18 countries, 1975-95. *The American Political Science Review*, 97, pp.425-446.

KORPI, W. 1980. Social policy and distributional conflict in the capitalist democracies. A preliminary comparative framework. *West European Politics*, 3, pp.296-316.

KORPI, W. 1989. Power, politics, and state autonomy in the development of social citizenship: Social rights during sickness in eighteen OECD countries since 1930. *American Sociological Review*, 54, pp.309-328.

KROUWEL, A. 2003. Otto Kirchheimer and the catch-all party. *West European Politics*, 26, 2, pp.23-40.

KWON, H. 2005. Transforming the developmental welfare state in East Asia. *Development and Change*, 36, pp.477-497.

KWON, S. 2007. Reform of the Medical Aid Program. *Health Policy Monitor*.

LANE, J.-E. 2000. *New Public Management*, London and New York, Routledge.

LASSWELL, H. D. 1936. *Politics: Who Gets What, When, How*, Michigan: Whittlesey house, McGraw-Hill book Company, Incorporated.

LAURELL, A. C. & ARELLANO, O. L. 1996. Market commodities and poor relief: the World Bank proposal for health. *International Journal of Health Services*, 26, pp.1-18.

LAURELL, A. C. 2001. Health reform in Mexico: The promotion of inequality. *International Journal of Health Services*, 31, pp.291-321.

LE GRAND, J. 1991. Quasi-markets and social policy. *The Economic Journal*, 101, pp.1256-1267.

LENG, C. H. & BARRACLOUGH, S. 2007. Introduction: The transformation of health care in Malaysia. *In: LENG, C. H. & BARRACLOUGH, S. (eds.) Health Care in Malaysia: The Dynamics of Provision, Financing and Access.* Oxon and New York: Routledge, pp.1-16.

LEYS, C. 2010. Health, health care and capitalism. *Socialist Register*, 46, pp.1-28.

LISTER, J. 2005. *Health Policy Reform: Driving the Wrong Way?*, Middlesex, Middlesex University Press.

LLOYD-SHERLOCK, P. 2005. Health sector reform in Argentina: a cautionary tale. *Social Science & Medicine*, 60, pp.1893-1903.

LLOYD-SHERLOCK, P. 2006. When social health insurance goes wrong: Lessons from Argentina and Mexico. *Social Policy & Administration*, 40, pp.353–368.

MACKINTOSH, M. & KOIVUSALO, M. 2005. *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, Hampshire and New York, Palgrave Macmillan.

MANOW, P. & KERSBERGEN, K. V. 2009. Religion and the western welfare State - The theoretical context. *In: KERSBERGEN, K. V. & MANOW, P. (eds.) Religion, Class Coalitions, and Welfare States.* New York: Cambridge University Press, pp.1-38.

MAPFRE GENEL SIGORTA 2012. Tamamlayıcı Sağlık Sigortası (Supplementary Health Insurance). Mapfre Genel Sigorta.

MARMOR, T. R. 1999. *The Politics of Medicare*, New York, Aldine De Gruyter.

MARX, K. 2008. *Capital*, Oxford, Oxford University Press.

MAYDA, M. 2014. TTB Anayasa Mahkemesi başkanı ile görüştü (The president of Turkish Medical Association talked to the head of the Constitutional Court). *Evrensel*, 26.03.2014.

MEDİMAGAZİN 2011a. Tedavi giderleri arttı, ilaç giderleri sabit kaldı (Expenditures for treatment increased, while expenditures for medications stayed the same). *Medimagazin*, 27.03.2011.

MEDİMAGAZİN 2011b. Akdağ'dan "ideolojik" suçlama ("Ideological" accusation from Akdağ). *Medimagazin*, 5 December 2011.

MEDİMAGAZİN 2012. Bin 157 hekim istifa etti (Thousand 157 medical doctors resigned). *Medimagazin*, 21.01.2012.

MILLAR, R., MULLA, A. & POWELL, M. 2013. Delivering reform in English healthcare: An ideational perspective. *Public Policy and Administration*, 28, 3, pp.233-252.

MİLLİYET 2002. Kimse hastanede rehin kalmayacak (Nobody would be put in pledge in hospitals). *Milliyet*, 28.11.2002.

MINISTRY OF HEALTH AND SOCIAL ASSISTANCE 1996. *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde Tedavi Edici Sağlık Hizmetlerinin bir Elden İdaresi Konusunda Yapılan Seminer Çalışmaları (Seminar on the Administrative Unification of Curative Health Care Services in the Ministry of Health and Social Assistance on 10-12 October 1966)*. Ankara.

MINISTRY OF HEALTH OF THE REPUBLIC OF TURKEY 2003.  
Transformation in Health.

MINISTRY OF HEALTH OF THE REPUBLIC OF TURKEY 2013. Sağlık İstatistikleri Yıllığı (Health Statistics Yearbook 2012). Ankara: Ministry of Health of the Republic of Turkey.

MINISTRY OF HEALTH OF THE REPUBLIC OF TURKEY. 2003.  
Transformation in Health.

MOONEY, G. 2009. *Challenging Health Economics*, Oxford and New York, Oxford University Press.

MORAN, M. 1992. The Health-care state in Europe: Convergence or divergence? *Environment and Planning C: Government and Policy*, 10, pp.77-90.

MORAN, M. 1998. Explaining the rise of the market in health care. In: RANADE, W. (ed.) *Markets and Health Care: A Comparative Analysis*. London and New York: Longman, pp.17-33.

MORAN, M. 1999. *Governing the Health Care State: A Comparative Study of the United Kingdom, the United States and Germany*, Manchester and New York, Manchester University Press.

MORAN, M. 2000. Understanding the welfare state: The case of health care. *British Journal of Politics and International Relations*, 2, pp.135-160.



MUNTANER, C., SALAZAR, R. M. G., BENACH, J. & ARMADA, F. 2006. Venezuela's Barrio Adentro: An alternative to neoliberalism in health care. *International Journal of Health Services*, 36, pp.803–811.

MÜSTAKIL SANAYİCİLER VE İŞADAMLARI DERNEĞİ. 2009. *Sağlık Sektörü 2008 Yılı Değerlendirmesi ve Sağlık Sektörünün Geleceği (Analysis of Health Sector in 2008 and the Future of Health Sector)*, İstanbul, Ofset Basım Yayın.

NAVARRO, V. 1976. *Medicine Under Capitalism*, New York and London, Prodist and Croom Helm.

NAVARRO, V. 1994. *The Politics of Health Policy: The U.S. Reforms, 1980-1984*, Oxford, UK & Cambridge, USA, Blackwell.

NORMAND, C. 1997. Health insurance: A solution to the financing gap? In: COLCLOUGH, C. (ed.) *Marketizing Education and Health in Developing Countries: Miracle or Mirage?* Oxford: Clarendon Press, pp.205-221.

NTVMSNBC 2009. *Özel hastanede katkı payına yargı freni (Judiciary granted a motion for stay of execution in the case on contributory payments in private hospitals)* [Online]. Ntvmsnbc. Available: <http://www.ntvmsnbc.com/id/24959716/> [Accessed 18.11 2010].

NTVMSNBC 2013. *Özel hastanelerin fark ücreti 2 kat arttı (Additional payments of private hospitals doubled)*. NTVMSNBC, 14.10.2013.

OECD & WORLD BANK 2008. Turkey. *OECD Reviews of Health Systems*.

ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT 2012. OECD Health Data 2012: How does Turkey compare?

OXLEY, H. & MACFARLAN, M. 1995. Health care reform: Controlling spending and increasing efficiency. *OECD Economic Studies*, 24, pp.8-55.

ÖNGEL, İ. 2014. Gül TTB'yi haklı buldu (Gül acknowledged Turkish Medical Association to be right). *Cumhuriyet*, 10.01.2014.

ÖNİŞ, Z. 2012. The triumph of conservative globalism: The political economy of the AKP Era. *Turkish Studies*, 13, pp.135-152.

ÖZBEK, N. 2006. *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar (Social Security and Social Policies in Republican Turkey)*, İstanbul, Tarih Vakfı.

ÖZBUDUN, E. 2006. From Political Islam to Conservative Democracy: The case of the Justice and Development Party in Turkey. *South European Society and Politics*, 11, pp.543-557.

PALA, K. 2007. Türkiye sağlık sistemi nereye gidiyor? (Where is Turkey's health system heading?). *Toplum ve Hekim*, 22, pp.62-69.

PATIENTS4NHS. 2014. EU/US free trade agreement.

<http://www.patients4nhs.org.uk/eu-us-free-trade-agreement-or-ttip/>

PETMESIDOU, M. & GUILLÉN, A. M. 2008. 'Southern-style' National Health Services? Recent reforms and trends in Spain and Greece. *Social Policy & Administration*, 42, pp.106-124.

PIERSON, C. 1991. *Beyond the Welfare State? The New Political Economy of Welfare*, Pennsylvania, The Pennsylvania State University Press.

PIERSON, P. 1993. When effect becomes cause: Policy feedback and political change. *World Politics*, 45, pp.595-628.

PIERSON, P. 1996. The new politics of the welfare state. *World Politics*, 48, pp.143-179.

POLANYI, K. 2001. *Great Transformation: The Political and Economic Origins of Our Time*, Boston, Beacon Press.

PRICEWATERHOUSE 1990. Health Sector Masterplan Study. Ankara: State Planning Organisation, Republic of Turkey.

PRIVATE HOSPITALS AND HEALTH INSTITUTIONS ASSOCIATION 2004. The Charter of the Association.

PRIVATE HOSPITALS AND HEALTH INSTITUTIONS ASSOCIATION 2011. OHSAD - Sağlık Bakanlığı toplantısı mutabakat metni (Agreement document of the meeting of Private Hospitals and Health Institutions Association and the Ministry of Health).

PUBLIC SPEECH NO. 4 2011. Recorded public speech in "Transformation of Turkey's Health Care System" Workshop organised by the author in Boğaziçi University. World Bank expert on healthcare reform in Turkey (25.11.2011). İstanbul.

PUBLIC SPEECH NO. 5 2011. Recorded public speech in "Transformation of Turkey's Health Care System" Workshop organised by the author in Boğaziçi University. Specialist medical doctor in a private hospital, former head of curative healthcare services department at the Ministry of Health,

former member of healthcare reform team (25.11.2011). İstanbul.

RAMESH, M. 2009. Malaysian health policy in a comparative perspective. *In: LENG, C. H. & BARRACLOUGH, S. (eds.) Health Care in Malaysia: The Dynamics of Provision, Financing and Access.* Oxon and New York: Routledge.

RANADE, W. 1994. *A Future for the NHS? Health Care in the 1990s,* London and New York, Longman.

RANADE, W. 1998. *Markets and Health Care: A Comparative Analysis.* London and New York: Longman.

REICH, M. R. 1995. The politics of health sector reform in developing countries: three cases of pharmaceutical policy. *Health Policy*, 32, pp. 47-77.

REPASS, D. E. 1971. Issue salience and party choice. *The American Political Science Review*, 65, 2, pp.389-400.

ROSSETTI, A. G. 2004. Strategic Options for the Implementation of the Health Sector Transformation in Turkey. Ankara: Ministry of Health and the World Bank.

ROTHGANG, H., CACACE, M., GRIMMEISEN, S. & WENDT, C. 2005. The changing role of the state in healthcare systems. *European Review*, 13, pp.187-212.

ROTHMAN, D.J., MCDONALD, W.J., BERKOWITZ, C.D., CHIMONAS, S.C., DEANGELIS, C.D., HALE, R.W., NISSEN, S.E., OSBORN, J.E., SCULLY JR, J. D., THOMSON, G.E. & WOFSEY, D. 2009. Professional

medical associations and their relationships with industry: A proposal for controlling conflict of interest. *JAMA*, 301, 13, pp.1367-1372.

ROTHSTEIN, B. & STEINMO, S. 2002. Restructuring politics: Institutional analysis and the challenges of modern welfare states. *In:* ROTHSTEIN, B. & STEINMO, S. (eds.) *Restructuring the Welfare State: Political Institutions and Policy Change*. New York and Hampshire: Palgrave Macmillan, pp.1-19.

RUDRA, N. 2007. Welfare states in developing countries: Unique or universal? *The Journal of Politics*, 69, 2, pp.378-396.

SABAH 2011. Danıştay'dan 'Tam Gün'e onay (The Council of State approved “the Full Time”). *Sabah*, 13/01/2011.

SALTER, B. 2004. *The New Politics of Medicine*, Hampshire and New York, Palgrave Macmillan.

SAMANYOLU 2012. Fazla fark ödeyen hasta parasını geri alamıyor (Patients paid more additional payments than required cannot get their money back). *Samanyolu Haber*, 6 May 2012.

SAVAS, E. S. 2000. *Privatization and Public-Private Partnerships*, New York, Seven Bridges Press.

SAVAŞ, N. 2012. “Sağlıkta dönüşüm sürecinde Dünya Bankası’nın ulusal sağlık mevzuatımıza etkisi” (The impact of the World Bank on our national health legislations) in *15. Ulusal Halk Sağlığı Kongresi: Sağlık Reformları*, Bursa.

SAYARI, S. 2007. Towards a new Turkish Party system? *Turkish Studies*, 8, pp.197-210.

SAYEK, F. 2012. *Türk Tabipleri Birliği Tarihine Giriş (Introduction to the History of Turkish Medical Association)* [Online]. Available: [http://www.ttb.org.tr/ttb\\_tarihi/index.html](http://www.ttb.org.tr/ttb_tarihi/index.html) [Accessed 21 February 2013].

SCHIEBER, G. & MAEDA, A. 1999. Health care financing and delivery in developing countries. *Health Affairs*, 18, pp.193-205.

SCHMITTER, P. 1974. Still the century of corporatism? *The Review of Politics*, 36, 1, pp.85-131.

SEN, K. & KOIVUSALO, M. 1998. Health care reforms and developing countries: A critical overview. *International Journal of Health Planning and Management*, 13, pp.199-215.

SEN, K. 2003. Restructuring health services and policies of privatisation – an overview of experience. In: SEN, K. (ed.) *Restructuring Health Services: Changing Contexts & Comparative Perspectives*. London and New York: Zed Books, pp.1-32.

SEXTON, S. 2003. Trading healthcare away: The WTO's General Agreement on Trade in Services (GATS). In: SEN, K. (ed.) *Restructuring Health Services: Changing Contexts & Comparative Perspectives*. London and New York: Zed Books, pp.33-52.

SKOCPOL, T. 1980. Political response to capitalist crisis: Neo-Marxist theories of the state and the case of the New Deal. *Politics & Society*, 10, pp.155-201.

SKOCPOL, T. 1985. Bringing the state back in: Strategies of analysis in current research. In: EVANS, P. B. (ed.) *Bringing the State Back In*. Cambridge: Cambridge University Press, pp.3-37.

SKOCPOL, T. 1992. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, Cambridge and London, The Belknap Press of Harvard University Press.

SKOCPOL, T. 1997. *Boomerang: Health Care Reform and the Turn against Government*, New York and London, W. W. Norton & Company.

SOCIAL SECURITY INSTITUTION OF TURKEY 2010. Özel Hastanelerin Puanlandırılması ve İlave Ücret Alınması Hakkında Yönerge (Directive on the Categorisation of Private Hospitals and Receiving Additional Payments). Sosyal Güvenlik Kurumu (Social Security Institution).

SOCIAL SECURITY INSTITUTION OF TURKEY 2010. Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği (Social Security Institution Health Implementation Statement). 27532. Social Security Institution.

SOCIAL SECURITY INSTITUTION OF TURKEY 2011. Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliğinde Değişiklik Yapılmasına Dair Tebliğ (Statement of Changing the Health Implementation Statement). 28159.

SOCIAL SECURITY INSTITUTION OF TURKEY 2014. Monthly Basic Indicators-April. Ankara: Social Security Institution of Turkey.

SOCIAL SECURITY INSTITUTION OF TURKEY. 2010. *Primsiz Ödemeler Genel Müdürlüğü Eylül Ayı İstatistik Bülteni (Directorate General of Non-contributory Payments September Statistics Bulletin)* [Online]. Available:

[http://www.sgk.gov.tr/wps/portal!/ut/p/c1/04\\_SB8K8xLLM9MSSzPy8xBz9CP0os\\_gAS-PAAE8TIwN3d09XAYNjr1AnQ6dgQ-dgI6B8JJK8hZuHOVDeMNTI1cXY0MDdiIBuP4\\_83FT9gtyIcgCElpjh/dl2/](http://www.sgk.gov.tr/wps/portal!/ut/p/c1/04_SB8K8xLLM9MSSzPy8xBz9CP0os_gAS-PAAE8TIwN3d09XAYNjr1AnQ6dgQ-dgI6B8JJK8hZuHOVDeMNTI1cXY0MDdiIBuP4_83FT9gtyIcgCElpjh/dl2/)

d1/L2dJQSEvUUt3QS9ZQnB3LzZfUDkzUVBJNDIwODhVMTAyVkRLTE  
lJTDBPODU! [Accessed 05.12 2010].

SONAY, N. 2012. Özel hastanelerde fark vurgunu (Sack of additional payments in private hospitals). *Bugün*, 10 June 2012.

SORGUN 2014. Başbakan Erdoğan Türkiye'ye Yozgat'tan seslendi (Prime Minister Erdoğan appealed to Turkey from Yozgat). *Sorgun Gazetesi*, 24.02.2014.

SOYER, A. 2004. *Sanayi Devriminden Küreselleşmeye Darbeden AK Partiye Sağlıkın Öyküsü (The History of Health: From the Industrial Revolution to Globalisation; From the Military Coup to the AK Party)*, İstanbul, Sorun Yayınları.

SOYER, A. 2005. *Bir Muhalefet Odağı Olarak Tabip Eylemleri, Bir Eylem Biçimi Olarak Beyaz Eylemler (Protests of Medical Doctors as a Node of Opposition, White Protests as a Form of Opposition)*. İstanbul: Sorun Yayınları.

SOYER, A. 2007. *AKP'nin Sağlık Raporu (Health Report of the AKP)*, İstanbul, Evrensel Basım Yayın.

SÖNMEZ, M. 2011. *Paran Kadar Sağlık: Türkiye'de Sağlıkın Ticarileşmesi (Health Care as Much as Your Money: Commercialisation of Health in Turkey)*, İstanbul, Yordam Kitap.

ŞENSES, F. 1993. Turkey's labor market policies in the 1980s against the background of its stabilization program. In: ERALP, A., TÜNAY, M. & YEŞİLADA, B. (eds.) *The Political and Socioeconomic Transformation of Turkey*. Westport, Connecticut and London: Praeger, pp.97-109.



TALAS, C. 1992. *Türkiye'nin Açıklamalı Sosyal Politika Tarihi (History of Social Policy in Turkey)*, Ankara, Bilgi Yayınevi.

TEKİN, P. Ş. 2012. Public-private partnerships and the healthcare sector. *Turkish Review*, 2, pp.48-55.

TEKSÖZ, T., KAYA, Y. & HELVACIOĞLU, K. 2009. Sağlık Reformunun Sonuçları İtibariyle Değerlendirmesi (Analysis of Health Reform by Examining its Results). İstanbul: Türkiye Ekonomi Politikaları Araştırma Vakfı (Economic Policy Research Foundation of Turkey).

TEMEL, T. 2003. Özel hastaneler sektör profili (Private hospitals sector profile). İstanbul: İstanbul Ticaret Odası (Istanbul Chamber of Commerce).

TEZEL, A. 2009. *Özel Hastaneler SGK'ya Hala İplemiyor* [Online]. Habertürk. Available: <http://www.alitezcel.com/tezel/index.php?sid=yazi&id=3065> [Accessed 18.11 2010].

THE CONSTITUTIONAL COURT OF TURKEY 2014. The Ruling of the Constitutional Court. *2014/61*.

THE CONSTITUTIONAL COURT OF TURKEY 1988. Temel Sağlık Hizmetleri Kanunu'nun bazı maddelerinin iptaline ilişkin (Request for cancellation of some of the clauses of the Basic Health Services Law). *1988/8*.

THE CONSTITUTIONAL COURT OF TURKEY 2010. 5947 sayılı Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanunun İptali ve Yürürlüğünün Durdurulması Anayasa Mahkemesi Kararı (Constitutional

Court Decision on the Stay of Execution of Law on Full Time Work for Medical Doctors). *2010/29*.

THE CONSTITUTIONAL COURT OF TURKEY 2012. The Ruling of the Constitutional Court. *2011/113*.

THE CONSTITUTIONAL COURT OF TURKEY 2013. The Ruling of the Constitutional Court. *2011/150*.

THE COUNCIL OF STATE OF TURKEY 2009. 03.04.2009 tarihinde Türkiye Sağlık İşletmecileri Derneği'nin başvurusuna müteakip verilen yürütmeyi durdurma kararı (Decision made on April 3rd, 2009 on the granting a motion for the stay of execution in response to the application of Association of Health Managers in Turkey). *2008/11388*.

THE INTERNATIONAL REPUBLICAN INSTITUTE 2011. Turkish Public Opinion Survey.

THE LABOUR PARTY OF TURKEY. 1964. *Türkiye İşçi Partisi Programı (The Program of the Labour Party of Turkey)*. Ankara.

THE MINISTRY OF ECONOMY OF TURKEY 2012. Uluslararası Doğrudan Yatırım Verileri Bülteni (International Direct Investment Figures Bulletin). Ankara: Teşvik Uygulama ve Yabancı Sermaye Genel Müdürlüğü (Directorate General for Incentive Implementation and Foreign Capital).

THE MINISTRY OF HEALTH OF TURKEY 1993. *Ulusal Sağlık Politikası (National Health Policy)*. Ankara: The Ministry of Health, Health Project General Coordination Unit.

THE MINISTRY OF HEALTH OF TURKEY 1997. *Health Sector Reforms in Turkey*, Ankara: The Ministry of Health, Health Project General Coordination Unit.

THE MINISTRY OF HEALTH OF TURKEY 1999. *Sağlık Hizmet Kullanıcıları Memnuniyet Araştırması (Satisfaction with Health Services Survey)*. İstanbul: MAKRO Araştırma.

THE MINISTRY OF HEALTH OF TURKEY 2004. *Turkey National Health Accounts 1999-2000*, Ankara, The Ministry of Health of Turkey, Refik Saydam School of Public Health.

THE MINISTRY OF HEALTH OF TURKEY 2008. *Özel Hastaneler Yönetmeliğinde Değişiklik Yapılmasına Dair Yönetmelik (Bylaw on the Changing of the Bylaw of Private Hospitals)*. 26788.

THE MINISTRY OF HEALTH OF TURKEY 2011. *Sağlık İstatistikleri Yıllığı 2010 (Health Statistics Yearbook 2010)*, Ankara.

THE MINISTRY OF HEALTH OF TURKEY 2012. *Sağlık İstatistikleri Yıllığı 2011 (Health Statistics Yearbook 2011)*, Ankara: Türkiye Cumhuriyeti Sağlık Bakanlığı Sağlık Araştırmaları Genel Müdürlüğü (Republic of Turkey Ministry of Health Directorate General of Health Research).

THE REPUBLIC OF TURKEY 1921. *Ereğli Havzai Fahmiye Maden Amelesinin Hukukuna Müteallik Kanun (Law on the Rights of Coal Mine Workers in Ereğli Basin)*. 151.

THE REPUBLIC OF TURKEY 1928. *Tababet ve Şuabatı Sanatlarının Tarzı İcrasına dair Kanun (Law on the Practice of Medicine)*. 1219.

THE REPUBLIC OF TURKEY 1930. Umumi Hıfzısıhha Kanunu (Public Health Law). 1593. Republic of Turkey: Official Gazette No. 1489.

THE REPUBLIC OF TURKEY 1947. Sendikalar Kanunu (Law on Trade Unions). 5018.

THE REPUBLIC OF TURKEY 1949. Türkiye Cumhuriyeti Emekli Sandığı Kanunu (Law on the Republic of Turkey Retirement Fund). 5434.

THE REPUBLIC OF TURKEY 1950. Hastalık ve Analık Sigortası Kanunu (Law on Sickness and Maternity Insurance). 5502.

THE REPUBLIC OF TURKEY 1953. Türk Tabipleri Birliği Kanunu (Turkish Medical Association Law). 6023.

THE REPUBLIC OF TURKEY 1955. Hastaneler Talimatnamesi (Hospitals Ordinance).

THE REPUBLIC OF TURKEY 1961. Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun (Law on the Socialization of Health Services). 224.

THE REPUBLIC OF TURKEY 1963a. Sendikalar Yasası (Law on Trade Unions). 274.

THE REPUBLIC OF TURKEY 1963b. Toplu İş Sözleşmesi, Grev ve Lokavt Yasası (Law on Collective Bargaining, Industrial Action and Lock-out). 275.

THE REPUBLIC OF TURKEY 1964. Sosyal Sigortalar Kanunu (Social Insurances Law). 506.

THE REPUBLIC OF TURKEY 1971. Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu Kanunu (Law on Shopkeepers, Artisans and Other Self-Employed Social Insurances Institution). *1479*.

THE REPUBLIC OF TURKEY 1978. Sağlık Personelinin Tam Süre Çalışma Esaslarına Dair Kanun (Law on Full-time Working Principles for Health Personnel). *2162*.

THE REPUBLIC OF TURKEY 1983a. Sendikalar Kanunu (Law on Trade Unions). *2821*.

THE REPUBLIC OF TURKEY 1983b. Toplu İş Sözleşmesi, Grev ve Lokavt Yasası (Law on Collective Bargaining, Industrial Action and Lock-out). *2822*.

THE REPUBLIC OF TURKEY 1987. Sağlık Hizmetleri Temel Kanunu (The Basic Health Law). *3359*.

THE REPUBLIC OF TURKEY 1992. Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun (Law on the Provision of Green Card that would Cover The Treatment Costs of Citizens Who do not Have the Ability to Pay).*3816*.

THE REPUBLIC OF TURKEY 1993. Sağlık Kanunu Tasarısı Taslağı (Draft Proposal of Health Law).

THE REPUBLIC OF TURKEY 2005. Bazı Kamu Kurum ve Kuruluşlarına Ait Sağlık Birimlerinin Sağlık Bakanlığına Devredilmesine Dair Kanun (Law on the Transfer of Health Institutions of Other Public Institutions to the Ministry of Health). *5283*.

THE REPUBLIC OF TURKEY 2006. Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu (Social Insurances and General Health Insurance Law). *5510*.

THE REPUBLIC OF TURKEY 2010. Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun (Law on Full Time Work for Medical Doctors). *5947*.

THE REPUBLIC OF TURKEY 2011a. Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Statutory Decree on the Organisation and Duties of the Ministry of Health and its Subsidiary Institutions). *KHK/663*.

THE REPUBLIC OF TURKEY 2011b. Adalet Bakanlığı'nın Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararnamenin Değiştirilerek Kabulü Hakkında Kanun ile Bazı Kanun ve Kanun Hükmünde Kararnamelerde Değişiklik Yapılmasına Dair Kanun Hükmünde Kararname (Statutory Decree on the Promulgation of the Law Changing the Organisation and Responsibilities of the Ministry of Justice and Statutory Decree Changing Other Statutory Decrees). *650*.

THE REPUBLIC OF TURKEY 2013. Sağlık Bakanlığınca Kamu Özel İş Birliği Modeli İle Tesis Yapıtırılması, Yenilenmesi ve Hizmet Alınması ile Bazı Kanun ve Kanun Hükmünde Kararnamelerde Değişiklik Yapılmasına Hakkında Kanun (Law on the Permittance of the Establishment and Renovation of Health Care Facilities with the Public-Private Partnership Model and Purchasing of Services for the Ministry of Health and on the Changes in Some Legislations and Decrees). *6428*.

THE REPUBLIC OF TURKEY 2014a. Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde

Kararname ile Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun (Statutory Decree on the Organisation and Responsibilities of the Ministry of Health and Affiliated Institutions and Law Changing Other Laws). *6514*.

THE REPUBLIC OF TURKEY 2014b. Tam gün yasası uygulaması (Implementation of full time law). *2014/8*.

THE REPUBLIC OF TURKEY. 1933. Hususi Hastaneler Kanunu (Private Hospitals Act). *2219*.

THE REPUBLIC OF TURKEY. 2003. T.C. 58. Hükümet Acil Eylem Planı (58th Government of Republic of Turkey Urgent Action Plan).

THE REPUBLIC OF TURKEY. 2003. *T.C. 58. Hükümet Acil Eylem Planı (58th Government of Republic of Turkey Urgent Action Plan)*. Ankara.

THE REPUBLIC OF TURKEY. 2005. Sağlık Hizmetleri Temel Kanununa Bir Ek Madde Eklenmesi Hakkında Kanun (Law on the Addition of a Clause to the Principal Law on Health Services). *5396*.

THE REPUBLIC OF TURKEY. 2011. Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Statutory Decree on the Organisation and Duties of the Ministry of Health and its Subsidiary Institutions). *KHK/663*.

THE REPUBLIC OF TURKEY. 2011. Sağlık Bakanlığı ve Bağlı Kuruluşlarının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Statutory Decree on the Organisation and Duties of the Ministry of Health and its Subsidiary Institutions). *KHK/663*.

THE REPUBLICAN PEOPLE'S PARTY OF TURKEY. 1973. *Ak Günlere: CHP 1973 Seçim Bildirgesi (To Bright Future: Election Declaration of the CHP in 1973)*. Ankara.

THE SOCIAL SECURITY INSTITUTION OF TURKEY 2012. Sosyal güvenliğe ilişkin temel parametreler (Basic parameters of social security). Ankara.

THE STATE PLANNING ORGANISATION OF TURKEY 1984. Five Year Development Plan for 1985-1989. Ankara.

THE STATE PLANNING ORGANISATION OF TURKEY 1989. Five Year Development Plan for 1990-1995. Ankara.

THE STATE PLANNING ORGANISATION OF TURKEY 1995. Five Year Development Plan for 1996-2000. Ankara.

THE STATE PLANNING ORGANISATION OF TURKEY 2000. Five Year Development Plan for 2001-2005. Ankara.

THELEN, K. 2004. *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States, and Japan*. Cambridge: Cambridge University Press.

TIP DÜNYASI 2003. TTB'nin 53. Büyük Kongresi'ne katılan Sağlık Bakanı Akdağ: "Hastanın cebinden elinizi çekin" (Minister of Health Akdağ participated in Turkish Medical Association's 53<sup>rd</sup> Congress: "Stay away from patients' pockets") . *Tıp Dünyası*, 108.

TOPRAK, Z. 1982. *Türkiye'de "Milli İktisat" 1908-1918 ("National Economy" in Turkey 1908-1918)*, Ankara, Yurt Yayınları.



TOUNTAS, Y., P.KARNAKI, PAVI, E. & SOULIOTIS, K. 2005. The "unexpected" growth of the private health sector in Greece. *Health Policy*, 74, pp.167-180.

TRUMAN, D. B. 1951. *The Governmental Process*, New York, Alfred A. Knopf.

TURKISH INDUSTRIALISTS' AND BUSINESSMEN'S ASSOCIATION (TUSIAD). 2005. *Charting the Way Forward: Health Care Reform in Turkey*, Istanbul, TUSIAD Publications.

TURKISH MEDICAL ASSOCIATION 2008. Sağlık Personelinin Tam Gün Çalışmasına ve Sağlıkla İlgili Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun Tasarısı Taslağı Hakkında Türk Tabipleri Birliği Görüşleri (Views of Turkish Medical Association on the Draft Law on Full Time Work for the Health Personnel and Changing Other Laws Related to Health). Ankara.

TURKISH MEDICAL ASSOCIATION, CONFEDERATION OF PROGRESSIVE TRADE UNIONS' OF TURKEY & UNION OF CHAMBERS OF TURKISH ENGINEERS AND ARCHITECTS (TMMOB) 2012. Bugün 69 KESK'li, sadece muhalif sendikacılık yaptıkları için cezaevlerinde! (69 members of KESK are imprisoned just because they were dissident unionists!).

TURKISH MEDICAL ASSOCIATION. 2011a. Sağlıklı Seçim, Seçimlerde Sağlık (Health Election, Health in Elections). *Ttb.org.tr*, 24.05.2011.

TURKISH MEDICAL ASSOCIATION. 2011b. AKP sağlık politikası: Yalanlar ve gerçekler (Health Policy of the AKP: Lies and Truths). *Bağımsız İletişim Ağı*, 25.05.2011.

TURKISH MEDICAL ASSOCIATION. 2011c. Sağlık Personelinin Tam Süre Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun Tasarısı Onerisi (Proposal for Draft Law on the Full Time Work for Medical Professionals and on Making Changes in Certain Laws). Türk Tabipleri Birliği Yayınları (Turkish Medical Association Publications).

TURKISH MEDICAL ASSOCIATION. 2012. Anayasa Mahkemesi (Bir Kez Daha) İptal Etti (The Constitutional Court Rescinded Once Again).

TURKISH MEDICAL ASSOCIATION. 2013. Anayasa Mahkemesi'nin 663 sayılı KHK'nin İptal Ettiği Maddeleri (Clauses that the Constitutional Court annulled in the Statutory Decree no. 663). 15.02.2013.

TURKISH MEDICAL ASSOCIATION. 2014. *Türk Tabipler Birliği: Nedir? Ne Yapar?* (Turkish Medical Association: What is it? What does it do?) [Online]. Available: <http://www.ttb.org.tr/index.php/bilgi.html> [Accessed 10.07 2014].

TURKISH STATISTICAL INSTITUTE 2014. Yaşam Memnuniyeti Araştırması 2013 (Life Satisfaction Study 2013). Ankara: Turkish Statistical Institute.

TURKISH STATISTICAL INSTITUTE Population Statistics.

TÜNAY, M. 1993. The Turkish New Right's Attempt at Hegemony. In: ERALP, A., TÜNAY, M. & YEŞİLADA, B. (eds.) *The Political and Socioeconomic Transformation of Turkey*. Westport, Connecticut and London: Praeger, pp.11-30.

UCKU, R. & ELÇİ, O. C. 2010. Turkey. In: JOHNSON, J. A. & STOSKOPF, C. H. (eds.) *Comparative Health Systems: Global*

*Perspectives*. Boston, Toronto, London and Singapore: Johns and Bartlett Publishers, pp.273-286.

ÜSTÜNDAĞ, N. & YOLTAR, Ç. 2007. Türkiye'de sağlık sisteminin dönüşümü: Bir devlet etnografisi (Transformation of Turkey's Health System: A State Ethnography). *In*: KEYDER, Ç., ÜSTÜNDAĞ, N., AĞARTAN, T. & YOLTAR, Ç. (eds.) *Avrupa'da ve Türkiye'de Sağlık Politikaları*. İstanbul: İletişim, pp.55-95.

VAN KERSBERGEN, K. 1995. *Social Capitalism: A Study of Christian Democracy and the Welfare State*. London and New York: Routledge.

VATAN 2012. 'İmzalamasaydık yarın 2 bin kişi ölürdü' ('2 thousand would die tomorrow unless we signed the agreement'). *Vatan*, 06.02.2012.

VROMEN, A. 2010. Debating methods: Rediscovering qualitative approaches. *In*: MARSH, D. & STOKER, G. (eds.) *Theory and Methods in Political Science*. Hampshire and New York: Palgrave Macmillan, pp.249-257.

WALL, A. 1996. *Health Care Systems in Liberal Democracies*. London and New York: Routledge.

WALT, G. & GILSON, L. 1994. Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, 9, pp.353-370.

WALT, G. 1994. *Health Policy: An Introduction to Process and Power*, Johannesburg: Witwatersrand University Press, London and New Jersey: Zed Books.

WALT, G. 1998. Globalisation of international health. *Lancet*, 351, pp.434-437.

WENDT, C., FRISINA, L. & ROTHGANG, H. 2009. Healthcare system types: A conceptual framework for comparison. *Social Policy & Administration*, 43, pp.70-90.

WESSEN, A. F. 1999. Structural Differences and Health Care Reform. *Health Care Systems in Transition: An International Perspective*. Thousand Oaks, London and New Delhi: Sage Publications.

WILENSKY, H. L. 1974. *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures*. California: University of California Press.

WILKINSON, R. & PICKETT, K. 2010. *The Spirit Level: Why Equality is Better for Everyone*, London, Penguin Books.

WOO, M. 2004. *The Politics of Social Welfare Policy in South Korea*.

WORLD BANK 1987. Financing Health Services in Developing Countries: An Agenda for Reform. Washington D.C.: The World Bank.

WORLD BANK 1993. World Development Report: Investing in Health. New York: World Bank.

WORLD BANK. 2003a. Turkey: Greater Prosperity with Social Justice. *Policy Notes*.

WORLD BANK. 2003b. Turkey Reforming the Health Sector for Improved Access and Efficiency. Human Development Sector Unit, Europe and Central Asia Region.

WORLD BANK. 2004. Project Appraisal Document on a Proposed Loan in the Amount of 49.40 Million Euro to the Republic of Turkey for a Health Transition Project in Support of the First Phase of the Program for Transformation in Health. Human Development Unit-Europe and Central Asia Region.

WORLD BANK. 2008. Country Partnership Strategy with the Republic of Turkey for the Period 2008-2011. Turkey Country Management Unit-Europe and Central Asia Region, International Finance Cooperation-Central and Eastern Europe Department, Multilateral Investment Guarantee Agency.

WORLD BANK. 2009. Project Appraisal Document on a Proposed Loan in the Amount of Euro 56.10 Million (US\$75.12 Million Equivalent) to the Republic of Turkey for a Health Transformation and Social Security Reform Project in Support of the Second Phase of the Health Transformation Program. Human Development Sector Unit, Turkey Country Unit, Europe and Central Asia Region.

WORLD BANK. 2010. Implementation Completion and Results Report on a Loan in the Amount of Euro 49.40 Million to the Republic of Turkey for a Health Transition Project. Human Development Unit-Turkey Country Unit.

WORLD BANK. 2010. Implementation Completion and Results Report on a Loan in the Amount of Euro 49.40 Million to the Republic of Turkey for a Health Transition Project Human Development Unit, Turkey Country Unit, Europe and Central Asia Region, the World Bank.

WORLD BANK. 2012. *World Bank-Turkey* [Online]. Available: <http://www.worldbank.org.tr> [Accessed 10.02 2012].

WORLD HEALTH ORGANIZATION 2000. Health Systems: Improving Performance. *The World Health Report*. Geneva: World Health Organization.

YALÇIN, Z. 2009. Bütün gürültü 1200 hoca için çıkarılıyor (All these mess is because of 1200 university professors). *Sabah*, 08.06.2009.

YALMAN, G. L. 2009. *Transition to Neoliberalism: The Case of Turkey in the 1980s*, Istanbul, Istanbul Bilgi University Press.

YANOW, D., SCHWARTZ-SHEA, P. & FREITAS, M. J. 2010. Case Study Research in Political Science. In: MILLS, A. J., EUREPOS, G. & WIEBE, E. (eds.) *Encyclopedia of Case Study Research*. California, London, New Delhi and Singapore: Sage Publications, pp.108-113.

YAŞAR, G. Y. & UĞURLUOĞLU, E. 2011. Can Turkey's general health insurance system achieve universal coverage? *International Journal of Health Planning and Management*, 26, pp.282-295.

YAŞAR, G. Y. 2011. Review: 'Health transformation programme' in Turkey: an assessment. *International Journal of Health Planning and Management*, 26, pp.110-133.

YELDAN, E. 2001. *Küreselleşme Sürecinde Türkiye Ekonomisi (Turkish Economy in the Process of Globalisation)*, İstanbul, İletişim.

YENİ ŞAFAK 2000. SSK'daki bağış soygununa son (Giving end to the 'donation' robbery in the Social Insurance Institution). *Yeni Şafak*, 02.10.2000.

YILMAZ, V. 2012. *Değerlendirme Notu: Türkiye’de Sosyal Güvenlik Harcamalarına Tarihsel Bir Bakış (Analysis Report: Historical Perspective towards Social Security Expenditures in Turkey)*, İstanbul: İstanbul Bilgi Üniversitesi Sivil Toplum Kuruluşları Eğitim ve Araştırma Birimi.

YILMAZ, V. 2013. Changing origins of inequalities in access to healthcare in Turkey: From occupational status to income? *New Perspectives on Turkey*, 48, pp.53-75.

## Appendix: List of Interviews

INTERVIEW NO.1 2011. Recorded face-to-to face indepth interview. *Civil servant-Green Card Office (05.08.2011)*. Samsun.

INTERVIEW NO.2 2011. Recorded focus group. *Pollsters worked for a nationwide survey on Green Card users (05.08.2011)*. Samsun.

INTERVIEW NO.3 2011. Recorded face-to-to face indepth interview. *Hospital manager of one branch of a nationwide private hospital chain (05.08.2011)*. Samsun.

INTERVIEW NO.4 2011. Recorded focus group. *Pollsters worked for a nationwide survey on Green Card users (09.08.2011)*. Adana.

INTERVIEW NO.5 2011. Recorded face-to-to face indepth interview. *Citizen whose application to Green Card was denied (09.08.2011)*. Adana.

INTERVIEW NO.6 2011. Recorded face-to-to face indepth interview. *Citizen whose application to Green Card was denied (09.08.2011)*. Adana.

INTERVIEW NO.7 2011. Recorded face-to-to face indepth interview. *Civil servant in Green Card Office (09.08.2011)*. Adana.

INTERVIEW NO.8 2011. Recorded face-to-to face indepth interview. *Hospital manager of one branch of a nationwide private hospital chain and a former member of healthcare reform team (09.08.2011)*. Adana.

INTERVIEW NO.9 2011. Unrecorded face-to-face indepth interview-  
personal interview notes available. *Specialist medical doctor and the head of Turkish Medical Association (13.08.2011)*. Ankara.



INTERVIEW NO.10 2011. Recorded face-to-to face indepth interview.  
*Hospital owner and the head of health sector union in the Union of Chamber and Commodity Exchanges in Turkey (13.08.2011).* Ankara.

INTERVIEW NO.11 2011. Unrecorded face-to-face indepth interview-  
personal interview notes available. *Ph.D. candidate specialised in Turkey's health sector affiliated with a public university in Berlin (20.09.2011).*  
Istanbul.

INTERVIEW NO.12 2011. Recorded face-to-to face indepth interview.  
*Specialist medical doctor, owner of a private clinic and the head of Association for Medical Doctors in the Private Sector (24.09.2011).*  
Istanbul.

INTERVIEW NO.13 2011. Recorded face-to-to face indepth interview.  
*Professor of public health in a public university (01.10.2011).* Ankara.

INTERVIEW NO.14 2011. Recorded face-to-to face indepth interview.  
*Specialist medical doctor and former head of Turkish Medical Association (05.10.2011).* Istanbul.

INTERVIEW NO.15 2011. Recorded face-to-to face indepth interview.  
*Specialist medical doctor and the head of Right to Health Movement Association (05.10.2011).* Istanbul.

INTERVIEW NO.16 2011. Recorded face-to-to face indepth interview.  
*Member of health staff in a public hospital and an active member of the Association for Human Health and Education (07.10.2011).* Istanbul.

INTERVIEW NO.17 2011. Recorded face-to-to face indepth interview.  
*Assistant specialist medical doctor and an active member of the Association for Human Health and Education (07.10.2011).* Istanbul.

INTERVIEW NO.18 2011. Recorded face-to-to face indepth interview.  
*Professor of public health in a public university and an active member of Izmir Medical Chamber (11.10.2011). Izmir.*

INTERVIEW NO.19 2011. Unrecorded face-to-face indepth interview-  
personal interview notes available. *Accountant in Turkey branch of an international private hospital chain (21.10.2011). Istanbul.*

INTERVIEW NO.20 2011. Recorded face-to-to face indepth interview.  
*Professor of medicine, president of a private medical university, a specialist medical doctor and a former member of healthcare reform team (26.10.2011). Istanbul.*

INTERVIEW NO.21 2011. Recorded face-to-to face indepth interview.  
*Senior economist in the World Bank and team leader in World Bank's health sector reform project in Turkey (01.11.2011). Ankara.*

INTERVIEW NO.22 2011. Recorded face-to-to face indepth interview.  
*Senior economist in the World Bank and former team leader in World Bank's health sector reform project in Turkey (01.11.2011). Ankara.*

INTERVIEW NO.23 2011. Recorded face-to-to face indepth interview.  
*Family physician and secretary general of Istanbul Family Physicians Association (04.11.2011). Istanbul.*

INTERVIEW NO.24 2011. Recorded face-to-to face indepth interview.  
*Specialist medical doctor and head of Private Hospitals and Health Institutions Association (04.11.2011). Istanbul.*

INTERVIEW NO.25 2011. Unrecorded indepth interview via  
teleconference-personal interview notes available. *Senior economist, head*

*of health sector in the World Bank headquarters, former team leader in World Bank's health sector reform project in Turkey (10.11.2011). via teleconference.*

INTERVIEW NO.26 2011. Unrecorded face-to-face indepth interview-personal interview notes available. Professor of medicine in a public university and head of Human Health and Education Foundation (18.11.2011): Istanbul.

INTERVIEW NO.27 2011. Recorded face-to-to face indepth interview. *Specialist medical doctor and owner of a private hospital (18.11.2011).* Istanbul.

INTERVIEW NO.28 2011. Unrecorded face-to-face indepth interview-personal interview notes available. *Specialist medical doctor and a member of executive board in Turkish Medical Association (20.11.2011).* Istanbul.

INTERVIEW NO.29 2011. Recorded face-to-to face indepth interview. *Medical doctor and the president of Health and Social Services Labourers Union (21.11.2011).* Ankara.

INTERVIEW NO.30 2011. Unrecorded face-to-face indepth interview-personal interview notes available. *Social security investigator and the head of Health Insurances Department at Social Security Institution (21.11.2011).* Ankara.

INTERVIEW NO.31. 2011. Recorded face-to-to face indepth interview. Specialist medical doctor and head of Revolutionary Health Workers Union (29.11.2011). Istanbul.

INTERVIEW NO.32 2011. Recorded face-to-to face indepth interview.

*General director of a public university hospital, former member of World Bank team in health sector reform project, former member of healthcare reform team (30.11.2011). Istanbul.*

INTERVIEW NO.33 2013. Unrecorded face-to-face indepth interview-personal interview notes available. *High level state official working for the Ministry of Finance (04.01.2013). Ankara.*

PUBLIC SPEECH NO.1 2011. Personal notes of the interviewee's public speech taken during the Supplementary Health Insurance Conference. *Turkey branch manager of an international private health insurance company (21.10.2011). Istanbul.*

PUBLIC SPEECH NO.2 2011. Personal notes of the interviewee's public speech taken during the Supplementary Health Insurance Conference. *President of the Association of the Insurance and Reinsurance Companies in Turkey (21.10.2011). Istanbul.*

PUBLIC SPEECH NO.3 2011. Recorded public speech in "Transformation of Turkey's Health Care System" Workshop organised by the author in Bogazici University. *Professor of sociology in a public university and expert on healthcare policy in Turkey (25.11.2011). Istanbul.*

PUBLIC SPEECH NO.4 2011. Recorded public speech in "Transformation of Turkey's Health Care System" Workshop organised by the author in Bogazici University. *World Bank expert on healthcare reform in Turkey (25.11.2011). Istanbul.*

PUBLIC SPEECH NO.5 2011. Recorded public speech in "Transformation of Turkey's Health Care System" Workshop organised by the author in Bogazici University. *Specialist medical doctor in a private hospital, former*

*head of curative healthcare services department at the Ministry of Health,  
former member of healthcare reform team (25.11.2011). Istanbul.*