TAKING THE RIGHT, SELLING IT IN THE MARKET

COMMODIFICATION AND COMMERCIALIZATION OF HEALTH CARE

IN TURKEY SINCE THE 1980s

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Hülya, Sedat ve Bedri'ye

CONTENTS

TABLES

ABBREVIATIONS

AKP: Justice and Development Party (*Adalet ve Kalkınma Partisi)*

ANAP: Motherland Party (*Anavatan Partisi)*

Bağ-Kur: The Social Insurance Institutions for the Craftsmen, Artisans and Other Self-Employed (*Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu)*

CHP: Republican People's Party (*Cumhuriyet Halk Partisi)*

DİSK: Trade Union Confederation of Revolutionary Workers (*Türkiye Devrimci İşçi Sendikaları Konfederasyonu)*

DPT: State Planning Organization (*Devlet Planlama Teşkilatı)*

ES: Public Servant's Retirement Fund (*Emekli Sandığı*)

FDI: Foreign Direct Investment

GATS: General Agreement on Trade in Services

GATT: General Agreement on Tariffs and Trade

GHI: General Health Insurance

IMF: International Monetary Fund

KESK: Trade Union Confederation of Public Workers (*Kamu Emekçileri Sendikaları Konfederasyonu)*

MOH: Ministry of Health

MOHSA: Ministry of Health and Social Assistance

NHS: National Health Service

NUC: National Union Committee

SHP: Social Democrat Populist Party (*Sosyal Demokrat Halkçı Parti)*

SGK: Social Security Institution (*Sosyal Güvenlik Kurumu)*

SSK: Social Insurance Institution *(Sosyal Sigortalar Kurumu)*

SIGHI: Social Insurance and General Health Insurance

TMMOB: Union of Turkish Engineers and Architects Associations (*Türk Mühendis ve Mimar Odaları Birliği)*

TMA: Turkish Medical Association

WB: World Bank

WTO: World Trade Organization

CHAPTER I

INTRODUCTION

This thesis aims to show the shift in the understanding of health care and provision of healthcare services since the 1980s in order to signify the commodification, commercialization and recently the privatization of health care services in Turkey. In the 1960s, the state was declared as a "social state" and health care was assumed as a right that should be provided by the state. As opposed to this characteristic, in the 1980s the state has started to withdraw from its role of provider in the area of health care. With the withdrawal of state, the right to health care has started to be converted into an ordinary commodity in the market. The beginning of this commodification process coincided with the commercialization of the healthcare services in 1987. By commercialization of health care, I refer to the autonomization of healthcare enterprises and establishment of revolving funds, monthly premiums and contribution payments as sources of health care financing with the Basic Law on Healthcare services in 1987. The commodification process has shifted into a new phase with the privatization of healthcare services in the last few years via the new laws on both health care and investment policies. In this period the ownership of the healthcare facilities changed hands from public to private sector as both the domestic and the foreign investors are encouraged by the profitable health care market.

Moreover, with the new law on general health insurance, though the whole population is claimed to be included into the public health insurance scheme, they are also forced to join the health care market in which they should pay the necessary premiums and contribution payments to access the services. Last but not least, further withdrawal of the state by supporting the private sector to invest in order to decrease the public investment in this sector and even paving the way for the privatization of public healthcare facilities through the new laws reflect the further neoliberalization in the area of health care.

Thus, this story tells the transformation of a right being provided and financed by the state to a commodity being sold and bought in the market. Recently, the developments in health care have been a crucial subject of debate due to the transformation of health program in the Justice and Development Party (*Adalet ve Kalkınma Partisi* – AKP) period. There are also other theses written on different sides of the developments in the health care, such as the Green Card, gender perspective in the Social Insurance and General Health Insurance (SIGHI) law and the socialization of healthcare services.[1] Yet, this thesis offers another perspective on the developments of health care in Turkey, claiming that the commodification of the services initiated by the commercialization process in the 1980s has passed onto the privatization phase in the 2000s. The shift in the 1980s was crucial, as the public healthcare facilities turned into business enterprises, thus initiating the period in which health care have started to be accepted as a good to be commercialized in the market. Yet,

[1] For more information see, Çağrı Yoltar, The Green Card Scheme: An Ethnography of 'the State' and Its 'Poor Citizens' in Adıyaman (master's thesis, Boğaziçi University, 2007), Azer Kılıç, Gender and Social Policy in Turkey: Positive Discrimination or a Second Class Female Citizenship? (master's thesis, Boğaziçi University, 2006), and Asena Günal, Health and Citizenship in Republican Turkey: An Analysis of Socialization of Health Services in Republican Historical Context (Ph.d diss., Boğaziçi University, 2008)

the transformation in the 2000s displays another feature other than reinforcement of the commodity status of health care. With the policies on investment and privatization, the state withdraws from the scene and leaves the provision of the healthcare services to the private sector, while the laws pave the way to privatize public healthcare facilities. As mentioned before, the financing of the general health insurance is designed through the collection of monthly premiums and the citizens would also contribute to the health care expenditures through contribution payments and board and room charges. Thus, with the recent legislation the state resigns from both of its functions, financing and provision.

Today, with the articles in the new law the state has legitimized the provision of healthcare services in return of the premium and contribution payments. Moreover, although the children below the age of 18 has gained the right of free general health insurance they will lose it at the age of 18 -or 25 if they will continue their university education. So they are forced to work and earn the money necessary for the general health insurance payment, which was not valid for the girls in the previous law. The women are forced to participate in the job market or marry in order to have a public health insurance losing their chance to benefit lifelong from their parent's insurance. As a woman above 25 years old, I am also concerned with the fortified right of mine, since in a situation of losing my job; I will be deprived of my own health insurance and will not have the chance to benefit from my father's health insurance anymore. Moreover, as a public employee who has been appointed before the coming into force of the SIGHI law, I do not pay the public health insurance premiums now. Yet if I lose my job and will return to the job market again as a public servant, I will have to

pay a definite percentage of the general health insurance premium in addition to the contribution payments to access healthcare services.

Such an exclusionary attitude towards the people outside the job market as in the former case and commodifying the status of health care gradually to the whole population through premiums, contribution payments and leaving the role of provision step by step to the private sector does not fit to the characteristic of being a social state. The Green Card application, which provided certain healthcare services to the population who were not covered by any public insurance scheme through employment have also been transformed by the SIGHI law. Now, if the people do not meet the necessary qualifications to get a green card, he/she is forced to join the health insurance scheme through paying the premiums and contribution payments.

Thus, contrary to the government's claim of universalization of health care, the state universalizes the health insurance for the people who are able to pay those premiums and contribution payments. In other words, the SIGHI law does not guarantee health insurance on the basis of citizenship; even the payment of the monthly premiums does not secure one's right to health care. In addition to the premiums, the patient should pay the contribution payments at the time of getting the services. So the ones who are not qualified to get a green card will be either excluded from the healthcare services, or forced to join the health care market in which they will be responsible to meet the above-mentioned payments. Thus, the state's further withdrawal from the health care provision can be observed in the Green Card case, as in the former practice the cardholders were not responsible to pay the contribution payments while they are to do so. And as mentioned before, the ones who will not meet the qualifications to get a green

card will be forced to join the general health insurance scheme through paying their premiums while they were not responsible to pay premiums in the previous system.

It is necessary to admit that the pre 2000 health care system is not praised here, while the poor, except the cardholders, were deprived of the health insurance. Yet, the point is to emphasize the fact that in the new system, there are others ways of exclusion through the premiums and contribution payments, as health care is universalized only to those who are able to pay these prices. Thus, as opposed to the citizenship based understanding of the 1960s, in the 2000s, the state assumed the qualified members to right to health care as either the ones who have the means to meet the charges or the ones who are able to prove their destitute.

In order to show the transformation of the role and approach of the state and the processes of the commodification of the healthcare services, I will analyze the legal developments, political debates and the role of international organizations since the 1980s. In terms of legal developments I choose the main transformation points in the health care policy arena as: (1) the 1961 Law on the Socialization of Healthcare services, in order to provide a comparative perspective between the pre 1980 and post 1980 period, (2) 1987 the Basic Law on Healthcare Services, as it gave the start to the commodification of health care with the commercialization phase, (3) 1992 Green Card Law as a reverse process in the commodification of healthcare services and (4) 2006 Social Insurance and General Health Insurance Law as the last step of commodification with the passage to privatization phase in the 2000s. In order to see the political debate both within and outside the parliament I reviewed the parliamentary minutes and

newspapers dated during the preparation and enactment of the above-mentioned laws. Last, I looked at the agreements with and reports of the international organizations especially of the World Bank and International Monetary Fund in order to assess their impact and the emphasis of their advises in the healthcare sector.

Moreover, I analyzed the direct and indirect policy developments in the economic policies of particular eras in which concerned laws on health care were enacted. These policies mainly consist of the laws concerning the access of the formal employees to healthcare services and the investment policies on this sector. I spent great amount of time and effort to reach the statistics on health care that would support my arguments in this thesis. I mainly made use of the works done by State Planning Organization, Ministry of Health, Turkish Statistical Institute and Turkish Medical Association. Yet, it is necessary to admit the fact that, the effort spent during the search for the statistics was the most exhausting part of the work as it was not possible to reach a comprehensive data on this issue. Most of the statistical data were collected for only a specific and short time period, which prevented me to make general projections on the time period I examined for these subjects. Moreover, the slowness of Turkish Institute of Health on preparing and publishing the 2008 statistical yearbook on healthcare institutions impeded my efforts to add that year's data in the research.

In my thesis in order to tell the story of commodification of health care in a process from commercialization to privatization and exclusion of more and more people from the healthcare services as the payment for those services is legitimized and settled for good with these processes, I will focus on the above mentioned transformation points in health care. In each chapter these

transformation points will be analyzed in a chronological order through the references to legal documents, political debates and the influence of international organizations. However, before going into the chronological narrative in the area of health care, in the next chapter I will briefly touch on the characteristics of different welfare state regimes and health care system typologies. Moreover, I will also define the major characteristics of the welfare and health care regime of Turkey in order to give an assessment on the placement of Turkey among those welfare and health care typologies and to show the shift in the health care system in Turkey.

In the third chapter, the focus point will be on the socialization of healthcare services in the 1960s which aimed at the integration of all healthcare facilities under the Ministry of Health and Social Assistance (MOHSA) and provision of health care to the population as a duty of social state and as a right based on citizenship. This chapter is designed to offer the reader the chance to compare the understanding of the status of health care and the role of the state in the provision of these services in the pre 1980 period as the 1980s marks a crucial shift in these terms.

In the fourth chapter, the focal point will be the 1987 basic law on health care services and the transformation of the role of the state in health care provision in Turkey. The transformation of public healthcare institutions to autonomous bodies and establishment of revolving funds as an essential source of revenue for these bodies form the main pillars of the transformation, which started the commodification of health care in Turkey.

In the fifth chapter, I will focus on a subject, which reflects a reverse process in my narrative of commodification of healthcare services in Turkey since the 1980s. This development is named as the Green Card Law, enacted in 1992 and aimed to provide free healthcare services to a specific group of people due to their neediness. Yet this development remained as an insufficient attempt concerning its limited coverage of services and the number of people who had the opportunity to benefit from the law.

In the sixth chapter, I will evaluate the transformation of health care program designed in the AKP period. I will focus on the developments of general health insurance, family medicine, devolution of Social Insurance Institution's hospitals to the Ministry of Health (MOH) and public private partnerships in health care. This period marks the two tendencies at work together as the whole population is aimed to be included into the general health insurance scheme while the people who were previously exempt from health care premiums and contribution payments (public servants and green card holders) are forced to pay those items. Thus universalization of public health insurance goes hand in hand with the commodification of health care for a larger segment of the population. Moreover, this era displays the drastic involvement of private initiative and especially the foreign capital into the health care sector of Turkey especially in the form of private hospitals.

Last, in the seventh chapter, I will conclude my thesis with a brief summary of the arguments made in the thesis and projections on further developments. Here I will also point some issues in the health care policy of Turkey, which should be covered in other theses in order to grasp other aspects of the course of developments in this arena since the 1960s.

CHAPTER II

WELFARE AND HEALTH CARE TYPOLOGIES

In the first chapter I would like to give a brief introduction on the different types of welfare and health care regimes and define the place of Turkey in those typologies. Though it is not feasible to find an exact match of the Turkish welfare and health care regimes in the ideal forms defined by theorists, it is possible to determine where Turkey fits with its historical formation of welfare provision and which characteristics are entrenched in today's regime. It is undoubtedly true that through welfare provisions, the state determines a certain type of relationship between itself and the citizens and between citizens who have different statuses in the society.

Bauman emphasizes the importance of the cultivation of social integration and sense of community through welfare provisions, although he stresses the significance of universalist and inclusionary approaches in fulfilling those aims. Otherwise, the result would be the opposite: the division of the population according to income and an exclusionary approach toward the lower classes.[2] Thus, the social rights provided such as health care and education are of the utmost importance in creating social cohesion. Through these rights, citizens secure their future regardless of their class and/or status in society and have the chance to participate in society having been stripped of their worries about their

[2] Zygmunt Bauman, *Work, Consumerism and the New Poor* (Buckingham; Philadelphia: Open University Press, 1998), p. 50

health, education, etc. In order to assess the position of Turkey in the provision of social rights, it is crucial to understand the characteristics of its welfare regime. In order to fulfill this aim, I will begin this chapter with a brief introduction on welfare and health care typologies, and then explain Turkey's welfare regime and health care system and its transition over the last three decades.

According to T. H. Marshall, citizenship is a status given to the full members of a community who are equal in terms of rights and duties. Social class is also prevalent in a society, yet unlike the notion of citizenship, it is based on the idea of inequality. Thus, citizenship and social class are at work in opposite directions in defining the place of an individual in a society.[3] Through citizenship, there is a set of rights bestowed to the people, which would make them equal regardless of their social class. Marshall divides these rights into three groups, namely civil, political and social rights. Civil rights refer to the group of rights related to individual freedom (i.e. freedom of speech, thought and faith), political rights refer to the rights to participate in the political processes both to elect and be elected, and social rights refer to a wide range of rights which cover economic welfare and security, and to live a decent life appropriate to the standards of the society.[4]

In order to concentrate on the subject matter of this thesis, I will continue with the definition of social rights. Marshall states that there are four elements which determine the provision of equality in social rights. They are: (1) whether

[3] T.H. Marshall, *Class, Citizenship, and Social Development: Essays* (New York: Anchor Books, 1965), p. 92

[4] Ibid., p. 78

some or all of the classes are granted the benefits, (2) whether those benefits are delivered though cash or services, (3) whether the minimum package of benefits is low or high and (4) how the money to finance these benefits is collected. He claims that if these benefits are provided in the form of services as in the case of health care, the quality and the coverage of the services are of crucial importance. If the benefits cover a very limited amount of services which are of poor quality, the equalization effect of the services would be very low, since the rich would choose to buy those services from the private sector, leaving the pubic services only to the poor. [5]

Marshall also points to the adverse effects of the "means testing mechanisms" used in granting social rights. Though it might be a mistake to call them rights, as they are not given on the basis of citizenship, these so-called rights involve the benefits that are offered only to the people who need them. Thus, while equalizing the economic situation of needy people they simultaneously strengthen the differences between classes. Means testing mechanisms not only mark the hierarchy between classes (those who are desperate to be backed by the state and those who are able to buy their services), they also cause discrimination by reinforcing stigma attached to the poor.[6] Zygmunt Bauman also indicates problems of discrimination and stigmatization effects created by the means testing mechanisms. He argues that the services, which are established to create equality and solidarity among the different classes of the society, may cause a greater discrimination against the poor. The better off would feel services established for the benefit of the poor as a burden on their

[5] Ibid., pp. 111-114

[6] Ibid., pp. 111-112

shoulders as the finance of those services would be a source of complain among the upper classes.[7]

As right to health care can be grouped under the category of social rights delivered through services, in order to scrutinize the equalization effect of a health care system in a country, it is necessary to observe the above-mentioned characteristics in the system. Before passing into detail in the following sections, briefly stating, the health care system in Turkey since the 1980s and up until the passage of SIGHI law, gave access only to the people with formal employment. Yet, this formal employment requirement did not guarantee equal package of services to the members of different employment schemes. In addition, a definite group of needy people was given free health insurance through a means testing mechanism, which covered a limited level of services. The people who did not have public health insurance neither though employment nor through means testing mechanism would have the opportunity only to apply to the aid funds on health care established by the state, in order to get financial assistance in their medical payments. The system was financed mainly through the premiums paid by employers and employees with a small amount transferred from the state budget.

After the SIGHI law, mainly two things have changed compared with the former system. On the positive side, the people are given the opportunity to join the public health insurance scheme through paying their premiums though they are not formally employed. On the negative side, the people will be forced to register the public health insurance scheme if they were not qualified for the free health insurance scheme after the means testing procedure. Only after registering

[7] Bauman, p. 50

to the general health insurance scheme and paying the premium they are responsible for, these people will get the chance to apply to the aid fund if they need any financial help.

Both the systems established in the 1980s and 2000s do not guarantee access to healthcare services to all citizens. Since Marshall defines citizen as the full members of a community and recognizes health care as a social right that should be provided on the basis of citizenship in order to equalize the different statuses among social classes, it is certain that, the health care system in Turkey do not have any equalizing effect as it serves only to the ones who are able to pay premiums or who are defined as the needy people with the set means testing procedures. The full member of the community who deserves the access to health care is the one who regularly pays his/her premiums.

In order to understand further the relation between the social classes and between the social classes and the state, it is not sufficient to discuss equalization effects and means testing mechanisms in general. It is necessary to evaluate the place of social rights in the contemporary welfare states through a comparative analysis. After placing Turkey's welfare regime type through such an analysis, it will be possible to see the degree of equality and solidarity reached among classes.

Types of Welfare Regimes

One of the most prominent researchers of the welfare states is Gøsta Esping-Andersen who argues that welfare state means a new political commitment, a new social contract between state and the citizens, in which the state recognizes the social rights of its citizens. With this new contract, the position of the citizen as opposed to the rest of the population is defined by way of control mechanisms of the social risks of the welfare state. The state may either undertake the role of protecting the poorest segments as in the residual or minimalist understandings or have a comprehensive or institutional role. Thus, the welfare benefits can be a source of despise while the poor become the helpless class in need of the state's care as in the residual welfare state, or the social services can be seen as a right of citizens while everyone has access to them as in the comprehensive systems.[8]

In this light, Esping-Andersen divides the welfare states into three, namely, Nordic, Continental European and liberal welfare states since in those three understandings the place of the citizen varies in terms of social policy access. While in Nordic countries social services are based on universal citizenship regardless of class or need-based status,[9] the continental European countries give emphasis to traditional ties like family, yet they have an understanding of responsible government which gives benefits on a corporatist

8 Esping-Andersen, Gøsta. "Toplumsal Riskler ve Refah Devletleri." In *Sosyal Politika Yazıları*, edited by Ayşe Buğra, Çağlar Keyder (İstanbul: İletişim Yayınları, 2006), p. 35

9 Gøsta Esping-Andersen, Duncan Gallie, Anton Hemerijick, John Myles, et al., *Why we need a New Welfare State* (Oxford: Oxford University Press, 2003), p. 13

base.[10] Last, the liberal welfare state takes the market as the most important pillar, in which welfare benefits largely rests on private sector and only the ones who are below a certain level of means or income are entitled to public welfare benefits.[11]

Esping-Andersen emphasizes two dimensions in classifying types of welfare states. These two dimensions are decommodification and stratification. The emphasis of decommidification is brought about by the opposite of the term which is salient in the capitalist economy, commodification. Commodification refers to the transformation of the labor power into a commodity in the market. However, as the people are turned into a commodity, it became impossible for a worker to leave the market, in order to survive.[12] Thus, decommodification means that certain services (i.e. unemployment benefits, health insurance, etc.) are considered to be rights, so that a person can live without worrying about the future: so that his/her welfare is not tied to market conditions.[13] Yet, Esping Andersen warns that decommodification does not entail the overall abolition of the commodity status of the worker. Rather, it implies the opportunity for individuals to have a socially acceptable standard of living without participating in the market.[14]

10 Ibid., pp. 16-27

11 Ibid., pp. 15, 48

12 Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Cambridge: Polity Press, 1990), pp. 35-37

13 Ibid., pp. 21-22

14 Ibid., pp. 37

Stratification refers to the process in which the state transforms pre-existing class loyalties into new ones through welfare state policies. It is used as a means for the legacy of regime institutionalization while the state manipulates the positions of certain groups and gives them rights in return for the loyalty to the state. Major examples of this are Bismarckian Germany and Von Taaffe's Austria, where the employment-based social insurance system was used to attach workers to the state and as a prevention mechanism against the prevalence of socialist ideas among the working class.[15]

When the characteristics of the ideal types of welfare state regimes are analyzed, it is seen that decommodification is high in Nordic states, moderate in continental European and low in the liberal welfare states. In terms of stratification, welfare states aim to provide solidarity and alleviate inequality among the population. However, while they act according to these aims, they also create new stratifications among the established classes. For example, the universalist approach in the Nordic welfare states may provide equality throughout the whole population while means-based tests and corporatist social insurance models create new types of inequalities or reproduce the existing ones. The corporatist social insurance model, which is a tool of Continental European welfare states, divides the society along occupational lines, putting an obstacle on equality and solidarity among the people who are members of different classes or status groups. The means testing model divides society into two parts, namely, those who are able to pay for services and those who are unable to do so. Individuals deprived of any resources to pay for services would be backed by the state in the liberal welfare states, though this also serves as a mechanism to

[15] Ibid., p. 40

exclude and stigmatize the poor. Thus liberal welfare states provide neither equality nor solidarity among the classes: on the contrary, they reinforce differences making them visible and legal.[16]

In terms of defining the dimensions of decommodification and stratification in Turkey, it is necessary to underline the fact that, the welfare benefits have been provided through public insurance systems, which cover the people with formal employment and the level of those benefits varies across the employment statuses. As the people need the be formally employed to have public insurance, they need to join the job market, and as the level of return differs according to their employment status, there is a high level of stratification among the society. Moreover, in terms of health care, the green card,which secure the access of the poor to the healthcare services is another source of stratification, as it created stigma against the poor.

Though Esping Andersen's typology forms the basis of comparative welfare state literature, it has also faced much criticism mainly due its evaluation of Mediterranean countries as a subgroup of the continental European ones.[17] Esping-Andersen defines Southern European countries as economies in transition, which would eventually become continental European welfare regimes. Yet, the critics of Esping-Andersen's typology, fiercely state that Southern European countries (i.e. Spain, Italy, Portugal and Greece) represent a totally different form of welfare state regime due to their particular economic organization as well as the decommodification and stratification levels provided

[16] Ibid., pp. 23-25

[17] Wil Arts and John Gelissen, "Three Worlds of Welfare Capitalism or More? A State-of-the-art Report", *Journal of European Social Policy*, 12, no.2 (2002), p. 142

by their welfare policies. According to Ferrera one of the main difference between the Southern European countries and the Continental ones was the employment structure in the 1940s and 1950s and its transformation to Fordist structure in the following decades. He points out to the fact that prior to the transformation to Fordism, the economy was defined by agriculture and self-employment with a large informal sector, while the complex Fordist arrangements created cleavages both within and outside of the formal economy in the Southern European states. Though occupation-based entitlements in social insurance schemes resemble the Continental European tradition of corporatist social insurance model, the marginalized groups of the population such as the workers who could not enter into a formal contract in terms of employment status were deprived of those formal insurance benefits.[18]

Apart from the large informal economy, two other characteristics also determines Southern European welfare state as a distinct group. These two characteristics are the strong role of the family and the weakness of the state apparatus. In the Southern European countries, the family acts as one of the major safety nets in absorbing the social consequences of financial breakdowns. The simultaneous presence of strong familialism and a large informal economy reduced the need of people to rely on state action as those two mechanisms provided a substantial level of sustenance to the population.[19]

In the section on the welfare and health care systems of Turkey, the welfare regime of Turkey will be discussed further, but as a brief introduction it

[18] Maurizio Ferrera, *Welfare State Reform in Southern Europe: Fighting Poverty and Social Exclusion in Italy, Spain, Portugal and Greece* (London; NewYork: Routledge, 2005), p. 5

[19] Ibid., pp: 8-9

could be said that, it resembles to both the Continental European and the Southern European welfare regimes due to employment based benefits, and high level of familialism and informal employment, respectively. Yet, as the welfare regime type does not necessarily reflect the health care regime of a country, it is required to evaluate the characteristics of different health care regimes, which is the subject discussed in the following section.

Types of Health Care Systems

As mentioned in the previous chapter, health care system of a country does not necessarily show similarity with the type of its welfare state regime. On the one hand, some countries with different types of welfare regimes may end up with the same health care system. For example, both a residual welfare state England and a Southern European welfare state Spain may have both national health services financed through taxes and offer healthcare services on universal citizenship based. On the other hand, some countries may have different health care systems though showing the same characteristics in terms of welfare provision. For example though the United States, Canada and England all have the same type of welfare state regime, known as the, Anglo Saxon, residual model, they all offer different types of healthcare services to their citizens. In the US, health care is provided only to the poor and the elderly by the state, through Medicaid and Medicare programs while the rest of the population is responsible to pay for their services or have private insurance. However, in the UK and Canada, national health services are in place, which serve the whole population

through different administrative mechanisms.[20] Thus, we see that it is possible even with a residualist welfare understanding, for the state to provide its citizens with universal health care, if the health care is considered to be a citizenship right.

The difference between the two Anglo-Saxon countries, the US and the UK becomes much more apparent by referring to the health services continuum created by Odin Anderson, which is based on the degree of centralization in decision making, especially on the issue of funding for health care. On this continuum the health services of these two countries are placed on the two extremes as "market maximized" and "market minimized" respectively.[21]

Apart from Odin's continuum, healthcare services are mainly divided into three categories: the National Health Service model (Beveridge Type), the social insurance model (Bismarckian Type) and the private insurance model. As mentioned above, the National Health Service model is the one, which minimizes the effects of the market on health care. In this system, health care services are financed though taxes and those services are offered to every citizen regardless of their employment status. In the social insurance or Bismarckian model of health care, the services are financed through the premiums paid by employees and employers, and the right to health care is granted only to employed people. While in those two health care systems we see the positive role of the state, either as the regulator or provider of healthcare services, in the private insurance

[20] Laurene A. Graig, *Health of Nations: An International Perspective on U.S. Health Care Reform* (Washington, D.C.: Congressional Quarterly, 1993), pp. 4-7

[21] Ibid., pp. 4-5

model the individual is left alone with market forces as the state is withdrawn from the scene.[22]

In terms of Turkey, while the welfare benefits are tied to employment status, the healthcare system had followed a dual path with having Beveridge and Bismarckian type simultaneously for decades. Although, British National Health Service (NHS) was followed and national health service practice was tried to be established in the country through the socialization law in the 1960s, the social insurance system could not be removed and it caused delays and problems in the implementation of the national health service practice. At the end of the day, Beveridge type health care system ended up as a failure in Turkey as health care has never accepted as a citizenship right, while the insurance system declared its victory especially in the 2000s, as the new legislation terminated the socialization law in practice despite the fact that is still in force on paper.

Developments in Welfare and Health Care Policies since the 1980s

The 1980s marks the neoliberal transformation around the world especially with the Margaret Thatcher in England, Ronald Reagan in the US and Turgut Özal in Turkey as the symbols of this transformation. The main idea backed by the neoliberal wave is that, due to the inefficiency of state, the market not the state should deal with the problems of economic development such as industrial growth and employment creation. Another neoliberal assumption is that, not the

[22] Ibid., p. 3

lack of infrastructure, machine and money, but the wrong type of state interventions and economic incentives, corruption and inefficiency are responsible for the underdevelopment of the poor countries. Moreover, neoliberals claim that the development plans should be based on not the domestic consumption but the international trade and finance. As the market starts to bear utmost importance in the eyes of the neoliberal, the state's role diminishes to only providing defense against external aggression, mediating the relations between the social classes within the country and forming the necessary infrastructure, in order to secure the steady functioning of the market. These ideas were imposed to the countries which, had balance of payment problems (as Turkey in especially in the 1980s) through the stabilization and structural adjustment agreements by the International Monetary Fund (IMF) and the World Bank (WB). However it should be noted that, those solutions could not prove to be the cure for the problems of some countries as they faced with severe financial crisis such as Mexico 1994-1995, East Asia 1996-1998, Russia 1998, Brazil 1999, Turkey and Argentina 2001.[23]

As the flow of information, people, goods and services accelerated with globalization, especially since the 1990s the dissemination of the neoliberal ideals further accelerated. Here the meaning of the term "globalization" should be elaborated in order to assess their effects on social policy (and health policy in particular). Globalization is a process gained pace with the Uruguay round of the General Agreement on Tariffs and Trade (GATT) and it refers to the increased attachment to liberalization and further openness of the international markets for

[23] Alfredo Saad-Filho and Deborah Johnston, *Neoliberalism: A Critical Reader*, (London; MI: Pluto Press, 2005), pp. 113-116

goods and capital. As stressed by Gooby a direct effect of the globalization process is the loss of sovereignty of the governments in domestic issues either due to the increased competition over various kinds of industry or the power of international speculation over the national currency due to the openness of the capital markets.[24] The Uruguay Round has another significance for the social services. As a result of the talks and negotiations there, the General agreement on Trade in Services (GATS) came into force in January 1995. The GATS underlines the necessity of the states to open their national service markets (i.e. health care, education, retail trade) to the foreign providers while limiting the public regulation of their activity. So, GATS become another determinant in the international arena in terms of health care. It is necessary to underline the fact that Turkey has been one of the countries that made specific commitments on health care in terms of hospital services.[25]

With the globalization and opening up the national economies and setting necessary measures to ease free trade, resulted in the increased competition around the world. Increased competition throughout the world fuels the need to restructure the welfare states in order to meet the new demands of the market economy. Bauman emphasizes the fact that, though the contraction of the welfare provisions since the 1980s have been attributed to the neoliberalisation, the thing that should be searched for is the driving force behind this neoliberalisation process. He admits that states do not decide to carry our neoliberal policies at

[24] Stefan Svallfors and Peter Taylor-Gooby, *The End of the Welfare State? : Responses to State Retrenchment*, (London; New York: Routledge, 1999), p. 3

[25] Rudolf Adlung and Antonia Carzaniga, "Health Services under the General Agreement on Trade in Services," *Bulletin of the World Health Organization,* 79, no.4 (2001), pp. 352-357

night so the political and economic reasons behind these developments should be analyzed carefully.[26]

As the markets are connected more than ever since the 1980s, the possibility to carry out policies based on merely national dynamics has ceased to exist. Contrary to the post war economic boom period, the openness of the markets necessitates national governments to help its industries to compete in the market through decreasing their costs through a decline in their share for social insurance payments or taxes collected for that aim.[27] Thus, as the state diminishes its revenues for social services, it starts to transfer its role to the private agencies in order to diminish the load on the budget, which would create various problems in the financial arena. Paul Starr defines this shift of activities, production and services from the state to the private sector started to be referred as "privatization" in the 1980s. He identifies privatization as the cutbacks in the regulatory and spending actions of the state in general. However, he states that in particular sectors privatization may indicate different processes. For example in health care, privatization may refer to the transfer of services from public to private bodies while privatization of consumption of health care designates the replacement of public health care expenditures with expenditures on individual medical care.[28] Starr points out the difference between privatization and commercialization, while in the former we see the shift of ownership from public to private, in the latter a state owned enterprise is turned into an autonomous body, which is competitive in the market. The commercialization process is

[26] Bauman, p. 51

[27] Svallfors and Taylor-Gooby, p. 2

[28] Starr, Paul. "The Meaning of Privatization." In *Privatization and the Welfare State* edited by Sheila B. Kamerman, Alfred J. Kahn (Princeton: Princeton University Press, 1989), pp. 21-23

generally accepted as an initial stage that would be followed by privatization.[29] The commercialization process and its relation to privatization are highly crucial for the Turkish health care system, due to the transformation of state hospitals in the last three decades in the country.

Although the birth of neoliberal ideas dates back to the 1980s, privatization of the health care sector mainly gained pace in the 1990s, due to the accelerated speed of globalization, the internationalization of markets and the decreased autonomy of the nation-states. Price, Pollock and Shaoul emphasize the fact that, on the debates concerning the so called modernization and privatization of the healthcare services, international organizations are backed by the US and the European Union governments for the benefit of their business corporations in pharmaceutical, insurance and service sectors. As the U.S market was saturated by the end of 1990s, US corporations needed other areas to sell their goods and services and their European counterparts wanted to earn their share from the foreign markets. That has been the major reason behind the demand to privatize and liberalize the health care market in the member states of the World Trade Organization (WTO), since there is a huge financial resource in the social security or tax pools of those states.[30] Pollock argues that British NHS was the first health care system in Europe that the market forces managed to penetrate in the mid 1980s and this process spread throughout Europe in the

[29] Starr, p. 22

[30] David Price, Allyson M. Pollock and Jean Shaoul, "How the World Trade Organization is Shaping Domestic Policies in Health Care," *The Lancet*, 354, no.9193 (1999), pp. 1889-1892

1990s until 2003 all European countries experienced such a market-driven reform in this sector.[31]

This situation also clarifies the arguments backing the separation of the financing and provision of healthcare services. One of the first things that the WB criticizes in the health sector reports of Turkey was the fact that, the MOH and the Social Insurance Institution (*Sosyal Sigortalar Kurumu* – SSK) fulfilled the actions of financing and providing the healthcare services. According to the WB the coexistence of these functions under the authority of one institution caused inefficiency and waste of resources. Thus the necessity to separate the financing role from the providers of health care was underlined through the establishment of an autonomous body of Health Fund. This body would be responsible for collecting premiums and buying the services in the name of the insured from the hospitals, which tried to sell their services in the competitive health care market.[32] Mostly, the main return from such a strategy would be the establishment of an easier access for the private sector to the social security funds through selling their services in a price which would be determined in the market through the supply and demand mechanism. According to Paton the split between the purchaser and the provider of healthcare services has been the most dispersed managerial ideal in the world especially in developing regions.

[31] Allyson M. Pollock, *NHS plc: The Privatization of Our Health Care* (London; New York: Verso, 2005) pp. 17-18.

[32] World Bank, *Turkey: Reforming the Health Sector for Improved Access and Efficiency*, vol. 1, (World Bank: Human Development Sector Unit Europe and Central Asia Region, 2003), pp. 23-24,57

However, contrary to expectations, it could not decrease the cost of healthcare services since the managerial costs have increased through such a system.[33]

As it is clear from the arguments above, international organizations have been acting as a major player in the field of social policy and heath care policy in particular especially since the 1980s. With the effects of increased globalization, states have started to open up the social services to the international markets. And in this way, not only the decision making process but also the provision and regulation of healthcare services has become globalized while states lose their autonomy over the issue.

Although there is a high pressure coming from international organizations and multinational corporations to open the markets in the field of medicine, the effects of globalization on health care and the direction of the policies should not be imagined as a single-track road on the way of privatization and exclusion of certain groups of people. According to Laurene Graig, as the states have more and more interaction with each other, they will come up with modeling others in order to solve the problems within their individual health care systems. Yet, Graig warns us on the limits to convergence that, although some characteristics of a system can be imitated in another place, it is almost impossible to copy the exact system since the health care regimes has their roots in the historical formation and socio-economic conditions of a society. This idea on convergence among different health care systems and limits on that convergence may be

[33] Calum Paton, "The Changing Political Economy of the NHS," *Public Finance and Management*, 6, no.4 (2006), p. 561

exemplified by the introduction of market mechanisms and competition within the British NHS and the debates on the public health insurance in the US.[34]

In Turkey a similar kind of tension has been on the agenda since the beginning of the AKP period. Although the government promised to universalize the health insurance scheme, at the same time the restructuring of public hospitals was planned towards higher autonomization and even privatization for the sake of greater efficiency. Thus, the Turkish health care system has been stretched from two opposite directions, while the failure to universalize healthcare services due to the premium based system caused the end result to be more inclined towards the market maximized direction on the health services continuum.

Turkish Welfare Regime and Health Care System

In terms of the Turkish welfare state, though recently merged together with the new legislation, three basic institutions have been at work for decades. They are: Public Servants' Retirement Fund (*Emekli Sandigi* - ES), which was founded in 1949 for the social services of civil servants and members of the army, the SSK was founded in 1964 in order to provide social services to workers who were employed on a work contract not in the public service sector but in private institutions[35] and the Social Security Institution for the Craftsmen, Artisans and

[34] Graig, pp. 6-10

[35] SSK was the successor of İsçi Sigortaları Kurumu which was founded in July 1945

other Self-Employed (Bağ-Kur), founded in 1972 for the provision of social services of self-employed people. These three different social insurance institutions have particular levels of premiums collected from the members and they provided different levels of services to these people. Thus it was obvious that the welfare provision was not seen as a right of the citizens as they earned them through their employment status. Moreover, earned welfare benefits are not equal and their levels differ according to the occupational ties of the insured, that is why the social insurance system in Turkey is called as "inegaliterian corporatist" due to the hierarchical structure among the formally insured people.[36] With the establishment of the Social Security Institution (*Sosyal Güvenlik Kurumu* - SGK) those three social insurance mechanisms are brought together in order to provide equality among the insured people. However, the difference among the occupational lines still persists contrary to the unification under the roof organization.

As Esping-Andersen forms the welfare state typology according to the interactions between state, market and family pillars, in search of Turkey's place in this typology, we cannot clearly define Turkey under one title. However, we may come to the conclusion that it mostly resembles the conservative continental European welfare states in terms of the benefit distribution with respect to the employment status and the importance given to the male breadwinner in social services. Yet, this placing of Turkey is not perfectly accurate as the share of informal sector is remarkably high, as almost half of the employed population is

[36] Ayşe Buğra and Çağlar Keyder, "The Turkish Welfare Regime in Transformation," *Journal of European Social Policy*, 16, no.3 (2006), p. 211

not covered under any social insurance scheme.[37] Thus, the corporatist lines are not enough to cover the whole population, leaving a significant portion outside any social safety net due to the informal sector. Moreover, until recently family ties played a significant role for the people who were outside the formal economy and not covered by any social insurance schemes. Based on these two characteristics we may define the Turkish welfare regime, as a variant of the southern European welfare regime rather than the continental European one, though the nationalization of healthcare services is not carried out in the country. However, we should keep in mind the fact that, due to the changing conditions in the market economy and demographic characteristics, family ties are getting weaker and there seems to be a movement towards a liberal welfare state where the state and family pillars leave their roles to the market gradually in welfare provision.

When the Turkish health care system is analyzed, it is seen that it approximates to the Bismarckian type of health care understanding, though it has gone through several transformations throughout the Republican era and incorporated various elements. Those transformations mainly reflect the characteristics of the periods in which they were carried out and the peculiarities of the agencies, which are involved in the policy-making processes. Though in the last three decades, while most of the Southern European countries that resemble the Turkish welfare state managed to build national health services, Turkey failed to carry out this reform.[38] National Health Services established in

[37] See Appendix A

[38] Ferrera, p. 5

Italy in 1978[39], in Portugal 1979[40] and in Spain in 1986[41] replacing the former insurance oriented systems and/or the private financing of the health care expenditures. Health care systems all in Italy, Portugal and Spain aimed at serving universal and free access to the citizens, as the expenditures would be met by taxation. While the Southern European states managed to shift their health care systems to models based on the British NHS three decades ago, today in Turkey the social insurance model is still valid for health care though it is accompanied by an expanding pool of private insurance schemes. As will be discussed in the following chapter a national health care system, which was modeled from the British NHS was aimed to be established in the 1960s, but due to the delays in the country wide implementation and the concurrent functioning of the social insurance funds paved the way for the failure of the system.

In Turkey, three types of institutions (public, private and philanthropic) provide the healthcare services. From these three types, public institutions are also fragmented in itself as the MOHs, SSK hospitals and University hospitals and the hospitals of Ministry of Defense. As mentioned before three social insurance mechanisms are at work in Turkey to serve the citizens (defined as the working population and their dependents). In terms of health care, the Green Card scheme should be added into the picture, in order to understand the complex nature of the health care provision and finance in the country. SSK was the only insurance institution that had its own healthcare facilities. Since the

[39] European Observatory on Health Systems and Policies, *Health Systems in Transition (HiTs): Italy, vol. 3, no. 4* (Copenhagen: World Health Organization, 2001), p. 91

[40] European Observatory on Health Systems and Policies, *Health Systems in Transition (HiTs): Portugal vol. 9, no. 5* (Copenhagen: World Health Organization, 2007), p. 16

[41] European Observatory on Health Systems and Policies, *Health Systems in Transition (HiTs): Spain vol. 8, no. 4* (Copenhagen: World Health Organization, 2006), p.19

excess demand on public healthcare institutions was unable to meet the demand in the late 1960, the SSK built its own health centers and hospitals as it was envisaged in the Social Insurances Law (number 506), which was passed in 1964. In the 1990s, the SSK started to buy healthcare services from the MOHs and private hospitals on the branches that the institution had contracted with due to the inadequate number of beds in the SSK hospitals so as to address the demands of the increased number of insured people. Unlike the SSK, ES and Bag-Kur did not have their own institutions to offer healthcare services. ES and Bağ-Kur contracted with MOH and university hospitals in order to meet the health care needs of the insurers.

Here a crucial fact should be emphasized about the discriminative approach towards citizens both within and out of the insurance schemes. As the three types of insurance mechanisms had different scopes of coverage, which targets different groups, they might discriminate against insured members within one scheme too. The most obvious example at this point is Bag-Kur, which was the social security institution of the self-employed founded in 1971 with the Law numbered 1479. At the beginning the self-employed people in the agriculture sector was not thought of a part of the Bag-Kur scheme though the rural population comprised more than 60 percent of the total population.[42] Their delayed inclusion to the social insurance scheme is a considerable part of the unequal status of the self-employed in the agriculture sector. The later inclusion of the provision of healthcare services reinforces this inequality.

[42] See Appendix B and Appendix C

The health care component added to the social security services provided by the Bag-Kur in 1985 with the Law numbered 3235. As discrimination between the social insurance schemes, health care provision was limited to 6 months in the 3235 law while the SSK and the ES had not imposed on time for health care provision. This inequality was repaired with the decree of the Constitutional Court in 1996. But more than ten years passed with this positioning of Bag-Kur members as inferiors to the ES and SSK.

Moreover, the example of discrimination within one social insurance scheme can again be found in the Bag-Kur. Health insurance, which was added with law 3235, was only provided to the people under the coverage of 1479 Bağ-Kur Law. Thus the agriculture sector was again excluded from the framework through the denial of their health insurance. They acquired this insurance legally in 1998 by the Law numbered 4386, though the implementation had started by January 1999. Besides, people could only reach the services in September 1999 due to the necessity of eight months premium payment. Thus we see the examples of the fragmented and hierarchical structure of the corporatist health insurance system in Turkey[43]. Neither the health care seen as a right based on citizenship, nor the people covered by the existing structure can reach equal quality of service even within one insurance scheme.

The health insurance system based on the employment status gained a new element in 1992 with the Green Card law. Green Card was established with the law numbered 3816 named "the Law on Covering the Treatment Expenses of

[43] Bugra and Keyder, *The Turkish Welfare Regime in Transformation*, p. 212

the Poor Citizens by the State through Green Card".[44] Green card has been offered to the people whose monthly income is less than 1/3 of the minimum wage. It is based on a means testing mechanism, and aim to provide healthcare service to the poorest segment of the population though it does not cover all types of medical services. Though it is viewed as a positive step in the health insurance coverage in Turkey, due to the legalization of means testing mechanism, and the failure to cover all of the population who is not entitled to benefit from any formal insurance schemes, it is a case of an insufficient decommodification experience. The issue of the Green Card will be analyzed further in the fifth chapter.

Another point of transformation in the field of health care comes with the AKP period. In this period there are four main points of the transformation of health program of the AKP, namely, establishing general health insurance, family medicine, place a strong referral chain and autonomous healthcare enterprises.[45]

Transformation of health care has been one of the most ambitious promises of the AKP. It has been widely debated in the public arena and both praised and criticized by the other political parties, NGOs on medicine and physicians, etc. Transformation of health care program was declared by the AKP government in 2003 though this transformation has been carried out step-by-step since then. Today some parts of the program still have not come into force such as the referral chain, although, this item forms a crucial pillar in the

[44] Original name of the law is: *Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun*

[45] T.C. Sağlık Bakanlığı. December 2003. *Sağlıkta Dönüşüm*. Available [online]: http://www.saglik.gov.tr/TR/Genel/BelgeGoster.aspx?F6E10F8892433CFF7A2395174CFB32E19ABF9BBCF4C02FA1 [15 April 2009] pp. 28-31

transformation program and the arguments for cost containment in the health care sector.

The gathering of the various health insurance schemes together under the name of General Health Insurance (GHI) has been one of the most praised points of the program. The most pretentious goals of the GHI have been the inclusion of the coverage of the whole population (including the ones outside the formal employment scheme) and the removal of differences among the social insurance schemes, through equalizing the contributions and benefits of the people under the general insurance law. Besides, through the GHI, the health premiums will be collected in a particular pool different than the other social insurance services so its revenues and expenditures will be obtained more accurately. Yet, this mechanism will also foster the division of finance and provision in the health care, which is an idea backed by the international finance organizations, mainly by the WB but challenged by the health economists. In the separation of finance and provision, the health funds are collected in a pool created for the healthcare services per se, and the provider, such as the public and private hospitals compete in the market to get higher share from this health fund. I will turn back to the discussion on the finance provision split in the fifth chapter in which the health care policies of the AKP will be scrutinized in detail.

Moreover, there are many contested parts of the program like the feasibility of family medicine in the socio-economic and demographic structure of Turkey and the devolution of the SSK hospitals to the MOH. However, none of the aforementioned parts of the program are unique to the AKP period. The referral chain was built with the socialization of healthcare services in 1961 though it failed to work systematically. In 1987, the Motherland Party (*Anavatan*

Partisi – ANAP) government tried to strengthen the referral chain, but as the new law reveals, it could not succeed on this matter either. Moreover, the devolution of the SSK hospitals had been discussed for nearly thirty decades, though none of the preceding governments was able to break the opposition of SSK authorities and take over the facilities, which are built by the premiums paid by the SSK workers.

Ayşe Buğra states that the conservative understanding of the AKP represents a different approach in social policy than the ANAP period though both of the governments are highly close to the international credit organizations and their ideas. She argues that, although the transformations in social policy and health policy in particular are not aimed to provide rights in terms of citizenship, many inclusionary policies are developed during the AKP government. Buğra underlines the importance of conservative liberal character of the party and the influence of international organizations in determining the policy developments in this era. On the one hand conservative liberal character of the party highlights the pillars of charity, family and the market rather than the state in terms of social assistance and the international organizations.[46] On the other hand, international organizations have two contrasting effects as the pressuring the government to reform the system in order to cover whole population while underlining the necessity to make cuts on the social spending through introducing cost-effective measures.

In light of these tensions on the policy making processes of the AKP period, the transformation of health care will be discussed in the sixth chapter

[46] Ayşe Buğra, *Kapitalizm, Yoksulluk ve Türkiye'de Sosyal Politika* (İstanbul: İletişim, 2008), pp. 217-233

with references to the social insurance and general health insurance law, political debates in the parliament and in the civil society and the impositions coming from the World Bank and the IMF. I will mainly argue that the policy developments in the AKP period are not unique to the new government, as their roots could be seen in the ANAP period. Yet, transformations could be carried out more smoothly due to the successful matching of class coalitions, high support from the international organizations and the power of a one-party government in utilizing the state apparatus.

CHAPTER III

UNDERSTANDING AND PROVISION OF HEALTH CARE IN THE PRE 1980 ERA: STATUS OF HEALTH PRIOR TO COMMODIFICATION

In the third chapter I will summarize the health care regime in Turkey prior to 1980 and focus on the Law on the Socialization of Healthcare Services (Law number 224), which was passed in 1961. The significance of this law lies at its distinct approach towards health care as it was assumed as a right and was envisaged as a public service, which should be financed by the state and provided to the whole population. Thus, this was an era when Beveridge type of citizenship based health care system was aimed to be established in the country. This law reflected the characteristics of the power in the government it was created by and the economic strategy of the era, which determined the role of the state whether being an active and interventionist one or withdrawn and left the market forces to act freely. As will be discussed in the following parts, in the beginning of the 1960s, the government policies foresaw a more interventionist state in the economic development and social welfare of the population. Health care was one of the areas that the state embraced an active role and it was accepted as a right of the citizens consistent with the social state understanding.

Among the pre-1980 developments, the Law on the Socialization of Healthcare Services[47] passed in 1961 deserves a crucial attention. The National

[47] Original name of the law is: *Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun*

Union Committee (NUC) that took over the government with the 1960 coup d'état prepared this law.[48] The health care reform was given the priority even before the constitution and it was drafted and passed beforehand. Yet, both of the documents shared the same spirit of embracing the peculiarity of being a "social state" with the inclusionary attempts towards the workers and peasants in terms of their status as citizens. In order to describe the atmosphere of the 1960, I would like to begin with references to the constitution before I pass onto the socialization of the healthcare services. In 1961 Constitution the state was declared as a "social state"[49] and accordingly it was stated that everybody had the right to have social security and it was the responsibility of the state to found a social security institution.[50] Besides, it was the first time in the history of the Republic when the union, strike and lockout rights of the workers included in the constitution,[51] which reflected the fact that the state paid a special interest to the workers rights and built new bonds and solidarity relations with this class in this decade. As another reflection of the new era - which is the major concern of this thesis- is the fact that right to health was embedded to the constitution for the first time with the expression of "it is the duty of the state to provide everyone to live in physical and mental health and medical care when it is necessary".[52]

[48] It should be noted here that, the law on the socialization of healthcare services passed in the parliament on January 5, 1961, just before the 1st National Union Committee government left its place to the 2nd NUC government in the constituent assembly in which the Chamber of deputies would participate in the legislation process.

[49] Republic of Turkey, *T.C. 1961 Anayasası,* Article 2

[50] Ibid., Article 48

[51] Ibid., Article 47

[52] Ibid., Article 49

It is obvious from the above-mentioned articles of the 1961 constitution; the state undertook a crucial role in the provision of social rights, and establishing new relations with the working class and strengthening their position vis-à-vis the industrialist classes. Needless to say that it was very much related with the economic transformation in that era. Turkey shifted its industrialization strategy to Import Substituting Industrialization (ISI) in 1954 though until the establishment of the State Planning Organization (*Devlet Planlama Teşkilatı* - DPT) and the publishing of its First Five Year Development Plan in 1963, the ISI was developed under the supervision of the private sector. However, as the state assumed such an important and complicated responsibility in term of industrialization and ordering the relations between the social classes with the NUC coming to power, DPT was instituted in order to help and advise the coordination of the economic, social and cultural policies of the state. With the article 41 it was stated that "It is the duty of the state to realize the economic, social and cultural development through democratic means, and to reach this end to increase the national savings, to channel the investments to the priorities necessitated by the society's benefit and to make development plans".[53][54] Reading the legal developments, it is easy to say that, in 1960s started in an atmosphere to strengthen the "social" and "planner" roles of the state.

As a brief description of the ISI policy it can be said that, generally ISI starts with the production of the previously imported simple consumer goods in

[53] *İktisadî, sosyal ve kültürel kalkınmayı demokratik yollarla gerçekleştirmek; bu maksatla, milli tasarrufu arttırmak, yatırımları toplum yararının gerektirdiği öncelikleri yöneltmek ve kalkınma plânlarını yapmak Devletin ödevidir.*

[54] Republic of Turkey, *T.C 1961 Anayasası* Article 41

the first stage and then moves to the production of more sophisticated intermediate goods and machinery in the higher stages.[55] To establish this kind of substitution of domestic production with previously imported materials, high tariff barriers and quotas put on imports. This creates a protective environment from the international competition, which eases the way for industrial classes to conform the demands of the working class in terms of high wages and social security.[56] Thus, again it can be asserted that, the state successfully managed to build the solidarity lines between the industrialist and worker classes. It is crucial here to mention the fact that, the agriculture sector also got its share from this environment, through the government policies of keeping the floor prices in agricultural goods in a high level.[57] The welfare of the society was not only necessary for its own sake, but also, it was crucial in order to develop a domestic market and create demand for the goods produced by the native industrialists.

In Turkey, the 1960s started with a transformation, both in economic and social terms. The NUC government emphasized the importance of the state in industrialization and social security. While the development of the native industry was supported by demand creation through high wages in industry and high prices in the agricultural sector, the workers were protected through decreasing their commodity status. The lockout, strike and collective bargaining agreements prevented the workers to be easily fired and changed by the other workers in the market thus helping decommodification of their status in the job market. State not only strengthened the position of the workers in the market but

[55] Albert O. Hirschman, *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States* (Princeton: Princeton University Press, 1970), p. 6

[56] Korkut Boratav, Çağlar Keyder and Şevket Pamuk, *Krizin gelişimi ve Türkiye'nin Alternatif Sorunu* (İstanbul: Kaynak Yayınları, 1984), pp. 20-21

[57] Korkut Boratav, *Türkiye İktisat Tarihi 1908-2002* (Ankara: İmge Yayınları, 2005), pp. 135-136

also provided them additional benefits such as public education and health care. Korkut Boratav emphasizes that this tradition of state through which the citizens could reach free healthcare services increased the social wage of the workers.

In the beginning of a decade where such transformations are carried out by the state, the Law on the Socialization of Healthcare Services numbered 224 was prepared and passed during the second National Union Committee government in 1961. This document was a proof for the attempt to establish a national health system in Turkey that aimed to provide health care on the basis of the British NHS system. Asena Günal underlines in her dissertation the fact the military officers were attracted by the British NHS due to its egalitarian and integrated form of healthcare services. The military officers were aware of the gap between the conditions of the rural and urban parts and especially the gap between the western and eastern regions of the country. That is why they aimed to improve the services offered to the peasant population in the rural and especially the eastern part of the country.[58]

Besides, when compared with the western industrialized or industrializing countries, Turkey's performance on health indicators was worse with a marked difference.[59] Thus, in order to reach their levels, the socialization law passed in the parliament and it was decided to initiate the socialization services in the most underdeveloped regions in order to equalize the distribution of the healthcare services. Through starting from the east and south east, the policy makers aimed

[58] Asena Günal, Health and Citizenship in Republican Turkey: An Analysis of Socialization of Health Services in Republican Historical Context (Ph.d diss., Boğaziçi University, 2008), pp. 235-238

[59] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Birinci Beş Yıllık Kalkınma Planı (1963-1967)* (Ankara: DPT, 1963), p. 29

to bring good quality care to the population living there and increase the average performance of the country simultaneously. Thus the priority given to the rural parts by the NUC government would increase the trust in the state and the respectability of Turkey in the in international arena, where right to live a healthy life as a part of human rights gaining a crucial importance with the universal declaration of human rights.

The right based and egalitarian aspect of the socialization law could be easily grasped from the first article, as the aim of the law was described as "health, which is a right defined as such in the Universal declaration of Human Rights, would be socialized with a program appropriate to the principle of social justice".[60] Through this law, in order to guarantee the comprehensive and equal care to the population throughout the country, all healthcare institutions (except the ones belonging to the Ministry of Defense) were integrated under the control of the MOHSA.[61] The socialization of healthcare services necessitated the formation of a new network of health facilities in an integrated system. In this network, health posts (*sağlık ocağı*) and health stations (*sağlık evi*) composed the first level of healthcare services. A health post would be responsible for meeting the preventive and curative services per approximately seven thousand people. In the second level health posts would subordinate to health center regions, each would serve for fifty thousand people and would cover hospital, dispensary and preventive medicine facilities. In the third level, local health authority took place, which would have only administrative responsibilities.

[60] Republic of Turkey, *Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun,* no. 224, *T.C. Resmi Gazete*, no. 10705*,* 12 January 1961, Article 1

[61] Ibid., Article 8

Last, at the fourth level, socialization program divided the country into 16 regions and obtained the foundation of major region hospitals, health schools, region laboratories, stores and maintenance halls.[62]

Nusret Fişek stated that during the preparation of the law, he took the British NHS as a model for the socialization of the services in order to establish a staged health care system. Fişek claimed that in Turkey the first level of preventive care was of high importance taking into consideration the social and demographic conditions of the country especially for the rural areas. He stated that in order to stop the accumulation in the hospitals and bring the first level of healthcare services close to the citizens, the health post exercise fitted the best for Turkey.[63] The socialization law brought the necessity of a referral chain between the first and second levels of health care. According to Article 13, except those of emergency cases, the people who wanted to utilize the socialized healthcare services, should first apply to the health posts and if the physicians in the health posts stated as necessary they could be directed to the health centers or hospitals.[64] If the patient would not follow the referral chain and applied directly to a hospital, she/he would be responsible to pay the expenditure of the diagnosis and the treatment, which are free of charge under the proper application of the socialization program.[65]

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[62] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Birinci Beş Yıllık Kalkınma Planı (1963-1967),* p: 409

[63] Türk Tabipler Birliği. 1986. *Nusret Fişek ile Söyleşi*. Available [online]: http://www.ttb.org.tr/n_fisek/kitap_3/38.html [1 May 2009]

[64] Republic of Turkey, *Sağlık Hizmetlerinin Sosyalleştirimesi Hakkında Kanun*, Article 13

[65] Ibid., Article 14

In terms of the implication, accordingly with the major concerns to improve the health care of the rural and eastern parts of the country, the socialization of healthcare services started at the East and Southeast part of the country. Especially, Muş was selected as the start point, due to the fact that it was one of the most underdeveloped cities in terms of both social and economics indicators. As can be seen from Table 1, it is a crucial fact that the unequal distribution of the doctors further increased while the number of doctors increased in the west and decreased in the east from 1953 to 1959. Moreover, when the ratio of number of beds to the population is analyzed in various cities in 1959, it is found that, it was 5.9 in Muş while it was 74.7 in İstanbul, 33.7 in Ankara and 27.2 in İzmir.[66]

Table 1: The Number of Doctors in Various Cities (1952-1959).[67]

	1953	1959
İstanbul	2947	2716
Ankara	593	1048
İzmir	429	670
Adana	150	205
Bursa	165	181
Eskişehir	100	121
Isparta	30	43
Bitlis	21	14
Ağrı	18	16
Gümüşhane	17	12
Bingöl	14	12
Muş	13	11
Hakkari	10	7

[66] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Birinci Beş Yıllık Kalkınma Planı (1963-1967)*, p. 56

[67] Ibid., p. 56

Although the implementation of the program was started in 1963 in Muş, the progress of the program could not be carried out as it was planned. The socialization program could not be implemented properly and drastic delays were experienced in dispersion of the services throughout the country. So, unfortunately the promises of the law remained peculiar to the socialized regions. Although in the law it was stated that the socialization law that the program would be completed in 15 years[68], it could not be managed until the beginning of the 1990s. In Table 2, the progress of the implementation can be seen with numbers of the socialized provinces and the health posts build since the beginning of the socialization process.

[68] Republic of Turkey, *Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun*, Article 20

Table 2: The Number of Health Posts and Health Stations by Years (1963-2001).[69]

Years	Social Provinces	Training Regions	Health Posts	Health Stations
1963	1	0	19	37
1965	12	1	416	970
1970	25	3	851	2,231
1975	26	4	995	3,243
1980	45	12	1,467	5,776
1985	67	18	2,887	8,464
1987	67	18	3,084	10,045
1988	67	18	3,170	10,531
1989	71	17	3,304	10,731
1990	73	17	3,454	11,075
1991	74	17	3,672	11,262
1992	76	17	3,901	11,490
1993	76	17	4,226	11,630
1994	76	17	4,575	11,878
1995	79	17	4,927	11,888
1996	80	17	5,167	11,877
1997	80	17	5,366	11,905
1998	80	17	5,538	11,881
1999	81	17	5,614	11,766
2000	81	17	5,700	11,747
2001	81	17	5,773	11,737

In addition to the delays in the progress of socialization practice throughout the country, there were other failures concerning the personnel laws encouraging the doctors to work in the socialized regions. The abolishment of the incentives given to the doctors working in the socialized regions, the failures in

[69] T.C. Sağlık Bakanlığı. 2002. *Yıllara Göre Sağlık Ocağı ve Sağlık Evi Sayıları.* Available [online]: http://www.saglik.gov.tr/extras/istatistikler/apk2001/063.htm [1 March 2009]

the full day law[70] for the physicians working in the public facilities and the simultaneous establishment of SSK hospitals in the country, all caused the decline in number of doctors employed in socialized services. The prospective of 25 beds for 10.000 people was materialized at the end of 1972 as 25.1, but the socialization program was slowed down due to the above-mentioned troubles faced in terms of employment of doctors and nurses in the socialized east and southeast regions of the country.[71] However, it is necessary to emphasize the fact that in spite of the personnel scarcity in the socialized regions, there was a significant improvement in the health indicators in those regions as can be seen from Table 3.[72] This proves the success of the planned program though there were many failures in the implementation process.

[70] The healthcare personnel laws are beyond the scope of this thesis. Yet in order to clarify the argument above I should refer to the arguments of Nusret Fişek, who claimed that, due to the failure to appoint doctors to western regions after having completed their compulsory service in the eastern socialized regions, the doctors were disappointed with the implementation of the law (see: http://www.ttb.org.tr/n_fisek/kitap_3/38.html) Moreover, the full day law, which guaranteed the doctors' loyalty to the system in the socialized regions, was abolished and caused deficiencies in the healthcare services in the health posts and hospitals in the socialized regions. For more information see: Gazanfer Aksakoğlu, "Sağlıkta Sosyalleştirmenin Öyküsü," *Memleket Siyaset Yönetim Dergisi,* 8 (2008), pp. 28-29.

[71] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Üçüncü Beş* Yıllık Kalkınma Planı (1973-1977) (Ankara: DPT, 1972), p. 91

[72] Ibid., p. 810

Table 3: Population per Health Personnel in the Socialized Regions.[73]
(1000 people)

	Prior to socialization (1962)	Period of socialization (1971)
Doctor	17.8	9.5
Health officer	12.0	6.2
Nurse	51.6	16.0
Midwife	10.0	3.7

The architect of the law, Nusret Fişek, who was the undersecretary of the Ministry of Health in the first half of the 1960s referred to the inability of governments to implement the socialization program and the small amount of money spared from the budget for health care as the major reasons for failure. According to Fişek, after the NUC, the following governments did not give priority to health care and spent little money on its expenditures, which was a political choice rather than an economic one for him. He even gave an example from the expression of Süleyman Demirel from the times of the AP government in the second half of the 1960s, as an example showing the contributions of him to the socialization of the healthcare services. He asserted that, the then Minister of Health Edip Somuncuoğlu wanted to remove the socialization law and requested Demirel to take step towards this goal. Yet, Demirel did not conform his request, as there was no alternative for this practice at that time. Demirel stated that if there were no alternatives then the socialization practice would continue, as the conditions would suffice.[74] This dialogue between the then prime minister and the minister of health and the final expression of Demirel were clear

[73] Ibid., p. 810

[74] Türk Tabipler Birliği. 1986. *Nusret Fişek ile Söyleşi*

examples for the government's failure to embrace the socialization law but merely letting it to survive on the paper.

The only reason for failure in the appropriate implementation of the socialization law was not the half-hearted actions of the successive governments for this individual law per se. It is necessary to underline the fact that the aims to install Beverigde type of healthcare system in Turkey were juxtaposed with the formation of Bismarckian employment based insurance system. As stated in the previous chapter, there were three public insurance schemes in Turkey, as the ES, SSK and Bağ-Kur. These three organizations all offered healthcare insurance to their members and their dependants. The fact that those employment-based insurance schemes at work showed the reflection of corporatist formal insurance tradition in the health care arena. However, the prevalence of employment based insurance schemes in the regions where socialization had not carried out yet, reinforced the delays and failures in the implementation of the socialization program.

The patchy structure of the social insurance mechanism in Turkey, also delayed the establishment of the GHI and the unification of the all social insurance schemes under the authority of one organization. Though this idea of unification and the GHI came out in the First Five Year Development Plan, its legalization and implementation was delayed nearly for four decades.[75] In these four decades the meaning of general health insurance and the approach towards healthcare services had undergone crucial transformations as will be seen in the following chapters.

[75] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Birinci Beş Yıllık Kalkınma Planı (1963-1967),* p. 110

The dual structure of the health care system in Turkey (the simultaneous running of the Beveridge and Bismarckian systems in the area of health care), has become one of the biggest obstacles on the way to establish a citizenship based health care understanding since the 1960s. Recently, the insurance system declared its victory in the 2000s with the latest law on health care that paved the way for the de facto abolishment of socialization practice as the health posts were replaced by the family doctors. However, before passing onto the transformation of health program in the 2000s, I would like to continue with the major breakdown with the understanding of health care as a right as opposed to the commercialization of healthcare services in the 1980s.

CHAPTER IV

START OF COMMODIFICATION OF HEALTH CARE WITH COMMERCIALIZATION OF THE SERVICES: THE ANALYSIS OF 1987 BASIC LAW ON HEALTHCARE SERVICES

As opposed to the ideal of the 1960s that aimed to provide citizenship based health care, the story of the commodification of healthcare services in Turkey, have started with the Basic Law on Healthcare Services passed in 1987 that brought the autonomization of public hospitals and revolving funds as the major items in meeting the expenses of the services. In this chapter this law will be analyzed by referring to the legal documents, political debates both within and outside the parliament and the influence of the international organizations. However, before going into detail of the specified law, I would like to explain the political and economic atmosphere of the country through the 1970s and 1980s.

On the way coming to the 1980s, the industrialization strategy in the country was not performing smoothly. In fact many troubles arose due to both the internal problems of the ISI and the international environment. In terms of internal problems, ISI was a strategy, which necessitated a huge reserve of foreign exchange in order to be able to buy the capital goods from abroad. However, because of the extended domestic market and the protective walls against international competition, the native firms were not encouraged to export

the goods they produce. As the exports were low, the major solution to obtain the foreign exchange was through credits from the international organizations. However, two oil crises experienced in the 1970s, which caused difficulty in access to dollar and depression around the world affected Turkey too. Though the foreign aids and the workers' remittances helped Turkey to get over the first crisis in the 1973, the crisis in 1977 hit the country harshly, weakening the position of the state against the demands of the international organizations.[76]

The international organizations, mainly the IMF, retreated their support for the economic program in the country and demanded for a stabilization policy in return for credits, that the country in urgent need of. Though Bülent Ecevit resisted administering a stabilization policy, which would put the burden of the depression on the workers, the tension between the industrialists and the working classes heightened gradually. Although a stand by agreement in the early 1979, due to the failure of Ecevit government to internalize the stabilization program, and maintaining the ISI strategy based on public investment and foreign borrowing, the economic conditions were not improved. As a result of the scarcity of foreign resources, the industrialists started to export their goods while the expenditures on workers created a huge obstacle on the competition in the international market. However, the companies met with the workers' resistance and strikes when they wanted to cut those expenditures.[77]

With the change of the government from Republican People's Party (*Cumhuriyet Halk Partisi* – CHP) to Adalet Partisi (AP), the AP government

[76] Paul Mosley, Jane Harrigan and John Toye, *Aid and Power: The World Bank and Policy-Based Lending* (London-New York: Routledge, 1991), p. 10

[77] Boratav, *Türkiye İktisat Tarihi 1908-2002,* pp.141-142

reached a new agreement with the IMF and the economic stabilization program prepared by Turgut Özal, which was also known as the "January 24 decisions". Turgut Özal was identified with the neoliberal transformation in Turkey as the 24 January decisions contained policies like, liberalization of imports, support for the exports and contraction of the domestic demand.

In general, the neoliberal transformation marks the cut back in the social spending of the state since the main emphasis shifted from aggregate demand to money supply. Thus, the state started to retreat from the provision of welfare services and left its role in these areas to the private and philanthropic institutions. While privatization gained importance, deregulation and decentralization were the main developments taking place in the public sector. The main stimulus which triggered such developments was the belief in the free market that it could produce the best and the most efficient outcomes. Due to the competitive environment in the free market, it was firmly believed that the most desirable outcomes would come at the cheapest level and the whole society would be better off. [78] The neoliberal transformation in Turkey took place in Turkey with the change of industrialization strategy, the shift of the government in power and the approach towards workers and the social rights. In order to see the results on the health care, I would like to start with focusing on the legal developments concerning the healthcare policy.

[78] Saad-Filho and Johnston, p.114

Legal Documents

In the beginning of the 1980s the economic transformation created a significant discomfort in Turkey and the government was not able to cope with the social and political unrest. While the civil governments were not able to end the turmoil, the coup d'état on September 12, 1980 was highly effective to crush the worker rights as a way to end the tension between the industrialists and the workers in order to fulfill the developments in the stabilization package. The military government named as the National Security Council took the power over the legislation and execution duties in the parliament. The strike and lockout rights were suspended which reflected the new perspective of the state towards the workers. The new constitution could be prepared in 1982, and it had huge discrepancies from the 1961 Constitution. Contrary to the articles in the 1961 Constitution, which established solidarity between the state and the workers through the strike, union and lockout rights, in the 1982 Constitution all these rights were defined with ambiguous statements in an effort to curtail the workers' position and limit the cases of strikes and lockouts.[79] As the industrialization strategy shifted form a protectionist ISI to a competitive Export Oriented Industrialization (EOI), the state reorganized its relations with the worker and industrialist classes. Indeed the military coup actively promoted restriction of the workers' rights as a necessary but an uncompleted condition for the neoliberal transformation in Turkey.

[79] Republic of Turkey, *T.C. 1982 Anayasası,* Article 54

The very first shift in terms of health care policies can be observed in the incentives given to the private healthcare institutions. With a decree of council of ministers in November 30 1981, the investments on the private hospitals and modern sanitary control institutions started to benefit from the exemptions from the customs, investment deductions, interest returns from intermediate terms credits.[80] Though, the private hospitals had been present in the country for long and their legal situation was defined under the law on private hospitals number 2219, for the first time a government in Turkey offered such a generous deal to the private sector in health care. It is especially interesting to witness such actions, which would decrease the revenues of the state at a time when the social expenditures were cut back due to budgetary constraints. This proves the ideological shift in this decade while the free market and private sector were supported as opposed to the investing in the public services.[81]

As the military government was ready to support the private sector, the crucial transformation in the role of the state in health care provision can be seen in the new constitution prepared by the military government in 1982. This time both the structure[82] and the concerns of the military government had significant discrepancies with the previous one. This discrepancy between those governments reflected itself in many of the articles of the 1982 constitution though in the scope of this thesis only the ones related to the health care would be analyzed.

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[80] Türkan Temel, *Özel Hataneler Sektör Profili* (İstanbul: İstanbul Ticaret Odası, 2003), p. 13

[81] Pollock, *NHS plc*, p. 38

[82] The coup d'état in the 1960 and the 1980 displayed a significant difference in terms of the groups organized the coups. While the 1960 coup was performed by the lower echelons of the military and the 1980 coup was carried out by the high ranking officers.

In the 1982 constitution in the article 56 it was stated that:

> Everybody has the right to live in a healthy and stable environment. It is the responsibility both of the state and the citizens to improve the environment, to protect the health of the environment and to prevent pollution. State exclusively regulates the health care institutions and their services in order to provide everyone to live in physical and mental health, increase the savings in human and material power, increase the performance and realize cooperation. State carries out this responsibility through the utilization and supervision of public and private health care and social institutions. General health insurance can be established through law in order to diffuse the provision of health care services.[83]

It is clear in the article 56, state's role in the health care sector declined drastically as the new constitution foresaw a regulator and a supervisor role to the state as opposed to the 1961 constitution.

Moreover, with the shift in the economic discourse of the state in the 1980s due to the financial crisis and impossibility to survive import substitution strategy, a tremendous wave of privatization gained pace and health care sector also got its share form this wave. Especially in the Fifth Five Year Development Plan it was stated that private healthcare institutions and hospitals would be encouraged through the liberation of the charges they determine from the services provided.[84] Although support for the private sector in health care had been mentioned since the First Five Year Development Plan, emphasis on such a

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[83] *Herkes, sağlıklı ve dengeli bir çevrede yaşama hakkına sahiptir.*

Çevreyi geliştirmek, çevre sağlığını korumak ve çevre kirlenmesini önlemek Devletin ve vatandaşların ödevidir.

Devlet, herkesin hayatını, beden ve ruh sağlığı içinde sürdürmesini sağlamak; insan ve madde gücünde tasarruf ve verimi artırarak, işbirliğini gerçekleştirmek amacıyla sağlık kuruluşlarını tek elden planlayıp hizmet vermesini düzenler.

Devlet, bu görevini kamu ve özel kesimlerdeki sağlık ve sosyal kurumlarından yararlanarak, onları denetleyerek yerine getirir.

Sağlık hizmetlerinin yaygın bir şekilde yerine getirilmesi için kanunla genel sağlık sigortası kurulabilir.

[84] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Beşinci Beş Yıllık Kalkınma Planı (1985-1989)* (Ankara: DPT, 1984), p. 152

crucial incentive like the liberation of the charges was seen for the first time in the development plans. It is crucial in the sense that the private sector would determine its prices on the market rules according to supply and demand in order to gain profit. In a country like Turkey, where the supply of the healthcare services could not meet the demand, private sector could earn significant amounts from the affluent people through determining high prices for the services they provide.

The major step towards the commodification of health care in Turkey was taken by the passage of Basic Law on Healthcare Services (Law number 3359). The content of the law was in an absolute consistency with the perspective of the 1982 constitution towards health care. This law did not replace the law on socialization, yet its legalization resulted in the malfunctioning of the former law and some delays of its implementation. The Basic Law on Healthcare Services passed from the parliament in May 1987, during the single majority government of the ANAP. Turgut Özal, the architect of the January 24 decisions, who subordinated the liberalization demands of the international organizations and changed the economic development policy accordingly, was the leader of the ANAP. So it was not surprising to see a law, which paved the way for the commodification of health care passed during that era. Though it will be reminded again, I would like to stress the fact that, the articles in the Basic Law on Healthcare Services had strong similarities with the AKP's transformation in health program. These points will be discussed further but briefly, the autonomization of healthcare institutions, general health insurance and establishment of referral chain were all included in the debates concerning the 1987 law.

In the Basic Law on Healthcare Services, the first thing that attracts the attention of the reader is the Article 5, which stated that all healthcare institutions would be transformed to business enterprises. [85] Through such a transformation, it was planned that, the major earnings of the healthcare institutions would be the payments collected in return for healthcare services, thus decreasing the priority or even proportion of the share from the budget. The policy makers aimed to increase the efficiency and prevent the waste of resources through the revolving funds. Revolving funds would strengthen the autonomous position of the healthcare institutions, as those enterprises would be responsible for their profits earned from the healthcare services.[86] Here it is easy to notice the approach of the government towards the health care. Consistent with the withdrawal of the role of the state from the provision of the healthcare services in the 1982 constitution, the new law paved the way for the commercialization of the healthcare services, as it encourages the competition of public institutions – which newly gained financial autonomy- with each other and with the private institutions in the health care market.

Another crucial point in the law is the statement concerning the GHI. The idea of the GHI was not a new invention; it was proposed in the First Five Year development Plan and then stated again in the 1982 constitution. It was asserted that, a definite amount of premium would be collected from the citizens and the ones who were not covered by any social insurance mechanism shall go and register to the health file and pay the necessary amount of premium she/he had to pay. Yet, if the person was unable to pay the premium, the amount would be met

[85] Republic of Turkey, *Sağlık Hizmetleri Temel Kanunu*, no. 3359, *Resmi Gazete,* no. 19461, 15 May 1987, Article 5

[86] Ibid., Temporary Article 2

through the foundations and organizations established to provide social assistance.[8788] In terms of the government's approach in social assistance, it is necessary to underline the fact that, charity was given a crucial role in establishing solidarity among the country. In the law, the order of the earnings of those social assistance funds and organizations was deliberately listed so as to clarify the priority given to charity item while the share from the general budget had a secondary importance.[89]

The third controversial issue in the law was concerned with the transformation of the personnel into a contractual based one, which had two effects on the structure of the health personnel. First, it was stated that the personnel in the health care enterprises would be categorized as contractual employees and they would receive additional premiums on their performance according to the quality and quantity of the treatments they made.[90] In the following article of the law it was stated that the personnel working in the field of preventive healthcare services might be incorporated into the healthcare enterprises in accordance with the criteria defined by the Ministry of Health and Social Assistance.[91] It is a significant point that the law differentiates the status

[87] Ibid., Temporary Article 3

[88] Social Cooperation and Solidarity Fund was accepted in the parliament on May 1986. This fund was established as a unit under the council of ministers, which aims to provide assistance to the poor. In terms of health care the Motherland government assumed this fund a crucial place in terms of helping the ones who are not able to pay for the health care services. However, it should be noted that, the people had to apply to the fund each time they need assistance in order to meet the hospital expenses, which was a degrading exercise, stigmatizing the status of the poor.

[89] Republic of Turkey, *Sağlık Hizmetleri Temel Kanunu,* Temporary Article 4

[90] Ibid., Article 5

[91] Ibid., Article 6

of personnel on preventive and curative services since the policy makers evaluated these two areas as having different level of profitability chances.

As another aspect of the law, the policy makers underline the importance of the referral chain, which was claimed to be established through the new law. Their argument was that, one of the reasons of the socialization program's failure was the absence of an effective referral chain. However, in the new law the wording of the article about the referral chain was nearly the same with the one in the socialization law. On the one hand Article 14 paragraph a in the socialization law states that:

> Article 14: In the socialized regions the examination and treatment of the patients are free of charge except the chargeable medicine determined in the article 16 of this law and the circumstances below:
>
> a) The ones who apply the health centers or hospitals without being referred from a health post and the ones who apply a hospital without being referred from another hospital (except the emergency cases).[92]

On the other hand, Article 3 paragraph d in 3359 states that:

> Healthcare institutions shall be arranged in a way to form health care chain without limiting the right of the people to choose the physician and institution freely. The ones who do not comply with the referral chain shall be charged additionally in return for the service they buy, except the emergency cases. The ones who are covered under any social insurance scheme shall pay the extra charge themselves.[93]

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[92] *Madde 14: Sağlık hizmetlerinin sosyalleştirildiği bölgelerde hasta muayene ve tedavisi bu kanunun 16. Maddesi hükümleri dairesinde ücrete tabi olan ilaç bedelleri ve aşağıda zikredilen haller hariç parasızdır:*
(a)Sağlık ocağı tarafından sevk edilmedikleri halde sağlık merkezlerine ya da hastanelere veya sağlık merkezi ve bir hastaneden diğer br hastaneye sevkedilmeden hastanelere müracaat edenler (acil vakalar hariç)

[93] *Madde 3, Paragraf d) Sağlık kurum ve kuruluşları,kişilerin hekim ve sağlık kuruluşunu seçme hakkı kısıtlanmaksızın sağlık hizmet zinciri oluşturulacak şekilde düzenlenir. Acil vakalar hariç olmak üzere sevk sistemine uymayanlar hizmet karşılığı fazla ücret öderler. Sosyal güvenlik kuruluşlarına bağlı olanlar bu farkı kendileri karşılar.*

As it is clear form the above quoted texts from the laws, the Basic Law on the Healthcare Services did not brought a novelty to the established staged system in the services. The referral chain has the same characteristics and rules as in the socialization law, and as will be discussed in the sixth chapter, in the 2000s the ineffectiveness of the referral chain again be put on the agenda.

Political Debate

In order to understand the political environment in which these laws and policies were prepared and enacted, it is necessary to focus on the debates took place both within and outside the parliament. During the legalization of the new law on health care in 1987, fierce discussions were held and the opposition parties highly criticized the governing party's perspective. In this part I will focus on the major points of discussion referring to the critical articles in the law.

In the parliamentary discussions of the Article 5, which was about the transformation of public healthcare institutions into healthcare enterprises and changing the status of the personal into a contractual based one, the opposition displayed significant discontent. The Democratic Left Party (*Demokratik Sol Parti* –DSP) and Social Democratic Populist Party (*Sosyal Demokrat Halkçı Parti* – SHP) deputies fiercely opposed the idea of healthcare enterprises. They argued that the healthcare services were essential public services but the enterprises would eventually seek for profits and charge the healthcare services in an effort to make profits in order to be able to pay the contractual employees.

Though the expenditures of the public services should be met by the general budget, in this system the burden would be accumulated on the citizens. They criticized the law on focusing financial concerns while ignoring the issue on how to increase the quality of those services.[94]

Turgut Sözer from the DSP and M. Nuri Üzel criticized the contractual employment of the healthcare personnel and claimed that this would create mistrust among the healthcare workers about their job security. The policy makers advocated that though contractual base employment the personnel would be encouraged to work harder as there would be a risk to lose their job if they did not work efficiently. Moreover, the premiums were regarded as rewards for high quality work, which would function as incentives to improve the healthcare services. Yet, Sözer stated that the personnel did not have a right to object to the cancellation of a contract, which would pave the way for arbitrary and even political decisions on the renewal of the contracts rather than the occupational concerns. He added that, the personnel regime of the whole healthcare system was aimed to be transformed, though the principles of the new regime were not clarified and the rights of the personnel were not guaranteed in the law.[95][96]

In the parliamentary discussions on the article 6, which was about the inclusion of personnel working in the field of preventive health care into the healthcare enterprises, Muzaffer Yıldırım spoke in the name of DSP and he stated that, in the first place they were against the idea of turning the healthcare institutions into business enterprises and changing the status of the personnel to

[94] Republic of Turkey, *TBMM Tutanak Dergisi*, term 17, session 99, vol. 40, 06 May 1987

[95] Republic of Turkey, *TBMM Tutanak Dergisi*, term 17, session 100, vol. 40, 07 May 1987.

[96] Republic of Turkey, *TBMM Tutanak Dergisi*, term 17, session 97, vol. 40, 30 April 1987

contractual employee. Yet he underlined the fact that the incentives attached to these enterprises and contractual employees, left the personnel in the preventive healthcare services in an inferior position. According to Yıldırım, preventive healthcare services composed the most essential chain of the health care network, yet the government did not prefer to encourage the personnel in this field, as they could not benefit from the financial earnings of the healthcare enterprises.[97]

It is necessary to point out to the fact that, although the opposition could not manage to impede the legalization of the articles on the contractual based employment, the following year the leader of the SHP applied to the constitutional court for the removal of certain articles. As a result of the constitutional court decree, the articles on the contractual personnel and the additional premiums determined to be given to those people were cancelled on the grounds of being unconstitutional.[98]

In terms of the article on the referral chain, İdris Gürpınar who spoke in the name of the SHP pointed out to the fact that, the socialization law had already established the referral chain in the 1960s. He added, the failure of the socialization law did not stem from the deficiency in the system but it was caused by the mistakes in the implementations of the law as the incentives given to the physicians in the socialized regions were decreased or totally withdrawn. Moreover, Kütahya deputy Turan Bayezit indicated this point and asked the minister of health and social assistance Mustafa Kalemli to explain the difference of the referral chain in the new law. However, it was not possible to find any

[97] Republic of Turkey, *TBMM Tutanak Dergisi,* term 17, session 99, vol. 40, 06 May 1987

[98] Republic of Turkey, *Anayasa Mahkemesi İptal Davasi*, esas sayısı 1987/16, karar sayısı 1988/8

explanation from Kalemli as he skipped this item while he answered the rest of the questions during the parliamentary discussions.[99]

There were many discussions that took place in the newspapers about the Basic Law on Healthcare Services even before the law came to the parliament. In the first half of the year 1987, the newspapers were filled up by the debates of the doctors and policy makers on the issue. There was only one theme in common in those debates that, the current health care system was not sufficient to meet the needs of the population. However, opposing camps based their arguments on different grounds; some pointed out to the imperfections in the socialization law and some complained about the mistakes during the implementation of it.

The ones who supported the passage of the new law appreciated the government's effort to improve the long time neglected issue of health care. Moreover, they approved of the shift to contractual employment, as they believed in the idea that the risk of losing the job or the chance to get reward by the additional premiums would create an incentive for the personnel to work harder and more efficiently. Another item that was regarded as a positive development was the GHI. The doctors who praised the foundation of the GHI were divided into two camps, some built correspondence with the American health system while others claimed that the new system would resemble the British NHS. Yet, the common point of their argument was that, the issue of money would be detached from the relationship between the doctor and the patient, which would

[99] Republic of Turkey, *TBMM Tutanak Dergisi*, term 17, session 97, vol. 40, 30 April 1987

strengthen the relationship between the patient and the doctor and increase the trust of the patient for the doctor.[100]

However, the ones who opposed the new law criticized exactly the very same item in the law, namely the GHI. According to the opponents, the government tried to close the budgetary deficits through the premiums collected from the citizens. For instance, the head of the DSP, Rahşan Ecevit emphasized the low level of share allocated from the budget to health care and opposed the idea of billing health expenditures to citizens through premiums and service fees.[101] In another news published in Milliyet Newspaper, it was stated that the share from the budget could only meet the expenditure of an aspirin per person. It was added that the World Health Organization (WHO) also criticized the amount of money spared to health care form the general budget, and advised to increase this amount to at least 5 percent in order to implement the new GHI scheme efficiently.[102] By looking at the statistics depicting the percent of health care share from the budget it can be seen that MOHSA's share composed around 3 percent in the 1980s, which was 2 points below the level of WHO's advises.[103]

Another point of criticism originated from the idea to unify of all healthcare institutions under the MOHSA. The SSK members and union leaders fiercely opposed this development due to the special status of the SSK healthcare institutions. The health posts and hospitals of the SSK were built by the

[100] Milliyet, 1 January 1987

[101] Milliyet, 22 January 1987

[102] Milliyet, 23 January 1987

[103] Onur Hamzaoğlu and Umut Özcan, *Türkiye Sağlık İstatistikleri 2006*, (Ankara: Türk Tabipler Birliği Yayınları, 2005), p. 98

premiums collected from the workers, thus these people regarded those facilities as their private property. Health Workers Union leader Mustafa Başoğlu stated that if the government would confiscate and nationalize the SSK hospitals, the workers would fill those hospitals in order to claim their ownership.[104]

As can be understood from the debates both in the parliament and the newspapers, neither the healthcare workers nor the population adopted the new law on health care smoothly. The main opposition centered around the transformation of health care from a service that was provided by the state to a commodity that should be bought from the market by the citizens. Even the idea of the GHI could not prevent the opponents' approach towards the new law, as they saw the GHI as a part of the commodification process. The collection of the premiums for the GHI and the additional fees for service completely destroyed the old understanding, which was established with the socialization of the healthcare services. Moreover, the government did not define any financial resource to build the new system, which made even the supporters of the law hopeless on the implementation of it. The government claimed to create a new computerized database for the health files of the citizens in order to watch the premium payments, yet the source of the financial expenses to build such a system was not clarified.[105][106][107] Though the opponents of the law claimed that the health care expenses should be met from the general budget, the government was not convinced to channel a greater share for the MOHSA for neither the healthcare services nor the foundation of a GHI system.

[104] Milliyet, 13 March 1987

[105] Republic of Turkey, *TBMM Tutanak Dergisi*, term 17, session 97, vol. 40, 30 April 1987

[106] Milliyet, 10 March 1987

[107] Milliyet, 12 April 1987

International Organizations

Following the failures of the Ecevit government in the late 1970s to secure the support of the international organizations due to its inability to shift the development strategy to a more outward looking one, the Süleyman Demirel government determined to build better relations with the IMF and the WB with the help of Turgut Özal who was responsible for economic affairs. Right at the beginning of the 1980s the efforts to closely cooperate with the international credit organization were seen. As the AP government was aware of the sensitivity among the society against the external pressure in terms of economic decision making, the party made an effort in order to display the to be announced economic program as the result of autonomous and independent decision of the government. Yet, as Kirkpatrick and Öniş argued it was known that AP government instantly initiated discussions with the IMF and send Turgut Özal to Washington in order to bargain the terms and prepare the economic stabilization package of Turkey.[108]

The January 24, 1980 economic program was implemented to convince the IMF and the WB on the determination of the government for a shift in the economic strategy from an inward looking one to a more liberal and outward looking one in order to secure the ongoing debates for a stand by agreement with the IMF and the structural adjustment loans (SAL) coming from the WB. Beginning with the 1980s, the IMF and the WB started to divide their

[108] Mosley, Harrigan and Toye, pp. 12-13

concentration areas and the WB became more and more involved and dominant in the policy-making processes of Turkey. As a result of the January 24 decisions, which contained restrictive monetary and fiscal policy, constraints on subsidies of public enterprise sector by the Central Bank, a three-year stand by agreement was signed with the IMF on June 1980 and the SAL agreement with the WB on March 1980.[109] The IMF conditionality in 1980 rested on the continuation of January 24 decisions and tow additional items, which were related to the interest rate and incomes policy. As a result of the former additional item, all the controls on commercial bank interest rates were abolished and the rates were left to be determined by market forces. In terms of the SAL agreements signed with the WB, the major items were focused on the state economic enterprises reform, trade liberalization; export promotion and rationalization of public investment.[110] Though these loan agreements did not have specific articles on the health care sector, the developments in the following years would show (as in the 1987 the Basic Law on the Healthcare Services), how the economic strategy affected the approach towards health care policy in Turkey.

The WB could not be seen as a major actor in the health care in the 1980 as there were no the sector specific plans or credit agreements in this area. However, as the Bank would admit in the following decade, the signing of the first health project in the 1989 was maintained through the accordance of the government with the advises of the WB during the enactment of the health care law in the 1987. As a new health care policy backed by the WB was legalized, it

[109] Ziya Öniş, *State and Market* (İstanbul: Boğaziçi University Press, 1998), p. 129

[110] Mosley, Harrigan and Toye, pp. 13-15

would be more easy and rational for the Bank to involve directly in this sector in the following years.[111]

It would be appropriate to argue that, although a direct involvement of neither the IMF nor the WB could be observed in the health care arena in Turkey, through the stand by agreements and structural adjustment loans, they triggered the shift in the economy and development strategy in the country. Thus, they paved the way for a greater role for the international organizations to directly influence and to have a strong say in the national health policy of Turkey for the future.

Conclusion

The case of the 1980s and especially the Basic Law on Healthcare Services is a significant example on the retreat of state from the provision of health care and leaving its place to market forces. However, it should be noted that, the withdrawal of the state from the health care provision and its replacement with private sector in this decade was not unique to Turkey. As Roberts, Hsiao, Berman and Reich state that, especially since the 1980s, the market has started to outweigh the social solidarity ties and government interventions globally. The idea that state enterprises are less efficient and governed by patronage mechanisms made them undesirable while strengthened the support for

[111] World Bank, *Republic of Turkey: Second Health Project: Essential Health Services and Management Development in Eastern and Southeastern Anatolia* (World Bank: Human Resources Sector Operations Division Central and Southern Europe Departments Europe and Central Asia Region, 1994), p. 8

privatization and competition. Especially if government intervention or state enterprises in social services creates large deficits in the budget, the country will be abandoned by the international lenders and tied to the loans coming from agencies like the IMF or the World Bank. However, such agencies eventually push the governments to reform their social services in order to cut their spending in the budget. At that point, Roberts, Hsiao, Berman and Reich remind to pay attention to national differences while deciding on the policy changes. Policy prescriptions coming from the external organizations or agencies may ignore the national characteristics thus it is highly probable for them to mistakenly diagnose the failures in the health care systems of specific countries.[112]

Though the privatization of the pubic services was on the agenda in the 1980s, it is necessary to be cautious in using the word privatization in this point. As emphasized in the previous chapter there is a significant difference between the privatization and commercialization. Privatization necessitates the transfer of assets from public ownership to private ownership, while commercialization refers to the transformation of public enterprises to autonomous bodies that would compete in the market. The transformation of health care in Turkey in this era fitted to the latter definition while, the healthcare institutions were converted into business enterprises in order to meet their expenses through their incomes and had the autonomy to compete in the market with the private sector.[113] Yet, in the following years, as will be analyzed in the sixth chapter, the policies

[112] Marc J. Roberts, William Hsiao, Peter Berman and Michael R. Reich, *Getting Health Reform Right* (Oxford; New York: Oxford University Press, 2004), pp. 5,16-17

[113] Republic of Turkey, *Sağlık Hizmetleri Temel Kanunu*, Article 5

implemented in the AKP period displayed the passage of privatization stage in commodification of health care process in Turkey.

CHAPTER V

ATTEMPT OF DECOMMODIFICATION: REVERSE TREND IN THE COMMODIFICATION OF HEALTH CARE: THE ANALYSIS OF GREEN CARD LAW

The main aim of the thesis is to show the commodification of health care in Turkey through pointing out to the steps of commercialization in the 1980s and privatization in the 2000s. However, this chapter marks a reverse process in the narrative of commodification of health care in Turkey as in the 1990s, an attempt was seen to decommodify health care to a certain group of people. With this attempt of decommodification, the state aimed to provide healthcare services not in return for premiums or other payments but on the basis of citizenship. Thus, the state tried to secure the access to health care to people whether or not they participated in the formal job market and had public health insurance through employment. As a result, in 1992 a crucial development, named as the Green Card Law, took place, which inclined to reverse the tendency in the understanding of health care through altering the commodity status of health care, which was established since the 1980s.

Yet, this aim could not be fulfilled due to the failure to expend the process started with the Green Card law, which enabled the poor to get a definite package of healthcare services free to the whole population. As stated before, although decommodification means the assurance of provision of certain services

by the state to the citizens as a right, in order to secure the access of people to those services regardless of their employment status, the Green Card exercise was not sufficient to fulfill this aim. It was only a mechanism to protect the people who were left outside the formal job market and had a very low level of income. In my opinion, it is necessary to underline this fact again that, the Green Card law did not guarantee the provision of healthcare services to all the people who were deprived of public health insurance. Besides, the insurance package provided though this scheme did cover certain minimal type of healthcare services that could not meet the needs of the population covered by the Green Card. Thus, in this chapter the Green Card law will be analyzed as a case of failed attempt of decommodification of health care in Turkey both in terms of the population it served and the types of services it covered.

The Green Card law will once again be analyzed by focusing on the legal documents, political debates and the influence of international organizations during the preparation and enactment of the law. The stand of the parties in the parliament and their approach towards health care will be scrutinized through examination of the parliamentary minutes and newspapers. Besides, the degree and direction of the influence of the international organizations are aimed to be evaluated through the review of the reports of and agreements with the IMF and especially the WB.

General Political Environment in the Beginning of the 1990s

In the 1990s, the economic policies based on integration with the world economy continued while the role of the international capital was increased in an accelerated pace. The liberalization of capital in 1989 was strongly responsible for this increase. Though this step may not have directly affected the health care policy of Turkey, as health care services began to be commercialized in 1987, and health became an ordinary good that can be bought and sold in the market, economic developments like the liberalization of capital would eventually have implications for this sector. As the major impact, domestic financial system of Turkey has integrated with the international markets while large amounts of international capital inflows coming into the country. This integration with neoliberal global economy not only had a significant impact on the distributional capacity of the state and influenced social policy understanding but also affected the investments in the country, in health care sector as well.[114]

In the previous decade, Turkey experienced a crucial transformation in terms of economic policy under the power of military officials and the ANAP, which emerged as the major political party after the military rule. In the 1990s, although the economic understanding did not change and the integration with the world economy continued under the policy of capital liberalization, Korkut Boratav makes a distinction between the 1980-1988 period with the 1989-1993 period in terms of the government's approach towards the working class and policies on income distribution. According to Boratav, the latter period marks the

[114] Buğra, *Kapitalizm, Yoksulluk ve Türkiye'de Sosyal Politika*, pp. 198-199

end of the anti-labor policies of the ANAP government with the influence of labor protests in 1989 and the defeat of the party in the local elections that was held in the same year. Those events necessitated the government to change its policies towards the working population, as the privileges given to the industrialist were not sufficient for the party to conserve its votes in the elections. To fulfill this aim, the government increased the wages of the workers in the public sector, which was followed by the wage increases of the workers employed in the private sector. Thus as Boratav argues, 1989 marked a shift from the negative consequences of the previous decade's economic policies for the working classes both in the public and the private sector.[115]

In this four-year period between 1989-1993, not only the conversion in the mentality of the ANAP but also 1991 general elections marked a significant shift in the characteristics of the government. As a result of the general elections, the True Path Party (*Doğru Yol Partisi* – DYP) received the highest number of seats in the parliament though it was not sufficient to form a single party government. Thus in the following years Turkey was governed by the coalition between the DYP and the SHP. Ayşe Buğra focuses on the difference of DYP-SHP government from the ANAP period, especially in terms of the social policy understanding, particularly in the health care sector. The most prominent development in this area is the Law on the Covering of the Treatment Expenses of the Poor Citizens by the State through a Green Card (Law number 3816). After a year passed from the formation of the new government, this law passed in the parliament in June 1992.

[115] Boratav, *Türkiye İktisat Tarihi 1908-2002*, pp. 175-176

The Law on the Covering of the Treatment Expenses of the Poor Citizens by the State through a Green Card also known as the Green Card Law legalized in 1992 after the government worked on the issue of health care for months and took the opinions of the civil society organizations related with this sector. Through the Green Card scheme, the state aimed to provide the health insurance to the people whose income was less than 1/3 of the minimum wage. However, this health insurance would not cover all of the healthcare services and treatments the green card holder received. According to the law, only the inpatient treatments and medical expenses were included in the coverage of the services met by the Green Card.[116] However, the outpatient treatments and medical expenses were excluded from this scheme, which was a fact that would cause significant criticisms from the opposition in the parliament.

Another point of criticism that will be illuminated in the political debate section is that Green Card did not bring any improvement for the conditions of the poor in the application and granting procedures for utilizing the free health insurance. However, the Green Card law embodied distinct characteristics than the solidarity fund's application rules, which aimed to remove the practices that hurt the dignity of the people. The Green Card applications would be made to the councils of provincial administrations. Then the qualifications of the candidates would be reviewed by those councils and the ones who were found eligible

[116] Republic of Turkey, *Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun*, no. 3816, *Resmi Gazete*, no. 21273, 3 July 1992

would be recommended to the provincial governors who were responsible for distributing the green cards.[117] The validity of the green cards would be for one year and the green card holders were required to extend the validity period every year by applying to the provincial councils. As this application was once for a year, contrary to the Social solidarity fund application, which should be done every time the patient needed the help of the state in meeting the hospital expenses, the Green Card exercise had a significant improvement in terms of the position of the poor and the state's approach towards them.

When the inclusionary capacity of the Green Card is examined through numbers for the early times it was enacted, it would be seen from Table 4 that, at the end of the first year of the Green Card application, approximately 2.5 million people reached health insurance through this scheme. Adding the people covered by formal social security institutions, the ratio of the population who had public insurance, either through ES, SSK, Bağ-Kur or Green Card was 63.8 percent in the end of 1993.[118] Yet, the remained 27.2 percent of the population was left to their own means to have an access to the healthcare services.

[117] Ibid., Article 6-8

[118] World Bank, *Turkey: Reforming the Health Sector for Improved Access and Efficiency,* p. 27

Table 4: The Number of People Who Applied to Green Card and the Number of People Who were Granted the Card in the years 1992-2003.[119]

Years	Number of People Applied	Number of People Granted Green Card
1992	910,873	365,509
1993	2,060,849	1,845,832
1994	1,498,213	1,460,111
1995	1,507,504	1,325,276
1996	970,889	716,338
1997	1,298,526	953,912
1998	1,345,953	1,093,465
1999	1,352,148	961,186
2000	1,610,828	1,404,677
2001	1,674,706	1,372,419
2002	2,137,520	1,502,452
2003	1,311,728	294,921
Total	17,679,737	13,296,098

Political Debate

The commodification of health and commercialization of health care with the law passed in 1987 caused many problems in terms of access to health care services especially by the poor in the country. Though the then government aimed to help the people who did not have any means and/or any social insurance to meet the expenses of the healthcare services through the Social Cooperation and Solidarity Fund, its implementation was degrading and the poor did not have any formal guarantee to access this fund. In the law it was stated that, the expenses of the people who were unable to pay for the services would

[119] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Yedinci Beş Yıllık Kalkınma Planı (1996-2005)* (Ankara: DPT, 1995), p. 113

be met fully or partially, from the resources of the fund.[120] Yet those people were forced to prove their poverty every time they applied to hospitals. Moreover, as there were no set criteria to determine the poverty of the people, there was a significant risk of corruption and no legal guarantee for the poor to get the funding. In such an environment the opposition parties and especially the DYP and the SHP used the universal access to health care as one of the main promises for the 1991 general elections. Particularly, the DYP came up with the idea of "Green Card" as a major propaganda tool with an argument that everyone would have a green card and through showing this card they would have access to healthcare services in the country".[121]

The DYP actually started the election campaigns with ambitious projects related with privatization of the public economic enterprises, reforms in the tax system, increase in the wages and securing social harmony through eradicating the antagonism between the employers and the employee. Besides, a motto was used in the campaigns as "two keys for a household" which implies the aim to increase the welfare of the people through making everyone owners of a house and a car.[122] Yet these projects planned by Tansu Çiller, the vice president of the party, created some discomfort among the other deputies of the party. According to them welfare of the people could not be measured through the number of keys they owned, but the state should provide development, basic needs, food, education, health and employment.[123] Thus in time, the major promise

[120] Republic of Turkey*, Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun,* Article 11

[121] Cumhuriyet, 29 September 1991

[122] Cumhuriyet, 9 September 1991

[123] Cumhuriyet, 11 September 1991

transformed from the "two keys for every household" motto to "10 reforms" which underlined the aforementioned points of development, education, health and social security.[124][125]

From these ten reforms, one of the most appealing was the health reform that was based on the promise that every one would have free and equal access to healthcare services. The party leader Süleyman Demirel promised free health care through Green Card first in the meetings of Rize. This was most probably because of the particularity of the city that it was the homeland of Mesut Yılmaz, the leader of the governing party ANAP. In Rize, Demirel stated that, everyone would receive green card and with this card they would have the right to use healthcare services regardless of their income level.[126] Later in an interview, he maintained that, people had two choices, whether they would prefer to pay for the healthcare services they received or they would get green card from the state, and state would pay for the healthcare services for the people. And he added that it was the duty of him to find the necessary resources for these services (implying that the people should not worry about the financing side of the healthcare services).[127] From the reform program of the party it is understood that the resources were planned to be channeled from the reformation of the tax system and privatization of public economic enterprises.[128] Though, the trust in

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[124] Cumhuriyet, 7 October 1991

[125] This reform package totally included: tax reform, public economic enterprises reform, financial reform, industrial reform, agricultural reform, education reform, health reform, environment reform, social security reform, human rights reform.

[126] Cumhuriyet, 14 September 1991

[127] Cumhuriyet, 29 September 1991

[128] Cumhuriyet, 9 September 1991

the market economy and privatization continued with the tendency to view the contraction of state as a positive development, the DYP differentiated from the ANAP with its approach especially towards the health care issue since the party assumed its provision as the duty of the state.

Besides, the to be coalition partner of the DYP, the SHP also emphasized the importance of the provision of equal and free access to healthcare services. In a meeting with the Turkish Medical Association, the vice secretary general of the SHP, Abdülkadir Ateş stated that healthcare services were public services that should be financed though the general budget.[129] During the passage of the Basic Law on Healthcare Services in 1987, a similar debate was carried out in terms of availability of resources required to realize the transformation. In those times, the ANAP was criticized for charging the expenses from the people while this time the new health care system was promised to be financed through state budget. Both the DYP and the SHP met in a common point as they both explicitly declared that the GHI they were planning to establish would be on a universal basis where it would be the duty of the state to pay for the healthcare services of the people. As opposed to the promises of the DYP and the SHP concerning the health care, the ANAP's approach towards the issue did not offer any significant difference from the previous times. In the election campaigns the party stressed the significance of universalized social security and health care as a part of it, while the issues of equality and financing of those services were not mentioned.[130]

[129] Cumhuriyet, 29 September 1991

[130] Cumhuriyet, 7 October 1991

After the elections of October 20, 1991, the DYP ended up being the first party receiving the 27 percent of the votes and made a coalition with the SHP that received the 20 percent of the votes and turned out as the third party in the elections. The issue of health care could be put on the agenda till the arrangement of the national health congress on March 1992 while it could not come to the parliament before June 1992. Apart from the delay to put the issue on the agenda, during the preparation of the law, a discrepancy came out concerning the contents of the law. The Green Card scheme was designed to cover only the people whose monthly income was lower than the 1/3 of the minimum wage while it was promised that everyone would have Green Card during the election campaigns. The then Minister of Health, Yıldırım Aktuna, explained this discrepancy as the realized Green Card to be a step towards the GHI, which was promised before the elections. According to Aktuna, to carry out a development like the GHI was a long and difficult process, which necessitated a detailed research and great investment for the transformation of the whole health database in the country. He stated that the government was determined to carry out this transformation, yet for the time being the Green Card law was prepared in order to end the grievances of the poor in access to health care.[131]

There were two main points of opposition to the law in the parliament by the major opposition party ANAP. First, they claimed that the Green Card brought nothing new to the health care policy of Turkey, as the poor was given the access to the healthcare services with the Social Cooperation and Solidarity Fund in the previous decade. The government responded such criticisms stating that it was despising and degrading human dignity to prove poverty every time

[131] Republic of Turkey, *TBMM Tutanak Dergisi*, term 19, session 84, vol. 12, 17 June 1992

they applied for healthcare services. Yet the opposition was not satisfied with these statements and did not regard this law as a positive step towards the treatment of the poor. According to the opposition there was nothing less degrading with applying and having green card once and extending validity every year, and proving the neediness every time going to the hospital. Besides, there was an article in the Green Card Law stating that for the people who were not qualified to get a green card but did not have enough resources to pay for the healthcare services would be supported though Social Cooperation and Solidarity Fund as it happened before.[132] This article also created a discomfort among the opposition especially in the ANAP as they claimed that the new law did not bring a new reform rather changed the name of the implementations for a small group of people.[133]

The second group of opposition stemmed from the coverage ratio of the population and the types of services given free access through this law. On the one hand, the opponents criticized the income criteria for coverage determined as lower than the 1/3 of the minimum wage. They claimed that, only a small number of people would have the chance to benefit from the Green Card Law due to the agreed lower income level as the 1/3 of the minimum wage. On the other hand they asserted that the services, which were granted access with the Green Card was very limited and did not effectively point out the deprivation of the poor in receiving the healthcare services. In the law it was stated that the Green Card would guarantee the holders' right to treatments and medical

[132] Republic of Turkey, *Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun,* Article 11

[133] Republic of Turkey, *TBMM Tutanak Dergisi*, term 19, session 85, vol. 13, 18 June 1992

expenses of the hospital inpatients.[134] Yet, the outpatient treatments and medical expenses were not included in the Green Card services. The opponents to the law proposed motions in order to change Article 2, which defined the coverage and access to the healthcare services through the Green Card, however, those motions were rejected in the parliament and the law passed with the text as it came from the planning and budgetary affairs commission.[135] Here it is necessary to note the fact that, before the draft law was submitted for approval in the parliament, the planning and budgetary commission denoted a dissenting opinion for the income level determined by the ministry of health. Thus while the law was presented before the parliament, the draft was included a statement that the lower limit of income for Green Card qualification can be raised to minimum wage with the approval of council of ministers. [136] Yet, for nearly two decades, this lower limit never raised to the minimum wage level.

On behalf of the government, Aktuna responded the above-mentioned criticisms declaring that, the Green Card scheme was only a small part and the initial phase of the government's aims to establish a national health policy, which was claimed to be absent by then minister of health. Aktuna stated that, in order to create a national health policy, he initiated the efforts to gather the first national health congress on March 1992. It is crucial to underline the fact that, civil society organizations, occupational chambers, political parties, private sector, media and unions were invited and represented in the congress. Exchange of ideas through such a wide scale participation in health policy-making had

[134] Republic of Turkey*, Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun,* Article 2

[135] Republic of Turkey, *TBMM Tutanak Dergisi*, term 19, session 84, vol. 12, 17 June 1992

[136] Republic of Turkey, *TBMM Tutanak Dergisi*, term 19, session 84, vol. 12, 17 June 1992

been realized for the first time in the republic's history. In this congress three points were determined to focus on in order to improve the healthcare services throughout the country. First item was decentralization of the administration of these services. Aktuna stated that as the population, personnel and demand in healthcare services increased, it was getting harder to administer this sector on a centralized basis from Ankara. Second item was the autonomization of MOH hospitals in order to be able to compete with the private sector in the health care market. Third was the passage to GHI starting on May 1993 on a gradual basis, as this transformation necessitates building a complex infrastructure throughout the country.[137]

Aktuna maintained that Green Card is a temporary application, which would last until the establishment of the GHI all over the country, and it aimed to solve the problems of the most marginalized segment of the population immediately. Thus, he stated that the lower limit of income was sufficient for the time being and according to the data of the State Statistics Institute (Devlet İstatistik Enstitüsü – DIE), by this criterion approximately 10 million people would benefit from the Green Card Law. Moreover, he stated that this law was designed to protect the dignity of the citizens in order to prevent them proving their destitute every time they applied to the hospital and avoid the partisan usage of the state budget or funds due to lack of a definite criteria for determining the ones who would be qualified as being in need of help.[138] Unfortunately, it was not possible to find a legitimate explanation from the government or the Minister of Health for leaving the outpatient treatments and medical expenses, which

[137] Republic of Turkey, *TBMM Tutanak Dergisi*, term 19, session 84, vol. 12, 17 June 1992

[138] Ibid.

composed 64 percent of the total health care expenditures out of the coverage of the law.[139]

International Organizations

It is necessary to underline the fact that, the shift in the social policy understanding cannot be attributed solely to the domestic developments. In the 1990s, the international organizations also paid a close attention to the problems of the poorest segments of the population, which were marginalized by the structural adjustment policies of the previous decade. This time they aimed to find solution to the problems they created, through offering various social assistance measures. As reflected in World Bank's focus on health in the World Development Report 1993: Investing in Health, the WB was determined to emphasize the issue of health and poverty more, as the crucial interaction between poverty relief, education, health status and economic development was admitted by the Bank.[140] Thus, in the 1990s apart from the indirect consequences of free trade and privatization measures imposed by the WB and the IMF, there was a direct involvement of those international credit organizations especially of the WB on the health care policies of the country. The first health project agreement was signed with the WB in 1989 (and became effective on October 1990). Both the first health project and the second health project, which was

[139] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Sekizinci Beş Yıllık Kalkınma Planı: Sağlık Hizmetlerinde Etkinlik Özel İhtisas Komisyonu Raporu,* (Ankara: DPT, 2001), p. 124

[140] World Bank, *World Development Report 1993: Investing in Health,* (Oxford; New York: Oxford University Press, 1993)

signed in 1994, had the aim to reach a better quality of health care with a low-cost strategy, especially in the underdeveloped parts of the country. Especially the second health project had a crucial timing and purpose. It was signed right after the financial crisis in Turkey, with the aim of complementing the IMF standby agreement came into force in 1994, which imposed a substantial contraction of public spending in the country.[141]

As stated above, both of the WB health projects were aimed at improving the healthcare services in rural and underdeveloped parts of Turkey (especially east and southeast), while the emphasis was to transform the provision of healthcare services generally through restructuring the services provided by the Ministry of Health. The importance of integrated health care system, family medicine and general health insurance were also mentioned. The report stated that, the government was more determined to reform the health care system and one of the major steps to realize that reform was a comprehensive examination of the social insurance system with the collaboration of Privatization Implementation Assistance Project.[142] It is crucial to observe the aim to privatize the social insurance system by the WB, yet it is of equal importance to be aware of the fact that, this inclination of the WB was not specific to Turkey. As it was stated by Price, Pollock and Shaoul, the mid 1990s marks a considerable increase in the interest of the WB on the traditionally publicly provided services and the idea to restructure those services through privatization gives a deep insight about the aims of the process. Although the situation of the poor and the provision of public services to those people attracted attention of the international

[141] World Bank, *Republic of Turkey: Second Health Project,* p. 10

[142] Ibid., p. 8

organization, simultaneously the privatization of those services was adopted as the best solution for restructuring. Thus, as Pollock argues while the coverage of basic health services expands, the services they included diminish, requiring the people to apply to the private sector for their treatments or other medical needs.[143]

As stated in the beginning of the chapter, in terms of health care sector, the IMF stand by agreement was complemented with the second health project signed with the WB. This agreement contained the involvement of privatization implementation assistance project in the area of health care. Apart from the IMF and the WB, another institution with economic focus had started to be interested in the health care issue in the 1990s. As stated in the second chapter, the World Trade Organization was founded in 1995, which was the successor of General Agreement on Tariffs and Trade, an international agreement established to promote international free trade and reduction of trade barriers. The WTO began to involve in the issue of health care in this decade, in order to open health care markets (i.e. insurance, pharmaceutical, etc.) to international competition. According to Price, Pollock and Shaul this process was very much related with the needs of private corporations in the US. They argue that due to the saturation of the US market by the end of 1990s, those corporations required to find other areas to sell their goods and services to make profit from the foreign markets.[144]

Besides, the fundamental agreement of the WTO in terms of health care sector has been the General Agreement on Trade in Services, which came into

[143] Pollock, *NHS plc*, pp. 41-42

[144] Price, Pollock and Shaoul, 1999, pp. 1889-1892

force in 1995. The GATS focus on the necessity of the opening up of national service markets (i.e. health care, education, retail trade) to foreign providers while limiting the public regulation of their activity. Turkey, one of the signatories of this agreement, was among the 44 countries, which committed to give access to the international investors to the hospital services.[145] Though the major changes in investment policies in healthcare facilities would be carried out in the 2000s, it is necessary to refer to the agreement in order to give an insight about the global trend in health care in the 1990s. Thus it was clear that in the 1990s two approaches prevailed simultaneously, one supported the public finance of the healthcare services while the other backed the private sector in the provision. The presence of two distinct approaches resulted in the creation of the Green Card scheme –as explained above- and a significant increase in the number of private healthcare institutions in this decade.

Conclusion

Reviewing the legal documents, political debates and the influence of international organizations, in order to conclude it is necessary to look at the results of the implementation process. When it comes to the application, it is necessary to stress the discrepancy between the number of people claimed to be granted green card and actual number of people who managed to get it. Though it

[145] Adlung and Carzaniga, pp. 352-357

was a significant development to guarantee a definite package of healthcare services for free to a group of people who did not have any means to reach those services, the actual number of green card holders did not reflect the expectations of the MOH. As mentioned before, Aktuna proclaimed approximately 10 million people would be qualified to get green card with the passage of the law, yet when the statistics were reviewed, the actual situation disproved this claim. In the first year of the Green Card's implementation only 365 thousand people received green card while the expectation of giving 10 million people the opportunity of free healthcare services fulfilled in the year 2000.[146] In the year 1993, only 60 percent of the population had health insurance while more than 20 million people were left uninsured in an health care system based on competition and users' contribution fees.[147]

Besides, the established framework of the Green Card was unable to offer a universal understanding of health care as a right of the citizens. Rather it was offered to the poorest segment of the population as a favor of the state. Bauman harshly criticizes this approach as it caused discrimination among the population that is totally opposite from the aim of the welfare state, which is to create solidarity among the classes.[148] Moreover, this approach approximates the Turkish welfare regime to the Anglo-Saxon welfare regime with a residualist understanding in offering services only to the needy.[149] As in the US Medicaid, the state undertook only the expenses of the most desperate population while

[146] Hamzaoğlu and Özcan, p. 96

[147] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Yedinci Beş Yıllık Kalkınma Planı (1996-2005)*, p. 113

[148] Bauman, 1998, pp. 49-50

[149] Esping-Andersen, *The Three Worlds of Welfare Capitalism*, p. 126

expected the rest to take care of themselves whether through participating in the formal job market and have a public social security or paying the healthcare services they bought.

Though the Green Card was assumed as a step towards the GHI, which was planned to be implemented on May 1993, the GHI could not be realized in this decade. As will be discussed in the next chapter the GHI was established in 2006 though the realized scheme had a crucial difference than the one intended by the DYP-SHP coalition. The difference of the DYP-SHP understanding was reflected during the election meetings and parliamentary discussions as both of the parties underlined the essence of healthcare services as a part of public services, which should be financed through the state budget. Demirel used the term "free general health insurance" during the election campaigns underlining the fact that the people would not pay for this insurance. Yet the GHI established in the AKP period was designed to be financed through the premiums and contribution payments of the users like the one envisaged in the ANAP period. Though, this time general insurance was stated to be compulsory, meaning that no one would be left outside the public insurance scheme.

In order to explain the reasons of failure to carry out GHI reform in the 1990s, it is required to note that, Turkey experienced an instable era in terms of the governments came to power. Not only the number of changes in the government but the nature of coalition governments created many disagreements on policy making level. Beginning with the DYP-SHP coalition until the end of the decade, the government changed for nine times in this period and nine different ministers administered the MOH, as well. Moreover, the financial circumstances did not proceed smoothly. In 1994, the country was hit with a

financial crisis, which made the economy more vulnerable and necessitated the intervention of the IMF with another stand-by agreement in order to support the austerity program announced by the then prime minister Tansu Çiller, resulting in the further contraction of the economy in return for the credits coming from the organization.

In the 1990s, due to the support coming from the international organizations to the private sector in the area of health care, as Çağlar Keyder points out, private healthcare institutions increased their share in the sector sharply.[150] As can be seen from the statistics on the private healthcare institutions, the number bed in private healthcare institutions nearly tripled between the years 1989 and 2001.[151] Moreover, the number of the private hospitals increased from 184 in 1997 to 239 in 2001. However, the most striking fact is that, 122 of those total 239 private hospitals in Turkey were found in Istanbul. Unfortunately, only twelve of these private hospitals were situated in the eastern part of the country and this caused to question the private sector's assistance on solving the gap between the east and the west.[152] Since one of the most significant problems was the gap in the quality of and access to the healthcare services between the eastern and the western parts of the country, the numbers revealed that this gap was widened by the investments of the private sector.[153]

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[150] Çağlar Keyder, Nazan Üstündağ, Tuba Ağartan and Çağrı Yoltar, *Avrupa'da ve Türkiye'de Sağlık Politikaları* (İstanbul: İletişim, 2007), pp. 18-19

[151] T.C. Başbakanlık Türkiye İstatistik Kurumu, *İstatistik Göstergeler 1923-2005* (Ankara: Türkiye İstatistik Kurumu Matbaası, 2006) p. 47 table 3.4

[152] See Appendix D

[153] See T.C. Sağlık Bakanlığı, *Yataklı Tedavi Kurumları İstatistik Yıllığı 2001*, Table 48

To conclude, the inconsistent health care policies of the governments due to the changes of the domestic and international circumstances, deprived Turkey a determined progress towards the universalized healthcare services through the GHI which was a development aimed to be accomplished since the 1960s. The 1990s witnessed the enactment of Green Card scheme which was a means based approached and far from the universalist citizenship based understanding. The Green Card exercise though accepted as a positive development in terms of securing the health care access of the poor through the defined criteria, as it draw bold lines between the ones who deserved the public insurance through paying premiums and the ones who deserved it through their neediness, widened the gap between the poor and the formally employed. Yet, in the 2000s it would be seen that, the AKP government managed to established a universal understanding in health care though it was based on not citizenship but premium payment. In the AKP period the status of the green card holders would be transformed and they would be forced to pay additional payments in order to receive healthcare services as will be discussed in the next chapter.

CHAPTER VI

FROM COMMERCIALIZATION TO PRIVATIZATION: DEEPER INTO NEOLIBERALISM IN THE 2000S

This chapter aims to fulfill the claim of commodification of health care passed into a new phase from commercialization to privatization in the 2000s. In this chapter I will focus on this decade and especially the developments of the AKP government as the major transformations in health care have been carried out during this period. The AKP came to power after November 2002 general elections and constituted a single party government following the 11 year long coalition governments experience in Turkey. After a brief introduction on the political atmosphere of the 2000s, I will pass onto the developments of the party in the health care arena. The party promoted "transformation of health care" motto since the 2002 election campaign and health policy still remains as one of the subjects of priority. It is necessary to underline the fact that, the party has not been alone in its efforts to improve the healthcare services; international organizations and civil society organizations backed the idea to reform the health care system in Turkey. Moreover, the voters upheld the promises of the government on this issue, as access to and quality of the healthcare services were indispensible sources of complaint from the people for years. Yet the AKP could not be able to satisfy the domestic groups with the policies enacted, though those policies were able to fulfill the expectations of the international organizations.

Political Atmosphere in the 2000s

In the 2000s, several interrelated factors emerged that resulted in the intervention of international organizations directly to the economy and especially health economy of Turkey. In 2001, Turkey went through a major financial crisis, which again necessitated the inclusion of the IMF and the WB into the matter as in the 1980s and 1990s. Right after the crisis Kemal Derviş was appointed as the Minister responsible for economic affairs. Derviş worked for the WB for 24 years and he was an expert on the Middle East and North Africa regions, poverty reduction and economic management subjects. With his participation to the cabinet and maintenance of the discussions with the IMF and the WB through his mediation, Turkey secured the support of and credits flowing from international lenders in 2001. However, as Günal mentions, as much as this may have contributed to the recovery of the Turkish economy, this situation have given the international organizations more right to intervene into the domestic affairs of the country.[154]

Moreover, the shift in the government to the AKP in 2002 contributed this unequal relationship, due to the party's readiness to embrace the impositions coming from the IMF, the WB and the EU most probably in order to be accepted as a legitimate player in the westerns politics despite their Islamic background. Last but not least, as the new ruling party had its roots in the congregational political tradition, the AKP supported the culture of solidarity and aid among the

[154] Günal, pp. 453-454

population. Thus, in terms of social policy, rather than assuming the state as the major player, the AKP has emphasized the cooperation of the state, market and society pillars. Besides, The AKP government has underlined the importance of charity as a part of its social policy approach in order to secure the withdrawal of state from this arena. That is a significant point, where the aims of the conservative government in Turkey met with the neoliberal intentions of international organizations.[155]

As stated earlier, the interest of the WB on poverty and health care continued in the 2000s, paving the way for a loan agreement for health transition project of Turkey in April 2004. Not only the loan agreement but also the WB's report on Turkish health care system had significant influences on the policy developments realized in this decade. Last but not least the pressures of the IMF to carry out the social security reform was a significant driving force behind the policy developments during the AKP period.

Legal Documents

In the 2002 general election campaigns there were two parties, which used health care reform as a propaganda tool. They were the AKP and the CHP, the only parties, which were able to enter the parliament at the end of the elections. Both parties underlined the necessity to cover all citizens, to remove the disparities between the MOH and the SSK hospitals and to stress the issue of preventive

[155] Buğra, *Kapitalizm, Yoksulluk ve Türkiye'de Sosyal Politika*, pp. 218-219

care.[156] The leader of the AKP, Tayyip Erdoğan, specifically pointed out the disparities between the west and Anatolia in terms of economy, health care and education as he criticized the previous government and promised that the AKP would give priority to eliminate the discrepancies between regions on these subjects.[157] Thus, after the November 3, 2002 elections, as those two parties managed to enter the parliament it was not surprising that the health care reform would gain a precedence among other policy arenas in the agenda.

The AKP gained the majority of seats in the parliament, but before the establishment of the new government, Erdoğan declared the "urgent action" plan, which included various subjects such as tax reform, transportation, privatization, agriculture, education and social policy. As the focal point of this thesis is the health care policy, it should be underlined that, in this plan a schedule was prepared according to which in a period of one year, the family medicine practice and general health insurance would be established, the efforts would be started in order to remove the disparities between the MOH and SSK hospitals and the private sector would be encouraged to invest in this sector. Moreover, this plan also included the unification of different social security organizations in order to provide equity in norms and standardization of the services. Yet, it should be underlined that, the social policy issues were handled as polices towards the poor, and poverty was assumed as the top problem the government should deal with. In order to fulfill this aim, it was planned to determine the families who were under the poverty line and help their children in terms of education and

[156] Hürriyet, 8 November 2002

[157] Hürriyet, 16 November 2002

health care.[158] This point would be a source of criticism from the CHP, which underlined the necessity to serve all of the citizens rather than only focusing on the poor in terms of social security.[159]

With the establishment of the new government by the AKP, Abdullah Gül, the then prime minister announced the government program and laid out the details of the health care reform project of the new government. Gül stated the importance of the GHI and the necessity to include the ones who were not covered by any social insurance scheme. Gül claimed that, with the formation of the GHI, the provision and finance of the healthcare services would be separated and the waste of resources would be prevented through this method.[160] The split of the provision and finance was an idea backed by the international organizations as stated earlier. The MOH and SSK both carried out the functions of financing and provision together, which according to the WB a characteristic that cause waste and inefficient use of resources.[161] So through the split of the finance and provision, the finance task would be passed to an autonomous health fund, which would collect the health care premiums from the citizens and it would buy the services provided by the MOH, SSK, university and private hospitals.

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[158] Ibid.

[159] Republic of Turkey, *TBMM Tutanak Dergisi*, term 22, session 4, vol. 1, 26 November 2002

[160] Adalet ve Kalkınma Partisi. (23 November 2002). *58. Hükümet Programı Tam Metni*. Available [online]: http://web.akparti.org.tr/basbakan-abdullah-gul-58-hukumet-programini-tbmmne-sundu_1939.html [1 April 2009]

[161] World Bank, *Turkey: Reforming the Health Sector for Improved Access and Efficiency,* pp. 23-24

Besides, as Erdoğan stated in the urgent action plan, Gül also stressed the family medicine and unification of the MOH and the SSK hospitals in the government program. Backing the idea inherited from the 1980s, the new government underlined the administrative and financial autonomy of the hospitals and aimed to fulfill this idea through creating a competitive environment in the health care sector between the private and public hospitals.[162] Though the health care reform was a common point between the AKP and the CHP during the election campaigns, it would be a source of conflict during the policy-making processes, and due to these conflicts the Social Insurance and the SIGHI law came into force causing several debates after undergoing various changes.

Before passing onto the detailed analysis of the AKP period and the developments carried out in that time, I would like to stress once again the fact that, the most crucial elements of the reform program in this era, had two or more decades of past, rather than being brand new ideas of the AKP government. The idea of general health insurance was proposed even in the First Five Year Development Plan in 1963, entered 1982 constitution, aimed to be established in the ANAP and DYP-SHP governments in the 1980s and 1990s whereas, family medicine practice started to be mentioned and the standardization of norms among the hospitals through devolution of the SSK hospitals to the MOH had been a source of debate since the 1980s.

Moreover, just before the AKP took the government, State Planning Organization published Eight Five Year Development Plan: Health Services Efficiency Specialized Commission Report, which indicated the deficiencies and

[162] Adalet ve Kalkınma Partisi, *58. Hükümet Programı Tam Metni*

offered the ways to overcome the problems in the health care sector in Turkey. The report determined the coverage of whole population through general health insurance as the top priority. In the report it was advised that the issues such as family medicine, improvement of outpatient services and hospital autonomy, which had been at the center of debates since the 1990s, should be dealt within the Eight Five Year period (which composed the years between 2001 and 2005).[163] Besides, it was asserted that an effective referral chain should be established in order to prevent the waste of resources in the sector. For a successful referral chain, first level healthcare services should be strengthened in terms of both additional preventive care measures and family medicine practice.[164] In the document it was advised that a general health insurance system should be built and financing and provision split should be maintained in the health care. In order to fulfill this aim, health and retirement insurance funds should be separated, an autonomous pool should be established for general health insurance and the differences between the citizens, in terms of the service they got and the premium they paid due to the presence of various formal insurance schemes, should be removed.[165]

The most striking elements in the document were concerned with the private investments in the sector. Though private sector had been supported in the previous development plans, this time it was delegated a crucial responsibility, since in the report it was asserted that, hospital services should be provided by the private sector and trusts due to the expensive investment

[163] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Sekizinci Beş Yıllık Kalkınma Planı: Sağlık Hizmetlerinde Etkinlik Özel İhtisas Komisyonu Raporu*, pp.11

[164] Ibid., pp. 34-35, 133

[165] Ibid., pp. 133-135,141

requirement in this area.[166] Last but not least, the specialized commission recommended arrangements to encourage foreign investments in health care sector.[167] All these suggestions came from the state planning organization just before the elections after which the AKP became the governing party. Yet the party's full accordance with this document could be easily grasped after focusing on the developments during this era. The developments in health policy in the AKP period can be gathered around three headings, provision, coverage and finance. In the following sections, the laws will be scrutinized under these titles respectively.

Provision

The AKP started its actions in health care area promptly after coming to the power, even before the declaration of the transformation of health care program. One of the first targets the AKP wanted to accomplish was to end the problems of the public hospitals due to the density of the population accumulated there. According to the government the best way to solve this problem was to give the people under the coverage of public insurance schemes the access to the private hospitals. On June 25, 2003 the Law on to Change the Public Servants' and Retirement Fund's Law numbered 4905, was passed. Through this law, the civil servants –both active and retired- and their families got the chance to be treated

[166] Ibid., pp. 198

[167] Ibid., pp. 143,231

in the private hospitals.[168] After the development on the public servants' was carried out, the long time struggled project was partially realized with a protocol signed between the MOH and the SSK on June 27, 2003. Through this agreement, it was accepted that the active members of the ES, the Bağ-Kur and the green card holders might utilize the healthcare facilities of the SSK while the patients of the SSK might use the MOH's healthcare facilities.[169]

After starting to take the actions on the health care issue so fast, the AKP declared its "transformation of health program" on December 2003. This program was designed to define the major deficiencies of the current system while laying out the principles, which would be the key pillars of the AKP government's basis in restructuring the healthcare services. In this document, the socialization law was criticized as being outmoded and insufficient to meet the demands of the current demographic and socio-economic conditions of the country. In an effort to replace the socialization law, three issues; organization, financing and provision of the healthcare services stated as the major points of the transformation. In order to restructure these points of the system, main policy targets were determined as: (1) a MOH which acts as the major planner and supervisor, (2) a GHI which covers every citizen regardless of their employment status, (3) extended and easily accessible healthcare services which would be served in a competitive environment, (4) more involvement of the private sector,

[168] Republic of Turkey, *Devlet Memurları Kanunu ile Türkiye Cumhuriyeti Emekli Sandığı Kanununda Değişiklik Yapılmasına Dair Kanun,* no. 4905, *Resmi Gazete*, no. 25155, 1 July 2003, Article 1

[169] T.C. Sağlık Bakanlığı, *Sağlık Bakanlığı - SSK Sağlık Tesislerinin Ortak Kullanımı Protokolü Hakkında Genelge ve Protokol Metni,* no. 12861, 27 June 2003

(5) family medicine practice, (6) strengthened referral chain, (7) administratively and financially autonomous healthcare enterprises.[170]

Following the declaration of transformation in health program, the development carried out in the health care sector was the agreement between the SSK and private hospitals on March 30, 2005. Through this agreement, the SSK workers gained the right to go and get their treatment from the private hospitals. Yet, as it appeared in the news, the access to private hospitals could not satisfy the needs of the SSK patients contrary to the expectations. As the current health care law that time had not conditioned the procedure on the collection of contribution payments until the establishment of the GHI, the private hospitals were free to determine the limit of contributions according to their wish. Thus, most of the SSK patients went to the C group private hospitals[171], which took low level of contribution payments compared to the A and B group hospitals. This time the long queues were formed in order to get an appointment from those private hospitals for the SSK patients after they suffered the same experience due to the density in the SSK hospitals.[172]

Another solution for the grievances of the SSK members was the unification of the MOH and the SSK hospitals. This step had been planned for more than two decades and realized through a devolution process, which was highly criticized by the opponent groups. Yet, in spite of the oppositions coming from the civil society, the Law on the Devolution of Healthcare Units of Certain

[170] T.C. Sağlık Bakanlığı, *Sağlıkta Dönüşüm*, pp. 24-32

[171] According to the Regulation on private hospitals, there are three groups of general private hospitals, A, B and C. They are set in order in terms of the bed capacity, number of specialized branches and the laboratory services.

[172] Hürriyet, 25 August 2005

Public Institutions numbered 5283 was accepted in the parliament on January 6, 2005. This development met a fierce opposition both within the parliament and the civil society. In fact, due to the presence and strength of this opposition, this step could not have been taken in the previous two decades. But, this time the government was able to overcome the opposition and managed to carry out the unification through devolution. In order to clarify the main points of opposition, the debates on the unification of MOH and SSK hospitals would be analyzed further in the political debates section.

Simultaneously with the reform processes concerning the second level healthcare services through the policy developments arranged on the access to and quality of hospitals, the first level healthcare services stared to be restructured in the end of 2004. The policy makers emphasized the importance of staged services in health care once again and underlined the necessity to establish a strong referral chain to offer more efficient and higher quality services. With a strong referral chain, it was aimed to prevent the accumulation of the patients in the hospitals, which composed the second level healthcare institutions. Thus, in order to fulfill this aim, the policy makers planned to replace the health posts with the family doctors.

The government had started to mention about the "family medicine" right at the beginning, since the declaration of the transformation of the health care program as they claimed that the health post practice was archaic and not suitable for the current context. Thus, in November 24, 2004 the Law on the Pilot Application of the Family Medicine Practice numbered 5258 passed in the parliament. In the law, the family doctor was defined as the specialist physician on family medicine who offered preventive healthcare services and first level

diagnosis, treatment and rehabilitation services.[173] Following the legalization of the family medicine practice, in order to determine and explain the basic principles of this application the Regulation on the Family Medicine Pilot Application was issued. In this regulation, performance criteria were set in order to assess the success of the family doctors[174], which might create ethical problems during implementation of the system. Because, the performance was very much related with the number of receipts written and examinations made for a period of time. Thus, this may trigger fraud in the reports in order to get promotion on the performance criteria. The news on such fraud cases has already started to appear in the media since the first year of the implementation. On April 2005, the president of Memur-Sen and Sağlık Sen, Ahmet Aksu claimed that, in order to earn more money from the revolving funds the doctors wrote for unnecessary examination and treatment reports for the patients to show their performance level higher.[175]

While some steps had taken towards to widen the access to healthcare services through inclusionary attempts towards private sector and common utilization agreement with the SSK and then the devolution of the SSK hospitals, the major transformation in health policy was carried out by enactment of the Social Insurance and General Health Insurance Law numbered 5510 which has been the most comprehensive law on healthcare in the history of the republic. The law was passed in the parliament on May 31, 2006 and it created serious debates on the articles concerning healthcare premiums, contribution payments

[173] Republic of Turkey, *Aile Hekimliği Pilot Uygulaması Hakkında Kanun,* no. 5258, *Resmi Gazete*, no. 25665, 9 December 2004, Article 2

[174] T.C. Sağlık Bakanlığı, *Aile Hekimliği Pilot Uygulaması Hakkında Yönetmelik, Resmi Gazete* no. 25867, 6 July 2005

[175] Hürriyet, 25 April 2005

and retirement age both in the parliament and the public. Before passing on the discussion points, I would like to lay out the main premises of the law which marks the major turning points in the healthcare provision, coverage and finance. In terms of provision, the steps began to be taken in advance, as observed in the developments concerning the family medicine and opening up the private hospitals to the publicly insured population. That is why I will continue with the coverage and finance pillars.

Coverage

In terms of coverage, the law contained both inclusionary and exclusionary articles towards certain parts of the population. As the right to be registered in the general health insurance scheme was based not on citizenship but on the ability to pay the necessary premiums, it would be wrong to argue that the new system covered the whole population. Although the government promised to pay the premiums of the needy from the state budget as in the Green Card case, the limits to be included in this scheme were very restrictive as before. In this section both the positive and negative developments in terms of coverage of the population would be analyzed through referring to the related articles in the SIGHI law.

First, with the article 61, all the children were accepted as eligible for the general health insurance without paying any premiums, regardless of their

parents' insurance scheme.[176] Although this step had positive results on the access of the children to the healthcare services, the necessity to pay contribution fees[177] would still be valid for their cases, which would cause problems at the time of the utilization of healthcare facilities for the children among the low-income group.

Second, the status of women above a certain age in the general health insurance scheme transformed in a significant way compared to the previous system. In the SIGHI law, it was stated that, women above the age of 18 (and above the age of 25, if their education continues) could not benefit from their parents' health insurance scheme.[178] However, in the previous law, the women, if they were not married and not working had the right to benefit from their parents' health insurance for their lifetime, as there was no age limit for this acquired right.[179] Since the new law signified a loss in the acquired right of the women and met with a fierce opposition both from the political parties and civil society organizations, the policy makers decided to add an article to the law in 2008 in order to soften the condition of the women's deprivation in terms of their social rights. With the new article, it was stated that, the women above the age of 18 who had the right to benefit from their parents' insurance at the time of the

[176] Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu*, no. 5510, *Resmi Gazete*, no. 26200, 16 June 2006, Article 61

[177] The law brought the necessity to pay contribution fees in every level of healthcare services except the examinations made by the family doctor. This issue would be explained further in the finance section.

[178] Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu,* Article 3, Paragraph 10

[179] Republic of Turkey, *Sosyal Sigortalar Kanunu*, no. 506, *Resmi Gazete*, no. 11766-11779, 29,30,31 July and 1 August 1964, Article 23 Paragraph a and Article 36 Paragrapgh b

law came into force would continue to be covered under their insurance till a change in their condition (i.e. marriage, having employed) would be realized.[180]

As the above mentioned articles clarified, the new law both includes and excludes certain groups of population while it is exactly impossible to argue that it would guarantee the access of the whole population on the base of citizenship. It is right to state that, the SIGHI law paved the way for the people who did not have employment based health insurance to be included in the general insurance scheme. But the "universality" of the GHI did not secure the right to health care to those who would not be able to pay the necessary premiums or contribution payments. Thus, in my opinion, the GHI was a failed attempt of universality from its birth and did not have the capacity to alter the commodity status of health as due to forcing the people to participate in the market in order to be able to pay the premiums and contribution payments.

Finance

In terms of finance, the new law foresaw the establishment of an insurance system, which would collect premiums proportional to one's revenue. In the law it was stated that, the ratio of the premium to be paid for the GHI was 12.5 percent of one's income, or if the person was only insured by the general health insurance (and not covered by the retirement or other branches of social

[180] Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu,* Temporary Article 12

insurance) his/her premium ratio would be 12 percent of the income.[181][182] In addition to the premiums, the citizens were obliged to pay contribution payments depending on the type of treatment they receive and this payment would be increased for the cases where the referral chain was not applied properly.[183] Here it is necessary to underline the fact that, the ones who did not pay contribution payments in the previous system, namely the public servants and the green card holders would also be charged with this payment in the new system.

As it can be understood from the above mentioned premium ratios, with the new law, the people gained the chance to register for the general health insurance even if they were not formally employed. With the article 50 in the SIGHI law, the people were given the opportunity to be covered with the public health insurance as long as they pay the necessary premiums determined by the law.[184] Even, it could be said that, the law not only gave the chance to the people to register in the health insurance scheme but also forced them to do so. In the law and the regulations, it was stated that, the people were required to notify the changes in their employment status, thus the terms of their compulsory insurance scheme, to the social security institution and determine the new terms of their health insurance based on the income level of the family. [185]

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[181] Ibid., Article 81, Paragraph f

[182] The law had further arrangements for the insured who were covered only by the GHI. According to Article 80, staged premium system was formed which divided the population into three according to their income levels and determined the health premium on those levels. For more information see Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu,* Temporary Article 12.

[183] Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu,* Article 73

[184] Ibid., Article 50

[185] T.C. Sosyal Güvenlik Kurumu Başkanlığı, *Genel Sağlık Sigortası İşlemleri Yönetmeliği, Resmi Gazete*, no. 26981, 28 August 2008

Moreover, the ones who had applied to the Green Card and had not been found as eligible for that scheme, would be obliged to register to the general health insurance scheme and pay the necessary premium.[186] Thus, as much as the state paved the way for the inclusion of the people to the general insurance scheme, it forced them to pay the premiums even if they did not prefer. This is also a crucial point of deviation from the previous system. As stated before, in the Green Card Law there was an article concerning the ones who were neither qualified to get a green card nor had the means to meet the health care expenses. Those people were given the opportunity to apply solidarity fund in order to get an aid. But with the new system, all the people except the ones who had income less than 1/3 of the minimum wage were forced to register in the general health insurance and pay the necessary monthly premiums and contribution payments during the utilization of the services.

The new system not only legitimized the collection of contribution payments in every step the individual applies to the healthcare services (except from the examinations done by the family doctor), but also opened the room for especially, private hospitals to obtain additional payment under the name of board and room charges. Through the new law, the private hospitals gained the opportunity to charge the people up to three times higher than the prices set by the Healthcare Services Pricing Commission (*Sağlık Hzmetleri Fiyatlandırma Komisyonu*) for the healthcare services.[187] Thus, the individual was forced to pay

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[186] T.C. Sosyal Güvenlik Kurumu Başkanlığı, *Genel Sağlık Sigortası Uygulamaları Genelgesi*, no. 2008/86, 13 October 2008, Article 4
[187] Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu,* Article 73

contribution payments and board and room charges at the time he/she utilized both public and private hospitals.

The controversial issue was the statement in law that, the private hospitals may collect charges up to three times higher than the set prices. This was a source of discomfort for both the people and the private hospitals. In terms of the people covered by the GHI, this level was very high counting the additional payments that would be paid to those hospitals. On the other hand, the private hospitals claimed that with such –low- level of contribution payment, it would be impossible to offer high quality services, and either the private hospitals would cancel their agreement with the SGK or they would offer low quality services to their patients in the future.[188] As the law has started to be implemented very recently it is not possible now to make exact judgments on the results. However, it is clear to see the increased role and strengthened voice of private hospitals in the policy making process of the health care arena in Turkey.

It is clear to see how the new health care system established the understanding of health care as a commodity through the payment rules it brought not only though the premiums but also during the time the person utilized these services. So, the individual would be aware of the fact that, in order to access the healthcare services, he/she had to pay the necessary premiums (except for the green card holders) and the additional payments. So it would be naïve to claim that the new law established the universalized health care system based on the citizenship, while a significant proportion of the population did not have the means to pay for the abovementioned charges. For example, as the ones who earned between the 1/3 of the minimum wage and minimum wage would

[188] Radikal, 26 October 2008

pay 12 percent of the 1/3 of minimum wage as health care premium according to the regulation[189]. If the case is analyzed for the time being, a person whose monthly income between the 1/3 of the minimum wage and the minimum wage has to pay 26 TL monthly premium.[190] As the 1/3 of the minimum wage is 222 TL now, the person has to pay 26 TL of it as a premium, and pay contribution payments to services and medical treatment he/she gets. After those expenses, it is questionable how that individual may maintain a healthy life or meet his/her other expenses in order to survive.

A complementary process to the SIGHI law was the unification of the public insurance schemes under the name of Social Security Institution (*Sosyal Güvenlik Kurumu* – SGK). The SKG law was accepted in the parliament on May 16, 2006. The unification of the different public insurance schemes was a process aimed to be realized by preceding governments, yet it was established in the AKP period, complementing many premises of the general health insurance law. With this law the policy makers aimed to remove the inequality among the various public insurance schemes in the country and to separate the social security and health insurance functions under different branches. In order to deal with the health insurance separately than the retirement and unemployment benefits, General Health Insurance Directorate was established under the SGK,

[189] T.C. Sosyal Güvenlik Kurumu Başkanlığı, *Genel Sağlık Sigortası İşlemleri Yönetmeliği,* Article 12

[190] According to the household surveys of the Turkish Statistical Institute, there were approximately 3.5 million people whose income was between the 1/3 of minimum wage and minimum wage. For more information please see www.tuik.gov.tr

which would be responsible to make the necessary arrangements concerning the GHI.[191]

Political Debate

It is crucial to see the perspectives of the opposition groups, the arguments they made to back the dissenting oppinions and the effects and results of their opposition. It is necessary to underline the fact that, although the opposition did have the chance to influence the governing party/ies in the previous decades, the single party government of the AKP heavily backed by the international organizations, stood firmly against the oppositions coming from the political parties and civil society organizations. In this section, I will review the political debates both within and outside the parliament concerning the new laws on health care. The debates will be analyzed in the chronological order of the laws passed in the parliament.

The Debates on the Devolution of the SSK Hospitals to the MOH

The preparation of the law on the devolution of healthcare units of the SSK started in the last months of 2004, and during this time, the unions and civil society organizations showed their discontent though public demonstrations.

[191] Republic of Turkey, *Sosyal Güvenlik Kurumu Kanunu*, no. 5502, *Resmi Gazete*, no. 26173, 20 May 2006, Article 14

Emek platformu[192] organized a meeting on November 20, 2004 in order to display their opposition on devolution of an organization, which was built by the premiums of the workers. In return for this protest, Prime minister Erdoğan criticized the attitude of the activists and declared that it would be better if they invest the money they spent on the meetings to hospital building. However, the leader of the Turk-İş responded to this criticism harshly, and asserted that, the SSK had already 148 hospitals throughout the country, and they did not prefer to build new ones for the government to confiscate those properties.[193] From the dialogue it was clear that the tensions were extremely high between the government and the unions due to the confiscation of the SSK property by the government.

Apart from the reactions coming from the civil society, the parliamentary discussions reflects that the opposition parties mainly rejected the passage of the law on the grounds that the SSK facilities belonged to the workers who made them built through the premiums they paid. Thus, they claimed, the ownership of those units could not be devolved through a law, but merely the administration could be passed to the state while reserving the ownership rights of the workers. Moreover, the opposition claimed that since it did not contain any articles on the standardization of norms and services between the MOH and SSK hospitals, this law would not help to improve the healthcare services provided by the SSK. [194] Yet, those criticisms did not result in any change in the law, and it was accepted on January 6, 2005, legalizing the devolution of SSK hospitals to the MOH.

[192] *Emek platformu* is a roof civil society organization, which is composed of the workers' and several occupational unions.

[193] Hürriyet, 21 November 2004

[194] Republic of Turkey, *TBMM Tutanak Dergisi*, term 22, session 48, vol. 72, 6 January 2005

According to the president of Ankara Chamber of Doctors, Ali Gökgöz, this law was a significant step towards the privatization of public healthcare institutions.[195] Although Prime Minister Erdoğan opposed this argument on privatization since the beginning of the preparation of the devolution process[196], the laws concerning build and sell system and/or build-operate and transfer system for the public institutions would prove the arguments of the Gökgöz in the subsequent months, as will be expressed in the following parts of this chapter.

Debates on the Social Insurance and General Health Insurance Law

As stated earlier the SIGHI law has been the most comprehensive law on social insurance and health insurance throughout the history of the republic. Yet, its comprehensiveness does not guarantee that the law would bring positive results to the whole population. In this section the discussions on the most striking articles in the SIGHI law would be scrutinized in order to clarify both the variances with the previous system and the stands of different groups to these differences.

The most appealing part of the SIGHI law was that, it gave access to the people who were not formally employed the opportunity to be included in the general health insurance scheme.[197] Yet, due to the level of premium and

[195] Hürriyet, 24 February 2005

[196] Hürriyet, 29 October 2004

[197] Republic of Turkey, *Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu,* Article 50

contribution payments, this inclusionary attempt of the law was not accepted as a realistic projection by the opposition.[198] Another point promoted by the governing party was the article on the children below 18 years of age. The AKP declared that, all the children regardless of the financial or employment status of their families would have the right to access healthcare services for free. However, the CHP, main opposition party in the parliament rejected the claim of free healthcare services in this system, since all the treatments would be charged with contribution payments. Moreover, Kemal Kılıçdaroğlu from the CHP stated that, as the private hospitals were included into the system, once a child below 18 years of age went to the private hospital, it would be charged not only with contribution payments but also the room and board charges would be added to the total expenditures. So the realization of the free healthcare services promise would not be possible when it would be applied.[199] So, the main opposition party, the CHP, based its arguments for resisting against the passage of the law, on the legalization of contribution and, board and room charges which prevent the healthcare services to served on citizenship basis and free of charge to the citizens when they would be in need.

Apart from the articles, which were presented as positive developments but criticized by the opposition due to their ambiguous definitions, or deficiencies in fulfilling their aim, there were some articles that created considerable disturbance in the parliament in the first place. One point is mentioned above on the contribution payments and room and board charges of

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[198] Republic of Turkey, *TBMM Tutanak Dergisi*, term 22, session 89, vol. 117, 18 April 2006

[199] Ibid.

the private hospitals. Kılıçdaroğlu fiercely opposed the contribution payment exercise and he argued that this item was put on the law in order to satisfy the demands of the IMF to contract the public expenditures.[200] Moreover, the pressure of the IMF on the passage of the law generated harsh criticisms against the law, not only from the CHP but also from the ANAP. İbrahim Özdoğan from the ANAP stated that, though Turkey tried to enter the EU and the government claimed to be determined to prepare laws in harmony with the EU, this law did not fit to the European social model where the state took a greater responsibility in financing the social expenditures. He added that this draft law was more compatible with the IMF's demands than the efforts to harmonize with the EU policies.[201] Another controversial article in the new law referred to the women and states that, women above the age of 18 (and above the age of 25, if their education continues) cannot benefit from their parents' health insurance scheme. The opposition claimed that, with this article the government left the women above 18 to the market forces so as to obliging them to find a way to afford their healthcare services.[202]

There were several other issues, which were criticized by the opposition concerning the retirement age and the necessary days to fulfill the premium paid work. As the government aimed to increase the minimum retirement age and the premium paid workdays through this law, the CHP and many civil society organizations opposed to this development. The opposition does not find it reasonable to increase the retirement age to 65 as in the European countries while

[200] Ibid.

[201] Ibid.

[202] Republic of Turkey, *TBMM Tutanak Dergisi*, term 22, session 90, vol. 117, 19 April 2006

the life expectancy was lower in Turkey compared to those countries. They called it "retirement in grave"[203] (*mezarda emeklilik*) and force the AKP to change the retirement age.[204] Moreover, the increase of the necessary days of premium paid work from 7000 to 9000 caused not only the discontent of the opposition but also many demonstrations organized throughout the country by the unions in order to stop the legalization of the SIGHI law.

The SIGHI law was accepted in the parliament due to the majority position of the AKP despite the criticisms from the opposition. However, the then president Ahmet Necdet Sezer vetoed the law since he assessed the law as a drawback from the social state understanding in Turkey. Sezer pointed out fifteen articles of the law, which he thought necessary to be changed in order not to harm the principle of being social state in the constitution. However, as the AKP government was so determined to pass the law as it was, they did not change any article before sending the law again to the president.[205] During the parliamentary meetings when the law was discussed for the second time, the main opposition party left the parliament as they complained about the attitude of the AKP since the governing party did not have an inclination to have an exchange of ideas with other parties, let alone the civil society organizations. Thus only the ANAP with its small number of deputies tried to show an

[203] The opponents used "retirement in grave" (*mezarda emeklilik*) motto in order to indicate the increase in the minimum age of retirement which was nearly equal to the life expectancy at birth in Turkey.

[204] Republic of Turkey, *TBMM Tutanak Dergisi*, term 22, session 90, vol. 117, 19 April 2006

[205] According to the TBMM legislation rules, the president cannot veto the law coming from the parliament if the law is not changed.

opposition but cannot manage to prevent the law to be accepted for the second time in the parliament.[206]

As it is obvious from the aforementioned discussions, the SIGHI law did not have a smooth start from the beginning. Even after coming into force, the law could not function properly. First, the application of Sezer and the CHP to the Constitutional Court claiming the law being unconstitutional and the Court's decree on nullity on some of the contested articles impeded the application of it. Moreover, during this process, the government faced with a fierce opposition from the civil society organizations and unions throughout the country. The Turkish Medical Association (TMA) and unions such as Trade Union Confederation of Revolutionary Workers (*Türkiye Devrimci İşçi Sendikaları Konfederasyonu* – DİSK) and Trade Union Confederation of Public Workers (*Kamu Emekçileri Sendikaları Konfederasyonu* – KESK) highly criticized the law making process in the passage of the SIGHI law. They claimed that while the IMF and WB had a strong say in the developments, the opinions of the domestic groups were not taken into consideration though this law would determine the future of every single individual in the country. The TMA and the unions requested people to vote in the referendum they held in several regions in the country in order to have the chance to express their opinions on this policy.[207] Unfortunately, the government harshly repressed the efforts of the workers to raise their voice on an issue, which interested them most. The Ministry of Interior gave out a notice, forbidding the referendum held by TMA, DİSK and KESK in public institutions and organizations. After the notification of circular

[206] Republic of Turkey, *TBMM Tutanak Dergisi*, term 22, session 109, vol. 121, 31 May 2006

[207] Hürriyet, 27 March 2006

order, the security officers in some institutions harassed the activist employees at the voting boxes.[208]

Although the government was determined to ignore the complaints of the workers on the law, the unions continued to express their ideas through the gatherings they arranged. The members of the KESK organized public demonstrations throughout the country and marched to the AKP county council building in order to made a speech on the SIGHI law. The leader of the KESK, İsmail Hakkı Tombul criticized the government due to its ignorance on the voices of the unions and its preference to listen to the international organizations and capitalist groups while the future of the whole population was on the table.[209]

The union members continued their demonstrations in Ankara on 18 April with participation of the TMA, Union of Turkish Engineers and Architects Associations (*Türk Mühendis ve Mimar Odaları Birliği* - TMMOB and *Halkevleri* though the demonstrations again repressed, this time by the police forces.[210] The government's approach towards dissenting voices coming from both within and outside the parliament discredited the claims of the AKP that the law was prepared for the sake of the people and it was not designed according to the fiscal concerns of the international organizations.

As the constitutional court nullified some of the articles of the law, and decided to stay the execution, the law could not be put into effect on the date it was planned. When the law was first accepted in the parliament, January 1, 2007

[208] Radikal, 29 March 2006

[209] Radikal, 16 April 2006

[210] Radikal, 19 April 2006

was determined to be the starting date of implementation. Yet, the nullification of some articles, the oppositions from the civil society organizations and the changes made in the law in the following days caused the delay of introducing the SIGHI law. So the law implemented with a gradual application, as some of the articles came into power on January 1, 2008, some would on April 30, 2008 and the rest would be started to implement on October 1, 2008.[211]

International Organizations

As stated in the begining of the chapter, the AKP period was an era when the determination to reform the healthcare and social insurance system of the party was backed by the international organizations as they advised the restructuring of those services in order to prevent waste and provide efficiency. In this section, the main advises of the international organizations, especially the WB and the IMF on the health care system and related social insurance developments would be scrutinized, in order to evaluate the validity of their arguments in the socioeconomic conditions of Turkey. Moreover, this analysis would give insight on the level of conformity of the government party to the prescriptions coming from the international organizations regardless of their compatibility to the country's characteristics.

As the government was so determined in reforming the health care sector, the international credit organizations and especially the WB was also ready to help the government through granting credits as a source to help the restructuring

[211] Republic of Turkey, *TBMM Tutanak Dergisi*, term 23, session 91, vol. 18, 16 April 2008

of the system. The WB declared its intentions on December 2002, yet due to some delays between the agreement with the government and preparation of the new health care law, the support of the WB could come in 2004.

Before coming to the loan agreements, I would like to refer some points from the WB report "Turkey: Reforming the Health Sector for Improved Access and Efficiency". In this report, the WB summarizes the characteristics of the health care system in Turkey, and proposes reform strategies in order to overcome the problems in the system. The first item stated in the report was the weakness of the first level healthcare services in Turkey and the necessity to establish family medicine in order to strengthen the information flow both within the same and among the different levels of health care.[212] In terms of organization and finance, the report criticized the presence of multiple funding sources due to the patchy structure of the public insurance mechanisms, and the variety of providers meeting the needs of different groups of people covered under certain formal insurance schemes. According to the WB the fragmentation of finance and provision systems of this kind was the foremost reason of the failure of the health care system in Turkey. The Bank stated that, the finance mechanisms should be harmonized in order to provide the unity of norms and procedures in premium collection in order to have an efficient and more accountable system. Moreover, the WB criticized the absence of competition among the MOH, SSK and private hospitals. According to the Bank, a

[212] World Bank, *Turkey: Reforming the Health Sector for Improved Access and Efficiency*, vol. 1, p. vi

competitive environment to reach the scarce source of health funds among them should be created in order to foster efficiency in the hospitals.[213]

The most striking point in the document was about the compulsory social health insurance system. In the document, the WB advised that, a Health Fund should be formed as an autonomous legal umbrella organization that would took the responsibility of collection of health premiums from other social security institutions. The WB also foresaw the incorporation of the Green Card scheme into the Health Fund, while the state would pay the premium of those who were unable to pay.[214] After the establishment of SIGHI law, it is easy to see that the government fully embraced the advises in the document concerning the reorganization and finance of the health care system in Turkey.

As the government showed its determination to transform the health care system by the policies enacted in 2003 and the declaration of transformation of health program by the government the WB was ready for a loan agreement in this sector. The bank gave Euro 49.40 million loan in order to help during the initial phase of the transformation of health program.[215] The loan agreement with the WB was signed in April 2004, and in the report it was asserted that, the WB continued to involve in the health care sector in Turkey, since they saw the determination of the new government to reform this area. In the document it was stated that, making corrections on the present system would not be efficient and

[213] Ibid., pp. 23-24

[214] Ibid., p. 57

[215] World Bank, *Project Appraisal Document on a Proposed Loan in the amount of Euro 49.40 Million to the Republic of Turkey for a Health Transition Project in Support of the First Phase of the Program for Transformation in Health* (World Bank: Human Development Unit Europe and Central Asia Region, 2004)

it was necessary to transform the health care system totally. Five crucial steps were pointed out in order to carry out this transformation project, such as the separation of provision and finance, introduction of universal public health insurance, financial and administrative autonomy for public hospitals, introduction of family medicine and increased emphasis on improving maternal and child care.[216]

According to the WB, there are two alternatives for this project, (1) "no new health project" or (2) "another sector investment or a pure technical assistance loan". Both alternatives were rejected due to the necessity of a wholesale transformation of the system and the complexity of this process.[217] The most interesting point of the WB here was the "all or nothing" approach of the bank according to which effectiveness and improvement could be provided only in the way suggested by the Bank that is through autonomization, finance and provision split and family medicine. However, the disadvantages of these policies were never discussed as they were considered the ideal solutions for contemporary health care systems. However, especially due to the different socio-economic conditions of the rural and urban parts of the country, family medicine was expected to create crucial problems in terms of childcare. In the previous health post practice the physicians were responsible to go to the houses and vaccinate the children in the rural parts while with the family medicine this responsibility has mostly passed on to the family, as it would be the duty of the parents to bring their children to the family doctor and had her/him vaccinated. Besides, the family medicine would be an area of specialization in medical

[216] Ibid., pp. 1-3

[217] Ibid., pp. 6-7

profession and would have three years of additional education as in other specialization branches. However, in the transformation process the general practitioners directly raised to the family doctor status after having training less than a month, which created mistrust to the first level healthcare services.

Not only the WB but also the IMF was backing the reform program in social security and health policy of Turkey. Due to the increased expenditures and shortages in the budgets of the formal social security schemes, the IMF had fiscal concerns in its support.[218] Yet the government fiercely claimed that the pressures coming from the IMF to contract the public services would not affect the public expenditures on health and education.[219] Moreover, Minister of State Ali Babacan stated that, no matter what the IMF said, the government was determined to carry out the health insurance reform, as they deemed it necessary in the socio-economic conditions of the country.[220] However, in the following days it was seen that the government was not that autonomous in taking its decisions in the social security and health policy of the country, as the IMF delayed to grant the credit of 830 million dollars due to the failure to realize the social security and health insurance law immediately.[221][222] These steps all proved the increased influence of the international organizations on the policy-making processes of the country, especially in the fields of social security and health care. In terms of the IMF as the main concern was to prevent the excessive

[218] T.C. Başbakanlık Devlet Planlama Teşkilatı, *Dokuzuncu Beş Yıllık Kalkınma Planı, Sosyal Güvenlik Özel İhtisas Komisyonu Raporu* (Ankara: DPT, 2006), p. 13,19 table 4,9

[219] Hürriyet, 21 July 2003

[220] Hürriyet 30 october 2004

[221] International Monetary Fund, *Statement by IMF First Deputy Managing Director Anne O. Krueger on Turkey*, IMF Press Release Press Release No. 05/157, July 7, 2005

[222] Hürriyet, 7 July 2005

spending on retirement and health care expenditures, the reform program was essential with its emphasis on efficiency through finance provision split and inclusion of private sector.

Conclusion

During the developments of the AKP government it is not sufficient to focus on the general health insurance, family medicine practices or the unification of social insurance organizations in order to understand the wholesale transformation of the health care understanding. As the main argument of this thesis is the commodification of health care through the steps of commercialization and privatization, to prove the latter claim, it is necessary to look briefly at the investment policies of the AKP government. As privatization and commercialization are two different processes while the former refers to the transfer of the ownership of production from public to private, the latter characterizes the autonomization of public entities in order to be able to compete in the market with the private sector. The 1980s marks the starting point of the commercialization of health care in Turkey, while the 2000s this process have transformed into privatization per se. Besides, the investment policies of the AKP period have supported not only domestic but also foreign investors who wish to profit from the health care market.

Just in the early years of the government, the AKP manifested its preference in development strategy as the continuation with the privatization

policies[223] and encouragement of the foreign direct investments (FDIs) in the country[224]. In tune with these policies, in the eight-year government period, several laws passed in order to attract the foreign investors in the country, particularly in the health care sector. As a first attempt to fulfill this aim, Law on Foreign Direct Investment numbered 4875 passed on June 5, 2003 in order to ease the entrance of the FDI into the country. Through this law, foreign investment in Turkey was liberalized and foreign investors' status was equalized with the domestic investors.[225] This law was only a beginning of a process in which private sector increased its share enormously among the investments in the country. The next step was changing the Basic Law on Healthcare Services (Law number 5396) on July 3, 2005, which paved the way for the privatization of the public healthcare facilities. In the law, it was stated that the land and property of the treasury or the MOH could be devolved to the natural persons or corporate bodies with the condition that the rents would not exceed 49 years.[226] Thus, as the union leaders argued when the debates on the devolution of the SSK hospitals were going on, the government initiated the privatization of public healthcare institutions in the are of health care which were built in order to serve for the citizens in the country through the premiums or taxes they paid.

There were many investment policies enacted on the second level healthcare services, however the preventive care does not seem to attracted the attention of the government. Although, in the urgent action plan and

[223] Hürriyet, 24 March 2003

[224] Hürriyet, 16 November 2002

[225] Republic of Turkey, *Doğrudan Yabancı Yatırımlar Kanunu*, no. 4875, *Resmi Gazete*, no. 25141, 17 June 2003, Article 3

[226] Republic of Turkey, *Sağlık Hizmetleri Temel Kanununa Bir Ek Madde Eklenmesi Hakkında Kanun,* no. 5396, *Resmi Gazete*, no. 25876, 15 July 2005, Additional Article 7

transformation in health program, the need to invest in the preventive healthcare services mentioned, in the AKP period, there was not seen any improvement in this area. The developments both in the health care and the investment policies triggered the expansion of second level healthcare institutions while the preventive care did not receive the desired interest or investment in this period. The tendency to privatize the public healthcare institutions and the aim of the private initiative to focus on the second level healthcare institutions caused the ignorance against preventive care which was not assumed to be a commercialized good by the international organizations as opposed to the marketized status of curative services. Thus as the private sector did not see any profit opportunity in this arena, it did not prefer to make investments on preventive care.

Through these developments, foreign direct investments into the country have been encouraged and the share of the FDI's has shown a considerable increase. The private sector's entity whether by the domestic or the foreign investment, has been eased. It can be observed that during the last five years, the number of corporations have grown more than three times than the previous fifty years.[227] Besides, since 2005 and especially in 2007 the total FDI in the country has been in significantly high. While the net total FDI was 10.301 million dollars in 2005, it increased to 20.185 million dollars in 2006 and 22.046 million dollars in 2007.[228] As it is clarified by the data at hand, in terms of both the invested

[227] T.C. Başbakanlık Hazine Müsteşarlığı, Uluslararası Doğrudan Yatırım Verileri Bülteni (Ankara: Yabancı Sermaye Genel Müdürlüğü, March 2009), p. 7

[228] Ibid., Additional Table 1

money and the number of corporations, the level of FDI displayed a drastic increase in the economy of Turkey, in general.

Apart from the general trend in the FDI, when those investments are analyzed in sector specific basis, it would be seen that, in 2006 and 2007 health and social services experienced a huge boom in attracting the FDI. While the FDI in this sector was 2 million dollars in 2002 and 35 million dollars in 2004, this amount sharply increased to increased to 265 million dollars in 2006 as can be seen from Table 5.[229]

[229] T.C. Başbakanlık Hazine Müsteşarlığı. 2009. *Foreign Direct Investment in Turkey By Sectors (Million USD) 2002-2008.* Available [online]: http://www.tcmb.gov.tr/odemedenge/table30.pdf [10 May 2009]

Table 5: Foreign Direct Investments in Turkey by Sectors (2002-2008)
(Million USD)

	2002	2003	2004	2005	2006	2007	2008
Agriculture (total)	0	1	6	7	6	8	45
Agriculture, Hunting and Forestry	0	1	4	5	5	5	28
Fishing	0	0	2	2	1	3	19
Industrial Sectors (total)	165	539	329	829	2,100	5,113	4,997
Mining and Quarrying	2	13	73	40	122	336	153
Manufacturing	95	440	190	785	1,866	4,210	3,791
Services (total)	406	156	855	7,699	15,533	14,015	9,694
Construction	0	8	3	80	222	285	517
Wholesale and retail trade; repair of motor vehicles, motorcycles and personal and household goods	75	58	72	68	1,166	169	2,073
Hotels and Restaurans	0	4	1	42	23	33	27
Transports, Storage and Communication	1	1	639	3,285	6,696	1,116	169
Financial Intermediation	246	51	69	4,018	6,957	11,663	6,025
Real Estate, Renting and Business Services	0	3	3	29	99	560	675

Table 6. continued

	2002	2003	2004	2005	2006	2007	2008
Public Administration and Defence; Compulsory Social Security	0	0	0	0	0	0	0
Education	0	0	0	17	0	0	0
Health and Social Work	4	21	35	74	265	177	149
Other community, social and personal service activities	80	10	33	86	105	13	59
Activities of households	0	0	0	0	0	0	0
Extra-territorial organizations and bodies	0	0	0	0	0	0	0
TOTAL	571	696	1,190	8,535	17,639	19,136	14,736

As a result of these policies, in the recent years the health care sector has attracted the attention of many foreign investors. From 2004 to 2007 more then 100 private hospitals were built throughout the country. As can bee seen from the table on the number of private and public hospitals[230] the number of private hospitals reached 365 while 139 of them could be found in Istanbul. As stated in

[230] See Türk Tabipler Birliği Sağlık Veri ve İstatistikleri Merkezi, www.info.dr.tr/savim

the previous chapter, the functional role of the private hospitals can be questioned in the area of health care when the aim is to remove the urban-rural differences. As it was the case in the 1990s, the investors have continued to focus on Istanbul, which is the city where they profit more than the eastern and southeastern parts of the country.

Besides, due to the performance criteria, the number of surgeries done in the in-bed healthcare institutions boomed in the recent years.[231] This resulted in the rising tendency of the private hospital expenses among the total private health care expenditure.[232] Thus, while the government prepared the laws which envisaged the withdrawal of state from the investment in and provision of healthcare services, step by step the share of the private sector increased in this area through the hospitals built and the operations done in those hospitals. Yet, the increased share of the private sector does not necessarily guarantee the improvement of the health status of the country. On the contrary, according to the research of Mackintosh and Koivusalo, the countries, which have higher share of private health expenditure in their GDP, do not have better health outcomes. Besides, the countries that have considerably low level of commercialization of health care expenditure also display better health outcomes compared to those with higher level of commercialized health expenditures.[233]

[231] Türk Sağlık-Sen. *Sağlıkta 2008 Raporu* (Ankara: Türk Sağlık-Sen, 2009)

[232] Türkiye Bilimsel ve Teknolojik Araştırma Kurumu. 1999. *Sağlık Hizmetlerinin Finansmanı.* Available [online]: http://www.tubitak.gov.tr/tubitak_content_files/vizyon2023/si/EK-18.pdf [10 May 2009]

[233] Maureen Mackintosh and Meri Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses* (Basingstoke; New York: Palgrave Macmillan, 2005), pp.14-15

To conclude, when the policy developments in health care carried out in the AKP period are reviewed, it is difficult to argue that the transformation of health program will reach the targets determined by the government as erasing the gap between the east and the west, providing universal access, equality and higher quality in the healthcare services. As stated throughout the chapter, due to the exclusionary items of monthly premiums and contribution payments, many peoples chance to reach healthcare services were impeded by the new law. Moreover, the withdrawal of the state and leaving its role gradually to the private sector with the investment policies endangered the equality of the services received by the people belonging to different income levels among the society. In addition to the quality of the services people received, the gap between the east and west widened, as the private sector prefers to invest in the more profitable areas of the country while the other regions were ignored as it could be easily grasped from looking at the distribution of private hospitals in the country.

Above all, the most crucial result of the developments in the AKP period was the institutionalization of the healthcare as a commodity, which could be deserved in return for monthly premiums and contribution payments. The universal health insurance understanding of the AKP did not universalized the access of the people to health care but universalized the entrance of the people to the health care market as it established a compulsory public health insurance system in which except a small portion of the population, all the citizens were forced to pay the necessary premiums to reach healthcare services. Thus, in this decade, Turkey have moved away from the Beveridge type of citizenship based health care system for good as the SIGHI law caused the de facto abolishment of the socialization law in healthcare services.

CHAPTER VII

CONCLUSION

In this thesis I have analyzed the laws concerning the health care policy of Turkey and aimed to show the process of commodification of healthcare, through the commercialization phase since the 1980s and privatization stage in the 2000s. Though there may be policies, which tried to reverse this trend such as the Green Card Law, they were not able to target the whole population and remained as stillborn exercises with their contents. Today, the healthcare system of Turkey has still been under the effects of neoliberal transformation, with the policy developments initiated by the government.

In Turkey, welfare provisions had never been provided on universal basis like the North European Welfare States, but the state embraced the corporatist approach as in the Continental European tradition. In the Continental European tradition the welfare benefits are distributed on employment status and the formally employed people gained the right to retirement benefits, sickness and health insurance and etc. through paying premiums during the time they are employed. Resembling to the Continental European tradition, in Turkey too, the welfare benefits were tied to the employment status of the people. The public employees were covered by Civil Servants' Retirement Fund since 1949, the employees in the private sector were covered by the Workers' Insurance Institution which was established in 1945 and later transformed into Social Security Institution in 1964 and the self-employed were covered under Bağ-Kur

since 1972. As they were bound with different insurance schemes, workers employed in different sectors have different levels of premiums to pay and different levels of services to get. Thus, the Turkish welfare state was called as "inegaliterian corporatist" due to the hierarchical status between the workers in the public sector, in the private sector and the self-employed. Moreover, there are other particular socio-economic conditions of the country which approximates Turkish welfare regime to the Southern European model, such as the large informal sector and dependency on family in the crisis rather than a strong state pillar. However, it is not possible to classify Turkey under the Southern European Welfare state type, as those countries managed to establish universal health care systems while Turkey failed to carry out such transformation.

In terms of welfare provision, the recent developments in the AKP period aimed to remove the different obligation and benefit schemes in welfare provisions for the people employed in different sectors. The formation of the Social Security Institution in 2006 represented a crucial step towards fulfilling this aim. Yet due to the interruptions in the implementation of the new Social Insurance and General Health Insurance Law, some delays occurred in equalization of the status of the formally insured people.

In terms of health care, the AKP government managed to enact many policies designed two or more decades before, yet failed to be established due to the political and economic conditions of that era. In the 2000s, the AKP established general health insurance and family medicine practices and managed to unify the SSK and the MOH hospitals, which were neither peculiar to this party's program nor envisaged in this decade. Moreover, although the party reflects the new developments as the transformation of healthcare system in

Turkey, which would solve the problems created by the previous governments, there has been no detachment from the neoliberal understanding in healthcare, which was started in the 1980s. The commodity status of health care still persists and the commercialization of healthcare services has been reinforced with the new laws on investment and privatization.

In order to show this shift in the health care policy of Turkey, I preferred to explain the socialization of healthcare services enacted in 1961 under the auspices of the military government. With this law, the healthcare services were aimed to be provided on universal basis with equal treatment of people through the integration of all healthcare institutions under the MOH and with an arrangement of referral chain in order to establish staged healthcare services. The health posts were envisaged as the best type of organization for serving the first level of health care services of preventive care and necessary examinations for a definite population in the regions they were established. The military government's ideal was to institute a healthcare system like the British NHS that was the reason why they chose to enact the Law on the Socialization of Healthcare Services in 1961, attributing all the responsibility to provide and finance the healthcare services on the state. This was the only time when right to health care was envisaged to be provided on the basis of citizenship as Marshall points out. With the law, the status of the citizens belonging different social classes were equalized as they all required to go to the health posts and then apply to the hospitals if necessary, while the law did not discriminate against the poor or the non working population.

Significant amounts of investments, long time and strong determination were necessary in order to establish the socialization of healthcare services as the

construction of health posts was required throughout the country. Unfortunately, changing governments could not continue the determined attitude of the military government, and the socialization process slowed down and could not meet the expectations though the health status was raised significantly in the socialized regions. When the financial breakdowns and shift in the economic perspective added to the unwillingness of the successive governments on investing in the socialization program, the law which was designed to cover the whole population and meet their needs in healthcare, resulted in being a source of complaint in Turkey in the 1980s.

The 1980s marked a significant transformation in the economy of Turkey, while the state embraced an outward looking strategy in economy, removing protectionist barriers built in the planned industrialization era. As norms of free trade and international competition were assumed to be the basis of the economic understanding, this shift affected the state-society relations, especially the approach of state towards the workers' rights in particular and social rights in general. In terms of health care, the first shift was observed in the constitution while the state abandoned its role in the provision of health care and undertook the supervision and regulation functions in this area. With the basic Law on Health Care Services this approach of the state was accomplished as in the new law, the healthcare institutions were transformed into business enterprises. In addition, the salaries of the personnel would be partially met by the revolving funds of those enterprises. Thus, the enterprise logic would necessitate making profits in health care. This marked the first point where health care became an ordinary commodity that would be met from the commercialized services.

In the following decade, in the 1990s, there was an attempt to reverse the tendency of commodification through establishing general health insurance. Yet, those efforts where remained insufficient as the decommodification of healthcare services were restricted to the people who were below a certain income level and for a definite and limited package of services through the Green Card Law. Despite its inadequacy in its aim to decommodify the status of health care, the law was certainly a positive step towards the treatment of the poor with its efforts to eliminate the hardship they experienced in accessing those services. Although the Green Card practice softens the stigmatizing approach of the previous applications to the Social Cooperation and Solidarity Fund, it is necessary to admit the fact that, Green Card was not a citizenship based practice but a means testing mechanism which secured the provision of certain services to the population who were in need of help.

The fundamental developments in healthcare policy of Turkey has been carried out in the 2000s, with the AKP coming to power as the party having the majority of seats in the parliament. One of the items in the urgent action program of the party was healthcare reform and the government was determined to realize this reform with the help of international credit organizations, specifically the IMF and the WB. The civil society organizations, such as the unions and medical associations had reservation on the draft laws from the beginning of the transformation process. In addition to the attitude of the civil society organizations, there was a strong opposition against the transformation of healthcare program in the parliament. However, these reactions could not manage to stop the legislation of the Social Insurance and General Health Insurance Law, which was the most detailed and comprehensive healthcare law

in the republican history. The law caused many debates concerning the possible positive and negative consequences of the new law. Though the government stressed the inclusion of every citizen through the compulsory general health insurance system, it was not clear how the people with a low level of income could meet both the expenses of monthly premiums and contribution payments in order to have an access to these services. Introduction of the private hospitals to the publicly insured people had also positive and negative consequences for the status of healthcare services. Though the government aimed to expand the access opportunities to health care services, it would create inequality between the people who would be able to pay the additional expenses that would be charged by those hospitals and the ones who would not be able.

Moreover, the status of green card holders was harmed, as in the new system they would be obliged to pay the contribution payments as opposed to getting free access to healthcare services which was the exercise up until then. The public employees whose health care expenditures were met by the state budget were also require to pay the premiums and contribution payments determined by the law. Though the equality among different employment schemes were secured through this practice, it can be also commented as the inclusion of other parts of the population, namely the civil servants and green card holders, to the commodification of health care process.

Not only the SIGHI law, but also the AKP government's perspective on foreign investment and especially investment in public sectors affected the health policy in Turkey. As the private sector was encouraged in the area of healthcare, both the domestic and international investors were welcomed. New laws were prepared and passed in order to ease the way of entrance of the foreign direct

investments into the country for the purpose of taking the burden from state to invest in health care. Public-private partnerships were designed to strengthen this process, yet the government did not question the results of such a great involvement of private sector in the healthcare area. As the private sector worked with the aim to increase the profits, the commodity status of health would be increases and the healthcare facilities would be more commercialized. The news on the fake reports of the doctors written to show their performance higher than actual was a clear example of ethical danger in the future of the healthcare as long as health was assumed as an ordinary commodity in the market.

As health care has not accepted as a citizenship right, which should be provided by the state as in the 1960s, it is impossible for the government to keep its promises concerning the universal health insurance. Although the name "general health insurance" may appear good on paper, the chances are very law for it to cover all the citizens in the country due to the premium-based system. The insurance system in Turkey legitimized the commodity status of healthcare through the prerequisites it established by the premium and contribution payments for getting healthcare services. Moreover, the increased share of the private hospitals expends the profit-making ideals of the investors from this sector.

As a result, Turkey have been moving more and more away from the citizenship based health care understanding which was tried to be established by the socialization law in the 1960s. Due to the simultaneous functioning of the employment based insurance systems and the inability and unwillingness of the governments to invest in the socialization program caused its failure though it is still in force on paper. Yet, the AKP government's policies have caused the de

facto cancellation of the socialization practice while the health posts were turned into institutions run by the family doctors. A person needs to be registered in the general health insurance scheme thus pay the necessary premiums even to go to the family doctor.

So, it is so obvious that it is not sufficient to be a citizen of this country to acquire the right to health care. As being a citizen is not sufficient to have the right to health care, it would be appropriate to state that the general health insurance scheme does not fit the social rights definition of Marshall. The claimed to be universalized health insurance scheme covers only the people who are able to pay their premiums. Thus, in order to be qualified as a citizen deserving the right to health care, a person needs to pay the necessary premiums and also additional charges to meet the expenses. Apart from the requirement to pay the premiums, the other way to gain the right to health care is to prove one's destitute, which is another practice criticized by Marshall and Bauman due to creating hierarchy among the society and discrimination against the poor. Thus, the general health insurance scheme implemented by the AKP government has in many ways in contrast with the social rights understanding of Marshall.

In this thesis I studied transformation of status of health care from a right to a commodity through the commercialization and the privatization of the services. For this thesis, it was necessary to examine the major laws on health care, the parliamentary minutes and newspapers in order to see the positions of the different parties and groups in civil society and to review the reports of and agreements with the international organizations in order to assess their influence in this arena. Apart from the laws scrutinized in this thesis, in order to grasp the transformation of healthcare from other perspectives, further studies may focus

on the full-time law, which was a crucial pillar of socialization law. In order to evaluate the reasons for failure of the socialization law, the full time law, its implications and the proper and/or improper implementation of it since the 1960s might be studied. Moreover, the researchers who want to contribute to the healthcare literature in Turkey concentrate on the role of the private hospitals as they have been increasing their share and influence in the health policies of Turkey. Especially with the attracting investment opportunities, the number of private healthcare institutions will continue to rise making the researches done in this field necessary and attractive to the researchers on social policy.

APPENDICES

APPENDIX A

Table 1: Employment Status of Persons who are not Registered to any Social Security Institution due to Main Job by Years (1988-1999)

(Thousand person, 15+ age)

Years	Total	Agriculture	Non-Agriculture
1988	10,320	7,711	2,609
1989	10,823	8,008	2,815
1990	10,494	7,869	2,625
1991	9,906	7,377	2,528
1992	9,679	6,826	2,853
1993	8,757	5,949	2,808
1994	8,822	5,722	3,100
1995	11,181	8,026	3,154
1996	11,307	8,370	2,937
1997	10,507	7,374	3,132
1998	11,306	8,250	3,056
1999	11,014	7,012	4,002

Source: Turkish Statistical Institute, The results of household labour force survey.

Note: October is taken as the reference month of the years for this table only.

Table 2: Employment Status of Persons who are not Registered to any Social Security Institution due to Main Job (2000-2007)

Years	Total	Agriculture	Non-Agriculture
2000	10,925	6,887	4,038
2001	11,382	7,422	3.959
2002	11,133	6,723	4,409
2003	10,943	6,531	4,411
2004	11,549	6,661	4,888
2005	11,050	5,726	5,323
2006	10,827	5,319	5,508
2007	9.929	4,191	5,023

Source: Turkish Statistical Institute, The results of household labour force survey.

APPENDIX B

Table 3: Employment Status by Years (1988-1999)

(Thousand person, 15+ age)

Years	Total	Agriculture	Non-Agriculture
1988	17,754	8,249	9,505
1989	18,223	8,596	9,627
1990	19,030	8,735	10,295
1991	19,209	9,078	10,131
1992	19,561	8,690	10,870
1993	18,679	7,606	11,073
1994	20,026	8,416	11,610
1995	20,912	9,205	11,707
1996	21,548	9,526	12,022
1997	21,082	8,321	12,761
1998	22,334	9,388	12,946
1999	21,507	7,894	13,613

Source: Turkish Statistical Institute, The results of household labour force survey.

Note: October is taken as the reference month of the years for this table only.

APPENDIX C

Table 4: Urban and Rural Population (1970-2006)

Years	Total Population (In Thousands)	Urban Population (In Thousands)	Proportion of Urban Population (%)	Rural Population (In Thousands)	Proportion of Rural Population (%)	Periods	Urbanization Rate (%)
1970	35,605	10,222	28.7	25,384	71.3	1965-1970	5.3
1975	40,348	13,272	32.9	27,076	67.1	1970-1975	5.4
1980	44,737	16,065	35.9	28,672	64.1	1975-1980	3.9
1985	50,664	23,238	45.9	27,426	54.1	1980-1985	7.7
1990	56,473	28,958	51.3	27,515	48.7	1985-1990	4.5
2000	67,420	38,661	57.3	28,759	42.7	2000	2.9
2001	68,407	39,709	58.0	28,698	42.0	2001	2.7
2002	69,388	40,823	58.8	28,565	41.2	2002	2.8
2003	70,363	41,924	59.6	28,439	40.4	2003	2.7
2004	71,332	43,036	60.3	28,296	39.7	2004	2.7
2005	72,065	44,747	62.1	27,318	37.9	2005	4.0
2006	72,974	45,754	62.7	27,220	37.3	2006	2.3

Source: Turkish Statistical Institute, State Planning Organization.

APPENDIX D

Table 5: Public and Private Hospitals (2004-2007)

2004

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total number of Bed
Total	922	160,114	253	11,774	171,888
Adana	16	4,641	5	261	4,902
Adıyaman	7	805	0	0	805
Afyon	17	2,101	1	50	2,151
Ağrı	8	292	0	0	292
Amasya	7	810	0	0	810
Ankara	51	15,280	14	833	16,113
Antalya	18	2,601	10	425	3,026
Artvin	9	580	0	0	580
Aydın	11	1,729	3	79	1,808
Balıkesir	19	2,561	3	72	2,633
Bilecik	5	278	0	0	278
Bingöl	7	530	0	0	530
Bitlis	8	525	0	0	525
Bolu	8	1,280	0	0	1,280
Burdur	5	670	0	0	670
Bursa	24	5,061	4	196	5,257
Çanakkale	11	1,047	0	0	1,047
Çankırı	7	565	1	35	600
Çorum	15	1,586	1	48	1,634
Denizli	13	1,278	4	143	1,421
Diyarbakır	9	2,745	2	35	2,780
Edirne	8	1,228	2	33	1,261
Elaziğ	10	2,340	1	27	2,367
Erzincan	10	651	0	0	651
Erzurum	13	3,055	1	45	3,100
Eskişehir	12	3,012	1	23	3,035
Gaziantep	8	2,030	4	340	2,370
Giresun	12	1,270	0	0	1,270
Gümüşhane	5	355	0	0	355
Hakkari	3	155	1	16	171
Hatay	11	1,500	4	142	1,642
Isparta	13	2,710	0	0	2,710

Table 5. continued

2004

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Mersin	12	2,972	4	204	3,176
İstanbul	73	28,785	123	6,368	35,153
İzmir	36	10,244	14	787	11,031
Kars	5	363	0		363
Kastamonu	15	1,448	1	29	1477
Kayseri	17	2,564	5	103	2,667
Kırklareli	8	709	1	18	727
Kırşehir	7	550	0	0	550
Kocaeli	14	2,268	6	156	2,424
Konya	30	3,487	4	104	3,591
Kütahya	12	1,283	0	0	1,283
Malatya	11	1,544	2	34	1,578
Manisa	22	2,904	4	134	3,038
K.Maraş	11	1,349	2	68	1,417
Mardin	6	586	0	0	586
Muğla	13	1,368	6	267	1,635
Muş	5	610	0	0	610
Nevşehir	6	484	1	30	514
Niğde	8	735	0	0	735
Ordu	15	1,825	0	0	1,825
Rize	7	818	0	0	818
Sakarya	10	1,225	4	146	1,371
Samsun	17	3,956	2	101	4,057
Siirt	6	370	0	0	370
Sinop	6	560	0	0	560
Sivas	15	2,613	0	0	2,613
Tekirdağ	11	1,095	6	201	1,296
Tokat	13	1,582	0	0	1,582
Trabzon	16	2,760	1	67	2,827
Tunceli	2	140	0	0	140
Şanlıurfa	13	1,750	1	19	1,769
Uşak	6	775	1	20	795
Van	11	1,415	0	0	1,415
Yozgat	11	980	0	0	980
Zonguldak	11	2,305	0	0	2,305
Aksaray	10	802	0	0	802
Bayburt	1	100	0	0	100
Karaman	4	515	0	0	515

Table 5. continued

2004

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Kırıkkale	8	1,025	0	0	1,025
Batman	4	260	1	34	294
Şırnak	5	235	0	0	235
Bartın	4	413	0	0	413
Ardahan	3	155	0	0	155
Iğdır	3	180	0	0	180
Yalova	2	364	0	0	364
Karabük	6	710	1	53	763
Kilis	1	190	0	0	190
Osmaniye	5	550	1	28	578
Düzce	5	922	0	0	922

2005

Total	888	164,446	268	12,339	176,785
Adana	17	4,788	5	231	5,019
Adıyaman	7	855	0	0	855
Afyon	17	2,078	1	50	2,128
Ağrı	8	455	0	0	455
Amasya	6	920	0	0	920
Ankara	51	15,394	15	934	16,328
Antalya	17	2,713	12	550	3,263
Artvin	8	595	0		595
Aydın	11	1,871	3	79	1,950
Balıkesir	20	2,940	3	72	3,012
Bilecik	4	278	0	0	278
Bingöl	6	480	0	0	480
Bitlis	8	575	0	0	575
Bolu	8	1,350	0	0	1,350
Burdur	5	700	0	0	700
Bursa	21	5,258	5	226	5,484
Çanakkale	10	1,102	0	0	1,102
Çankırı	7	565	1	35	600
Çorum	15	1,649	1	48	1,697
Denizli	13	1,602	4	138	1,740
Diyarbakır	10	2,875	3	84	2,959
Edirne	8	1,578	2	33	1,611
Elazığ	10	2,630	1	20	2,650
Erzincan	10	652	0	0	652
Erzurum	13	2,926	2	122	3,048

Table 5. continued

2005

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Eskişehir	11	3,164	1	23	3,187
Gaziantep	8	2,049	4	376	2,425
Giresun	12	1,316	0	0	1,316
Gümüşhane	5	355	0	0	355
Hakkari	3	205	1	16	221
Hatay	11	1,581	5	201	1,782
Isparta	13	2,810	0	0	2,810
Mersin	12	2,977	4	176	3,153
İstanbul	73	27,323	123	6,307	33,630
İzmir	33	10,315	14	812	11,127
Kars	4	380	0	0	380
Kastamonu	15	1,093	1	29	1,122
Kayseri	16	2,590	6	131	2,721
Kırklareli	6	786	1	18	804
Kırşehir	6	550	0	0	550
Kocaeli	12	2,222	7	230	2,452
Konya	28	4,080	5	139	4,219
Kütahya	9	1,467	0	0	1,467
Malatya	10	1,979	2	28	2,007
Manisa	20	3,053	4	122	3,175
Kahramanmaraş	10	1,511	2	68	1,579
Mardin	9	690	0	0	690
Muğla	11	1,385	6	274	1,659
Muş	6	610	0	0	610
Nevşehir	5	465	1	30	495
Niğde	7	720	0	0	720
Ordu	13	1,799	0	0	1,799
Rize	6	1,002	0	0	1,002
Sakarya	10	1,292	4	147	1,439
Samsun	17	3,889	2	60	3,949
Siirt	6	465	1	20	485
Sinop	6	605	0	0	605
Sivas	16	2,655	0	0	2,655
Tekirdağ	9	1,275	5	171	1,446
Tokat	13	1,627	0	0	1,627
Trabzon	15	2,823	1	67	2,890
Tunceli	1	150	0	0	150

Table 5. continued

2005

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Şanlıurfa	13	1,746	1	19	1,765
Uşak	6	931	1	20	951
Van	11	1,517	1	25	1,542
Yozgat	11	1,080	0	0	1,080
Zonguldak	9	2,327	0	0	2,327
Aksaray	10	837	1	22	859
Bayburt	1	150	0	0	150
Karaman	4	535	0	0	535
Kırıkkale	8	1,025	0	0	1,025
Batman	5	365	2	79	444
Şırnak	5	235	0	0	235
Bartın	4	445	0	0	445
Ardahan	3	155	0	0	155
Iğdır	3	280	1	10	290
Yalova	2	373	0	0	373
Karabük	6	743	1	53	796
Kilis	1	190	0	0	190
Osmaniye	5	550	2	44	594
Düzce	4	875	0	0	875

2006

Total	858	167,060	305	13,707	180,767
Adana	16	4,994	5	231	5,225
Adıyaman	7	855	0	0	855
Afyon	17	2,324	3	73	2,397
Ağrı	8	455	1	29	484
Amasya	6	960	0		960
Ankara	50	14,827	15	936	15,763
Antalya	17	3,272	16	748	4,020
Artvin	8	715	0		715
Aydın	11	2,003	3	79	2,082
Balıkesir	20	3,041	3	60	3,101
Bilecik	4	278	0	0	278
Bingöl	4	430	0	0	430
Bitlis	8	575	0	0	575
Bolu	8	1,220			1,220
Burdur	5	700	1	47	747
Bursa	21	5,542	8	598	6,140

Table 5. continued

2006

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Çanakkale	10	1,102	1	44	1,146
Çankırı	7	565	1	35	600
Çorum	15	1,649	1	48	1,697
Denizli	13	1,697	4	132	1,829
Diyarbakır	10	2,940	5	150	3,090
Edirne	7	1,791	2	33	1,824
Elazığ	10	3,298	2	76	3,374
Erzincan	10	680	0	0	680
Erzurum	10	2,642	2	122	2,764
Eskişehir	9	2,757	1	23	2,780
Gaziantep	8	2,357	5	396	2,753
Giresun	13	1,346	0	0	1,346
Gümüşhane	5	355	0	0	355
Hakkari	3	205			205
Hatay	11	1,716	5	201	1,917
Isparta	11	3,124	2	43	3,167
Mersin	14	3,326	4	127	3,453
İstanbul	74	25,464	124	6,217	31,681
İzmir	32	10,495	14	777	11,272
Kars	4	385	0		385
Kastamonu	15	1,140	2	85	1,225
Kayseri	11	2,832	7	156	2,988
Kırklareli	6	786	1	18	804
Kırşehir	6	575	0		575
Kocaeli	11	2,630	9	322	2,952
Konya	26	4,700	8	216	4,916
Kütahya	9	1,567	0		1,567
Malatya	10	2,043	5	105	2,148
Manisa	19	3,290	4	122	3,412
Kahramanmaraş	10	1,517	2	48	1,565
Mardin	6	600	0	0	600
Muğla	11	1,389	6	282	1,671
Muş	6	630	0		630
Nevşehir	5	465	1	30	495
Niğde	7	720	1	29	749
Ordu	13	1,799	1	46	1,845
Rize	6	1,002	0	0	1,002
Sakarya	9	1,170	5	157	1,327

Table 5. continued

2006

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Samsun	17	4,010	3	106	4,116
Siirt	3	380	2	43	423
Sinop	6	605	0	0	605
Sivas	15	2,737	0		2,737
Tekirdağ	9	1,275	5	185	1,460
Tokat	13	1,668	0	0	1,668
Trabzon	14	2,814	1	67	2,881
Tunceli	1	150	0	0	150
Şanlıurfa	13	1,856	1	19	1,875
Uşak	6	931	1	20	951
Van	12	1,762	1	39	1,801
Yozgat	11	1,080	1	46	1,126
Zonguldak	9	2,094	0	0	2,094
Aksaray	10	837	1	22	859
Bayburt	1	150	0	0	150
Karaman	4	535	0	0	535
Kırıkkale	5	1,020	0	0	1,020
Batman	5	365	3	149	514
Şırnak	5	235	0	0	235
Bartın	4	495	0	0	495
Ardahan	3	155	0	0	155
Iğdır	3	280	1	10	290
Yalova	2	373	1	14	387
Karabük	6	743	1	53	796
Kilis	1	190	0	0	190
Osmaniye	5	550	2	44	594
Düzce	3	830	1	49	879

2007

Total	911	166,988	365	17,995	184,983
Adana	15	4,964	5	231	5,195
Adıyaman	8	855			855
Afyon	17	2,294	3	73	2,367
Ağrı	8	455	1	29	484
Amasya	6	960			960
Ankara	48	14,693	21	1,334	16,027
Antalya	17	3,622	17	805	4,427

Table 5. continued

2007

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Artvin	8	690			690
Aydın	11	2,003	2	54	2,057
Balıkesir	21	3,041	3	61	3,102
Bilecik	6	298			298
Bingöl	6	430			430
Bitlis	8	475			475
Bolu	9	1,165	1	60	1,225
Burdur	7	700	1	49	749
Bursa	23	5,642	8	639	6,281
Çanakkale	10	1,102	1	44	1,146
Çankırı	8	480	1	75	555
Çorum	15	1,779	1	48	1,827
Denizli	15	1,759	6	153	1,912
Diyarbakır	12	3,015	6	247	3,262
Edirne	9	1,751	3	67	1,818
Elazığ	10	3,208	2	81	3,289
Erzincan	9	525			525
Erzurum	15	3,142	1	97	3,239
Eskişehir	11	2,741	3	93	2,834
Gaziantep	11	2,607	7	485	3,092
Giresun	13	1,266			1,266
Gümüşhane	6	300			300
Hakkari	3	205			205
Hatay	11	1,716	5	236	1,952
Isparta	13	2,999	3	87	3,086
Mersin	13	3,286	5	187	3,473
İstanbul	62	24,551	139	7,861	32,412
İzmir	30	10,350	17	961	11,311
Kars	6	385			385
Kastamonu	15	1,010	2	115	1,125
Kayseri	14	2,784	12	492	3,276
Kırklareli	6	786	1	24	810
Kırşehir	6	525			525
Kocaeli	12	3,030	10	342	3,372
Konya	24	4,798	10	383	5,181
Kütahya	12	1,567			1,567
Malatya	11	2,043	5	147	2,190
Manisa	20	3,305	4	122	3,427

Table 5. continued

2007

	Public		Private		
Provinces	Number of Hospital	Number of Bed	Number of Hospital	Number of Bed	Total Number of Bed
Kahramanmaraş	10	1,517	3	72	1,589
Mardin	10	600			600
Muğla	11	1,410	8	359	1,769
Muş	6	630			630
Nevşehir	5	440	2	67	507
Niğde	7	660	1	29	689
Ordu	13	1,794	1	49	1,843
Rize	7	1,002	1	43	1045
Sakarya	12	1,420	5	157	1,577
Samsun	17	4,060	3	130	4,190
Siirt	6	380	2	43	423
Sinop	6	605			605
Sivas	19	2,607	1	84	2,691
Tekirdağ	9	1,275	6	232	1,507
Tokat	14	1,668	1	47	1,715
Trabzon	17	2,814	2	131	2,945
Tunceli	5	150			150
Şanlıurfa	14	1,856	1	19	1,875
Uşak	5	910	1	20	930
Van	12	1,732	3	119	1,851
Yozgat	12	1,025	1	46	1,071
Zonguldak	9	2,094	1	47	2,141
Aksaray	10	702	3	65	767
Bayburt	1	150			150
Karaman	5	595			595
Kırıkkale	8	1,020			1,020
Batman	6	615	5	265	880
Şırnak	5	310			310
Bartın	4	495			495
Ardahan	3	155			155
Iğdır	4	280	1	10	290
Yalova	2	323	1	12	335
Karabük	6	743	1	53	796
Kilis	3	190			190
Osmaniye	5	629	4	165	794
Düzce	3	830	1	49	879

Source: T.C. Sağlık Bakanlığı, Tedavi Hizmetleri Genel Müdürlüğü

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