THE PHENOMENON OF SUBCONTRACTED WORK

IN TURKISH HEALTH CARE SECTOR:

A STATE ETHNOGRAPHY

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Thesis Abstract

Cemal Taylan Acar, "The Phenomenon of Subcontracted Work in Turkish Health Care Sector: A State Ethnography"

This thesis examines the recently emerged phenomenon of subcontracting work in the Turkish public health system. The main focus is on the health care workers, who are employed via subcontracting practices at Istanbul Faculty of Medicine Çapa University Hospital. It is argued that the emergence of these practices leads to the commodification of health care work, since the supportive health care workers are deprived of being public servants in a public health institution.

This development is part of a bigger transformation in the health care field. Thanks to the rise of neoliberalism, the health care system goes through a deep restructuring, in which health care is ceasing to be a public good –though it was not a social right of citizenship with equal access for everyone- and transforms into a commodity to be marketed. On this point, a detailed analysis is provided regarding the health care "reform" and it is argued that Turkish health care sector is in process of marketization via autonomization by disengaging the public health care institutions from the central state budget. The state deserts from the area of health care provision by leaving it to the market forces by producing a discourse, which brings an unprecedented change in the conceptualization of health care with reliance on neoliberal principles of efficiency and cost-containment in health care.

This thesis illuminates the reflections of this macro reform project on a particular hospital environment and the situation of its workers, who are primarily affected from this. Regarding the fact that introduction of subcontracted work in health care sector is a highly contested issue, blurring the boundaries and the relationship between the state and this particular public service, the subcontracted workers' perceptions about themselves and their work lead to new subject positions.

Tez Özeti

Cemal Taylan Acar, "Türk Sağlık Sisteminde Taşeronluk Hadisesi: Bir Devlet Etnografisi"

Bu tez Türkiye sağlık sisteminde kısa süre önce ortaya çıkmış olan taşeron çalışma hadisesini incelemektedir. İstanbul Tıp Fakültesi Çapa Üniversite hastanesinde taşeron olarak istihdam edilen sağlık işçileri çalışmanın ana odak noktasıdır. Bir kamu sağlık kurumunda memuriyet hakkından mahrum bir şekilde çalıştırılan bu taşeronlaştırma pratiklerinden hareketle, temel argüman, sağlık emeğinin metalaştırıldığı ileri sürülmektedir.

Bu gelişme sağlık alanında yaşanan daha kapsamlı bir dönüşümün bir parçasıdır. Neoliberalizmin yükselişi sayesinde, sağlık sistemi derin bir yeniden yapılanma sürecinden geçmektedir. Bunun sonucu olarak sağlık –hiç bir zaman herkesin eşit bir şekilde ulayabildiği toplumsal bir vatandaşlık hakkı olmamasına rağmen- bir kamu yararı olmaktan çıkıp pazarlanabilir bir piyasa dönüşmektedir. Bu noktada sağlık "reformu" hakkında detaylı bir çözümleme yapılmış ve Türk sağlık sektörünün özerkleşme vasıtasıyla piyasalaştırma yoluyla kamu sağlık kurumlarının merkezi devlet bütçesinden ayrıştırıldığı ileri sürülmektedir. Devlet sağlık alanından çekilerek bu alanı piyasa güçlerine bırakmakta, bunu da yaparken sağlık hizmetinin kavramsallaştırılmasını görülmemiş bir şekilde değiştiren ve verimlilik ve masrafların kısılması gibi neoliberal ilkelere dayanan bir söylem geliştirmektedir.

Bu tez makro düzeyde gerçekleşen bir reform projesinin tek bir hastane üzerindeki yansımalarına ve o hastanenin bu projeden birincil düzeyde etkilenen personelinin durumuna eğilmektedir. Sağlık sektöründe taşeronlaştırmanın devlet ve belirli bir kamu hizmeti arasındaki ilişkiyi ve sınırları bulanıklaştıran ihtilaflı bir konu olması göz önünde bulundurulduğunda, taşeron işçilerin kendileri ve işleriyle ilgili algıları yeni öznellik konumları ortaya çıkarmaktadır.

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CONTENTS

PREFACE

The idea behind writing this thesis was the fact that Turkey has been going through a neoliberal structuring, which could be summarized as the manifestation of market principles in different areas of life. That's why I have decided to study a field, which is in a process of transformation from a non-market to a market, profit-sought one, as in Colin Leys's words.

Turkish health care system has always been criticized in terms of its inefficient functioning and problems of its quality, but more importantly for its unequal structure in terms of access of citizens. This situation pretty much depends on the tri-partite structure of social security systems, which relies on the status of employment. Hence health care service has never been a right equal for everyone on citizenship basis. In addition to that it never had been a single payer system, compensated by the state budget.

The debates on the issue were calling for a reform in the health care system, as well as in the social security structure, which is interconnected to health care services. In this atmosphere the long-time necessitated health care reform has been implemented during the successive Justice and Development Party governments since 2002.

This thesis, first of all analyzes this transformation in health care for its particular objective, by dwelling on the primary highlights and policy assessment. This thesis particularly aims to focus one fact, which is conceptualized as a necessary aspect of the change in health care: cost reduction of health care personnel. For this I am going to analyze a recent phenomenon of subcontracting practices introduced in university hospitals among supportive and secondary health care service occupations such as nurses, technicians, medical secretaries, caregivers, laboratorians, biologists etc. In other words, the introduction of subcontracting practices is not only limited to cleaning, cafeteria, security and parking personnel, which is today in Turkey rather common in every public institution. Here the workers, who perform the primary tasks of an hospital are employed via subcontracting practices; a fact that constitutes the authenticity of this study in the literature.

The experiences and perceptions of the subcontracted workers gave this study its main path. The data of the study relies on an ethnographic study conducted in Istanbul University, Istanbul Faculty of Medicine Çapa University Hospital. It was rather important to achieve to give a voice to subcontracted workers themselves. My main goal was to reflect the experience of this neoliberal transformation in health care from the narratives of the subcontracted workers themselves. In this respect, special emphasis is given to the new employment policy of state authority with regards to its own employees.

The important point here is to dwell upon the dialectic relationship between the general transformation of health care system and its micro reflections on a particular hospital environment and the experiences of the workers in that hospital. Inspired by the works of Richard Sennett, I try to show how the work in health care is redefined in a process from routine to flexible. It is argued that the introduction of subcontracted work leads to the commodification of health care work, which might in the future harm the quality of health care provision. However, I have to underline that the scope of the thesis is limited to health care workers themselves. Any examination of the reflections on the receiver end could not be conducted for practical constraints and saved for possible future researches. This commodification manifests itself by depriving the health care workers from the socio-economic rights

and benefits, which their public servants attain. More significantly the experience of subcontracting creates a hierarchization between colleagues performing the same jobs. It has harmful effects on the workers, where in which the subjective relations between the workers and their work, as well as their institution and colleagues take an estranging form.

Finally, I have to underscore that this study is conducted during the process of this change towards subcontracted, flexible work, when the number of subcontracted workers in some occupational groups such as nurses, is still in minority in respect to the public servants. That's why it should be noted that some arguments this thesis assert are peculiar to this transition process. Nonetheless the main argument of commodification of health care work seems to be realized in the very near future.

In the first chapter of this thesis, I am going to draw the theoretical background and the capital ideas this study relies on. In the second chapter, the discussion will be on the transformation of health care system special emphasis on marketization via autonomization in public health institutions. Both current and envisaged changes and proposals regarding health care "reform" will be taken into consideration. In the third chapter, the legal background of emergence of subcontracted work will be examined with respect to official documents and the analysis of the change in the understanding of work from the point of view of state. The fourth chapter examines the interviews and observations made in Çapa Hospital environment. The experience of being a subcontracted health care worker is going to be conveyed within their own narratives. In the conclusion, I am going to wrap up my argument and raise the significant issues, which would contribute to the literature, as well as point possible future research projects.

CHAPTER 1

INTRODUCTION

The Theoretical Background

The literature on the phenomenon of neoliberalism with all the political, social and cultural transformations it entailed is far from being scant. The impacts of neoliberalism on state and society have been studied by social scientists from several aspects. It has been widely argued that the first and foremost objective of the new capitalism, so-called "neoliberalism," was putting an end to the intervention of the state into the functioning of the economy. Privatizations, deregulation of the labor markets, the handing over of the public services to the market, the cut-offs in welfare spending and the elimination of protectionist economies were aimed to shrink state's role in the economical sphere of life. The universal provision of the welfare, specifically the right to health and to education, began to be questioned with respect to whether the state should be providing these equally for all its citizens. The notion of job security that underscored the previous era started fading away as decades passed and became a privilege of few in the turn of the twenty-first century. Opening up Third World economies to the global flow of capital by lowering/eliminating the customs barriers brought the transfer of the labor-intensive industry to these areas. With the abrogation of the "Fordist" contract with labor, the industrial capital downsized firms and relocated manufacturing activities to low-wage, non-union regions of the South, Southwest, and overseas.[1]

[1] Judith Goode and Jeff Maskovsky, *New Poverty Studies: The Ethnography of Power, Politics and Impoverished People in United States* (New York and London: New York University Press, 2000), p. 4.

The impetus for this study is to reveal the effects of the above-summarized transformation on the everyday practices of the people and the enforced subjective positions of them. I attempt to analyze the micro-phenomenon of the introduction of subcontracting practices in the general framework of reform in health care in line with neoliberal prescription. Therefore, I think, it is essential to problematize *the state* in the transformation of the new political economy. The Turkish state still assumes the role of primary health care provider. However, the new positioning of the state itself, following the neoliberal policies, has to be identified with regards to its direct or indirect influences on the micro realities of the livelihoods of its citizens. By focusing on the state, I propose that it is necessary to contextualize this ongoing transformation and analyze the relations between the state and the society in Turkey in a historical and sociological point of view in order to convey the significance of the subject matter of this study.

The area of this study is a university hospital, that of Istanbul University, Istanbul Faculty of Medicine Çapa University Hospital.[2] More specifically, the focus will be on the health care service providing employees, who are employed via subcontracting schemes. Subcontracting has recently been introduced among the university hospitals in Turkey. In other words, the study focuses on a public service shop floor environment, in which the clinical service providers/supportive medical employees as well as secondary service workers are employed via subcontracting arrangements. Focusing on this area, I will problematize the employment without job security in the

[2] There are two faculties of medicine under the body of Istanbul University. Istanbul Faculty of Medicine in Çapa and Cerrahpaşa Faculty of Medicine. The name Çapa comes from the district, where the Faculty of Medicine and the University Hospital are located. Although the official name of the hospital does not involve the Çapa, the word Çapa is commonly used to refer both to the Faculty and the Hospital. For this reason, throughout the study, the author will use the name "Çapa" to refer to the Hospital. Cerrahpaşa Faculty of Medicine and Hospital Campus is located 15 minutes of walking distance from Çapa.

health care sector; in one of the main public services. Here, the important question to ask is in what ways the state repositions itself in respect to health care system and where would the new regime of health care look like.

Hence, the aim of the study is twofold. First of all, this thesis aims to provide a brief analysis of the recent "Transformation in Health Program"[3] realized in Turkish health care system. On this point, by dwelling on the proposals of such a great transformation, I will argue that the "reform" program pinpoints a passage to a "marketized" health care service provision in Turkey. Although Turkey has never been able to establish a universal, single-payer model in health care structure; providing an equal access to every citizen in theory, nonetheless the system was embedded in a loose form of publicness, where the state had always been the primary actor in providing medical services, as well as taking the necessary measures for protective health care services. Thus, what we witness at the hospitals, i.e. on the secondary and tertiary levels of medical care, is what I call marketization via autonomization; not only administratively from central government, but also financially from the general budget. Hence, the steps taken are aiming the creation of a health care market, in order to achieve the cost-containment and flexible employment necessitated by the neoliberal understanding.

As a result, I will put forward that the new health care "reform" in Turkey marks a paradigmatic shift from a notion of health care as public good –although not a right of citizenship- to a health care as a commodity to be marketed. This shift corresponds to a dramatic transformation in terms of the relation of the state to the society. The desert of state and its leaving the area to market forces makes possible the employment of

[3] Ministry of Health, *Sağlıkta Dönüşüm Programı*, 2003.

subcontracted workers in a university hospital, where the most complex and specialization-required secondary and tertiary level health care services are provided.

This brings me to my second point: how is the self-understanding of health care providers affected by being employed as subcontracted workers in a public university hospital without job security, i.e. the commodification of health care work? The relationship between the subcontracted workers and the existing health care providing personnel, employed as government employees –*memur*-, will be an important aspect of this study. The subcontracting process not only leads to a division, eventually a discrimination, within the health care providers performing the identical tasks, but also to hierarchization and otherization related to their different status at work: the subcontracted worker and the government employee.

The subjectivities constructed by subcontracted workers in relation to their more deprived and less privileged status with respect to their "government employee/public servant" colleagues reveal one of the harmful effects of the changing policy of state with regards to public employment in line with the neoliberal recipe; a situation which follows the commodification of health care labor. The subcontracted workers, despite spatially working in a public institution and providing the very crucial service of health care, are treated as not part of the state or public. There are no files issued for them regarding their employment in a public institution. To the state they do not exist, notwithstanding they are providing health care services in the most famous and one of the biggest university hospitals in Turkey.

To sum up, on the first point I focus on the relationship between state and its citizens with regards to the changing epistemology of a particular public service; in this case the most vital of them, health care provision. In the light of re-definition of the

nature of health care through privatization and autonomization practices, the reform anticipates to diminish the role of the state in health care provision and protection. As a matter of fact, the reform project in general aims to achieve efficiency measures, as well as cost-containment by promoting the private sector and reforming the public health care as health care enterprises[4].

Whereas on the second point, I will examine the relationship between the state and its employees in the light of the notion of subcontracting, which emerged in the field of health care provision. This notion deserves particular attention, because it corresponds to a dramatic alteration in respect to the employment model of Turkish state. Through an ethnographic fieldwork conducted in Çapa University Hospital, I will argue that the emergence of subcontracting has harmful effects on the health care providers by leaving them in a precarious situation. Moreover, during the transformation process, in which the subcontracted workers and government employees are employed side-by-side imposes a division among the health care personnel, which harms the unity and trust among them; notions particularly vital in health care provision.

In the remaining part of this section, I will develop an argument regarding the theoretical background on which this endeavor is based. The focus will be on the flexible and insecure labor on the one hand, and the state initiating this form of labor on the other. It is important to note that the empirical data compiled from the ethnographic study is very recent. Therefore, it should be noted that the existing literature on the particular case of Turkey is scant. However, the wider anthropological works employed provide a solid theoretical framework to this study. I will provide an analysis of Turkish

[4] Asena Günal, *Health and Citizenship in Republican Turkey: An Analysis of Socialization of Health Services in Republican Historical Context*, Unpublished Ph.D. Thesis. Boğaziçi Üniversitesi, Istanbul, 2008, pp. 1-3.

state from an ethnographic perspective articulated with the flexible employment model, as well as tracking the changing nature of a public service that accompanies it. Although I will refer to the fieldwork during the course of the study, a detailed analysis of the ethnography in the Çapa Hospital will be provided in the third chapter. The transformation emerges with regards to the conceptualization of state creates new power relations, while forcing the actors to develop new subject positions in the new circumstance.

Fieldwork and Methodology

The data of this study relies on a fieldwork conducted through a six-month period at the end of the 2007 and in the first half of 2008. Visiting Çapa on a regular basis gave me the opportunity to make a detailed ethnographic study regarding the everyday encounters of the subcontracted workers within their shop-floor environment. It is not easy for me to specify the number of people, whom I get into contact. Sometimes, I was able to talk with the workers for several hours in a face-to-face setting. Mostly, there were little groups of co-workers, within which I had conducted semi-structured group interviews; or occasionally conversed with them in a non-structured conversation environment. Sometimes, I found myself in a discussion within a group of workers who were casually talking about their situation in the workplace. Methodologically, I can describe my position advancing from a participant-observer to an observing-participant one. According to Anderson, the former is an early, tentative process of negotiating a relationship with the group under study, while the latter may not be satisfied with this

position; rather has become close to the subjects, profoundly empathizing with them, and is more able to articulate their point of view.[5]

Since the *Dev-Sağlık-İş* union have provided me the most important help to get into contact with the subcontracted workers, I have usually been visited the subcontracted working people in their workplaces with the organizers of the union. Moreover, through Zeki Kılıçaslan, a professor at Respiratory Diseases Department, who has been helping the subcontracted workers in their unionization struggle and several other issues, I was able to meet and talk to considerable number of workers. The workers I talked, with whom I get into contact via *Belediye-İş* union were all from cleaning personnel, since this union conducts its activity in that field.

On the other hand, I continuously attended the gatherings organized by *Dev-Sağlık-İş* union and *Belediye-İş* union both in university campus and in the union branch offices. In these gathering, I only confined myself to introducing myself to the workers and I merely observed and listened to them, rather than asking questions to them. I have also attended two important demonstrations organized by the unions.

The first one was the demonstration of *Dev-Sağlık-İş* in the capital city of Turkey, Ankara, organized with the main slogan: "*Down with employing human beings through bidding, down with the subcontracted work in health care!*"[6] It was a national demonstration of the union, to which the subcontracted workers from different university hospitals throughout Turkey attended. The second one was that of *Belediye-İş*, organized among cleaning personnel that took place in Çapa University Hospital with

[5] Elijah Anderson, "Urban Ethnography", in *The International Encyclopedia of the Social and Behavioral Sciences*, eds., N.J. Smelser ve P.B. Bates (Elsevier Inc, 2001): pp. 16004–16008, p. 16005.

[6] İhaleyle insan çalıştırılmaz, sağlıkta taşeron olmaz!

the objective of getting recognized by the Dean's Office as permanent workers with a collective agreement. In the demonstration, the decision of the subcontracting firm to lay off workers who did not have primary education and who were over fifty years of age was also protested by the workers. At that time, *Belediye-İş* union and the dean were about to sign a collective agreement, which was considered to be an improvement in the working conditions of the subcontracted workers, particularly in respect to their insecure employment. Therefore, participant observation method should be regarded within the scope of this study, as well as both the semi-structured and the non-structured face-to-face and group interviews conducted dominantly in the workplaces on the Çapa University Hospital campus.

Lastly, I would like to make a sketchy classification of the people that I interviewed. First of all, I tried to talk as many subcontracted workers as possible. And these were from different groups such as caregivers, cleaning personnel, nurses, technicians and medical secretaries. The number of people interviewed from these different groups is more or less equal to each other, ranging between five to seven persons. In addition to that, I have interviewed with the union activists from two unions (*Belediye-İş* and *Dev-Sağlık-İş*); in fact I owe the large proportion of my sample to the activists of *Dev-Sağlık-İş*. Regarding the number of the subcontracted workers, I am not able to present an exact number of subcontracted workers at Çapa. However, the number of cleaning workers is 400; and they are all subcontracted workers. Furthermore, a unionized nurse, Aysel, provided me with the figures regarding the nurses: out of 880 nurses in total, 160 of them are subcontracted. Despite the fact that the number of subcontracted nurses is one-fifth of the total; she stated that this number is likely to increase in the very near future in tandem with my argument of the transformation to the

subcontracted and insecure health care work. According to Aysel, there are two main groups among nurses: one group consists of nurses, who have been working for 15 to 20 years; so they are close to their retirement. The second group is that of the recently employed ones composed of both government employees and subcontracted workers. Thus, she argued that more and more nurses would be employed via subcontracting, as long as the senior group of nurses retires.

In addition to that, I deemed it necessary to interview the civil servants, i.e., non-subcontracted employees in the Çapa hospital, in order to analyze how they perceive the emergence of subcontracted work in the hospital environment, since they are co-workers and the situation within the subcontracted work might affect the provision of health care in general. This group comprises only few doctors and nurses; because of the fact that there is not a single cleaning personnel who is a civil servant exist and only very few of that remained in the caregiver category in the hospital, thus the sample of the study does not include any civil servant cleaning or caregiver personnel. During some group interviews, civil servant employees were present, who were working in that particular department. Again, some doctors and nurses, though very few of them, attended the demonstrations organized by the unions. Finally, I did not interview anyone occupying managerial position or someone who could provide any information about the managerial arrangement at Çapa, because my primary intention was to ask the health care workers themselves how they make sense of the particular experience, as well as their personal perceptions about their encounters with the precarious situation they have been facing.

Constructing the State as a Site

In this study, I analyze the reflections of a macro structural change in the general tendency of the employment model of the state on the service-providing sector at the micro level of a hospital environment. In fact, the relationship between the two is a dialectical one; being part of a whole and operating with an inter-dynamical mutuality, rather than a cause-and-effect relationship. I will show that in this particular hospital, daily experiences of the employees with each other and the notion of health care work in general was considerably influenced by this change. The relevance and contribution of my study lies in coming up with an analytical connection between a macro structural phenomenon and micro realities of the workers. These workers are embedded in a deprived position with an image of little self-confidence, diminished allegiance to work and hopelessness with regards to the future because of the implementation of the former. I attempt to analyze the relationship between this situation and the transformation in health program in the context of Turkey.

In line with that, in this study I will also utilize the literature on state ethnography in order to understand the role of the state in manifestation of the neoliberal policies and in rendering a new form of neoliberal governmentality. The anthropological studies, which examined the impact of decisions and policies of the state authority on the everyday experiences and encounters of the citizens in various historical and cultural contexts, led me in my endeavor of analyzing the transformation within the state itself and its reflection on its personnel. Besides examining the production and circulation of discourses about the state, ethnographies of the state also involve analyzing how messages about the state are interpreted and mobilized by the people according to their particular contexts and social localities.

Studying the notion of state from an anthropological perspective provided me with an understanding of how the subcontracting workers in Çapa University Hospital – who are working at a public institution, but not classified as part of that public- perceive themselves in that particular "public environment" in relation to the state and to their civil servant co-workers. An ethnographic study of state reveals how the people interpret the discourses and practices of the state power within a specific space and react accordingly, as well as how the culture in this particular public space and the positions of the actors embedded in that space alter dramatically. Gupta and Sharma argue that such a perspective allows paying careful attention to 'how the people perceive the state, how their understandings are shaped by their particular locations and intimate embodied encounters with state processes and officials, and how state manifests itself in their lives.'[7]

In this thesis I intend to trace the linkages between the macro-structural change of the general approach of political power to the concept of health care and the micro experiences of this in a university hospital environment. The provision of health care now is falling outside the scope of the everyday practices of state. Providing health care services would gradually cease to be 'a performance of statehood' through the retreat of the state from the space of health care. This retreat also changes the perception of the citizens about the state, for whom the state supposedly provides the health care service. In the context of withdrawal from health care, the state constitutes itself as the "non-health care provider". In other words, the state redefines its relation to health care and ceases to be the provider of it and establishes a novel *governmentality* for the Turkish

[7] Aradhana Sharma and Akhil Gupta, "Introduction" In *The Anthropology of the State: a reader*, ed. Aradhana Sharma and Akhil Gupta (Malden, MA; Oxford: Blackwell Pub., 2006), p. 11.

context, since it attempts to change the major understanding regarding health care provision in a complete manner

On this point, the collection of essays in *Anthropology of the Policy: critical perspectives on governance and power* edited by Cris Shore and Susan Wright provide an insightful analysis regarding the practical and discursive reflections of policy making on the *state level* on the lives of the ordinary citizens. Shore and Wright ask how policy discourses work to control political agendas and show the complexity of the ways in which policies construct their subjects as objects of power.[8] Theoretically, I rely on their work in terms of defining the introduction of subcontracting practices in the general framework of social policy, which takes the form of marketization of health care provision sector. I analyze that the introduction of these practices as a part of the "reform" process of health care sector in general, where in which the marketization of both health care service and health care labor goes hand in hand.

Shore and Wright argue that policy 'became an increasingly central organizing principle in contemporary society, shaping the way we live, act and think.'[9] Starting from this point, according to them, 'the policy' is a tool in the hands of the government. That's why policies are suitable means of examining the systems of governance, and the shaping of its citizens through the tool of policy. They assert that 'policy provides a powerful conceptual tool for analyzing the processes and agencies of government.'[10]

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[8] Cris Shore and Susan Wright, *Anthropology of the Policy: critical perspectives on governance and power* (London; New York: Routledge, 1997), p. 3.

[9] Ibid, p. 6.

[10] Ibid, p. 14.

In this respect, my study is an effort to combine micro and macro levels of analysis from a perspective of rendering the subcontracted work in a general framework of policy regarding the field of public service in Turkey. And this neoliberal policy justifies itself with the problems resulting from the existing health care structure. The policy makers often utilize the problems of access and quality in health care in order to implement the neoliberal policy of commodification in the sphere of health care. While analyzing the process of commodification of labor in public health care through the experiences of Çapa workers, at the same time I will come up with preliminary links that this process is part of a general orientation of policy regarding the model of employment in the neoliberal era.

Focusing on this neoliberal policy provides a new avenue for studying the localization of global processes in the contemporary world, regarding the fact that the newly introduced policy modalities like "the transformation in health care systems" are not peculiar to Turkey. On the contrary the health care reform policies in general are the result of the recently expanding application of public service policies produced by supra-national organizations like World Bank and Word Health Organization (WHO) on the global scale.[11] Policy analysis provides an opportunity to render the direct or indirect impact of deregulation processes on health care providing workers regarding the particular objective of this study. The outsourcing of the health care jobs might be presented as a positive phenomenon in order to boost the effectiveness of the provision of the service. The central argument is that market forces would increase the quality of

[11] Tuğba Ağartan, "Sağlıkta Reform Salgını", in *Avrupa'da ve Türkiye'de Sağlık Politikaları*, eds. Çağlar Keyder, Nazan Üstündağ, Tuba Ağartan and Çağrı Yoltar, (Istanbul: İletişim Publishing, 2007).

health care provision, which favors the "shrinking" of the state in the era of new capitalism. As Shore and Wright put it very clearly:

> "Policies are most obviously political phenomena, yet it is a feature of policies that their political nature is disguised by the objective, natural, legal-rational idioms in which they are portrayed. In this guise, policies appear to be mere instruments for promoting efficiency and effectiveness. This masking of the political under the cloak of neutrality is a key feature of modern power".[12]

The edition of Shore and Wright focuses the policy analysis in three aspects: policy as a language in relation to discourse and power; policy as a cultural agent in terms of constructing national identity and policy as political technology with regards to the concepts of governmentality and subjectivity.[13] What closely relates to the subject of this study is their last point; policy as political technology. By introducing the subcontracted work in health care sector, which manifests flexible and insecure employment, the government implementing the neoliberal recipe, governs the public health with a new form of power. And, this new form of power brings a deeper deprivation for health care workers. Here, the significant point is focusing on the social and political content of the policy. It would be misleading to doom policy without taking on its effects on the society. The policy, I discuss in this study introduces market principles in health care system, while using emancipatory and egalitarian discourses.

In this section, I have tried to link my study within the existing literature on state ethnography with an emphasis on the role of the state in relation to its practical and discursive relations to control the society. In the next section, I will develop my

[12] Cris Shore and Susan Wright, *Anthropology of Policy*, p. 8.

[13] ibid, pp. 18-29.

theoretical point by taking a closer look at the phenomenon of subcontracting. The existing literature on subcontracting practices will provide me with a perspective on constructing my own argument about subcontracting within a public service environment, in this case within a university hospital affected by the general change in health care system. However, I have to emphasize that this study mainly focuses on the relationship between the state and its personnel, and the commodification of health care labor. That's why the referral to anthropology of state literature should be misleading, as if I will analyze the reflections of health care policy on citizens. Nor I will come up with an anthropological examination regarding the relationship between the state and the citizens mediated through the service of health care. Nonetheless, I think it is necessary to partially rely on the works on state ethnography in order to place the emergence of subcontracting practices to a general framework of policy regarding health care services, which is guided by neoliberal principles. Although a discussion on the effects of the health care "reform" on citizens looks tangential for the sake of main subject matter of this study, it is important to realize that the emergence subcontracting practice is part of an all-encompassing project in the area of health care.

Another notion I would like to theorize regarding the situation of the subcontracted workers is the marginalization, most importantly the margins of the state; a concept I borrowed from Das and Poole.[14] The discussions and conversations gave birth to their book in the light of the relation between sovereign and disciplinary forms of power, as well as specific genealogies of political and economic subjects led them to

[14] Veena Das and Deborah Poole, *Anthropology in the Margins of the State,* eds., (Santa Fe: School of American Research Press, 2004)

formulate three concepts of margins.[15] The first idea was the one about margins as peripheries seen to form natural containers for people considered insufficiently socialized into the law'. The second approach to the concept of margin dwells with the difference between legibility and illegibility, where the primacy is given to the construction of state through writing practices. Finally, the third understanding focuses on margins as a space between bodies, law and discipline.[16]

Through a discussion on the strategies of citizenship, technological imaginaries and new regions of language analyzed as co-constructing forces of the state and the margins, Das and Poole argue that the margins create exceptions in respect to laws and that they are never inert, but produce new spaces of power by using Agamben's notion of state of exception. The production of new spaces of power is important with regards to the legitimacy and the sovereignty of the state over its subjects.[17] Taking this study in consideration, the blurring the boundaries of health care work in public institutions is of primary importance, since the subcontracted workers in health care are invisible from the point of view of law. Yet, at the same time they are very central in the policy of establishing the neoliberal principles in health care, because their exceptional situation, i.e. commodified health care work will be manifested as the defining rule in the near future. So, their deprived position in relation to their government employee colleagues will be articulated within the notion of marginalization with regards to how they are perceived by the state. The point here is the neoliberal ideology in the field of health care is established through the creation of a marginal space within the field, as well as

[15] ibid, 8.

[16] ibid, 9-10.

[17] İbid, 12-19

the dividing practices, which transforms the health care providing workers into subjects. Though they do not have official files showing that they work for the hospital, they are of capital importance for deregulation of health care labor market. A detailed analysis about the legal position of subcontracted workers, and an inquiry about the concerned laws and regulations will be provided in the third chapter.

What is Subcontracting?

In this section, I will dwell upon to the existing literature on subcontracting and outsourcing in order to underscore the contribution of this study in showing how the notion of subcontracting emanates in different forms. The global context, in which these developments take place, deserves to be analyzed. Since the demise of the post World War II, Keynesian consensus in the economy, which relied on the vertically integrated Fordist mode of production, relying on large assembly lines, task fragmentation[18] and national development policies, the labor market went through dramatic changes. Along with the opening up of the national economies, the abolishment of tariff and non-tariff barriers, the free flow of capital, the rise of the service sector, economies adopted the principles of flexible employment policies and the liquidation of job protection. *The* worker of the so-called pre-globalization era; male, unionized, highly paid industrial worker, attired with rigid social protections and job guarantee, was erased from the scene of industrial production. Moreover, the contemporary era started to be defined as post-industrial society.[19] What defines the contemporary labor market is its diverse structure, whose basic foundations are the flexibility of labor and employment without

[18] Robert Feenstra, "Integration of Trade and Disintegration of Production in the Global Economy", *Journal of Economic Perspectives*, Vol. 12, No. 4 (1998), p. 2.

[19] Daniel Bell, *The Coming of Post-industrial society: a venture in social forecasting* (New York: Basic Books, 1976).

job security. Furthermore, the new era necessitates de-unionization in order to leave the working people in "absolute freedom" against the impositions of capital. The new labor codes are introduced in order to facilitate lay-offs without paying compensations and the employment without collective agreements.

The disintegration of production not only resulted in structural changes in the regimes of economic activity, i.e. from import-substitution and protected economies to export-oriented economies resulting in the formation of "global market". In addition, the spatial organization of the economy, especially in industrial production and manufacturing has altered dramatically with the emergence, better said, gaining prominence of the subcontracting and outsourcing practices. These practices opened the path for different tasks in the process of production to be performed not by the employees of the firm, who own the products or equipment at the end of the process, but by the employees of a subcontractor to which one specific task is outsourced by the main firm. This creates a large "web" of disintegrated and spatially fragmented production process, in which indefinable actors are involved, such as piece-wage paid workers, subcontractors, retailers and middlemen from various countries from different continents of the world.[20] Grossman and Helpman argue that we live in an age of outsourcing.[21] They refer to a recent annual report of World Trade Organization (1998), which illustrates the subcontracting phenomenon as the following:

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[20] Manuel Castells, "The Informational Economy and the New International Division of Labor", In *The New Global Economy in the Information Age*, eds. Martin Carnoy, et.al. (University Park, PA: Pennsylvania State University Press, 1993), pp. 15-43.

[21] G.M. Grossman and Elhanan Helpman, "Outsourcing in a Global Economy," *The Review of Economic Studies*, Vol. 72, No. 250 (Jan 2005), p. 135.

> "Thirty per cent of the car's value goes to Korea for assembly, 17.5% to Japan for components and advanced technology 7.5% to Germany for design, 4% to Taiwan and Singapore for minor parts, 2.5% to the United Kingdom for advertising and marketing services and 1.5% to Ireland and Barbados for data processing. This means that only 37% of the production value is generated in the United States."[22]

If we take a brief look at the scholarly literature on the topic, we see that mainstream economists and neoclassical economy as a discipline developed a positive approach towards subcontracting and outsourcing practices, especially those that occur on the international level. Their main argument seems to be the considerable reduction in labor costs that could be affected through subcontracting activity. Increased competition in the context of globalization justifies the profitable practice. By the same token, the advocates of subcontracting practices emphasize its positive impact on international trade and its contribution to the globalization of the economy.[23] Moreover, it is argued that greater competition is achieved and private sector developments and new investments are encouraged due to the introduction of subcontracting practices.[24] Furthermore, some scholars argue that decentralizing has been introduced through subcontracting practices and has a favorable impact on the flexible specialization of production.[25] Also they assert that the disintegration of production is influential in creating more jobs, particularly for women.

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[22] World Trade Organization, *Annual Report 1998* (Geneva:World Trade Organization, 1998), P. 36.

[23] Jagdish Bhagwati, Arvind Panagariya and T.N. Srinivasan, "Muddles over Outsourcing," *The Journal of Economic Perspectives*, Vol. 18, No. 4 (Fall 2004), pp. 93-114.

[24] Charles Bingman and Bernard Pitsvada, "The Case for Contracting out and Privatization", *Challenge,* Vol. 40, No. 6 (Nov/Dec, 1997), pp. 99-116.

[25] Michael J. Piore and Charles F. Sabel, *The Second Industrial Divide: Possibilities for Prosperity* (New York: Basic Books, 1984).

Similarly, Nishiguchi's study, which provides a detailed analysis on subcontracting practices in Japanese industrial development, points to the prosperous impact of subcontracting to Japanese industrial production.[26] In the case of Turkey, Kaytaz, in an article relying on his personal findings as early as 1989, compares subcontracting practices in Turkish textile and metal-working industries in two main industrial areas, and asks whether subcontracting promotes the development of small and medium sized enterprises.[27] He concludes that in the metal working industry, subcontracting has a developmental character and in an export-oriented economic environment through comprehensive policies at large and small-scale enterprises, subcontracting may lead to a faster rate of industrialization.[28]

On the other side of the literature, there are the scholars who focus on the dramatically changing lives of Third World people within the introduction of the subcontracting practices, as an effect of globalizing economy. Their emphasis is on the harmful effects of existing working conditions and over-exploitation of cheap labor. Feminist political economists have made important contributions by shedding light on the micro realities of women working via outsourcing activities. In general, the shared idea is that these flexible arrangements are exploitative of women and the idea that their impact on the status of women is transformative is questionable. However, the existing literature underlines the "double burden" of women that came with the work, rather than

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[26] Toshihiro Nishiguchi, *Strategic Industrial Outsourcing: The Japanese Advantage*, (New York: Oxford University Press, 1994).

[27] Mehmet Kaytaz, "Subcontracting Practices in Turkish Textile and Metal-Working Industries," In *Recent Industrialisation Experience of Turkey in a Global Context*, ed. Fikret Şenses (London: Greenwood Press, 1994).

[28] Ibid, 153.

focusing on the emancipatory effects of making their own money. Balakrishnan et. al. developed a profound perspective on the effects of globalizing economy on the women of five Southeast Asia countries via subcontracting arrangements.[29] In the ethnographic studies, it is argued that in India, Thailand, Sri Lanka, Philippines and Pakistan, the changing character of capitalist production has lead to the flexibilization of work, where women became the primary objects of these over-exploitative processes. The widespread flexible employment via subcontracting brought on the replacement of working men by women, which marked a change in the nature of employment.[30] These changes; especially came with the loss of the "family wage" paid to the workers[31], also forced women to join the working population along with their "traditional" responsibilities regarding the household.

Similarly, Sassen[32] talks about the feminization of survival and the increasing role of women within the globalizing economy. She points to the emergence of alternative global circuits that she calls counter-geographies of globalization, through which households and communities in Third World countries become increasingly dependent on women for their survival. Özar and Günlük-Şenesen point to the rising number of women working in informal economy in Turkey, especially with subcontracted works at their home. They argue that those workers in putting out industry

[29] Radhika Balakrishnan ed., *The Hidden Assembly Line: Gender Dynamics of Subcontracted Work in a Global Economy* (Connecticut: Kumarian Press, 2002).

[30] Guy Standing, "Global Feminization Through Flexible Labour: A Theme Revisited", *World Development*, Vol. 27, No. 3 (1999), pp. 583-602.

[31] Ibid 586.

[32] Saskia Sassen, "Women's burden: Counter-geographies of Globalisation and Feminisation of Survival," *Journal of International Affairs*. Spring, Vol. 53, No. 2 (2000), pp. 503-524.

are mostly composed of "wives and mothers" revealing a division according to marital status, whereas the women workers in the manufacture industry have rather been young and single ones.[33]

Finally, it should be emphasized that subcontracting does not have deteriorating effects only on the working people of so-called Third World countries. In a study on the nuclear remediation sector in United States, Gochfeld and Mohr argue, that the monitoring of safety conditions in the workplace became impossible within the introduction of subcontracting practices in the sector. They argue that the subcontracting firms do not regularly report industrial accidents, which makes the workers vulnerable in a completely hazardous environment.[34]

Related to the objective of my study, the critical question here is whether this deterioration of working conditions implies a considerable setback within the gains and rights of working people in general. Particularly, regarding the fashionable form of employment of the new capitalism: the flexibility. In the next section I will dwell on the issue that the notion of subcontracted work is part of a greater phenomenon of flexibility of work. In the particular example of Çapa University Hospital, the flexible and insecure employment is initiated by the state within its own spatiality. The subcontracted health care workers practically remain outside the boundaries of state through the process of commodification of their labor, although they work in a public institution whose publicness increasingly attains a nominal character. On the one hand, employed via subcontracting practices, they are *invisible* from state's point of view. They are not

[33] Şemsa Özar and Gülay Günlük-Şenesen, "Determinants of Female (Non-) Participation in the Urban Labor Force in Turkey," *METU Studies in Development*. Vol. 25, No. 2 (1998), pp. 311-328.

[34] Michael Gochfeld and Sandra Mohr, "Protecting Contract Workers: Case Study of the US Department of Energy's Nuclear and Chemical Waste Management," *American Journal of Public Health,* Vol. 97, No. 9 (Sep. 2007), pp. 1607-1613.

issued any files within the employment. Practically, they are not there. However, on the other hand they have central importance in terms of implementing the policies of marketization in health care sector, via commodification and deregulation of health care work. As long as the subcontracted workers are non-public servant employees at a public hospital, they are the epitome of the commodified labor in health care.

The Aim of Subcontracting: Flexibility and Work Insecurity

The above summarized literature on subcontracting practices is obviously focused on the manufacturing and industrial sectors. What generally happens is that outsourcing occurs, both overseas and within a country in order to lower production costs. In Turkey, the practices of subcontracting recently became prominent in industrial sectors such as textile, shipbuilding and putting out industry. Here, I will take on subcontracting in the sector of public services. The significance of my endeavor is to point out that the introduction of subcontracting practices in health care not only leads to the commodification of health care service but also to the commodification of health care work, which should be seen as part of the general tendency of cost-containment of the cost of employment in health care.

So, what I add to the existing literature is that with the emerging subcontracting practices in health care sector, both the notions of health care work and health care provision change dramatically. This situation follows the effort of establishing the market principle in health care in Turkish context via health care enterprises and efficiency measures, which leads to commodification of health care labor. What I will show is that the flexibility measures proposed in this particular university hospital negatively effects the socio-economic position of the health care workers. Furthermore,

what I have observed is the newly emerging subjectivities of the subcontracted health care workers in relation to their civil servant co-workers and to their vocation.

Within the analysis of the new conceptualization of work I base my argument on Richard Sennett's theories on new capitalism. In his study *The Corrosion of Character*, in which he analyzes the effects of the new capitalism on the personality, Sennett, talks about the power relations implicit to the newly emerging forms of flexible labor. According to Sennett, "in transition from routine to flexible", the flexible organization is presented as a free environment for the individual by the ostensible elimination of the notorious bureaucracy. However, according to him, the power structure is preserved; in fact, the new system is more harmful on individuals because of its imposition of unpredictability. According to Sennett, the power in the new capitalism has three essential pillars. The first one is the *total transformation of institutions*, which has a significant impact on our notion of time and imposes flexible behavior. Sennett argues that institutions aim to "achieve more with less" with the implementation of reengineering practices such as delayering and vertical disaggregation in the workplace organization, meaning large lay-offs and the liquidation of bureaucratic hierarchies.[35]

Second is the *flexible specialization in production*, which simply means 'to deliver more of a variety of goods to the market in a shorter period of time'. Flexible specialization replaces the production model that is epitomized in the Fordist era with a nouvelle model. Moreover, this new model is completely sensible to the demands of the market; so sensible that it lets the market to form the inner structure of the institution.[36]

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[35] Richard Sennett, *The Corrosion of Character: The Personel Consequences of Work in the New Capitalism* (New York; London: Norton, 1998), pp. 49-51.

[36] ibid, pp 54-55.

So, the institution as a whole becomes flexible enough to transform itself according to the pressures from the market. The third element is crucial in understanding the nature of work in the new capitalism. Borrowing the term from Harrison, Sennett calls this phenomenon the *concentration of power without centralization.* Regarding production in general, the new model of health care in particular, we are pledged, "the new organization of work (…) creates decentralization, which renders the people in the lower levels of the institution free"[37]. In the following chapters on the "reform" in health care and on the experiences of subcontracted health care workers; however, reveals that the decentralization relying on privatization and autonomization not only puts the health care personnel in a precarious situation in the workplace, but also is likely to undermine the proper provision of health care.

This situation is epitomized in the premise of the replacement of bureaucratic and hierarchical structures with more flexible and autonomous managements. Although it sounds harmless, the fact that the new health care organization will be subjected to performance measures such as "quality", "patient/customer satisfaction" and "efficiency"[38] would not only enhance the dependency of the health care sphere on the market, but it would also exacerbate the pressure on health care providers. Sennett's argument on cultural connotations of the new capitalist era is especially important for my study. The culture of health care, although being far from a right for all citizen; nonetheless could be defined as solidaristic, caring though patriarchal and gendered in many aspects; however based on the ethos of saving-lives and helping people, is being

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[37] ibid, p. 57.

[38] Soyer, Ata, Bülent Aslanhan, Eriş Bilaloğlu, Güray Kılıç, Osman Öztürk, Cavit Işık Yavuz and Mehmet Zencir, *Sağlıkta Piyasacı Tahribatın Son Halkası: AKP* (Ankara: Türk Tabipleri Birliği, 2007).

replaced by one, which is divorced from any sort of affection and empathy, but driven by profit-maximization and efficiency. Hence the elimination of the notion of "common good" in health care service field.

It is illusory to think that the institutions, whose nature has been changed dramatically, would provide a more emancipatory environment for the individuals. According to Sennett, the modern institutions of the new capitalist era in which flexibility reigns, are neither more democratic, nor smaller than those of the previous one, what he calls "social capitalism". On the contrary, in this new era the central authority is reconfigured and the power is divorced from the authority.[39]

With the introduction of subcontracting practices and job insecurity, the workers found themselves in a conundrum. The elimination of government incumbency brings the abandonment of the tenure of the working people. More importantly the skills required from a worker alter in a dramatic way. In the culture of the new flexible organizations, the "ideal-self" is identified with the ability to work with different people on short-term basis and the predisposition towards teamwork, instead of characteristics such as seniority. All kinds of long-term planning and projects are dismissed.[40] The reason for this is that the new institutions are designed as flexible, as they are able to shift their inner structures according to the pressures from the market. The market continuously defines the organization and functioning of the new institutions.

On this point, Sennett particularly underlines the fact that the flexible organization of time is in accordance to the demands from the market. The reformation

[39] Richard Sennett, *The Culture of New Capitalsim* (New Haven and London, Yale University Press, 2006),
p. 181.

[40] ibid, p. 126.

of the institutions deteriorates the *sine qua non* of the civil servant incumbency: institutional loyalty and the mutual informal trust within the workers. Furthermore, the lack of these notions leads to enervation of the workers by causing depreciation of the skill and meritocracy, hence to the endless anxiety of the workers through the feeling of unworthiness and ability to adapt to constant changes within the work place environment. The individuals lose trust and confidence regarding their position in the work.[41] On this point, it should be underlined that trust is crucial in the sphere of health care both in terms of the relationship between the providers and receivers, as well as within the health care providing personnel.[42] The major tangible reason of this unending anxiety and that leading to the lack of self-confidence is insecurity. Sennett argues that the insecurity in the new capitalist institution is not the undesirable consequence of the fluctuations in the market, but an embedded characteristic of the new institutional model. Against the rigidity of obsolete social capitalist organization, insecurity becomes the underlying principle of the new form of institutional organization.[43] The reason for abstaining from all kinds of long-term planning, then, is the notion of insecurity, which turns the workers into "people without future". In the third and fourth chapters, I will elaborate further on the expressions of the subcontracted workers regarding how this predicament profoundly affects the dreams and the expectations of the future.

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[41] ibid, pp. 179-197.

[42] Çağlar Keyder, "Giriş" in *Avrupa'da ve Türkiye'de Sağlık Politikaları*, eds. Çağlar Keyder, Tuğba Ağartan, Nazan Üstündağ and Çağrı Yoltar (Istanbul: İletişim Yayınları, 2007), p. 26; personal interview with Ayşel, a nurse from Çapa.

[43] Richard Sennett, *The Culture of New Capitalism,* p. 187.

Conclusion

The Turkish state goes through a historical moment of transformation, which changes the understanding of very notion of public service and public employment. While withdrawing itself as a provider from the field of health care, within the health care reform, the state promotes what Colin Leys calls 'market-driven politics'.[44] This initiative brings the rupture of the link between the health care and the people as citizens and introduces a transition towards a new one where the recipients of health care are constellated as consumers. The ontology of world of welfare, of which health care is the main part, changes in such a way that the ideal of an equal and free right to health care for everyone will not even be sought, nor even be dreamed of.[45] This transformation is articulated with the idea of the rollback of the state as an employer in all aspects of goods and services production, thus imposes the elimination of government employment in health care sector, which leaves the health care personnel in a precarious situation.

Leys' argument about market-driven politics derives from the Polanyi's analysis of pre-1914 market society, in which market forces, i.e. capital had escaped political control leading to the demolition of society. However, Leys argues that the global economy that manifests itself from the 1970s onwards has significant novel characteristics: wider choice of locations for capital investment; the omnipresence of global financial markets; the importance of transnational manufacturing and service corporations and the advanced communications technology on which both financial

[44] Colin Leys, *Market-driven Politics: Neoliberal Democracy and the Public Interest*, London, New York: Verso, 2001).

[45] Personal conversation with Ayşe Buğra.

markets and corporations depend.[46] Focusing on public service television and health care, Leys argues that in the new global economy necessitates 'the destruction of non-market spheres of life on which social solidarity and active democracy have always depended', by reconfiguration of the services in question so that they can be priced and sold and transformation of the workforce involved from one functioning for collective aims to one to produce profits for owners of capital.[47]

Leys' analysis is significant regarding the purpose of this study: the examination of the commodification of a non-profit sphere of life, i.e. health care service, and the following transition emerged regarding the health care personnel, as well as their employment model. He underlines the specificity of health care services in transition to the establishment of "enterprise model", where in which the discourses about inequality of provision, high costs and corruption gave rise to particular consequences in the course of commodification of health care services, those, I argue, used as sources of legitimacy by the political power in order to implement the neoliberal policies in the field of health care.[48]

Since the implementation of neoliberal principles in the health care systems initiated by the state itself, it is fallacious to think that the state is getting incapable or losing control over the health care. In the name of elimination of problems regarding health care, new hierarchies are introduced. By focusing on the notions of verticality and encompassment of the state, Ferguson and Gupta argue that in the neoliberal governance technologies where the states do not necessarily become weaker or stronger, but they

[46] Colin Leys, *Market-driven Politics: Neoliberal Democracy and the Public Interest*, p. 2.

[47] Ibid, p. 4.

[48] Ibid, 81-107.

became integral parts of transnational apparatus of governmentality, which works at the same spatiality and scale with other non-governmental or supranational actors.[49] Their work helped me to question the elimination of state from the health care field would lead to a better organization in access and provision of health care service.

In the next chapter, I will give a detailed analysis of the recent "Transformation of Health Care" program initiated by the ruling party. A discussion on the general characteristics of the "reform" program will provide a clearer understanding, what I mean by "changing nature of health care in Turkey: from a non-profit, public service to a commodity". The significant argument of this chapter will be the exploration of the redefinition of the relationship between the state and health care service, which has been leading to the epistemological change in the understanding of health care from a citizenship right to a commodity.

The third chapter will serve as a passage from the general picture of health care reform to the ethnographic analysis of subcontracted health care workers in Çapa University Hospital. Here, I will position the subcontracted workers in relation to state, as well as to the government employees, which still occupy the majority of the health care personnel in public health care institutions. Later, in the Chapter 4, relying on my fieldwork at Çapa University Hospital, I will dwell upon the everyday experiences of subcontracted workers and their subject positions, in the new picture of health care system, which will illustrate the realization of the health care reform on a hospital model. The dividing practices among Çapa health care personnel, I argue, creates

[49] James Ferguson and Akhil Gupta, "Spatializing States: Towards an ethnography of Neoliberal Governmentality", *American Ethnologist,* Vol. 29, No. 4, 981-1002 (2002).

destructive effects on the operation of a health care institution by undermining the integrity and trust and harming the ethos of health care providing for collective good.

CHAPTER 2

HEALTH CARE SERVICES ON THE VERGE OF COMMODIFICATON

Introduction

The elections of November 2002 marked an important turning point for the public service sector, which according to many political economists has been urging a reform program for many years. Since then, the stepping out of political authority from service providing sectors underlined the transformation in process in Turkey. The hegemony of neoliberal understanding epitomized in the privatizations, deregulatory practices within the labor market and the outsourcing of public services has become more prominent since the current ruling party took the office. In the area of public service sector, the newly elected government quickly launched a "reform package" in order to transform the very nature of the existing public services. The health sector, obviously, was not outside of the scope of the government's reform program; on the contrary it was one of the main topics in this prospective transformation. Marked by the new global division of labor, in Turkey we witnessed the emergence of irregular and flexible employment started extending itself in the area of service sector.[50] Freshened its power in the July 2007 elections, the ruling party -Justice and Development Party (JDP) - continues to its "reforms" in health sector. In the past five years "health" in general has been the one of the most frequent subject matters of the passed laws in the Turkish parliament.

In this chapter, I will provide an analysis on the content of the recent "Program of Transformation in Health" initiated by the ruling party in Turkey. I will argue that

[50] Gosta Esping-Andersen, *Foundations of Postindustrial Economics* (Oxford and New York: Oxford University Press, 1999).

with the recent "reform" program the conceptualization of health service has been changing dramatically: it has ceased to be understood as a public notion, of which the provision is undertaken by state, but as a commodity left to the hands of the market forces. Moreover, I argue that although health care has never been conceptualized as a social rights based on citizenship, the recent developments abolishes the ground for achieving a general health care guarantee for every citizen; it pulls the carpet, on which the propagators of a universal health care stand. My central aim, following Buğra's approach, will be to elucidate the new political economy of citizenship in relation to health care. Theoretically, I dwell on a discussion regarding the vast literature on social citizenship, and definition of health care as a social right. Then, I will develop an argument, although health care had never been a social right based on citizenship, it was still a public phenomenon provided by the state; however the new reform transforms health care to a commodity to be marketed divorced from the idea of common good. Relying on these reflections and widespread debate the reform program provoked, in the conclusion, I will sketch a policy analysis on welfare regime in contemporary Turkey, and propose several future research areas.

In the light of the recent developments in health care, especially the unions organized in the health sector and doctors associations developed a quite critical approach towards government's policies regarding the health sector. They base their main arguments on the deteriorating working conditions of the health care providers, as well as the handing over the health services to private sector. Furthermore, they argue that the quality of the health care provided diminishes within the manifestation of profit seeking understanding in public health sector.

However, the four-partite structure of Turkish health system, inarguably,

necessitates an extensive reform, regarding the fact that in Turkey millions of people do not have any access to health care services, especially those living in rural areas. In addition to that, the huge informal employment rate is also a considerable fact adding to the problems, in respect to the Bismarckian tradition of Turkish health care system, which bases itself on the status of employment.[51] A study on the Turkish health sector should not miss to focus on these matters and it should put attention to analyze the arguments of both sides –the government and the beneficiaries of reform on the one hand, and the unions, the associations and some nongovernmental organizations on the other, regarding the ongoing "Program of Transformation in Health". In fact, there is no doubt that the success of the ruling JDP in 2002 elections was, partially though, a result of the election campaign, of which the general health insurance was at the center of it.[52] Before illustrating the Turkish public health structure prior to reform process, and what the reform process has brought, I, first, will open a theoretical discussion on the issue of citizenship, since my main argument is that the "reform" program in health care undermines health care as a right deriving from citizenship. Then, I will go over the basic characteristics of the reform program arguing that it reproduces the inequalities of the already existing system by not anticipating a universal health care system, as well as introducing the marketization of health care services, which would exacerbate the existing inequalities within the structure. Here, I dwell upon the criticisms came from the unions and doctors' associations.

[51] Çağlar Keyder, "Giris", in *Avrupa'da ve Türkiye'de Sağlık Politikaları*, eds. Çağlar Keyder, Nazan Üstündağ, Tuba Ağartan and Çağrı Yoltar (Istanbul: İletişim Yayınları, 2007), p. 15.

[52] Ibid, p. 22.

Health Care as a Social Citizenship Right

Citizenship emerged progressively against the medieval orders, in a transition toward a social structure centered on individual as subject of rights.[53] However, the egalitarian foundations relying on the civil contracts among individuals took a form supporting the social inequality in the society. In his piece, *On the Jewish Question*, Marx criticizes the modern/bourgeois notion of citizenship, being as the source of legitimacy in expropriating surplus labor from working classes.[54] Moreover, in his criticism against the bourgeois order of citizenship, we know that Marx defines the "free" worker who sells his labor power with his free will, but has no means to survive without doing this. In other words, the citizen, who is the product of the bourgeois revolution, is depicted according to the process of expropriation and the commodification of the labor power of the worker. He argues that the propertyless situation of the laborer and the commodification of labor are the loss of social being and the ceasing of the social existence.[55] This argumentation sets an important theoretical background for thinkers, who base the possibility of active citizenship on the attainment of the social and welfare rights, because only with those rights such as health care and education the subjects are provided opportunity to bodily integrity and survival.

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[53] Giovanna Procacci, "Poor Citizens: Social Citizenship and the Crisis of Welfare States", *European University Institute Working Papers*, EUF No. 96/5 (Badia Fiesolana, San Domenico: European University Institute, 1996).

[54] Karl Marx, "On the Jewish Question", in *The Marx-Engels Reader*, ed. Robert C. Tucker (New York: Norton, 1972).

[55] Karl Marx, *Grundrisse: Introduction to the Critique of Political Economy* (Middlesex, England: Penguin, 1973), pp. 483-515, cited in Ayşe Buğra, "Sınıf ve Siyaset", *Toplum ve Bilim*, No. 113 (2008), p. 11.

It was a common strategy of depoliticization of poverty problems via protecting market and the state from responsibility, by means of disparaging the poverty issue from the issue of labor and that of rights of individual. On this point de Tocqueville's work, *Memoirs on Pauperism*[56] had been always an influential source of *pathologizing* the issue of poverty and *stigmatizing* the poor and the deprived throughout the course of history. According to his conceptualization of poverty, the family, charitable individuals, and philanthropic associations were assigned the responsibility of relieving the political authority from the task of assisting the truly deserving poor.[57] The argument that I make here is that the issue of poverty had long been defined without social terms, which lead to the moral conceptualization of poverty and ignoring the responsibility of the political authority. In this context, the *social policy* throughout the modernization period is perceived as a way of controlling the larger populations and making them docile subjects from the power's point of view in a Foucauldian sense.

However, lately the notion citizenship is widely accepted as a means of fruitfully analyzing the existing problems regarding the functioning of society, yet at the same a consensus exists regarding the problematic nature of citizenship as a concept, the meaning of which has never been univocal; on the contrary different historical traditions in this respect oppose each other on way or other.[58] Social rights have been part of the citizenship literature, since T.H. Marshall's influential work produced in the aftermath of Second World War relying on the British welfare model; *Citizenship and Social*

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[56] Alexis de Tocqueville, *Memoirs on Pauperism* (Chicago : Ivan R. Dee, 1997).

[57] Ayşe Buğra, "Poverty and Citizenship: An Overview of the Social Policy Environment in Republican Turkey." *International Journal of Middle Eastern Studies*, vol. 39 (2007): 27-46, p. 34.

[58] Bart Van Steenbergen, "The Condition of Citizenship: An Introduction", in *The Condition of Citizenship*, ed. Bart van Steenbergen (London: Sage Publications, 1994), p. 1.

Class.[59] Marshall's argument on the third stage of citizenship; the *social*, following *civil* and *political* rights of citizenship has set what we today mean now by Welfare State and social democracy[60] and taken as the main reference point within the discussions on citizenship. In Marshall's words the social citizenship referred to 'the whole range from the right to modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society'.[61]

However, most of the countries, particularly 'the most powerful capitalist state, i.e. the United States, followed other roads to tackle with the issue of citizenship rather than the one Marshall anticipated for Britain, what Michael Mann calls 'ruling class strategies'. He argues that the British strategy of citizenship described by Marshall has been only one among five strategies pursued by the advanced capitalist countries: reformist, which was the contemporary Britain, and liberal, authoritarian monarchist, Fascist and authoritarian socialist.[62]

The Marshallian social citizenship relying on the atmosphere of post-WWII period, where we witness the prevalence of the welfare state is in a process of setback since 1980's, especially with the new developments and problems have put pressure on the notions of citizenship. Social citizenship, which was mostly the product of the post-war revolutionary period in European countries, now, is under attack by the

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[59] T. H. Marshall, "Citizenship and Social Class" in *Sociology at the crossroads and other essays*, (London : Heinemann, 1963).

[60] Michael Mann, "Ruling Class Strategies and Citizenship", *Sociology*, vol. 21 (1987): 339-354, p. 339.

[61] Marshall, "Citizenship and Social Class", p. 20.

[62] Mann, "Ruling Class Strategies and Citizenship", pp. 341-346.

globalization and neoliberal transformation.[63] Since social rights incorporate occupational citizenship rights of employees within their work organizations such as rights to union representation, legal entitlements to certain standards and good working conditions, rights to consultation ad co-determination, major developments in technology and marketing and the new mobility of capital might pose further threats to the content of the social rights.[64]

Right to health as a human right is institutionalized in the course of the twentieth century. Gross argues that the notion of right to health is rooted in two historical developments: first the public health movement that began in the nineteenth century and second, the recognition of social rights that crystallized in the twentieth century.[65] As the start of the discussion he pinpoints the 1948 Universal Declaration of Human Rights and 1966 International Covenant on Economic, Social and Cultural Rights, as the translation of the right into specific clauses.[66] He underlines two components of the right to health; first being the background conditions that affect health, which I think is very important in terms of setting the protective basis for the public health, whereas the second component is the medical care. Furthermore, for the sake of the argument articulated here the funding issue has significant role in terms of accessibility and equality of the health care provided. The two prominent forms of funding are state budget relying on

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[63] Van Steenbergen, "The Condition of Citizenship", p. 3.

[64] Colin Crouch, Klaus Eder and Damian Tambini, "Introduction: Dilemmas of Citizenship", in *Citizenship, Markets, and the State*, eds. Colin Crouch, Klaus Eder and Damian Tambini (New York: Oxford University Press, 2001), pp. 2-3.

[65] Aeyal M. Gross, "The Right to Health in an Era of Privatization and Globalization: National and International Perspectives", in *Exploring Social Rights: Between Theory and Practice,* eds. Daphne Barak-Erez and Aeyal M. Gross (Oxford Portland, Oregon: Hart Publishing, 1998), p. 292.

[66] Ibid, p. 293.

taxation and direct out-of-pocket payment by patients.[67] The latter constrains the poor sections of the society in access to the health care. The contribution of Gross here is important that he underlines that we must recognize the limitations of the legal rights discourse regarding right to health. He refers to Paul Farmer, who has pointed to the need to reconsider health and human rights in a way that our hopes will not be limited on the legal battle approach.[68] When health care and social rights are in question, we should always underline the social aspects of these notions and the necessity to deal with them on political grounds.

An important issue is the discourses regarding the right to health, particularly in the current period, where social rights are under fire. The individualization of poverty and divorcing poverty and deprivation from its social context is an important aspect of this attack, where the crisis of the welfare state today puts in question the legitimacy and efficiency of welfare as a response to the risk of poverty. Fraser and Gordon argue that in United States for instance, the discussions on citizenship do not involve any place for the social aspect of citizenship. The interpretation of the issue in United States relies on a contract-versus-charity dichotomy. In this debate, welfare, hence the social citizenship is portrayed as a threat to civil citizenship and the recipients of welfare are usually regarded with disrespect.[69] We see the realization of this American approach to welfare in the discussion about "welfare queens"[70] and "welfare-to-work programs"[71] initiated in

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[67] Ibid, pp. 305-306.

[68] Ibid, p. 336.

[69] Nancy Fraser and Linda Gordon, "Civil Citizenship against Social Citizenship", in *The Condition of Citizenship*, ed. Bart van Steenbergen (London: Sage Publications, 1994).

[70] Frances Fox Piven, "Welfare Reform and the Economic and Cultural Reconstruction of Low Wage Labor Markets", in *New Poverty Studies*, eds. Judith Goode and Jeff Maskovsky (New York and London:

the mid-1990's in United States Here we see the conceptualization of the social rights as being the result of a charity, rather than part of a notion of citizenship.

The same attitude can be seen in Friedrich von Hayek's interpretation of social rights, who is today widely recognized as one of the founding father of the new economy. Buğra argues that Hayek's conservative liberal outlook, which stated that a free-market economy requires the moral basis provided by traditional values and institutions in order to limit the dose of state intervention to ensure social cohesion.[72] Similarly, Carlos Espada argues that according to Hayek, it is not possible to reach and maintain a peaceful consensus regarding the common criterion of distributive measures.[73] In addition to that, even if a consensus has reached to define the criterion of distribution that would give a central authority the power to determine what each member of a society has to do. From Hayek's point of view, this would lead to irrevocable loss of a crucial feature of free society on the basis of morality and efficiency, which allows individuals to use the best of their knowledge to pursue their on ends.[74]

New York University Press, 2002).

[71] Sandra Morgen and Jill Weight. "Poor-Women, Fair Work and Welfare-to-Work That Works", in *New Poverty Studies*, eds. Judith Goode and Jeff Maskovsky (New York and London: New York University Press, 2002).

[72] Buğra, "Poverty and Citizenship", p. 47.

[73] João Carlos Espada, *Social Citizenship Rights: A Critique of F.A. Hayek and Raymond Plant*, (Oxford: St. Antony's College, 1994), p. 180.

[74] Ibid, pp. 181-182.

And, not surprisingly this free society bases itself on the notion of choice, instead of settling for the offered.[75] Asking the question of how 'the median-voter' is persuaded to behave against welfare, Bauman argues that the advent of the consumer society and the entrenchment of consumerist culture are of basic significance in the replacement of welfare state ideology with the free market one. He asserts that the consumer market must first shape the consumer in its own understanding: 'the choice is what competition offers, and discrimination is what makes the offer attractive'.[76] He gives a striking example of how a considerable and growing number of African-Americans are joining to the white protesters against 'affirmative action' measures in the United States. The affluent black middle-class Americans –most of them, according to Bauman, were able to get there so thanks to the affirmative action- are becoming against affirmative action, because it puts their personal and effortful achievements in canopy and saying 'we do not need crutches'. According to Bauman, affirmative action and welfare state share the parallel faiths in terms of the socio-psychological mechanism of 'working itself out of a job' operated in both cases in quite similar fashion within the rise of consumerist society, where free choice and everyone-for-himself glorified over the collective good and share of social costs.[77]

When we take Turkey into the consideration, it should be emphasized that she has significant differences in terms of development of welfare state and citizenship rights, as well as social rights. It should be underlined that the welfare state, or better

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[75] Zygmunt Bauman, *Work, Consumerism and the New Poor*, 2nd Edition, (Berkshire: McGraw-Hill Education, 2004), p. 58.

[76] Ibid, p. 59.

[77] Ibid, pp. 60-62.

said the notion of citizenship anticipated by Marshall in 1949 remained limited to Western European polities, if not to Britain. The welfare structure in countries like Turkey has been historically limited leaving first of all, the vast rural population and secondly the informally or atypically employed of the urban population outside the scope of the welfare.

Parallel to that, the welfare regime of Turkey, along with the other Southern European countries[78], has to be evaluated outside the three-fold typology (the family, the market, the state) of Esping-Andersen's model,[79] regarding the issues such as structure of employment, the nature of formal security system and the extent of social security coverage, the peculiar characteristics of the relationship between state and citizen, the employment opportunities presented to individuals through informal networks.[80] I think that the most significant peculiarity of Turkey among these is the unprecedented size of informal employment. This situation leads and adds to the problems caused by the social security system with corporatist tendencies, which relies on the status of employment and where social rights are unequally distributed, in an environment, where universal health insurance is absent.

In other words, in an economic system, where informal employment is prominent –followed by the utter disregard of the situation by those, who held the political power-, a social security structure relies on the status of employment leads to the current dire situation of millions of people with regards to benefit from social

[78] For a discussion on the South European countries' welfare regimes see the articles of Ferrera (1996), Gough (1996) and Mingione (2001).

[79] Gosta Esping-Andersen, *Three Worlds of Welfare Capitalism* (Cambridge: Policy Press, 1990).

[80] Ayşe Buğra and Çağlar Keyder, *New Poverty and Changing Welfare Regime of Turkey.* Report prepared for United Nations Development Programme, www.undp.org (2003), p. 13.

security and access to health care. In addition to that, the strategies to handle the large poverty in Turkey were mostly absent until the last couple of decades in Turkey. On this point Buğra's analysis of the pre-1980 period is noteworthy:

> "Western forms of regulating the poor designed to face the consequences of such dislocations were largely absent in Turkey until the 1980s. Absent also was the influence of notions of social citizenship rights in shaping state–society relations. Such notions, which would necessarily call for redistributive measures to ensure fulfillment of the state's responsibilities toward citizens, were replaced by several mechanisms that were hardly compatible with the logic of either state redistribution or market exchange. The livelihood of people was not left to the functioning of self-regulating markets, but it was also not protected on the basis of formal redistributive processes either."[81]

That's why, before going into the discussion of the transformation in the Turkish health care, it should be emphasized that welfare state in Turkey has never properly developed and the right to health care was never enjoyed by the entire population in Turkey. The system was outright an unequal and incapable one, in terms of access and coverage. Yet, what I argue in this chapter is that the new "reform" paves the way to the total marketization of the health care, by leaving the room to private sector by anticipating the transfer of equipmental resources to them, as well as introducing financially and administratively autonomous public health care "enterprises".

The Pre-Reform History of Public Health in Turkey

As stated above, while the welfare state was living its heyday in Western European countries, in Turkey it was far from being well established. Bearing this fact in mind, social policy in general or public health in particular, in the context of the new economy, came with the end of Bretton Woods system and relying itself on flexibility in all aspects

[81] Buğra, "Poverty and Citizenship", p. 48.

deserves to be handled with more attention.[82] In fact, Turkey's expenditure on health has increased steadily since 1960; only in ten years period between 1995 and 2005 it was more than doubled in terms of the spending to the GDP.

The Bismarckian Tradition of Health Organization

Before starting the discussion on reforms in process, let me briefly introduce the structure of health care in Turkey in the turn of the millennium: a four-partite, non-universal system relying on nuclear family model. Buğra and Keyder state that according to some official figures, the percentage of population with no social security and is not covered by health insurance seems 11%, whereas 12 million Green Card program recipients makes us think that the number is much higher than that indicated by these figures.[83] According to the numbers of 2003 World Bank Household Survey, 30% of the Turkish population is outside of any kind of social security or health care.[84] As I emphasized in the first part, Turkey's health care structure relies on the Bismarckian tradition that bases itself on the employment status. This tradition lead Turkey to a four-partite social security and health care structure: the first is *Emekli Sandığı* (the Retirement Chest) covers the state employees; the second is the *Sosyal Sigortalar Kurumu* (SSK- Social Insurance Institution) for any kind of worker both employed in public or private sectors; thirdly, *Bağ-Kur* for the self-employed people and artisans and the last one is the *Yeşil Kart* (Green Card) program, which is the most recent one;

[82] Ayşe Buğra and Çağlar Keyder, "Önsöz." In *Sosyal Politika Yazıları*, eds. Ayşe Buğra and Çağlar Keyder (Istanbul: İletişim Yayınları, 2006), pp. 8-9.

[83] Buğra and Keyder, *New Poverty and Changing Welfare Regime of Turkey*, p. 18.

[84] Nazan Üstündağ and Çağrı Yoltar. "Türkiye'de Saglık Sisteminin Dönüşümü: Bir Devlet Etnografisi." In *Avrupa'da ve Türkiye'de Saglık Politikaları: Reformlar, Sorunlar, Tartısmalar*, eds. Çağlar Keyder, Nazan Üstündağ, Tuba Agartan and Çağrı Yoltar (Istanbul: İletişim Yayınları, 2007), p. 74.

introduced in the year of 1992 for those families, whose per capita income is less than one third of the minimum wage.[85] So, the eligibility of the recipient is set on a means-tested mechanism.[86] In average, it can be said that a family composed of two parents and two children with a single breadwinner paid at minimum wage is valid to be covered by the Green Card program.

Another important consequence of basing the health care on the status of employment leads to a model, which takes nuclear family as its basic unit. In other words, in a country like Turkey, where the labor force participation among women is relatively very low, hence the ideal breadwinner is male, the women and children do not have direct access to the health care service, but thanks to the social security of their husbands or fathers. As Üstündağ and Yoltar argue, this is a political choice made by the state authority in order to shape the Republican citizen excluding certain groups *per se,* who do not conform to the projected model of male breadwinner.[87] This situation leads to the maintenance of the patriarchal relationship within the family rendering the women dependent on men in addition to the other patriarchy enforcing factors related to the socio-historical particularities of the Turkish context.

Finally, although there is no recognized academic work focusing on the issue yet,

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[85] The minimum wage in Turkey is 477 TL for the first half of 2009; approximately 300 USD.

[86] Asena Günal, *Health and Citizenship in Republican Turkey: An Analysis of Socialization of Health Services in Republican Historical Context* Unpublished Ph.D Thesis, Atatürk İlkeleri ve İnkılâp Tarihi Enstitüsü, Boğaziçi Üniversitesi, Istanbul (2008), pp. 4; 31; 58. Günal defines "means-test" as an investigative process undertaken to determine whether or not an individual or family is eligible to receive certain types of benefits from the government. Furthermore, Günal emphasizes Bauman's warning about the means-tested mechanism in welfare services. According to Bauman's analysis, provision based on means-testing has two considerably negative consequences for the recipients: first is the PREVALENT deterioration of the quality of the services and the second is the attachment of stigma to recipient, who become subjected to a unpleasant examination process.

[87] Üstündağ and Yoltar, "Türkiye'de Sağlık Sisteminin Dönüşümü", p. 60.

arguing that the social security structure and health care is "ethnicized" will be far from speculation. Along with the problems of housing and education, the opportunities access to health care, more significantly to be part of social security coverage, i.e. having a regular, formal job is relatively low among Kurdish population. Not only the rural population in the Southeastern Anatolia, whose situation has been worsened with the civil war in the region for the last twenty years, but also the livelihoods of the Kurds in the urban areas are relatively in jeopardy, especially for those subjected to the village evacuations and forced to immigrate to the Western part of Turkey, as well as urban areas within the region. The ethnic aspect of unemployment, social policy and health are cardinal strands of the general *problematique*, deserving academic attention.

Inequalities within the Structure

In fact, the first three of the four above are social security institutions, which provide other benefits, especially pension payments to their receivers. Those are founded by the state and are independent from each other. Whereas Green Card is only for those, who do not have coverage from any social security system and attained to the ones, who are able to "prove" that they are poor enough not to purchase the health service themselves out on the market. Mostly the Green Card receivers live in the Southeastern, Eastern and Northeastern regions of Turkey. The reason for this is the high percentage of rural population in these regions. Today the fact that the number of Green Card recipients exceeds 12 million people reveals the non-universal characteristic of the prior social security structure.[88]

[88] It should be emphasized that the number of studies on Green Card program in are embarrassingly scant on such a noteworthy phenomenon in respect to the poverty in Turkey. For an impressive analysis of Green Card program, see Çağrı Yoltar's ethnographic study; *The green card scheme: an ethnography of*

In social welfare regimes similar to that of Turkey, which does not base itself on citizenship, as it is in the case in Beveridge model rely highly on family, kinship or communities to take care of the welfare.[89] Keyder argues that the reason for this is in a non-universal health care system, in which certain groups are *a priori* ignored by the structure. Thus, those outside the coverage of health sector are left to the familial or communal relationships. It can be identified two major groups, who are outside the protection of any social security regime. Here, it should be emphasized that they are not the source of errors within the health regime; on the contrary the regime itself is deficient because it left out or ignored these two groups. The first group of people is the rural population, which mostly relies on agricultural production, barely reaching levels of subsistence, let alone paying their premiums to Bağ-Kur, as I underlined above. The second group is the informal workers in the urban areas, who supposedly are under the coverage of SII system. The political authority should solve the acute problem of informal employment part of its general approach regarding the social policy[90].

Those do not covered aside, there were also visible hierarchies among the existing social security structures both in terms of access to and quality of the health care. Prior to reform program, the best health care services were provided to those under the Retirement Fund, i.e. the state employees. They were allowed to go any kind of

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'the state' and its 'poor citizens' in Adıyaman, Unpublished MA thesis, (Istanbul, Boğaziçi University, 2007).

[89] Çağlar Keyder, "Giriş." In *Avrupa'da ve Türkiye'de Saglık Politikaları: Reformlar, Sorunlar, Tartısmalar*, eds. Çağlar Keyder, Nazan Üstündağ, Tuba Agartan and Çağrı Yoltar (Istanbul: İletişim Yayınları, 2007), p. 74.

[90] According to a report of Ministry of Labor and Social Security, the total number of informally employed people is around 11 million, more than half of it working in agricultural production. Furthermore, 3.5 million of these 11 million are self-employed, 1.7 million are salaried wage workers, 1.5 million are daily waged workers and 3.9 million are unpaid family workers, whereas only 0.18 million of them are employers (MLSS, 2004), p. 43.

health care institution without going through the referral chain. On the second level are the workers under social security of SII. Obviously, those under the Bağ-Kur system receive the least quality of health care services. In addition to that, Bağ-Kur system, because of its composition, has lots of problems in functioning. The reason for that is the Bağ-Kur system is for self-employed people, –including the small peasantry- who lack regular income. That's why; people in this system have difficulties in paying their premiums, which resulted to great budget deficits in comparison to other two social security systems. The BK system prior the reform program was practically not functioning at all. The total population under the coverage of BK system is 16.5 million in the year of 2006.[91] In 2005, the government passed a law for the planning of the payments for the existing premium debts of the Bağ-Kur and SII receivers, which was mounting to more than 20 million liras on that day. The law itself was admitting that among the 3.4 million under Bağ-Kur system, every two persons from three were indebted to Bağ-Kur, meaning unable to pay their premiums.[92] For the sector in general, the people were becoming less and less confident both to the structure and the health care providers.

That's why the JDP –almost unrivalled in the area of social policy, even today- won the 2002 elections by building its election campaign on a reform program in health care sector. It also took advantage of the international trends, of which I am going to talk about in the next section.[93] And, that's why, its performance was impressive in the low-

[91] Bağ-Kur Official Web Site, www.bagkur.gov.tr

[92] Ahmet Kıvanç, "Bağ-Kur'luya tam destek", *Radikal*, 27.10.2005; Ahmet Kıvanç, "Bağ-Kur'lu İçin Değişen bir şey yok", *Radikal,* 24.1.2008.

[93] Keyder, "Giriş", p. 25.

income neighborhoods and districts of metropolitan areas, whereas its main opponent, the so-called social democratic Republican People's Party, pioneered the ballots in middle and upper income dominated districts.

The Reform Package in Process

The main objective of reform package in the health sector declared by prime minister as following: a single social security institution and a general health care insurance, which will provide a high quality and equal health care service for every single Turkish-born citizen.[94] In fact, the new reform anticipates free health care provision for every single citizen under the age of 18. From my point of view, today, studying in the field of health sector is one of the most complicated academic vocations in Turkey. The same situation holds true for the unions, associations and NGOs active in this field. The reason is this: the extensive and almost exhaustive scope of the reform program. Let me emphasize, this does not mean what the government has been doing is positive. On the contrary, in this chapter I argue that the reform program is far from being a solution for the chronic problems of health care in Turkey, particularly because of its non-universal characteristic. Within the reform, there is no aspect of health care, which would escape uninfluenced from it.

The party in power –JDP- "kept his promise" given before its first electoral victory in 2002 by meddling a great transformation policy in the health care services. In fact, the "reform" project is a continuation of the reform attempts, which were part of the political agenda during the 1990's; yet could not be realized. Like those initiatives, this reform program aims to redefine the nature of health care service, as well as the

[94] *Hürriyet*, 24.11.2005.

relationship between the state and the health care system by the claim of establishing the necessary governance in health care provision and increasing the efficiency of and the access to the services.[95]

The reform of the health system in Turkey can be considered as part of the "reform epidemic" in health sector, which has manifested itself in the last decade throughout the world, mainly resulted from the rising costs and the pressure of increasing demand for health care services.[96] Ağartan argues that the rise of costs has become the prominent source of legitimacy for the reform programs in health sector. In Turkey the reform also brings what Collins argues that one main change came with the reforms is introduced in the financing of health care as governments seek to widen their options and reduce levels of public spending with a shift away from collective tax-based systems to more individually based forms of financing health care.[97] In addition to Collins' point what this transformation brings in Turkey, as it is the case in other countries went through reforms in health sector, is the separation of services and financing of the health care services. Though these reform packages are formed as answers to similar questions of sector, necessitated from similar pressures and rely on the reports, experiences and recipes of the institutions like World Bank or World Health Organization according to Ağartan, they differ from each other in policy making and

[95] Tuba Ağartan, "Health Sector Reform in Turkey: Old Policies New Politics", Paper Presented at the ESPANET Young Researchers' Workshop, (2005), pp. 1-2.

[96] Tuba Ağartan, "Sağlıkta Reform Salgını", in *Avrupa'da ve Türkiye'de Saglık Politikaları: Reformlar, Sorunlar, Tartısmalar*, eds. Çağlar Keyder, Nazan Üstündağ, Tuba Agartan and Çağrı Yoltar (Istanbul: İletişim Yayınları, 2007), p. 37.

[97] Charles Collins, Andrew Green and David Hunter, "Health Sector Reform and the Interpretation of Policy Context", *Health Policy*, vol. 47 (1999): 69-83, p. 70.

policy implementation processes;[98] a phenomenon that is called as 'global division of labor' by Keyder.[99]

Transformation in Health: To What?

The government initiated "Program of Transformation in Health", which has been subjected to a wide debate throughout the country, has three basic tenets: General Health Insurance and Basic Assurance Package; the handing over of the health care units belonging to Social Insurance Institution (SII), i.e. 148 hospitals, 212 dispensaries, 202 health care stations, 9 dental care centers, 2 hemodialysis stations, 1 nursing home and 1 pharmaceutical plant to Ministry of Health[100] and following unification of three social insurance institutions under "single framework" of Social Security Institution, and finally, the introduction of family physician system on the first level health care, which will bring the closure of the neighborhood clinics, which are responsible for the provision of protective health care service. To this three, we should also add the "Public Hospital Associations" proposal, which has not been put into the effect yet.

All these elements of the "reform" manifest the changing epistemology of the health care structures around the world: evolution of the health care service providing units to the health care enterprises, which function within the framework of market principles and rely on the notions such as efficiency and performance criteria. It will be suitable to call the new "health policy" initiated by the government as the "liberalization" of health in respect to the introduction of rises of the out of pocket payments, the purchase of secondary health care and subsidiary services from the private

[98] Ağartan, "Sağlıkta Reform Salgını", p. 52.

[99] Keyder, "Giriş", p. 23.

[100] Tufan Kaan and Selçuk Atalay, *SSK Gerçeği*, Ankara Tabip Odası, www.ato.org.tr, Ankara (2004).

sector and the passage to autonomous hospital administrations.[101] These policies reflect an unprecedented transformation in the Turkish health care structure: commodification of health care with putting an end to the provision of it by the public sector. Following this, the employment of the whole health care personnel will be dependent on the market principle and the provision of health care service will be under auspices of the neoliberal incentives such as profitability and efficiency.

Now, I will take a deeper look at the reflections of the basic tenets of the transformation in health program in more detail. Family physician system has put into effect in ten pilot cities in the last two years. In Izmir, the third biggest city of Turkey with a population slightly under 4 millions and a significant harbor for immigrants, the Chamber of Medicine took on an extensive opposition against the recently introduced family physician model. ICM has been stated that the introduction of family physician model aims the privatization of the first level health care services and argued that the demographic data collection conducted under the areas of responsibility of the neighborhood clinics was a result of the creation of consumer databases for the eventual family physicians.[102] During this period, the newspapers and televisions were covered with news saying that the Ministry of Health was putting coercive measures against the members of Turkish Doctors' Association, which had an adversary stance against the model and were refusing take part of the family physician model.[103]

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[101] Ömer Gider and Mehmet Top, "Kamu Hastane Sektöründe Liberalleşme ve Türkiye'de Yansımaları", *Ekonomist*, www.e-konomist.net (2007).

[102] İzmir Tabip Odası, *İzmir'de Sağlık Çalışanlarına Baskı ile T.C. Kimlik Numarası Toplatılması Devam Ediyor!* İzmir Tabip Odası, İzmir, Press Release (September 29, 2006).

[103] İzmir Tabip Odası, *Aile Hekimliğini Seçmeyen Hekimlerimiz Üzerindeki Baskıya Son Verilsin!* İzmir Tabip Odası, İzmir, Press Release (April 19, 2007).

Üstündağ and Yoltar, regarding the closure of the neighborhood clinics, questioned who is going to provide the protective health care services after the closure of the neighborhood clinics, which played historically important roles particularly in poor and rural regions of Turkey, where proper health care institutions and even sometimes doctors were in absent.[104] These clinics, throughout the course of Republic were the sole access of the people in villages, Eastern and South-Eastern Anatolian regions to health care in terms of receiving vaccines and fighting against endemics, especially in terms of Turkey's fight against tuberculosis.[105]

It has been argued that autonomization and privatization policies are inevitable for the health care institutions, which are unable to function on their own and have become a burden on the state budget.[106] The objective of reform is to decentralize health care structure via achieving the localization of the system. Hence, hospitals with a financially self-contained without receiving assistance from the central budget, aiming savings in terms of available resources. The hospitals will be administratively organized according to market principle of profitability. The fact that autonomization is the first step towards privatization is revealed by the fact that during the handing over the SII health care institutions to the Ministry of Health, with a small change made on the Basic Law on Health Care Services, the Ministry of Finance had given the authorization to sell the "Property assigned to Ministry of Health and the real estate property given to the use

[104] Üstündağ and Yoltar, "Türkiye'de Sağlık Sisteminin Dönüşümü", p. 87.

[105] Personal Interview with Zeki Kılıçaslan.

[106] Ömer Gider and Mehmet Top, "Otonominin Hastane Yönetim Politikasına Getirdikleri", *Verimlilik*, Sayı 4, (2003): 147–168.

of Ministry of Health".[107] In addition to that, the first regulation paved the way to the autonomization of public hospitals, "Regulation on Principles and Methods of Working of Public Health Institutions" dating back to 1994 said the following: "...the passage to the autonomous health care institutions will lay the pitch of the privatizations of the public hospitals in the following phase and..."[108] The university hospitals, where the most complicated, tertiary level health care services are provided 'are in a process of downsizing. Since the "drill" of marketization is the clearance of the way of the private monopolies in the sector, the shrinking of the area of conduct of university hospitals is a necessity'.[109]

Finally, the most important step in the health care reform is that the transformation of the Ministry of Health to a strategic decision-making body responsible for 'assessment of the general health policies, coordination and supervision and regulation of the health care market'. It is going to be put an end to the Ministry's role as a health care service providing institution. This process will be finalized by the handing over the administration and conduct of the secondary and third level health care institutions to above-mentioned "Public Hospital Associations".[110] The proposal anticipates the self-responsibility of the hospital managements from their own budgets and most importantly the withdrawal of the state from the financing of the health care

[107] Kaan and Atalay, *SSK Gerçeği*, p. 12.

[108] Cited in, İlker Belek, "Desantralizasyon ve Özerkleştirme", Toplum ve Hekim, 10 (69–70), Eylül-Aralık (1995): pp. 147–150.

[109] Ata Soyer, "Sağlık Harcamalarında AKP'nin "Pembe Tablosu"nun Akıbeti", BİA Haber Merkezi, www.bianet.org, March 13, Istanbul (2008).

[110] Faruk Ataay, "Kamu Hastane Birlikleri Tasarısı: Yerelleştirme, Özelleştirme ve Yönetişim", YAYED, www.yayed.org.tr (2007a), p. 4.

provision. The fact that the government assistance is addressed as a "donation" under "necessary situations" reveals that the formation of the associations will be the most significant step towards privatization.[111] In short, the supposition of elimination of the state as a service providing body has been realized step by step. Keyder puts the epitome of this process as the following: "exactly like the assumption about the functioning of capitalist market mechanism, in health care sector it is assumed that the customers' choices of the receiving part of the health care services would bring more competition, promote effectiveness, establish a discipline on doctors and health care institutions and the advancement of the quality of health care provision" (my translation).[112]

In fact, health care is not a matter of spending. The problem of health care has nothing to do with the money spent on the services. The total amount of health care spending was 4.7 billion TL, the 4.7% of the GDP in 1999, whereas, in 2007, it has risen to an amount of 35.8 billon TL, equaling to 8% of the GNP.[113] On the other hand, according to statistics, Turkey does have a worse then average performance in health care services traditionally. Parallel to that, being the country with a lowest GDP per capita among thirty OECD countries, it also has the lowest spending per capita among OECD countries with spending of 586 USD in 2005, compared with the OECD average of 2759 USD.[114] In terms of health personnel, Turkey, again, has the poorest performance among OECD countries: in 2004 Turkey had 1.5 physicians per 1000

[111] Ibid, p. 15.

[112] Keyder, "Giriş", p. 25.

[113] Hakan Yılmaz, "Sağlıkta Harcama Politikaları", Bursa Presentation, December 1 (2007), cited in Soyer (2008).

[114] OECD Health Data 2007.

population (OECD average was 3.0), only 1.8 nurses per 1000 population (OECD average was 8.6) and in 2005 the number of acute beds was 2.0 per 1000 population about half the OECD average of 3.9 beds.[115]

In the United States, where the discussion on the crisis of the health care system has been prominent, the money spent on health care system arose from 5.2% of the GDP in 1960 to %16 of the GDP today. United States, for a long time, have been the country by far spending the most amount to health care, in spite of 50 million people, who does not have any coverage from any social security institution; nor any access to health care. Krugman and Wells, argue that the big chunk of this amount covers the treatment costs of a very tiny minority of the American society, however there is no protective health care policies for the wider public, particularly for the poor.[116] Krugman and Wells emphasize the fact that 1% of the population is responsible for the 22% of the total health care spending, as well as according to the 80-20 ratio, a significant amount of money is comprehended for the illnesses those comprise only very small portion of the society.[117] These figures reveal that health care provision has less to do with the money spent on it, if the large amounts flow to the curative-purposes with the policies of consumption promotion. Rather, it is more related to how and where the money is spent, particularly in terms of protecting the health care of the wider public.[118]

The extraordinary expansion of the health care pie and the introduction of terms

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[115] OECD Health Data 2006

[116] Paul Krugman and Robin Wells, "Health Care Crisis and What to Do About It", *New York Review of Books*, Vol. 53, No. 5, (March 23, 2006): 38-43, p. 39.

[117] Ibid, p. 42.

[118] Personal Interview with Zeki Kılıçaslan.

such as “market” or “sector” comprise a very important change of the new health care policy and people are driven to “consume” more and more health care services. Ali Çerkezoğlu, the Member of Executive Committee of Turkish Doctors’ Association argues that the people recently have been internalized the idea that health care is a commodity available out there for their consumption and persuaded that they should purchase of it as much as possible. According to him, what the current government achieved that establishing the basis for a marketized health care system by deploying the notion of consumerism regarding health care.[119] On this point, I think that the conceptualization of health care as a commodity to be consumed by the wider public owes much to the long-lasting unequal access of different groups of people to health care services. It has not been difficult to create a health care market, since large amount of the population has lacked this right for a long time, especially when they are promised that their expenses will be covered by public institutions, even if they go to private health care enterprises.

In the process of realization of transformation in health program, the discursive and practical reflections of these policies to the daily experiences of the citizens and the people who are employed in the health care provision deserve closer analysis. I have already mentioned that the previous deprivation paves the way to a great appreciation, which owes much to the visibility of the Prime Minister Erdoğan himself using health care reform as a means of national propaganda. It is not easy to be critical with a policy, while a prime minister having the majority of the votes, first time in the post 1980-coup period, wanders city-by-city and promising ‘free health care provision in private hospitals’. What we witness here, as Shore and Wright argues, is that the state, with its

[119] Personal Interview with Ali Çerkezoğlu.

policies and its representation of these policies to citizens defines the 'the way we live, act and think', where in which policy became an increasingly central organizing principle in contemporary necessities of capitalist society.[120] They underline the complicated role of the discourses generated by the agents of the state in controlling the political arena and in making the citizen subjects of the power. The focus here is on how 'techniques of the self' work to produce new subjects of power.[121] In this guise, while policies appear to be mere instruments for promoting efficiency and accountability, the masking of political under the cloak of neutrality sets a key feature of modern power. Regarding the "reform" of Turkish health care system, in the passage of the health care from a right to a commodity, the discourse of government defines the health care service outside the sphere of statehood and reproduces this as a commonsense among the citizens. Here, the governance method of subjects relies on the notions such as efficiency and austerity, while disguising the political intention behind the health care reform. In this particular case, the policy emerges as a vehicle of introducing neoliberal and post-social rationalities of governance, which creates the new individual's sense of self, and hence the new society.[122] As a speculative assertion, we can also articulate 'making people be fed up with' the public health care institutions as a political mechanism. As an instance for this situation, I refer to the collective infant deaths in two public hospitals and the wide public discussion and the coverage of the media in the aftermath of these incidents.

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[120] Cris Shore and Susan Wright, "Introduction", in *Anthropology of Policy: Critical Perspectives on Governance and Power,* eds. Cris Shore and Susan Wright (London and New York: Routledge, 1997), pp. 3-7.

[121] Ibid, p. 29.

[122] Ibid, pp. 29-35.

When we go back to the above-mentioned proposal on "Public Hospital Associations", it authorizes the associations to "outsource services" and "employ subcontracted health care personnel" if necessary, as well as comprises measures in order to prevent "over-employment" in health care sector, aiming to promote efficiency and lower costs of hospitals.[123] However, these concepts are not peculiar to this specific proposal. They are already in effect; a fact that undermines secure employment and job security in health care, more significantly eliminates the notion of public employment among health care workers. If the all tenets of the health care "reform" taken into the consideration, it is obvious that health care personnel as a whole will be employed on a contract basis, as well as via subcontracting practices, which would create a health care labor market by depriving the doctors, nurses, technicians and other health care personnel of guaranteed jobs. This process of liberalization, in the long run, will establish a health care labor market, which functions on the basis of competition and lowering of costs of health care labor like any other sector.[124] In today's transition period, the important question regarding 'work in health care' is not only the differentiation between the eliminated state employees –traditionally employed in the health care service provision, thanks to the dominance of public sector in the area- and subcontracted workers, but whether this situation leaves hurtful effects on the insecurely employed subcontracted workers, which is one of the most noteworthy consequences of the ongoing health care reform project.

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[123] Faruk Ataay, *Kamu Hastane Birlikleri Tasarısı Üzerine Değerlendirme.* (Ankara: Türk Tabipleri Birliği Yayınları, 2007b).

[124] See Kaan ve Atalay, *SSK Gerçeği* (2004); Ata Soyer, Ata, Bülent Aslanhan, Eriş Bilaloğlu, Güray Kılıç, Osman Öztürk, Cavit Işık Yavuz and Mehmet Zencir, *Sağlıkta Piyasacı Tahribatın Son Halkası: AKP* (Ankara: Türk Tabipleri Birliği, 2007); Erinç Yeldan, "Sağlıkta Dönüşüm Programı ve Gerçekler", *Cumhuriyet*, Istanbul (January 12, 2005).

Conclusion

As I have tried to show, the recent "reform" program initiated by the government in Turkish health care system, points a passage of conceptualization of health care from a right to a commodity. I have already emphasized that in Turkey health care has never been accessible by the whole population. Health care structure and social security system never had a universal character funded by the state budget, which should be introduced as soon as possible in order to eliminate the inequalities caused by both the Bismarckian structure of social security and peculiar informal employment, which hinders the access of the significant portion of population any kind of social rights.

In Turkey, the livelihoods of the most marginal groups, especially within the metropolitan areas; primarily in Istanbul, deserve closer scholarly attention in order to track the consequences of the recent health care transformation. The survival of unemployed or temporary employed urban poor in Istanbul became more precarious in the past couple of years within the shrinking of employment opportunities. In these circumstances, the access to health care is of great importance for the marginalized people of the Turkish society. As Keyder offers a universal health care system funded by the central budget is necessary in order to eliminate the existing problems of access and availability.[125]

As Buğra and Keyder state that the preconception arguing that the fiscally restrained state is unable to help the poor, does not hold true and owes its wide acceptance largely to the influence of neoliberalism; and on the contrary the Turkish state is, in fact, in a position to solve the problems of poverty and social exclusion with

[125] Keyder, "Giriş", p. 20.

roughly small amounts from the budget.[126] They argue that the objections such as "poor state, hence an impossible situation" are not valid. This, again, reveals that the area of social policy and the issue of social rights are political matters related to political authority and providing those rights would result from political decisions rather than being a part of moral theorizations of justice.

However, in Turkey, in line with the above-mentioned ideas of de Tocqueville and Hayek, social policy has recently adopted more and more philanthropic tunes, with marriage of conservative and neoliberal ideologies under the rule of JDP. As Buğra argues that JDP government's approach towards social policy in general refers very much on the idea of philanthropy, in the ideological context characterized by mutually reinforcing role of Islam and neoliberalism, which together provide a uniquely strong support to the traditional tendency to undermine the responsibility of the political authority in combating poverty.[127] In line with her analysis, in the field of health care, we witness the political choice of government to manifest the irresponsibility of political authority in its provision. Again, this point reveals the necessity to conceptualize social policy and health care as social matters and should be perceived in the historical and cultural contextualization of the particular time of today's political discussion. The responsibility of political authority in providing the citizens a minimum level of livelihood, as emphasized by Marshall, should be at the center of the discussion. The struggle for social rights through a moralistic approach on justice or on legal fields should go hand in hand with a struggle the political and social level should be the strategy to be followed by ones, who seek a universal model of health care based on

[126] Buğra and Keyder, *New Poverty and Changing Welfare Regime of Turkey*, p. 11.

[127] Buğra, "Poverty and Citizenship", p. 46.

citizenship rights.

Finally, the introduction of subcontracting practices in the employment of health care personnel, especially in the university hospitals, where third level services are provided, raises important questions not only in terms of the relation between the state and the employees, but also between the state and health care receivers on the basis of citizenship.

CHAPTER 3

THE SUBCONTRACTING PRACTICES MANIFESTED

Introduction

In the previous chapter, I have tried to provide an analysis of the recent process of transformation in the health care structure in Turkey, underlying the withdrawal of the state from the health care field and the following –rather said the initial- process of marketization of health care structure. This transformation, which is I argue follows a neoliberal track, is introduced by the policies to establish 'a post-social form of governance'[128] in the area of health care. I emphasized that although public health sector is not in a process of privatization *en masse*, the fact that rollback of the subsidies from the state to the health care and rendering the hospitals –or the hospital associations in the future- responsible for their own budget paves the way to the commodification of health care. Every aspect of health care "reform" such as the premium-based general health insurance, family medicine, purchaser-provider split and the buying of services from the private sector are all components of the marketization process of health care services.[129]

The "reform program" initiating the autonomization of health care institutions corresponds to the transition of health care right to a commodity, where 'social' state of Turkey dodges from its responsibilities as health care provider, epitomized in the transformation of the Ministry of Health to a 'strategically decision-making and supervising body'. The so-called single-framework system, the product of the

[128] Shore and Wright, *Anthopology of Policy.*

[129] Günal, *Health and Citizenship in Republican Turkey: An Analysis of Socialization of Health Services in Republican Historical Context*, p. 499.

unification of the previous three social security institutions continues relying on a premium system, wherein which those unable to pay their premiums will be deprived from all kinds of health care services. The state only chips into this system by paying the premiums of those families, whose monthly per capita income does not excess the one-third of the minimum wage.

While developing this argument, I do not claim that the Turkish health care prior to reform did have an egalitarian nature, nor was it universal. On the contrary, I would like to restate that with its multi-partite structure and reliance on a Bismarckian notion of status of employment, the previous system left a big chunk of the population outside. As Yoltar and Üstündağ argue, the system was gendered, because it was basing itself on a male breadwinner model. Furthermore, as Yoltar argues it was ethnicized, because of the massive lack of access to health care and social security institutions among Kurdish people. What I argue is the new "reform" did not alter the unequal premium based system, yet did change the conception of health care by imposing market principle on the health care provision, as well as eliminating the subsidies from the state budget to health care via creation of autonomous, *public* health institutions held responsible from their own budgets.

To counter this argument, it could be said that the state is still the paramount actor in health care provision. However, the trick here is although the state seems to continue dominating the health care field, it ceases to be the provider, yet a financier of it. The most obvious example of this was the allowance of the SII recipients to private institutions, where the state promised the reimbursement 70% of the amount spent out-of-pocket by the patients. Hence we witness the promotion of the private health care provision with the resources of the state. On the other hand, the primary goal of the

contemporary transformation is the creation of a self-responsible health care system, in which the role of the state is confined to pay the premium of those, who earn less then one-third of the minimum wage. What I argue is that this re-structuring of health care body, which follows the principles of cost-containment and efficiency, causes the marketization of health care provision.

In light of this, the main aim of this thesis is to give a detailed analysis about the ethnographic explorations of one particular reflection of the manifestation of the above-described process: the subcontracting practices. My analysis, first of all, will show the everyday experience of marketization of health care with regards to the emerging outsourcing of health care work. On the other hand, it will go into depth of the newly produced subjectivities of health care providers employed via subcontracting practices. In relation to this; since I have studied the transitionary process of this marketization, I will give an analysis on the co-existence of the previous form of health care and the outsourced form of that.

The relational objective and subjective positions of; and tensions between the two groups provide a comprehensive understanding of the liquidation of health care quality and the crucial association and trust among health care providers. Before going into the details of my fieldwork, I think it is important to raise a theoretical discussion about what subcontracting refers and in which forms and experiences does it affect the livelihoods of the working people in general. Then, I will explain what is meant by subcontracting in this thesis and contextualize the notion within the framework of Turkish labor regime in general and health care in particular. Without providing an analysis of the how subcontracted work embedded into the historical turning point of general notion of work, the study would miss one of its basic aims.

The Legal/Social Background of Subcontracted Work in Health Care

In the previous chapter I dwelled upon the process of transformation in the Turkish health care system, in which the subcontracting practices appeared. The new conceptualization of health care, which anticipates the marketization and commodification, necessitates the change of employment of health care personnel among others to guarantee the so-called cost-containment through commodification of health care work.

I have referred to studies of Gider and Top, where in which they provide extensive analyses of liberalization and autonomization of health care in Turkey.[130] In respect to the new employment practices of health care personnel, in one of their studies, they argue that the outsourcing of the employment health care personnel was introduced by a Law on "Principles and Methods About the Purchase of Services Performed by Health Care and Supplementary Health Care Personnel in 2004".[131] Furthermore, they argue that the law in question could not take place and the execution of this law was abolished.[132] In fact, the Council of State suspended the execution of this law on April 19, 2007, as a result of application for annulment made by Turkish Doctors Association. Thus, Council of State appealed to Constitutional Court claiming that the law was

[130] Ömer Gider and Mehmet Top, "Otonominin Hastane Yönetim Politikasına Getirdikleri", *Verimlilik*, Vol. 4, 147–168, (2003); Ömer Gider and Mehmet Top, "Kamu Hastane Sektöründe Liberalleşme ve Türkiye'de Yansımaları", *Ekonomist*, www.e-konomist.net (2007).

[131] Sağlık ve Yardımcı Sağlık Personeli Tarafından Yerine Getirilmesi Gereken Hizmetlerin Satın Alma Yoluyla Gördürülmesine İlişkin Esas ve Usuller. Ministry of Health, 2004, http://www.saglik.gov.tr/TR/dosyagoster.aspx?DIL=1&BELGEANAH=15555&DOSYAISIM=g_uygulama_talimati.doc

[132] Gider and Top, "Kamu Hastene Sektöründe Liberalleşme ve Türkiye'de Yansımaları", p. 20.

violating the basic premises of the constitution and requested abolishment of law.[133] However, the Constitutional Court, in its decision on November 11, overruled the request of Council of State and adjudicated that the law was not in controversy with the Constitution of Turkish Republic.[134] Therefore, the legal-institutional aspect of the issue of subcontracting the health care workers remained in confusion, with a judgment of suspension from the Council of State and a judgment of suitability to Constitution by the Constitutional Court. This situation gave way to the introduction of subcontracting practices in university hospitals in Turkey.

In the meantime, the hospitals were already outsourcing some services such as visualization services, i.e., magnetic resonance and tomography, and the supportive health care workers in university hospitals. The parking, cleaning and cafeteria services were already transferred to outsourcing firms for a long time, not only in hospitals, but in every single public institution.

Furthermore, or the first time in the Turkish Republic, Denizli Public Hospital announced a tender for employment of subcontracted doctors. However, the firms willing to make offer could not find doctors willing to be hired as subcontracted workers; hence the tender was cancelled.[135]

From this, we can derive that there is a tension on the different levels of state, regarding the regulation of the employment, better said the restructuring the employment

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[133] SES, Union of Health Care and Social Service Workers Website, http://www.ses.org.tr/index.php?option=com_content&view=article&catid=50:kazan-davalar&id=68:daniay-saik-hmetler-satin-alinmasini-durdurdu

[134] Memurlar.net, “Sağlık hizmetlerinin 'hizmet satın alınması' yoluyla gördürülmesine vize”, 24.12.2007, http://www.memurlar.net/haber/96906

[135] Personnal İnterview with *Dev-Sağlık İş* Union Representative.

model of government employees. This debate is embedded into the wider issue of changing the regime of general employment in the state body and restructuring the bureaucracy. Health care is only one aspect of a greater transformation of marketization anticipated for all public works and services. The big step in the contracting of government employment and elimination of secure employment in public sector will be finalized with the draft law on "Public Administration Reform"[136], which has been ready for a long time; ratified by the parliament, overruled by the previous president; hence could not be put into effect. The law anticipates a dramatic change in the institutional structure of Turkish state; that's why there is a struggle going on between different branches of bureaucratic system.

Now, the Turkish state is in a process of restructuration itself. In the new body, there is no place for life-long employment as public servants. The new structure foresees the contracting out of government jobs. As Sennett argues, the routine and the bureaucracy are replaced by the flexible and the network. In the new culture of capitalist economy, the notions such as flexibility, short-term employment and task-oriented work flourishes, whereas notions of seniority, attachment to work and long-term employment lose their ground.[137] Not surprisingly, this new culture penetrates into every aspect of life. Along with health care, we see a similar transformation in the field of education. More and more retired teachers are replaced by the new army of contracted ones. The similar tension also occurred in this field. The Council of State annulled the law on employing temporary teachers arguing that education is one of the basic and most

[136] Kamu Yönetimi Reformu Kanunu.

[137] Richard Sennett, *The Culture of New Capitalism*

crucial services provided by Turkish state and that should not be left provided by contracted personnel. However, with the introduction of different forms of status such as substitute teachers, contracted public servant teachers etc, it has practically realized, despite the judgment of Council of State.[138] Furthermore, the 2009 Performance Programme recently announced Prime-Ministry Personnel Directorate anticipates flexible employment models for government employment.[139]

In its essence, the picture represents a class struggle, within which different parts of Turkish bureaucracy involve as well. On the one side, there is the JDP government pushing for a neoliberal transformation of employment regime, backed by international organizations such as IMF and World Bank, who demand for the implementation of these "reforms" within the state structure. On the other hand, there are unions and the workers, public servants, who have to face the direct consequences of these. On the ground of their limited power and resources, they have to hope for resistance from the uncompromising sections of the Kemalist-bureaucratic elite. In reality, as the primary cause of the previous unequal structure, this elite acts with the instinct of protecting of its privileged position and sides itself against the forces of the new global economy.

Nonetheless, it should be remembered that the previous President Ahmet Necdet Sezer, as a former member of Supreme Court and Head of Constitutional Court, was more inclined to overrule the legislative decisions imposing changes within the state personnel structure, social services, judicial body, etc. So much so that, the JDP

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[138] Esin Ertürk Asar, Transformation of Teaching Profession in Turkey, Unpublished Paper, Boğaziçi University, Atatürk Institute for Modern Turkish History (Spring 2008).

[139] Radikal Daily Website, "Memurlar İçin Çok Önemli Gelişme", 18.09.2009, http://www.radikal.com.tr/Radikal.aspx?aType=RadikalDetay&ArticleID=934302&Date=04.05.2009&CategoryID=77

government decided took the draft laws either overruled or appealed to Constitutional Court by Sezer, into the parliament agenda after the election of Abdullah Gül as President of Turkish Republic in June 2007. These laws comprise all controversial Oil Law, 2B Forestry Lands and Public Administration Reform.[140]

Regardless of the judgments made by the legal bodies, on the workplace level, the transformation from secured and tenured jobs to outsourcing manifests itself. The 'success' of the implementation depends on the particular context of workplace. In a university hospital, in Istanbul Çapa Faculty of Medicine, the conflict is subject to hustle and bustle between different actors within the university such as Dean's Office; subcontracting workers and their unions, the subcontracting firm; the government employees union *SES* and the professors.

The Division among Health Care Workers

As a second issue, I would like to clarify, what does being a subcontracted worker legally mean and what are the differences between them and the government employees. Although the situation regarding the employment of subcontracted workers in health care is in a state of confusion, deriving from the overall transformation of the health care system, people working as subcontracted workers in Çapa and their ambiguous position does create their basic problems in terms of benefits and status. It is significant to explain this situation of ambiguity, since the experiences and subjectivities of these workers are closely affected from their marginality in respect to legal documents.

As I explained above, the employment in government institutions in general, and health care in particular has been in a process of dismantling with the aim of establishing

[140] Tercüman Daily Website, "O Yasalar Raftan İniyor!", 25.12.2007, http://www.tercuman.com/v1/haber.asp?id=73235

flexible employment in public sector, if not the particular institution is already privatized. And the transformation in Turkish health care relies on privatization on the first-level health care services via passing to family physician model. Thus, what we witness on the hospital basis, secondary and tertiary levels of medical care, is what I called marketization via autonomization; not only administratively from central authority, but also financially from general budget. Hence, the steps taken are aiming the creation of a health care market, in order to achieve the cost-containment and flexible employment necessitated by the neoliberal understanding.

Since health care work in Turkey has been dominated by public sector, the personnel employed in the health care institutions are public servants; *memurs*, like any public institution employee. Public servants work on the basis of Law No. 657 on Government Employees, which is based on a long-term, secure employment and fringe benefits.[141] However, the new ideology demands not to employ government employees in the public institutions anymore. Therefore, what happens in Istanbul Çapa Faculty of Medicine; and in other university hospitals in general, is the manifestation of contract-basis employment. So, they are workers-*işçi*, rather than public servant-*memur*; and they are employed on the basis of Labor Law No. 4857.[142]

Furthermore, they are not only workers, but subcontracted workers, who are employed according to this Labor Code. Article 2, Clause 6 of the law defines the notion of subcontracting practices as the following:

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[141] 657 Sayılı Devlet Memurları Kanunu, 1972
http://www.khgm.gov.tr/mevzuat/Kanun/devletmemurlarikanunu.htm

[142] 4857 Sayılı İş Kanunu, 2003 www.calisma.gov.tr/mevzuat/kanunlar/4857.doc

> "Main employer-sub-employer relationship is constituted when an employer contracts out the secondary work regarding the good or service production in process; the certain sections of the main work; technological requirements of main work and employs the workers for those tasks in question only in that workplace. In this relationship the main employer is equally responsible as sub-employer against the workers for the obligations deriving from this Law, work contracts and the collective agreements those the sub-employer has been part of"[143] (my translation).

The main discussion here is this: *Dev-Sağlık İş* union argues that this clause on subcontracted work draws the boundaries of subcontracting employment to secondary work related to the good and service production; certain sections of the main work or the technological reasons of main work requiring specialty. However, the argument of the union is the following: what happens in Çapa is that the personnel who perform the main work of a hospital are subcontracted. Now in Çapa the supportive personnel of the health care service providing work such as nurses, technicians, laboratarians, biologists, medical secretaries and caregivers are working via subcontracting practices. That means, today, what has been realized in Çapa, as well as in other university hospitals is illegal. Employing subcontracting workers in these jobs violates the Labor Code.[144] Despite this "illegality" the subcontracting process keeps on continuing and expanding among university hospitals; likely to extend to public hospitals in the future.

As evidence, *Dev-Sağlık İş* puts forward that in order to circumvent the restrictions of the law, on the written contracts the subcontracted workers are referred as "cleaning

[143] Ibid, Article 2, Clause 6, Bir işverenden, işyerinde yürüttüğü mal veya hizmet üretimine ilişkin yardımcı işlerinde veya asıl işin bir bölümünde işletmenin ve işin gereği ile teknolojik nedenlerle uzmanlık gerektiren işlerde iş alan ve bu iş için görevlendirdiği işçilerini sadece bu işyerinde aldığı işte çalıştıran diğer işveren ile iş aldığı işveren arasında kurulan ilişkiye asıl işveren-alt işveren ilişkisi denir. Bu ilişkide asıl işveren, alt işverenin işçilerine karşı o işyeri ile ilgili olarak bu Kanundan, iş sözleşmesinden veya alt işverenin taraf olduğu toplu iş sözleşmesinden doğan yükümlülüklerinden alt işveren ile birlikte sorumludur.

[144] Interview with *Dev-Sağlık İş* Union President Arzu Çerkezoğlu.

personnel." In other words, the Dean's Office signs a contract with the subcontracting firms; hires merely cleaning personnel on paper. Yet, the assignment of them with the tasks in the main operating areas of the hospital, since employing subcontracted nurses or technicians are illegal. In fact, the university hospital does hire cleaning personnel. However they represent only a certain amount of the total workers employed.

From this picture, it goes without saying that the space of subcontracting practices in the public health care sector is contested. This is very much related to the ambiguous situation regarding the interpretation of legal documents and the decisions given by legal bodies. However, in the last stance, one way or the other the university hospitals employ subcontracted workers in order to be assigned to the main tasks of the hospitals. It should be underlined that as long as the process of subcontracting continues, this field will remain highly contested and the ambiguity of the legal situation of the subcontracted workers will persist.

This was the situation of the supportive health care personnel. There is another aspect of the issue, regarding health care cleaning personnel. As I said before, the jobs such as cleaning, parking and cafeteria services have been outsourced long before not only in health care, but also in almost every public institutions in order to increase efficiency and reduce costs resulting from the employment this personnel.

In respect to health care institutions, the outsourcing of the non-medical services in hospitals started from 1980's. In the year of 1985, the Ministry of Health issued a circular in order to purchase of cleaning services from private companies in public hospitals.[145] These practices are expanded to other non-medical services. The reason I

[145] Fahrettin Tatar, *Privitization and Turkish Health Policy*. Unpublished PhD Thesis, University of Nottingham (1993), cited in Gider and Top, "Kamu Hastane Sektöründe Liberalleşme ve Türkiye'ye

raised up this issue is that both the union representatives and some of the cleaning personnel argue that cleaning in a hospital environment should not be seen as a non-medical vocation.

This argument relies on the fact that what the cleaning workers do is not cleaning any place; rather in a hospital they have to involve with medical waste, which would contain any kind of disease from the hospital. They are fragile to get infected with any disease, since they have not been trained to perform medical cleaning, as well as no necessary measures are taken in that respect. On the other hand, as cleaning personnel, they walk in and out to the main waste containers of the hospital during the deposit of collected garbage, through which they might bring infections out of waste containers back to hospital environment. As far as my study concerned, I have not witnessed any practice to hinder the possibly hazardous consequences of this situation, which might result from the working conditions of health care personnel.

To sum up this section, I want to re-emphasize the ongoing confusion regarding the health care sector in general, which creates considerable questions in respect to the provision of health care services. The redefinition of the relation of the state with health care, as a result of the general transformation of the neoliberal structuring of state alters the experiences and representations of the state for the citizens. In particular to university hospital of the health care system, we witness a process of contracting out the supportive health care service employees, upon which I will dwell in more detail in the following chapter. Furthermore, I will provide an analysis of the newly constructed subject positions in relation both to their government employee colleagues and to their

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Etkileri, P. 72.

own work. The illegal position the supportive health care personnel got stuck in and the demands of cleaning personnel to be supportive health care services is significant, since they represent slight differentiation among subcontracted personnel as well. However before proceeding to that it is necessary to provide a general understanding about Istanbul Faculty of Medicine and some preliminary information regarding the study.

Conclusion: General Overview of Çapa

Istanbul Faculty of Medicine Çapa University Hospital, arguably, is the most popular hospital in the city of Istanbul. Because it is a university hospital, it harbors the most complicated tertiary health care departments, such as oncology, neurology and neurosurgery.[146] The total number of employees is around 5,000. And according to Data Processing Department, the daily average of patients benefiting from poly-clinical services is around 1,500, whereas the number of in-patients is 35,000 per year; and number the beds is 1,537.[147] To these numbers, we should also add the patient relatives and a considerable number of medical students at the campus. The security guard, to whom I asked, whether he has any idea, how many people come to Çapa Campus on daily basis replied me: "A lot. Really lot." But he was not able to express even an estimation of it.

The campus is geographically located at the very center of Istanbul, just in the middle of the metropolitan are of Istanbul on the European side. What I derived from my fieldwork is that the people from diverse backgrounds and cultures, belonging to different class and status groups, speaking both Turkish and Kurdish are provided health

[146] It should be noted that cardiology department is located in antoher campus of Istanbul Faculty of Medicine, though very close to Çapa, i.e. in Haseki. Nonetheless, the cardiovascular surgery department is in the main Çapa campus.

[147] See Appendix, Istanbul University, Istanbul Faculty of Medicine Website, http://www.istanbul.edu.tr/itf/index.php?id=5

care services in Çapa University Hospital. Being one of the main addresses of infamous illnesses, it is the "melting pot" of the city of Istanbul, where one of every six Turkish Republic citizen lives.

The period I conducted my fieldwork was coincided with the implementation of the Law on Social Security and General Health Security, to which the unions, doctors' associations and various non-governmental organizations opposed fiercely, throughout Turkey in general and in the hospital environments in particular. That's why, during my ethnographic fieldwork, the hospital was quite "political" in the sense that the opposition of the employees to the passage of law in the parliament was quite visible. In that period, the unions, especially those organized in health care sector, were quite active and capable of evoking this militancy –though for a short period of time- in their rank and file members, in contrast to poor union effectiveness in the Turkish context in the last decade.[148]

Regarding the fact that Çapa is a public institution, the biggest union here is the civil servant union *SES* (Union of Health Care Employees).[149] Apart from *SES*, there are four workers' unions: *Dev-Sağlık-İş, Belediye-İş, Tez-Koop-İş* and *Sağlık İş*. These unions are crucial in getting organized the subcontracted workers and providing them an opportunity to claim their rights both against the firms and the university management,

[148] Alpkan Birelma. *Three Cases of Workers Mobilization in Contemporary Turkey*. Unpublished M.A. Thesis. Atatürk İlkeleri ve İnkılâp Tarihi Enstitüsü, Boğaziçi Üniversitesi, Istanbul, 2007.

[149] The division that I mentioned in the introduction of this chapter prevails when the issue comes to unionization. In Turkey, the civil servants and workers have different unions. Until 1995, the civil servants did not have the right to unionize, which could be perceived as a legacy of the 1982 Constitution, passed under the military regime after September 12, 1980 coup. Though they obtain the right to organize in 1995, the civil servants still lack the right of collective bargaining and the right to strike.

collectively. Since subcontracted personnel are *workers,* they cannot be organized in *SES* union.

Dev-Sağlık-İş, with broadest vision in terms of organizing the workers, tries to organize the workers under the subcontractor firms regardless their employee group. It achieved successful organizations in other cities of Turkey such as Diyarbakır and Bursa. However, their campaign in Çapa and other university hospitals in Istanbul proceed very slowly. *Belediye-İş* started an organization activity both Çapa and Cerrahpaşa[150] cleaning workers in Spring 2007; according to law they are not "authorized" to organize among other employee groups. Only in an eight-month period, the union organized more than 700 people from both hospitals, of which 395 were from Çapa out of total 400 cleaning personnel. *Tez-Koop-İş*, on the other hand, organizes the workers those do not work via subcontractor firms but under the body of university. *Sağlık İş* practically does not have any activity in Çapa.

To sum up, as I mentioned before, the structure of the staff in Çapa is diverse. The reason, I have chosen the University Hospital of Çapa Faculty of Medicine was to analyze the reflections of a general tendency of the political power in respect to the insecure employment in the public service sector. My aim was not only to focus on the experiences of subcontracted workers within a public university hospital, but also to take the possible effects of the practice of subcontracting on the provision of health care service into the consideration. However, I was astounded what I witnessed there. More or less, I was informed about the groping health care provision within the Çapa University Hospital, as it is the fact in most of the public service institutions does not

[150] Cerrahpaşa is another Faculty of Medicine within the Istanbul University, which also has a university hospital. Its size is slightly smaller than Çapa and its location is very close to Çapa campus. Since they are different medicine faculties, they are autonomous from each other.

given necessary funding from the budget as well as the considerable shortage of the personnel. Furthermore, I was told as well about the fact that the departments within hospital were greatly disconnected from each other because of the size of the hospital and lack of common spaces for them.

What astounded me was the fact that the horrific diverse structure of service providing personnel such as permanent civil servants, subcontracted workers and the division within them to groups of nurses, medical secretaries etc., Ministry of Finance appointees, associations' employees and informal working staff. And, let me emphasize again that this situation materializes itself in a public service providing institution, which is supposed to give health care to the citizens of the Turkish state, and that the providing personnel should perform their tasks in teamwork, as collective as possible. Eventually, this study aims to clarify this reality of a public service providing institution, on which the existing literature is relatively insufficient.

CHAPTER 4

THE REFLECTIONS OF SUBCONTRACTING IN ÇAPA

Introduction

"They are lucky if there are leftovers from the patients. Otherwise, everyone is hungry here."

Taşeronda çalışan –subcontracted- Halil was the person, with whom I had the most sincere relationship in Çapa. He has been always the friendliest and the most frank worker towards me. We have met on the day, when the trade union organizing among subcontracted workers, *Dev-Sağlık İş* (The Union of Revolutionary Health Care Workers), was organizing a meeting in Ankara, the capital of Turkey. That was also my first encounter with the subcontracted workers in Çapa as a researcher. While waiting for the buses at the union headquarters in Aksaray, we started talking about their situation at the hospital; later moved to more political matters in Turkey. His first reaction to my interest in studying subcontracted workers in health care was the following: "So, you want to study us. You have a crunchy work coming. Don't you have better things to do?" He was working as a radiology technician at the Respiratory Diseases Department. At the time we met, there were only few weeks to the birth of his first child –a boy. Besides Çapa Istanbul Faculty of Medicine, he was working on the night shift at a private policlinic in Nurtepe; a poor neighborhood in the outskirts of Istanbul, comprising immigrants from every part of Anatolia and a quintessential example of unplanned urbanization. He told me that at the policlinic he does everything necessary:

> "I work as a technician, a secretary, nurse people and I suture. I am all-alone during the night. Moreover, what else I am going to do but having a second job, brother? The baby is on the verge of coming. He has only

> couple of weeks to go. How I am going to raise him? How I am going to feed him? Besides, I cannot ask his mother to work right now".

In fact, usually the subcontracted workers at Çapa have second jobs, if they –usually women- do not work there for an extra contribution to the family budget, in addition to their husbands' incomes. Some work in the textile industry, some, like Halil, in other private health clinics, some work at hairdressers or other miscellaneous jobs. Halil and I were sitting on a bench at the second floor of the Respiratory Diseases Department and waiting for Zeki *Hoca* to come. It was the lunch break; hence there was a complete silence at the floor. Besides us there were only a few subcontracted workers were present. One was staring out the window; one was playing with her cell-phone; the other reading a newspaper. While I was having pain of not being able to ask Halil, why those people were spending the entire lunch-break sitting idly in the empty corridor, the opening door of *servis* –the room where the patients rest- broke the silence. A waitress with a food cart appeared at the door. Suddenly, the workers twiddling their thumbs wobbly headed to the food cart. The words of Halil conveyed above cleared what was going on. The leftovers of the *table d'hôte* cooked for in-patients become the lunch of the subcontracted health care workers.

Kazım, one of the organizing professionals of *Dev Sağlık-İş* enlightened me on this issue. In general, the public institutions compensate part of the contracted price of the meal per employee, set by the contract between the institution and the catering firm. The individual employee pays the remaining part out-of-pocket. Istanbul Faculty of Medicine compensates 70% of the agreed meal price of 5 liras. The 30%, i.e. one and half lira, is paid by the employees themselves. However, for subcontracted workers it is not possible to benefit from this right, because they are not university personnel, not government

employees; they are not *memur*, according to the number of which the lunch contracts are concluded. According to legal distinction above, they are only subcontracted workers, who "were just happened to be there". The law defines them temporary workers; hence the university does not employ them as its own personnel, despite the fact that they are *de facto* employed for permanent tasks. On top of that they perform the main services of a hospital; a situation, which violates the law on subcontracted work, which only anticipates either temporary employment or technological necessities of the nature of task. Though, no one forbids them to eat the lunch provided by the university for personnel. Yet, in that case, they should be prepared to sacrifice the whole five liras. Since they work at minimum wage; one and a half or two minimum wages, the subcontracted workers are not able to afford that amount on daily basis.

There are other consequences of this *non-existing* position of subcontracted workers. In terms of socio-economic rights, apart from right to lunch, they are deprived from the right to use personnel shuttles as well. Just like in the case of lunch-contracts, the shuttle contracts are made with regards the number of the government employees at the university. Since the subcontracted workers *memur*ally do not work at the faculty, they are only cogs in the machine. However, as Nurten conveyed in some cases, the government employees allow them to use the shuttle service, who herself was able to do so. She continues: "Of course, it is not possible in some shuttles. I don't know exactly, which shuttle it was, but I have been told that two workers were yelled and brought down by others. They said, get out! And force them to leave the shuttle". In addition to lunch and personnel shuttles, nor they have the right to use the nursery of the hospital. The nursery issue causes considerable difficulties for women with children, which is quite common in health care sector.

It is obvious that this kind of a relationship between the government employees and subcontracted workers, as well as humiliating treatment coming from the relatively well-off government employee part creates irreparable damages. These incidents spread rather quickly among the subcontracted workers, which drift two groups apart from each other. It goes without saying that the subcontracted workers depend on the support from the government employees in the struggle for their rights. However, above-mentioned incident makes them to think they are all on themselves in their situation and more importantly leads to mistrust to the collective right seeking.

Second issue is the Sennettian corrosive personal results of these experiences on the subcontracted workers. Being already secondary-class people within the system in general, plus being treated in hostility by their fellow colleagues hurts the subcontracted workers psychologically. As Sennett and Cobb argued, this situation paves the way to putting the blame on themselves with regards to their deprived situation.[151] More and more, the subcontracted workers think that it is their own failure to be in a deprived position than their co-workers and being treated like that; a situation particularly undermines any sort of right seeking within the given situation. In few pages, I will give a detailed analysis on this issue.

Thirdly and in its simplest sense, it deteriorates the relationship of trust, which is extremely crucial in respect to the nature of the tasks performed. Since these people are part of the same institution; an institution provides health care to citizens, including the most complicated tertiary level services, sometimes they save lives together, share a big responsibility, which requires relationships based on trust. It undermines the ethos of

[151] Sennett and Cobb, *Hidden Injuries of Class.*

health care provision, in relation to life-saving and helping people. The division, which seems as a matter of form of employment deriving from a legal contract relationship, first deprives one group from the benefits the other group has; secondly evolves into a schism depending on the everyday encounters of these groups. The perceptions about the *others* create a relational self-positioning in the emergence of the different forms of subjectivities between the two groups of people. Aysel, a nurse working in the pediatrics service told me significant details about the relationship of trust and how it has been affected by the subcontracting practices:

> "...(I)t has been always said that the health care should be based on team work. However, it is unable to maintain teamwork. By policies, we have been pushed away from it. Working together was always a problem and now thanks to the subcontracting, there is a novel schism among the health care personnel. We were already unable to establish the integrity of doctors, nurses and caregivers. At the moment, it is far more difficult then before to achieve that. It was already hard to create an emotional association among the different occupational groups. Now, we have the subcontracted cleaning personnel; the subcontracted caregivers and the subcontracted nurses in the picture. There is no integrity within the team left. It has been already dismantled. Let the doctors aside, we live this through within the group of nurses; a division between the government employees and subcontracted nurses".

The inequality regarding the socio-economic status has further devastating consequences on the subcontracted workers, deriving from their *non-existing* positions. Let alone that they do not receive the proper rewards for their effort and paid poorly, the disappointment of being employed as "temporary" and remaining like that for so many years haunts them constantly. They never feel that they belong to their institution, for which in some cases they have been working for years. As Standing argues, flexibilization and unsecuritization of jobs are seen as the practices those reduced the costs and increased the efficiency of the work; however, the fear of being laid and

constant anxiety they cause, undermines the sense of devotion to work and a healthy attachment to the vocation[152]; notions critical within a health care providing institution.

The issue of vacation is a significant problem for them. Even in order to have a half-day off they have to beat around the bush. Nalân says: "They do not even let us take one day off. We sometimes have illness at home. Our kids get sick. In order not to come, they ask for sick report, do this or that; you are not allowed to go. We suffer a lot regarding the vacation and taking days off. They do not give us any break". The best way to have a day off seems to be asking help from the professors. Obviously, however, it is no way a general and durable solution for the problems of vacation. Since they are employed with contracts for a certain amount of time, which is always less than a one-year period, it is hard mentioning of vacation. Sinem, one of the laboratarians in the Pathology Department told me that the contractor firm canceled the vacations last year, which caused a lot of trouble for workers: "We tried to find a solution; talked to the professor. Yet, we were not able to have our proper vacations".

In order to be able to have vacation or take a day off, they have to knock on the doors of professors; if they cannot go through it, they have to go to the company, talk to the manager and should be able to convince them. That's to say, in order to get a right of an every working person, they have to go through a troublesome and displeasing process; by all means without having the guarantee to go out on a vacation. The temporary employment on paper deprives them from any sort of right for having vacations and forces them seeking other –mostly irksome- ways in order to have one. I have to underline that during the time I spent in the hospital, I have realized that this

[152] Guy Standing, *Beyond the New Paternalism: Basic Security as Equality* (London and New York: Verso, 2002), p. 68.

issue came to the fore more often with the approaching summer. The primary aim of the unions –*Dev-Sağlık İş* and *Belediye-İş*- were getting the right to have vacations, which was tried to be impeded by the subcontracting company by all means.

Regarding the working hours, there is an absolute inequality between the government employees and subcontracted workers. The workweek for the former is 40 hours, whereas the latter has to complete 45 hours in a week. The obvious disequilibrium between the two groups aside, this situation is also harmful for the subcontracted workers in another way, particularly related for the mutual trust between the groups. What Ayten told me is an instance for this situation: "For instance it is 4 p.m. in the afternoon. Even though, there is still some work to be finished the *kadrolu* – permanently employed government employee- leaves. Why is she doing that? Because she knows that I have to stay there longer, since I am working 45 hours a week. She does not even care. She thinks that since she has to stay here, she could finish the work. That's the way they think. She buggers off".

The *Dev-Sağlık İş* organization specialist Piraye told me that although some departments do not work after 4 p.m., however, the subcontracted workers are kept in the empty department only in order to make them complete 45 hours work-week. Nuray, a nurse from Special Care Department, told me that another unjust practice happens in relation to the night shifts. According to normal procedure, the health care personnel receive one and a half of the daily wages for one night shift. Therefore, the right sets the ratio of extra shifts one to one and a half. However for the subcontracted workers there is no payment for extra shifts. They are only given days off for their night shifts; moreover the ratio is not one to one and a half as in the case of government employees. They are only given one day off for their one night shift. As it is obvious the inequality

and discrimination against subcontracted workers apply in every single detail of the working life of subcontracted workers. Here, I would like to reemphasize that these two groups perform the identical tasks, yet the rights and benefits of them differentiate significantly.

There several instances I have witnessed that the collegiality among the workers is in a process of deterioration, a situation, which has further harmful effects on the ethos of health care work. Hasan Şevket, who was elected shop-steward after the union of *Belediye-İş* obtained the authorization in the cleaning branch of the hospital and conducted a highly successful organization campaign, indicated this lack of confidence: "I mean, I am thankful to my friends. Even to the ones who did not vote for me. They elected me at the moment as the shop steward of our union. However, I do not know, whether I will be here tomorrow. I cannot see any support behind me, which would make me feel more confident. I am not sure, where this thing is going. Do you know what I mean?"

In a similar vein, Halil told that they decided to gather up and go to the office of the subcontracting firm in the campus. Everyone was complaining, because the firm kept delaying the payment of the salaries: He underlines the mistrust and fear among the subcontracted workers by saying "Do you know what happened in the end. I was the only one in front of the office. Nobody showed up except for me". Galip responded to the question of whether she will be coming to the union meeting at one afternoon in a similar manner: "When you go after these things here, nobody comes behind you. We were three people left here. There was one youngster, Haydar. And they fired him eventually after all. Poor guy. Fortunately, the professor did not let me go; otherwise they were going to lay me off as well. And you know there was no one around. No one.

That day I said, from now on I do not trust anyone here any longer". She never showed up in the union meeting.

Ayşe, who was really frustrated that she was registered as a primary-school graduate according to the company documents, although she was a high-school documents, despite she was aware of the fact that this will not ameliorate her situation by no means, preferred to express her distrust to her colleagues in a rather political way: "I did not give my vote. I did not even give one thread of my hair to this AKP. Those who voted for AKP should be thinking about again what they did. Unfortunately, our friends are not going to change in terms of intellect. I mean there is nothing yet there. It is just one of the first meetings of the union here. I do not know how many of them, but 20-25 colleagues came to me said, why I am going to the union meeting, what I am doing, what if I get fired. I mean, there is this thing against the trade union. People freak out instantly, when they hear something about it.

Süleyman reproached his friends, who were hesitant about attending the demonstration, organized by *Dev Sağlık-İş* in Ankara: "They rebuke their situation, they always complain, but they do not claim their rights. And they have cold feet, when I encourage them to defend their rights. What if we get laid off; what if we become unemployed; I don't know what! But for this, we should go and see first, right? How do you decide, without even knowing what's going on. First, you should put some effort. Then, you can ask something positive. You cannot get anything without trying, right?"

In line with my argument in the previous chapter, about the marketization of health care system and commodification of health care services, the subcontracting practices emerge as a technique of governance, which gives an absolute bald form to health care work by divorcing it from every sorts of protection. These processes, in

parallel with the requirements of neoliberal transformation of health care, could be read in a Foucauldian way that in the contemporary culture the human beings are made subjects.[153] The health care work is subjugated to the principles of cost-containment and efficiency imposed by hegemonic neoliberal economy. This recipe, on the other hand, is presented as the inevitable and the necessary. Furthermore, according to Rainbow Foucault's first of 'three modes of objectification of subject' is called "dividing practices". He argues that the objectification of subject manifests through a process of division either within himself or from others. 'Essentially,' Rainbow argues, 'dividing practices are modes of manipulation that combine the mediation of a science and the practice of exclusion.[154]

However, it should be underlined that this study explores the transitionary process to the commodified health care work, in which more and more government jobs are eliminated and subcontracted work manifests itself. Here, what I have witnessed was the (re)emergence of the Marxian naked labor next to the protected, secured form of health care labor. On the other hand, the co-existence of two forms of employment creates a schism among the health care personnel, based both on the socio-economic deprivation and socio-psychological deficiency of subcontracted workers. Hence my argument follows that the marketization of health care work imposes rendering the health care work as a naked form, 'freed' from every sort of benefit –particularly establishing it on a short-term contract basis. That's the critical turning point, which will in the near future jeopardize the sake of health care provision.

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[153] Michel Foucault, "Nietzsche, Genealogy, History", In *The Foucault Reader*, ed., Paul Rainbow (New York: Pantheon Press, 1984), P. 95.

[154] Paul Rainbow, *The Foucault Reader* (New York: Pantheon Press, 1984), 8.

Aysel, despite her young age, has been working as a nurse for 18 years. Before her resignation she worked at a public institution for 4 years. Later, she worked at different private health care institutions in different cities for a long time. Now she is working at Çapa as a subcontracted nurse. Her experience in both public and private sector was informative for me to comprehend how health care institutions in Turkey work from within. When I first asked her: "So, you are back to public work after 13 years?", she replied that she is not back to public work, "I am working as a subcontracted nurse"; emphasizing working at a public institution without being a public servant, i.e. government employee. Probably, thanks to her long experience in different parts of the field or being political awareness of the situation –she is one of the important activists of *Dev-Sağlık İş*- she made striking analyses about subcontracted work and its reflections to the everyday encounters within the hospital. Here, I think it is necessary to give a rather long quotation from her:

> "Even when people introduce each other, they always mention whether the person is on subcontracted work or permanent employment. For instance; Taylan is a *kadrolu* –government employee- and Aysel is subcontracted. People say this when they introduce someone with others. Do you understand what I mean? These forms of status are becoming an attachment to the people. There is no teamwork here. You have already been destroying the integrity. I do not say that people have bad intentions in doing this. We have been taught this, and we carry out, what we have been taught. We are already experiencing this in terms of working hours. I know that in different departments, this situation is manifested in relation to social circles of the employees. Public servants usually hang out with each other; subcontracting workers have their own groups of friends. Or, regarding the issue of lodging. There are problems regarding sharing the room with the people from other group. People do not want the others to live with them. There are subtle discriminations. In fact, they are so obvious. You have to face with them in their practical life".

All these social and economic inequalities establish a given division among the health care providers, in a sector, which requires the integrity of the personnel the most. What

we witness is a deep otherization and a harmful hierarchization among the people who perform the same tasks and operations as a part of the same institution. Despite this, I have to state that it is hard to argue that the subcontracted workers in general have a hostile attitude towards the government employees. Nonetheless, causal confrontations and interpretations of the unequal status might lead to resentment among the subcontracted workers against the government employees. Sometimes government employees are framed as the epitome of precarious situation.

On this issue, I have witnessed a significant discussion between Halil and Musa. Musa was asserting that the government employees in his department had always been very nice and understanding with him, as well as other subcontracted workers employed in that department. Like Halil, he was also a radiology technician in Emergency Room. Whereas Halil, although in agreement with Musa on that point, he was complaining that the government employees in general were indifferent about the precarious situation of subcontracted workers. Moreover, he stated that they, as subcontracted workers, would not receive any cooperation from the side of government employees in case of confrontation with the hospital management, except for a limited, passive support.

Exit-Entry Practices: A Control Mechanism

The above-described picture shows that the emergence of subcontracting not only imposes in-class division, but also creates a differentiation among the people, who perform the identical tasks in the very same institution. The most obvious consequence of this flexibility, as Sennett argues, is the loss of trust between these people in a complete manner, as well as the deterioration of the adherence to their work. The entry-exit practices play a considerable role in manifestation of distrust and individual solution seeking. They are the main reason of their *non-existence.* The subcontracted workers are

temporary workers, where they have been working for years. They are *not there* on paper; via entry-exit. These practices were part of every conversation I had with the subcontracted workers. I can say that the subcontracted workers occasionally remained silent with respect to their relational deprived position. Yet, almost every one of them is concerned about the entry-exit practices at the end of the contract, if not anything else. For instance, in the beginning of interview Hazal, a laboratarian in Pathology Department said: "In fact we do not have many problems. They regularly pay our social security contributions. Thank God, we do not have any problems regarding that. I have no significant problems, maybe because I am new here"[155]. However, towards the end of interview, she told me about the difficulties of these practices and how she and her colleagues are concerned about the harms that they cause.

Entry-exit refers to the employment of workers for certain amount of time, which never exceeds ten months; and re-hiring at the end of each contract season. Therefore, they are not entitled to the benefits of severance payment, seniority indemnity, as well as right to vacation.[156] However, I have to underline that entry-exit is not a "technology" peculiar to subcontracted employment, but to other forms of flexible employment. It can

[155] Here what Hazal told me about social security payments is provoking. In a country, where according to the figures of Ministry of Labour and Social Security 11 millon people are working informally, i.e., without having any insurance, the authorities do not take action, while the huge debt of SII has been the main topic of discussions regarding the issue. In the last stance, the position where we ended up is that a biologist, who has just graduated from college and working in Istanbul Çapa Faculty of Medicine Hospital, appreciates that she has a no problem in the payments of her social security contributions and rejoices that she does not lack a basic and simple benefit to formal employment.

[156] The organizing specialists, as well as the President of *Dev-Sağlık İş,* Arzu Çerkezoğlu, continuously argue that the severance payments could be obtained via litigation. I consulted this issue to Mehmet Cemil Ozansü, a Research Assistant at Istanbul Universtiy Faculty of Law. He supported the argument of *Dev-Sağlık İş* and pointed to the high probability of the Labor Courts' judgments in favor of the workers in these issues. However, the important point here is that not only in the health care sector, but also in whole sectors, the subcontracted workers and others, who work on short-term contract basis should be enlightened about the issue. As a matter of fact during my interviews, I have realized that only a small portion of workers were aware of the fact that they can attain their compensation benefits via litigation.

reveal as fraudulence in employment documents, as revealed in the study of Birelma. Birelma states that employer accommodates three different companies in a single factory. He manipulates the official documents, as if a different company employs the workers of the factory for a certain amount of time, which does not exceed twelve months. On paper, the workers of a single factory have been employed by a different company of three on a rotation basis, despite their workplace remains the same. The employer, via the recurring entry-exits, attempts to seize workers' right of vacation and severance payment[157].

During my study, I witnessed that the subcontracted workers who had qualified jobs, such as nurses and technicians were cognizant of other job opportunities outside Çapa. It could be argued that they have more opportunities to find jobs somewhere else and quit Çapa than other occupational groups such as cleaning personnel, caregivers and medical secretaries, regarding the recent large investments of private sector to health care, and the following rise of the private health care institutions. However, they are aware of the hard working conditions in private hospitals, especially regarding the working hours. Piraye explained regarding this situation the following: "Continuously, all of them watch over the *privates* [institutions]. They conceive this place as somewhere they can leave at any moment. No one considers here as a permanent place to work for themselves. They are always looking outside of this place. After all, there are shortages of nurses in lots of departments. People are tended to leave as soon as they find another job outside". That's why; she interprets the objective of the extensive raise of 70% given

[157] Alpkan Birelma. *Three Cases of Workers Mobilization in Contemporary Turkey*.

to the nurses during the study, as a concern of finding nurses to work, as well as keeping the ones they have; of both the firm and university

Bearing this in-between position of them in mind, there is another issue, which hurts them significantly: since, according to the law, it is illegal to outsource the employment of the supportive health care providing personnel, whose job is among the main undertakings of a hospital; not a temporary task, rather permanent, on the written agreement they are referred as *temizlik elemanı* (cleaning personnel). In other words, in order to circumvent the restrictions of the law regulating the subcontracted work to temporary and non-fundamental tasks, the company and dean's office in collaboration violate the Labor Code, in order to be able to employ subcontracted nurses, technicians, laboratarians, etc.

Emotionally, this situation creates harmful effects, particularly –according to my observation- on nurses. If the nurse was aware of the fact that she is a janitor on paper– because sometimes they had no idea about this situation- I observed the resentment in their silence and willingness to change the subject. Although they have graduated from schools of nursing or vocational high-schools on nursing; however not being seen as nurses and not being referred as nurses, affects the relationship between themselves and their vocation negatively. Especially, recently graduated, relatively idealist, young nurses, the situation exacerbates with the lack of satisfaction from the work; therefore leads to a tremendous feeling of disappointment.

Here we see what Sennett and Cobb argued that since having a white-collar job and being a qualified employee is understood as a personal development and success in the culture of new work, the people are tended to consider that the reasons behind the problems and disappointments they experience in that particular job are their own

personal failure and individual ineptitude of taking advantage of the opportunities provided by that particular privileged position.[158] In their book, *The Hidden Injuries of Class*, Sennett and Cobb argue that the white collar workers, who have respectful and acknowledged jobs and symbolically in a superior status within the society; –what they call "badges of ability"- experience profound traumas and get into a personal questioning, in the case of failing to meet the necessities of these jobs and unsuccessfulness.

This constant lack of confidence and anxiety leads workers to develop hopes for the impossible and build castles in the air. They also start looking for 'alternative', better-said informal ways of getting guaranteed jobs. I was able to observe this in the sub-text of the statements of the workers during my interviews. However, I owe this analysis mostly to *Dev-Sağlık İş* organization experts Kazım and Piraye. Kazım explained this situation as the following:

> "Three or four times a year, different rumors spread among the workers. Stuff like; they are going to give positions to these many people. They are going to distribute positions permanent cadres to that many people; they are going take all of us to the university positions. Things like that. Couple of times a year they reckon these fictitious rumors. In the end, these delusions, dreams, hopes cause deeper disappointments after they realize the rumor to be a bubble. It is obvious nothing is going to change from the beginning, however, yet they still follow these tantalizing hopes. Since these rumors are always intermittent, they influence the collective adversely; the situation disrupts the class struggle in the hospital. People long for a never-coming pleasing news".

Piraye mentioned another issue regarding this: "They never take a breath. Ceaselessly, they go and talk with professors and ask for personal favors from them, just with a little

[158] Sennett and Cobb, *Hidden Injuries of Class,* pp. 179-181

hope of an improvement in their situation. They beat paths to professors' doors. However, the professors are not in a position to help them. They have nothing to do".

The Ritual of Documentation

What the subcontracted personnel live through is being pushed to the margins of the hospital and the health care system in general. And they find it sometimes unbearable. These workers are constantly haunted by the tension of membership/belongingness; the term used by Poole in her study on experience of citizenship and its relation to the understanding of nation-state in margins of the Peruvian state.[159] They work in Çapa; although they have been working in Çapa for years, however, they are not *Çapalı*. The future of theirs regarding their jobs is always cloudy. On this issue Piraye said: "For God's sake! Is it possible that someone would spend here 19 years with the fear of being laid off?" She was talking about an old caregiver, who has been working in Çapa for long time as an employee working in the cadre of University Foundation, who ultimately had to be transferred to the staff of subcontracting firm, as a result of a legal regulation about the foundations.

As it is argued above, the introduction of subcontracted practices leads to a bundle of negative effects from the deterioration of social and economic benefits of the workers to the loss of pleasure and joy of providing health care services; saving lives of people. The existence of entry-exit forces workers to renew and resubmit their documents for the never-ending repetition of bidding.[160] Submission of the photocopies of identity cards,

[159] Deborah Poole, "Between Threat and Guarantee: Justice and Community in the Margins of Peruvian State" in *Anthropology in the Margins of the State,* eds. Veena Das and Deborah Poole (Santa Fe: School of American Research Press, 2004), pp. 35–65.

[160] During my study in Çapa, because of the delays occurred in the previous contract season, Dean's Office and the new firm signed a contract, to be started on January 1, 2008. However, because of the appeal of the losing firm, the signed contract could not be put into the effect. In the meantime, the workers

diplomas, several documents taken from the *muhtar*, etc., which is pretty much required for all kinds of official procedures and employment process in Turkey; this "ritual of documentation", has become an ordinary routine of the lives of subcontracted workers. The subcontracted workers are tired of being obliged to resubmit all the necessary documents to the subcontracted firm in every renewal of the contract, which happens more frequent than usual as I described above. The time they spend to gather these documents; plus the money they spend became extremely annoying for them.

In order to get those documents, they have to leave the work –which is another difficult issue for them- and visit the civil registry offices, *muhtars*, national education directorates for diplomas, clinics for their health care monitoring and miscellaneous offices. Galip told me the previous story during the re-submitting of the documents: "They made an agreement with a clinic in Haseki for the medical screening. They necessarily ask for screening documents from that particular clinic. And they do not accept the ones we took from dispensary of tuberculosis –*Verem Savaş Dispanseri.* They took 60 liras from each one of us. And it was around 10 liras at the dispensary. Think about it, how many of us we are here. They made enormous amount of money. But I said; I went to them and I said, I wonder how are you going to spend this much money now". Ahmet, working as a caregiver at the Emergency Room: "Now, they ask for public notary approval for every copy of document. You know how expensive the notary fees are. They gave us chickenfeed of raise recently, and now they discover new ways for us to waste that". Rukiye said: "We spend all our money to this thing. Every time we

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are employed via temporary one-month contracts. Finally, a new contract came into effect, only on July 1, 2008; resulted the lay off of 88 workers.

start from scratch. They don't even have a file of us, nor a record. This thing eats up all our money and time".

Let me repeat what I said in the previous paragraph: There are no files, nor dossiers kept at the hospital for the subcontracted personnel working at Çapa. They have to re-submit their necessary documents on the eve of every contract, as if they start working there for the very first time. As I mentioned earlier, they do not exist; on paper they are not there. At the most recognized university hospital of Turkey, at the center of Istanbul, there are not a single paper of information about the workers, employed there via subcontracted practices; nor there is a data-base for the screening of the health situation of these workers, nor they receive any protective vaccines or regular medical monitoring, whereas at the same time these workers are exposed to different kinds of diseases from thousands of people and to medical wastes of a big university hospital. Needless to say the necessary sanitary conditions for them are not supervised at all, due to their *non-existence* at the hospital.

As a final point, I want to state that as people working at a hospital as health care providers, the subcontracted workers are not allowed to get medical treatment at their own hospital. They are deprived of the right to get any kind of consultation, examination or treatment in the hospital, where they have been working. When I first learned this, I could not restrain my astonishment. Halil started laughing, when he saw the expression: "Of course, my friend. What were you assuming? Would they take us in as patients after making us to work under these conditions? No way!" When I asked him and other subcontracted workers, what they do, they usually replied that they usually go to the clinics they had in their neighborhoods or to public hospitals if necessary. I also heard stories that in case of serious diseases, which require a close attention or special

treatment, some subcontracted workers might ask the professors they personally know for favors. However, these rare incidents should only be seen as exceptions proving the rule.

Conclusion

In this study, I have tried to get into the details of the lives of the subcontracted workers and try to provide a comprehensive analysis of their subject positions in relation to the general transformation in the health care system. I opened up the experiences of the changing notion of health care work in respect to the everyday encounters and the self-positioning of health care providers. The redefinition of health care service, followed by the restructuring the health care work is analyzed in relation to the bigger picture of neoliberal transformation of the state.

Following Sharma and Gupta, in the new era, I argue the state establishes an unprecedented form of relation to its subjects, while reinstituting its position.[161] In other words, the state asserts its dissociation from health care field. Thus, following the change of general understanding that the state does not represent itself as the employer and the provider anymore, it deserts the public space leaving it to the forces of market, i.e. to flexible, to insecure and to temporary employment. Once again, I have to underline that efficiency, cost-containment, quality and competitiveness are the main principles, upon which the ideology behind this transformation relies.

However, there is another aspect that should be realized regarding the working conditions of health care workers, which has been portrayed as the very consequences of the subcontracting practices. Although I framed these practices brings marginalization of

[161] Sharma and Gupta, *The Anthropology of the State.*

the workers with regards to health care and representations of state, it is hard to argue that the subcontracted health care workers represent the most marginalized type of work, when we take other sectors of Turkish economy into consideration. To clarify my point I will refer to two significant and widely debated sectors: the apparel industry and the shipbuilding yards.

Yörük's study on apparel producing workshops dispersed over the city of Istanbul reveals the experiences of apparel sector workers at the lowest segments of the global apparel commodity chains. The workshops recruit their workers mostly from informal markets, a practice which not only leaves them desperate in terms of job-security, but also deprives them from any form of social security system. By focusing on the workshop system of Istanbul apparel industry in its articulation with the global apparel commodity chains, Yörük argues that this workshop system is 'embedded in a set of power and exploitation relations in reference to the global transformations in production processes'.[162] And the workers in the trapped in these power and exploitation relations represent one of the most marginalized groups of people within the Turkish economy.

The second sector I want to mention is the shipbuilding industry. In their provocative study on the controversial shipbuilding yards in Istanbul's Tuzla district, Odman and Akdemir unfolds the hidden story of social and economic relations behind the Turkey's one of the most successful export investments. In the study, they examine the forms of class positions in the Tuzla yards' zone articulated within the hometown

[162] Erdem Yörük, *Social Relations of Production within the Workshop System in Istanbul's Apparel Industry*, Unpublished M.A. Thesis. Boğaziçi University, Istanbul, 2006.

fellowship and the global shipbuilding industry.[163] Odman and Akdemir provide us a great analysis of the relations of power and class, where in which the subcontracting practices emerge as the main form of employment. The significant fact is that up to date, in Tuzla yards' zone 120 workers have been deceased because of the lack of safety precautions in the yards; most of them being unprotected subcontracted workers.[164] This issue has been occupying the agenda of the Turkish socio-political debate; however it is hard to say that the authorities are inclined to promulgate an effective regulation for establishing vital safety measures in the Tuzla zone.

Arguably, the workers in these sectors are the most marginalized sectors of the Turkish working class in terms of their informality, lack of access to social security services, long working hours and dependence on the mercy of the employers, as well as the latter's constant risk of death resulting from the working conditions. They have been exposed to most atypical forms of employment deriving from their informal status. In comparison to those workers, subcontracted workers might seem to be in a better situation, although they lack a bundle of benefits *normal* workers possess. Nonetheless, they have crucial importance regarding the fact that they are embedded in the recent greater transformation of state and its policies in the Turkish context.

By setting the theoretical basis on the notion of the marginal positions of these workers, I do not argue that the most marginalized section of the Turkish class structure is the subcontracted health care workers. Although, according to Labor Law, the employment of supportive health care personnel via subcontracting practices is illegal,

[163] Aslı Odman and Nevra Akdemir, "Tuzla Tersaneler Bölgesi'nde örülen ve üstü örtülen sınıfsallıklar", *Toplum ve Bilim*, Vol. 113, No. 3, 2008.

[164] Birgün Daily, *Tuzla Ölüm Kampında Bir Cinayet Daha İşlendi*, 20 February 2009.

in the last stance the subcontracted workers are not part of the informal economy, which occupies more than the half of the Turkish economy. Therefore, their position should be analyzed in a wider context of a change in the welfare policy of Turkish state, which manifests itself through creation of a health care market, both for services and providers. Their marginality stems from their current in-between position of being not state employees in a public institution; a situation which is closely attached to the transformation of the public nature of health care in Turkey.

On the other hand, the aim of this study is to explore the everyday encounters of the health care providers as a direct result of the dividing practices articulated with the greater picture of health care "reform". Following the Sennettian approach to the personal consequences of work in the culture of new capitalism[165], I have answered the questions how the subcontracted workers perceive their own situation; how they react to it both collectively and individually; how they associate themselves with their work of health care provision and their colleagues, in articulation with the wider policy changes and discourses introduced in the field of health care.

[165] Sennett, *Corrosion of Character*, 1998; *The Culture of New Capitalism*, 2004.

CHAPTER 5

CONCLUSION

The recent developments in Turkish health care structure deserve academic interest, particularly in respect to the changing epistemology of health care service, as well as the relationality of state to the phenomenon. In this I have analyzed the general –and ongoing- transformation in health care system in a brief manner relying on the existing literature on the erosion of the welfare state and health as a social right. These works in general follow the dichotomy of social right versus commodification in the analysis of health care and welfare in general with an emphasis on the need of publicness. They underscore the necessity of handling health care issue from a vantage point of common good, which should be centrally and equally distributed on citizenship basis, rather than multi-partite structures based on employment and premium basis provision. It goes without saying the work of T.H. Marshall had set the framework for further scholarly analysis of social rights as part of citizenship. Obviously, scholars like Mann, Fraser, Buğra and Leys in different extents adopted the discourse of Marshall and developed it from different aspects and for various contexts.

The main contribution of this literature is to place the social right versus commodification dichotomy into neoliberal context and articulate the recent developments in health care with the characteristic of neoliberal period. Obviously, the ideas and the ideology of neoliberal period are central in order to initiate an assault against existing welfare states via underlining the particularity of individuality, freedom of choice from a variety of alternatives, accompanied by the more economic principles such as the necessity of cost-containment; efficiency and inability of the state in

achieving it; the lack of monitoring of patient/customer-satisfaction and finally –mostly as an appropriate criticism- problems in access and provision of medical services. The same tendency has manifested itself in Turkey as well, with the continuous conceptualization of decades-old structures and institutions of public services as cumbersome, inefficient, non-egalitarian etc. In respect to health care, the structure is marketized through joining of private sector to the picture and autonomization of public health care institutions, as well as deprivation from central budget, which would force them to adopt measures abandoning the notion of public good and ethos of saving people's life, but profit-maximization in order to survive financially. As I made clear throughout the thesis, despite the fact that health care never had a universal nature in Turkey and was never provided for free for everyone and there were many who were not at all covered by social security, it was nevertheless not based on market principles and it was embedded in a loose form of publicness with capital problems of access and quality, as well as equal distribution.

This point brought me to the main objective of thesis. In order to achieve the profit-maximization and cost-containment a new method of employment model has introduced, which will eliminate the protected, long-term employed personnel: the subcontracting. For this I focused on the neoliberal understanding of work and how the notion of work is defined by the neoliberal phase of capitalist mode of production. On this point, Sennett's argument is central in terms of defining the new culture of capitalism in relation to passage from secure to insecure work; from routine to flexible model of employment. In addition to that Sennett's and to a lesser extent Standing's analysis of the effects of this insecure, flexible and temporary employment models on the individuals. The experience of subcontracting obviously is not a new phenomenon.

Yet, prior, the notion has been discussed in the sphere of industrial production. In this context the subcontracting manifests itself in a public service production area, which I argued, paves the way for dismantling of this particular service of health care. Moreover, this "reformation" of the employment model should be conceptualized as one component of a wider transformation in the regime of public employment. In other words, the flexibilization and commodification of labor is not qualified for health care sector. This transformation is expectant to pose new questions for further discussion of the relations of state and society in contemporary Turkey.

The model of subcontracting is embedded in the general transformation in the area of health care. At the time, the model was introduced only in university hospitals, where not only cleaning services, but also every kind of supportive and secondary-medical employees were started to be employed via subcontracting practices. Following Sennett's analysis and methodology I developed an argument, which relied on the daily encounters and particular narratives of those subcontracted workers in relation to the changing environment in health care. This gave me the opportunity to observe the reflections a neoliberal transformation in a public service sector through the primary subjects of this transformation. The perceptions of these workers about themselves and their relationality with their work and institutions uncloaked new subjective positions articulated with the deprivation from socio-economic rights and being secondary-class employees in the hospital, which reflect harmful emotional effects of flexible employment. This situation signifies a new form of neoliberal governmentality, in which although the state seems to desert the space of health care in the first glance, in fact it establishes a new form of divisions and disparities through commodification of health care labor and marketization of health care services.

This is mostly related to the period, in which this study has been conducted. Though the primary argument of thesis derives from the neoliberal restructuring of health care establishment and anticipates the complete manifestation of commodification of health care labor in the very future, the particular period coincides a transformation period, in which the newly employed subcontracted workers and senior government employees coexist. Thus, the subjectivity defined above involves the rhetoric of "class within class," where in which the subcontracted workers feel the pressure of otherization and hierarchization in respect to their government employee colleagues. The subcontracted workers are marginalized in respect to the work environment and their coworkers, since they *exceptionally* work in a public institution as non-public employees from the point of view of that particular institution.

To this we should also add the ambiguity of the position of subcontracted workers, which forces them to abandon any expectancy from the future. Needless to say, the contested legal position of subcontracted workers will be decided by the struggle between the propagators of this neoliberal transformation, the private sector whose role has been expanding in the health care sector and those, who are in defense of their rights and benefits. The opposition to the policies of marketization not only leads towards the commodification of health care labor. It also deprives the poor and wider public from access to health care.

That's why the opposition against neoliberal transformation should be a collective one, not that of unions such as *Dev-Sağlık İş* and *Belediye-İş* or doctors' associations. It should comprise non-governmental organizations, citizenship collectives and local organizations and those who argue for a single-payer, universal health care model, where the state budget is the main financier for the provision off health care

services. It goes without saying that the consequences of this transformation in health care will be on the whole of the society. The introduction of subcontracting practices in a sector such as health care is not only harmful for the very working people, but it is likely to affect the quality and access to health care, since what I have witnessed was that it deteriorates the adherence to work and harms the joy of performing health care work.

In this thesis I have focused on the provider part of the health care services in a particular hospital and gave a brief analysis of recent policy on health care. However, it is important to see how the health care reform is experienced on the other side of the chain, i.e. among the recipients of health care. The health care "reform" comprises changes in several aspects of the system. For scholars, it is important to study and reveal how these changes the access of wider public to health care services. Particularly, I am interested in tracking the situation of poor section of society after the elimination of Green Card scheme and the closure of neighborhood clinics with the introduction of family-physician model in several years.

The health care pie is extending every day, which attracts more investments particularly from the private sector. Along with pharmaceutical industry health care sector balances the total spending in arms industry. At the same time, it becomes a bonanza for social scientists in relation to its social, political and cultural implications on both global and local scales. The ever-expanding sector comes along with new inequalities, new hierarchizations and new class struggles, which deserve the attention of the academia.

APPENDIX

TABLO 4

İSTANBUL TIP FAKÜLTESİ HASTANESİNİN BEŞ YILLIK İSTATİSTİK SONUÇLARI

	2001	%	2002	%	2003	%	2004	%	2005	%
KADRO YATAK	2940		2940		2940		2940		2940	
MEVCUT YATAK	1559		1531		1483		1514		1537	
POLİKLİNİKTE MUAYENE OLAN HASTA	514739		523790	100,00	558811	100,00	561818	100,00	603621	100,00
POLİKLİNİKTE MUAYENE OLAN HASTA TOPLAMI *	428939	100,00								
ANLAŞMALI	1867	0,44	2381	0,45	3033	0,54	2152	0,38	1214	0,20
EMEKLİ SANDIĞI	110457	25,75	136358	26,03	147482	26,39	163924	29,18	182361	30,21
RESMİ	155787	36,32	202077	38,58	215146	38,50	185604	33,04	179603	29,75
SB	40017	9,33	44092	8,42	48027	8,59	47021	8,37	73265	12,14
YEŞİLKART	413	0,10	172	0,03	247	0,04	1725	0,31	4909	0,81
İ.Ü PERSONEL	14856	3,46	19472	3,72	25764	4,61	28699	5,11	24904	4,13
İ.Ü REKTÖRLÜK	786	0,18	582	0,11	550	0,10	495	0,09	451	0,07
İ.Ü ÖĞRENCİ	3139	0,73	4200	0,80	4389	0,79	3116	0,55	2770	0,46
EVRAKLI HASTA TOPLAMI	327322	76,31	409334	78,15	444638	79,57	432736	77,02	469477	77,78
YASAL ÜCRETSİZ	416	0,10	615	0,12	852	0,15	1964	0,35	2871	0,48
ÜCRETSİZ	1426	0,33	517	0,10	559	0,10	253	0,05	32	0,01
ÜCRETSİZ TOPLAMI	1842	0,43	1132	0,22	1411	0,25	2217	0,39	2903	0,48
ÜCRETLİ	99775	23,26	113324	21,64	112762	20,18	126865	22,58	131241	21,74
YATIRILAN HASTA DAĞILIMI	35081	100,00	34159	100,00	34175	100,00	35427	100,00	35666	100,00
ANLAŞMALI	217	0,62	314	0,92	330	0,97	256	0,72	134	0,38
EMEKLİ SANDIĞI	5992	17,08	7483	21,91	7847	22,96	8113	22,90	7813	21,91
RESMİ	12677	36,14	10202	29,87	9257	27,09	8173	23,07	7540	21,14
SB	6840	19,50	7963	23,31	8806	25,77	10076	28,44	11533	32,34
YEŞİLKART	532	1,52	271	0,79	289	0,85	620	1,75	1314	3,68
İ.Ü PERSONEL	729	2,08	668	1,96	712	2,08	709	2,00	662	1,86
İ.Ü REKTÖRLÜK	57	0,16	33	0,10	27	0,08	22	0,06	28	0,08
İ.Ü ÖĞRENCİ	127	0,36	123	0,36	128	0,37	85	0,24	67	0,19
EVRAKLI TOPLAMI	27171	77,45	27057	79,21	27396	80,16	28054	79,19	29091	81,57
YASAL ÜCRETSİZ	20	0,06	29	0,08	35	0,10	116	0,33	169	0,47
ÜCRETSİZ	270	0,77	176	0,52	226	0,66	105	0,30	42	0,12
ÜCRETSİZ TOPLAMI	290	0,83	205	0,60	261	0,76	221	0,62	211	0,59
ÜCRETLİ	7620	21,72	6897	20,19	6518	19,07	7152	20,19	6364	17,84

NOT :* 2001 yılı Poliklinik hasta dağılımı 15.02.2001-31.12.2001 dönemini kapsar.
Beş yıla alt çizilen grafikler bu tabloya ait veriler esas alınarak hazırlanmıştır.

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