AN ANALYSIS OF TURKISH ORAL HEALTHCARE SYSTEM: PATIENTS' PERCEPTIONS AND TREATMENT PATHWAYS

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2021

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Thesis submitted to the

Institute for Graduate Studies in Social Sciences

In partial fulfilment of the requirements for the degree of

Master of Arts

In

Social Policy

by

Sibel Aydın

Boğaziçi University

2021

DECLARATION OF ORIGINALITY

I, Sibel Aydın, certify that

- I am the sole author of this thesis and I have fully acknowledged and documented in my thesis all sources of ideas and words, including digital resources, which have been produced or published by another person or institution;
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ABSTRACT

AN ANALYSIS OF TURKISH ORAL HEALTHCARE SYSTEM: PATIENTS' PERCEPTIONS AND TREATMENT PATHWAYS

Universal Health Coverage (UHC), as a globally set policy target in the United Nations Sustainable Development Goals, offers a unique opportunity for countries to make their healthcare systems more inclusive. However, oral healthcare provision and financial protection in oral healthcare have not been adequately addressed in the literature on UHC, despite its significance for health outcomes. Against this background, this thesis examines patient perceptions and treatment pathways in oral healthcare in the case of Turkey — a country that has achieved UHC and has taken steps to make oral healthcare more accessible in the recent years. In this context, this thesis explores the way the Turkish oral healthcare system shapes patient pathways to diagnosis and treatment. It relies on an explanatory qualitative study that includes 19 in-depth semi-structured interviews conducted in April 2021 with dental patients from a public and a private dental clinic in one neighbourhood in Istanbul. The thematic analysis reveals that four major factors have a significant impact on shaping the dental patients' pathway towards diagnosis and treatment: Dentist stability, perceived dentist responsiveness to patient preferences, medical care costs, and waiting time. Based on these factors, this thesis identifies two distinct patient pathways that the Turkish oral healthcare system has: Shortcut and undefined pathways. Patients willing and able to purchase private services have a direct and fast access (shortcut pathway), whereas patients relying on the General Health Insurance have an unpredictable and meandering one (undefined pathway).

ÖZET

TÜRK AĞIZ VE DİŞ SAĞLIK BAKIMI SİSTEMİNİN DEĞERLENDİRİLMESİ: HASTALARIN ALGILARI VE TEDAVİ PATİKALARI

Birleşmiş Milletler Sürdürülebilir Kalkınma Amaçları'nın küresel bir politika hedefi olarak ortaya koyduğu Evrensel Sağlık Kapsayıcılığı (ESK), ülkelere sağlık sistemlerini daha kapsayıcı hale getirmeleri için bir fırsat sunmaktadır. Bununla birlikte, ağız ve diş sağlığı hizmetlerindeki hizmet sunumu ve finansal koruma ESK literatüründe yeterince ele alınmamıştır. Bu tez, ağız sağlığı bakımında hasta algılarını ve tedavi yollarını, ESK'yi gerçekleştirmiş ve son yıllarda ağız sağlığını daha erişilebilir hale getirmek için adımlar atmış bir ülke olan Türkiye örneğinde incelemektedir. Bu bağlamda, bu tez Türk ağız sağlığı sisteminin hastaların teşhis ve tedaviye giden yollarını nasıl şekillendirdiğini araştırmaktadır. Bu tez, İstanbul'daki bir ilçede bir kamu ve bir özel diş kliniğinden hastalar ile Nisan 2021'de gerçekleştirilen 19 derinlemesine yarı yapılandırılmış görüşmeyi içeren keşfedici niteliksel bir çalışmaya dayanmaktadır. Hastalarla yapılan görüşmelerin tematik analizi, diş hastalarının teşhis ve tedaviye giden yolunu şekillendirmede dört ana faktörün önemli bir etkiye sahip olduğunu ortaya koymaktadır: Sabit bir diş hekimine sahip olmak, diş hekiminin hasta tercihlerine karşı algılanan duyarlılığı, tedavi maliyetleri ve bekleme süresi. Bu faktörlere dayanarak, bu tez Türk ağız sağlığı sisteminde iki farklı tedavi patikası tespit etmiştir: Kestirme ve belirsiz patika. Özel diş kliniğinde tedavi olmak isteyen ve olabilen hastalar hizmete doğrudan ve hızlı bir biçimde erişebilirken (kestirme patika), tedavisini Genel Sağlık Sigortası'ndan faydalanarak almak isteyen hastaların öngörülemeyen ve dolambaçlı bir yol (belirsiz patika) takip ettikleri gözlemlenmiştir.

ACKNOWLEDGEMENTS

First of all, I would like to express my sincere gratitude to my supervisor Assoc. Prof. Volkan Yılmaz for providing guidance and feedback throughout this study. I would also like to thank other members of my thesis committee, Prof. Biray Kolluoğlu and Assoc. Prof. Fatih Artvinli, for their insightful comments, contributions, and feedback.

I owe many thanks to my dear friend Ayşe Altay for her presence, solid friendship, and support from the very beginning of my graduate study. I wish to thank also Ayşenur Cumurcu, Hülya Cumurcu and Zehra Tunçbilek for making beautiful memories with me in this intense academic year.

I would thank to my sister Hatice Aydın for her support. I am indebted to my brother Mahmut Aydın who made my research logistically and practically possible. I am also grateful for him for his selfless and sincere support through all my life. I would like to thank my sister Güler Diren and my dear nieces Semanur, Şehzanur and Ayşenur for their endless support and for making possible for me to focus on my thesis in these unprecedented times.

I would also like to extend my sincere thanks to my beloved fiancé İbrahim Halil Çomaktekin for his unending support, encouragement and understanding.

All praise is for Allah, who has given me the will and strength to study.

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CHAPTER 1

INTRODUCTION

Dentists alone cannot solve the oral health problems of society. During the ongoing process before securing a dental appointment, in the course of the treatment, and afterward the dental examination, the healthcare system, in which the dental patient receives the treatment, is an indispensable part of the procedure. The healthcare system can play a hindering or facilitating role in influencing the health status of the population. This thesis aims to explore how the oral healthcare system shapes patients' care-seeking behaviour and provider choices while receiving dental treatment.

World Dental Federation (FDI) (2020) defines oral health as “multi-faceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex”. Although oral diseases are largely preventable, they affect roughly 3.5 billion people around the world (Peres et al., 2019). Global Burden of Disease (GBD) 2015 study displays that the oral health of the world population has not improved during the last 25 years. Regarding economic burden, dental expenditures currently account for the third largest item of health spending in the European Union, with €90bn compared to €111bn spent on diabetes and €119bn spent on cardiovascular diseases (Peres et al., 2019). The share of expenditures spent on oral disease treatment in the Organisation of Economic Cooperation and Development (OECD) countries accounts for 5% of total health expenditure (OECD, 2013). In addition to economic burden, poor oral health may contribute to social isolation, lower wages, and loss of self-esteem.

The distinctive position of oral healthcare in the context of general healthcare requires further research. This need for further research originates from the fact that oral healthcare system does not always reflect the general characteristics of the healthcare system. Although these are interconnected, there are three main reasons for the different position of oral healthcare: (1) In many countries, oral healthcare is "not fully integrated into the health care system" (Guarnizo-Herreño, Watt, Garzón-Orjuela and Tsakos, 2019, p.47). (2) Private sector has a comparatively larger share in the provision of oral healthcare (Widström & Eaton, 2004). (3) Unmet needs, lack of access, and health inequality in oral healthcare are more pervasive compared to other healthcare services (OECD, 2020). Therefore, achieving universal health coverage in a country may not be reflected in its oral healthcare coverage.

Although dental coverage and universalisation appear as a solution for barriers to access to oral healthcare (Watt et al., 2019), coverage alone may not bring about the improvement of oral health and may not automatically lead to the fulfilment of the needs for and accessibility and accountability of oral healthcare services. Three factors should be considered: (1) The competence of oral healthcare systems including appropriate facilities, and balanced distribution of oral health personnel (Fisher, Selikowitz, Mathur & Varenne, 2018). (2) The coverage of necessary oral healthcare services and the lifting of cost barriers to access to oral healthcare (Matsuyama et al., 2014) (3) The realised publicness that puts an end to providers denying service to publicly covered dental patients (Pegon-Machat et al., 2016). Therefore, the incorporation of oral healthcare into the understanding of universal health coverage is the first step towards better oral healthcare systems. Second, relying on the theory of publicness, accessibility, affordability,

accountability, and equity of oral healthcare services should be secured through public, private sectors, or their combination.

The availability and accessibility of oral healthcare rely on at least two factors: the involvement of the government in financing and planning of oral healthcare provision, and the share of the oral healthcare workforce (Widström & Eaton, 2004). However, increasing share of the workforce may not always bring about enhanced access to healthcare. For instance, Greece has the highest number of dentists per capita (OECD, 2020) yet access to services is highly unequal and patients have to make high rates of out-of-pocket payments due to the predominance of the private sector (Damaskinos, Koletsi-Kounari, Economou, Eaton and Widström, 2016).

The Turkish oral healthcare system provides an exceptional example for its quite inclusive dental coverage policy, the increasing number of dentists per population, and the growing share of public provision in oral healthcare services. To have a closer look at the Turkish oral healthcare system, this thesis searches an answer the question of "how does the Turkish oral healthcare system shape patient pathways to diagnosis and treatment?" For this purpose, through in-depth interviews with dental patients from a public oral and dental health centre and a private dental clinic, this thesis examines three elements of the functioning of the oral healthcare system in Turkey: (1) Dental patients' care-seeking patterns and strategies that shape their pathways to dental diagnosis and treatment; (2) the reasons behind bypassing publicly funded oral healthcare service providers by which quite generous coverage is offered; and (3) the Turkish oral healthcare system's role in shaping dental patient treatment pathways.

In the literature, patient pathway, as a term, has been used interchangeably with the care pathway, treatment pathway, and patient journey, and lacks a common definition. In this thesis, I use Richter and Schlieter's concept of the patient pathway, which refers to "not a predefined, standardised process" but rather "the actual, unplanned journey of a patient seeking health care services to address her/his health conditions" (Richter & Schlieter, 2019, p.993).

Since every patient's experience, needs, and priorities are varied in many respects, analysing the patient's pathway to dental diagnosis and treatment may uncover the pearls and pitfalls of the oral healthcare system. Therefore, to draw a picture of the Turkish oral healthcare system, this study relies on the thematic analysis of the interviews conducted with dental patients. The thesis is built upon a qualitative study that focuses on personal stories of the patients by which their dental care-seeking behaviour and experience are at the centre of the subject.

To our knowledge, not many studies exist tackling dental patients' pathways and perception of the oral healthcare systems. This study, therefore, contributes to the emerging literature on this subject and the incorporation of oral healthcare into the broader studies on healthcare systems and patient pathways. The thesis also offers a well-rounded review of the Turkish oral healthcare system and can make a contribution to comparative or country-specific oral healthcare system studies.

1.1 Research methodology

This research contains two mutually complementary parts. The first part offers comprehensive review of the Turkish oral healthcare system based on secondary sources, reports of the international organisations, legislation, policy papers, official statistics, and reports. The second and the main part of this research relies on

thematic analysis of semi-structured in-depth interviews conducted with dental patients in Istanbul in April of 2020. I recruited the respondents from patients of a private dental clinic (10 persons) and a public oral and dental health centre (9 persons). The participants of the research constitute a heterogenous group with respect to their socio-economic situation and the private dental clinic I chose for this study appeals to middle- and upper-class patients. The two service providers are chosen from the same neighbourhood. The neighbourhood is located in the European side of Istanbul and is one of the second tier developed districts of Istanbul according to socio-economic development ranking (Ministry of Industry and Technology, 2019).

This research was conducted by a dentist who has four years of experience in a public oral and dental centre (full time) and four years in a private dental clinic (part time). While the researcher's professional experience in the system provides an insider view, the discussion of the system by a dentist based on the patients' perspective makes a unique contribution to the existing literature on oral health systems. During the interviews, since the researcher is a dentist, the respondents raise questions about their oral healthcare problems and generally share candidly and comfortably their personal dental treatment stories with her.

Having access to dental patients was not an easy task, despite I am myself a dentist with an experience in both public and private providers. The dentists of the private clinic and the administrators of the public provider were important gatekeepers for this study. One of the dentists from my social circle accepted to open his dental clinic to my research. I went three times to this private dental clinic and took 12 dental patients' consents and contact information. The first respondent preferred to answer my questions via e-mail and quite short, so I excluded this

interview from the analysis. One dental patient gave me an invalid phone number, so I failed to reach her. This left 10 interviews conducted with patients that used this private clinic for dental treatment.

For the public sector, I first negotiated with executives of an oral and dental health centre, and an oral and dental health hospital to get their consent for this study. While the administration of the former gave permission, she decided not to let me conduct interviews when I went there to start the interview process. The administrator of the latter asked me to get an official permission from the Health Directorate of Istanbul, yet I failed to receive one as the Directorate informed me that researchers without institutional affiliation with the Ministry of Health are not allowed to carry out a research due to the COVID-19 restrictions. Under these circumstances, I sat at the open-air garden of the oral and dental health centre and approached the patients coming out of the hospital like pollsters. I collected 6 respondents and received their consent in person with this method. I reached four former dental patients of the centre through my old colleagues with whom I encountered in the garden of the hospital, and I took the consent of the participants over the phone. Only one of the patients did not answer my calls later.

As part of this research, nineteen semi-structured in-depth interviews were conducted through phone calls. Interviews were recorded with the consent of the informants. They were asked questions (listed in the appendix) about their experiences in accessing dental treatment. For this purpose, through interview questions, the respondents were encouraged to share their dental treatment experience in the past as well as present service provider choices.

Interview recordings were fully anonymised during the verbatim transcription process. Inductive thematic analysis was applied to identify the emerging themes

related to the healthcare system-driven factors shaping patient pathways and varied pathways patients have in accessing treatment. Quotes were selected, translated into English and used in the text to substantiate the arguments made in the thesis.

1.2 Outline of the chapters

Following the introductory chapter, Chapter 2 offers the literature review on general and oral healthcare systems, universal health coverage, and the theory of publicness. In addition to this, this part of the thesis presents different country examples of oral healthcare systems. This chapter is concluded with an overview of the literature on patient pathways in general and oral healthcare. Chapter 3 offers an overview of the main characteristics of the Turkish oral healthcare system and its comparison with the other OECD countries. The chapter pays special attention to the situation of the Turkish oral healthcare system afterward the launching of the Health Transformation Programme (2003) and examines the aspects of provision, access, financing, dental education, and workforce capacity of oral healthcare in Turkey. Chapter 4 offers the analysis of the interviews conducted with dental patients and presents four themes that emerged from the analysis: Dentist stability; perceived dentist responsiveness to patient preferences; medical care costs; and waiting time. Chapter 5 discusses the findings in relation to its contribution to the existing literature.

CHAPTER 2

ORAL HEALTHCARE IN THE CONTEXT OF HEALTHCARE SYSTEMS FROM THE PERSPECTIVES OF UNIVERSALISM AND PUBLICNESS

2.1 Introduction

This chapter has two objectives. First, it presents an overview of the literature on healthcare systems and universalism in healthcare with a special focus on oral healthcare. Second, it introduces the key concepts that this thesis relies on in examining the state of oral healthcare in Turkey. To achieve these objectives, this chapter starts with descriptions of healthcare and healthcare systems. Then, through giving a historical background of healthcare systems, this chapter offers an overview of current healthcare systems. Following this, recent directions in the present healthcare systems are investigated with country specific examples. Then the chapter offers a brief summary of common oral diseases and the importance of oral healthcare. This chapter continues with an examination of the concept of publicness in healthcare and the emergence of universal health coverage as a global policy target. After discussing the potentials for universalisation and strengthening publicness of oral healthcare, this chapter explore the concept of patient pathways in the literature.

2.2 Healthcare systems

Healthcare refers to the goods and services provided to individuals or communities by agents of the health services or professions to promote, maintain, monitor, or restore health, and prevent, alleviate or eliminate ill-health (Last, 1993; Culyer, 2010). Donev, Kovacic and Laaser (2013) suggest that healthcare is a “societal

effort" that "attempts to guarantee, provide, finance, and promote health" (p.3). Healthcare services are provided by health professionals, for the purpose of promoting, maintaining, or restoring health. Moreover, healthcare services contain measures for health protection, health promotion, and disease prevention (Culyer, 2010). World Health Organization (WHO) defines health services as "any service which can contribute to improved health or the diagnosis, treatment and rehabilitation of sick people and not necessarily limited to medical or healthcare services" (1998, p.45). Mosadeghrad (2013) suggests that healthcare service is an intangible product, which means "cannot physically be touched, felt, viewed, counted or measured like manufactured goods", it is often "difficult to reproduce" and "healthcare services are simultaneously produced and consumed and cannot be stored for later consumption" (p.204).

Healthcare systems involves "all the activities whose primary purpose is to promote, restore and/or maintain health" and in these systems "the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve" and through these activities and agents, systems respond to "people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health" (WHO, 2012, p.9).

Historically, healthcare systems emerged as subsystems of broader welfare systems and it is still a useful approach today to explain the historical background and foundational principles of healthcare systems through social policies (Hassentaufel & Palier, 2007). According to Hassentaufel and Palier (2007), varied systems of social insurance constitute main characteristics of welfare states and,

therefore, the reforms of healthcare systems and social policy reforms are often interrelated.

Regarding healthcare systems, OECD's (1987) classical tripartite typology of healthcare systems offers not only the historical background of healthcare system developments but also a reference point to uncover the differentiation, the transformation and the evolution of the healthcare systems among OECD countries. The OECD (1987) classified healthcare systems according to the extent of coverage, the mode of financing, and ownership. Three main models of healthcare systems that OECD offers are Social Health Insurance (SHI) model (Bismarkian) that is known for compulsory health insurance and being related to income, and exemplified by Germany; National Health System (NHS) model (Beveridgean) that is based on state budget sourced from taxation and not related to income, and the UK is the role model for this system; and Private Health Insurance (PHI) model that is characterised by private insurance and funding, and the USA is featured for this system (Donev et al., 2013). All three social protection systems lay the foundations of current healthcare systems and illustrating the expanding role of government and various mechanisms to guarantee the sustainability of financing and delivery systems. In terms of regulation, SHI model systems internalize the corporatist approach as a way of regulation through non-governmental actors in which networks and collegiality are crucial components of governance. In the SHI system, the main source of funding is contributions and delivery could be public or private, whereas in the NHS system funding comes from general tax revenues. Conversely, coordination and governance in NHS systems have a statist character in which state-based actors play the main role, in the command-control system environment and through a hierarchical order.

On the other hand, in PHI systems, the type of regulation is private, and the market appears as a typical regulatory mechanism (Böhm et al., 2013).

"The classificatory models" that emerged from welfare systems paved the way for comparative healthcare research and typologies of healthcare systems (Steffen, 2010). To begin with the classification of welfare states, Esping-Andersen's seminal work, *The Three Worlds of Welfare Capitalism* (1990), displays an analysis of 18 the OECD countries regarding decommodification of welfare components; the effects of welfare states to social stratification; and the roles of the state, family, and market in welfare provision. Esping-Andersen (1987) defines decommodification as "the extent to which individuals and families can maintain a normal and socially acceptable standard of living regardless of their market performance" (p. 86). The comparison of welfare regimes in Esping-Andersen's work is particularly based upon three cash benefit programmes: Pensions, sickness benefits, and unemployment benefits.

Although it fails to include healthcare as a core dimension of welfare systems, Esping-Andersen's work paved the way for alternative welfare typologies based on healthcare (Bambra, 2007). According to Bambra (2005), regarding classification of welfare regimes, taking into consideration only cash benefits and disregarding service delivery may lead to overlook the actual characteristics of the welfare regimes. Therefore, Bambra (2005), beside cash benefits, takes into consideration healthcare services of the countries and compares and contrasts them not only according to cash benefit index (which is based on pensions, unemployment and sickness cash benefits) but also to the tripartite healthcare index: (1) Private health expenditure as a percentage of Gross Domestic Product (GDP); (2) private

hospital beds as a percentage of total bed stock; and (3) the percentage of the population covered by the healthcare system.

Based on the abovementioned indicators, Bambra builds healthcare decommodification index. Bambra classifies 18 countries into five types: Liberal, Conservative, Social Democratic, Conservative sub-group, and Liberal sub-group. In Liberal regime countries, such as Australia, Japan and the USA, both cash benefits and welfare services are at the low level. On the contrary, in social democratic regime countries, such as Finland, Norway and Sweden, both cash benefits and welfare services are at high levels. Ireland, New Zealand, and the UK, as liberal sub-group regime countries, stand out with being highly reliant upon welfare service than cash benefits. On the other hand, in conservative regime countries, such as Austria, Belgium, Canada, Denmark, France, and Italy, cash benefits and welfare services share similar scores but not at high levels as the social democratic welfare regime countries. Germany, Switzerland and the Netherland, as conservative sub-group regime countries, are characterised by high levels of cash benefits comparing to welfare services. Bambra's (2005) typology reveals that healthcare systems are at the centre of the welfare regimes; therefore, different healthcare policies and systems define certain and common characteristics of countries.

According to an updated typology, developed by Rothgang, Cacace, & Wendt (2005) and elaborated by Wendt, Frisina, & Rothgang (2009), healthcare systems can be categorised into three: state, societal, and private systems. Therefore, three core dimensions (regulation, financing, and service provision) accompanied by three types of actors (state, societal and private sector) bring about 27 different combinations regarding healthcare systems (Rothgang et al., 2005). However, according to Böhm, Schmid, Götze, Landwehr and Rothgang (2013), there is a hierarchy between core

dimensions of the healthcare systems and the 'regulation', for instance, plays the leading role and followed by the 'financing' and lastly the 'service provision'. Therefore, 'hierarchy rule' restricts the theoretically plausible types to 10. Böhm et al. analyse 30 OECD countries according to the hierarchy rule, and they identify 5 system types: The National Health Service, the National Health Insurance, the Social Health Insurance, the Etatist Social Health Insurance and the Private Health System (2013).

Following Rothgang and Wendt (RW) typology, Wendt (2009) suggests a new typology in his study "Mapping European Healthcare Systems" in which health expenditure, public-private mix of financing, privatisation of risk, healthcare provision, entitlement to care, payment of doctors and patients' access to providers are accounted as key dimensions of healthcare systems. Wendt (2009) investigates 15 European countries and distinguishes three types of healthcare systems: Health service provision-oriented type; universal coverage-controlled access type; and low budget-restricted access type. According to Wendt (2009), Austria, Belgium, France, and Germany are countries that embraced health service provision-oriented type healthcare systems. This type is mainly characterised by "high level and unquestioned importance of service provision especially outpatient sector" (p.441) and in this system, the number of service providers is high, out-of-pocket (OPP) payments[1] are at the low level and patients have free choice of and free access to doctors. Denmark, Great Britain, Sweden, Italy, and Ireland emerge as countries with universal coverage-controlled access type healthcare systems. Although this type of healthcare system is mainly characterised by universal health coverage, the state regulates decisively the patients' access to healthcare providers. Furthermore, though

1 Out-of-pocket payments refer to "the expenditures borne directly by a patient where neither nor private insurance cover the full cost of the health good and service" (OECD, 2020).

patients may have to wait a longer period of time to access physicians, the system is popular owing to the equity of access, and the total population is covered, and out-of-pocket payments are quite low. Lastly, Portugal, Spain, and Finland are the countries that preferring low budget-restricted access type healthcare systems in which total health expenditure per capita is particularly low. In this type of healthcare system, the presence of direct private and high out-of-pocket payments limit patients' access to healthcare. Therefore, equity of access to care is threatened especially for lower-income groups.

2.2.1 Recent directions in healthcare systems

Following the 1970s oil crises, the role of the state in regulation, financing, and provision of healthcare was challenged. Since routine mechanisms fail to solve unprecedented challenges that welfare states face, healthcare systems started to converge and followed a sort of “hybridisation” trend (Schmid, Cacace, Götze & Rothgang, 2010; Beckfield & Olafsdottir, 2013; Hassentaufel & Palier, 2007). Convergence implies “growing more similar over time”, though “not necessarily becoming identical” (Schmid et al., 2010, p.457). States, simultaneously, aimed at changing “the logic of institutions” rather than the institutions themselves, which refers to a conversion type of change (Hassentaufel & Palier, 2007). In a similar way, hybridisation brings about a kind of convergence that “the uniqueness of certain features disappeared” (Rothgang, 2010, p.21). For instance, Doetter et al. (2015), in examining healthcare system changes in five OECD countries (England, Italy, Germany, the Netherlands, and the United States), suggest that regulatory structures are becoming hybrid in all these countries. Such hybridisation trends are visible in the “the use of competition through internal markets”, “decentralisation in national

health systems", "the introduction of quasi-markets in SHI systems", and "the development of instruments of hierarchical control in private insurance markets, accompanied by the introduction or expansion of public schemes for the uninsured" (p.244).

Similar to Doetter et al. (2015), Schmid et al. (2010) claim that the state's place in the new distribution of the roles in OECD healthcare systems brings together "convergence in the financing, common trends in service provision, and the regulatory hybridisation of systems" (p.460). Therefore, novel typologies have raised not only because the previous three-pillar typology of OECD ignores the possible combinations that may emerge from varied models (Steffen, 2010), but also clear boundaries among the three ideal healthcare system types have disappeared. Attempts to re-classify healthcare systems generally adopt a comparative approach, in which regulation, financing, and service provision form the core dimensions (Wendt et al., 2009).

Inefficiency problems and fiscal austerity pave the way for privatisation in service provision and increasing private sources such as patient co-payments. During the 1970s, due to ageing populations especially in the Western European countries, healthcare expenditure increased excessively, and following this, in SHI countries, state-driven cost-containment policies are adopted. In France, for instance, since the 1980s, implicit privatisation is in practise in which private providers start to take a considerable role in the provision of outpatient services (Schmid et al., 2010).

In this new era, states adopt structural changes in healthcare systems without undertaking revolutionary reforms, they strengthen the regulatory role of the state while reducing its financial responsibilities or its provider role (Hassentaufel & Palier, 2007; Schmid et al., 2010). According to Hassentaufel and Palier (2007), for

instance, the new regulatory characteristics are visible in Germany, France, and the Netherlands. In these countries, on the one hand, health insurance schemes are used to serve universalisation, on the other, marketisation through regulated competition is introduced in the delivery of the services.

2.2.2 Universalist character of healthcare systems

WHO (2013) defines universal health coverage (UHC) as full access to high-quality services for health promotion, prevention, treatment, rehabilitation, palliation, and financial risk protection. Historically, “universal” did not necessarily refer to “straightforwardly whole population”, for instance, Bismarck’s scheme (1882) in Germany “universal adoption of sickness insurance" was aiming at the participation of industrial workers in sick funds (Gorsky & Sirrs, 2018). Indeed, the term “universal” requires an emphasis on equity, regarding definition of UHC as “explicitly a gap-narrowing one that prioritises the attainment of greatly improved health outcomes for those who are at present left behind” (O’Connell, Rasanathan, & Chopra, 2014, p.278).

Before the emergence of UHC as a global health initiative, the world witnessed the expansion of healthcare provision and financing through universalisation trend. In the Netherlands, for example, the first universal component was constituted in 1967 and afterward extended, and in 2005, became compulsory for whole population. In France, although the French Sécurité Sociale was introduced in 1945, the system provided insurance only for workers and their families. As the unemployment rates increased rapidly (Pegon-Machat et al., 2016), *Plan Juppé* was introduced in 1995 for universal medical coverage but could not be implemented until the universal health coverage (*Couverture Médicale Universelle* – CMU) was

achieved at the end of 1999. According to this law, all legal residents have the right to health insurance. On the other hand, in Germany, by 2007, the total population was covered thanks to reform that paved the way for the introduction of health insurance for those who lose their private insurance (Hassenteufel & Palier, 2007).

2.3 Oral healthcare

2.3.1 Oral health and diseases

As being an essential and indispensable part of general health and well-being, oral health refers to not only the teeth, but the entire mouth, including the periodontal tissues (gums) and supporting hard and soft tissues (Heilman and Watt, 2018). Therefore, oral healthcare "prevent oral diseases, restore oral function, alleviate pain and discomfort" and, by doing so, help to improve one's appearance, overall well-being, and social communication and relations (Somkotra, 2013, p. 110).

Oral diseases refer to various clinical conditions that affect the teeth and mouth, such as dental caries (tooth decay, cavities), periodontal (gum) disease and oral cancers (Peres et al., 2019). Dental caries is "the result of complex interaction of biological processes on the tooth surface and process in the environment" in which dental hard tissues (enamel and dentin) are damaged "by acidic by-products from the bacterial fermentation of free sugar" (Peres, Peres & Antunes, 2020, p.173). The dental treatment of caries may require fillings by which the teeth is restored by using materials such as metal, alloy, plastic or porcelain after removing carious lesions or root canal treatment (also called endodontics) which aims to retain teeth in which tooth decay or trauma has reached the pulp tissues (the root canal system at the centre of a tooth) (Abdelfettah, 2016; American Dental Association (ADA), 2020). The world prevalence of untreated caries of permanent teeth is 35% of the

population, with this rate, untreated caries of permanent teeth take place as the single most prevalent condition in the Global Burden of Disease (GBD) 2015 study[2] (Marcenes et al., 2013; Kassebaum et al., 2015; Marcenes & Bernabe, 2020).

Periodontal diseases are defined as "chronic inflammatory conditions that affect the tissues surrounding and supporting the teeth" (Peres et al., 2019, p.250). Periodontal treatments aim at removal of bacterial plaque and calculus on the surface of a tooth, that is not surrounded by gingiva, or beneath the gums by periodontal scaling (Bimstein, 1999). The world prevalence of severe periodontal disease is 11%, which makes it the sixth common health problem in the world (Marcenes et al., 2013). Oral cancers generally develop in lips, tongue, gum floor of mouth, palate and cheek mucosa (Peres et al., 2019) and characterised by localisation for neoplasm and presence of tumours (Antunes, Toporcov, Biazevic & Convay, 2020). Moreover, unless prevented or treated, poor oral health may give rise to general health problems due to the bacterial systemic exposure and increased inflammatory factors (Benyamini, Leventhal, & Leventhal, 2004).

Nevertheless, globally, the greatest burden of oral disease is on the disadvantaged and marginalised groups (Petersen, Bourgeois, Ogawa, Estupian-Day & Ndiaye, 2005) and "the current global and regional patterns of oral disease largely reflect distinct risk profiles across countries, related to living conditions, lifestyles and the implementation of preventive oral health systems" (Petersen et al., 2005, p.665). Therefore, there is a persistent "social gradient in the use of preventive dental and medical services among adults" in Europe (Kino, Bernabe & Sabbah, 2019, p.7) and around the world (Cheng et al., 2020; Raittio, Aromaa, Kiiskinen, Helminen &

2 The GBD study "systematically produces comparable estimates of the burden of more than 300 diseases and injuries, and their associated sequelae, by age, sex, geography, and time" (Marcenes & Bernabe, 2020, p.23).

Suominen, 2016; Somkotra, 2013; Palència, Espelt, Cornejo-Ovalle & Borrell, 2014).

2.3.2 Oral healthcare systems

Oral healthcare systems differ regarding service delivery, leadership and governance, health workforce and health financing (Chowdhury & Chakraborty, 2017). Researchers sometimes analyse oral healthcare characteristics of countries under their healthcare system clusters or welfare regime types. For instance, Guarnizo-Herreño et al. (2019) compare oral health inequalities in European countries in accordance with Ferrera's (1996) typology of European welfare regimes, in which Scandinavian, Anglo-Saxon, Bismarkian, Southern and Eastern welfare regimes constitute the main welfare regimes types. Similarly, Sanders et al. (2009) conduct a cross-national comparison of income gradients in oral health quality of life in four welfare regimes (the UK, Finland, Australia and Germany) by using Korpi and Palme's (1998) welfare typology which is based on the coverage (eligibility for benefits) and generosity (benefit levels). However, "it is possible that the welfare regime approach could be less relevant for oral health than for other health outcomes since, in many countries, dental care is not fully integrated into the healthcare system" (Guarnizo-Herreño et al., 2019, p.47). In Italy, for instance, general healthcare is provided through the public National Health System (NHS), whilst the oral healthcare system is nearly entirely private (Widström & Eaton, 2004).

For this reason, researchers develop standalone examining oral healthcare systems according to their unique characteristics. For instance, Widström and Eaton's (2004) study presents, six oral healthcare systems, in 28 member and candidate states of the European Union (EU) / European Economic Area (EEA),

based on regulation and financing: 1) Beveridgean, 2) Bismarckian, 3) The Eastern European (in transition), 4) Nordic, 5) Southern European, and 6) Hybrid. Although the aforementioned oral healthcare system types remind general healthcare system typology, the classification of countries in the former diverges significantly from the latter.

Regarding general characteristics of the different models for oral healthcare, the Beveridgean oral healthcare system is unique to the United Kingdom where independent dentists are contracted with the NHS to provide general dental care (Widström & Eaton, 2004). Historically, covering dental treatment under national health insurance took place after the Beveridge Report (1942) which became the blueprint for modern British welfare state. The report states that "there is general demand that these services should become statutory benefits available to all under health insurance" (p. 854) and underline that free dental service should be as universal as the remaining components of the medical service.

Dentistry was involved in the NHS in 1948 and general dental practitioners (dentists employed by NHS dentistry) agreed a national contract by which they retain independent and self-employed status (Tickle, 2012). At that time, demand for oral healthcare was huge due to the World War II conditions such that more than three quarters of the population over the age of 18 had complete dentures which means they had no natural teeth (British Dental Association, 2020). As a result of "huge amount of unmet need and the efficiency of dentists working on a fee-for-item basis", dental services appeared as a threat for the financial sustainability of the newly established NHS (Tickle, 2012, p.111) and, as a result, patient charges were introduced in 1951.

In the UK, dentist's renumeration policy based on the fee-for-item replaced by a prescribed of units of dental activity in 2006. The open-ended NHS dental budget was restrained and devolved to Primary Care Trusts (local organisations of the NHS) (Freeman, 2008; Tickle, 2012). In this new system, general dental practitioners are remunerated for their certain number of dental activities. As a contract holder and provider, general dental practitioners are independent regarding decision making of the materials and equipment they use, the hours and days they work, staff they employ and how to run their practise (Ahmed, 2019). However, they have a certain number of Units of Dental Activity (UDA) in a year that shapes the funding of the next session. UDA consist of three types of dental practice: Bond 1 (examination, scaling and prevention) in which patients' co-payment fees is £16.50; Bond 2 (fillings, root canal treatments, extractions and gum treatment) in which patients' co-payment fees is £45.60; and Bond 3 (dentures, crowns and dentures) in which patients' co-payment fees is £198. In this system, each group of treatment has UDA per Course of Treatment (CoT), for instance, Bond 1 practices bring 1 UDA per CoT; Bond 2 treatments bring 3 UDA per CoT and Bond 3 applications bring 12 UDA per CoT. Hence, according to this chart, for a general dental practitioner, root filling which is quite more complex and time-consuming treatment than filling have the same yield with fillings, and three prevention practices equal to one extraction (Tickle et al., 2011).

British Dental Association (BDA) (2019) states three priorities for the future of NHS dentistry: access, workforce and prevention. The main indicator to measure to dental access in NHS dentistry takes into consideration the proportion of the population who have attended an NHS dentist in the last 24 mounts (Harris, 2013). West, Stones and Wanyonyi (2020) suggest that "patients often do not attend planned

routine dental appointments. This leads to unmet dental needs, under-utilisation of dental services, lost revenue for dental practice owners" (p.98). According to Freeman (1999), there are four psycho-social factors that take role as a barrier to accessing dental care that "do not act independently of each other but combine to act in unison": Dental anxiety states, financial costs, perception of need and lack of access (p.141). Costs and lack of access appear as directly linked factors to the oral healthcare system. In the NHS dentistry, since only children and pregnant women can get treatment for free, co-payments arise a barrier to receive a treatment. In terms of lack of access, according to BDA's analysis based on the government's General Practitioner survey, regarding feedback from over 350,000 adults, "nearly 1 in 4 new patients (estimated at over 1 million in total) not currently on the books with an NHS dentist have tried and failed to secure an NHS appointment" (2019).

Regarding workforce, BDA (2020) claims that 60% of NHS dentists in England are planning on leaving the NHS dentistry. Target driven culture in the NHS, intensive paperwork and massive underfunding of NHS dentistry are counted as the disincentives of the system for general dentist practitioners (Ly, 2017; Ahmed, 2019). In terms of prevention, according to BDA (2019), NHS dental charges undermining prevention, thus, nearly 1 in 5 patients have delayed treatment for reasons of cost according to official statistics. BDA (2019) recommends a collaboration with professionals for genuinely preventive policy framework.

The Bismarkian oral healthcare system is observed in Austria, Belgium, France and Germany (Widström & Eaton, 2004). Bismarckian systems are heterogeneous. Germany, for instance, differs from other EU member states in terms of the high numbers of practising dentists, dental technicians, and dental nurses. Moreover, 86% of the German population are covered by a health insurance scheme

that includes standard oral healthcare services (Ziller, Eaton & Widström, 2018) and general dental practitioners in the private sector also provide such services.

In France, oral healthcare is based on a fee-per-item model and funded by mix of public and complementary health insurance schemes. In the fee-per-item model, each year, a list of treatment items for reimbursement negotiated by a national body (Caisse Nationale) and a national fixed fee is applicable for each of these items (Pegon-Machat et al., 2016). Oral healthcare provision is predominantly private and there is no nationally organized public dental service in France. However, the majority of the dentists have contracts with the national health insurance institutions (Widström & Eaton, 2004; Sinclair, Eaton & Widström, 2019). In French oral healthcare system, dental treatments are covered mainly three different ways: The first group includes items such as, examination, extractions, restorative dentistry (fillings), endodontic treatment (root canal treatment), radiography, fissure sealing (thin coatings placed over the fissures of back teeth to help form a protective layer) and scaling. In this group, treatments are fully regulated, and the public health insurance reimburses 70% of their fixed cost. The second group consists of items such as, crowns, bridges, removable dentures and orthodontic treatments (if started before the age of 16), and these treatments have a fixed fee, but the practitioner may demand extra charges. The third group includes all other treatments such as, periodontal treatment, implants, consciousness sedation, and they are non-regulated and not reimbursed by the public health insurance (Pegon-Machat et al., 2016). According to Pegon-Machat et al. (2016), although the majority of the population has access to affordable dental treatments, oral health inequalities persist to exist due to the exclusion of “socially deprived people, persons with disabilities, dependent

elderly (absence of accommodation within the system for persons with special needs), persons living in rural areas or areas of suburban poverty" (p.202).

The Eastern European system is observed in Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia. In these countries, oral healthcare was universally free or almost free previously (Widström & Eaton, 2004). Yet with the collapse of the Soviet Union, universal coverage for oral healthcare was abolished (Rao et al., 2014). Today majority of oral healthcare provision is carried out by the private sector (Widström & Eaton, 2004).

Countries with Nordic oral healthcare system consists of Denmark, Finland, Norway, and Sweden. These countries have large public capacity in dental service provision (Widström & Eaton, 2004). In the study of a cross-national analysis of European countries that analyses oral healthcare systems, Guarnizo-Herreno et al. (2013) suggest that, regarding Scandinavian countries (especially Sweden), "the generosity and universalism of their welfare state benefits, appear to be linked to better oral health outcomes" (p.173).

In Sweden, a decentralised health system exists in which the county councils (regions) are responsible for operating and financing healthcare services, including oral healthcare. The Public Dental Service (PDS) takes the primary role in delivering and county tax (a tax mainly sourced from personal income) ensures financing of large amount of oral healthcare services. In Sweden, children's and adolescents' (3-21 years) oral healthcare financed merely by tax revenues of the county councils. However, adult oral healthcare financed through patient fees and national tax revenues. The county councils may contract out with the private sector, especially for adult oral healthcare. In addition to this, 5-15% of children and adolescents are seen by private dentist. For adults, 50% of dental patients receive treatment from private

dentists and 42% from PDS (Pälvärinne, Widström, Forsberg, Eaton & Birkhed, 2018). According to Pälvärinne et al. (2018), in Sweden, regarding oral healthcare, "the public and private sectors continue to complement each other, rather than compete with each other" (p.650). However, the rate of adults who renounced dental care due to the financial reasons is higher in Sweden compared to Germany and the UK (Tchicaya & Lorentz, 2014).

The Southern European model is observed in Italy, Spain, Portugal, and to some extent Greece and Malta. This model is characterised by the predominance of the private sector without state's influence. Insurance schemes do not cover oral healthcare. Public sector offers a few services such as some treatment for children and emergency dental treatment (Widström & Eaton, 2004). In Italy, for instance, the public facilities provide only 5% of all oral healthcare services (Bindi, Paganelli, Eaton & Widström, 2017).

In the hybrid model, publicly funded oral healthcare is available for the children, while, for adults, provision is based on the private sector (Eaton et al., 2019). Ireland is a good example for hybrid oral healthcare system (Widström & Eaton, 2004), where one may observe Beveridgian and Bismarkian features together (Nikolavska, 2008). According to Nikolavska (2008), the Netherlands's system also can be counted as a hybrid oral healthcare model. Turkey can also be counted as one of the hybrid model countries since it relies both on publicly-funded provision and private provision in return for out-of-pocket payments. However, the Turkish oral healthcare system is a rarely seen example with demanding almost zero out-of-pocket payment for the treatments received from publicly funded oral healthcare providers by which quite generous dental coverage is offered and excluding the

private sector from insurance schemes except contracted foundation dentistry universities.

2.4 The publicness of healthcare services

Rather than defining healthcare systems based on the ownership of health facilities as public, private, or their combinations, the theory of organisational publicness offers an understanding of the "continuum of publicness" (Goldstein & Naur, 2005). Although as Powell and Miller (2014) state "publicness is largely absent from social policy literature" (p.593), recently, a growing number of studies (Kang et al., 2020; Min, Lee & Yang, 2020; Meritt, 2014; Miller & Moultan, 2014; Anderson, 2012) shed light on the publicness of healthcare organisations regardless of being public or private. They pave the way for inquiring public values in privately and for-profit organisations as well as in publicly owned facilities.

Anderson (2011) defines publicness as "a characteristic of an organisation which reflects the extent to which the organisation is influenced by political authority" (p.313). According to Antonsen and Jorgensen (1997), publicness is "organizational attachment to public sector values: for example, due process, accountability, and welfare provision" (p.337). Therefore, adopting a publicness lens to healthcare systems offers "a means of exploring key issues in a healthcare organisation, whether they be private, neither or both" (Anderson, 2011, p.321). Publicness is built upon four dimensions: Ownership, goal setting, funding, and control (Goldstein & Naur, 2005).

In the literature, mainly four different conceptual frameworks of publicness are present: Generic, core, dimensional and normative publicness approach. The generic approach, for instance, ignores the potential differences between public and

private organisations and claims that organizational characteristics, such as management values and managerial functioning, are identical for each organisation type (Murray, 1975; Goldstein & Naur, 2005). On the other hand, the core approach suggests that there are certain distinctions between public and private organisations, for instance, the ownership of the organisation (Rainey, Backoff & Levine, 1976; Goldstein & Naur, 2005). The dimensional approach takes into consideration the extent of the political or economic influences on the organisations and its formative characteristics such as ownership, funding, goal setting and control (Bozeman & Bretschneider, 1994; Miller & Moulton, 2013; Min, Lee & Yang, 2020). The normative approach embraces public values as norms and measures the publicness of an organisation according to the scope of adoption of public values (Moulton, 2009).

Due to a large number of approaches available, “there is less clarity regarding appropriate publicness and public service outcomes indicators” (Anderson, 2011, p. 320). Taking into consideration core publicness, for example, indicators of an organisation's publicness refer to ownership and legal status of the institution. On the other hand, dimensional publicness wields the extent of the political and economic authority that the organisation is subject to. While the coexistence of varied approaches and indicators regarding publicness is in question, according to Anderson (2011), different approaches do not have to conflict with each other and can be used in a complementary manner.

Anderson (2011), using publicness theory, finds a direct link between public service outcomes and publicness when he analyses British NHS. According to him, patient service outcomes are targeted together with public values, such as access and choice. At this point, public service outcomes refer to the outcomes based on public values. Therefore, publicness requires fulfilment of public service outcomes. The

measurement of public service outcomes refers to the evaluation of the implementation of public values and objectives. Hence, the measurements of organisational performance such as productivity or budget efficiency are not helpful in evaluating the publicness of the institution (Bozeman, 2007).

According to Moulton (2009), public service outcomes could be carried out by private organisations as well. Thus, for Moulton, publicness is not necessarily a characteristic of public organisations only. Therefore, "realised publicness" occurs, regardless of whether being public, private or other forms of organisation, when "public outcomes predicted in part by institutions embodying public values" (p.889).

Min, Lee and Yang (2020) apply dimensional publicness in the hospital context by taking into consideration the collaboration for community benefits (CCB) of hospitals in the US. They define CCB as "the activities that engage organizations and people across the boundaries of the public, private, and civic spheres to carry out a public purpose that could not be accomplished effectively by one organization alone" (p. 382) and claim that fulfilling CCB is coherent with Moulton's (2009) "realised publicness". In this study of Min et al. (2020), CCB is measured according to four dimensions:

(1) whether the hospital works with other providers to collect, track, and communicate clinical and health information across cooperating organizations,

(2) whether the hospital partners with their local school system to offer health or wellness programs to help the community,

(3) whether the hospital works with other providers, public agencies, or community representatives to conduct a health status assessment of the community, and

> (4) whether the hospital works with other providers, public agencies, or community representatives to develop a written assessment of the appropriate capacity for health services in the community (p.384).

After using primary data from the 2009 American Hospital Association survey for their investigation, the researchers conclude that public and non-profit hospitals have higher scores of CCB that they are more likely to collaborate to enhance community benefits comparing to their for-profit peers. Moreover, “even in an era of sector blurring and privatisation”, public and non-profit organisations continue to take more prominent role in carrying out CCBs (Min et al., 2020, p.388).

Similarly, Zhu and Johansen (2014) examine the effects of three dimensions (ownership, financing and control) of publicness on inequality in the health insurance coverage across 50 American state-led healthcare systems from 2002 to 2010. Healthcare systems vary across states in the US. For instance, in Delaware and New Hampshire, there is no state or local government-owned hospitals, whilst in California and Georgia most hospitals are owned and managed by state or local governments. Zhu and Johansen (2014) argue, “There is a significant and negative relationship between public ownership and inequality in health insurance coverage” (p.422), namely, public financing and control bring about decreasing inequality in health insurance coverage among income groups.

Similarly, Kang, Kim and Jung (2020) examine the effects of organisational and managerial factors of publicness to the equity of healthcare in South Korea by analysing data from 328 general hospitals between 2008 and 2012. The researchers argue, “Government owned hospitals show the better performance for equity than non-profit or individually owned hospitals do” (p. 1). Additionally, receiving government assessments positively affects the level of equity in hospitals. For

instance, hospitals that receive government evaluation illustrate higher levels of equity comparing to hospitals do not receive government assessments.

2.5 UHC as a global policy target

As suggested in the literature on publicness, researchers find that the universalisation of healthcare provision might materialize through the private providers (Agartan, 2012; Rao, Petrosyan, Araujo & McIntyre, 2014). In Turkey, for example, universalisation of healthcare insurance coverage has proceeded hand in hand with the expansion of the role of the private sector in provision (Ağartan, 2012). Similarly, Brazil, Russia, India, China and South Africa (BRICS), where private financing forms a large share of health spending, have followed "different paths to universal health coverage and they began travelling along those paths at different points of time" (Rao et al., 2014, p.430). Hence, countries may adopt different paths towards achieving UHC (Rao et al., 2014). However, others suggest that strong public provision is crucial to guarantee equity and universal coverage in healthcare provision (Yılmaz, 2017; Mukhopadhyay, 2013).

The idea of Universal Health Coverage (UHC), as a global policy objective, originates from the Philadelphia Declaration (1944) of the International Labor Organisation (ILO) in which universal social security, including medical coverage and care, was announced as a common goal. However, this early attempt for UHC fails to succeed due to the "too divided" positions of member states during the Cold War (Gorsky & Sirrs, 2018). In the 1970s, the United Nations (UN) emphasized universalism with the concept of the Primary Healthcare (PHC) and Health for All initiative of the World Health Organisation (WHO). In Alma Ata Conference of WHO in 1978, with the subheading "Health for All by 2020", the provision of PHC

was defined as a responsibility of all countries. During the conference, PHC was defined as “essential healthcare made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford” (WHO, 1978).

On the 30th anniversary of the Alma Ata Conference on PHC, WHO declared UHC as one of the four global policy priorities (Evans & Pablos-Mendez, 2020). In 2012, during her address to the Sixty-fifth World Assembly, the then WHO's Director-General Margaret Chan declared UHC as “the single most powerful concept public health has to offer.” In the same way, the World Bank President Jim Kim, during his address to the World Health Assembly in May 2013, underlined the World Bank Group’s (WBG) commitment to achieving UHC for the purpose of ending extreme poverty.

In 2015, UN member states have agreed to achieve UHC by 2030, as part of the Sustainable Development Goals (SDGs). For this purpose, SDG 3, the health goal, includes a target to “achieve UHC, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.” In the same way, WHO, in 2018, announced the Declaration of Astana stating, "Primary Healthcare is a cornerstone of the sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals." Concurrently, at the World Health Assembly in May 2018, Dr. Tedros Ghebreyesus, Director-General of WHO announced the triple targets to be achieved by 2023: An additional 1 billion people covered by UHC; 1 billion people with better protection from health emergencies; and 1 billion people enjoying better health and wellbeing. The United Nations General Assembly reiterated its commitment to accelerate progress toward UHC,

including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all (UN, 2019).

The indicators of UHC need to be clearly defined in order to be able to evaluate if countries fulfil their commitments (The Lancet Editorial, 2019; Wong, Allotey & Reidpath, 2016). WHO defines two indicators to evaluate country's performance in achieving UHC: 1) The proportion of a population that can access essential quality health services, and 2) The proportion of the population that spends 25 per cent or more of their total household income on health care. WHO uses 16 essential health services in 4 categories as indicators of the level and equity of coverage in countries. The first category entitled "reproductive, maternal, new-born, and child health" focuses on family planning, antenatal and delivery care, full child immunization, and health-seeking behaviour for pneumonia. The second category entitled "infectious diseases" involves tuberculosis treatment, HIV antiretroviral treatment, hepatitis treatment, use of insecticide-treated bed nets for malaria prevention, and adequate sanitation. The third category entitled "non-communicable diseases" contains the prevention and treatment of raised blood pressure, prevention, and treatment of raised blood glucose, cervical cancer screening, tobacco smoking. The fourth category entitled "service capacity and access" refers to basic hospital access, health worker density, access to essential medicines, health security, and compliance with the International Health Regulations (WHO, 2019).

The selection of the abovementioned indicators for UHC has received criticisms in the literature. "Identifying an indicator that can adequately capture the multiple components underlying the UHC initiative" (Ng et al, 2014) poses challenges to the researchers. Fullman and Lozano (2018) suggest that the challenges

in the measurement of UHC do not emerge from limited knowledge or methods but rather originate from the lack of consensus on how to best track UHC progress. In addition to this, the lack of comparative data also hampers the development of UHC indicators. Even though an indicator is considered to be useful in monitoring UHC, the data gaps in health service indicators around the world prevent researchers from measuring UHC in its fullest sense (Hogan, Stevens, Hosseinpoor & Boerma, 2018).

To compensate for the deficiencies of two indicators used to assess UHC, scholars developed a new indicator: effective coverage. Effective coverage refers to "the fraction of potential health gain that is actually delivered to the population through the health system, given its capacity" (Ng et al., 2014, p.1). Need, use and quality constitute the main components of this metric. Need refers to individual and/or societal need for service; use implies the use of services and quality is defined as "the actual health benefit experienced from the service" (Ng et al., 2014, p.1). According to Ng et al. (2014), the genuine use of effective coverage as a metric for monitoring progress toward UHC requires certain factors that need to be taken into consideration. First, the entire health needs and priorities need to be identified. Second, the country has and develop strategies to collect data on the needs and quality of interventions. Third, the provision of resources must be guaranteed to collect data on health and monitor health information throughout the country.

2.6 The potentials for universalisation and strengthening publicness of oral healthcare

Although oral health is directly linked to general health and well-being and quality of life (FDI, 2015; Peres et al., 2019), and the Global Burden of Diseases (GBD) studies constantly have illustrated that oral diseases affect almost half of the world's

population, oral health is often a neglected area (Lozano et al., 2018; Marcenes et al., 2013; Kassebaum et al., 2017; Bernabe et al. 2020; Watt et al., 2019; OECD,2020). Even in developed countries with strong healthcare systems, access to oral healthcare remains a challenge. For instance, only three European Union (EU) countries (Croatia, Germany and the Slovak Republic) publicly cover more than half of total cost for oral healthcare and "on average only around 30% of costs are borne by government schemes or compulsory insurance" in EU countries (OECD, 2020, p.210). In this situation, dental coverage emerges as a potential solution to improve state of oral health globally and for countries. As Watt et al. (2019) state "universal health coverage provides an opportunity for dental services to become more integrated in the wider health-care system and to be more accessible and responsive to the oral health needs of population" (p.262).

Although the inclusion of oral healthcare into universal health coverage is a precondition for guaranteeing access to oral healthcare, securing the publicness of the oral healthcare services requires a genuine accomplishment regarding improvement of oral health of society and communities.

2.7 Patient pathways and choice in healthcare systems

In the health management literature, patient preferences of providers are discussed in the context of a purely marketized healthcare landscape. For instance, Mosadeghrad (2014) combines ten factors (ten P's of healthcare marketing) that affects patients' healthcare facility choice: Product, place, price, physical environment, people, process, package, performance, position, and promotion. The product refers to the type of healthcare service and the circumstances of the availability of the product, here healthcare, which has a crucial role in patients' pathways in a given healthcare

system. Accompanied by availability, accessibility of the place, in which healthcare is consumed, affects patients' healthcare-seeking patterns. Although the proximity of the healthcare service may be counted as a positive factor to choose a service provider, the reasons for bypassing the nearby healthcare facilities and possible answers to Adams and Wright's (1991) question of "why not the closest?" may provide a deeper insight into healthcare systems. The factor of price also requires particular attention as the relevance of this factor depends on the main features of the healthcare system the patient navigates. The physical environment appears as a reason for the choice of a healthcare facility and the hospital size, cleanliness, tidiness, and quietness may be counted as advantages for patients' preferences. The people refer to the health professionals and patients may take into consideration the knowledge, skills, and experience of not only physicians but also other personnel in making their decisions. Besides professional knowledge, patients may look for a friendly, caring, polite, and courteous environment when they are to choose a healthcare provider. Mosadeghrad (2014) defines process as "all those healthcare activities in a setting for a patient to help him or her retrieve his/her health" (p.155). The procedures that patients need to follow may affect patients' provider preferences. Package implies the extent of the comprehensiveness of the healthcare service provided. A wider variety of healthcare services may entail different care-seeking patterns and patients may look for alternatives. Performance refers to the clinical effectiveness of the healthcare provider and, from a patient's point of view, unmet healthcare needs, high expectations or overall improvement of health influence the performance assessment of the healthcare service provider. Position refers to the overall image of a healthcare setting and all the above-mentioned factors help to create this image. Promotion corresponds to one step further of the image and

covers word of mouth, advertisement of the healthcare settings and visibility of the healthcare facility in the social or conventional media.

Nevertheless, the literature on patient pathways offers a sociological lens to patient preferences and situate these preferences within a broader healthcare system setting. Patient pathway analysis aims to illuminate how patients decide where to seek care and what factors influence this decision (Gage-Bouchard, Rodriguez, Saad-Harfouche, Miller & Erwin, 2014) and to identify "common systemic barriers impeding patients' ability to access diagnostic and treatment services, based on patient care-seeking patterns" (Hanson, Osberg, Brown, Durham & Chin, 2017, p.686).

According to Lismont et al. (2016), whilst many researchers see patients' care-seeking patterns as a regular behaviour or standardised process, "every patient follows a unique path and is thus accompanied by a unique flow" (p.126). Namely, "different patients make different choices in different situations" (Victoor, Delnoij, Friele & Rademakers, 2012, p.1) thus follows different pathways throughout the healthcare utilisation process. Therefore, a medical perspective disregarding patients' experiences in the healthcare system may lead to an imperfect comprehension of the patients' needs and expectations during the whole care experience as they differ regarding spatial and temporal dimensions of their healthcare choices, beliefs and involvement along the healthcare process (Cherif, Martin-Verdier & Rochette, 2020). At this point, the spatial choice of a patient refers to her healthcare provider preference. The patient may choose a public provider, a private provider or may combine both public and private providers. The temporal choice of the patient is a function of the agreed time to receive healthcare and her own schedule. In other words, spatial choice corresponds to where to seek care and temporal choice implies

when to take care. The combination of these situated choices of patients forms the individual patient pathway.

2.8 Patient pathways in oral healthcare

Regarding the utilisation of oral healthcare, patient pathways have three main components: Contact, choice of service-sector dentist and frequency. Deciding whether to go to a dentist or not determines the first contact and the decision of where to seek care (public or private oral healthcare provider) is the following step that shapes the pathway. Finally, the number of appointments, the choice of the sector for following visits and the amount of the treatment to be received put the finishing touches to a patient pathway towards oral healthcare (Nguyen & Häkkinen, 2006).

Nguyen and Häkkinen (2006) claim that "seeking care is mainly determined by pain and dentist's recall, but is deterred by both the perceived expense of private care and the insufficient availability of public services" (p.3). Therefore, the availability and price of oral healthcare directly shape the patients' seeking care patterns. In their study, Nguyen and Häkkinen examine the determinants of the utilization of dentists' services, especially the factors affecting the choice between public and private sectors among adults by using the data from the Finnish Health Care Survey of 1996 and conclude that "the choice of a private dentist is positively associated with the perception of insufficient public services, age, recall, and the perception of sufficient private services" (p.12).

In the context of prevalent out-of-pocket payments, the price appears as a major factor shaping the patients' pathway. In the United Kingdom, for instance, Adult Dental Health Survey in 2009, in which 11,380 individuals were interviewed,

reveals that a quarter of adults' (26%) decision of the type of dental treatment they chose to have in the past "had been affected by the cost of this treatment and almost one-fifth (19%) said that they had delayed dental treatment for the same reason" (Hill, Chadwick, Freeman, O'Sullivan & Murray, 2013, p.6). The findings of this study are especially important as it demonstrates how out-of-pocket payments affect patient pathways in oral healthcare in an otherwise fully socialised healthcare system.

Another study examining patients' reasons for selecting a dental clinic by paying fully out of pocket payment instead of using free or highly subsidised public dental services in Iran displays that dental patients choose to receive treatment from these private dental clinics due to the good interpersonal and technical aspects that patients perceive in these clinics (Bayat, Vehkalahti, Murtomaa & Tala, 2010). It seems that the financial advantage of using public providers is not always the main determinant of patient pathways. On the other hand, another study indicates that when patients perceive a specific dentist is primarily driven by her economic interest, their trust in this dentist decreases (Östberg, Ahlström & Hakeberg, 2013, p.136). Decreasing trust may lead the patient to change her dentist, even if she does not change the sector from which she receives treatment.

2.9 Conclusion

This chapter provides an overview of the literature on healthcare systems, universalism and publicness in healthcare with a special focus on oral healthcare. Presenting the varied types of oral healthcare systems in Europe, this chapter shows that oral healthcare systems differ in their main characteristics from the broader healthcare systems. In addition, this chapter concludes that despite the key

importance of oral healthcare services in decreasing the existing burden of related diseases, oral healthcare has been neglected both in global policy discourses and in the existing healthcare literature. Through an overview of oral healthcare system characteristics especially in Europe and the discussion on the publicness of healthcare, this chapter lays the ground for an examination of oral healthcare system in the Turkish case. Finally, this chapter offers an overview of the existing literature on patient pathways.

CHAPTER 3

ORAL HEALTHCARE IN TURKEY

3.1 Introduction

In Turkey, oral healthcare is delivered by both public and private providers. The direction of change in oral healthcare differs from the general healthcare services. Unlike general healthcare services, the Health Transformation Programme (HTP), launched in 2003, has not aimed to expand the private provision in oral healthcare. Therefore, the dynamics of change in oral healthcare in Turkey display distinctive characteristics that cannot be adequately addressed in reference to broader changes in healthcare.

This chapter provides an overview of oral healthcare services in Turkey. It describes social insurance coverage, oral healthcare providers, workforce, associations and situates the main characteristics of oral healthcare in Turkey within Organisation for Economic Co-operation and Development (OECD) countries.

3.2 Oral healthcare history of Turkey

The transition to modern oral healthcare in Turkey started in the 19th century and the first dentistry school, İstanbul School of Dentistry, was established in 1908 (Efeoğlu, Erdemir & Öncel, 2000). Indeed, the School of Dentistry had always been affiliated with and administered by the Faculty of Medicine. As a result, the School of Dentistry, like other schools, could not develop independently. Thanks to the efforts of the teachers who wanted their schools to develop faster, on July 11, 1964, the School of Dentistry was separated from the Faculty of Medicine and transformed into Istanbul University Faculty of Dentistry. From 1908 to 1959 there was only one

dental school (İstanbul School of Dentistry), later İstanbul University Faculty of Dentistry providing dental education for prospective dentists. Currently, there are 79 dentistry faculties receiving students and 29 dentistry faculties that are established but have not started education yet (Turkish Dental Association, TDA, 2021).

Since 1908, oral healthcare services were delivered through public and private facilities. Between 1923 and 1934 the oral healthcare was mainly provided through local administrations and the first dental treatment and prosthesis centre affiliated to the MoH was established in 1980 (Atasever, 2015). Although until 2014 dentists were able to practise in both the private and public sector at the same time, currently they have to choose to work for one of these providers. However, a dentist is allowed to practice in two different private oral healthcare service providers in a condition that he/she is a permanent employee in one of them (Arslan, 2011).

3.3 Oral healthcare in Turkey: The Current Situation

Turkish Dental Association's study research on the benefit from oral and dental health services (2015) offers useful hints to cover regarding oral healthcare habits and citizens' perspective on oral healthcare services. The study is a cross-sectional study conducted through face-to-face survey with 803 participants over the age of 18 from city centres in all regions except Southeast Anatolia.

According to this survey, 33% of the participants claim that healthy teeth are important since they are useful for general health. The significance of healthy teeth for 26.2% of participants in the same research is that they are required for a beautiful smile and appearance. On the other hand, according to 7.5% of the participants, healthy teeth are necessary for a pain-free mouth. In terms of dental hygiene

practices, in the same research, 48,4% of participants claim that they brush their teeth twice a day whereas 26,8% of them brush their teeth once a day.

Although oral and dental health problems have not been ranked as one of the most frequent diseases among adults, in 2019, for children of 7-14 age, oral and dental health problems with 14,4% emerged as the third most frequent diseases. For children of 0-7 age, the same problems are the fifth most frequent diseases with 6,4% according to Turkey Health Survey conducted in 2019. (Turkish Statistical Institute, TUIK).

However, 2012 version of Turkey Health Survey indicates that oral and dental health problems with 24.5% took in the first rank among children of 7-14 age (TUIK, 2013). In 2014, for the 0-6 age group of children oral and dental health problems ranked the fifth most common diseases with 9.3% (TUIK, 2015).

The figure below shows that the prevalence of oral and dental problems has decreased in recent years, and the most dramatic change occurred for the 7-14 age group between 2016 and 2019. Due to the diminishing trend in oral and dental health problems seen in 7-14-year-old group, the gap between 0-6- and 7–14-year-old groups narrowed.

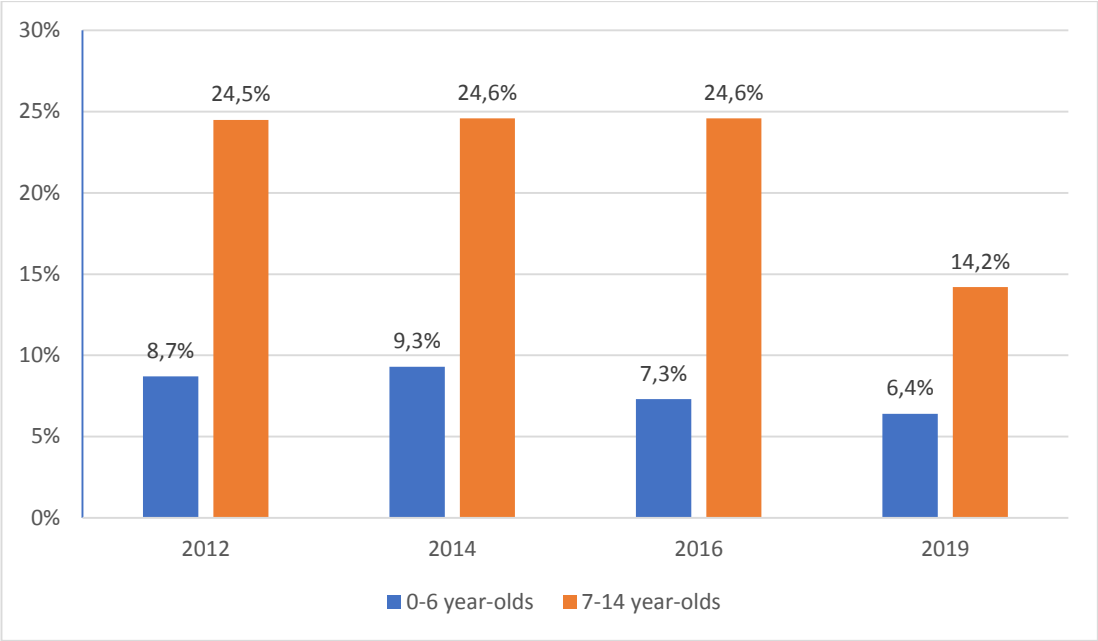

Figure 1 The incidence of oral and dental problems among 0-14-year-olds

Source: TUIK (2013, 2015, 2017, 2020)

The Global Burden of Disease Study 2017 (GBD-2017) illustrates that, in Turkey, oral disorders increased by %34,91 compared to 2002 and ranked 10th common disorder among others for the same reason.

The latest DMFT index[3] score for Turkey belongs to the year 2004. According to the Oral Health Profile of Adults and Elderly, Turkey-2004 survey (2007), DMFT score for 12-year-olds is 1,9 (low) and 5-year-olds is 3,7 (moderate) in Turkey. Meanwhile, in 2006, the OECD average DMFT index was 1,6 (low) for 12-year-olds (OECD, 2009). Similarly, according to the World Dental Federation's (FDI) Oral Health Atlas (2015b), DMFT index for 12-yer-olds, concerning the latest

3 The DMFT/dmft index is used to measure the prevalence and severity of dental caries in a given population. The index displays the number of decayed (D), missing due to caries (M) and filled (F) teeth (T) for permanent teeth. Same scores for primary teeth are displayed with dmft index. To compare internationally, the DMFT is usually measured in 12-year-olds. A DMFT index of less than 1.2 is judged to be very low, 1.2-2.6 is low, 2.7-4.4 is moderate, and 4.5 or more is high.

data available between 1994-2014, Turkey is one of the countries classified as having a low (level of between 1.2-2.5) DMFT score. In this study, France and Portugal have the same level as Turkey, whereas the UK, Germany, Italy, and Sweden are at very low (0.0-1.1) levels.

Although Turkey's DMFT index for 12-year-olds was not too far from the OECD average in 2000s, according to FDI's report Oral Health Worldwide (2015a), Turkey is on the 80% or more band in the world map of the percentage of 6-19-year-olds with dental decay. Regarding this map, Argentina has the highest share with 100 %, Japan has the lowest with %16, and Italy, France, Poland, and Romania are at the same percentage cluster with Turkey, whereas the UK and Sweden are marked with a 40-59% ratio.

In terms of periodontal diseases, the estimated average prevalence of severe chronic periodontitis among those 15 years or older, in 2010, is 10-15% in Turkey. For the same indicator, Germany, Italy, Denmark, Norway, and Sweden have the same ratio as Turkey, whilst France, Spain, the UK, and Bulgaria have a 10% or less average prevalence of severe chronic periodontitis (FDI, 2015b).

Turkey, Greece, and North Macedonia are the three countries that have the lowest (less than 2,5) incidence per 100,000 population of oral and lip cancer among those 15 years or older in 2012, in Europe (FDI, 2015b). According to the FDI's (2015b) estimation, for the same indicator, France and Germany have 5-6.9% incidence, whereas the UK, Sweden, Italy, and Spain have 2.5-4.9%.

3.4 Health Transformation Programme (HTP) and dental coverage in Turkey

Since 2003, the Turkish healthcare system underwent a dramatic change by the enactment of the HTP that has reshaped the financing system, coverage model, and distribution of healthcare facilities gradually in following years (Yılmaz, 2017).

3.4.1 Health Transformation Programme and universal health coverage (UHC)

Following the HTP, the state's responsibility to finance universal public health insurance increased, and although the new system did not automatically provide insurance coverage to the very poor, the increase in citizen satisfaction, particularly satisfaction of low-income individuals, has been realized (Yılmaz, 2017).

However, Yılmaz (2017) asserts that the healthcare financing model that the HTP provides is a regressive[4] one since the contributory payments for public healthcare services and medications; the additional payments for private healthcare services; and informal payments still exists.

Regarding healthcare delivery, the HTP lead to transform MoH into a planning and monitoring body and paved the way increasing role of private sector in healthcare services provision. Through healthcare reform, the share in the total bed capacity evolved from “negligible” to the constitution of around 20 percent of total hospital bed capacity in the country (Yılmaz, 2017).

There are two dimensions of the expanding role of the private sector in healthcare delivery. First, after SSI become the single payer of healthcare services in accordance with the HTP, private hospitals are included the public health insurance plan and, therefore, the share of public expenditures for private providers have enhanced since 2002 (Yilmaz, 2017). The figure 2 below shows that the portion of

4 “A system is regressive when the poor contribute proportionately more”. On the other hand, “in a progressive financing system, poorer households contribute a smaller proportion of their ability to pay to finance health services compared to richer households” (Ataguba, Asante, Limwattananon & Wiseman, 2018, p.436).

public sector decreased, whilst the share of the private sector regarding SSI expenditures made for healthcare services increased.

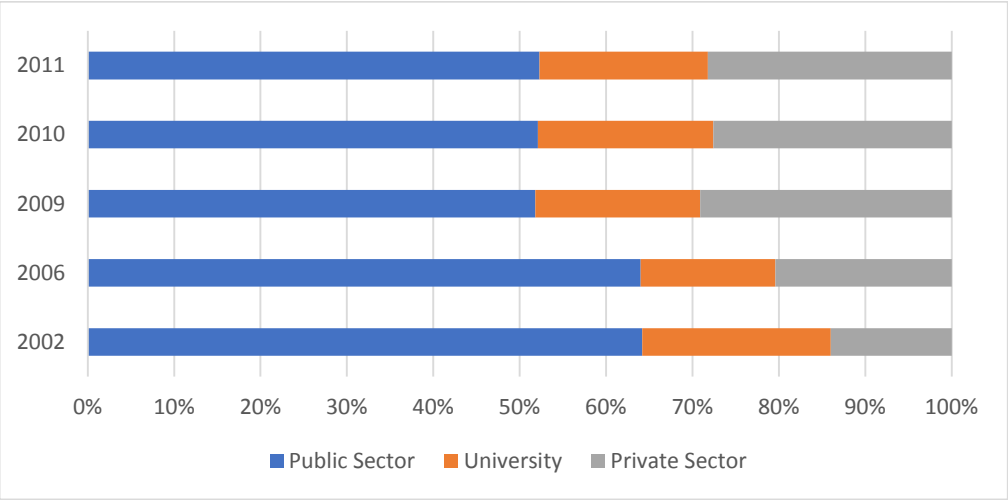

Figure 2 Breakdown of the share of SSI expenditures according to different hospital types, 2002-2011

Source: Yilmaz, 2017.

Second, increasing financial resources of private healthcare providers paved the way for expansion in bed capacity and the number of hospitals. As the figure below shows, the number of hospitals owned by private providers has steadily increased since 2002, and although the number of public and university-owned hospitals has also enhanced, the narrowing gap between the scale of public and private hospitals is conspicuous.

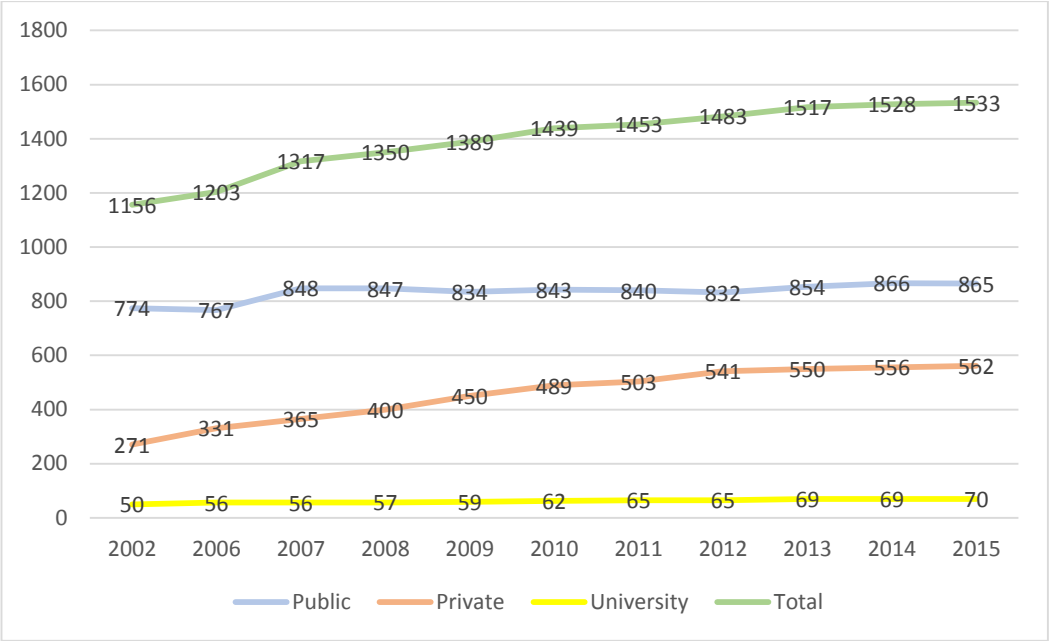

Figure 3 Number of hospitals, in terms of ownership of hospitals, 2002-2015

Source: Yilmaz, 2017.

As one of major goals of the HTP, universalisation, has expanded hand in hand with growing role of private sector in healthcare provision. Ağartan (2012) draws attention to the market elements in the universalisation process of healthcare system Turkey following the HTP and claims that since private providers lead to socially stratified service consumption and inequalities in access to healthcare, the market elements "may lead to some erosion in universalism" (p.456). Similarly, Yilmaz (2013) suggests that although the HTP succeed to diminish the occupational status-based inequalities regarding access to healthcare, the program lead the emergence of income-based inequalities which poses a threat realisation of the promise of equal access to healthcare of the government.

On the other hand, according to Atun et al., the HTP has ensured the enhancement of equity through health insurance coverage, improved financial

protection and reduced catastrophic expenditures. The authors suggest that in 2003 only 24% of the poorest decile was covered by health insurance, whilst by 2011, this proportion had increased to 85%. Regarding the richest decile, health insurance coverage has expanded from 90% in 2003, to 96% in 2011. Therefore, after the enactment of the HTP, "UHC led to rapid expansion of health insurance coverage and access to healthcare services for all citizens, especially for the poorest population groups" (Atun et al., 2013, p.65). However, according to the authors, Turkey's equity agenda is unfinished and requires a special focus on quality and safety in healthcare.

3.4.2 HTP and oral healthcare

The Ministry of Health (MoH) (2012) suggests that, together with the HTP, a significant emphasis has been put on preventive oral healthcare and so that community-based primary protection services are specified as the most efficient preventive method for public oral health. For this purpose, in accordance with the HTP (2003), Preventive Oral and Dental Health Strategic Action Plan and Application Programme are adopted, and the following risk groups are identified: The parents of 0–3-year-olds; the age group in which 6-year-old teeth erupt; pregnant women; and the persons with disabilities. Throughout school-linked programs offer oral and dental health screen and education in schools, in the 2011-2012 education year, 2.840.186 children were screened (MoH Turkey HTP Evaluation Report 2003-2011, 2012).

After launching HTP, the number of publicly provided oral healthcare institutions and dental units has increased, while the share of the private sector in the field has decreased over time. As illustrated in figure below, the number of dentists in publicly funded oral healthcare facilities has increased, whilst the number dentists

employed in private sector has decreased since the enactment of the HTP (MoH, 2012). The figure shows that the HTP has led to a significant shift regarding sector-based distribution of dentists.

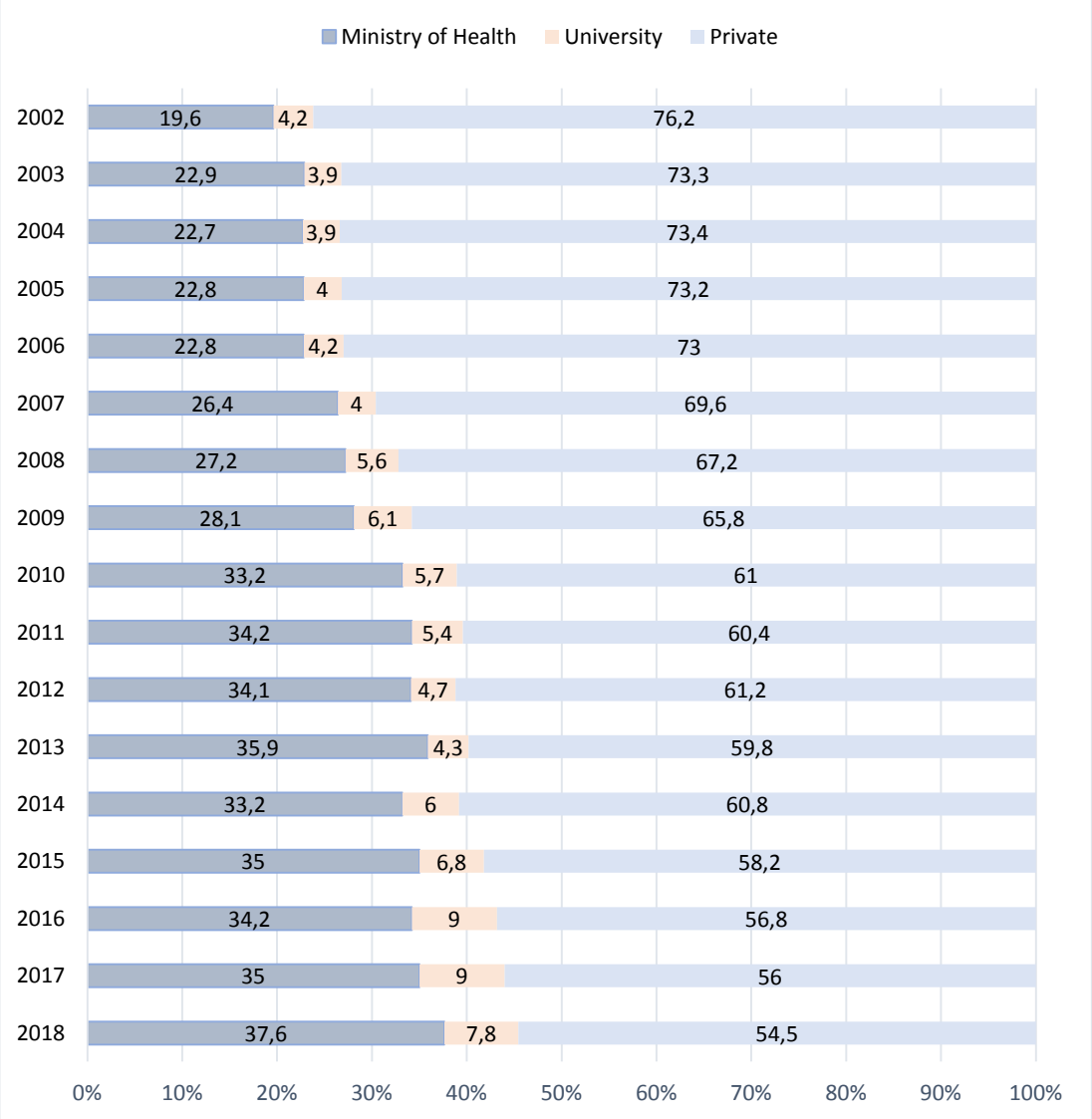

Figure 4 Distribution of dentists by years and sectors

Source: Health Statistics Yearbook 2011, 2013, 2018

Therefore, the oral healthcare provision system has not followed the trend of general healthcare provision that have left more space private sector by time after the HTP.

After the HTP, the capacity of dental unit of MoH increased significantly and population per dental unit decreased to 7.931 in 2018. The figure below shows decreasing number of populations per dental unit by years in oral healthcare providers affiliated to Ministry of Health.

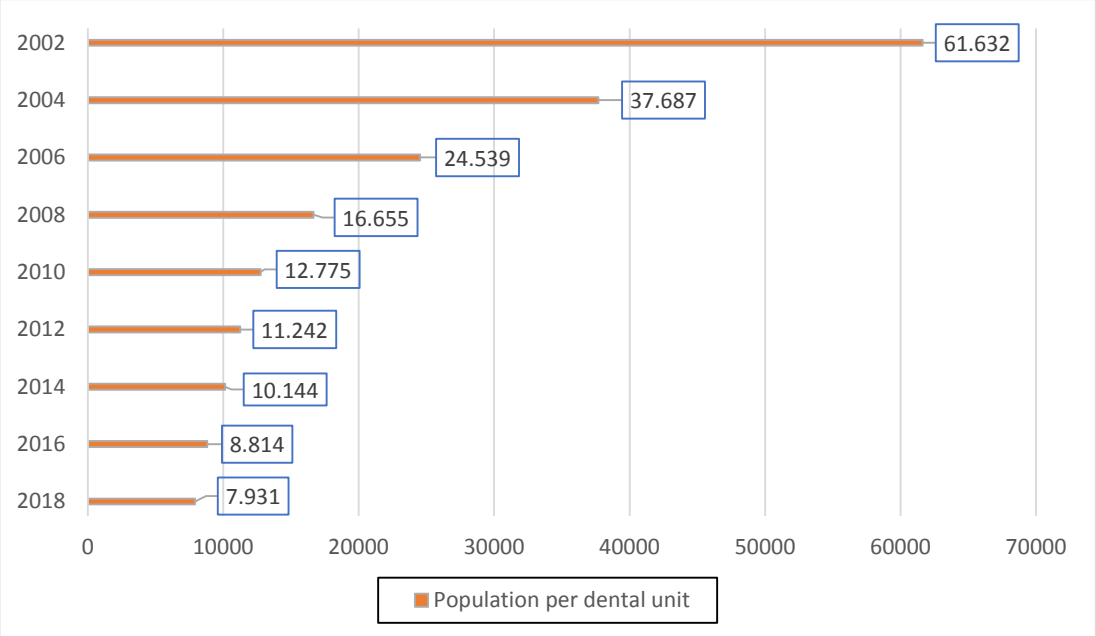

Figure 5 Population per dental unit by years, Ministry of Health

Source: Health Statistics Yearbook 2011, 2012, 2018

As the figure above shows, population per dental unit of MoH facilities has decreased significantly since the HTP was launched and, 2018 has the score almost nine times less than 2002. The figure indicates that after enactment of the HTP, the dental unit capacity of publicly funded providers has increased dramatically.

3.4.3 Dental coverage in Turkey

The HTP aimed at addressing fragmented and partial coverage of the insurance system to increase access to services and, for this purpose, consolidated the health insurance schemes into unified Universal Health Insurance (UHI) (Menon, Mollahaliloglu & Postolovska, 2013). The benefits package covered by the unified Universal Health Insurance provides inpatient and outpatient oral healthcare that includes:

> Diagnostic tests and procedures; all medical interventions and treatments after diagnosis; oral prosthesis; emergency services; orthodontic treatment; tooth extraction; conservative dental treatment; dental care provision for children less than 18 years of age, irrespective of their insurance status; endodontic treatment; follow-up services (Atun et al., 2003, p.76).

Costs of dental implants are not paid by GHI and, in case of excessive tissue loss due to the maxillofacial trauma cysts and tumours; congenital tooth deficiency; and cleft lip and palate, with the health committee report, a maximum of 4 implants for each jaw and only 90 tl (apx 11 USD) for each implant could be charged. Dental treatments of the disabled people with %40 or more disability received from private oral healthcare providers are covered by the GHI in case of documenting the disability status and obtaining a health board report. Expenses related to orthodontic dental treatment of persons under the age of 18 are covered by the GHI if the treatment is received in institutions affiliated with the MoH or universities. Moreover, in case a health board report is issued by three dentists and it is clearly stated in the report that the treatment performed is not for aesthetic purposes and the

type of malocclusion, then the GHI covers the treatment received from a private oral healthcare provider (Social Security Institution, 2021).

Turkey was counted as one of the four countries (along with Spain, Poland, and Austria) that has a 100% coverage level of basic oral healthcare services in 2008 (FDI, 2015b). At present, the GHI dental coverage list indicates that the oral healthcare system in Turkey provides comprehensive coverage for oral healthcare received from publicly funded providers. In terms of the private sector, only private universities might contract with the Social Security Institution (SSI) and make discounts on the fees.

3.5 Oral healthcare system in Turkey

Oral healthcare system in Turkey has witnessed quite important changes considering the share of public and private sectors in oral healthcare provision. The system has unique characteristics that distinguish it from the general healthcare system in Turkey and the oral healthcare systems in other OECD countries. As discussed before, after the enactment of the HTP, oral healthcare system in Turkey did not follow suit but draw a picture in which the private sector was not supported as in the case of general healthcare system and, thereby, public sector has expanded steadily. However, despite the increasing in the number of visits to dentists and dentists per population, Turkey has found a place quite below of the OECD and EU averages regarding these two indicators.

To better understand the outcomes of the oral healthcare system in Turkey, it seems important to analyse service providers, financing and cost of oral healthcare, access and utilisation, and dental workforce, and by doing so have a closer look into system.

3.5.1 Oral healthcare service providers

In Turkey, there are four types of oral healthcare providers in terms of their affiliated institutions: Service units affiliated to the Ministry of Health (MoH); service units affiliated to the universities; service units affiliated to the Ministry of National Defence (MoND); and service units affiliated to the private sector (Atasever, 2015). The figure below indicates the share of the private sector in oral healthcare provision constitutes 53% regarding the number of dentists employed.

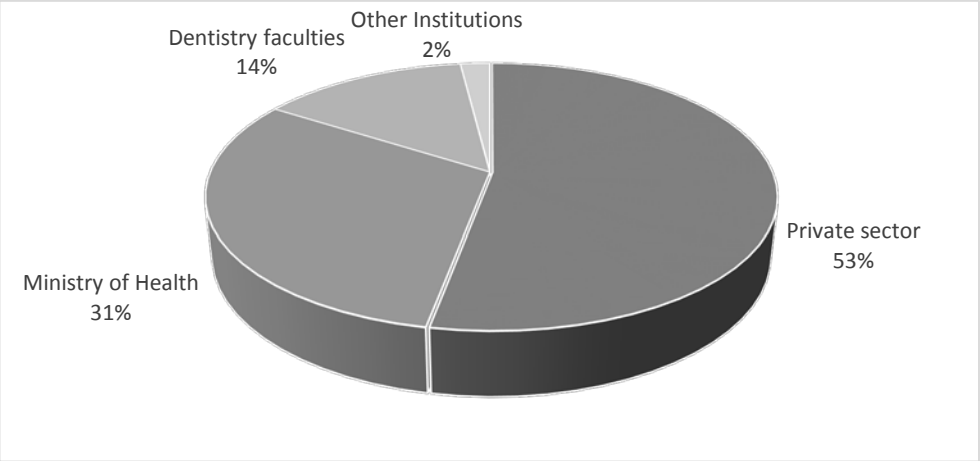

Figure 6 The distribution of dentists in practice by sector in 2015

Source: TBA, 2015

As the figure above shows, by 2015, nearly half of the dentists in practise in Turkey is employed by the public sector. On this account, it seems that public sector a preferable alternative to practice their professional for dentists.

Regarding the number of institutions providing oral and dental healthcare services by sector, as the figure below indicates, MoH has the largest share unit capacity comparing to universities and private sector.

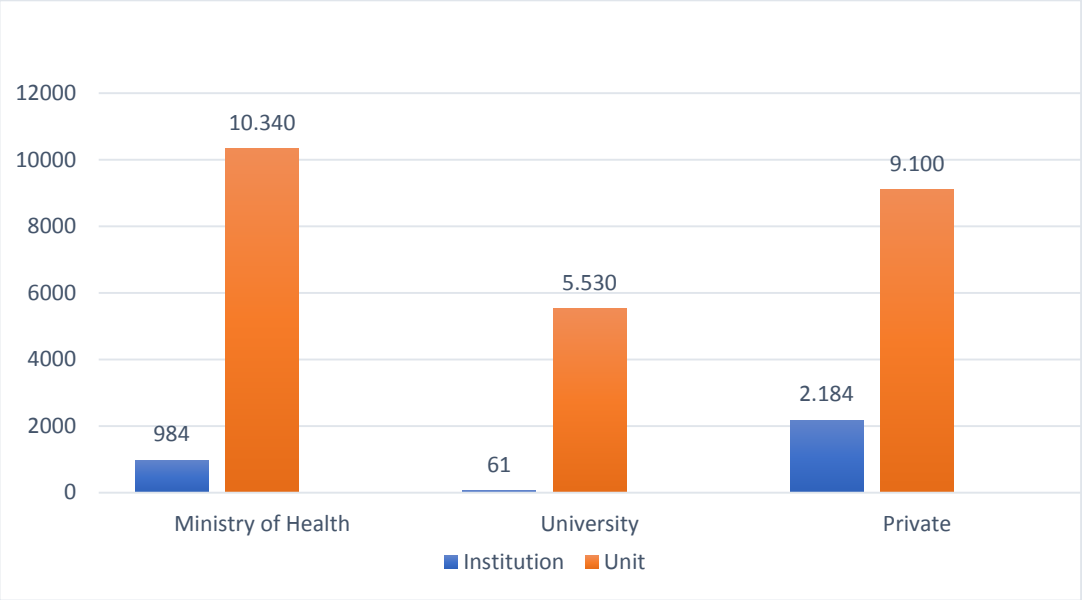

Figure 7 Number of the Institution Providing Oral and Dental Healthcare Services by Sectors, 2018

Source: health Statistics Yearbook 2018, 2019.

As the figure above shows, although the private sector has more than two times institutions comparing to public sector, considering the number of units, MoH is the greatest service provider among oral healthcare service providers. The statistics of number of dentists, institutions and units notify that oral healthcare system has been undergoing a competition between public and private sector.

3.5.1.1 Oral healthcare service providers affiliated to MoH

Service units affiliated to MoH consist of Oral-Dental Health Training and Research Hospitals (ODHTRHs), Oral-Dental Health Hospitals (ODHHs), Oral-Dental Health Centres (ODHCs), Dental Treatment and Prosthesis Centres, Oral-Dental Health Policlinics, and Integrated District Hospitals and Community Health Centres. These hospitals and centres are classified according to their capacity, the number of dental units[5] and whether or not they provide inpatient services. ODHTRHs, besides providing oral healthcare services to the public, aims to educate dental specialists and provide master and doctorate programmes in the field of dentistry. ODHHs and ODHCs are detached health institutions that might open dental treatment and prosthesis centres and oral-dental health policlinics under their administrations. Dental treatment and prosthesis centres provide preventive and curative oral healthcare services and might be administratively and financially attached to a public hospital, training and research hospital, ODHC or ODHH. Oral-dental health policlinics are similar to dental treatment and prosthesis centres in terms of administrative and financial dependence, and they deliver services under the purview of a public hospital or training and research hospital. These policlinics predominantly provide preventive oral healthcare services (Atasever, 2015).

The first ODHC in Turkey was opened in 1988 and, in 2002, the number of ODHCs was 14. However, after launching Health Transformation Programme (HTP), the number of ODHCs and dental treatment and prosthesis centres that are part of the ODHCs increased rapidly. Similarly, the first ODHH started to serve in 1986 in İzmir (İzmir Eğitim Diş Hastanesi) and the second was opened in İstanbul

5 A dental unit is the necessary work tool of every dental professional and generally consists of a dental chair, stool, lighting, hydric box, aspiration, cuspidor, and other elements.

(İstanbul Okmeydanı Diş Hastanesi) in 2002, at present, the number of ODHHs reached 28 (Health Statistics, 2018; Atasever, 2015).

As the table below shows ODHCs have similar capacity to ODHHs in terms of the scope of treatments they offer and stand out as public facilities where more than half of the patients prefer to receive services.

Table 1. Oral and Dental Healthcare Services Provided in 2017

			Oral and Dental Health Hospital (ODHH)	Oral and Dental Health Centre (ODHC)	Hospitals providing oral healthcare	Total
Number of Institutions			22	132	510	664
Number of Dental Units			2.118	5.304	2.010	9.432
Specialist Dentists			311	489	41	841
Dentists			1.702	4.467	1.675	7.844
Number of Patients			6.057.737	15.370.044	5.846.098	27.273.879
Number of examinations			9.370.793	23.260.852	7.724.792	40.356.437
Tooth Extraction			1.700.538	4.369.957	1.903.819	7.974.314
Root Canal Treatment			923.332	2.075.554	443.435	3.442.321
Filling Treatment			3.285.196	8.286.775	1.722.930	13.294.901
Surgical Intervention			258.104	533.284	122.008	913.396
Fixed Prosthetics	Number of Patients		266.250	640.468	194.103	1.100.821
	Number of Parts (Retainers and pontics)		1.795.533	4.112.299	1.188.018	7.095.850
Removable Prosthetics	Number of Patients		79.758	205.239	92.439	377.436
	Number of Parts		116.765	306.147	139.444	562.356
	Partial Prosthetics	Number of Patients	108.508	282.949	108.527	499.984
		Number of Parts	148.648	393.296	152.105	694.049
Number of Patients had scaling			323.735	942.385	332.545	1.598.665
Number of Patients had Root Planing			116.129	280.102	97.236	493.467
Orthodontic Treatment			53.811	35.655	15.260	104.726
Fissure sealant	Number of Patients		147.432	353.515	96.233	597.180

	Number of Teeth	864.954	2.286.272	558.917	3.710.143
Number of Patients Applied Fluoride Varnish		134.928	286.315	136.103	557.346
Implant	Number of Patients	1.483	4.738	313	6.534
	Number of Teeth	3.807	12.997	733	17.537

Source: Public Hospitals General Directorate, 2017

As can be seen in the table above, ODHCs are located at the centre of the public oral healthcare provision since the number of patients and examinations these facilities have, constitutes more than half of the number of patients choosing public sector (15.370.044 of 27.273.879) and dental examinations performed in publicly funded facilities (23.260.852 of 40.356.437).

The oral-dental health institutions can change their status once they meet adequate conditions for the transition. Keçiören ODHERH in Ankara, for instance, in 2008, was an ODHC with 15 dental units and 5 hospital beds capacity. In 2011, it turned into an ODHH with 115 dental units and 7 hospital beds. After affiliation with University of Ankara Yıldırım Beyazıt in 2017, it was renamed as the dental school (Ankara Yıldırım Beyazıt University Faculty of Dentistry, AYBUFD) and, finally, in 2018, it became Keçiören ODHERH and, at present, with 43 clinics, 6 educational clinics, 37 academics personal, 141 dental units and 2 oral-dental health policlinics, it has delivered oral healthcare services and education (AYBUFD, 2021).

During COVID-19 outbreak, the government decided to employ dentists affiliated with the MoH in pandemic hospitals to help contact tracing and PCR test teams and closed most of the oral and dental health centres or significantly reduced the number of dentists practising in these institutions (Anadolu Agency, 2020).

3.5.1.2 Oral healthcare service providers affiliated to universities

Dentistry Education Hospitals, District Policlinics of Dental Education Hospitals, and Oral-Dental Health Policlinics of University Hospitals provide oral healthcare under the responsibility of universities (Atasever, 2015). As teaching and patient care institutions, dentistry education hospitals provide tertiary care and teach dental medicine to prospective dentists and other dental professionals. In these facilities, fourth and fifth-grade students take clinical internship classes and provide oral healthcare to dental patients under the supervision of academic dental professionals.

At present, beside 62 state faculty of dentistry, there are 22 dentistry faculties affiliated with a foundation (private) university in Turkey and, some of them, through contracts with SGK, have a discount on treatment fees.

3.5.1.3 Oral healthcare service providers affiliated to Ministry of National Defence

Oral-dental policlinics in military hospitals and facilities are affiliated to the Ministry of National Defence and provide oral healthcare service to the staff who work in military services. Approximately 5% service quota is reserved to the civilian citizens outside the military forces (Atasever, 2015).

3.5.1.4 Oral healthcare service providers affiliated to the private sector

According to the Regulation on Private Health Institutions Providing Oral and Dental Health Services (2015), oral healthcare might be provided in the private sector through Private Oral-Dental Health Centres (PODHCs), private policlinics, joint clinics of dentists, individual clinics or oral-dental policlinics in private healthcare facilities.

Private oral healthcare providers are classified in terms of their specialty in dental practice, ownership status, service infrastructure, and the number of dental units they have. PODHCs can be established by at least two dentists or one dentist (her/his share must be at least %51) and a legal entity. Private policlinics are allowed to be established by at least two dentists and the structure of the facility has to ensure the interconnection of the service units. Individual clinics are allowed to open by a dentist and, corporations or companies are not allowed to establish individual clinics. More than one dentist can own an individual clinic in the same apartment as joint individual clinics, provided that each has a separate practicing room, and every practising room is licenced separately (Atasever, 2015).

As the table below shows, a significant amount of oral healthcare provision is offered through dental policlinics. Although the number of dentists employed in each institution type is not available, the distribution of units implies that dental policlinics in hospitals and independent dental policlinics can be counted as institutions where most of the dentists in the private sector practice.

Table 2. Number of the Institution Providing Oral and Dental Healthcare Services by the Private Sector, 2018

	Private Oral Healthcare Providers, 2018	
	Institution	Unit
Oral and Dental Health Centre	79	851
Dental Hospital	3	85
Dental Policlinic (Hospital)	214	472

Dental Policlinic	1.888	7.692
Total	2.184	9.100

Source: Health Statistics Yearbook 2018, 2019

As the table above shows, dental clinics are the most common institution type in private sector and oral and dental health centres stand out by their magnitude of unit numbers with respect to the number of institutions.

3.5.2 Financing and cost of oral healthcare

Between 2002 and 2013, total spending on oral healthcare increased four times in nominal terms and 0,8 in real terms[6] (Atasever, 2015). In the same period, total oral healthcare expenditure increased from 0,26% (of GDP) in 2002 to 0,29% in 2013 (Atasever, 2015). Figure 8 below demonstrates the changes in the share of spending on oral healthcare providers in different sectors between 2002 and 2013.

6 Nominal terms reflect current monetary values, whereas real values are adjusted for inflation and indicate values at constant prices. Therefore, calculating real increase requires adjusting 2002 values to 2013 prices.

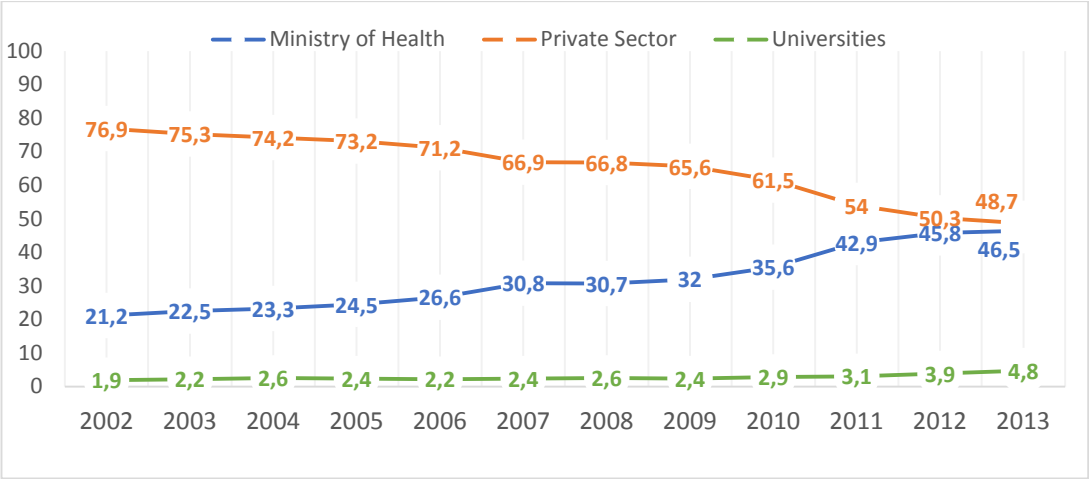

Figure 8 Service providers' share in total oral healthcare expenditure by years

Source: Atasever, 2015

As Figure 8 illustrates, in 2002, 76,9% of oral healthcare expenditure were made to the private sector, whilst the share of spending on public providers was 21,2%. By 2013, the portion of the spending on private sector decreased to 48,7% and the expenditures on public providers increased to 46,5%.

The financial structure of oral healthcare has a mixed characteristic in Turkey (Atasever, 2015). For services covered by general health insurance, fees for oral healthcare practices is determined by Social Security Institution, which announces them in the Health Implementation Statement (Sağlık Uygulama Tebliği, SUT). Out-of-pocket payments are made in the form of co-payments in the public sector (the examination contribution fee and the material contribution fee). The procedures and principles regarding the application of the Dentist Examination Contribution Fee are regulated in article 1.8.1 of the SUT (Republic of Turkey Social Security Institution, SGK, 2021a). According to this regulation, no contribution fee is charged for the dental examination performed in primary healthcare providers. However, in

secondary and tertiary health service providers, 5 TL is charged from service users. These co-payments are collected by pharmacies. When a dental patient's oral-dental health condition requires an oral prosthesis practice, then the material contribution fee is collected from the persons by the health institutions or organizations. Fixed and removable dentures renewed before four years and fillings before 6 months are not covered by general health insurance and they are charged according to the SUT tariffs. When the patient or the treatment or both are not covered by general health insurance and the treatment is received in public oral healthcare facilities, the price is set according to the Public Health Services Sales Tariff (Kamu Sağlık Hizmetleri Satış Tarifesi) determined by MoH.

Citizens whose monthly income per person is less than one-third of the minimum wage in the family; stateless persons and asylum seekers; and persons who receive a pension under the provisions of Law No. 2022, dated 1/7/1976, on giving pension to the needy, weak and orphans Turkish citizens over 65 years old, and the contribution fees paid by their dependents, upon their request, can be reimbursed by the Social Assistance and Solidarity Foundations.

Oral healthcare services provided within the scope of health tourism or tourist health are priced according to the Directive on Health Tourism and Health Services to be Provided in the Scope of Tourist Health (Sağlık Turizmi ve Turist Sağlığı Kapsamında Sunulacak Sağlık Hizmetleri Hakkında Yönerge).

The oral-dental examination and treatment fees in the private sector are determined by the Turkish Dental Association (TDA). TDA was founded on June 7th, 1985 as a regulatory body for dentistry in Turkey, and the central office is located in Ankara. In every city, where the number of dentists is more than 100, a local chamber could be established, and the delegates of the chambers are

represented in TDA. Today, the number of chambers is 37 and the council of TDA consists of 11 members (TDA, 2021). There are 6 categories in TDA tariffs in which three groups of cities and three groups of districts are classified (1st group of cities, 1st group of districts, 2nd group of cities, 2nd group of districts, 3rd group of cities, and 3rd group of districts). In this categorisation 1st group cities and districts, such as İstanbul, Ankara, Antalya, and Kocaeli have the most expensive fees regarding TDA tariffs. The number of groups is not a strict policy, for instance, in 2020, TDA declared two groups of cities and, in the 1st group, there are 69 cities, and the 2nd group consists of 12 cities (Adıyaman, Bitlis, Çorum, Hakkari, Malatya, Mardin, Muş, Sivas, Şırnak, Tokat, Van, and Yozgat). According to 2020 tariffs, in the 1st group of cities fee for a root canal treatment (without restoration) for a tooth with a single canal is 305 tl, whilst in the 2nd group of cities fee for the same treatment is 270 tl.

3.5.3 Access and utilisation

3.5.3.1 Access to oral healthcare services

Arranging an appointment for all the oral healthcare service institutions affiliated to the Ministry of Health is realised through the Central Physician Appointment System (Merkezi Hekim Randevu Sistemi, MHRS). MHRS was launched in 2010 as a pilot implementation in Erzurum and Kayseri and started to serve in all cities in Turkey in 2012 (MHRS, 2017). Persons might choose hospitals or health centres and physicians by calling ALO 182 MHRS calling centre or through the internet and mobile application. MHRS is a project realised by MoH with AssisTT, a subsidiary of Türk Telekom company, and awarded for Best Outsourcing Partnership in the world by Contact Centers World Awards (Türk Telekom, 2017; MHRS, 2021) and

known as the first and only system that administrates whole hospitals affiliated to Ministry of Health appointments from one centre in a country (MHRS, 2017).

In public oral healthcare services, once a dental patient takes a first examination appointment through MHRS, the physicians are expected to arrange appointments for ongoing treatments, however, they might demand a new MHRS appointment for other dental treatment needs of the patient. In this system, 5 TL extra examination contribution fee is charged for applications made to different service providers in the same branch in ten days (Atasever, 2015). On the other hand, for follow-up appointments arranged by the physician or through MHRS (ten days after the last appointment through MHRS), the examination contribution fee is charged biweekly.

Regarding university hospitals, each dentistry faculty has its appointment system and patients can make an appointment by phone calling or online. Similarly, there is no centralized appointment service for oral healthcare providers in the private sector.

3.5.3.2 Utilisation of oral healthcare services

MoH indicates that the number of dental visits has risen steadily in Turkey. As Figure 9 illustrates, the number of visits to dentists increased constantly and reached 53.115.784 in 2018 (Health Statistics Yearbook 2018).

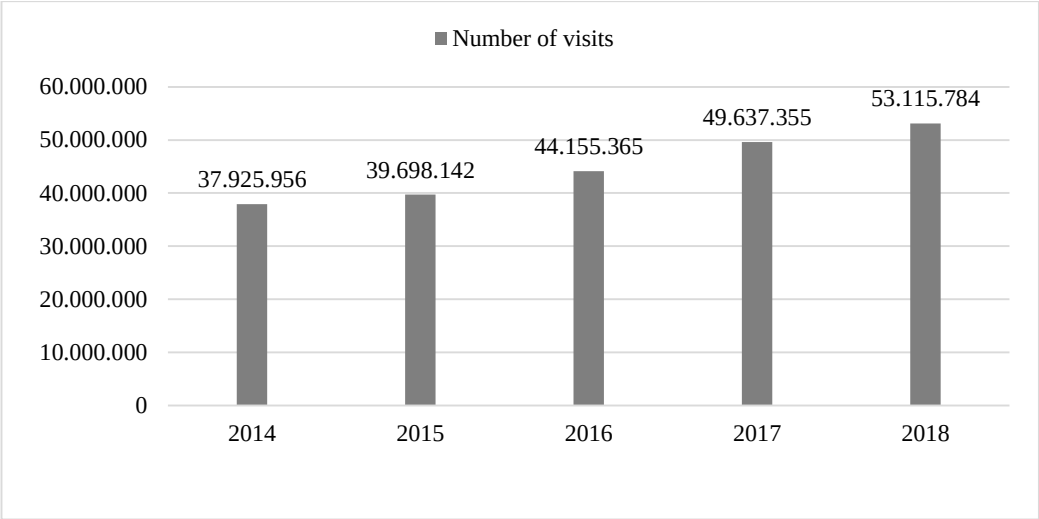

Figure 9 Number of visits to dentists by year in all sectors

Source: Health Statistics Yearbook 2018.

As Figure 9 displays, the number of persons who visit a dentist in a year is increasing in a steady fashion which implies more frequent usage of oral healthcare services. Regarding the decision-making processes, it is important to note that oral healthcare seekers have different motivations for their choice of the service provider.

According to the TBA's (2015) research conducted with 803 participants, public oral healthcare providers and universities are preferred over private providers owing to mainly their insurance coverage, while private oral health care clinics are the reason for the preference for being good. The table below illustrates the reasons behind dental patients' choice of oral healthcare service provider and indicates that persons have different motivations for preferring public or private sector.

Table 3. Reasons for Provider Preferences of Dental Patients in 2015

	Private	Public	University	Total
Insurance	%17.1	%39.0	%38.0	%25.4
Emergency	%3.3	%0.8	%2.0	%2.4
Familiarity	%13.5	%3.2	%8.0	%9.9
Proximity	%4.5	%6.8	%4.0	%5.2
Good	%38.9	%8.0	%14.0	%27.5
Trust	%20.0	%14.3	%22.0	%18.4
Cheap	%1.2	%27.1	%10.0	%10.0
Other	%1.4	%0.8	%2.0	%1.3
Total Number	489	251	50	790

Source: TBA, 2015

For a closer look at patients' perception of accessibility of oral healthcare services, TDA's investigation on the use of oral and dental health services in 2015 provides useful hints. According to the research, the percentage of participants who have an agreement on the statement that "I can easily have dental treatments" is %65.6 in 2015, which represents a modest increase from %60.4 in 2000. The ratio who are disagreed with this statement is %13.1 in 2015, which indicates a significant decrease from %33.8 in 2000. In the same research, the percentage of persons who agreed with the statement that "it is necessary to sacrifice some money for dental treatment" is %81.3 in 2015 comparing to %84.4 in 2000. The ratio of the

participants who disagree with this statement is %7.1 in 2015 and %10.3 in 2000 (TDA, 2015). As Figure 10 illustrates, regarding oral healthcare-seeking habits, the number of dentist consultations per person in Turkey, in 2018, was 0,7 and Turkey was having one of the lowest levels among European countries (OECD, 2020).

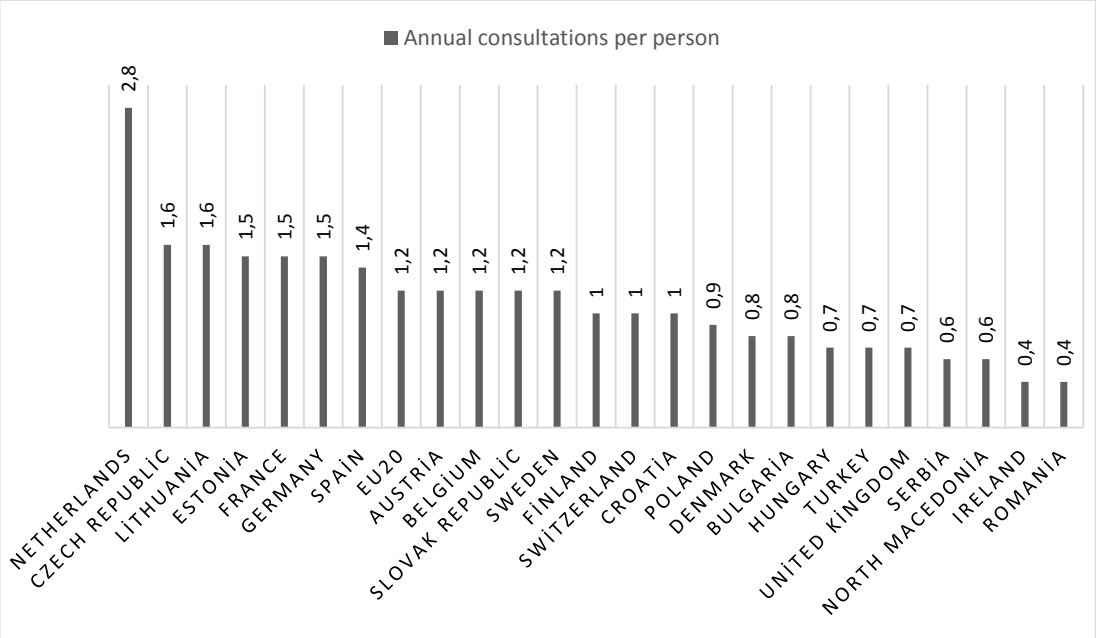

Figure 10 Number of dentist consultations per person in 2018 or nearest year

Sources: OECD Health Statistics 2020, Eurostat Database

The figure above shows that in terms of per capita visits to dentists, Turkey has found place quite below the EU and the OECD average. At this stage, the figure indicates that oral healthcare in Turkey has a different story comparing to general healthcare system since the per capita visits to a physician in Turkey was one of the highest scores with 9,5, while the EU and OECD average were 6,9 and 6,8

respectively, in 2017 (MoH, 2019; OECD, 2019). The table below shows that since the HTP started, per capita hospital visits have increased in all sectors.

Table 4. Per Capita Hospital Visits by Years and Sectors

	2002	2004	2006	2008	2010	2012	2014	2016	2018
Ministry of Health	1,7	2,0	2,7	3,0	3,2	3,5	3,8	4,3	4,6
University	0,1	0,2	0,2	0,3	0,3	0,4	0,4	0,5	0,5
Private	0,1	0,1	0,2	0,7	0,6	0,9	0,9	0,9	0,9
Total	1,9	2,3	3,1	4,1	4,1	4,7	5,1	5,6	6,1

Source: Health Statistics Yearbook 2011, 2015, 2018, 2019

As the table above shows, per capita hospital visits have increased gradually in total and, although private sector has been receiving nine times more visits in 2018, comparing to 2002, MoH hospitals have still the greatest share regarding the number of per capita hospital visits in 2018.

The number of per capita visits to dentists in 2002 is not available since only the values of the MoH were published. However, the same indicators for the year 2017 with 0,61 and 2018 with 0,65 show that per capita visits to dentists is quite far away from per capita visits to physicians for the same years with 9,5 (MoH, 2018).

The table below indicates the number of visits to primary, secondary and tertiary healthcare facilities and dental visits, and per capita physician and dentists visits in Turkey, in 2018.

Table 5. Some Health Indicators in Turkey, 2018

Primary Healthcare Facilities Visits	Secondary and Tertiary Healthcare Visits	Per capita Physician Visits	Number of Dentist Visits	Per Capita Dentist Visits
265.496.223	517.018.981	9,5	53.115.784	0,65

Source: Health Statistics Yearbook 2018, 2019

As the table above shows, in 2018, the number of visits to general healthcare facilities significantly higher comparing to dental visits. Besides that, as can be seen in the table per capita dentist visits is quite far from per capita physician visits. Therefore, the table illustrates that the utilisation of general healthcare services has drawn rather different picture from utilisation of oral healthcare services by which persons visit dental facilities less than general healthcare institutions.

3.5.4 Dental education, training, and workforce

Dentistry education is a five-year undergraduate program in which the first three years are mainly based on theoretical learning and pre-clinical practices. Starting

from the third year of the education, the fourth and fifth grades aim to enhance the clinical skills of the students through internship training programmes with real dental patients. After graduation, dentists might pursue a doctorate programme in dentistry faculties.

The table below shows that the number of dentistry faculties increased steadily since the enactment of the HTP. As a result, the number of students and academic staff members in these faculties enhanced simultaneously.

Table 6. Number of Students and Academic Staff Member in faculties of Dentistry by Education Terms

Education Term	Number of Faculties	Number of Students			Number of Academic Staff Member
		Recently Enrolled	Total	Graduates	
2002-2003	14	975	5.256	813	605
2005-2006	15	1.030	5.609	855	691
2006-2007	17	1.078	5.873	763	749
2008-2009	19	1.458	6.322	994	823
2009-2010	22	1.700	7.082	927	879
2010-2011	27	1.998	7.528	950	945
2011-2012	31	2.347	9.358	1.098	998
2013-2014	37	3.151	12.842	1.313	1.306
2014-2015	40	3.526	14.963	1.567	1.493
2015-2016	43	3.825	17.027	1.710	1.636

2016-2017	46	4.269	18.890	2.128	1.541
2017-2018	50	4.895	21.285	2.584	1.723
2018-2019	63	6.612	24.896	2.980	1.930

Source: Council of Higher Education, Health Statistics Yearbook 2011, 2012, 2015, 2018

Note: Graduate numbers belong to previous education term

As can be seen in the table, the number of dentistry faculties is 4,5 times more in 2019 comparing to 2002. This growth rate is striking especially comparing with the same indicators belonged to faculties of medicine. In 2002-2003 education term, there were 44 faculty of medicine in Turkey, and in 2018-2019 education year, the number reached 96, so that the number of faculties of medicine have increased 2,1 times between 2002 to 2019 years (MoH, 2019).

Since the dentistry specialty exam (DUS) was introduce in 2012, specialty education on dentistry has been provided at universities. Before this application, there was no specialist training in dentistry and postgraduate education could only be obtained through doctoral programs. According to the regulation on specialisation training in medicine and dentistry (2011), the specialty education continues for a period of 3 or 4 years according to the specialisation and there are 8 departments could be obtained a specialist degree in dentistry: Mouth, tooth, and chin surgery; mouth, tooth and chin radiology; paediatric dentistry; endodontics; orthodontics; periodontology; prosthetic dental treatment; and restorative tooth treatment. Table 7

indicates the distribution of specialist dentists, dentists, and dental residents[7] in all sectors.

Table 7. Distribution of Dentists by Sectors and Titles in 2018

	Ministry of Health	Universities	Private	Total
Specialist Dentist	902	1.959	2.029	4.890
Dentists	9.844	277	13.548	23.669
Dental Residents	68	1.988	-	2.056
Total Dentists	10.814	4.224	15.577	30.615

Source: Health Statistics Yearbook 2018

The table above shows that, by the year of 2018, the number of specialist dentists and dentists are employed by private sector is greater than the number of specialist dentists and dentists employed in the Ministry of Health and universities. The table also indicates that specialist dentists are employed most commonly in private sector, then universities and MoH respectively. As the figure below shows, the number of total dentists per 100.000 population has increased in a steady fashion in recent years.

7 Dental residents are assistant dentists who are a doctoral student or specialty trainees.

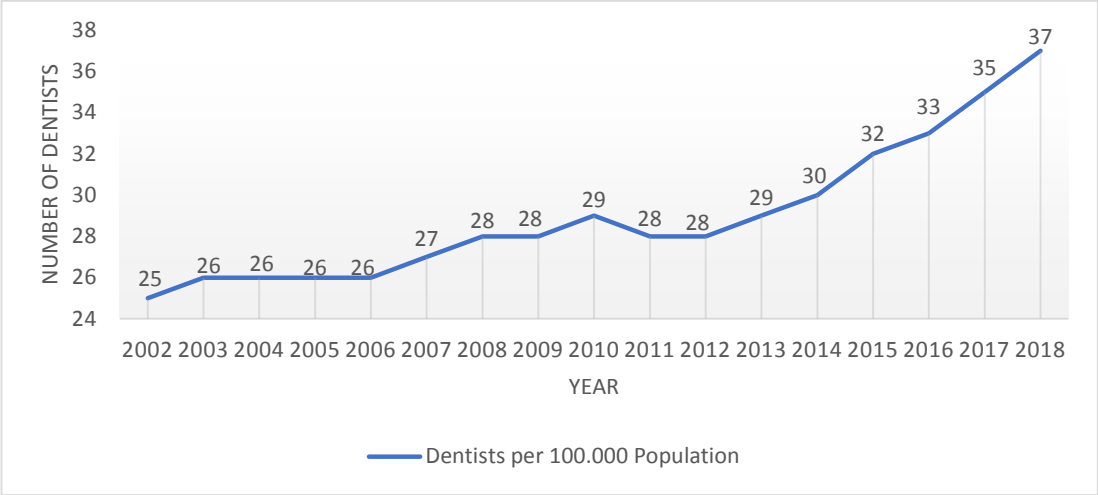

Figure 11 Number of total dentists per 100.000 population by years, all sectors

Source: Health Statistics Yearbook 2018, 2019

The number of practising dentists in all sectors in 2018 was 30.615 and, as the figure above demonstrates, the number of dentists per 100.00 population was 37 by the same year (Health Statistics Yearbook 2018, 2018). As figure below illustrates, the OECD mean number of dentists per 100.000 population is 70 and the EU mean for the same situation is 77 (OECD, 2020). Comparing with the OECD countries and EU nations, the figure shows that Turkey takes place at a relatively low level in terms of the number of dentists per population. Although number of dentists per 100.000 population increased from 25 in 2002 to 37 in 2018 (MoH, 2019), the figure below shows that there is still a shortage of dentists in oral healthcare system in Turkey.

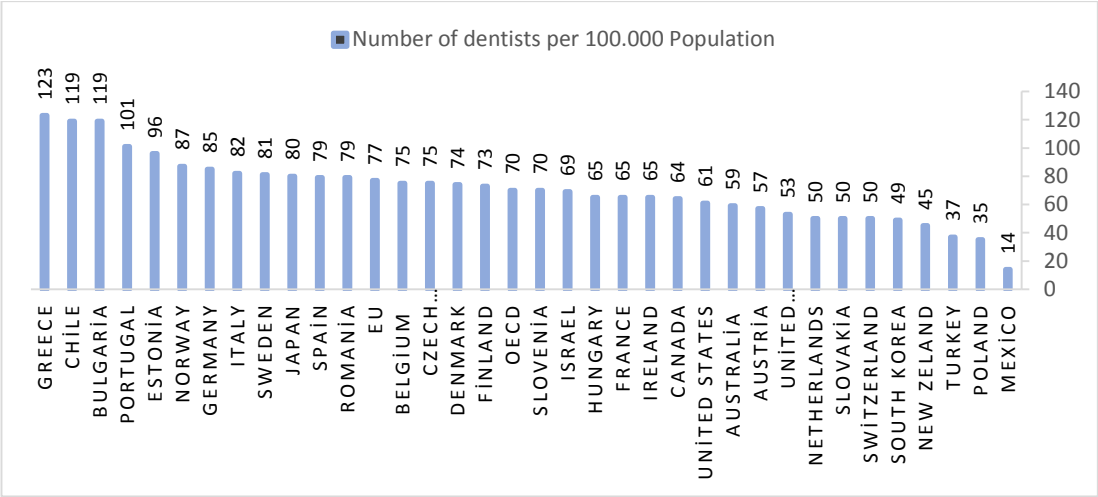

Figure 12 The number of dentists per 100.000 population for 2017

Sources: Health Statistics Yearbook 2018, OECD Health Data.

Note: Turkey's data belong to the year 2018. Countries' data belong to the year of 2017 or nearest.

In terms of 2023 targets of the Ministry of Health, 30.000 new dentists targeted will be practising. However, the study of the Year 2023 Health Workforce Targets and Health Education conducted by the Ministry of Health in 2014 asserts that "if the student enrolment in the faculties of dentistry continues in its current state, approximately 6,000 dentists more than 2023 targets" will be in practice (p.30). TDA and Health and Social Workers' Union (Sağlık-Sen) have been concerned about the increasing number of dentistry faculties (TDA, 2020; SASAM, 2018). TDA (2020) suggests that in order not to waste resources of the country, dentistry faculties should not be opened without workforce planning, and student quotas for these faculties should be minimised.

Other than dentists, the dental workforce includes dental technicians, nurses, and dental chairside assistants. There is no specialty in dental nursery in Turkey yet

and nurses who work in healthcare facilities can work as well in oral healthcare providers. Dental technicians receive a two-year education provided by universities and, after graduation, work in public or private oral healthcare institutions or private dental prosthesis laboratories. They have also the right to operate their laboratories. Dental chairside assistants might have an associate degree like the dental technicians have or might follow a certificate programme. However, persons who do not have any training or education can also become dental assistants and, in this case, they are trained by dentists in dental clinics.

To have closer look oral healthcare professionals' evaluation of the current situation of the Turkish oral healthcare system, the study of Ekici, Tengilimoğlu and Işık (2017) may provide an insider's perspective. According to the participants of their study (560 dentists and 84 managers working in public oral and dental health centres) the Turkish oral healthcare system has structural and functional problems that emerged from management and organization; service delivery; human resources; and financing issues:

(1) insufficient number of dentists in high-level management positions and in decision-making bodies in the field of oral and dental healthcare
(2) the lack of preventive oral and dental services and insufficient infrastructural and physical conditions of service-providing units,
(3) insufficient human resources, financial and personal employee rights and the disparity of distribution across Turkey,
(4) the lack of sufficient funding that could be allocated from the overall health budget to oral and dental healthcare—especially to preventive healthcare services—

(5) the lack of public–private cooperation in the oral and dental services. (p.374).

3.6 Conclusion

The oral healthcare system in Turkey is undergoing a dynamic process since the launching of the HTP in 2003. Over the years, the use of oral health care services has increased. In addition, the reform paved the way for achieving universal health coverage in oral healthcare, which is quite rare in the OECD countries, by increasing share of the public sector in oral healthcare provision.

There are three inferences this chapter provides about present situation of oral healthcare system: (1) The share of public sector has been increasing in oral healthcare. (2) Considering the number of dentists per capita population, Turkey is still approximately half of the OECD countries. (3) Turkey is below the OECD average in the number of dentist consultations per person.

At this stage, it seems important to understand how and why the private sector is still preferred by some dental patients and the reasons for bypassing public oral health service providers and following various ways to obtain oral health care. Therefore, this chapter provides a broad description of the oral healthcare system in Turkey to better understand patients' pathways towards oral healthcare services in present circumstances.

CHAPTER 4

ORAL HEALTHCARE SYSTEM CHARACTERISTICS THAT SHAPE PATIENT PATHWAYS TO DIAGNOSIS AND TREATMENT

4.1 Introduction

This chapter explores the way the oral healthcare system shapes patient pathways to diagnosis and treatment, the factors affecting the choice between dental sectors, and patients' perceptions of the state of the oral healthcare system in a country that achieved universal health coverage in oral healthcare. The study relies on 19 semistructured in-depth interviews conducted through phone calls with dental patients who submitted to oral healthcare in public and private dental clinics in Istanbul. The interviews were held with 10 patients who received care in a private dental clinic and 9 patients who received care in a publicly funded oral and dental health centre. The dentist whose clinic was chosen for this field research labelled as Dt. M., and the respondents are attributed numbers to disguise their identities and labelled as State or Private according to the sector they choose for their last dental visit. The original (Turkish) quotations of the respondents are listed in the Appendix E according to their order in the text. Each dental clinic is located in the same neighbourhood in Istanbul and some of the respondents of this research had submitted to both types of clinics.

This chapter offers a thematic and exploratory analysis of these interviews, which were transcribed verbatim and analysed in Turkish. The selected quotes were then translated into English. Four major themes that shape patient pathways in Turkish oral healthcare system emerged from this analysis: Dentist stability, perceived dentist responsiveness to patient preferences, medical care costs, and waiting time. This chapter presents the general patterns observed in the

abovementioned themes; diverging tendencies in these themes among public and private sector users; and exceptional but important personal experiences of dental patients in the oral healthcare system in Turkey.

4.2 Dentist stability

One of the main differences between oral healthcare experiences received in public and private providers was that although patients who chose the private clinic mentioned a single dentist whom they were familiar with and was responsible for their whole oral diagnosis and treatments, patients from public clinic referred to several dentists they encountered during their dental attendances.

When I asked patients, who had experience in both public and private dental clinics, the difference between dental visits to these two types of providers, they mentioned changing diagnosis and treatment plans due to the constantly changing dentists during their visits to public providers. For example:

> In private, when you have a complaint, I can find the same doctor. You can raise your complaint and they can do it without charge when you have a complaint again. But in the public, it is a problem both to get an appointment to go to the same doctor, for example, I will go to another doctor in 1.5 months, for example, I will go to once again this week and this is my third dentist. Or the initial treatment started with such a treatment, for example, 1.5 months ago, on the post or on something, the doctor I went to ten days ago pulled the teeth, he said it will not work, we will change it, he said we will make a coating. The other said there would be no bridge, he said it would be a bridge. For example, he referred me to another doctor tomorrow because of the pandemic. Another doctor, I have not seen this one before, I will go to that doctor on Friday. For example, not the same doctor.
> (State 8, Quote 1)

According to the patient quoted above, lack of contact with a stable dentist and encountering several dentists during the treatment of a specific dental problem may lead to changes in diagnosis and treatment plan. Although State 8 was not able to change its provider sector due to financial concerns, for Private 7, having a stable

contact with a certain dentist appeared as one of the main reasons for choosing a private dental clinic instead of a public one. Private 7 stated:

> Now, when we go to the public, we can come across different people. When it comes to teeth, one is also afraid of the dentist's chair. One always prefers a familiar dentist. So, it was caused by it. I used to go to another female dentist before, since she did not make implant treatment, I started to see Dt. M. So that I can always be in contact with one person. Since we deal with different people in public hospitals, that is why we do not continue the treatment.
> (Private 7, Quote 2)

As this quotation demonstrates, besides having a stable contact with dentist was perceived as a prerequisite for a healthy treatment procedure, a familiar physician also appeared a factor diminishing dental anxiety. The familiarity of the dentist came forward as one of the most significant motivations behind the care-seeking patterns of the attendants of the private dental clinic. So that Private 2, for example, stated that if her dentist started to practice in the public sector, she also would move to the public sector to continue its treatment with the same dentist. Private 2 explained this shift by saying “because we are looking for the doctor” and described the dentist as “our own doctor”: “Because we have our own doctor, we pay as we wish. God bless her. She also makes the discount she can make, and we do not see any problem, we trust her.” (Private 2, Quote 3).

Besides financial convenience as mentioned above, a familiar stable dentist brought about proper treatment according to some patients. For instance, Private 10 perceived dentists practising in the public sector offer “sloppy treatment” and adopted a "so I get my salary anyway, just do it in a way” style (Quote 4). When I asked Private 10 if the General Health Insurance (GHI) covered the treatments in private dental clinics, would it lead dentists in the private sector making the treatment in a sloppy way too, she responded: “Now if there is a familiar dentist in the private sector, it won’t be like that, I think.” (Private 10, Quote 5)

One respondent stated that she would not follow her dentist if she would change sector. The respondent maintained:

> So yes, I prefer Mr. M (Dt. M.) because he also gives confidence, but for example, if Mr. M. goes to the public sector, I am still not a supporter of the public sector because I think I will continue to receive care in the private sector. In other words, the role of Mr. M. is very big, of course, I visit him especially because he serves in the private sector, but this time I may have to go to another (private) clinic. The public sector is always the last resort for me, after all this.
> (Private 3, Quote 6)

As the statements of the patients demonstrate, dentist stability was linked to many other components of the dental treatment procedures. For some respondents, a stable dentist guaranteed the continuity of the treatment process and increased the likelihood of completion of the dental treatment. However, a stable contact with a familiar dentist was not always the primary concern for all respondents. For example, in response to the question of whether they would change the provider sector if their dentist changed her provider type, one of the participants stated that she could change the provider sector in order to continue with the same dentist, while another stated that she would change the dentist instead of changing the sector following the dentist.

4.3 Perceived dentist responsiveness to patient preferences

The statements of most of the patients, who had been to a public dental clinic before and currently preferred private one, demonstrate that, in the public dental clinics, the perceived lack of dentists' skills to examine properly and assess professionally and their perceived unresponsiveness towards patients, especially concerning the provision of adequate information about treatment and alternative treatment options were counted as the main reasons for their bypassing insurance covered treatments in publicly funded dental clinics. For example:

> For others (health care services), I generally try to prefer the state. I cannot choose it for teeth, I preferred the state several times, unfortunately, I realized that my teeth disappear each time. So, in the first stage, they go directly to the tooth extraction. I was obliged to do this, and I was immediately bowing to that pain. You may have seen my teeth that day too, although we are at this age, there are enormous deficits, that is, they have always suffered from extraction. It could be done with a coating or short treatment, but unfortunately, even when I went to B. (a foundation university hospital), which is also a private institution, they applied directly to the extraction straight away, so now I have to go to private (referring to private clinics of dentists) with that confidence.
> (Private 8, Quote 7)

As this quotation shows, for some patients, there was a perceived lack of dentist responsiveness to their preferences and concern for prevention and, according to her, pulling out the teeth was accepted as the most common treatment in publicly funded dental clinics. For this reason, the patient thought that her teeth were extracted, which could somehow be treated. At this point, Private 8 thought the lack of empathy was the cause of the problem and had the perception that dentists were selfish and uninterested in public oral healthcare services. She argued that:

> As my general comment, there is nothing here (in public providers) on tooth recovery, that is, they directly sacrifice the tooth. You are asking questions to find out if it is necessary. They say that the tooth can no longer be saved. ... When a person is over a certain age, teeth do not come out anymore. It is as if we are eight-yearolds, you try to shoot right away.
> (Private 8, Quote 8)

She had also concerned about possible differences between medical protocols used in the Eastern and Western cities of Turkey regarding dental treatments and about immediately applying the tooth extraction without evaluating other treatment options. For example:

> If this is the western side, this is the shape, especially the eastern side, I myself am from K. (a city located on the eastern side of Turkey), when you look at the people of the village or something, there is a lot more extraction directly there without any interest, so it is completely disgraceful there. At least here,

> maybe people express themselves, but people there don't listen either. They start shooting straight away.
> (Private 8, Quote 9)

As this quotation shows, the perceived unresponsiveness of the dentist eventually gave rise to loss of teeth instead of applying preservative measures. In addition, Private 8 had concerns about the state of public oral healthcare services in the eastern side of the country, especially in rural areas, since she thought that physicians practicing there did not listen to patients which gave rise to more tooth extraction instead of applying preservative measures.

As Private 9 pointed out below, while she was offered tooth extraction as the only alternative treatment in the public dental clinic, the same tooth was treated with conservative methods in a private dental clinic and the patient continued to use her tooth.

> I went (to the public dental clinic) and I had something like this: I sat on the seat, actually I went to Y State Hospital once, it was very well looked after, they were very interested because it is a small place. But here in Istanbul, I went to the public dental clinic, he put me on the seat directly, because they ask in a private clinic, they used to explain it like this, physicians in the public sector should also be asking like this. He pressed the needle directly and said, "I'll pull your teeth out."… I got up immediately, I said I don't want it, I got out even though I had an injection, I didn't go afterward… It was said directly as follows: "This tooth cannot be saved in any way, we will pull your tooth, I shoot the needle" he said. On the one hand, I was surprised at what I was going through, I have pain on the one hand. At that moment he shot the needle. Then I recovered myself and I still use that tooth, thanks to Mr. M. (Dt. M.) Let me say so."
> (Private 9, Quote 10)

As the quotation above demonstrates, the differences between communication skills of two dentists both working in public sector and practising in a small town in which patient density was quite low or in a metropole such as Istanbul, brought about varied patient experiences in the same sector. Besides this, the statement of the patient raise

question about whether the informed consent, which is obligatory to be obtained before the treatment, was taken in an appropriate way.

When I asked Private 6 the reason behind its choice of private clinics for oral health issues as she stated that she preferred public hospitals for general health problems, she responded as follows:

> State hospitals are very troublesome in dental treatments. We prefer dental care (in private dental clinics) because we cannot make it in the state (hospital). When I say it is troublesome and we cannot make it (I mean) when it is a long-term dental issue, but we prefer the state in others because it is very comfortable. So, there is no problem with this when the problem does not require a long-term attention.
> (Private 6, Quote 11)

Following this, when I asked how she saw the role of the state in the provision of oral healthcare services in Turkey, the respondent answered my question as follows:

> I do not want to comment much on the state. The state is doing its best, and I myself worked in state institutions. The important thing is the attitudes and behaviour of the people there. In other words, the state does not prolong the process there, it is a situation caused by the relaxed work attitude of individuals there. If the dental parts there were as in the private, theirs would be more comfortable. The state is doing it perfectly, it has done everything perfectly, and it cannot be better than this. It is only about these people, that is, it is about management. Otherwise, why wouldn't I choose it? I went to Z. (a public provider), I saw that it would take a lot of time, I was going to lose my tooth. In other words, I should have started the treatment as soon as possible. I can't say anything to them either. It was crowded, timing was an issue, so I preferred the private provider.
> (Private 6, Quote 12)

Regarding the caring attitude and interest of the dentist, some of the patients were quite satisfied with physicians practising in the public sector. Respondents from the public dental clinic chosen for this research had a positive opinion about dentist efforts to reducing pain, being interested in their oral health condition, and concerned about the patient's pain threshold. For instance, State 5 compared its current dentist

with both a dentist from another public dental clinic and a dentist from a private one and she stated:

> Yes, yes, they were both (two public dental clinics the patient attended) good, I was pleased with both of them, frankly, they were very interested. You know, I am very fond of my own comfort, but you know both were trying to be very kind… So, I can say; they were both (one private and one public dental clinic the patient attended) very interested, they were both very good, but the state seemed better to me, I don't know, their attitude seemed more interested or something. I do not know if it is because I saw it that way, but you know. The state is better, I always prefer it. They say doctors are better in the public sector so a little.
> (State 5, Quote 13)

There was also a respondent (Private 5), who was involved to the research as a patient from the private clinic, but she also had an experience in the public dental clinic, had a positive opinion about dentists practising at public dental clinics. However, she reported that she failed to arrange an appointment since a limited number of dentists are available in public dental clinics due to the COVID-19.

> They greeted me very well at ADSM, it was like a private one. Their tools, their attention, everything seemed like the private sector. Since it is a hospital, you can take your x-rays comfortably. It was so great in that way.
> (Private 5, Quote 14)

As the quotation above shows, the caring dentists, and the technological infrastructure of the public clinic reminded the patient of the private oral health care providers. Therefore, it seems that, if they were found to be appropriate and clean with caring dentists, a public dental clinic was compared to private ones and likened to them.

As it comes to the image of the public providers in the eye of private provider users, the statements of some respondents described them as careless with a lack of responsiveness of patient's preferences. However, this perception was not

always grounded in personal experience. Some of them had never been at the public dental hospital before. As in the examples below:

> They pay more attention (to patients) in private because they behave differently in the public sector.
> (Private 4, Quote 15)

> The dentist is not very interested in public (dental clinics), that's why.
> (Private 2, Quote 16)

> I think this is due to the dentist (the problem in the public sector originates from). It is sloppy. I mean they have a style like "I get my salary, anyway, just do it".
> (Private 10, Quote 17)

These quotations above belong to the respondents who had never attended the public dental clinic, however, as the statements of patients demonstrate, they had a negative perception of the treatment procedures and the approach of the dentists practising public hospitals.

On the other hand, there was one respondent (State 4) who had never been to private dental clinics, she mentioned how pleased she was with the treatment experience in public dental clinic, also stated: "Thank God they are very good, if we go to the private, they will be interested that much." (Quote 18). As this quotation shows, the image of the private sector was quite good and was sometimes used as a reference point for good treatment by some patients.

4.4 Medical care costs

Medical care costs of private providers were one of the shared concerns which were mentioned by both public and private service users. Some patients preferred to change their private provider due to the difference in prices between private clinics. Some others chose to submit to public providers when they faced with the high cost of private clinics.

In terms of the effect of varied cost of medical care and payment policies among private providers for the private oral healthcare service users, Private 9 shared her experience with different private dental clinics:

> I've known Brother M. (Dt. M.) from time immemorial. It is only the last time I went to his clinic. The first was someone whom my spouse knew, and we were going there. I had found someone (a dentist practicing in the private sector) of my own before that, let me say so, we were going there. But there is Brother M., whom I am pleased with right now, both financially
> and in terms of the attention he pays, let me say so.
> (Private 9, Quote 19)

When I asked the reason behind changing previous dentists, she responded as follows:

> I quit the first one because I had a little concern about hygiene problems. For the second time, financially, you know, he is so full of money now that he admits a few patients only. He wanted 500TL for a root canal treatment at that time. Later, when my mother contacted Brother M. again, I wanted to go. So, we went to him that way.
> (Private 9, Quote 20)

As these quotations demonstrate, besides the interest of the dentist and hygiene of the clinic environment, the cost of the care had a decisive effect on deciding which private service provider was to be chosen.

In addition, for most of the patients from the private dental clinic, one of the main reasons for their choice among other private oral healthcare providers was that the process of paying the bills was easy, comfortable, and flexible. For example, when I asked Private 1 whether she would make a payment or the amount of the payment she would make had been effective in her provider choice, she responded by noting that “Mr. M. (Dt. M.) provided flexibility for us, this also had an effect on (for her dental clinic choice)” (Quote 21). Similarly, Private 2 mentioned taking advantage of the flexible payment option that Dt. M. offers to his patients: “In truth, since we have our doctor, we pay as we wish. God bless him. He also makes the

discount he can make, so we do not see any problem, we trust him, we trust him" (Quote 22).

As mentioned above, some patients who used private providers before reported that they had to change their service provider sector due to the medical care costs took and thought that they had no other option because of their financial situation. For example:

> I went (to a private clinic) because I had to, but they paid good attention. They measured something there. We were going to get it done there, but we couldn't do it because it was too expensive. My tooth had to be filled. But other than that, I was satisfied with the attention I received.
> (State 5, Quote 23)

As stated by State 5 above, the medical cost of the care was the only reason for foregone dental care in a private dental clinic in this case. Similarly, State 8 was one of the patients who submitted to private clinics before and was satisfied, however, could not receive dental treatment there due to the cost of the care. She explained the process as follows:

> I had to make implants, so many implants, and that was very expensive. I decided to go to the state (public dental clinic) for it.
> (State 8, Quote 24)

As this quotation shows, the patient had to postpone some part of the planned treatment and sought dental care in the publicly funded dental clinics. When I asked the same respondent how decisive the physician was in her provider choice, she replied as:

> The physician is very decisive, for example, here is a dentist in G., and I live here. There is T. Hodja (Dt. T.) there at the entrance of G neighbourhood. For example, I went to him 30 years ago, I had my fillings and changed them. It's a bit expensive now if it were cheap, I'll go straight to him, so I mean.
> (State 8, Quote 25)

As stated by State 8 above, it seems that dentists had a crucial role in terms of influencing the patients' pathway towards dental treatment. However, the medical cost of dental care was a game changer by which the dental patients had to make different choices.

Another narrative about a foregone dental treatment I heard was when I asked a patient, who complained about having difficulty and being not able to find endodontist appointment in public dental clinics. I asked her whether she received treatment from private clinics and she responded as: “How can I tell you now, I am getting a salary of 4500 lira; How can I give one-fourth of my salary to root canal treatment while living in Istanbul?” (State 6, Quote 26)

Some patients who were satisfied with the treatment they received in the public dental clinics; however, they would prefer private oral healthcare providers if they had the means to pay for private treatment. State 1, for instance, stated that:

> I mostly prefer public hospitals because I am not rich enough to spend on private ones, so I don't have money that much money. I don't go private unless I run into a difficulty... I don't go private because of the price, otherwise private is my first choice of course.
> (State 1, Quote 27)

Subsequently, when I asked if she was satisfied with services in the public dental clinic, she replied as follows:

> I do not know, I have always had my teeth are done by the state (in the public dental clinics) from the beginning, I am glad, I have not encountered anything bad until today, there has been no setback. I just got that one done in a private clinic in M.; I went there also because the price was affordable, as I had gone to another private provider, their price was too expensive, so I had to go there, I had it done there. I don't know why I didn't go to the state (to a public dental clinic) at that time.
> (State 1, Quote 28)

As the quotations above demonstrate, for some patients, the private sector was the preferred provider even though they had no dissatisfaction with the public ones.

There was one patient who was a former public oral healthcare service user and currently preferred private dental clinic due to the improvement in her economic situation besides dissatisfaction with the treatment process and painful experience in public dental clinics. She shared the reasons behind her decision of changing providers by comparing her experiences at the public and private dental clinics:

> Because I had a tooth extraction before (in the public dental clinic) it was so painful for me. I recently had a tooth extraction again, but this time I performed in a private (clinic) the tooth extraction; there were mountains of difference between the two. Before my tooth extraction, I was dying of excitement, almost because of what I had experienced before in the state, now I overcome my prejudice a little. I mean, I had to have a tooth extracted at that time because I had a lot of pain, that is, I wouldn't have to have a tooth extracted if I didn't have to, so even though I went there, they gave me a later date, I became even more victim this time. I had no choice but to wait. I was younger then, our financial situation was also troubled, now that I have taken my own freedom, I preferred my options to be more private (clinics) because I have accumulated my income. I did not want to choose the state again because it was painful and troubling.
> (Private 3, Quote 29)

As the quotation above shows, dissatisfaction with the treatment process was a necessary but not sufficient condition for some patients to change their provider. Cost of treatment in the private sector poses an obstacle for them to make this change. But once they have the means, previous negative experiences they had in the public sector motivates them to use private providers.

It seems that medical care costs and payment policy of the service provider had a crucial role for shaping patient pathways. The statements of patients demonstrate that the financial aspect of the dental treatment had a decisive influence across and within the provider sectors. Thus, while the respondents from the private clinic put emphasis on the flexibility in paying the bills, some of the patients from the public dental clinic had a complaint about the expensiveness of the private oral healthcare providers that leave no choice for them other than public providers.

4.5 Waiting time

Another shared concern about being public dental services as out of reach was waiting time beyond the desirable period. The length of waiting time for an appointment or for certain dental treatments such as orthodontics appeared as a barrier on patients accessing public oral healthcare services. As far as the private ones were concerned, the respondents complained of neither the difficulty in getting an appointment nor the length of time waiting for the appointment. Therefore, generally, private provider users put forward waiting time as one of the reasons why they chose private dental clinics instead of public ones, whereas public provider users mentioned waiting time and having trouble in making an appointment for public dental services, as the cause of their delayed dental treatment. Therefore, it seems that, waiting time had a significant role on the patients' pathways toward dental diagnosis and treatment either as a road changer or as a path extender.

According to some patients, one of the main reasons why they find public dental services insufficient was long waiting time. When I asked a private service user if she had ever tried to make an appointment for a public dental clinic, she replied as follows:

> I tried, I tried. Of course, I tried, for example, the simplest is that there is no implant in the state. I needed an implant. There is also a lot of queues in the state… They keep you waiting, you know the tooth is not like any other, if your tooth hurts, you have to go (and fix it). You are not in a position to sit and wait.
> In this case, I only want to assign myself to the doctor. (Private 2, Quote 30)

As this quotation shows, especially the length of time for an urgent appointment and sense of urgency during dental problems led some patients to forgo treatment options offered by publicly funded oral healthcare services.

Similarly, Private 3 complained of arranging an appointment for a quite advanced date at the time she applied to a public dental hospital in urgency. She shared her experience at the public dental clinic as:

> I mean, I had to have a tooth extracted at that time because I had a lot of pain, that is, I wouldn't have to have a tooth extracted if I didn't have to, so even though I went there, they gave me a later date, I was even more victim this time. I had no choice but to wait. (Private 3, Quote 31)

As the quotation above shows, the respondent had to delay and failed to access dental treatment at that time due to the long waiting time in the public service provider. Private 3 mentioned that this had happened when she was a child and her family's financial situation was not good, and therefore could not apply to private dental clinics for dental treatment.

However, Private 5 was fortunate enough to receive dental treatment in a private dental clinic when she could not make an appointment at the public dental clinic, where she had been treated before and was satisfied. When I asked the respondent, which provider she would choose if she had an oral health problem, she replied as:

> So I first examine the state (public dental clinics). Normally, before this pandemic, it was easier to get an appointment with the state, now there is almost no. It gets very hard. When I have to, if I am in a very bad situation, I prefer the ones nearby, I prefer the private ones close to my home. (Private 5, Quote 32)

As shown in the quote above, there was a long waiting time for Private 5 during the appointment scheduling process, and as a result, was unable to arrange an appointment. But she could access private services as she could afford to do so. In a similar way, State 6, who was having implant treatment when I interviewed her, complained about the non-availability of specialised clinicians in public dental clinics. When I asked her if she had trouble getting an appointment, she replied:

> I did not have difficulty with the implant, but I had a lot of trouble before or two months ago in getting an appointment for the root canal treatment in an endodontics outpatient clinic, and even applied to CIMER twice because not even one endodontist was not working in Istanbul.
> (State 6, Quote 33)

In the case of State 6, waiting time due to lack of specialised dentist led to a foregone treatment since the respondent could not afford co-payments in private dental clinics.

For Private 6 and Private 7, although they managed to arrange an appointment for public dental clinic, the waiting period for a treatment covered a process that spanned years. When I asked Private 6, if she went to a public dental hospital, she answered: “I went in 2010, they made an appointment for 2015. I went to Z university (a public university dentistry hospital), they spread it over the years. … Life is not long enough for it.” (Quote 34)

Similarly, Private 7 shared one of her public dental hospital experiences when she could not secure orthodontic treatment for her teen daughter due to the long waiting list. She stated:

> I took my daughter to L (a public university dentistry hospital) when she was 10 to have braces (to have orthodontic treatment). They said we will call when your turn comes. She became, 2122 years old, still, they haven't called. They said that after the age of 18, the state does not afford to wear braces. Therefore, we experienced something like that at that time. You cannot make those things (such as orthodontic treatment) in the state (public dental clinics).
> (Private 7, Quote 35)

As the quotation above demonstrates, waiting time spanning years may give rise to distrust of public dental clinics for certain dental treatments.

Some respondents were receiving their delayed dental treatment in the public dental clinic when I conducted interviews with them. For instance, when I asked State 5 if she had trouble finding a dentist appointment, she replied: "Yes, I have, I have been trying to keep an appointment for the last 5-6 months, it barely arrived, let

me tell you this way." (Quote 36). State 5 was quite satisfied with the public dental clinic experience and the dental treatment she was receiving, nevertheless, she pointed out the difficulties in making an appointment as the most important problem in public oral health service providers. As she stated:

> As you have just mentioned, they have a lot of trouble with these appointments, people, in general, have a lot of trouble, I think this (number of appointments) can be increased more. Apart from that, there is no problem in terms of satisfaction in this particular ADSM, let me tell you that.
> (State 5, Quote 37)

As the quotation above shows, waiting time was cited as the main problem for accessing treatment in public providers.

Regarding the role of waiting time as a road determining factor in patient pathways toward dental diagnosis and treatment, State 9's dental care-seeking behaviour provides useful hints. For instance, the respondent failed to take advantage of proximity and had to receive dental treatment from a public dental clinic an hour away. When I asked which dental hospital sector she would prefer and why, she replied as:

> I went to the university hospital. Now I'm going to the state (public dental clinic) for the tooth… I prefer it (dentistry university hospital) more, but I cannot manage to find an appointment there. There, I see that hospital (dentistry university hospital) as superior …Since I have celiac disease, I received a lot of treatment there, I find it more reliable.
>
> I came here from an hour's way. I got on the subway, got off the subway, got on the minibus, I went again… There is a public hospital close to us, I cannot find an appointment there… I go wherever I find an appointment because my dental problem is severe.
> (State 9, Quote 38)

As the quotation above demonstrates, waiting time had a tremendous impact on if and where patients receive the dental treatment. So that, proximity or preferred

institutions for dental treatment were out of choice when waiting time was in question.

It seems that the waiting time emerged as one of the path changers on the road of accessing dental diagnosis and treatment for dental patients. Some respondents had shared concerns about long waiting lists in the public sector that spanned for years and some of them put emphasis on the discrepancy between the urgent character of oral health problems and waiting times beyond the acceptable period. The respondents, who were receiving dental treatment at the time of the interview but had also other public dental clinic experiences, underlined the decisive impact of long waiting lists and time, and the effect of them on their present choice of oral healthcare provider sector. Some respondents using public dental clinics voiced how waiting time shaped their dental treatment and at times gave rise to the foregone treatment.

4.6 Varied patient pathways

Overall, the analysis here demonstrates that patients use diverse, and often complex pathways to dental care. Besides this, it is understood that they follow different paths for general and dental health problems. In this thesis, it was previously stated that oral healthcare systems are rarely integrated with general healthcare systems worldwide, however, it seems still quite interesting that the same difference exists in the healthcare-seeking behaviours of the patients. According to the interviews with private oral healthcare service users, seven out of ten patients prefer public hospitals or primary healthcare institutions for general health problems, while one prefers private hospitals and another one does not go to a public hospital because it does not get sick often. With respect to public oral healthcare service users, seven out of nine patients prefer public hospitals, one of the patients both public and private hospitals

and another one goes to private hospitals only in the case of emergency. Table 8 indicates that for both public and private oral healthcare service users, public hospitals were more preferred for general healthcare problems.

Table 8. Distribution of Patients According to Their General Healthcare Service Provider Preferences

Healthcare service provider preferences for general healthcare problems				
	Public Hospitals	Private Hospitals	None	Both
Public oral healthcare service users (9 Persons)	7	-	-	2
Private oral healthcare service users (10 Persons)	7	1	1	1

The table above shows that when it comes to general health problems, both public and private oral healthcare service users generally preferred public hospitals.

According to the patients, who prefer private providers for oral healthcare while choosing public providers general healthcare problems, public dental clinics are insufficient, and they are not able to get their job done in public dental clinics.

4.7 Conclusion

This chapter explains how oral healthcare system characteristics shape patient pathways to diagnosis and treatment in Turkey. From the analysis of the interviews, four major themes that had a significant impact on patients' oral healthcare-seeking

behaviour emerged: Dentist stability, perceived dentist responsiveness to patient preferences, medical cost, and waiting time. Some of these themes had a stronger influence on patients' service provider choice, whereas some others had an impact when combined with other factors.

Dentist stability was seen as a crucial component of a healthy relationship and communication between the physician and the patient, and a guarantee for the successful completion of the dental treatment. According to the statements of the respondents, encountering varied dentists during the dental treatment process gave rise to changing diagnosis and dental treatment plans. Besides this, dentist stability was found as one of the important aspects to build trust between two parties and decreasing dental anxiety. Dentist stability is also presented as one of the advantages of receiving dental treatment in the private sector, whereas constantly changing dentists is counted as a drawback by some of the public oral healthcare service users.

Perceived dentist responsiveness to patient preferences was counted as one of the determinants that shape the decision of the patient where to seek dental care. So much so that the respondents decide whether they were satisfied with the dental experience according to the dentist's responsiveness to their preferences and expectations from the dental treatment process. The statements of some patients illustrate that a patient adopted an idea of possible consequences of treatment according to the dentist's demeanour, communication skills, and attitude towards patients. While some of those who used private dental services had the perception that dentists practising in public dental clinics were uninterested, non-empathic, and negligent, according to some participants from the public dental clinic, dentists were as interested, or even better than dentists practising in the private sector. It seems that for some present private oral healthcare service their previous unpleasant experience in public dental clinics caused them to change the oral healthcare service provider.

Nevertheless, there is no common pattern in the perception of public providers' responsiveness in the eyes of respondents as some of these respondents did not use the public sector before.

Medical care costs had an impact on dental care-seeking behaviour. Since for most of the public service users the cost of dental care in the private sector required sacrificing a significant amount of their income, medical care cost emerged as a barrier or a road changer on a patient's pathway to dental treatment. It seems interesting that some participants from the public dental clinic, who were satisfied with the present service provider, stated that they would choose a private dental clinic instead of making this effort to receive dental treatment if they were financially sufficient. Similarly, some patients from the private dental clinic with an unpleasant experience in public oral health service providers mentioned that they had to wait to change their service provider sector until their finances were sufficient for the cost of dental services in the private sector. In addition, for the respondents from the private dental clinic, the process of paying the charge, flexibility in payment conditions, and thoughtfulness of the dentist about financial matters played a crucial role in their choice of this private dental clinic among others.

Long waiting time posed a significant challenge for those who sought dental care in public service providers, whereas with respect to the respondents from the private dental clinic, waiting time did not have an impact on their dental treatment process, and even during pandemic circumstances, they did not have to wait to receive dental treatment. Long waiting time and waiting lists spanning years in the public sector, for some respondents from the private dental clinic, shaped their pathway to dental treatment and brought them to the present service provider at the end of the road. Concerning public oral healthcare service provider users, waiting time deeply affected the dental treatment process and shaped where, when, and from

whom they received dental treatment. For instance, having a struggle in making appointments may lead to delay dental treatment by six months, or cause the dental patient to choose more distant public dental clinics rather than locations close to their residence. However, waiting time and lists are not the determining factors in shaping the pathway of patients to dental diagnosis and treatment for all public oral healthcare applicants. For instance, one respondent who receive dental implant treatment stated that they did not have any problems about the waiting time at the public oral health service provider.

Interviews with patients from private dental clinics showed that dental patients may have different treatment strategies for dental and general health problems. In other words, in the case of seeking general health services, the separation between public and private dental clinics disappeared and most of the patients from both public and private dental clinics preferred to be treated in public hospitals for their general health problems.

When it comes to patients' healthcare-seeking behaviour for their oral health problems, there were two routes to dental diagnosis and treatment patients follow: Shortcut and undefined patient pathways. The shortcut patient pathway was characterised by bypassing public dental clinics in which a significant number of dental treatments are covered by GHI and submitting to private oral healthcare service providers. The undefined patient pathway, on the other hand, represented a rather uncertain route towards dental diagnosis and treatment for patients planning to be treated in public dental clinics since it is ambiguous and unpredictable when, where and by whom they will receive the dental treatment if possible.

The shortcut patient pathway was followed by nine out of ten patients from the private dental clinic. Five of them had unpleasant experiences in public dental clinics and they had never thought of going there again. On the other hand, three of

them had never been to the public dental clinic and only one of these three mentioned that she could choose public dental clinics if her present dentist starts to practice there. As a result, when they had an oral health problem, these nine patients applied directly to their dentist practising private dental clinic and bypassed public institutions where their dental treatments were covered by GHI on a large scale. They had no problem with the cost of medical care thanks to their ability to pay (and the physician's flexible and comfortable payment policy for this sample) and refrain from public dental clinics because of possible long waiting lists and time, and the risk of encountering uninterested, non-empathic, and inattentive dentists. Therefore, their pathway was a shortcut and one of the easiest ways to receive dental treatment in Turkey.

The undefined patient pathway was characterised by uncertainty regarding where, from whom, and when the patient would receive the dental treatment. The dental patient took this road when it preferred to take advantage of the GHI and did not want to pay out-of-pocket payments. After deciding to receive dental treatment from public dental clinics, waiting time, and ability to secure an appointment, shaped a patient's road route to dental diagnosis and treatment. When the dental problem was severe and unbearable, and the patient cannot make an appointment at public dental clinics, it was possible to go to a private dental clinic by sacrificing a significant amount of money, as one of the private dental clinic users did. However, this pathway was still not a shortcut since, in the beginning, the patient did not know how the process of dental treatment would unfold. In the case of financial hardship, the patient waited until arranging a proper appointment was available. During this effort, they may need to choose remote public clinics rather than nearby locations or postpone the treatment for months. Since they applied whichever dentist is available, the pathway is still uncertain and a cause of concern regarding dentist responsiveness

to patient preferences. Following the dental appointment, dentist stability and continuation of the treatment were undetermined aspects of the process and, therefore, undefined patient pathways lengthened or shortened and took shape according to each patient's own experience.

As in the shortcut and undefined patient pathways, the roadmap of the patient to dental diagnosis and treatment took shape according to which service provider the patient decided to receive dental treatment and her ability to pay. Besides this, the statements of the patients demonstrate that medical care costs played a crucial role at the beginning of the journey; uncertainty characteristics of the patient pathway does not necessarily lead to unsatisfied treatment experience; and after being pleasant about the result of the treatment received public dental clinics, a patient still may be willing to change service provider sector when the financial status is sufficient.

CHAPTER 5

CONCLUSION

Based on a small-scale qualitative research, this thesis offers a gateway into the dental patients' care-seeking patterns and treatment pathways in a country, Turkey, in which universal health coverage is achieved and dental coverage is quite inclusive. The thesis specifically focused on the question of "how does the Turkish oral healthcare system shape patient pathways to diagnosis and treatment?" and pursued this question through the individual experiences of dental patients.

From the thematic analysis of these interviews, four themes that shape patients' pathway towards dental diagnosis and treatment emerged: Dentist stability, perceived dentist responsiveness to patient preferences, medical cost, and waiting time. Dentist stability comes forward as an advantage of receiving dental treatment from private dental clinics. Having a dentist that patients are familiar with seems to have a positive effect on decreasing their dental anxiety, whereas constantly changing dentists during the treatment process may lead to treatment dropouts or delays in the completion of treatment. Therefore, my findings demonstrate that encountering the same dentist throughout the dental treatment has a crucial impact on developing a healthy dentist patient relationship based on trust and seems like a guarantee for the steadiness and success of the treatment in the eyes of the patients.

Perceived dentist responsiveness appears as one of the important aspects of a healthy dental treatment process in patients' perspectives, whereas unresponsive dentists to patients' preferences push patients to seek alternative providers. For this reason, the results of this study reveal that searching for a stable dentist who is also

sensitive to the patient's dental treatment needs is a crucial component of patients' pathway to dental diagnosis and treatment.

However, the cost of treatment in private providers often overshadows the impact of two above-mentioned themes on patient pathways. Hence, the medical cost of the dental treatments seems to be the main determinant of which provider the patient receives the dental treatment. The analysis reveals that besides the total medical cost of the treatment, the financial policy of the dental clinic and flexible payment options a clinic offers also have an impact on dental patients' provider preferences. This finding corroborates the results of the study by Östberg, Ahlström and Hakeberg (2013) claiming that due the dental patient may consider changing the dentist, even if she does not change the sector, if she finds the dentist is primarily driven by her/his economic interests. Thus, the medical cost of the care and payment policy of the dentist have a quite significant role in making a choice between and within service provider sectors.

Since the medical cost of the care is directly linked to UHC, which has received special focus in this thesis, this theme will be elaborated for the sake of the main objectives of the study. In Turkey, public dental clinics offer dental treatment almost without any charge, whereas private dental clinics receive out-of-pocket payments from patients. For this reason, receiving dental treatment in the private sector brings about not being able to benefit from insurance and may result in sacrificing an important share of one's income. Therefore, in the case of financial insufficiency, dental patients have no choice but to wait until a dental appointment is available in publicly funded dental clinics. As previous studies (e.g. Peterson et al., 2005) indicates, these are often the same group of patients that bear the largest burden of oral diseases. My findings show that some patients would prefer a private

dental clinic rather than endure public oral health services if their financial situation was sufficient.

This thesis demonstrates that patients have different care-seeking strategies for general and oral health problems. Most of the patients from the private clinic (seven out of ten), prefers public hospitals for their general health issues, likewise, the patients using public dental clinic also do. Therefore, I argue that universalisation in dental coverage has not led to utilisation patterns similar to that of general healthcare. To grasp the reasons behind this discrepancy between oral and general healthcare, having a closer look into different characteristics of universalisation of general and oral healthcare in Turkey could be helpful.

My study provides an examination of an oral healthcare system in which universalisation takes place only through the extended public provision without including the private providers into public reimbursement. Since the Turkish general healthcare system provides an example of realisation of universalisation that occurred by the inclusion of the private sector, the findings of this study on oral healthcare offer a different picture in which universalisation is implemented without the private sector. In Turkey, UHC is realised hand-in-hand with the private sector, whereas in the oral healthcare system, the private sector, except foundation dentistry universities, is excluded from insurance schemes. This distinctive type of universalisation in oral healthcare seems not to change the provider preferences of patients using private dental clinics, as respondents from this group prefers the private sector although most of the dental treatments are covered in publicly funded dental clinics. Therefore, my findings demonstrate the relevance of the previous claims that strong public provision may not guarantee equity and UHC by Yılmaz (2017) and Mukhopadhyay (2013) to the domain of oral healthcare. At this point, by

all means, the term “strong” public provision is a crucial point to figure out the role of the state in the system and its capacity of expansion for a stronger position.

In the literature (Guarnizo-Herreño, Watt, Garzón-Orjuela and Tsakos, 2019), oral healthcare is characterised as being not fully integrated into general healthcare systems. Besides this, according to Watt et al. (2019) UHC brings about an opportunity to oral healthcare systems for both integrating to wider healthcare systems and being more accessible and responsive to the oral health needs of the society. At this point, my findings are in contrast with Watt et al. (2019), so that universalisation of oral healthcare may not bring together automatically the accessibility and accountability of the oral healthcare services. More research is needed to uncover how universalisation affect patient pathways to treatment, their provider preferences and their care seeking strategies.

The analysis in this thesis reveals that although universal dental coverage is a necessary step forward in granting access to care, it is not a sufficient factor to guarantee accountability and equity of oral healthcare. Therefore, besides access, other factors such as dentist responsiveness to patient preferences and waiting time need to be taken into consideration for more comprehensive oral healthcare policies. Therefore, I agree with Moulton’s (2009) realised publicness theory that emphasizes the importance of subjective experiences of service users in assessing if the publicness in theory is reflected in the everyday lives of people. Thus, my study suggests that along with the universalisation, elements such as accessibility, affordability, accountability, and equity of the healthcare should also be adopted as important aspects of evaluating the performance of oral healthcare services.

The fourth theme that emerged from the analysis is waiting time. My findings reveal that waiting time may lead to foregone and delayed treatment, and sometimes

lead patients to shift provider type albeit with the burden of associated financial costs. This finding confirms Nguyen and Häkkinen's (2006) suggestion that besides the price of oral healthcare, the availability of the services directly shapes the patients' care-seeking patterns.

The four above-mentioned themes have varied impacts on patients' pathways towards dental diagnosis and treatment. The patient pathways observed in this fieldwork are in line with Richter and Schlieter's (2019) definition of patient pathway as a not predefined and often unstandardised journey of a patient looking for a healthcare service to meet her healthcare needs.

I argue that even though it is an individual journey, a patient's pathways are mostly shaped by the healthcare system. Therefore, while I agree with Lismont et al.'s (2006) suggestion that "every patient follows a unique path" (p.126), my findings also reveal that there are some healthcare system-induced patterns. Similarly, it is not the case as Victoor et al. (2012) suggest "different patients make different choices in different situations" (p.1) but rather every patient is left with quite limited options and some of them have to wait until an appropriate dental appointment is available without being able to predict where, when and from whom she will receive the dental treatment.

This research identifies two patient pathways: Shortcut and undefined pathways. I argue that the shortcut pathway is the quickest way to dental diagnosis and treatment and is applicable to patients receiving service from the private sector. The scope of the universal dental coverage or the insurance schemes does not affect this group's decision because its members often bypass the publicly funded oral healthcare providers. The publicness of the shortcut pathway is weak as the affordability of the treatment is always an issue for patients on low incomes.

The undefined patient pathway is unpredictable and provides different road maps for almost every single patient who submitted to oral healthcare in public dental clinics. The uniqueness of the patient's pathways is mentioned in the literature (Lismont, 2016; Victoor, Delnoij, Friele & Rademakers, 2012), however, this research findings reveal that oral healthcare system-specific characteristics lead to common patterns in treatment pathways. Therefore, my study reveals that rather than the agency of the patient, the cost dimension, dentist factor and waiting time that matter in shaping many patients' pathways to dental treatment.

My findings are in line with the suggestion of Nguyen and Häkkinen (2006) on deterrents of seeking care that is "the perceived expense of private care and the insufficient availability of public services" (p.3). However, according to my study dentist's recall does not appear as one of the main determinants of seeking care as the study of Nguyen and Häkkinen (2006) reveals. On the other hand, I observed that pain is another determinant of seeking care. In my study, some patients from the private dental clinic explained the rationale behind their choice of provider with the urgent nature of dental pain and the long waiting time at publicly funded oral health care providers.

Despite the limitations of a small-scale qualitative research, this thesis offers a comprehensive overview of the present status of the oral healthcare system in Turkey. Public provision of oral healthcare services has indeed substantially increased following the 2003 reform, however, private providers are still preferable for some oral healthcare patients. Having explored the reasons behind some patients' bypassing publicly funded oral healthcare providers, this thesis suggests that dental patients prefer to see a stable dentist who is responsive to their oral healthcare needs and accessible in any time. Therefore, they are willing to pay out-of-pocket payments

to have quick, appropriate, and reliable oral healthcare services. This finding is in line with the results of Bayat et al.'s (2010) study in Iran, that dental patients prefer to receive treatment from private dental clinics by paying fully out-of-pocket for the sake of good interpersonal and good technical aspects that private dental clinics provide rather than using free or highly subsidized public dental services.

The thesis contributes to the growing body of literature on patient's pathways and perception of healthcare systems and provides comprehensive information about the Turkish oral healthcare system for singular or comparative oral healthcare system studies. Since the study takes place in two dental clinics in Istanbul and is conducted with 19 dental patients, its findings cannot be generalised to reflect the complexity of patient experiences in the Turkish oral healthcare system. However, every respondent's experience and struggles in the system, their expectations from providers, and the rationale behind their provider choice still offer useful hints to have a better understanding of the strengths and weaknesses of the Turkish oral healthcare system.

APPENDIX A

SEMI-STRUCTURED INTERVIEW QUESTIONS IN ENGLISH

1) How old are you?

2) What is your job? What do you do?

3) What is your insurance status? Do you have private or supplementary health insurance?

4) In the last three months, have you been examined by a dentist or received treatment from the dentist for oral and dental health problems?

5) Which of the private sector or public sector dental clinic did you choose for the examination?

6) Why did you choose this clinic for dental treatment?

Prompt these factors if the respondent does not refer:

- Do you generally receive treatment for other health problems in this clinic?
- Was it decisive for you to know and trust the physician you are examining in advance or to be recommended to you?
- Has making or not making a payment or the amount of the payment you will make influenced your choice?
- Did the easy access to the clinic determine your choice?
- Was being able to find a quick appointment effective in this choice?
- Did a positive or negative experience in previous examination or treatment affect your choice?

7) If you were offered a treatment plan after the examination, did you start this treatment? If you have not started treatment, can I find out why you did not start yet?

8) If you started treatment, do you receive this treatment from the same healthcare provider and physician? If yes / no, why?

Prompt these factors if the respondent does not refer:

- Was it decisive for you to know and trust the physician you are treating in advance or to be recommended this physician to you?
- Whether you will make a payment or the amount of the payment you will make has been effective in your choice?
- Did the access to the clinic and the location of the clinic determine your choice?
- Was being able to find a quick appointment effective in this choice?

9) How do you see the role of the state in the provision of oral health services in Turkey?

a. Is it as it should be? Is it insufficient? Or should the state take on a different role?
b. If you think the state is playing the role it should be, can you explain the rationale for your assessment a little? What makes you think that way?
c. If you think the state's role is inadequate or it should play a different role, what role do you think it should play?

APPENDIX B

SEMI-STRUCTURED INTERVIEW QUESTIONS IN TURKISH

1) Kaç yaşındasınız?
2) Mesleğiniz nedir? Ne iş yapıyorsunuz?
3) Sigorta durumunuz nedir? Özel sağlık veya tamamlayıcı sağlık sigortanız var mı?
4) Son üç ay içerisinde ağız ve diş sağlığı problemi nedeniyle diş hekimine muayene oldunuz veya diş hekiminden tedavi aldınız mı?
5) Muayene için özel muayenehane, özel poliklinik veya devlet hastanesinden hangisini tercih ettiniz?
6) Diğer sağlık problemleriniz için de genelde bu tür bir sağlık kuruluşunda mı muayene olursunuz ya da tedavi görürsünüz?
7) Bu tercihi yapmanızı belirleyen ne oldu?
    - Muayene olduğunuz hekimi önceden tanımanız ve güvenmeniz veya bu hekimin size tavsiye edilmesi belirleyici oldu mu?
    - Ödeme yapıp yapmayacağınız ya da yapacağınız ödemenin miktarı tercihinizde etkili oldu mu?
    - Kliniğe ulaşım ve kliniğin konumu bu tercihinizde belirleyici oldu mu?
    - Hızlı randevu bulabilmek bu tercihinizde etkili oldu mu?
    - Daha önce yaşadığınız iyi veya kötü bir muayene ya da tedavi tecrübesi bu tercihinizde etkili oldu mu?
8) Muayene sonrasında size bir tedavi planı önerildiyse bu tedaviye başladınız mı? Tedaviye başlamadıysanız, başlamama nedeninizi öğrenebilir miyim?

9) Tedaviye başladıysanız bu tedaviyi aynı sağlık kuruluşu ve hekimden mi alıyorsunuz? Evetse/Hayırsa, neden?
    a. Tedavi olduğunuz hekimi önceden tanımanız ve güvenmeniz veya bu hekimin size tavsiye edilmesi belirleyici oldu mu?
    b. Ödeme yapıp yapmayacağınız ya da yapacağınız ödemenin miktarı tercihinizde etkili oldu mu?
    c. Kliniğe ulaşım ve kliniğin konumu bu tercihinizde belirleyici oldu mu?
    d. Hızlı randevu bulabilmek bu tercihinizde etkili oldu mu?
10) Türkiye'de ağız diş sağlığı hizmetlerinin sunumunda devletin rolünü nasıl görüyorsunuz?
    a. Olması gerektiği gibi mi? Yetersiz mi? Ya da daha farklı bir rol mü üstlenmeli?
    b. Olması gerektiği gibi bir rol üstlendiğini düşünüyorsanız, bu değerlendirmenizi biraz açar mısınız? Gözlemlediğiniz ne tür hizmetler size böyle düşündürüyor?
    c. Yetersiz veya daha farklı bir rol üstlenmesi gerektiğini düşünüyorsanız, sizce nasıl bir rol üstlenmeli?

APPENDIX C

ETHICS COMMITTEE APPROVAL

T.C.
BOĞAZİÇİ ÜNİVERSİTESİ
SOSYAL VE BEŞERİ BİLİMLER YÜKSEK LİSANS VE DOKTORA TEZLERİ ETİK İNCELEME KOMİSYONU
TOPLANTI TUTANAĞI

Toplantı Sayısı	:	14
Toplantı Tarihi	:	25.03.2021
Toplantı Saati	:	13:00
Toplantı Yeri	:	Zoom Sanal Toplantı
Bulunanlar	:	Dr. Öğr. Üyesi Yasemin Sohtorik İlkmen, Prof. Dr. Ebru Kaya, Prof. Dr. Fatma Nevra Seggie
Bulunmayanlar	:	

Sibel Aydın

Sosyal Politika

Sayın Araştırmacı,
"An Analysis of Turkish Oral Healthcare System: Patients' Perceptions and Treatment Pathways" başlıklı projeniz ile ilgili olarak yaptığınız SBB-EAK 2021/5 sayılı başvuru komisyonumuz tarafından 25 Mart 2021 tarihli toplantıda incelenmiş ve uygun bulunmuştur.

Bu karar tüm üyelerin toplantıya çevrimiçi olarak katılımı ve oybirliği ile alınmıştır. COVID-19 önlemleri kapsamında kurul üyelerinden ıslak imza alınamadığı için bu onam mektubu üye ve raportör olarak Ebru Kaya tarafından bütün üyeler adına e-imzalanmıştır.

Saygılarımızla, bilgilerinizi rica ederiz.

Prof. Dr. Ebru KAYA
ÜYE

e-imzalıdır
Prof. Dr.Ebru KAYA
Raportör

APPENDIX D

PARTICIPANT INFORMATION AND CONSENT FORM

KATILIMCI BİLGİ ve ONAM FORMU

Araştırmayı destekleyen kurum: Boğaziçi Üniversitesi

Araştırmanın adı: An Analysis of Turkish Oral Healthcare System: Patients' Perceptions and Treatment Pathways (Türk Ağız ve Diş Sağlık Bakımı Sisteminin Değerlendirilmesi: Hastaların Algısı ve Tedavi Patikaları)

Proje Yürütücüsü: Doç. Dr. Volkan Yılmaz / Boğaziçi Üniversitesi Sosyal Politika Yüksek Lisans Programı Direktörü

E-mail adresi: vyilmaz@boun.edu.tr

Telefonu: 0212 359 75 63

Araştırmacının adı: Dt. Sibel Aydın / Boğaziçi Üniversitesi Sosyal Politika Yüksek Lisans Öğrencisi

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Telefonu:

Sayın ilgili,

Boğaziçi Üniversitesi Sosyal Politika Yüksek Lisans öğrencisi Diş Hekimi Sibel Aydın "Türk Ağız ve Diş Sağlık Bakımı Sisteminin Değerlendirilmesi: Hastaların Algısı ve Tedavi Patikaları" adı altında bilimsel bir araştırma projesi yürütmektedir. Bu çalışmanın amacı Türkiye'deki güncel ağız ve diş sağlığı sistemini ve sistemin hastaların teşhis ve tedavi yollarını nasıl şekillendirdiğini analiz ederek hastaların

bakış açısından ağız ve diş tedavisi sisteminin mevcut durumunu incelemektir. Bu araştırmada ağız ve diş sağlığı hizmetlerine ilişkin tecrübenizi bizimle paylaşarak projemizde bize yardımcı olmanız için sizi projemize davet ediyoruz. Kararınızı vermeden önce araştırma hakkında sizi bilgilendirmek istiyoruz.

Bu araştırmaya katılmayı kabul ettiğiniz taktirde sizinle 9 sorudan oluşan, yarı yapılandırılmış internet üzerinden veya telefon aracılığıyla bir mülakat yapmayı rica edeceğiz. Bu sorular, sizin ağız diş sağlığı hizmeti deneyiminiz hakkında olacaktır. Bu soruları cevaplamak yaklaşık 30 dakikanızı alacaktır.

Bu araştırma bilimsel bir amaçla yapılmaktadır ve katılımcılar yönünden araştırmanın herhangi bir risk doğurması öngörülmemektedir. Katılımcıların kişisel hiçbir zarara uğramaması bizim için esastır. Dolayısıyla katılımcılar anonim kalacak; isim ve soy isimleri, tercih ettikleri ağız ve diş sağlığı kliniğinin ismi, konumu gibi bilgiler belirtilmeyecektir. Görüşmeler katılımcının isteğine bağlı olarak ses kaydı ya da not alma şeklinde yapılacaktır. Ses kayıtlarında ve/veya tutulan saha notlarında katılımcıya belirtilmiş bütün kurallara uyulacaktır. Ses dosyası ve tutulan notlar zaman kaybetmeden bilgisayar ortamına aktarılacak ve şahsi bilgisayarda şifreli bir dosyada araştırma projemiz süresince muhafaza edilip, araştırma sona erdiğinde silinecektir. Bu bilgiler, aksi katılımcılar tarafından belirtilmediği müddetçe tez projesinde veya bilimsel nitelikteki sunumlarda kullanılabilir.

Bu çalışmaya katılmanız tamamen isteğe bağlıdır. Sizden ücret talep etmiyoruz ve size herhangi bir ödeme yapmayacağız. Katıldığınız taktirde çalışmanın herhangi bir aşamasında sebep göstermeksizin onayınızı çekme hakkına da sahipsiniz. Sürecin

herhangi bir yerinde çalışmadan çekilmeniz durumunda alınan ses kaydı silinecek, notlar imha edilecektir. Araştırma projesi hakkında ek bilgi almak isterseniz lütfen Boğaziçi Üniversitesi Sosyal Politika Yüksek Lisans Programı Direktörü Doç. Dr. Volkan Yılmaz ile temasa geçebilirsiniz (E-mail: vyilmaz@boun.edu.tr , Telefon: 0212 359 75 63, Adres: Boğaziçi Üniversitesi Sosyal Politika Forumu Uygulama ve Araştırma Merkezi, Kuzey Kampüs Otopark Binası K.1 N:119, Bebek 34342 İstanbul, Türkiye). Araştırmayla ilgili haklarınız konusunda Boğaziçi Üniversitesi Sosyal ve Beşerî Bilimler Yüksek Lisans ve Doktora Tezleri Etik İnceleme Komisyonu'na (SOBETİK) (sbe-ethics@boun.edu.tr) danışabilirsiniz.

Adres ve telefon numaranız değişirse, bize haber vermenizi rica ederiz.

Ben, (katılımcının adı) ……, yukarıdaki metni okudum ve katılmam istenen çalışmanın kapsamını ve amacını, gönüllü olarak üzerime düşen sorumlulukları tamamen anladım. Çalışma hakkında soru sorma imkânı buldum. Bu çalışmayı istediğim zaman ve herhangi bir neden belirtmek zorunda kalmadan bırakabileceğimi ve bıraktığım taktirde herhangi bir ters tutum ile karşılaşmayacağımı anladım.

Bu koşullarda söz konusu araştırmaya kendi isteğimle, hiçbir baskı ve zorlama olmaksızın katılmayı kabul ediyorum.

☐ Görüşme esnasında ses kaydı alınmasını onaylıyorum.

Formun bir örneğini aldım / almak istemiyorum (bu durumda araştırmacı bu kopyayı saklar).

Katılımcının Adı-Soyadı:

İmzası:

Adresi:

Telefon Numarası:

E-mail adresi:

Tarih (gün/ay/yıl): ……/……/……

Proje yürütücüsünün Adı-Soyadı: Doç. Dr. Volkan Yılmaz

İmzası:

Adresi: Boğaziçi Üniversitesi Sosyal Politika Forumu Uygulama ve Araştırma Merkezi, Kuzey Kampüs Otopark Binası K.1 N:119, Bebek 34342 İstanbul, Türkiye

Telefon Numarası: 0212 359 75 63

E-mail adresi: vyilmaz@boun.edu.tr

Tarih (gün/ay/yıl): ……/……/……...

Araştırmacının Adı-Soyadı: Dt. Sibel Aydın

İmzası:

Adresi: Boğaziçi Üniversitesi Sosyal Politika Forumu Uygulama ve Araştırma Merkezi, Kuzey Kampüs Otopark Binası K.1 N:119, Bebek 34342 İstanbul, Türkiye

Telefon Numarası:

E-mail adresi: sibel.aydin@boun.edu.tr

Tarih (gün/ay/yıl): ……/……/……

APPENDIX E

QUOTATIONS OF THE RESPONDENTS

Quote 1: Özelde mesela bir şikâyetin olduğunda aynı doktoru bulabiliyorum. Şikâyetiniz getirip onu yani ücret almadan da yapabiliyor yeniden bir şikâyetin olduğunda. Ama devlette hem sorun oluyor randevu alması, gitmesi mesela aynı doktoru mesela ben 1,5 ay içinde üçüncü, bu hafta mesela bir daha gideceğim üçüncü doktor değişikliği. Ya bi de ilk başta yapılan tedavi mesela 1,5 ay önce post mu ne diyorsunuz ya şeyin üzerine yapılan öyle bir tedaviyle başladı, on gün önce gittiğim doktor dişleri çekti, o olmayacak bunu değiştiriyoruz dedi, kaplama yapacağız dedi. Öbürü de köprü olmaz demişti bu köprü olur dedi. Mesela yarın da başka bir doktora yönlendirdi o görevlendirilmiş herhalde pandemiden dolayı. Başka bir doktor yani bunu görmedim daha önce, cuma günü de o doktora gideceğim. Mesela aynı doktor değil.

Quote 2: Şimdi devlete gidince farklı farklı kişilere denk gelebiliyoruz. Diş olunca insan biraz dişçi koltuğundan da korkuyor. Hep tanıdık olsun diyor. Yani ondan kaynaklandı. Ben daha önce başka bir hanım diş hekimine gidiyordum, o implant yapmayınca işte M. Bey'e başladım. Ondan dolayı yani devamlı bir kişiyle muhatap olalım diye. Devlet hastanelerinde farklı kişilerle muhatap olduğumuz için yani tedavinin devamı gelmiyor o yüzden.

Quote 3: "Vallahi kendi doktorumuz olduğu için istediğimiz gibi ödüyoruz doğrusu. Allah razı olsun. Onlar da yapacağı indirimi yapıyorlar da biz de yani mahsur görmüyoruz, güveniyoruz karşı tarafa güveniyoruz."

Quote 4: "Baştan savma yapıyor. Yani nasıl olsa maaşımı alıyorum hemen yap geç tarzında."

Quote 5: "Şimdi özelde tanıdığım biri olursa olmaz herhalde diye düşünüyorum."

Quote 6: Yani M. Bey evet biraz da güven verdiği için tercih ediyorum ama mesela M. Bey devlete geçse ben devlet hala taraftarı değilim çünkü özelde işlerimi görmeye devam ederim diye düşünüyorum. Yani M. Bey'in rolü çok büyük tabii özelde kendisi hizmet verdiği için ona gidiyorum ama mecburen başka kapıya gitmek zorunda kalabilirim bu sefer. Devlet benim için her zaman en son planda bu saatten sonra yani.

Quote 7: Diğerleri için genelde devleti tercih etmeye çalışıyorum. Diş için tercih edemiyorum, birkaç defa tercih ettim devleti maalesef her seferinde dişlerimin yok olduğunu fark ettim. Yani ilk aşamada direkt çekime gidiyorlar. Ben de buna mecbur o ağrıdan dolayı hemen boyun eğiyordum. O gün de dişlerimi görmüşsünüzdür belki, bu yaşta olmamıza rağmen muazzam açıklar var yani sürekli çekimlerden falan oldu, hep çektiler. Kaplamayla veyahut kısa tedavilerle yapılabilirdi ama maalesef kendisi özel olan B. (vakıf üniversitesi)'e bile gittiğim zaman bile direkt hemencecik çekime başvurdular o yüzden artık mecbur o güvenle artık özele gitmek zorunda kalıyorum.

Quote 8: Genel yorumum olarak yani burada yani diş kurtarma üzerine hiç yok yani tamamıyla dişi feda edin diyorlar. Diyorsunuz ki peki illaki gerekiyor mu gibisinden soru soruyorsunuz. Diyorlar ki diş artık kurtarılamaz. ... Bir insan artık belli bir yaşı geçtiğinde artık dişler de çıkmıyor. Sanki biz sekiz yaşındaki çocuk muyuz hemen çekmeye kalkışıyorsunuz.

Quote 9: Bu batı tarafı bu şekil böyleyse özellikle doğu tarafı, kendim X şehirliyim ben, orada bu işlemler olduğu zaman köy halkına falan baktığınız zaman sade hiç ilgilenme olmaksızın direkt orada daha çok fazla çekim var, yani orada tamamıyla rezalet bir durumda. En azından burada belki insan kendini ifade ediyor ama oradakiler insan da dinlemiyorlar. Direkt hemen çekime başlıyorlar.

Quote 10: Gittim şöyle bir şeyim olmuştu: Koltuğa oturdum, aslında bir kere Y Devlet Hastanesi'ne gittim, orada çok iyi bakıldı, küçük bir yer olduğu için çok ilgilendiler. Ama burada İstanbul'da, diş hekimliğine gittim devletin, beni direkt koltuğa oturttu hani çünkü özelde soruyorlar şöyle olması gerekiyor, böyle anlatıyorlar. Direkt iğneyi bastı, dişinizi çekeceğim dedi." -Siz ne yaptınız? "Kalktım hemen, istemiyorum dedim öyle iğne olduğum halde çıktım dışarı sonrasında da gitmedim." -Size iğneyi yapmadan önce dişiniz çekilecek denmedi mi? "Şöyle direkt şöyle dendi: 'Bu diş hiçbir şekilde kurtarılamaz dişinizi çekeceğiz, iğneyi vuruyorum' dedi. Ben zaten bir yandan neye uğradığımı şaşırdım ağrım var bir taraftan. O sırada iğneyi vurdu. Sonra ben kendimi toparladım ve hala o dişimi kullanıyorum M. Bey sayesinde öyle söyleyeyim.

Quote 11: "Dişte çok sıkıntılı devlet. Diş için özeli tercih ediyoruz çünkü devlette işimizi halledemiyoruz. Sıkıntılı oluyor halledemiyoruz derken. Uzun süreçli diş konusu ama diğerlerinde devleti tercih ediyoruz çünkü çok rahat oluyor. Onda bir sıkıntı yok yani. Uzun süreçli değil."

Quote 12: Ben devlet hakkında pek yorum yapmak istemiyorum. Devlet en idealini yapıyor, ben kendim de devlet kurumlarında çalışmıştım. Önemli olan oradaki şahısların tutum ve davranışları. Yani oradaki süreci devlet uzatmıyor, şahısların tamamen rahat çalışmasından kaynaklanan bir durum. Oradaki diş bölümleri özeldeki gibi olmuş olsa onlarınkini daha rahat olacaktır. Devlet mükemmel yapıyor, her şeyini mükemmel yapmış, bundan daha güzeli de olmaz yani. Sadece bu şahıslarla alakalı yani yönetimle alakalı bir konu. Yoksa niye tercih etmemeyim? Z'ye gittim baktım bir sürü zaman yapıyor o orada şu şu şu e canım zaten diş elden gidecek. Yani bir an önce tedaviye başlanması lazımdı. Onlara da bir şey diyemiyorum. Kalabalıktı, zamandı şuydu buydu yani onun için özeli tercih ediyoruz.

Quote 13: Evet evet ikisi de (daha önce gittiği devlete bağlı iki diş kliniği) iyiydi, ikisinden de memnun kaldım açıkçası çok ilgililerdi. Hani böyle benim canım çok tatlıdır ama hani ikisi de çok nazik davranmaya çalışıyorlardı… Yani şöyle diyebilirim; ikisi de (daha önce gittiği biri özel biri devlete bağlı diş kliniği) çok ilgiliydi, ikisi de çok şeydi ama devlet bana daha iyi geldi bilmiyorum tavırları falan daha ilgiliydi sanki. Acaba ben öyle gördüğüm için mi bilmiyorum ama hani pek. Devlet daha iyi ben hep onu tercih ediyorum. Doktorların daha iyi olduğunu söylüyorlar devlette o yüzden biraz.

Quote 14: "ADSM'de çok güzel karşıladılar özel gibiydi. Aletleri, ilgileri, her şeyleri özel gibiydi. Rahatça röntgenini çektirebiliyorsun hastane olduğu için. O yönden çok güzeldi yani."

Quote 15: "Özelde daha çok ilgileniyorlar çünkü devlette daha farklı davranıyorlar."

Quote 16: "Devlette fazla ilgilenmiyor dişçi, ondandır yani."

Quote 17: "Hekimden bence. Baştan savma yapıyor. Yani nasıl olsa maaşımı alıyorum hemen yap geç tarzında."

Quote 18: "Çok şükür yani çok iyi bundan iyi özele de gitsek bu kadar ilgilenirler."

Quote 19: M. Abi'yi eskiden beri tanıyorum. Ona en son başladım, öyle söyleyeyim. İlk eşimin tanıdığı biri vardı oraya gidiyorduk. Ondan önce de kendi herhangi birini bulmuştum, öyle söyleyeyim, oraya gidiyorduk. Ama şu anda memnun kaldığım M. Abi var hem maddi açıdan da kendisi daha şey hem de ilgilenme açısından öyle söyleyeyim.

Quote 20: İlk gittiğimde biraz hijyen sıkıntısını gözettiğim için bıraktım. İkincisinde maddi olarak böyle hani artık o kadar paraya doymuş ki çok tek tük bakıyor öyle söyleyeyim. Bir kanala 500 diyordu o zamanları. Daha sonradan da M. Abi'yi tekrardan annemler bir şekilde irtibat sağlayınca ben de gitmek istedim. O şekilde gittik yani.

Quote 21: "Yani esneklik sağladı M. Bey bizim için, onların da etkisi oldu tabii."

Quote 22: "Vallahi kendi doktorumuz olduğu için istediğimiz gibi ödüyoruz doğrusu. Allah razı olsun. Onlar da yapacağı indirimi yapıyorlar da biz de yani mahsur görmüyoruz, güveniyoruz karşı tarafa güveniyoruz."

Quote 23: "Ben şöyle çok mecbur kaldığım için gitmiştim ama ilgilenmişlerdi, ölçüm falan yapmışlardı. Onun haricinde yaptıracaktık ama çok pahalı geldiği için yaptırmamıştık. Dişime dolgu yapılması gerekiyordu. Ama onu haricinde ilgiden şeyden memnun kalmıştım."

Quote 24: "İmplant yani çok implant yapmam gerekiyordu, o da çok pahalıydı implant. Onun için devlete gitmeye karar verdim."

Quote 25: "Hekim çok belirleyici mesela burada G var ben burada oturuyorum. Orada T. Hoca var G'nin girişinde, mesela 30 sene önce ona gitmiştim

ben dolgularım vardı değiştirmiştim. Şimdi biraz pahalı oldu, ucuz olsa direkt ona gideceğim yani"

Quote 26: "Ben size şimdi nasıl diyeyim, 4500 lira maaş alıyorum; maaşımın dörtte birini kanal tedavisine nasıl verebilirim İstanbul'da yaşarken?"

Quote 27: "Çoğunlukla devlet hastanelerini tercih ediyorum çünkü özellere harcayacak kadar zenginliğim yok param pulum yok yani. Çok zora kalmadıkça özele gitmiyorum... ücretinden dolayı özele gitmiyorum yoksa özel tercihimdir tabii ki."

Quote 28: Ya ne bileyim, ben başından beri hep devlete dişlerimi yaptırıyorum, memnunum, bugüne kadar kötü bir şeyle karşılaşmadım, bir aksilik olmadı. Sadece o bir tanesini M'de özel bir klinikte yaptırdım; o da yine maddiyattan dolayı yani, başka bir özele gittim çok pahalı dediler, oraya mecburen gittim, yaptırdım. O anda niye devlete gitmediysem onu da bilmiyorum o anda.

Quote 29: Çünkü ben daha önce çünkü devlette bir diş çekiminde bulundum yani o kadar ağrılı geçti ki benim için. Yakın zamanda tekrar bir diş çekiminde bulundum ama bu sefer özelde diş çekimini gerçekleştirdim; ya arasında dağlar kadar fark vardı. Benim diş çektirmeden önce heyecandan ölmek üzereydim neredeyse daha önce yaşadığım şeyden dolayı devlette, ön yargımı kırdım biraz da tabii. Yani hem de ben mesela çok ağrım olduğu için o sıra mecbur kaldığım için, yani mecbur kalmasam diş çektirmem, o halde oraya gittiğim halde bana daha çok geç bir tarihe verdiler, daha da mağdur oldum bu sefer. Beklemekten başka çarem yoktu. Biraz da küçüktüm o zamanlar, maddi durumumuz da sıkıntılıydı, şu anda hani kendi özgürlüğümü elime aldığım için seçeneklerimi, gelirimi biriktirdiğim için daha özele yönelmeyi tercih ettim. Ağrılı, sıkıntılı geçtiği için bir daha devleti tercih etmek istemedim.

Quote 30: Denedim, denedim. Tabi denedim mesela en basiti implant yok mesela devlette. Bana implant lazımdı. Bir de sıra çok var devlette baya sıra var… Bekletiyorlar seni, diş başka şeye benzemiyor

biliyorsun, dişin ağrıdı mı gideceksin. Oturup bekleyecek halin de olmuyor. Bu durumda kendimi ancak doktora atmak istiyorum.

Quote 31: Yani hem de ben mesela çok ağrım olduğu için o sıra mecbur kaldığım için, yani mecbur kalmasam diş çektirmem, o halde oraya gittiğim halde bana daha çok geç bir tarihe verdiler, daha da mağdur oldum bu sefer. Beklemekten başka çarem yoktu.

Quote 32: "Yani önce devleti yokluyorum. Normalde, bu pandemiden önce daha rahat alınıyordu devletten randevu şu anda neredeyse hiç yok. Çok zor oluyor. Mecbur kalınca, çok kötü durumdaysak özeli tercih ettim yakındakileri, evimizin yakınında bulunan özelleri tercih ediyoruz."

Quote 33: İmplant konusunda zorlanmadım ama daha öncesinde veya bundan iki ay öncesine kadar kanal tedavisi endodonti polikliniğine randevu almada çok sıkıntı yaşadım hatta iki defa da CİMER'e başvuruda bulundum çünkü İstanbul genelinde bir tane endodonti çalışmıyordu.

Quote 34: "2010 yılında gittim, 2015 yılına randevu verdiler. Z'ye gittim yıllara yaydılar. … Bir ömür yetmez ona."

Quote 35: Ben kızım için de diş teli taktırmak için 10 yaşındayken götürmüştüm Çapa'ya. Sırası gelince arayacağız dediler. Kız oldu 21-22 yaşında, hala aramadılar. Zaten 18 yaşından sonra da devlet karşılamıyor dediler tel takmayı. O bakımdan o zaman öyle bir şey yaşadık. O şeylere devlete gidilmiyor.

Quote 36: "Evet yaşadım, ben son 5-6 aydır sürekli randevu kovalamaya çalışıyorum, anca denk gelebildi öyle söyleyeyim size."

Quote 37: Az önce sizin de belirttiğiniz gibi şu randevular konusunda çok sıkıntı yaşıyor, genel olarak insanlar çok sıkıntı yaşıyor, bu daha çok çoğaltılabilir bence. Onun haricinde yani P'de (ADSM'yi kastediyor) memnuniyet açısından bir sorun yok, öyle söyleyeyim ben size.

Quote 38: Üniversite hastanesine gittim. Şimdi diş için devlete gidiyorum. Onu (üniversite hastanesini) daha çok tercih ediyorum ama oraya randevu düşüremiyorum. Orada (üniversite hastanesinde) yani o hastaneyi daha üstün görüyorum yani ne bileyim. Ben çölyak hastası olduğum için ben orada da çok tedavi gördüm, orayı daha güvenilir buluyorum. Ben bir saatlik yoldan geldim. Metroya indim metrodan indim minibüse bindim bi daha gittim… Yakınımızda aslında devlet hastanesi var randevu düşüremiyorum… Nerede bulsam oraya gidiyorum çünkü diş sorunum ağır olduğu için.

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