HEALTH AND CITIZENSHIP IN REPUBLICAN TURKEY: AN ANALYSIS OF THE SOCIALIZATION OF HEALTH SERVICES IN REPUBLICAN HISTORICAL CONTEXT

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HEALTH AND CITIZENSHIP IN REPUBLICAN TURKEY: AN ANALYSIS OF THE SOCIALIZATION OF HEALTH SERVICES IN REPUBLICAN HISTORICAL CONTEXT

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Title: Health and Citizenship in Republican Turkey: An Analysis of the Socialization of Health Services in Republican Historical Context

This thesis presents an evaluation of the Turkish health system by focusing on the socialization of health services undertaken in 1961. The historical analysis is situated within a theoretical framework that addresses the questions pertaining to social policy and citizenship through the analysis of welfare regime typologies and health care systems. The thesis also draws on the theoretical contributions to the analysis of state and class in Turkey.

The fragmented health care system in Turkey created a hierarchy of access and accordingly citizenship. By means of different security systems the state established differential relationships with its citizens, dividing them along the lines of their affinity with the state and their employment status. The problems within this inegalitarian system and the current attempts at its modification constitute the starting point of this thesis. Although the study focuses on the attempt at the socialization of health services undertaken in 1961, after the military intervention of 27 May 1960, it will present a comprehensive picture of the Turkish health system in the Republican period with a view to providing the historical background against which the current debate around health sector reform can be better understood.

Through the socialization of health services everyone, without any distinction in terms of economic power, status in employment, region, ethnicity, and rural/urban divide would be provided health service, both preventive and curative. However, the efforts to establish socialization of health services as the health system of Turkey has failed mainly due to the simultaneous development of inegalitarian corporatist system which provides medical coverage to those in the formal sector.

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Başlık: Cumhuriyet Türkiyesi'nde Sağlık ve Vatandaşlık: Sağlık Hizmetlerinin Sosyalleştirilmesi'nin Tarihsel Bağlamı İçinde Değerlendirilmesi

Bu tezde, 1961 yılında başlatılan sağlık hizmetlerinin sosyalleştirilmesine odaklanılarak Türkiye sağlık sistemine dair bir değerlendirme sunulmaktadır. Tarihsel analiz, sosyal politika ve vatandaşlıkla ilgili soruları refah rejimi tipolojileri ve sağlık sistemleri bağlamında ele alan bir kuramsal çerçeveye dayanmaktadır. Tezde ayrıca Türkiye'de sınıf ve devletin analizine yönelik kuramsal değerlendirmelerden de yararlanılmıştır.

Türkiye'deki parçalı sağlık sistemi, sağlık hizmetlerinden yararlanma ve vatandaşlık bağlamında bir hiyerarşi yaratmıştır. Devlet, farklı sosyal güvenlik sistemleri aracılığıyla vatandaşlarıyla farklı ilişkiler kurmuş, onları devlete olan yakınlıklarına ve istihdam konumlarına göre ayırmıştır. Bu eşitsiz sistem içerisindeki sorunlar ve sistemi değiştirme yönünde son dönemde atılan adımlar bu tezin hareket noktasını oluşturmaktadır. Tezde, 27 Mayıs darbesinden sonra, 1961'de başlatılan sağlık hizmetlerinin sosyalleştirilmesi projesi üzerine odaklanılmaktadır; ama Cumhuriyet dönemi boyunca Türkiye'de izlenen sağlık politikalarına dair kapsamlı bir tablo sunularak, sağlık sektöründeki reformla ilgili son tartışmaların daha iyi kavranmasını sağlayacak tarihsel bir arka plan da çıkarılmaktadır.

Sağlık hizmetlerinin sosyalleştirilmesi aracılığıyla, maddî durum, istihdam konumu, bölge, etnisite ya da kır/kent ayrımı olmaksızın herkese, gerek koruyucu gerekse tedavi edici sağlık hizmetleri sunulacaktı. Ne var ki, sosyalleştirme projesiyle aynı anda gelişen, formel sektördeki vatandaşlara sağlık hizmeti sunan eşitsiz korporatist sistem yüzünden sağlık hizmetlerinin sosyalleştirilmesi Türkiye'nin genel sağlık sistemi olarak yerleşemedi.

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CONTENTS

CHAPTER ONE

INTRODUCTION

This dissertation presents an evaluation of the Turkish health system by focusing on the socialization of health services undertaken in 1961. The historical analysis is situated within a theoretical framework that addresses the questions pertaining to social policy and citizenship through the analysis of welfare regime typologies and health care systems. The dissertation also draws on the theoretical contributions to the analysis of state and class in Turkey.

The study was undertaken in a period in which the Turkish health system was, and still is, undergoing a process of comprehensive reform and restructuring. The need to make structural reforms in social security and health care imposed itself on the governments throughout the 1980s and the 1990s. The existing system was an inegalitarian corporatist one in which civil servants, workers in the formal sector and self-employed were provided pensions and health care, although hierarchically, while the rural population and urban informal sector employees were excluded. Not only the will to end the hierarchy in terms of access and accordingly citizenship among the members of different schemes (the Retirement Fund for civil servants, the Social Insurance Institution for workers, Bağ-Kur for the self-employed) and to include all on the basis of equality, but also the need to control rising social expenditures led the Justice and Development Party (JDP, *Adalet ve Kalkınma Partisi*) government to take a major step in the field of social policy. As in many other countries inaugurating a reform process, the target of cost-containment was articulated in terms

of equity and efficiency. Actually, in Turkey, public social expenditure has in general remained very limited throughout the Republican era, lagging behind the European members of the OECD and among OECD members, exceeding only Mexico and Korea. Both the amount and the share of public expenditure on health have also been lower than the OECD average. Since the 1990s however, there has been some increase in public social spending, which is in part the result of the rising level of transfers made from the state budget to cover the deficit of the social security system. The burden of these transfers on the fiscal balance put social security reform as an urgent task before the government.[1]

In the draft text prepared by the Ministry of Labor and Social Security - Social Security Institution (29 July 2004), the need for reform in the field of social security is explained with reference to the change in population structure (Turkey has a young population structure, but the projections suggest that this population will rapidly get older), the inability of the current systems to provide protections against poverty, the negative impacts of the financial deficits of social security institutions on the economy, the inability to protect the whole population (only 48% of the labor force was covered by a social insurance institution as of 2003 and approximately 20% of the population is not effectively covered by any health security), and the (financial and organizational) problems of the current social security institutions.

The reform attempt was faced with considerable resistance from labor unions and civil servants. In fact, it was the protection of the interests of the latter which formed the basis of the Constitutional Court decision of 15 December 2006 that annulled some of the articles of the Social Security Institution and General Health Insurance Law approved by the Parliament.

[1] Ayşe Buğra and Çağlar Keyder, "The Turkish Welfare Regime in Transformation," *Journal of European Social Policy*, 16(3) (2006): 211-228, p. 213.

A detailed discussion of the recent reform process will be provided in the sixth chapter of this study, but for the time being the decision of the Constitutional Court will be taken as the starting point. This decision reveals the resistance of the bureaucracy to an egalitarian structuring of the social security system. Throughout the Republican era, it has been usually the civil servants and especially the bureaucrats who have benefited most from the social security system. It is not only that their pensions have been higher than those in the formal sector, but the health care delivery that they might benefit from has also been the best available usually. It has been only the civil servants who has the right to apply directly to university hospitals. Actually, health services provided for the workers in the formal sector by the Social Insurance Institute have been high in quality. However, throughout the 1980s and 90s, the irresponsible use of the governments of the accumulated funds of the Institute resulted in newspaper reports of long queues and apathetic doctors in the SII hospitals. But still, workers were covered by a security scheme starting from 1946 onwards. Civil servants were protected under separate funds which were brought together in 1950. The self-employed joined the group of those with insurance in 1971, but they had to wait until 1985 to benefit from health insurance.[2] They could apply to the Ministry of Health hospitals, which were in no better condition than the SII hospitals. Significant differences existed among these funds in terms of the premium rates,[3] benefit packages and co-payments[4] as well as the

[2] Calculations based on the data in TURKSTAT tables on population covered by security schemes result in these percentages: In 1980, those covered by SII constituted 23.85% of the population, RF 12.12%, and Bağ-Kur 10.14%. These figures are 34.50, 11.65, and 20.06 in 1990, and 50.30, 14.40, and 22.53 in 2000 respectively. In Bağ-Kur health coverage is optional. TURKSTAT - Turkish Statistical Institute, *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), pp.107-112.

[3] SII beneficiaries and Retirement Fund members do not pay separately for health insurance, but Bağ-Kur members have to pay 12% of their income in addition to the 20% they pay for pensions.

quality of the services[5] provided by health care institutions, which constituted one of the major reasons for reforming the health sector.

The fragmented health care system in Turkey created a hierarchy of access and accordingly citizenship. By means of different security systems the state established differential relationships with its citizens, dividing them along the lines of their affinity with the state and their employment status.[6] Within this hierarchy, civil servants were the most advantaged. They were followed by the workers in the formal sector and then the self-employed. After 1992, a fourth health insurance scheme was established for the poor, whose eligibility would be determined through a means-tested mechanism.[7] Green Card holders followed the self-employed, but still did not constitute the bottom layer. As mentioned, those who had no health insurance including the Green Card were officially estimated to be about 20% of the total population.[8] In its household survey in 2003, the Turkish Statistics Institute found

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[4] Co-payments differed among the schemes, ranging from 10% to 20% of the total costs (most of the time in the case of pharmaceuticals or medically necessary equipments such as prosthesis or spectacles). At the same time, the informal payments at almost every level of service provision constituted a bigger share of out of pocket payments, which was a major source of dissatisfaction with the public delivery of health services.

[5] For example in 2005, the health care expenditure per insured person was 188 YTL in SII, 227 YTL in Bağ-Kur, and 1,141 YTL in RF. Part of this difference might be explained with reference to differences in the efficiency of each institution, but it is clear that there is a serious problem of service quality differentiation. Ayşe Buğra, "AKP Döneminde Sosyal Politika ve Vatandaşlık." *Toplum ve Bilim*, 108 (2007): 143-166, p. 154, footnote 7.

[6] Nazan Üstündağ, "Health and Health Care from the Perspective of Citizens." Paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, Boğaziçi University, İstanbul, 2005.

[7] "Means-test" refers to an investigative process undertaken to determine whether or not an individual or family is eligible to receive certain types of benefits from the government. The test can consist of quantifying the party's income, or assets, or a combination of both.

[8] Buğra and Adar use this data with reference to *National Health Accounts 2002*. They warn us to be cautious about the reliability of the data since some people move between the formal and informal sector jobs and the number of people who have multiple health insurance coverage in different systems is unknown. Ayşe Buğra and Sinem Adar, "An Analysis of Social Protection Expenditures in Turkey in a Comparative Perspective." Social Policy Forum, Research Papers, İstanbul: Boğaziçi Üniversitesi, 2007, p.28. This category covers peasants and workers who are not in the formal economy, such as petty producers and those self-employed people who have not paid their premiums,

that 68% of those who were below the food poverty line and 58% of those who were below the poverty line did not have any health insurance.[9] These figures reveal that a considerable portion of the disadvantageous is still devoid of any security notwithstanding the Green Card scheme designed to provide health care to the poor.

The Subject Matter of the Study and the Theoretical Framework

The problems within this inegalitarian system and the current attempts at its modification constitute the starting point of this thesis. Although the study focuses on the attempt at the socialization of health services undertaken in 1961, after the military intervention of 27 May 1960, it will present a comprehensive picture of the Turkish health system in the Republican period with a view to providing the historical background against which the current debate around health sector reform could be better understood.

Basically, socialization is the establishment of a system which ensures that everyone benefits equally from health services, that to benefit from such service is not conditioned upon the financial means of the person in need of such service, that these services are administered by the state and that they are developed according to a well-determined program. The inequalities in health care in terms of economic power, status in employment, region, ethnicity, and rural/urban divide are all supposed to be abolished. The term "socialize" was used to explain the application of the law in a particular region. This comprised the establishment of a health station or

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and also those who are unable to prove their poverty in order to qualify for a Green Card. Ayşe Buğra and Çağlar Keyder, "The Turkish Welfare Regime in Transformation." p. 215.

[9] World Bank, *Turkey: Joint Poverty Assessment Report*, August 8, 2005, SIS and Human Development Sector Unit, Europe and Central Asia Region, World Bank, 2005, p. 73.

a health post responsible for the well-being of a certain population, the integration of all the health institutions and the operating of the referral chain. The state is responsible for both preventive care and curative services. Citizens would conform to the referral chain and apply to health posts first before going to a hospital. Each health post is to serve a population of 5,000 to 10,000 and would be staffed by general practitioners, nurses, midwives and health officers. Diagnosis and life-saving medicine in posts would be free of charge. If a patient is referred to a hospital from a health post, then hospital services would also be free of charge. Health post doctors would monitor the population for which they are responsible.

In the socialization of health services, the major task was to bring primary care even to the remotest villages of the country. The state assumed the responsibility of sending health personnel everywhere and improving the health condition of all citizens. Citizens would be protected from illnesses through public health measures, which would result in a decline in the demand for curative services. The basic assumption was that eliminating the conditions leading to illnesses was much more efficient than curing these illnesses. This would also lift the heavy burden on hospitals. Socialization is a population-based system which emphasizes public health and preventive care, yet it defines the responsibility of the state much more broadly than earlier approaches. The program started in the East and was planned to cover the whole country in fifteen years time.

Through the study, a series of questions pertaining to the nature of state-society relations are raised in the specific context of the health care system and health policy. These questions include: What is the role of the state in terms of health policies? For whom does the state feel responsible? Who is included in the system and who is excluded? Is there any kind of hierarchy in terms of receiving health

care? How does the health insurance system take shape and what does this tell us about the welfare regime of Turkey? What are the major characteristics of different health care models and where does Turkey fit among them? How does the state approach the people, as a population whose health conditions should be improved for national development or as citizens who should be provided all kinds of health care? What do the different population policies signify in terms of state-society relations? Does the state limit its function to public health or take responsibility for curative services, too? How do regional, ethnic, and rural/urban differences effect the policy decisions and their application? What is the role of doctors as a professional group in the formation and application of health policies? Is there any tension between their interests and state policies? How does the role of markets in health care change in the course of time? Does the state take the responsibility of the poor or does it leave them to the discretion of health personnel and charitable institutions? Through what mechanisms are the poor classified as "deserving" and "undeserving" in terms of receiving health services? Have there been major turning points in Republican history in terms of all these issues? What are the continuities and ruptures? I will explain the historical process that brings us to the contemporary debates around health care reform, and the formation and consolidation of the inegalitarian corporatist structure of the Turkish health care system.

These questions emerge from three currents of analysis relevant to the subject matter of the thesis: Welfare state and citizenship, social policy literature on national health systems and health sector reform, and the literature on state-society relations, bureaucracy and class in Turkey. Presenting a thorough survey of the literature on the welfare state and national health systems in their current transformations in a separate chapter is needed to clarify the theoretical approach that guides and directs

the historical analysis of the Turkish health sector. The third current of analysis on which the study draws will be discussed more thoroughly in this introductory chapter.

The socialization of health services was initiated with the influence of Keynesian welfare state developments in Europe. The British and Swedish health care systems, which are universal in character, were taken as models. "Social justice" was considered to be an inseparable component of development and the role of the state in promoting welfare was emphasized. The Constitution of 1961 defined the Turkish state as a "welfare state" and assigned it the task of providing a physically and mentally healthy life and medical care to all its citizens. Throughout the 1960s and 1970s, not only the welfare duties of the Turkish state but also the rate of population covered by a security scheme expanded. Despite the inegalitarian structure of the social security system and the large number of people excluded from it, the idea that the state should maintain social rights was widely accepted. Together with civil and political rights, social rights constitute the major components of modern citizenship.

In his classical essay "Citizenship and Social Class," T. H. Marshall attempts to clarify the relation between social rights and citizenship.[10] He analyzes the extension of citizenship rights in terms of a progressive tale of democratization and class-abatement. Social rights started to constitute an important component of citizenship after the end of the nineteenth century and this made the maintenance of economic inequalities difficult. In Marshall's conception, welfare state institutions counter market processes by providing citizens with a minimum income, a basic standard of social services (health and education) and respite against economic

[10] T.H. Marshall, "Citizenship and Social Class." In *Class, Citizenship and Social Development: Essays by T. H. Marshall* (Garden City, New York: Doubleday and Company, 1964).

uncertainty. Social rights impose modifications on the capitalist system by diminishing class differences.

As will be discussed in more detail in the next chapter, Marshall has been criticized for ignoring other forms of inequality.[11] Yet, his framework might still be useful in any analysis of social rights. Especially the importance of equal citizenship in the establishment of a democratic and egalitarian society should be kept in mind while elaborating the attempts to improve citizenship status such as the "socialization of health services."

It is possible to adopt his framework to the Turkish context, within which inequalities other than class might play a decisive role. Actually, there is a complex relation between class and other differences which usually overlap. We can look at the socialization of health services that aimed to eradicate regional, ethnic, and rural-urban inequalities along with class inequalities with Marshall's notion of "social citizenship." The socialization of health services was a project of social inclusion. Peasants, Kurds, and the poor would all be provided health services and there would be no distinction between the citizens.[12] The inequalities among citizens would be reduced by the application of a basic social right, i.e. health care. If they are provided access to health services on the basis of equality people's sense of equal worth would improve. They would feel a sense of belonging to the wider community. The

[11] Nancy Fraser and Linda Gordon, "Civil Citizenship against Social Citizenship: On the Ideology of Contract versus Charity." In *The Condition of Citizenship*, ed. Bart van Steenbergen (London: Sage Publications, 1994).

[12] The rural-urban divide was much more decisive in the formulation of the socialization. Nearly 70% of the population lived in rural areas and they lacked basic health care as well as roads, water, and electiricity. For Özbay and Yücel, the citizens of the Republic were the urban Sunni Muslim middle class Turks. They had access to the services in the cities. So, the migration from the villages to the cities was a search for "citizenship right." Ferhunde Özbay and Banu Yücel, "Türkiye'de Göç Hareketleri, Devlet Politikaları ve Demografik Yapı." In *Nüfus ve Kalkınma: Göç, Eğitim, Demokrasi ve Yaşam Kalitesi*, ed. Ferhunde Özbay et.al. (Ankara: Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü, 2001).

citizenship-membership-welfare link that Marshall constructs provides, therefore, insights for the analysis of this particular health policy.

The next chapter of the thesis presents a discussion of the welfare typologies which were developed by Esping-Andersen.[13] In Esping-Andersen's typology, conservative welfare regimes are those in which corporatist arrangements are most pronounced, liberal welfare regimes are principally characterized by an emphasis on market-based social insurance and the use of means-testing in the distribution of benefits, and social democratic regimes are characterized by the principles of universalism and equality. He analyzes these different welfare regimes in terms of de-commodification and stratification. He criticizes Marshall for constructing an automatic relation between welfare state and class-abatement. For him, the welfare state is a system of stratification in its own right. For example, in conservative regimes, welfare is used to maintain (and even reinforce) the existing class and status differentials, thus encouraging social and political stability and constant loyalty to the state. The state (rather than the market) is likely to be important in the delivery of welfare, but not in ways which encourage redistribution or equalization. For example in Germany, civil servants are covered by a scheme financed directly by government, as is the case in Turkey. Turkish civil servants pay premiums for the health service they will receive after retirement. Their health expenditures are covered by the public institutions they work for during the period they are employed.

The Turkish welfare regime might be analyzed within this group as it is also based on maintaining status differentials and traditional family forms. The welfare regime, which is now in a state of transition, reproduces existing inequalities. Civil servants comprise the most privileged group whose continuing loyalty to the state is

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

sought. However, in the conservative welfare regimes of Europe, people are not left outside the system although there exist inequalities among those within the system. In this sense, the Turkish welfare regime does not fit this model exactly, but rather the statist version of "inegalitarian corporatist" model developed by Seekings[14] and the Southern European model developed primarily by Ferrera.[15]

In "inegalitarian corporatist" systems the claims are dependent on membership of occupationally-defined corporate groups as in the European conservative welfare regimes, but unlike those regimes, there is a section of the population that is excluded from formal employment and hence membership in these corporate groups. In the statist version of this system, formal social insurance is provided to those within the system.

The Southern European model is characterized by a highly fragmented and "corporatist" income maintenance system, a low degree of state penetration of the welfare, the persistent diffusion of small family businesses, and a relatively high level of family responsibility for welfare services. Turkey is categorized under this type of regime. For example, Ian Gough included Turkey as the fifth country in his analysis on social assistance in Southern Europe. He identifies a distinct social assistance regime in these countries, which is characterized by the absence of a national minimum income safety net.[16] Buğra and Keyder point out the common traits of the Turkish welfare regime with that of Southern European regimes. An important one is the fragmented and hierarchical formal social security system. It has

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[14] Jeremy Seekings, "Prospects for Basic Income in Developing Countries: A Comparative Analysis of Welfare Regimes in the South." Paper presented at the *BIEN Conference on The Right to a Basic Income: Egalitarian Democracy*, Barcelona, 20 September 2004.

[15] Maurizio Ferrera, "The 'Southern Model' of Welfare in Social Europe." *Journal of European Social Policy* 6(1) (1996): 17-37.

[16] Ian Gough, "Social Assistance in Southern Europe." *South European Society and Politics*, 1(1) (1996):1-23.

a corporatist character and it provides combined health and pension benefits to formally employed heads of households according to their status at work. Self-employment, unpaid family labor, and informal employment practices characterize the labor market. So, given these circumstances, the formal social security system remains inadequate as it covers only those in the formal sector. Rural population and urban informal sector employees are excluded from the system. As there is no meaningful social assistance scheme those excluded have to rely on family ties in risk situations. Centrality of the family is another similarity with the Southern European model.[17]

The model of selective welfare developmentalism developed by Kwon might be useful in explaining the Turkish welfare regime.[18] This model, in which the creation of employment through development is given priority and the care of the vulnerable is left to the disposal of families and traditional networks, has been adopted also in Turkey. It is based on the assumption that through economic development everyone will be employed within the formal sector, and thereby will have social insurance. However, this assumption proved to be false in the 1980s and the 1990s. It was understood that economic development does not necessarily create employment and employment does not reduce poverty. The need to establish citizenship-based coverage, rather than coverage based on employment or status in employment imposed itself.

In the following chapter, after describing the welfare typologies, I will focus on health care typologies and see whether they overlap or not. The basic typology in

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[17] Buğra and Keyder, "The Turkish Welfare Regime in Transformation." p. 212; Ayşe Buğra and Çağlar Keyder, "Önsöz." In *Sosyal Politika Yazıları*, eds. Ayşe Buğra and Çağlar Keyder (İstanbul: İletişim Yayınları, 2006), pp. 14-15.

[18] Huck-ju Kwon, "Transforming the Developmental Welfare State in East Asia." *Development and Change*, 36(3) (2005): 477-497.

terms of health care also consists of three clusters: national health services, social insurance systems and private insurance systems. National health services (NHS) are funded by general taxation and are based on universal coverage, the public ownership of health care facilities, and a salaried medical profession. Social insurance systems are funded by payroll contributions. Insurance contributions are collected under funds categorized by occupation or region. Funds contract with what is usually a greater mixture of public and private providers of inpatient care, and with independent physicians paid with respect to the services they provide. Private insurance systems are characterized by private financing, service provision by private for-profit enterprises, and a limited degree of public regulation. In case of overlapping, social democratic systems have national health service, conservative systems have social insurance, and liberal systems have private insurance. Usually this is the case, but there are exceptions like Canada and Great Britain with NHS, although they are within the liberal cluster, and Southern European countries with NHS although they are within the conservative cluster. This reveals the peculiarity of health care. I will try to analyze these models in terms of the underlying values and principles. Health care embodies a particular set of expressly political assumptions about the state, its responsibilities and the rights of citizenship. So, analyzing different health care models will reveal the different approaches towards citizenship.

The Turkish welfare system overlaps with its health care system. Those employed in the formal sector have social insurance. The inegalitarian corporatist structure of the Turkish welfare system becomes much more apparent in its health care system. There is a hierarchy among those with health insurance and there is a large group of people excluded from the system. In health care, Turkey does not fit the Southern European model, which is characterized by a transition from a mature

Bismarckian health insurance system to a national health service system. In late 1970s and the early 1980s Southern European countries adopted national health services. Actually, the socialization of health services in 1961 was an attempt to establish an NHS-type system but it failed. It was not considered to be the health system of Turkey and there was always the project of establishing a social insurance system to cover all. So, these health care typologies will help us understand both the existing system and the intended ones.

The distinction between public health and medical care will also be analyzed in the following chapter. From the late nineteenth century onwards public health, which focuses on preventive services for the population, left its place to medical care which focuses on curative services for the individual. Due to the achievements in the field of public health, emphasis in health care shifted towards curative medicine. The states, which had previously limited their role to public health, started to assume the responsibility for providing medical care. Actually, the history of Turkish health care system fits this picture. In the early Republican era, the role of the state was limited to public health. The task of medical care was left to the private practice and local authorities. This changed after 1950 and the state took the responsibility in medical services as the major problems in the field of public health had already been solved. Whenever the state became active in medical care in the 1950s there arose the problem of financing since medical care, unlike public health, was not considered to be a duty of the state that should be financed from the general budget. The insurance system that covered medical care started to develop on its own path apart from public health. The distinction between public health and medical care will help us understand both the early Republican mentality, which limited the role of the state to public health, and the debates on socialization.

The pressure on welfare and health care systems and the various responses of the states will also be analyzed in the following chapter. For the last thirty years "welfare" has almost invariably been pronounced together with "crisis." Globalization, aging, and family instability are the reasons cited most often for this crisis.[19] The health sector reform movement which entails a limited role for the state in the provision and financing of health services and a greater reliance on the market influenced countries at different levels. However, as in the case of welfare, there is no consensus on whether there is retrenchment or not. All governments have to take certain measures to control health expenditures which are escalating rapidly due to population aging, technological innovations and the profit-seeking companies' control over medical technology and medicine.

As in the case of welfare the way each country responds to this pressure depends on its existing model. There are different answers to the question of how the recent attack on the welfare state and the health reform process reflects and changes the inequalities sustained or controlled by the welfare state policies in general and health policies in particular. These answers will be elaborated to understand the reform process in Turkey. The reform in the health sector brought to the fore a debate on the nature of health care as a commodity. The commodity status of health

[19] Contemporary welfare states have their origins in a society that no longer exists: an economy dominated by industrial production with strong demand for low-skilled workers; a relatively homogenous and undifferentiated, predominantly male, labour force; stable families with high fertility; and a female population primarily devoted to housewifery. Industrial employment is leaving its place to flexible employment which made the financing of social security institutions by premiums and taxes difficult. Due to de-industrialization and population aging, the number of contribution years has shrunk and the number of beneficiary years has expanded. Population aging intensifies the financial strains on both pension and health systems. Longer life expectancy contribute to an intensive demand for health and caring services. Families are much less stable, and women often face trade-offs between employment and family obligations. Given that women's educational attainment today matches men's, the opportunity cost of having children becomes very high if care services are unavailable. The new "atypical" family forms, especially single-parent, are often highly vulnerable to poverty; a high cost of children means low fertility. Low fertility means low activity rate. Gosta Esping-Andersen, "The Sustainability of Welfare States into the Twenty-First Century." *International Journal of Health Services*, 30(1) (2000): 1-12.

care will be challenged with reference to economic theory and human rights literature.

In terms of responding to the pressures on welfare and health care Turkey follows the World Bank (WB) and the International Monetary Fund (IMF) proposals, like many other developing countries. These proposals bring the expansion of health coverage together with market reforms. Actually, the expansion of health coverage through the establishment of general health insurance which would abolish the existing inequalities has been on the agenda since the 1950s. The socialization of health services as a universal tax-based NHS system has failed and general health insurance, which has appeared in nearly all government programs, could be legalized during the single party government of the JDP. Although the reform package of the JDP has quite a few problems that call for criticism, its aim to abolish the inequalities within the existing system is noteworthy. However, as already mentioned, the JDP faces the resistance of the bureaucracy, which wants to protect the privileged position of civil servants. This brings us to the third current of analysis, which is the literature on bureaucracy and class in Turkey.

The traces of the privileged position of civil servants within the welfare system can be found in "the bureaucratic ruling tradition of Turkey," a concept formulated by Metin Heper. He introduces his state tradition thesis, which is based on a demarcation between a strong state and a weak civil society. Similar to Şerif Mardin who adopted Edward Shils' "center-periphery dichotomy" to Ottoman-Turkish society, Heper talks about the tension between the bureaucratic center and the peripheral forces.[20] He makes a comparison between the Western countries and

[20] In the special issue of *Toplum ve Bilim* on "center-periphery," all of the contributors criticize the a-historical, modernizationist, reductionist and Orientalist character of this model and declare the need for a new framework which would help us understand the complex and multi-dimensional power relations in Turkey. *Toplum ve Bilim*. Special issue on center-periphery, no. 105 (2006). Heper's

the Ottoman-Turkish state and asserts that while the "emergence and strengthening of bourgeois middle classes, and later of working classes, transformed the mercantilist state first into a bourgeois, and, later, a welfare state," in historical-bureaucratic empires like the Ottoman Empire, "ruling elites usually developed into a 'caste' or 'guardian bureaucracy' which became self-serving and/or assumed a paternalistic attitude toward the ruled".[21] For the long centuries of Ottoman-Turkish political development he talks about a bureaucracy-dominated polity. Bureaucracy is autonomous in the political system and has not only administrative but also political functions. So, the main axis of struggle is not between the bourgeois and the proletariat, but between the bureaucracy and the peasant (or the ruled).

The civil bureaucracy moved into a position of power and was completely politicized in the power vacuum of the mid-nineteenth century. With the transition to the Republican period, the bureaucracy in general -and civil bureaucracy in particular- rose to further prominence.[22] In this period, there was no political elite apart from the civil bureaucracy. The salaries of bureaucrats were high and during the Second World War these salaries were consolidated with allowances in kind.[23] As the formation of the Democrat Party (DP, *Demokrat Parti*) reveals, by the 1940s there appeared a distinction between the civil bureaucracy and the new political elite. There was then a clash between the "underdeveloped bourgeoisie" and the traditional

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framework has also been criticized in these terms. Ali Rıza Güngen and Şafak Erten, "Approaches of Şerif Mardin and Metin Heper on State and Civil Society in Turkey." *Journal of Historical Studies*, 3 (2005): 1-14. Despite all these criticisms Heper's formulation of strong bureaucracy might still be useful in analyzing the historical roots of the advantageous position of the bureaucracy within the Turkish welfare system.

[21] Metin Heper, "Political Modernization as Reflected in Bureaucratic Change: The Turkish Bureaucracy and a 'Historical Bureaucratic Empire' Tradition." In *Readings in Turkish Politics*, ed. Metin Heper (İstanbul: Boğaziçi Üniversitesi, imprint, 1980), p. 276.

[22] Ibid., p. 280.

[23] Metin Heper, *Bürokratik Yönetim Geleneği: Osmanlı İmparatorluğu ve Türkiye Cumhuriyetinde Gelişimi ve Niteliği* (Ankara: ODTÜ İdari İlimler Fakültesi, Yayın No. 23, 1974), p.115.

"intellectual-bureaucratic elite." Heper analyzes the 1960 coup as the latter's insistence on its own hegemonic position.[24] Starting from the 1960s, the civil bureaucracy began to lose its towering position in society and to be influenced by the emerging socioeconomic groups.[25] Nevertheless, there is continuity with the early Republican period in terms of the bureaucratic tradition. Heper explains this continuity with reference to the lack of a free entrepreneurial middle class, the inability of the political elite to develop a new set of principles, and the continuation of the former bureaucratic elite class at its post.[26] The bureaucracy resembles a closed system as it is based on seniority and "caste" structure related to education. Although it is the government that holds the right of assignment and advance, a civil servant might apply to the Council of State when he/she is removed from office.[27]

It would be problematical to analyze all the late Ottoman and early Republican periods as bureaucracy-dominated eras. Heper does not talk about such a static structure either. Of course, we should look at the power relations among different groups as a much more complex process changing over time, but Heper's framework might be useful in positioning the bureaucracy as a party in Turkish politics. Though its strength and impact might have changed, the bureaucracy has always been a party in the alliances that shape the economic and the political structure.

The prominent role of the bureaucracy is analyzed also by Çağlar Keyder, who looks at the class alliances throughout the nineteenth and twentieth centuries in Turkey. Similar to Heper, he emphasizes the bureaucratic control over politics, but

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[24] Heper, "Political Modernization as Reflected in Bureaucratic Change," p. 281.

[25] Ibid., p. 287.

[26] Heper, *Bürokratik Yönetim Geleneği*, p.130.

[27] Ibid., p. 115.

focuses more on the alliance between the bureaucracy and the bourgeoisie. In the early Republican period, politics were the business of the elite, with power being transferred within the bureaucracy or shared among the bourgeoisie, who constituted a very small group.[28] Here by "bourgeoisie," Keyder means the small merchants, urban petty bourgeoisie, and commercial farmers. In this period, "the people" were politically dominated, socially oppressed and economically exploited by the bureaucrat-bourgeois bloc.[29]

Until 1950, the bourgeoisie remained within the bureaucratic alliance, but after the victory of the DP in the elections, it subordinated the bureaucracy. In Keyder's words,

> The bureaucracy lost its status as a social class with its own project and became a group of state managers whose level of autonomy depended on the nature of the accumulation process and intra-bourgeois balances. Despite the rich historical heritage of state tradition, political power after 1950 remained in the hands of the bourgeoisie. From then on, the relative autonomy of the state managers could be understood in terms of the weakness of the dominant bourgeois fraction, conflict within the bourgeoisie, or by reference to Turkey's conjunctural relationship with the world system.[30]

There is no complete subordination of the bureaucracy to the bourgeoisie, but rather a relative autonomy. In terms of their roles in the economy and social status, the bureaucratic cadres have a certain relative autonomy although they have been unable to regain their prewar status.

The period between the coups of 1960 and 1980 is characterized by the politicization of certain economic allocation mechanisms and the constitution of a domestic market. For this period, Keyder talks about an alliance between the

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[28] Çağlar Keyder, *State and Class in Turkey: A Study in Capitalist Development* (London and New York: Verso, 1987), p.117.

[29] Ibid., p. 122.

bourgeoisie, the bureaucracy and formal sector workers. The model of accumulation, the foundations of which were laid by the architects of the coup of 1960, functioned with considerable success in the following two decades. According to Keyder, this new model accorded with the aspirations of the intelligentsia and with the as yet unformulated demands of the industrial working class. This was a regulation by the state, which "served the needs of the industrial bourgeoisie while also responding to the demands of the state functionaries and the intelligentsia who had been eclipsed during the previous decade."[31]

At this level of generality, it resembles post-war Keynesianism, which also involves the management of the economy by the state, the ascendancy of state managers, and the redistribution of income in order to constitute and reproduce a domestic market. But this model is different in terms of the external relations of the economy; the industrial sector was protected from international competition. Keyder labels this economic regulation Import Substituting Industrialization (ISI), the defining feature of which is the protection of domestic industry through producing the very manufactures hitherto imported.[32] It was the project of the manufacturing bourgeoisie and conformed well with the short- and medium-term interests of the working class and a certain stratum of the bureaucracy.[33] The 1961 Constitution empowered the organized working class with the right to collective bargaining and the government employees with the right of recourse to powerful state courts. In 1963 workers obtained the right to strike and real wages increased 5-7% annually in the following decade. The Turkish working class was in a better position compared

[30] Ibid., p. 127.

[31] Ibid., p. 150.

[32] Ibid., p. 151.

[33] Ibid., p. 144.

with its counterparts in other equally less developed societies. It was not only the right to collective bargaining and strike or the relatively high wages, but also the social rights like advanced pensions and health insurance which distinguished the position of the Turkish working class from that of its counterparts. This advantageous position of organized workers was in line with the interests of the industrial bourgeoisie, who needed consumers for their products. So until 1980, formal sector workers, the bureaucracy and the bourgeoisie benefited most from the relatively closed ISI-based economy.

However, the relatively advantageous organized stratum comprised only one-third of the working class. The majority of the workers were employed in "marginal" sectors, without job security and with much lower pay.[34] Most of them did not even have social security records and the opportunity to be members of a trade union; some of them were children. The conditions of those in the modern industrial sector were much better than those in the sector of small capital. In the national developmentalist environment of the 1960s and 1970s, it was thought that all workers would obtain these conditions in time and that the social security coverage would expand. These evolutionary hopes were pursued until the coming of the crisis in the late 1970s.[35] Although there was a rise in both the number and the ratio of people who were covered by a security scheme, which in most cases was a result of including the dependents, a large number of people were without any social insurance.

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[34] Çağlar Keyder, "The Political Economy of Turkish Democracy." In *Turkey in Transition: New Perspectives*, eds. R. Benatar, İ.C. Schick and R. Margulies (New York, Oxford: Oxford University Press, 1987), p.59.

[35] Çağlar Keyder, *Ulusal Kalkınmacılığın İflası*, 2nd ed. (İstanbul: Metis, 1996), p.78.

After presenting the analytical and theoretical framework both here and in the second chapter, the third chapter will give an overview of the period before the socialization. This third chapter will cover the period starting from the establishment of the Ministry of Health and Social Assistance (*Sıhhat ve İçtimai Muavenet Vekaleti*) in 1920 to the socialization of health services in 1961. The early Republican governments were faced with the hard task of improving the health of the population which had been damaged by long-lasting wars and took special measures to combat infectious diseases like malaria, tuberculosis, trachoma, syphilis and leprosy. Preventive care was given top priority and the doctors assigned to this work were given extra incentives. The parliament worked hard on health legislation. The Law of Public Health (*Umumi Hıfzıssıhha Kanunu*), which is still in force with minor changes, was issued in 1930. By this law it was accepted that the protection of the health of the nation was a state mission. The law reflects the priority of the struggle against infectious diseases. The early Republican governments tried to improve the health of the people and establish basic practices of collective and individual hygiene. They realized that the population was the most important input of economic development and national defense. The primary objective of health care was not the individual but the biological population as a whole. Health care was provided because it was perceived to be in the best interest of the nation. To activate the productive capacity of the population, public health and physical education were promoted. The most important accomplishment of the Turkish state in the interwar period might be considered to have been in the field of public health. The young Republic took over a small population (13 million) in which the ratio of active

population was very little. Through public health measures and pro-natalist policies both the amount and the well-being of the population improved.

With the accomplishments of the early Republican health policies, successive Democrat Party (DP, *Demokrat Parti*) governments were able to adopt a more individualistic approach towards health care in the 1950s. The state, which previously had not assumed the responsibility of curative services adopted the role of main provider, financier and administrator of health care. When the DP was in power, the share of MHSA in the general budget increased above five, for the first time in Republican history. The rise in the number of public hospitals and beds was noteworthy, so was the fall in the number of population per bed. Yet, existing health services could not meet the rising expectations of the people, and peasants who constituted nearly 70% of the population were devoid of basic health care. The unjust distribution of health services, the lack of basic health care in the rural area, and the difficulties poor people faced in receiving medical care necessitated the formulation of a national health program. It was the military which initiated the formulation and application of such a program. Early Republican policies and mentality related with health care and the rupture in the DP period will be analyzed to present a picture of welfare and health care before the coup of 27 May 1960.

The fourth chapter will begin with the social, political, ideological and economic context within which the Socialization Law was prepared. The actors of the legislation (the National Unity Committee, the Ministry of Health and Social Assistance, the Ministry of Finance, and the State Planning Organization) and their positions will be analyzed. The incentives of the actors will be examined: social justice, comprehensive development and regional development, integration of the Kurds, modernization, and population planning. The simplistic pro-natalism of the

1930s left its place to anti-natalism in the 1960s as the rapid population growth started to create so many developmental problems and public health issues. The anti-natalist policies and their ideological implications will be analyzed in this chapter. The discussions around the legislation of the socialization majored in feasibility, especially the financial and human resources.

After portraying the conditions that generated the need to formulate a new health care system, the intentions of the actors, and the discussions around a new model, I will focus on the main principles of socialization, especially with reference to the writings of Nusret Fişek, the architect of the project. The problems the socialization of health services anticipates and the gaps it leaves will also be dealt here. The continuities and ruptures with the early Republican and DP periods will be elaborated. The peculiarity of the 1960s in terms of adopting of health care as a basic citizenship right should be emphasized here.

The fifth chapter will cover the period starting from the enactment of the law in 1961 to the military coup of 1980. The periodization will be made with respect to government changes and accomplishments. This time the social, political and economic context within which the Socialization Law was applied will be analyzed and the actors of the application. Targets, accomplishments, and failures of the program will be examined. Related to targets, I will examine to what extent universal health coverage was aimed, and to what extent it was a "modernization" and "public health" program. Related to specific targets about service provision like the number of doctors and health posts, and about outcomes like the fall in child mortality, fall in infectious diseases and rise in vaccination, health statistics will be utilized. The failures will also be investigated for specific targets and for more general ones like the establishment of a tax-based universal health scheme. The reasons behind the

failure will be specified under headings such as the concurrent development of the corporatist system, and the corporatist resistance; the problems in financial (struggle on the budget) and human resources (supply of health personnel and the structure of medical education); and the starting of the program in the East.

There were also problems related with mentality, i.e., the program was not embraced by all and a lot of people did not believe in universal health care. But this does not mean that the socialization did not affect the mentality of the people. After socialization it was widely accepted that the state had the responsibility of sending doctors to areas of multiple deprivation and providing both preventive and curative services. There will be a chronological discussion about the approaches towards health and about the policies under successive governments. The socialization was not adopted as the national health service scheme of Turkey and was confined to the providing of primary care for the poor and the peasants. The governments tried to include all through the establishment of a general health insurance. However, all the attempts to legislate general health insurance in the late 1970s failed. After explaining these I will look at another failed attempt: the law on full-time working of the health personnel. It was enacted to solve the problems of personnel shortage and unethical confrontations resulting from the dual employment of doctors. The failure of this attempt reveals the importance of the position of the doctors as a professional group in the application of national health policies.

The thesis will argue that although the socialization had certain achievements, especially in places where it was properly applied, it did not become the national health service of Turkey. Although the socialization was not limited to public health and primary care for rural population and the poor, its priority area was this and throughout the 1960s and the 1970s it was wedged in to its priority area. Even in the

field it was limited to, i.e., the establishment of a primary care network, there were many problems. The pressure on hospitals continued to rise and the referral chain did not function. The number of health posts did not reach the expected levels and the existing institutions were underfunded and understaffed. In places where it was properly applied people were satisfied with the services, health indicators improved, and costs were controlled. So, by "failure" I do not refer to the principles or the proper practice, but to the limits of its consolidation as a universalist health system.

In the thesis this idea is developed with reference to a distinction between the "citizens" and the "people." Citizens were provided with every kind of health service through insurance while people were provided only with public health. Government employees and workers in the formal sector could apply hospitals in city centers while those without insurance could apply health posts. As the referral system (hospital services would be free for those referred from health posts) did not work, those without insurance could not benefit from hospitals free of charge. The health posts could not develop since a separate hospital system was expanding to serve the insured. And as the insured could apply hospitals directly, health posts served only to those without insurance, peasants and the poor. Various studies conducted in different years on the utilization of health posts reveal that it is usually people without insurance, and the poor who attend them. As Richard Titmuss argues, services for the poor are always poor services.[36] When confined to the poor part of the population notorious for its lack of political muscle and public audibility, a social service cannot improve.

The universal and comprehensive system could not be established and people without insurance had to appeal to informal mechanisms. A large segment of the

[36] Richard Titmuss, *Social Policy: An Introduction*, eds. Brian Abel-Smith and Kay Titmuss (London: Allen & Unwin, 1974).

population, those in the informal and agricultural sector, who were not covered by any of the three basic social security schemes, faced problems in receiving health services. Only primary care in health centers, vaccination and pre- and ante-natal care were free. It was a real problem for the poor to pay for the health expenses. They could apply with the poverty record taken from the *muhtar*, but it was not a guarantee for receiving free health service. The head doctors of hospitals had the right to decide who would be provided free health service. Although this is a formal right clearly stated in regulations on the management of hospitals, it is hard to consider it as a formal arrangement. Poor patients were left to the discretion of head doctors, who would distinguish the "deserving" poor from the "undeserving" ones. The criteria of this decision were not clarified and people were forced to the position of begging for free service everytime they went to a hospital. The state was handling the issue outside the framework of formal rules and bureaucratic processes. There was certainly a kind of protection. Those who took refuge in state "compassion" might be provided free service, but it was not legalized and people did not feel the comfort that anytime they went to a hospital they would be welcome.

Another informal mechanism was related with the status of being dependent. Those in the informal sector might receive health services as family members of the formally employed. Also, the use of health insurance card by relatives and neighbors especially for medication was a common practice. Rather than establishing a universal health scheme that guarantees health service to everyone regardless of employment status or income, the state ran informal mechanisms and led people to develop new informal mechanisms like the misuse of health insurance cards. In receiving health services network relations were also very important. To know someone who worked in the hospital, a doctor, a nurse, or an aid, proved to be more

helpful than an insurance card in receiving a proper service. But, as can be expected, it was usually not the poor who had strong network connections.

This is in line with the traditional welfare regime of Turkey as defined by Ayşe Buğra.[37] Before the 1980s the state protected those in the formal sector, but this does not mean that those outside the system were abandoned to their fate. The state protected them in a different way; not through formal institutional arrangements, but through informal relations. The traditional welfare regime of Turkey has largely been based on informal networks of reciprocity. Relatives, neighbors or members of ethnic and religious communities have been very important in determining the livelihood of the individual and the mechanisms on which he/she relies in coping with risk situations. Interestingly, the role of the state in economy has also been shaped according to the family model and defined by informal relations of trust, loyalty and solidarity. For example, rather than enacting formal laws which provide unemployment insurance or job security, employment opportunities in State Economic Enterprises were created which would be utilized through processes of *hemşerilik* and party belonging. Or, rather than establishing formal housing credits or public housing projects, *gecekondu* model which was based on the encroachment of public land and passing over of the violation of building codes was allowed. Ownership of a *gecekondu* depended on the personal family relations and *hemşeri* solidarity, and political affinities. Another example is related with the funds of SII. The state spent the funds of SII irresponsibly in different areas and did not invest them with a reasonable rate of return. But when a social security crisis occurred it was again the state which met the budget deficit of SII. According to Buğra, all these reveal that the state *did not act like a state*. It did not act within the framework of

[37] Ayşe Buğra, "Ekonomik Kriz Karşısında Türkiye'nin Geleneksel Refah Rejimi." *Toplum ve Bilim*, 89 (Yaz 2001): 22-30.

formal rules and rational bureaucratic processes and did not treat people as equal citizens.[38]

Such a relation between state and society can be observed in countries other than the developed capitalist ones. When we look at the social policy environment of these countries we can observe the dominance of informal protection. It is not the labor markets functioning within a legal framework but rather the informal sector that dominates the working life. Both exploitation and protection result from power relations that have a personal character. As Chatterjee claims, within such a framework state is not unimportant but people might be defined not as "citizens," but as "governed population" in terms of their position in view of the state. The mechanisms they use might be defined as "politics of the governed." Chatterjee argues that although modern politics is based on the universal ideals and promises such as equal rights, liberty and citizenship, which includes everyone regardless of their race, religion, ethnicity, gender or class, *this is not how things work*. In developmental contexts, the inhabitants are divided into two categories, namely the *citizens* and the *population*, and *property* and *community* constitute the major axes of this differentiation. In other words, those who do not own property or who belong to a certain community are *marked* as improper or suspect citizens, and their relations with the state and their integration into the category of citizenship are constituted through the use of some governmental technologies.[39]

It is a constitutional right of every Turkish citizen to live a healthy life. The Socialization Law which is still in force today guarantees health care to all regardless of status in employment. However, *this is not how things work* in reality. A part of

[38] Ibid., p. 25.

[39] Partha Chatterjee, *The Politics of the Governed: Reflections on Popular Politics in Most of the World* (New York: Columbia University Press, 2004).

the inhabitants of Turkey who are *marked* by their poor economic conditions cannot afford access to health care services by using their status as citizens.

The sixth chapter deals with the situation of those outside the system which became worse especially after the coup of 12 September 1980. The failure of a universal and comprehensive system combined with the marketization trends of the 1980s had devastating consequences especially for the poor. Throughout the 1980s, when the Motherland Party (MP, *Anavatan Partisi*) was in power, the former restrictions for the markets were lifted and private sector was promoted in many fields, including health care. Regional and statutory inequalities, infrastructural problems and poor quality service to people with no financial means became salient in this period. The public resources were transferred to the private health sector and preventive care was neglected. The share of health in the state budget declined and hospitals were forced to derive their own resources. The privatization of health implies that hospitals are to be administered as if they are business enterprises and involves the practice of revolving funds based on the distribution of the profit to the doctors and other health personnel. So, the state hospitals started to accept only those who were covered by a security scheme or who had the necessary financial means. It also became harder to appeal to informal mechanisms because of the rise in health care costs. By the 1990s the health system was in a deep crisis and newspapers were full of stories of poor people who could not pay for health expenses and were held in pledge by the hospital administrations. The following True Path Party – Social Democratic People's Party (TPP-SDPP, *Doğru Yol Partisi – Sosyal Demokrat Halkçı Parti*) coalition introduced the Green Card scheme in 1992 to provide health insurance to those who were not covered by any social security institution and whose monthly income was less than one-third of net minimum wage. Although it was

designed as a temporary measure until the establishment of a general health insurance, it has functioned as the fourth security scheme for the last fifteen years, covering nearly 10 million people today. Obviously, it is a means-tested mechanism, a residual practice. In social policy literature such practices are criticized for creating stigma and dualisms. But we should consider the historical context while criticizing the Green Card as a means-tested mechanism. It is an improvement in citizenship status when compared with the former situation. In the sixth chapter I will explain the degrading former practice with reference to the interviews I conducted with various health personnel. Also the former legislation related with the health care for the poor will be summarized to locate the peculiarity of the Green Card. If the Socialization Law which defined health care as a citizenship right that is accrued to all regardless of need or labor force participation were applied in its entirety the need for a means-tested mechanism would not arise.

The TPP– SDPP coalition worked hard to implement the health reform which was supported by the World Bank. There was the need for a reform to solve the recurrent problems. The problems of low coverage, weakness of primary care network, unjust distribution of services and personnel, inefficiency of hospitals, resistance of the doctors to become civil servants, lack of integration, and inequality of access to health care were the problems that the socialization of health services tried to solve years ago. The rise in urbanization and the rise in percentage and number of those covered by a security scheme increased the demand, together with the developments in medicine, which in turn intensified these problems. So, it was not only the neo-liberal transformation or the budget deficits in insurance that forced the governments to work on health reform. A major component of the reform, the general health insurance, had already been discussed for years. The TPP-SDPP

coalition designed a national health program which covered decentralization in health services, the autonomization of public hospitals, and the transition to general health insurance. The abolishing of regional inequalities and the establishment of the Green Card Scheme for the poor were the other two major targets. Among these targets only Green Card could be actualized. The Green Card served the diminishing of regional inequalities as the uninsured poor concentrated in Eastern and Southeastern provinces. Yet, regional and urban-rural disparities continued which can be observed from comparative health indicators. One important objective of the socialization was to address regional and rural-urban disparities. However, the failure in its proper realization hindered their abolition. The persistence of regional inequalities will also be analyzed in the sixth chapter.

The reform project of the JDP will be discussed in terms of universalization and privatization. The JDP took radical steps in the field of health care and abolished some of the inequalities among the members of different security schemes. The reform project of the JDP was much more comprehensive than those of the former governments but the major components like general health insurance, family medicine, and autonomization of hospitals were exactly the same. What distinguishes the JDP is its determinacy in changing the system. The developments in the field of health care after the coup of 1980 and their connections with the socialization will be the main points of focus in this chapter.

The Existing Literature on Turkish Welfare and Health Care System and the Sources of Data Used in the Dissertation

Up until now, the social science in Turkey have focused on civil and political rights in analyzing the state-citizen relations. Social rights have been neglected or wedged in the narrow technicist field of industrial relations, labor law, and social security legislation. The research in this field is usually descriptive and does not handle the topic within a wider perspective of history, political philosophy, political economy and sociology. The Boğaziçi University Social Policy Forum was established with a view to change this situation and to encourage researches to incorporate different disciplines and the existing international literature on welfare and citizenship. The books and research papers prepared by the members of the Forum helps the construction of a new literature on social policy.[40] Except for the recent studies within the Forum,[41] health care has also not been analyzed within the context of welfare and citizenship.

It has usually been the public health specialists who have analyzed the health system of Turkey within a historical framework.[42] However, they have had a limited vision of Marxism, which has led them to analyze health policies as components of the capitalist structuring of the Turkish state. Within this framework, all specific

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[40] Social Policy Forum web site, www.spf.boun.edu.tr (December 2007).

[41] Çağlar Keyder, "Health Sector Reform in the Context of Turkish Political Economy." Paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, Boğaziçi University, İstanbul, 2005; Nazan Üstündağ; Tuba Ağartan, "Health Sector Reform in Turkey: Towards a Mixed Economy of Health Care." unpublished paper, 2007; Çağlar Keyder, Nazan Üstündağ, Tuba Ağartan and Çağrı Yoltar (eds.), *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar* (İstanbul: İletişim Yayınları, 2007).

[42] İlker Belek, Erhan Nalçacı, Hamza Onuroğulları and Fatma Ardıç, *Sınıfsız Toplum Yolunda Türkiye İçin Sağlık Tezi*, 2nd edition (İstanbul: Sorun Yayınları, 1998); İlker Belek, *Sosyal Devletin Çöküşü ve Sağlığın Ekonomi Politiği*, 3rd edition (İstanbul: Sorun Yayınları, 2001); Tolga Ersoy, *Türkiye Tıp Tarihi İçin Materyalist Notlar* (İstanbul: Sorun Yayınları, 1998); Ata Soyer, *Sanayi Devriminden Küreselleşmeye Darbeden AK Partiye Sağlığın Öyküsü* (İstanbul: Sorun Yayınları, 2004).

health policies are viewed as serving the exploitation of the proletariat by the bourgeoisie. The lack of a rights-based perspective leads to explaining policies that extend health coverage, like the Green Card, as palliative measures which serve the capitalist system. Marxist class analysis has been adapted too readily and simplistically to the Turkish context. The categories of "bourgeoisie" and "proletariat" are not problematized and the existing health system is analyzed as an apparatus of the bourgeoisie. In this literature, only the Soviet model in which physical and human resources have been taken over by government is seen as the ideal. All the health systems including the British NHS are viewed as serving the capitalist classes. Within this framework, not only health services but all welfare policies serve the maintenance of the capitalist system.

Although there have been quite informative studies on the history of health care in Turkey, they are rarely situated in a theoretical framework.[43] Despite the fact that they are very useful in figuring out the historical trajectory of health system in Turkey, the historical analysis they provide fails to establish a connection between the fields of public health and social sciences. Consequently, health care remains a marginal topic within the social sciences. Happily, there is a currently growing literature to which young scholars who use the Foucauldian notion of "governmentality" have contributed through analyses of the early Republican social

[43] Erdem Aydın, "Türkiye'de Taşra ve Kırsal Kesim Sağlık Hizmetleri Örgütlenmesi Tarihi." *Toplum ve Hekim*, 12(80) (1997): 21-44; Erdem Aydın, "Cumhuriyet Döneminde Sağlık Örgütlenmesi." *Yeni Tıp Tarihi Araştırmaları*, 5 (1999): 141-172; Erdem Aydın, *Türkiye'de Sağlık Teşkilatlanması Tarihi* (Ankara: Naturel Kitap Yayıncılık, 2002); Nevzat Eren and Nuray Tanrıtanır, *Cumhuriyet ve Sağlık* (Ankara: TTB, 1998); Ali Gürsel, *Cumhuriyet Dönemi Sağlık Politikaları (1920-1960)*, Doktora Tezi, Hacettepe Üniversitesi, Atatürk İlkeleri ve İnkılap Tarihi Enstitüsü, YÖK Tez No: 73695, 1998; Esin Kâhya and Demirhan Erdemir, *Bilimsel Çalışmalar Işığında Osmanlıdan Cumhuriyete Tıp ve Sağlık Kurumları* (Ankara: Türkiye Diyanet Vakfı Yayınları, 2000); Uysal Kerman, *1980 Sonrası Siyasal İktidarların Sağlık Politikaları*, Yüksek Lisans, Süleyman Demirel Üniversitesi, SBE, YÖK Tez No: 74480, 1999.

policy in general and health and population policies in particular.[44] Their contribution is important in terms of understanding the early Republican mentality which regarded health and population policies as components of the formation of the nation-state.

There is also a body of literature on the socialization of health services, the specific subject matter of this thesis. The contributions to this literature are in general made by the public health specialists who were active in the application of the program but they do not try to provide an analysis of the socialization within the framework of the Turkish welfare regime. They usually have a nostalgic look at the system and emphasize the role of the bureaucrats in its "failure."[45] Although they provide valuable information in terms of the problems in the application process, they do not address the characteristics of the social policy environment of Turkey in its relevance to the developments within the health sector. They analyze the socialization program within the narrow framework of health policy. Still, it must be mentioned that Öztek refers to a wider framework of factors[46] some of which are used in this thesis and Aydın does not share the nostalgic look of the public health specialists and criticizes the system as it had an ambiguous financial basis.[47] There is also a specific literature on the services in health posts and health research and

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[44] Yiğit Akın, *"Gürbüz ve Yavuz Evlatlar": Erken Cumhuriyet'te Beden Terbiyesi ve Spor* (İstanbul: İletişim Yayınları, 2004); Ceren Gülser İlikan, *Tuberculosis, Medicine and Politics: Public Health in the Early Republican Turkey*, MA Thesis, Boğaziçi University, Atatürk Institute, 2006; Pınar Öztamur, *Defining a Population: Women and Children in Early Republican Turkey, 1923-1950*, MA Thesis, Boğaziçi University, Atatürk Institute, 2004.

[45] Gazanfer Aksakoğlu, "Denenmeyen Model: Sosyalleştirme." *Toplum ve Hekim*, 9(60) (Nisan 1994): 52-55; M. Rahmi Dirican, "Sağlık Hizmetlerinin Sosyalleştirilmesi ve Başarısızlık Nedenleri." *Toplum ve Hekim*, 9(60) (Nisan 1994): 49-51; Caner Fidaner, "Otuzüç Yıl Sonra Sosyalleştirme Yasası." *Toplum ve Hekim*, 9(60) (Nisan 1994): 56-58; Necati Dedeoğlu, "Bir Yasanın Hikayesi." *Toplum ve Hekim*, 9(60) (Nisan 1994): 59-60, Nisan.

[46] Zafer Öztek, *Sağlık Hizmetlerinin Sosyalleştirilmesi ve Sağlık Ocağı Yönetimi*, Ankara: Palme Yayıncılık, 2004.

training districts which evaluate the application of the system in terms of the services provided and the improvement in basic health indicators.[48]

Although I used the studies on socialization in particular and the Turkish health system in general, I tried to evaluate them within the analytical framework of welfare, health care and citizenship literature, and the literature on state-society relations, bureaucracy and class in Turkey. I believe that such an approach could contribute to a better understanding of the socialization of health services and the reasons of its failure. It could also contribute to the analysis of the current reform process, which has, at its background, the consolidation of inegalitarian corporatism that prevented the success of the socialization of health services as a universalist project.

The Republican history of health care has not been analyzed within the welfare, health care and citizenship literature. Although there is a growing body of literature on the current reform process which draws on this literature,[49] its historical

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[47] Erdem Aydın, "Sosyalleştirme Yasasındaki Teknik Hatalar ve 32. Madde Olayı." *Toplum ve Hekim*, 10(68) (1995): 60-63; Erdem Aydın, "Sağlık Hizmetlerinde Sosyalleştirmenin Tarihsel Yönü."

[48] Gazanfer Aksakoğlu, *Sağlık Hizmetlerinin Sosyalleştirildiği Bir Bölgede Halkın İyileştirici Hizmetler İçin Seçtiği Sağlık Kuruluşları ve Bu Seçimi Etkileyen Etmenler Üzerine Bir İnceleme*, Hacettepe Üniversitesi Tıp Fakültesi, Toplum Hekimliği Bilim Dalı, Uzmanlık Tezi, Ankara, 1979; Nevres Baykan, "Sağlık Ocakları Çalışmaları Nasıl Değerlendirilmelidir?" *Sağlık Dergisi*, 56(1-12) (1982): 5-13; Nazmi Bilir and Yusuf Öztürk, "Sağlık Hizmetlerinin Sosyalleştirilmesinin Kişilerin Sağlık Konusundaki Bilgi Düzeylerine Etkisi." *Sağlık Dergisi*, 58(7-9) (1984): 13-20; Hür Hassoy, *Gülyaka Sağlık Ocağı Bölgesinde 0-6 Yaş Çocukların Sağlık Hizmeti Kullanımları, Sürekli Hizmet Kaynakları ve Etkileyen Faktörler*, Uzmanlık Tezi, Ege Üniversitesi Tıp Fakültesi, Halk Sağlığı Anabilim Dalı, İzmir, 2005; Hür Hassoy and Meltem Çiçeklioğlu, "İzmir İli Gülyaka Sağlık Ocağı Bölgesinde 0-6 Yaş Çocukların Sağlık Hizmeti Kullanımları ve Etkileyen Faktörler." *Toplum ve Hekim*, 20(5) (2005): 361-371; Bülent Kılıç and Gazanfer Aksakoğlu, "Eğitim Araştırma ve Sağlık Bölgeleri." *Toplum Hekimliği Bülteni*, 25(3) (2006): 7-14; Nilgün Kırcalıoğlu, Hilal Özcebe and Ayşe Akın Dervişoğlu, "Çubuk Sağlık Eğitim ve Araştırma Bölgesinin Ana-Çocuk Sağlığı Ölçütlerinin İrdelenmesi ve Türkiye ile Karşılaştırılması." *Nüfusbilim Dergisi*, 13 (1991): 65-80; Yusuf Öztürk and Nazmi Bilir, "Sağlık Hizmetlerinden Yararlanmayı Etkileyen Bazı Etmenler." *Sağlık Dergisi*, 55 (4-12) (1981): 183-192; Kayıhan Pala and Hamdi Aytekin, *Gemlik Eğitim Araştırma Bölgesi'nde 20 Yıl (1980-1999)*, Bursa: Uludağ Üniversitesi Tıp Fakültesi Halk Sağlığı Anabilim Dalı, 2000; Hüseyin Polat, Ferit Koçoğlu, Servet Özgür and Gülay Koçoğlu. "Sağlık Ocağı Hekimleri – Koruyucu Hekimlik." *Sağlık Dergisi*, 61(2) (1989): 47-53.

[49] Ağartan, "Health Sector Reform in Turkey"; Tuba Ağartan, "Sağlıkta Reform Salgını." In *Avrupa'da ve Türkiye'de Sağlık Politikaları*; Keyder, "Health Sector Reform"; Çağlar Keyder et.al.; Üstündağ; Üstündağ and Yoltar.

background remains to be elaborated. It is by situating the analysis of the health care policies of the Republican period within an analytical framework based on the vast body of literature on welfare, health care, and citizenship that this dissertation attempts to make a contribution to the subject. Here, the provision of health care is seen as a policy of integration. The continuities and ruptures in the health policies of the whole Republican period are identified in order to reveal the parallel continuities and ruptures in state-society-citizen relations.

Some of the primary sources used in the thesis had not been used previously in research on health policies. Among those primary sources there are laws, regulations, by-laws, law drafts, parliamentary minutes of the major laws, government programs, health sector expertise commission reports of five year development plans, the State Planning Organization reports, books, reports, documents, and journals (*Sağlık Dergisi*) of the Ministry of Health and Social Assistance, the minutes of meetings on health care organized by the MHSA and the Turkish Medical Association, the minutes of the First General Assembly on the Socialization of Health Services, the summary of the Second General Assembly on the Socialization of Health Services, theses on specialization in public health, all the books and articles written by Nusret Fişek -the architect of both the Socialization and the Population Planning laws-, newspaper accounts, memoirs, and interviews.

I conducted interviews with public health specialists and physicians, some of whom worked in the socialization program with Nusret Fişek. I conducted an interview with Necat Erder, one of the founders of the SPO, to better understand the role of planning in the socialization of health services. The interviews provided me insights related to the process of application which would otherwise be hard to figure out from the laws and regulations. The health personnel gave me valuable

information about the functioning of the system both in the past and in the present. I learnt a lot from the health personnel who are retired or who are still active in work related to the practice, not only of the socialization but also of other health policies. The universalist system could not be established and the poor was left to the discretion of head doctors of hospitals or charities. The Green Card Law was an attempt to change this and to bring a formal coverage. The interviews helped me a lot in figuring out the practice before the enactment of Green Card Law, which will be analyzed in a separate section in the sixth chapter.

The thesis brings together previously fragmented statistical material and presents it systematically. The Statistics of the Ministry of Health budget, health care expenditures of different security schemes, hospitals and number of beds, personnel, and distribution of personnel will be presented together with the statistics of basic health indicators like annual population growth, crude birth rate, crude death rate, infant mortality rate, total fertility rate, and life expectancy at birth. Regional inequalities will also be highlighted through statistical material.

Throughout the text some technical concepts will be used such as life expectancy, infant mortality rate, preventive medicine, primary, secondary and tertiary care and inpatient and outpatient care. It is better to clarify them at this point: Life expectancy is the average number of years a human has before death. Infant mortality rate is the probability of dying between birth and exactly one year of age, expressed per 1000 live births. Preventive medicine is a branch of medicine that is concerned with the prevention of disease and methods for increasing the power of the patient and community to resist disease and prolong life. Primary health care is the first level of contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors,

nurses or other health staff are termed primary health care, as opposed to secondary health care or referral services. In systems with direct access to specialists, the distinction is usually based on facilities, with polyclinics, for example, providing primary care and hospitals secondary care. Secondary health care is specialized ambulatory medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary health care services. It does not include highly specialized, technical inpatient medical services (which is tertiary health care). Tertiary care refers to medical and related services of high complexity and usually high cost. Patients are referred from secondary care for diagnosis and treatment, and which is not available in primary and secondary care. Inpatient is a patient who is formally admitted (or "hospitalized") to an institution for treatment and/or care and stays for a minimum of one night in the hospital or other institution providing inpatient care. Outpatient is medical and paramedical services delivered to patients who are not formally admitted to the facility (physician's private office, hospital outpatient centre or ambulatory-care centre) and do not stay overnight.[50]

[50] WHO official web site, http://www.euro.who.int/observatory/Glossary/TopPage?phrase=H. (December 2007).

CHAPTER TWO

WELFARE, HEALTH CARE AND CITIZENSHIP

Introduction

It has been more than two decades now since the welfare state has been viewed to be in crisis. Population aging, family instability and the labor market consequences of globalization, and technological changes are the three most cited sources of this crisis. Global competitive pressures are undermining the capacity of governments to secure education, health and social protection. While social policies during the "Golden Age" aimed at expanding the scope and generosity of the welfare state, by the 1980s and the 1990s "retrenchment" had become the watchword. States now felt the pressure to reform their welfare policies. This pressure was strong especially in the domain of health care because costs were escalating tremendously due to population aging, rising rates of health care utilization, developments in medicine and biotechnology, rising expectations, and the control of profit-seeking companies over medical technology and medicine. So, the health sector reform movement, which entails a restricted role for the state in the provision and financing of health services and a greater reliance on the market influenced countries in different levels. Here in this chapter this process will be examined in its different dimensions.

In order to be able to grasp the responses to this shift, a clear picture of the existing systems is necessary. Welfare and health care typologies enable us to realize the more general tendencies which cut across national developments. The welfare

categorization developed by Esping-Andersen is used here: conservative, liberal, and social democratic. After a description of the common traits of these regimes, their position in terms of decommodification and stratification will be analyzed. The welfare state does not necessarily bring about equality and it might be a stratification system in its own right. Although Esping-Andersen is not convinced of the need for a fourth model, the Southern European model is analyzed since it has certain peculiarities that go beyond the variations within the distinct overall logic of the three systems. Health care systems usually correspond to welfare systems, but there are cases of discrepancies which reveal the peculiarity of health care. Three principal types of health systems are specified: national health services funded by general taxation, social insurance systems funded by payroll contributions, and private systems funded by private insurance companies. These systems are analyzed in terms of the ways health care is provided, financed, and regulated. Also a distinction is made between public health and medical care in order to locate the role of the state in health care within its historical context. It was through public health that the state was first involved in health care.

Different welfare regimes respond in different ways to the current pressures on welfare. Although there is consensus on the existence of pressure on the welfare state due to globalization, population aging and family instability, whether the welfare state retrenched or not is controversial. The same is also true for health care. When some emphasize the retrenchment of the health care state, others emphasize continuity. No policy area has been more dominated by the search for cost containment since the end of the long boom.

The other fact which makes health care a crucial area as such is that it is widely recognized as a basic citizenship right. More than any other social policy field, health care provision is seen as an important task of the state that cannot be left to the disposal

of the commercial sector or to the charities. It determines how citizens view their relationship to the broader society around them as well as to the state. Health is very important for feeling secure and it is an issue which cannot be left to personal solutions. Yet, the pressure on states towards expanding the share of markets in health service provision is obvious. The IMF and the WB played an important role in the formulation of health reforms in developing countries. The emphasis on universal access has gone hand in hand with the emphasis on a high degree of private sector involvement. This latter one, which is relevant also for developed countries, brings to the fore a debate on the nature of health care as a public good. Within this context I will try to challenge commodity status of health care with reference to Arrow, who demonstrates the inapplicability of the standard rules of market economics to health care.

Before going into the details of welfare typologies, health care typologies, pressures of retrenchment, various responses to these pressures, their determinants, and the peculiarity of health care in the field of social policy I would like to refer to the classical work of T.H. Marshall to put citizenship and class at the center of all these discussions on welfare and health care. T.H. Marshall's famous lecture, which was given in the optimistic environment of the post-World War II period, highlights social rights in providing equal status to citizens and diminishing class inequalities. This framework can be used to analyze the role of social rights in diminishing class inequalities and other kinds of inequalities by expanding citizenship status.

Welfare and Citizenship

T. H. Marshall's famous 1949 lectures, published together in 1963 under the title *Citizenship and Social Class*, resulted in the reorientation of the whole discussion of

the class structure in capitalist societies. In these lectures, Marshall portrays the extension of citizenship rights in terms of a progressive tale of democratization and class-abatement. Based on the British experience, he locates the origins of the struggle for citizenship with the affirmation of civil rights in the eighteenth, political rights in the nineteenth, and social rights in the twentieth century.

Marshall differentiates between three layers of citizenship rights and the institutions which supported them. The civil element is composed of the rights necessary for individual freedom –liberty of the person, freedom of speech, thought and faith, the right to own property and to conclude valid contracts, and the right to justice.[51] Civil rights are associated principally with the institutions of legal justice, such as the courts. By the political element he means the right to participate in the exercise of political power, as a member of a body invested with political authority or as an elector of the members of such a body. The corresponding institutions are the parliament and councils of local government.[52] And by the social element he means the whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society. The institutions most closely connected with it are the educational system and social services.[53] The idea is that by providing civil rights, society mitigates the impact of force and violence in relations between people. By providing political rights, it ensures that power is not confined to the elite. And by providing minimum standards in these

[51] Marshall.

[52] Ibid., p. 72.

[53] Ibid.

areas the state offsets the vagaries of market processes and corrects the gross inequalities of distribution arising from the market.

In Britain, civil rights were established between the Revolution and the First Reform Act in the eighteenth century. Political rights emerged in the nineteenth century, as the franchise was steadily extended and the status of citizenship expanded to include rights of democratic participation. Twentieth century rights to education, health and assured income are in many ways opposed to the earlier practices in this area, like the 1834 Poor Law and the Factory Acts. Marshall contrasts the 1834 Poor Law with the twentieth century welfare developments.

> The Poor Law treated the claims of the poor, not as an integral part of the rights of citizen, but as an alternative to them – as claims which could be met only if the claimants ceased to be citizens in any true sense of the word. For paupers forfeited in practice the civil right of personal liberty, by internment in the workhouse, and they forfeited by law any political rights they might possess.[54]

Through such a practice, the community of citizens was separated from the outcast company of the destitute.

Marshall's conception of citizenship revolves around three constitutive elements. First, citizenship is about the membership in a nation-state and a relationship between the state and citizens. Second, it delienates a bundle of universal rights. Third, it refers to a particular collective identity of a political community, within which citizenship rights can be exercised. Social rights do not only provide individuals with a sense of material security against the adverse effects of poverty, illness, disability, unemployment and old age in a territorially bound state. In turn, social security encourages a sense of belonging and commitment to a kind of society, i.e., the welfare state, within which citizens live.

Marshall's primary concern is with citizenship and his special interest is in its impact on social inequality. He takes the end of the nineteenth century as the turning point as he believes that the impact of citizenship on social inequality after that date was fundamentally different from what it had been before it.[55] The Poor Law approach to welfare was replaced with provision for need that is given universally, that is provided without stigma, and that avoids as far as possible official discretion. He associates welfare provision with citizenship, which is a way of making a proposal about how welfare should be handled in society. For Marshall, citizenship seems to be about expanding and enriching society's notion of equality by extending its scope through civil, political and social rights.

He puts the twentieth century citizenship and the capitalist system at war with each other. For him, the equality implicit in the concept of citizenship, even though limited in content, undermined the inequality of the class system, which was in principle a total inequality.[56]

> Citizenship is a status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed. ... Social class, on the other hand, is a system of inequality. And it too, like citizenship, can be based on a set of ideals, beliefs and values. It is therefore reasonable to expect that the impact of citizenship on social class should take the form of a conflict between opposing principles.[57]

In the twentieth century social rights have undergone enormous expansion as the state's responsibility in education, health, welfare and employment has been increasingly expanded and taken for granted. These developments were stimulated,

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[54] Ibid., p. 80.

[55] Ibid., p. 83.

[56] Ibid., p. 85.

[57] Ibid., p. 84.

in part, by growth in money incomes (unequally distributed), the introduction of direct taxation, and mass production or consumerism, which fuelled demands for reductions in inequality. Welfare state institutions directly counter market processes by providing citizens with a minimum income, a basic standard of social services (health and education) and respite against economic uncertainty. According to Marshall, class-abatement acquired a new meaning and aimed to modify the whole pattern of social inequality rather than helping the destitute in the lowest ranks of society.[58] This development is based on a growing interest in equality as a principle of social justice and an appreciation of the fact that the formal recognition of an equal capacity for rights was not enough.

Social services would decouple real income from money income and in this way, would eventually help dissolve divergent class cultures into a "unified civilization." Marshall does not see the extension of social services as a means for equalizing incomes. For him,

> What matters is that there is a general enrichment of the concrete substance of civilized life, a general reduction of risk and insecurity, an equalization between the more and the less fortunate at all levels – between the healthy and the sick, the employed and the unemployed, the old and the active, the bachelor and the father of a large family. Equalization is not so much between classes as between individuals within a population which is now treated for this purpose as though it were one class. Equality of status is more important than equality of income.[59]

He envisages a state that would not only smooth the roughest edges off the sharp inequalities of class society, but actually erode some class-based status differences altogether.

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[58] Ibid., p. 96.

[59] Ibid., pp. 102-103.

With the enrichment of the status of citizenship the maintenance of economic inequalities became more difficult.[60] Twentieth century citizenship imposed modifications on the capitalist system, which is basically a class system. Marshall explains this relation as follows: "Social rights in their modern form imply an invasion of contract by status, the subordination of market price to social justice, the replacement of the free bargain by the declaration of rights."[61] So, the twentieth century capitalism must be distinguished from its earlier forms. That is why Marshall describes our modern system as a socialist system. Here in this system, the state tries to balance the capitalist class structure. Marshall accepts Marx's thinking that capitalism divides and polarizes society. So, it is hard to maintain a capitalist society. But, in practice, capitalism develops within a system established by the state and the state utilizes citizenship status to balance class structure. The introduction of citizenship rights implies that we can no longer define society only with the logic of capitalism.[62] We have to distinguish welfare capitalism from nineteenth century capitalism, which was also declared by Karl Polanyi to have collapsed.[63]

Nineteenth century capitalism, defined by the free play and eventually total control of the market evading all political and social control, collapsed after a series of economic and political crises. Polanyi talks about the reconstructing of a new life-world, and welfare state is one of the essential components of this reconstruction process together with national developmentalism and socialist planning. So, both Marshall and Polanyi emphasize the difference between the nineteenth century

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[60] Ibid., p. 117.

[61] Ibid., p. 111.

[62] Ayşe Buğra and Çağlar Keyder, "Önsöz." In *Sosyal Politika Yazıları*, p.11.

[63] Karl Polanyi, *Büyük Dönüşüm: Çağımızın Siyasal ve Ekonomik Kökenleri*, trans. Ayşe Buğra, (İstanbul: İletişim Yayınları, 2000).

market capitalism and the twentieth century welfare capitalism. Class-abatement through controlling market forces and providing welfare distinguishes the latter from the former.

Marshall's seminal work was criticized for being a linear development model which does not fit to the historical process. But its analytical value rather than its historical explanatory strength makes it the starting point for many discussions on social rights and citizenship. Nancy Fraser and Linda Gordon criticize his periodization as it can only be applied for the experience of white working men.[64] According to them, his conceptual distinctions between civil, political and social citizenship presuppose gender and racial hierarchy. They assert that his assumption "that the chief aim of social citizenship is erosion of *class* inequality and protection from *market* forces slights other key axes of inequality and other mechanisms and arenas of domination."[65]

Marshall's conscious acceptance of universal male suffrage as the turning point for universal citizenship is an indicator of his ignoring of the female perspective. He is criticized for overlooking the ways other social relations of gender and family "produced inequalities and insecurities, as well as the myriad ways in which the institutions of the welfare state either redressed or compounded these problems."[66] Against gendered citizenship, which is based on the exclusion of women, feminist scholars elaborate on alternative theorizations of citizenship from a gender perspective. Ruth Lister sums up these approaches in three categories:

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[64] Fraser and Gordon.

[65] Ibid., p.93.

[66] Susan Pedersen, *Family, Dependence and the Origins of the Welfare State: Britain and France 1914-1945* (Cambridge, New York: Cambridge University Press, 1995), p. 5.

gender-neutral, gender-differentiated, and gender-pluralist.[67] Gender-neutral citizenship refers to equal rights and obligations for both sexes. Gender-differentiated citizenship bases its claims on the difference of women, such as maternity. Gender-pluralist approach emphasizes that gender is only one element of the subject position and identity of individuals, others being ethnic, racial, sexual, and so forth.[68]

Keeping in mind all these criticisms, I think Marshall's framework can still be utilized in analyzing social rights. His focus on the eradication of class inequality led him to ignore other forms of inequality, but still his framework might be useful in any analysis of social rights. His emphasis on participation in society as equal citizens and its impact on people's relation with the community at large should be taken into account in studying welfare policies. Marshall's framework helps us comprehend the importance of equal citizenship in the establishment of a democratic and egalitarian society. Only through social rights can people act as citizens.

Although they too criticize Marshall for ignoring the other-than-class inequalities, Fraser and Gordon use Marshall's conception of "social citizenship" in their analysis of American thinking about social provision. Fraser and Gordon talk about the tendency to focus on two forms of human relationships: discrete contractual exchanges of equivalents, on the one hand, and unreciprocated, unilateral charity, on the other. Most debates over welfare-state policy have been framed in terms of this contract-versus-charity opposition. Invidious distinctions are drawn between "contributory" programs and "non-contributory" ones, between social

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[67] Ruth Lister, "Citizenship and Changing Welfare States." In *Changing Labour Markets, Welfare Policies and Citizenship*, eds. Jorgen Goul Andersen and Per H. Jensen (London: Polity Press, 2004).

[68] There have been various critiques of these constructions of citizenship, the question of "equality or difference" being a fundamental discussion in feminist theory and politics. For a discussion of these critiques and the reasons and the need for a differentiated social policy approach, see Azer Kılıç, *Gender and Social Policy in Turkey: Positive Discrimination or a Second-Class Female Citizenship?* MA Thesis, Boğaziçi University, Atatürk Institute, 2006.

insurance –where beneficiaries have a right to what they receive since they merely "get back what they put in," and public assistance – where they have no such right since they "get something for nothing." "Social citizenship," in contrast, points to another sort of relationship altogether.[69]

Fraser and Gordon claim that the hegemony of contract helped to generate a specifically modern conception of "charity" as its complementary other. In this conception, charity appeared as a pure, unilateral gift, on which the recipient had no claim and for which the donor had no obligation. Thus, whereas contract connoted equal exchange, mutual benefit, self-interest, rationality and masculinity, charity took on contrasting connotations of inequality, unilateral gift-giving, altruism, sentiment, and, at times, femininity.[70] The gender-coded contract-versus-charity dichotomy persists today in many countries in the opposition between "social insurance" and "public assistance" programs. The first were designed by reformers to appear "contributory," seemingly embodying the principle of exchange; recipients, originally intended to be male and relatively privileged members of the working class, are defined as "entitled." "Public assistance," in contrast, continued the "non-contributory" charity tradition, so that its recipients appear to get something for nothing, in violation of contractual norms.[71]

For Fraser and Gordon the contract-centered model of civil citizenship is premised on either/or oppositions between gift and exchange, dependence and independence, while social citizenship points beyond these oppositions to solidarity and interdependence.[72] Solidarity, non-contractual reciprocity, and interdependence

[69] Fraser and Gordon, pp. 90-91.

[70] Ibid., p. 101.

[71] Ibid., p. 102.

[72] Ibid., p. 104.

are central to any humane social citizenship. When we talk about "social citizenship" we refer to "social rights," not "handouts." People enjoy guarantees of help in forms that maintain their status as full members of society entitled to "equal respect." It also means that they share a common set of institutions and services designed for all citizens, the use of which constitutes the practice of social citizenship: for example, public schools, public parks, universal social insurance, public health services.[73] There can be no democratic citizenship without social rights.[74] So, within this framework we might say that only universal welfare and health care systems can go beyond this contract-versus-charity opposition and guarantee social citizenship, a point that will be clarified in the section on these systems.

The common textbook definition of the welfare state involves the state's responsibility for the protection and promotion of the economic and social well-being of its citizens. It is based on the principles of equality of opportunity, the equitable distribution of wealth, and public responsibility for those unable to avail themselves of the minimal provisions for a good life. Following Marshall's definition of the social rights of citizenship, we can define the welfare state as the state responsible for securing some basic modicum of welfare to its citizens. However, such a definition would not be clear enough as both the measure of "basic modicum" and the content of "welfare" are contested domains.

The British historian Asa Briggs defines the welfare state as follows:

> A welfare state is a state in which organized power is deliberately used (through politics and administration) in an effort to modify the play of market forces in at least three directions –first, by guaranteeing individuals and families a minimum income irrespective of the market value of their work or their property; second, by narrowing the extent of insecurity by enabling individuals and families to meet certain

[73] Ibid., p. 90.

[74] Ibid., p. 105.

> social contingencies (for example, sickness, old age and unemployment) which lead otherwise to individual and family crises; and third, by ensuring that all citizens without distinction of status or class are offered the best standards available in relation to a certain agreed range of social services.[75]

He makes a distinction between the social service state and the welfare state. The first and second of these objectives may be accomplished by the social service state, in which communal resources are employed to abate poverty and to assist those in distress. However, the third objective "goes beyond the aims of a social service state. It brings in the idea of the optimum rather than the older idea of the minimum."[76] Here, the proper function of the state is not limited to helping the poor. Welfare is disassociated from Poor Law stigmas and this means a rise in standards. This definition is in line with Marshall's thinking which contrasts the 1834 Poor Law with twentieth century welfare developments. The Poor Law approach to welfare was replaced with provision for need that is given universally, and this is the main factor which distinguishes the welfare state from earlier forms of basic safety-net. Nevertheless, the problem of clarity continues as the "range of agreed social services" set out in the provisional definition of welfare state is a shifting range, since the actual policies which materialize such definitions are always temporal.

To be more precise we can cite the purposes and methods of a welfare state following Mark Kleinman's analysis.[77] The purposes can be grouped as follows: risk management and insurance against interruptions in earnings; redistribution over the life-cycle; redistribution across households (from richer to poorer, from capital to

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[75] Asa Briggs, "The Welfare State in Historical Perspective." In *The Collected Essays of Asa Briggs, vol 2: Images, Problems, Standpoints, Forecasts* (Urbana, Chicago: The University of Illinois Press, 1985), p. 183.

[76] Ibid.

[77] Mark Kleinman, *A European Welfare State? European Social Policy in Context* (Basingstoke: Palgrave, 2002).

labor, from non-families to families); the provision of public goods which the market will not supply; remedying externalities which would otherwise result in under provision; the provision of merit goods; state-building; the promotion of "social peace" or cohesion across groups; and development and promotion of certain values. Fiscal policies (taxing and spending), regulation, and direct provision are the three main ways of state intervention. The specific welfare policies to accomplish these purposes are: social protection (pensions, unemployment and disability benefits); family and child welfare policies; social care; anti-poverty and social inclusion policies; provision of services (health services, education, personal social services and housing); regulation of the labor market, working conditions and industrial relations; public health; and equal opportunities and anti-discrimination policies.[78] These are widely accepted welfare policies, but there are differences among countries in terms of their application and effectiveness.

Welfare Regimes and Their Levels of De-commodification and Stratification

Esping-Andersen defines the welfare state as one among three sources of managing social risks, the other two being family and market. Social policy means the public management of social risks. Social policy can exist without welfare states, but not the other way around. Social policy has existed as long as there has been some kind of collective political action in address to a social risk. "It was social policy, not a welfare state, when the Romans meted out food to the poor; when the church, guilds, or nobility distributed charity and alms; or when nascent nation states and absolutist monarchs legislated poor relief (and welfare plans for public employees)." The

[78] Ibid., p. 3-4.

welfare state is more than social policy; it is a unique historical construction, an explicit redefinition of what the state is all about.[79]

Social risks can be perennial, like poverty, homelessness, handicaps, violence, and sudden death, or they can come and go with the flow of history, like unemployment and nuclear radiation. Some risks, like old-age infirmity, are "democratic" as they will afflict us all, and some, like unemployment and poverty, are socially stratified. In addition, there are life-course specific risks, like income loss in old age.[80] Markets alone are incapable of absorbing risks, so are the families. It is the triad of state, market, and family which deals with social risks. Esping-Andersen introduces the concept of "welfare regime" as the combined, interdependent way in which welfare is produced and allocated between the state, the market, and the family. As studying just the welfare *state* leaves a huge "welfare residual" unaccounted for, there occurs the need to formulate a new term. A welfare regime is based on the way risks are pooled: the state's role can be defined as residual and minimalist or, alternatively, as comprehensive and institutional as regards the range of risks that is to be considered "social," or the collectivity of the people that is to be considered eligible for protection. Until the twentieth century, most risks were not considered social, that is, a matter of state.

In his widely referred book, *Three Worlds of Welfare Capitalism*, Esping-Andersen analyses the clustering of advanced capitalist democracies into three distinct regimes and examines how this came to be. He elaborates three highly diverse regime types, each organized around its own discrete logic of organization, stratification, and societal integration. They owe their origins to different historical

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[79] Gosta Esping-Andersen, *Social Foundations of Postindustrial Economies* (Oxford, NY: Oxford University Press, 1999), pp. 33-34.

[80] Ibid., p. 36.

forces, and they follow qualitatively different developmental trajectories.[81] He explains welfare state variations with reference to the history of political class coalitions, the nature of class mobilization and the historical legacy of regime institutionalization. For example, the origins of the Keynesian full-employment commitment and the social democratic welfare-state edifice have been traced to the capacity of strong working-class movements to forge a political alliance with farmer organizations. The formation of a new working-class – white-collar coalition can be considered to be the basis of sustained social democracy.[82] He proposes an interactive model such as the coalition approach to be able to look at distinct welfare regime types which are conservative, liberal and social democratic.

Conservative welfare regimes are those in which corporatist arrangements are most pronounced. Esping-Andersen defines these in terms which stress the ways in which state welfare is used to maintain (and even reinforce) existing class and status differentials, thus encouraging social and political stability and continued loyalty to the state. The state (rather than the market) is likely to be important in the delivery of welfare, but not in ways which encourage redistribution or equalization. These welfare regimes tend to dominate in those countries in which Catholic parties are strong, parties of the left weak and there has been a history of absolutism and authoritarianism. Because such regimes tend to be highly influenced by the Church, they are also usually committed to the maintenance of traditional family forms, and the state intervenes only when it is felt that the family cannot resolve the problems of its members. The entry of married woman into the labor market is discouraged and benefits tend to encourage motherhood, while collective forms of childcare provision

[81] Esping-Andersen, *The Three Worlds of Welfare Capitalism*, p. 2.

[82] Ibid., p. 18.

are underdeveloped. Esping-Andersen suggests that Austria, France, Germany and Italy can all be seen as regimes of this type.

Liberal welfare regimes are principally characterized by an emphasis on market-based social insurance and the use of means-testing in the distribution of benefits. Levels of universal transfer payments and forms of social insurance are "modest" and welfare is largely oriented towards a class of the poor dependent on the state. Benefits are limited and stigmatized because the model assumes that higher levels of benefit will reduce incentives to work. Private schemes are encouraged for those who wish to go beyond the minimum, and in some cases may be actively subsidized. Such regimes are, therefore, highly differentiated and stratified, with "a blend of a relative equality of poverty among state-welfare recipients, market-differentiated welfare among the majorities, and a class-political dualism between the two."[83] Examples of this model are said to include the US, Canada and Australia.

In contrast to the other two, the social democratic regime is characterized by principles of universalism and equality. This regime tends to encourage equality across classes, based on high standards, rather than the minima endorsed elsewhere. In order to achieve this, services and benefits have to be provided at levels acceptable (and attractive) to middle class groups, and members of the working class are to have access to the same rights as those of the middle class. According to Esping-Andersen, "This model crowds out the market, and consequently constructs an essentially universal solidarity in favor of the welfare state. All benefit; all are dependent; and all will presumably feel obliged to pay."[84] The attitude to the family within this model contrasts with those of the other two, because the state takes on

[83] Ibid., p. 27.

[84] Ibid., p. 28.

and socializes many aspects of traditional family responsibilities (such as in providing support for children and the old), effectively encouraging individual independence, particularly for women who choose to work. Full employment is a central element in this regime, both because it provides income support and because it makes it possible to cover the costs of welfare. The Scandinavian countries provide the best examples of such regimes.

This typology allows us to acquire an overview of more general tendencies which cut across national developments rather than focusing solely on the details of legislative programs and their implementation in individual countries. As Esping-Andersen makes clear, none of the regimes he identifies can be found in a perfect or pure form. Instead, each particular welfare state will have elements of all three in its make-up, and some may have quite distinctive features which are not reflected in the types he has identified. The GB provides a good example of a system which fits uneasily into any of the three regime types, although Esping-Andersen suggests that it is closest to the liberal one.

Esping-Andersen analyses the levels of de-commodification and stratification of these different regime types. He defines "de-commodification" as the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation. He distinguishes three kinds of arrangements, each one with its own peculiar effect on de-commodification. One type of system, historically most pronounced in the Anglo-Saxon nations, builds entitlements around demonstrable and abject need. With its mainsprings in the poor-law tradition, the social assistance tradition is characterized by the application of a means- or income-test with varying degrees of stringency. These systems do not properly extend citizen rights. A second type of system extends entitlements on the basis of work

performance. This variant has its roots in the insurance tradition that was most consistently developed first in Germany, and then across the European continent. Rights here are clearly conditional upon a blend of labor-market attachment and financial contributions, and have usually been subjected to a logic of actuarialism; i.e., the idea that the individual has a personal entitlement of a contractual nature. The third type of system springs from the Beveridge principle of universal rights of citizenship, regardless of degree of need or extent of work performance. Eligibility rests instead on being a citizen or long-time resident of the country. Invariably, these types of programs are built on the flat-rate benefit principle. In principle, this "people's welfare" approach has a strong de-commodifying potential, but obviously is circumscribed by the largesse of the benefits.[85]

The table of de-commodification indices for the leading 18 industrial democracies in terms of old-age pensions, sickness benefits, and unemployment insurance, 1980[86] reveals that the typology of welfare state regimes overlap with the levels of de-commodification. The social democratic Nordic countries are consistently de-commodifying, while the liberal Anglo-Saxon countries tend to be consistently the least so. In between these two extremes, there is the conservative

[85] Ibid., p. 48. This typology mirrors Richard Titmuss' welfare state models. Titmuss formulates three separate models representing different ideologies of, and stages in, welfare formation: 1.The laissez-faire Poor Law (the residual model) 2.The postwar mixed economy (the industrial-achievement-performance model) 3.A stage where the state promotes core institutions responsible for the welfare of its citizens (the institutional-redistributive model) (Titmuss, chapter 2). Wilensky and Lebeaux (Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare*, New York: Russell Sage Foundation, 1958) make a distinction between institutional and residual conceptions of welfare. Institutional conception sees welfare as a dominant institution. The state should meet the needs not only of the disadvantaged but of everyone. It should provide comprehensive and universal programs. Only by this way a much stronger sense of public ownership of a policy or program can be established. Residual conception sees welfare as a secondary institution only for those who might be seen as 'disadvantaged' in some way. It is based on selective means-tested programs and leads to a much weaker sense of ownership. Residual welfare marginalises and stigmatises.

[86] Esping-Andersen, *The Three Worlds of Welfare Capitalism*, p. 50.

continental European countries, some of which (especially Belgium and the Netherlands) fall close to the Nordic cluster.

Esping-Andersen's assertions on stratification should be kept in mind while evaluating the class abatement dimension of the welfare state. He criticizes Marshall's analysis of citizenship and social class and rejects the idea that the welfare state is just a mechanism that corrects the structure of inequality. For him, the welfare state is a system of stratification in its own right.[87] He identifies alternative systems of stratification embedded in welfare states.

The poor-relief tradition, and its contemporary means-tested social assistance offshoot, was conspicuously designed for purposes of stratification. By punishing and stigmatizing recipients, it promotes social dualisms and has therefore been a chief target of labor-movement attacks. In liberal welfare regimes, government aid is targeted solely at the genuinely poor, who are marginalized as dependents.

In the social policy literature, means-tested mechanisms are criticized for provoking stigma and dualisms. In his later book, Esping-Andersen criticizes residual approach to risk pooling, which divides society into "them" and "us": on one side, a self-reliant majority of citizens who can secure adequate insurance through private means; on the other side, a minoritarian and dependent welfare state clientele. Residual programs are typically needs-tested and generally destined to be ungenerous since the median voter is unlikely to extend much support to benefits of scarce personal relevance.[88] Zygmunt Bauman warns us about the negative effects of means-testing on social integration and sense of communality. When you confine the provision of services to a means-test the community is immediately split into those

[87] Ibid., p. 23.

[88] Esping-Andersen, *Social Foundations of Postindustrial Economies*, p. 40.

who give without getting anything in exchange, and those who get without giving. The overall effect of means testing is division instead of integration, exclusion instead of inclusion. When the welfare state is reduced to servicing the needs of a small and, in popular opinion, inferior section of the population, politics is impoverished and political interest among the citizenship at large fades. One of the long-term effects of the principle of means-testing is the steady and relentless deterioration of the quality of welfare services. In line with expectations, once they are reserved for those who need them, these services cannot count on the political muscle of those others who (at least thus far) "need them not," and so become a natural target for economies sought by politicians in order to lower taxes, and thus to curry the favors of those more fortunate others.[89]

The social-insurance model promoted by conservative reformers such as Bismarck and von Taffe was also explicitly a form of class politics. It sought, in fact, to achieve two simultaneous results in terms of stratification. The first was to consolidate divisions among wage-earners by legislating distinct programs for different class and status groups. The second objective was to tie the loyalties of the individual directly to the monarchy or the central state authority. This was Bismarck's motive when he promoted a direct state supplement to the pension benefit. This state-corporatist model was pursued mainly in nations such as Germany, Austria, Italy, and France, and often resulted in status specific insurance funds. Of special importance in this corporatist tradition was the establishment of particularly privileged welfare provisions for the civil service (*Beamten*). This was a

[89] Zygmunt Bauman, "The Rise and Fall of the Welfare State." In *Work, Consumerism and the New Poor* (Buckingham, Phil: Open University Press, 1998), p. 57.

means of rewarding loyalty to the state, and a way of demarcating this group's uniquely exalted social status.[90]

As an alternative to means-tested assistance and corporatist social insurance, the universalistic system promotes equality of status. All citizens are endowed with similar rights, irrespective of class or market position. In this sense, the system is meant to cultivate cross-class solidarity, a solidarity of the nation. The solidarity of the flat-rate universalism however presumes a historically peculiar class structure, one in which the vast majority of the population are the "little people" for whom a modest, albeit egalitarian, benefit may be considered adequate. If working-class prosperity grows and the new middle classes rise, however, flat-rate universalism promotes dualism because the better-off would turn to private insurance. Where this happens (as in Canada or Great Britain), the result is that the wonderfully egalitarian spirit of universalism turns into a dualism similar to that of the social-assistance state: the poor rely on the state, and the remainder on the market.[91]

Esping-Andersen reveals that the clustering of de-commodification and stratification is very similar. There is a clear coincidence of high de-commodification and strong universalism in the Scandinavian, social democratically influenced welfare states. There is an equally clear coincidence of low de-commodification and strong individualistic self-reliance in the Anglo-Saxon nations. Finally, the continental European countries group closely together in terms of being corporatist and etatist, and also being fairly modestly de-commodifying.[92]

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[90] Esping-Andersen, *The Three Worlds of Welfare Capitalism*, p. 24.

[91] Ibid., p. 25.

[92] Ibid., p. 77.

Actually, this is in line with Fraser and Gordon's analysis on social citizenship. In terms of de-commodification and equality social democratic systems perform better than the conservative systems based on contract and the liberal systems based on means-testing. Only through universal welfare and health care can social citizenship be maintained. However, even the universalistic system itself does not guarantee equality when there is the opportunity for the better off to opt out.

The assertions of Esping-Andersen on de-commodification and stratification should be kept in mind while analyzing welfare states and social policies. The welfare state cannot be understood just in terms of the rights it grants. Social rights should be viewed in terms of their capacity for "de-commodification." The outstanding criterion for social rights must be the degree to which they permit people to make their living standards independent of pure market forces. It is in this sense that social rights diminish citizens' status as "commodities."[93] Social stratification is part and parcel of welfare states. Social policy is supposed to address problems of stratification, but it also produces it. The really neglected issue is the welfare state as a stratification system in its own right. Does it enhance or diminish existing status or class differences; does it create dualisms, individualism, or broad social solidarity?[94] This makes it obvious that the social spending levels of welfare states do not necessarily reveal their class and status abatement functions. Actually, not all spending counts equally. Some welfare states, the Austrian one, for example, spend a large share on benefits to privileged civil servants. This is normally not what we could consider a commitment to social citizenship and solidarity. Others spend

[93] Ibid., p. 2.

[94] Ibid., p. 4.

disproportionately on means-tested social assistance[95] and some nations spend enormous sums on fiscal welfare in the form of tax privileges to private insurance plans that mainly benefit the middle classes.[96] So, we should be suspicious of an automatic relation between spending and citizenship-based welfare expansion.

Other Welfare Typologies

Esping-Andersen kept this welfare regime typology in his later book on the effects of post-industrial transformation on welfare.[97] He claims that "post-industrial" transformation is institutionally path-dependent. "This means that existing institutional arrangements heavily determine, maybe even overdetermine, national trajectories. More concretely, the divergent kinds of welfare regimes that nations built over the post-war decades, have a lasting and overpowering effect on which kind of adaptation strategies can and will be pursued."[98] One of the reasons for the contemporary welfare crisis is globalization, which undercuts polities' discretionary use of fiscal and monetary policy. There is general agreement that globalization may have a negative impact on welfare systems, because of the need to reduce public expenditure to make individual countries more competitive, and the need to make the workforce as adaptable as possible to changing market structures. Slower economic growth associated with the transition to a post-industrial economy, the maturation of

[95] Ibid., p. 19.

[96] Ibid., p. 20.

[97] Esping-Andersen, *Social Foundations of Postindustrial Economies.*

[98] Ibid., p. 5.

government policy commitments, and population aging[99] and changing household structures have all combined to create a context of essentially permanent austerity. The effect of all these on welfare is a highly contested issue. Whether there is a welfare retrenchment or not is open to discussion.

At this point, Esping-Andersen demonstrates the path dependent responses of different welfare regimes. Liberal welfare regimes increased targeting which implies a clear drift from collective risk-pooling toward *individual* market solutions in pensions, health, and services. The reliance on markets for welfare solutions has been strengthened. Scandinavian welfare regimes redirected resources and expanded public programs for young families. They have expanded the realm of collective provision. While the conservative welfare regimes utilized pension plans as the main instrument of managing industrial reconversion and delegated emerging new social problems to families.[100] He depicts what we see in most countries not as a radical change but rather a "frozen" landscape. "Resistance to change is to be expected: long-established policies become institutionalized, and cultivate vested interests in their perpetuation; major interest groups define their interests in terms of how the welfare state works."[101] This means, today we are dealing with hegemonic systems, an assertion shared by various welfare scholars.

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[99] Esping-Andersen claims that the aging problem is frequently misdiagnosed. The real problem lies not in the number of old people, but in low fertility, early retirement, delayed first-job entry, and low overall employment rates. Esping-Andersen, "The Sustainability of Welfare States into the Twenty-First Century," p. 2. What is important is the activity rate. Francis G. Castles also says that the aged are not the problem, some pension systems are. Differential coverage and generosity of national pensions sytems are determinate. Francis G. Castles, "The Future of the Welfare State: Crisis Myths and Crisis Realities." *International Journal of Health Services*, 32(2) (2002): 255-277, p. 266. Both Castles and Esping-Andersen find the effect of low fertility on welfare much more important.

[100] Esping-Andersen, *Social Foundations of Postindustrial Economies*, pp. 165-170; Esping-Andersen, "The Sustainability of Welfare States."

[101] Gosta Esping-Andersen, "After the Golden Age? Welfare State Dilemmas in a Global Economy." In *Welfare States in Transition: National Adaptations in Global Economies*, ed. Gosta Esping-Andersen (London: Sage, 1996), p. 24.

In this later book, Esping-Andersen answers the criticisms related with his welfare regime typology. There are two major lines of objection: The first is principally classificatory (are there more than, simply, three models?) and the second has to do with his failure to recognize gender differences and, more generally, with his severely underdeveloped analysis of the family. He accepts the second criticism and emphasizes the household as a core component of any welfare regime. He puts the changing role of women and evolving new household forms as the leading part of the current transformation. He analyzes the role of the family in welfare regimes together with the labor markets and the state. As to the first criticism, which proposes an additional fourth model, however, Esping-Andersen is not convinced of such an addition. The Antipodean, Mediterranean, or East Asian fourth world proposals are not convincing for him. He argues that the peculiarities of these cases are variations within a distinct overall logic, not the foundations of a wholly different logic per se.[102] After adding the role of families in the typology of welfare regimes, there appeared no need to formulate a fourth model. For him, the case for a fourth, uniquely familialistic, world of welfare capitalism is not convincing. There is no great difference between the Southern European sub-regime (Spain, Portugal, Greece, and Italy) and the remainder of Continental Europe. So, he insists on the three world typology. Although Esping-Andersen is not convinced of the need to formulate a fourth model, the work of those scholars who demonstrate the peculiarity of Southern European model is based on solid arguments.

[102] Esping-Andersen, *Social Foundations of Postindustrial Economies*, p. 92.

Maurizio Ferrera identifies the common traits of the welfare states of Italy, Spain, Portugal, and Greece in his widely referred article on the Southern European welfare model.[103] The main traits he identified are:

First, a highly fragmented and "corporatist" income maintenance system, displaying a marked internal polarization: peaks of generosity (e.g., as regards pensions) accompanied by macroscopic gaps of protection. As in other "Bismarckian" and "corporatist" countries, Southern Europe's income maintenance is based on occupational status and its degree of institutional fragmentation is very marked. There are different schemes for private employees, civil servants and the self-employed, often with widely differing regulations concerning contributions and benefit formulas. What separates Southern welfare from Continental welfare is the dualistic character of the protection. On the one hand, the schemes of these countries provide generous protection (at least in principle; e.g., pensions) to the core sectors of the labor force located within the regular and "institutional" labor market; on the other hand, they only provide weak subsidization to those located in the so-called irregular or non-institutional market (a fairly large occupational sector).[104]

Second, the departure from corporatist traditions in the field of health care and the establishment (at least partially) of national health services based on universalistic principles. While displaying high institutional fragmentation along occupational lines in their income maintenance systems, the South European welfare states are characterized by a universalistic approach in their health care systems. Explicit reference to health care as a basic citizen's (rather than workers') right is made by the Italian, Spanish, Greek and Portuguese constitutions, and although the

[103] Ferrera.

[104] Ibid., p. 19.

historical legacy of their health systems has been (as in income maintenance) occupationally fragmented, all four countries have striven to reform these systems in the last two decades, with a view to establishing full-fledged national health services, characterized by open and free access for all residents, standardized rules and organization, and tax financing.[105] Italy in 1978, Portugal in 1976, Greece in 1983, and Spain in 1986 adopted national health services. Ferrera addresses the persisting occupational differentiations regarding access and treatment, the large territorial disparities, the mixed form of financing which generates quite extensive distributive distortions, and the public/private mix which promotes private provision. I will look at the health care system of Southern Europe in the section on health care systems.

Third, a low degree of state penetration of the welfare sphere and a highly collusive mix between public and non public actors and institutions. The Mediterranean welfare states are characterized by a double deficit of "stateness." On the one hand, they display a low degree of state penetration of welfare institutions – as just illustrated in the case of health care. On the other hand, however, they also display a low degree of state power proper – public institutions, meaning that in these countries are highly vulnerable to partisan pressures and manipulations.[106]

Fourth, the persistence of clientalism and the formation –in some cases- of fairly elaborated "patronage machines" for the selective distribution of cash subsidies. The social policy institutions of Italy, Spain, Portugal and Greece may formally resemble those of other, "corporatist" (and Catholic) countries; however the "socio-political etiquette" which inspire their functioning is hugely different. Welfare rights are not embedded in an open, universalistic, political culture and a solid,

[105] Ibid., p. 23.

[106] Ibid., p. 25.

Weberian state impartial in the administration of its own rules. Rather, they rest on a closed, particularistic culture and a "soft" state apparatus, both still highly imbued with the logic of patron-client relationships which has been a historical constant in this area of Europe.[107]

Ferrera explains these peculiarities with reference to the historical weakness of the state apparatus in this area of Europe, the preeminence of parties as main actors for interest articulation and aggregation, ideological polarizations and, in particular, the presence of a maximalist and divided Left.

Ferrera's analysis promoted further work on the functioning of Southern European welfare regimes. For example, Guillén and Matsaganis evaluated the welfare policies in Greece and Spain during the 1980s and 1990s, to test the "social dumping" hypothesis in Southern Europe.[108] They reveal that there has not been a retreat but an expansion of welfare in Southern Europe. Greece's social protection system has converged to a remarkable degree with the rest of Europe in quantitative terms. In the case of Spain, welfare convergence seems to have been quantitative as well as qualitative. Not only has social expenditure moved closer to that of the other EU members, but imbalances in its welfare have been reduced during the last two decades.[109] Southern Europe is analyzed as a relatively homogeneous macro-region also by Enzo Mingione. He defines the basic characteristics of the Southern European welfare model as follows: weak and inefficient but interventionist state, strong regionalism and localism, the persistent diffusion of small family businesses,

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[107] Ibid., p. 29.

[108] Ana Guillén and Manos Matsaganis, "Testing the 'Social Dumping' Hypothesis in Southern Europe: Welfare Policies in Greece and Spain during the last 20 years." *Journal of European Social Policy*, 10(2) (2000):120-145.

[109] Ibid., p. 121.

and a relatively high level of family responsibility for welfare services (coupled with persistent economic inequalities affecting women).[110]

Jeremy Seekings develops a new "three worlds" typology as he finds Esping-Andersen's approach inadequate in Southern conditions primarily due to its neglect of the ways in which states influence distribution through shaping the development or economic growth path.[111] For him, even if we narrow our analysis to the provision of income security, Esping-Andersen's "three worlds" typology is less useful in the South than an alternative typology that distinguishes between "agrarian," "inegalitarian corporatist" and "redistributive" welfare regimes. He claims that the "three worlds" typology was developed for, and continues to fit reasonably well, the advanced industrialized countries of Europe and North America. It fits less easily the later industrializing countries of Southern Europe, Japan, Australia and New Zealand. It fits even less easily the countries of Latin America and East Asia that industrialized still later, or the post-Communist countries of Central and Eastern Europe. So, he develops a new three-fold typology of Southern welfare regimes that is consistent with the spirit of Esping-Andersen's project.

In this typology, agrarian regimes are defined by the private provision of welfare, dependent on access to land and/or kin, which itself depends on a set of supportive state policies. Inegalitarian corporatist regimes are defined by achieving income security through forms of risk-pooling and/or saving that are dependent on employment. The label "inegalitarian corporatist" is intended to draw attention to both the corporatist element (with claims dependent on membership of

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[110] Enzo Mingione, "The Southern European Welfare Model and The Fight Against Poverty and Social Exclusion." In *Our Fragile World: Challenges and Opportunities for Sustainable Development*, ed. Mostafa Tolba (Oxford, UK: Eolss Publishers, 2001), p. 1042.

[111] Seekings.

occupationally-defined corporate groups, as in the European conservative or corporatist welfare regimes) and the fundamentally inegalitarian character given the exclusion of the poor from formal employment and hence membership of these corporate groups. These regimes come in two versions: the more market-based version (either provident funds as in Singapore, etc., or employer-based schemes as in much of East Asia until recently) and the more statist one (formal social insurance). Finally, the redistributive regimes are defined by their recognition of citizens' rights to income security through, especially, non-contributory social assistance.

Health Care Typologies

Welfare typologies collide mostly with health care typologies. Social democratic welfare regimes in Esping-Andersen's typology have national health services, conservative welfare regimes have social insurance systems, and liberal welfare regimes have private insurance systems. This is inevitable as health care system is one of the determinants of a welfare regime. However, there are countries whose welfare regimes do not collide with their health care systems. Canada and GB are in the liberal welfare regime cluster although they have national health services. Esping-Andersen finds GB to be an interesting case since in the 1950s it would have been difficult to distinguish it from the Scandinavian. Italy is in conservative cluster, but it has adopted national health service model like other Southern European countries such as Spain, Portugal, and Greece which denotes the need to elaborate Southern European countries as a separate model. Also several European nations appear quite private (20% of the total in Germany, 36% in Austria) because much of

health care is run by "third sector," non-profit associations. Private health care dominates in the US (57% of the total), but here again non-profit firms (like Blue Cross-Blue Shield) play a decisive role.[112] So, health care systems do not necessarily correspond to welfare typologies. Health care has a certain peculiarity. According to Michael Moran, health care is not the subset of welfare policy, and the health care system is not the subset of welfare state. Health care institutions are influenced by, and of course influence, the wider welfare state, but they are also shaped by dynamics of their own –some of which are internal to, and some of which are external to, the health care system.[113] He criticizes writings on the welfare state as they often seem to marginalize health care policy. Although it is obvious that health is a big component of the welfare provision, many of the major contributions that have in recent years shaped debates about the welfare state (Esping-Andersen's *The Three Worlds of Welfare Capitalism* is a good example) did not pay enough attention. His conception of "health care state" is also based on the understanding that "welfare state" does not cover everything related with health care. Moran defines the health care state as that part of any state concerned with regulating access to, financing, and organizing the delivery of, health care to the population.[114]

The World Health Organization defines health care as all the goods and services designed to promote health including preventive, curative and palliative interventions, whether directed to individuals or populations. The organized provision of such services constitutes a health care system. There are different classification proposals, but the most basic one that is widely used in the health care

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[112] Esping-Andersen, *Social Foundations of Postindustrial Economies*, p. 76.

[113] Michael Moran, "Understanding the Welfare State: The Case of Health Care." *British Journal of Politics and International Relations*, 2(2) (2000): 135-160, p. 139.

[114] Ibid., p. 136.

literature refers to the ways health care is provided, financed and regulated.[115] Three principal types of health systems are determined: national health services, funded by general taxation, social insurance systems, funded by payroll contributions, and private systems funded by private insurance companies. Tax-based finance tends to imply universal coverage, the public ownership of health care facilities and a salaried medical profession. Insurance contributions, meanwhile, are paid into funds organized by occupation or region. Funds contract with what is usually a greater mixture of public and private providers of inpatient care, and with independent physicians paid according to the services they provide. Private health care systems are characterized by private financing (with an emphasis on private insurance), service provision by private for-profit enterprises, and a limited degree of public regulation. The coordination between providers, financiers, and users is largely left to the market. Great Britain, Denmark, Finland, Sweden, Norway, Ireland, Iceland, Spain, Greece, Portugal, Italy, Canada, Australia, New Zealand, Korea, and Taiwan have national health services; Germany, France, Austria, Belgium, Netherlands, Luxembourg, Switzerland, Turkey, Israel, Japan, and Chile have social insurance systems; and the United States, the Philippines and Kenya have private health care systems.

As Freeman asserts, actual systems are only approximations to ideal types: no pure form exists, and all contemporary health systems are hybrid. So it is better to think of a range or spectrum of cases rather than discrete categories.[116] For example,

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[115] For a detailed account of different classifications, see Bülent Kılıç and Çiğdem Bumin, "Sağlık Sistemleri." *Toplum ve Hekim*, 53 (Şubat 1993): 41-47; Bülent Kılıç and Gazanfer Aksakoğlu, "Sağlık Sistemlerinin Sınıflandırılmasına İlişkin Yaklaşımlar." *Toplum ve Hekim*, 9 (64-65) (Kasım-Şubat 1994-95): 4-13; İlker Belek, "Sağlık Sistemleri Hangi Dinamiklerle Gelişiyor ve Nasıl Gruplanıyor." *Toplum ve Hekim*, 9(64-65) (Kasım-Şubat 1994-95): 14-25; and İlker Belek, "Nasıl Bir Sağlık Sistemi: Sigorta Değil Genel Vergi." *Toplum ve Hekim*, 15(2) (2000): 92-108.

[116] Richard Freeman, *The Politics of Health in Europe* (Manchester, New York: Manchester University Press, 2000), p. 7.

although we might talk about the dominance of a form of funding in each country, usually there is a mixture of sources. Taxation, national or social insurance, private insurance and patient charges are used together. Even the most strongly tax-based systems –Sweden being a good example- have a significant insurance component, while mandated insurance premiums are normally levied as payroll tax on employers and employees. Actually there is not a great distinction to be made between the two principal methods of financing health care; rather, there is a wide range of ways of raising public money to pay for health services. Fundamentally, the difference between tax-based and insurance-based systems is not as great as it is often made to seem. Taxation may be thought of as a form of compulsory insurance, while insurance premiums are normally levied as a compulsory payroll tax on employers and employees.[117]

The health care state in Europe came on to the scene in the late nineteenth century. Before that, people saw private physicians and the care of the sick was often a special duty of certain holy orders. Some hospital care was provided by local parishes and municipal governments. Poor Law arrangements met the immediate needs of the destitute. Until the late nineteenth century the role of the state was limited to public health. The introduction of statutory health insurance is conventionally taken to mark the entry of the state into health care. By 1980, almost all European states had guaranteed access to health care to almost all of their citizens. In 1880, none of them had. Freeman defines the hundred-year period of increasing state involvement as the *étatisation* of health and health care.[118] He explains the development of health care states with reference to industrialization, urbanization,

[117] Ibid., p. 6-7.

[118] Ibid., p. 14.

and democratization. There is a close connection between social insurance and industrial labor. This implies a shift from assistance to insurance, from the provision of minimum benefits financed by public (usually local) sources to entitlement to benefit in proportion to contributions paid. Then, policy coverage is extended upward and outward to the general population.

Across European countries, health care entitlements have been extended to increasing proportions of European populations in the post-war period. The proportion of populations with entitlement to hospital care under a public scheme was near universal by the early 1970s.[119] This made the opposition to public schemes difficult as they are utilized by the whole population, not by certain portions of it. The state-supported health insurance unleashed demand for health care which was met by increased supply, especially in the hospital sector.

Public Health – Medical Care

Before going into the details of three principal types of health systems I would like to clarify the distinction between public health and medical care. So far I have used the notion of health care to denote medical care. Public health has been left out of the picture although it was through public health that the state first intervened in the field of health care. Roemer explains the distinction between public health services and medical care programs with reference to the separate historical origins of the two movements. Medical care insurance programs grew from the experience and demand of the labor movement; social security was a response to the insecurity of the

[119] Health care coverage was 95.7% in France, 88.0% in Germany, 93.0% in Italy, 100.0% in Sweden, and 100.0% in UK in 1970. By 1990, these figures became 99.5, 92.2, 100.0, 100.0, and 100.0 respectively. Ibid., p.105.

industrial worker dependent on wages and faced always with the hazard of unemployment. Public health had foundations in general community development, as urbanization created problems of crowding and spread of communicable disease.[120]

Public health is one of the efforts organized by society to protect, promote, and restore the people's health. It is the combination of sciences, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services, and institutions involved emphasize the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, rates of premature death, and disease-produced discomfort and disability in the population. Public health, and specifically efforts focusing on health promotion and disease prevention, has been given insufficient attention by decision makers.

Prior to the Second World War, health care was predominantly primary care and public health oriented, in part because its curative capacities were limited and often ineffective at best. Through the early decades of the twentieth century, health care was normally limited to performing "public health" functions. Hospitals were primarily designed to protect the public health, often by appealing to measures as quarantine rather than treating individual patients, and largely served only people who could not afford a private physician. During the 1950s and 1960s, the emphasis in health care shifted perceptibly towards curative medicine. The modern medical profession has developed primarily around the search for finding cures to disease rather than promoting health, preventing disease and protecting the public health. The growth of high-tech medical centers, the expectation of ever more sophisticated

[120] Milton I. Roemer, *Health Care Systems in World Perspective* (Ann Arbor: Health Administration Press, 1976), p. 97.

diagnostic capacity, and expansion of dramatic life-saving procedures changed the nature of medical care. Public health which focuses on preventive services for the population had left its place to medical care which focuses on curative services for the individual.

Public health has, from the outset, been identified with the state. Indeed, the very conception of public health centers around the state, whether explicitly or implicitly. Public health not only privileges the state as the unique agency capable of creating a healthy society, but also understands the parameters of the community through the perspective of the state. Public health is distinguished within the health field by two defining features, a focus on prevention and an approach which stresses community rather than individual well-being. Public health preventive programs aim to reduce the incidence of ill-health through the improvement of environments, the reduction of risky behaviors, inoculation against diseases and the use of isolation to prevent disease transmission. These preventive activities have been carried out primarily by state programs at the local, provincial or national levels. The state is uniquely equipped, in terms of legal powers, financial clout and ideological responsibility, to carry out such programs. Public health approaches issues of health and illness at the level of society rather than the individual.

In the first half of the nineteenth century an interest in public health was developing. Outside the hospitals, the devastating effects of widespread industrialization and urbanization were impossible to ignore, and by the 1840s the relationship between disease and urban living and working conditions has become widely accepted. It was clear that any significant improvement in health would necessitate detailed knowledge of the health hazards of the urban environment, and during this period many studies were undertaken of particular urban areas. The

public health movement, however, was not part of the mainstream of medical development, and only a few of its important activists were doctors. It received few theoretical insights and little practical assistance from medicine proper, since the nature of infections and contagion had not yet been understood on a mechanistic basis, and preventive and environmental strategies were of little interest to most practitioners of curative medicine. Ironically, however, it was due in large part to the success of these preventive health measures that mainstream medicine was able to consolidate its emphasis on cure in the late nineteenth and twentieth centuries. The major epidemic illnesses of the nineteenth century had been brought under control, and with the development of the germ theory of disease in the late nineteenth century, the emphasis in medical practice swung even more sharply towards the individual "case." This was the period of "laboratory medicine," when doctors were able to probe even deeper into the workings of human bodies, paying less and less attention to the social and economic environment within which these bodies existed.[121]

In spite of a growing awareness of the importance of prevention and public health, governments are still reluctant to spend on prevention programs. Prevention is still a marginal activity of medicine and a peripheral aspect of social policy although this was challenged by AIDS in the 1980s. There is no debate related with the public health functions of the state, i.e., measuring, monitoring, regulating and improving the public's health. Unlike the field of medical care, public health is widely accepted to be the duty of the state which should be covered from the general budget.

Although public health is a welfare duty of the state it is the medical care which defines social citizenship. After the establishment of the basic infrastructure in

[121] Lesley Doyal with Imogen Pennell, *The Political Economy of Health* (Boston MA: South End Press, 1981), pp. 32-33.

public health, the states started to focus on medical care as a social right of the individual. Public health has always been the task of the state as it requires comprehensive action that affects society as a whole. It is the medical care which has always been a contested domain and health care typologies are distinguished in terms of the role of the state in financing, providing and regulating of medical care, not public health.

National Health Services

National health services are characterized by a high degree of state intervention: for the most part, health services are publicly financed and delivered by public employees in facilities which are publicly owned. NHS of Great Britain continues to serve as a prototype of this kind of health system. Access to health care is a right of residence or citizenship. It is not based, as in social insurance systems, on an individual's contribution record: perhaps the defining characteristic of the national health service is the abolition of the individual basis of health funding. Yet, health finance is not derived entirely from general taxation –Denmark being the sole exception- but from a mixture of general taxation, social insurance and patient co-payment. The symbolic achievement of national health services is the socialization (the public funding and delivery) of health care. But this does not mean that there is no room for any private practice. Countries retain a system of patient co-payment. And in each country, too, a small proportion of acute beds are still provided privately.

Medical professional freedom to practice privately is legally guaranteed, though it is perhaps most circumscribed in Sweden and most extensive in Italy.

Ambulatory care doctors in both Italy and GB have retained their status as private, independent contractors to the public health service instead of becoming its salaried employees. This is largely due to the intense medical lobbying of successive reform discussions. Doctors' interests lie in maintaining their professional autonomy and in maximizing their earnings. The Minister of Health, Aneurin Bevan, who established the NHS, said that they "stuffed the consultants mouth with gold" to ensure their participation in the prospective NHS legislated in 1946. It is ironic that to be able to establish a national health service you need to allow doctors to continue private practice. This implies that a full-scale nationalization is incompatible with the establishment of a national health service.

Primary care is a prominent feature of national health services; its significance lies in the role assigned to the General Practitioner as gatekeeper to more specialized (and expensive) care. GP activity is normally restricted to diagnosis, basic treatment and referral, including pharmaceutical prescription and sick note certification, while the hospital remains the locus of high technology treatment, specialized care and clinical research. This is one of the reasons for the lower health spending in national health services. A large percent of patients do not need specialized or hospital care. They can be treated and cured by a GP. Such a system prevents the needless applications to hospitals.

National health services tend to absorb lower proportions of national wealth than do social insurance systems. As a proportion of GDP, health spending in national health services is significantly lower compared to the social insurance systems. In Europe, real health spending grew 70% faster than GDP from 1960 to 1975, but only 30% faster in the period immediately after that. Health spending grew more quickly in the period of the long boom from the mid-1950s to the early 1970s

than in the period of economic austerity which followed. This was due to the positive relationship between national wealth and health spending and to the rise of the number of insured people.

Yet, again, there are differences between different kinds of health systems. Elasticity of health spending is lower in national health services. The implication is that public funding makes for public control.[122] However, this does not mean that national health services are necessarily any more successful than other kinds of health systems. Indeed, the political control of health finance may itself constitute a problem, if its consequence is that services are starved of funds. GB spends less but patients have to wait for treatment, notably for specialist outpatient consultation and diagnostic testing, and then for subsequent non-urgent surgery. Of course, cost containment is an important asset for health systems, but it cannot be the major criteria in evaluating the health care. The NHS's great achievement was to "universalize the adequate." But times had changed and the adequate is no longer enough.[123] Cost containment is not necessarily a virtue in its own right.

The term "Beveridge model" is used for national health services. In 1941, the government commissioned a report into the ways that Britain should be rebuilt after World War Two. The principal of the London School of Economics, Sir William Beveridge, published a report in 1942 recommending that government should find ways to fight the five "Giant Evils" of "Want, Disease, Ignorance, Squalor, and Idleness." In 1945, the Labor Party defeated Winston Churchill's Conservative Party in the general election. The new Prime Minister, Clement Attlee, announced that he would introduce the welfare state outlined in the 1942 Beveridge Report. This

[122] Freeman, p. 44.

[123] Ibid., p. 47.

included the establishment of the National Health Service in 1948 with free medical treatment for all. A national system of benefits was also introduced to provide "social security" so that the population would be protected from the "cradle to the grave".

Consistent with the aspirations of the Beveridge Report, the new health service would be universal (available to all), comprehensive (including all services, both preventive and curative), and free (involving no payment at the point of delivery). The Labor government's Minister of Health, Aneurin Bevan, worked hard to establish the system and struggled against the opposition from the medical profession and the Conservative Party. Specialists were given high wages and the permission to treat private patients in NHS hospitals. Otherwise the system could not have been established. The promise of a free service constituted one of the greatest attractions among the public and a major source of relief from anxiety. In the first page of the leaflet, *The New National Health Service*, distributed to all homes at the outset of the new service it is written that:

> It will provide you with all medical, dental, and nursing care. Everyone –rich or poor, man, woman, or child- can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a charity. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.[124]

It is based neither on contract nor on charity. Health care is a basic citizenship right that is provided to all on the basis of equality.

[124] Cited in Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002), p. 24.

Social Insurance Systems

Social insurance systems are based on compulsory, universal, social insurance, usually within the context of other social security measures. It is financed by contributions from employers and individuals through government-regulated, non-profit-making insurance funds. These funds are essentially purchasing organizations rather than providers, acting for their members by arranging contracts for services from self-employed physicians and from independent hospitals as well as publicly owned facilities. It is viewed as a way of ensuring access to care without too much government interference with the autonomy of providers, especially doctors. In this model, ownership of services and facilities may be public or private, but they are regulated by the government. Health care has the status of a social right.[125]

"Social" and "insurance" denote the two fundamental dimensions of health systems in turn, and each of them has both an organizational and an ideological basis. The idea of the social reflects their public, collective, compulsory aspect; that of insurance a more private, individual, voluntaristic one. Social insurance is publicly mandated, though paid for and provided by independent institutions. The obligation to be insured against health risks rests on the individual, though contribution rates are set at levels to cover the collective risks of those insured with a given fund. Members are entitled to health care on the basis of need, but receive income benefits proportionate to the value of the contributions they have made. The term "social insurance" indicates that the system is a combination of these two, very different ways of organizing health care. The individualism of the insurance principle is

[125] Ann Wall, "Conclusion." In *Health Care Sytems in Liberal Democracies*, ed. Ann Wall (London and New York: Routledge, 1996), p. 184.

encased in a collectivism which guarantees universal access and makes for a degree of equity in burden sharing.[126]

In both Germany and France, sickness insurance benefits cover the costs of medical treatment (ambulatory and hospital care) as well as providing income replacement (sick pay). The French national funds cover 99% of the French population for health costs, 87% has supplementary insurance. In Germany, over 99% of the population is insured against health risks, 88% in the statutory scheme. Individuals are only exempt from statutory cover if their income is above a given ceiling, which is to say that only high earners are allowed to rely on private insurance arrangements, which are usually non-profit schemes. In both countries there exists a set of independent occupational funds. These are the remnants of history, testifying to the workplace origins of social insurance, whether organized and financed by workers, employers or both. But they are indicators also of the continuing significance of the relationship between social rights and paid labor. Two-thirds of hospital beds in France and half in Germany are located in the public sector. Other facilities are run by both for-profit and non-profit agencies.[127] In France, patients may consult a hospital physician directly, without referral. German patients may consult a specialist directly, too, though that specialist will be in independent local practice. Access to hospital is by referral from a local practitioner; hospitals in Germany provide very little out-patient care. Public hospitals in both France and Germany, as well as municipal medical centers in France, are staffed by salaried

[126] Freeman, pp. 54-55.

[127] Ibid., p. 55.

doctors. Other doctors work independently in local practice, and include both generalists and specialists.[128]

Where income levels are more or less fixed a priori by capitation the material interest, if any, lies in treating less rather than more; the GP in Great Britain, for example, has little economic incentive to treat, prescribe or refer. But where only the value of procedures is fixed by national or regional arrangements, as is still the case in France and was so until very recently in Germany, doctors respond by writing more prescriptions and carrying out more diagnostic tests. This behavior seems to be encouraged, moreover, by patient demand. The relatively high degrees of freedom allowed to both patient and doctor in social insurance systems seem to correlate with high levels of consumer satisfaction. Providers compete to meet demand by supplying more, better quality services; high numbers of consultations, procedures and prescriptions in turn fuel overall costs.[129]

For the most part, health service prices in both systems are regulated by government, usually in negotiation with payers (sickness insurance funds) and providers (doctors and hospitals). But because health care is paid for by third parties (insurers), fixed prices in practice fail to regulate either the production or the consumption of health care. In turn, this means that those systems which, historically, emphasize micro-level efficiency, have come to be at risk of macro-level unsustainability. In both France and Germany, the dominant discourse in health policy making for the last two decades has been the control of health spending. The contrast with the NHS is clear. There, where central control of health service finance amounts to effective control of the volume of service production, the perceived

[128] Ibid., p. 56.

[129] Ibid., p. 57.

problem is that of underfunding. In social insurance systems, where governments have no such control, it is overspending. Social insurance systems absorb larger amounts of GDP than national health services, and slightly lower proportions of their funding are derived from public sources. This does not, however, make them "private" systems. Insurance contributions are deducted from wages, effectively constituting a form of payroll taxation.[130] Social insurance systems are clearly not public systems in the way that national health services are, but nor can they be said to be "private." Finance and delivery are organizationally separate but publicly mandated: these are public systems with prices, not private systems with elements of public regulation. The space left by the state is not filled by a market.

The term "Bismarck model" is used for social insurance systems. It was German Reich Bismarck who established compulsory health insurance for industrial workers in 1883. The Health Insurance Law of 1883 and state support for old age and disability in 1889 allowed Bismarck to create a model of social insurance which became highly influential throughout the industrializing European community. The logic underlying the Bismarckian policy was the prevention of a socialist challenge to the authority of the state by the industrial proletariat. Since 1883 health insurance in Germany has been compulsory, premiums are paid as advance concessions, members have a legal claim to services without a means test and rates are dependent upon levels of gross income and not upon risk factors such as the age or medical history of an individual.[131]

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[130] Ibid., p. 57-58.

[131] Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (London, New York: Routledge, 1999), pp. 198-199.

Private Insurance System

A private insurance system is that with the least state involvement in the direct funding or provision of health care services. This type is characterized by the purchase of private health insurance financed by employers and/or individual contributions that are risk oriented. This system is also largely based on private ownership of health care providers and the factors of production although it might include a publicly funded safety net for the most vulnerable groups such as the poor, the elderly, or the young. The basic assumption of this approach is that the funding and provision of health care is best left to market forces.[132] Health is viewed as a commodity and ill health as an insurable risk. The US constitutes the archetypical example of this system.

The most striking feature of the American health system is the absence of a statutory universal health care program and an employment-based fringe benefits system in its stead. Most Americans look to their employers to provide health insurance, while public programs are confined to designated categories of the population, such as the elderly, disabled, the military, and the very poorest in society. Such arrangements make employers the pivotal players in the health care system and health care politics. They are free to decide whether or not to provide insurance as a fringe benefit. Government actors have few mechanisms to control the behavior of employers and insurers. Both the state governments and the federal governments have limited regulatory authority over the employment-based insurance sector.[133]

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[132] Robert H. Blank and Viola Burau, *Comparative Health Policy* (Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, 2004), p. 24.

[133] Susan Giaimo, "Who Pays for Health Care Reform." In *The New Politics of the Welfare State*, ed. Paul Pierson (Oxford, NY: Oxford University Press, 2001), pp. 357-58.

Universal health insurance has not been introduced in the US, although there have been serious attempts towards it. The most serious recent attempt was during the Clinton administration. Together with Hillary Clinton, Bill Clinton supported the idea that there is the need to establish a universal health insurance. However, private insurance firms prevented its implementation by sustaining that people would not be allowed to go to the doctors they want. Health insurance firms spent millions of dollars to blow up the new program. In the US, actual delivery both of insurance and of care is undertaken by a crazy guilt of private insurers, for-profit hospitals, and other players who add cost without adding value. The US health care system is more privatized than that of any other advanced country, but nearly half of total health care spending nonetheless comes from the government. Most of this government spending is accounted for by two great social insurance programs, Medicare and Medicaid. The largest public coverage program is Medicare, with 39.7 million enrollees or 14% of the population. The majority (84%) of Medicare beneficiaries are elderly individuals age 65 and older (though some are under-65 and either disabled or patients with End stageRenal disease). The next largest government program is Medicaid, which in the Current Population Survey includes those enrolled in the State Children's Health Insurance Program (SCHIP). Medicaid and SCHIP cover 37.5 million low-income individuals (12.9% of the population), primarily children, pregnant women, elderly, and disabled people. The smallest coverage source was military/veterans coverage, providing insurance to 10.7 million people, or 4% of the population.[134]

There is still, however, a large number of people who do not have any health insurance. According to the Census Bureau's 2005 Current Population Survey, there

[134] *Overview of the Uninsured in the United States: An Analysis of the 2005 Current Population Survey*, http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm (December 2007).

were 45.8 million uninsured individuals in 2004, or 15.7% of the civilian non-institutionalized population. It is a matter of life and death in many cases for people who do not have access to care. The high proportion of people who are uninsured in the US leads to rising costs because conditions that could be either prevented or treated inexpensively in the early stages often develop into health crises. Treatment of crisis conditions later on is much more expensive, such as emergency room treatment, or intensive care when an untreated illness progresses to a more serious stage. Actually, the private character of health care in the US is the reason behind the high costs. The US has by far the most expensive health care system in the world, based on health expenditures per capita, and on total expenditures as a percentage of GDP. The US spent $ 4,114 per capita on health care in 1998, more than twice the OECD median of $ 1,783 and $ 5,306 in 2002, 140% above the OECD average of $ 2,144. The US spends almost twice as much per capita as France, almost two and a half times as much as Britain. US health expenditure grew 2.3 times faster than the GDP, rising from 13.1% in 1997 to 14.7% in 2002. Across other OECD countries, health expenditure outpaced economic growth by 1.7 times.[135]

Krugman and Wells explore why US health care costs so much.[136] They claim that the main source of the high costs is probably the unique degree to which the US system relies on private rather than public health insurance, reflected in the uniquely high US share of private spending in total health care expenditure.[137] They explain the cost advantage of public health insurance with reference to two main

[135] OECD official web site, http://www.oecd.org/document/12/0,2340,en_2649_201185_31938380_1_1_1_1,00.html (December 2007).

[136] Paul Krugman and Robin Wells, "The Health Care Crisis and What to Do About It." *The New York Review of Books* (March 23, 2006): 38-43.

[137] Ibid., p. 41-42.

sources. The first is lower administrative costs. Private insurers spend large sums fighting adverse selection, trying to identify and screen out high cost customers. Systems such as Medicare, which covers every American 65 or older, or the Canadian single-payer system, which covers everyone, avoid these costs.

In 2003 Medicare spent less than 2% of its resources on administration, while private insurance companies spent more than 13%. The second source of savings in a system of public health insurance is the ability to bargain with suppliers, especially drug companies, for lower prices. Residents of the US notoriously pay much higher prices for prescription drugs than residents of other advanced countries, including Canada.[138] In the US, one fourth of health expenditure goes to private insurance companies. If there were no private insurance companies, the percentage of health expenditure in the GDP would fall from 16 to 12.

Krugman and Wells propose a shift from private insurance to public insurance, and greater government involvement in the provision of health care to have a more efficient and egalitarian system.[139] They give the example of Taiwan which adopted a single-payer system in 1995. The percentage of the population with health insurance increased from 57% to 97% and health care costs grew more slowly

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[138] Ibid., p. 42.

[139] In 22 May 2003, John Hutton (Minister of State for Health at the Department of Health in England) and Lars Engqvist (Minister for Health and Social Affairs, Sweden) presented a paper in the 2nd meeting of the International Forum on Common Access to Health Care (John Hutton and Lars Engqvist, "Making Publicly Funded Health Services More Responsive." *Eurohealth*, 9(3), http://www.euro.who.int/document/Obs/Eurohealth9_3.pdf, 2003) (December 2007). In this paper, they explore the advantages of public financing. The same as Krugman and Wells they emphasize the inefficiency of private insurance due to high administrative costs to assess risk, set premiums, design complex benefit packages, and review, pay, or refuse claims and due to the need to spend money on advertising, marketing, and reinsurance. Public financing is important not only to contain costs, but also to ensure fair access. Unlike out of pocket payments and private health insurance, where those who are sick pay more, public financing separates the need for health care from the ability to pay for care. It minimizes the financial barriers to health care and ensures health care is affordable and accessible for all. Public financing is important also to ensure fair financing. Private health insurance premiums are usually related to individual risk and not income and are therefore regressive. Those with a higher risk of ill health, such as those with a personal or family history of disease, with a genetic predisposition, already suffering from chronic illness and the elderly, face higher premiums (Ibid., p. 3).

than one would have predicted from trends before the change in system. So, if the US were to replace its current complex mix of health insurance systems with standardized, universal coverage the savings would be so large that all those uninsured would be covered and spending would be diminished.[140]

Although the US spends the highest amount for health care, it is not in the first rank in terms of health indicators. There are many different indicators of the overall health status and well-being of a country's population, but among the most commonly used measures are infant mortality rates and life-expectancy, particularly disability-adjusted life expectancy (DALE). DALE is the number of healthy years that can be expected on average in a given population. As of 1998, the infant mortality rate in the US was 7.2 infant deaths per 1,000 live births. In 1996, the US ranked 26th among industrialized countries for infant mortality rates. The WHO figures also show that the US ranks very low (24th) on DALE among high-income OECD countries.[141] American men ranked 22nd out of 28 OECD countries for life expectancy in 1996 (72.7), while American women ranked 19th (79.4).[142]

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[140] Krugman and Wells, p. 42.

[141] *The US Health Care System: Best in the World, or Just the Most Expensive?*, Summer 2001, http://dll.umaine.edu/ble/U.S.%20HCweb.pdf (December 2007).

[142] Ichiro Kawachi and Bruce P. Kennedy, *The Health of Nations: Why Inequality Is Harmful to Your Health* (New York and London: The New Press, 2006), p. 46. There is a large body of literature which explains these poor health indicators of US with reference to the inequality in society. They say, lack of access to health care cannot be solely responsible for the pattern of health inequality. Once societies pass beyond the threshold of absolute deprivation, further increases in the size of the economic pie are not what matter for health achievement. It is how the slices of the pie are divided across society. The main figure of this literature, Richard Wilkinson reveals that the greater the inequality in the share of incomes, the lower the average life expectancy of that society. They explain poor health indicators as an outcome of low level of solidarity in the society. See Grace Budrys, *Unequal Health: How Inequality Contributes to Health or Illness* (Rowman & Littlefield Publishers, Inc., 2003); Norman Daniels, Bruce P. Kennedy and Ichiro Kawachi, "Why Justice is Good for Our Health: The Social Determinants of Health Inequalities." *Daedalus*, 128(4) (1999): 215-252; Norman Daniels, Bruce Kennedy and Ichiro Kawachi, *Is Inequality Bad for Our Health?* (Boston: Beacon Press, 2000); Ichiro Kawachi, Bruce P. Kennedy and Richard G. Wilkinson (eds.), *The Society and Population Health Reader, Volume 1: Income Inequality and Health* (New York: New Press, 1999); M. G. Marmot and Richard G. Wilkinson (eds.), *Social Determinants of Health* (Oxford: Oxford University Press, 1999); Vicente Navarro (ed.), *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life* (Amityville, New York: Baywood, 2001); Vicente Navarro (ed.), *The Political and*

In his latest documentary, *Sicko* (2007), Michael Moore looks at the cruel health system in the US. The film is not about the 50 million Americans who do not have health insurance; it is about some of the 250 million who have/had health insurance and their lives have still been ruined. The health insurance firms insure those who are healthy. The applications of those with any illness or those who are judged too fat or too thin are rejected. Those profit-seeking health insurance companies do everything to deny claims and do not cover some crucial expenses. There are stories of people who are condemned to bankruptcy or even death as their insurance firms do not accept their claims. The firms refuse to cover vital diagnosis tests and treatments. Advancement in these companies is based upon how many claims an employee denies and any claims that are actually paid out are seen as failures. Poor old people who cannot pay hospital bills are not treated and left in front of dispensaries. Moore compares the system in the US with that in Canada, GB, France, and Cuba and asks why the US does not have such an ideal system. Moore's documentary reveals the inhuman state in which populations find themselves when health care is left to market forces. Health care cannot be a market good, a point that will be discussed further with reference to the work of Arrow.

Social Contexts of Health (Amityville, New York: Baywood Publishing, 2004); Vicente Navarro and C. Muntaner (eds.), *The Political and Economic Determinants of Population Health and Well-Being, Controversies and Developments* (Amityville, New York: Baywood Publishing, 2004); Vicente Navarro and Leiyu Shi, "The Political Context of Social Inequalities and Health." *Social Science and Medicine*, 52(3) (2001): 481-491; Richard G. Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996); Richard Wilkinson, *The Impact of Inequality: How to Make Sick Societies Healthier* (New York and London: The New Press, 2005); Richard G. Wilkinson (ed.), *Class and Health: Research and Longitudinal Data* (London: Routledge, 1986).

Other Health Care Typologies

Another widely referred classification is the one developed by Milton I. Roemer.[143] He analyzes national health systems in terms of five principal components: resources, organization, management, economic support, and delivery of services.[144] He scales the national health systems in the world's approximately 165 sovereign countries into four main types. Going from the least market intervention to the most, these health system types are: entrepreneurial, welfare-oriented, comprehensive, and socialist. His work comprises the period between the late 1980s and 1990.

An entrepreneurial health system in a highly industrialized country is best illustrated by that in the US. Indeed, in 1990, probably no other country belonged in this category, although Australia may have fitted into it 20 years ago. Within medicine, there is a high degree of specialization, so that only about 15% doctors are generalists. The largest channel for providing health care is the private market of thousands of independent medical practitioners, pharmacies, laboratories, and so on. Economic support for the US health system comes predominantly from private sources. Roemer cites the Philippine Republic and Kenya as the other countries with entrepreneurial systems.

In welfare-oriented health systems most of the public sector funds came from the social insurance, administered by the sickness funds. Many health systems of Western Europe are welfare-oriented, as are the systems of Canada, Japan, Peru,

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[143] Milton I. Roemer is a prominent figure in the international health care literature. He joined WHO as section chief in 1950 and started conducting research on health care systems. He wrote a monumental comparative analysis of the health systems of 71 countries. Roemer, *Health Care Systems in World Perspective*. Roemer advocates for a major government role in health services, national health insurance program covering the whole population, and a strong public sector in health care. He is critical of the market system in the US.

[144] Milton I. Roemer, "National Health Systems Throughout the World." *Annual Review of Public Health*, 14 (1993): 335-353, p. 335.

India and Australia. In comprehensive health systems 100% of the national population is entitled to complete health service, and the financial support has shifted almost entirely towards general tax revenues. Larger proportions of doctors and other health personnel work in organized frameworks on salary. Almost all health facilities are under the direct control of government. Great Britain, the Scandinavian countries, Italy, Greece, Spain, Costa Rica, and Sri Lanka have comprehensive health systems.

In socialist health systems, all physical and human resources are taken over by government, and health services are theoretically available to everyone. The Soviet Union, socialist countries of Eastern Europe, Cuba, and the People's Republic of China have socialist health systems. In the epilogue of his article, Roemer writes about the impact of turbulent political changes on health systems. The transformation of health systems with the demise of socialism is important, a point that will be discussed below.

Guido Giarelli separates European health systems into four: First, the Scandinavian countries and Great Britain, which after World War II gradually moved from social insurance programs to comprehensive national health service models with universal coverage and an organized pattern of service delivery. Second, Central Western European countries such as France, Germany, Belgium or the Netherlands with highly developed compulsory health insurance models which have collectivized the financing of health services providing coverage to all or nearly all the population, but with little modification of the delivery pattern. Third, Southern European countries which more recently parted from social insurance models to establish national health services against the background of the two other major groups of health care systems in Europe. Last, the Central Eastern countries of the former Eastern Europe (Estonia, Latvia, Lithuania, Poland, Czech Republic, Hungary,

Slovakia, and Slovenia), whose health systems are engaged in a complex transition from their previous socialist health care systems.[145] As in the case of welfare typology, Southern Europe and Central and Eastern Europe comprise separate categories in health care.

There are various explanations for the reasons for different health systems. Vicente Navarro[146] develops a framework based on class relations. In his article "Why Some Countries Have National Health Insurance, Others Have National Health Services, and the United States Has Neither," Navarro claims that the starting point for an analysis of the diversity in the systems of funding and organization of health services in different societies has to be based on an understanding of class relations in those societies, i.e., the class structure, class formation, class alliances, and class interests, as well as the behavior of the political and economic instruments of those classes.[147] He starts with asking why the US is the only major Western industrialized nation that does not have a comprehensive and universal government health program. And he answers the question with the lack of a powerful working class and its labor movement. He asserts that the establishment of a national health program in any country is related primarily to the establishment and influence of the labor movement in that country, realized through labor's economic (unions) and

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[145] Guido Giarelli, "Mediterranean Paradigm in a European Perspective." Paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, Boğaziçi University, İstanbul, 2005.

[146] Navarro is the head of Johns Hopkins School of Public Health. He has written many books and articles on social policy, public policy, the socio-political economic forces that shape health policy, and international comparisons of health and social policy. His class anlaysis of health care has found an audience among public health specialists in Turkey, especially those who are active in the Turkish Medical Association. See İlker Belek et.al., *Sınıfsız Toplum Yolunda Türkiye İçin Sağlık Tezi*; İlker Belek, *Sınıf, Sağlık, Eşitsizlik* (İstanbul: Sorun Yayınları, 1998); İlker Belek, "Sağlıkta Eşitsizlik: Önlenebilir ve Kabul Edilemez Bir Politik Ekonomi Sorunu." *Toplum ve Hekim*, 13(2) (Mart-Nisan 1998):96-104; Soyer, *Sanayi Devriminden Küreselleşmeye Darbeden AK Partiye Sağlığın Öyküsü.*

[147] Vicente Navarro, "Why Some Countries Have National Health Insurance, Others Have National Health Services, and the U.S. Has Neither." In *Why the United States Does Not Have a National Health Program*, ed. Vicente Navarro (Amityville, New York: Baywood Publishing, 1992), p. 136.

political (parties) instruments. The different types of funding and organization of health services are explained primarily by the degree to which the differing class aims in the health sector have been achieved through the realization of class power relations.

For Navarro, the critical force in the birth of health and other social insurance schemes was the political and economic strength of the working class. He bases this claim on the synchronicity of the development of working-class parties, trade union federations, and social insurance programs. He makes a table which reveals the fall in the number of means-tested programs when socialist parties were in power.[148] He says the working class would support the principle of universality and oppose the provision of benefits according to wages or economic sectors of the labor force, and the means-tested programs. For Navarro, the corporate model appears in countries such as Germany, Austria, France and Italy where the capitalist classes were rather weak and unable to break with the feudal order.[149] In the liberal model, the capitalist class did not need to establish alliances with a feudal aristocracy; social and health policies reflected the aims of the capitalist class.[150] Briefly, it is the weakness of the US working class, with the absence of a mass-based socialist party and with very low levels of unionization, together with the strength of the US capitalist class that explain the absence of a comprehensive and universal health program in the US.[151] However, this is a deterministic explanation which excludes factors other than labor movement. Such an analysis would not explain the reasons for the formation of national health services and social insurance systems. Navarro talks about a

[148] Ibid., p. 138.

[149] Ibid., p. 141.

[150] Ibid., p. 143.

[151] Ibid., p. 144.

corporate model in Italy, but it has a national health service. Also many of the developing countries with weak working classes and labor movements have social insurance systems. Democratization might be a factor in the extension of health care coverage, but labor movement alone cannot be determinate.

Is There a Retrenchment of the Welfare State?

There is pressure on the welfare state in general and health systems in particular. As already mentioned, whether the welfare state retrenched or not is a highly controversial issue. There is a consensus on the existence of pressure on the welfare state due to globalization, population aging, and family instability. There is no such consensus, however, on the characteristic of the responses of the welfare states.[152] Some emphasize the increasing dominance of the market economy, while others emphasize the relative stability of the welfare state. Usually, it is asserted that different welfare states are differently affected by these changes and so respond in different ways. Esping-Andersen is one of those who demonstrate the path-dependent character of these responses.

Those who assert the inevitability of social spending cuts and welfare state retrenchment emphasize first the incompatibility of flexible employment practices, which resulted from competitive pressures generated by globalization, with job security, income protection and employment related social security provision. Second, the increasing costs associated with mature welfare states, especially in the

[152] For a critical summary of different approaches on welfare state responses see Bruno Palier and Robert Sykes, "Challenges and Change: Issues and Perspectives in the Analysis of Globalization and the European Welfare States." In *Globalization and European Welfare States: Challenges and Change*, ed. Robert Sykes; Bruno Palier and Pauline Prior (New York: Palgrave, 2001).

context of population aging.[153] Finally, political shifts to the right, which marked the electoral victories of market fundamentalists such as Reagan, Thatcher and Kohl in the 1980s.[154] Despite these factors the state's commitment to social policy has not grown weaker in advanced welfare states and has actually become more important in developing countries. Nevertheless there have been important changes culminating in a new type of "governance of welfare."[155] This new type brings the devolution of central state responsibilities in welfare provision to the local government and the increase in the role attributed to diverse partnerships between public authorities and the private sector that significantly involve the voluntary sector.[156]

Paul Pierson's analysis is effective in challenging the widely accepted welfare retrenchment thesis. In his influential book on welfare policies of Reagan and Thatcher, who became the symbols of the dismantling of the welfare state in the neo-liberal era, Pierson reveals that compared with reforms engineered in other arenas (e.g., macroeconomic policy, industrial relations, or regulatory and industrial policy), the welfare state stands out as an island of relative stability.[157] Poor economic performance undermined both the budgetary foundations of welfare states and the Keynesian faith in the virtuous link between public spending and economic growth. It helped generate an electoral reaction that propelled the conservative critics of the

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[153] Between 1960-2004, the OECD average annual percentage growth in life expectancy was 0.31. See Table 1 for life expectancy and average annual percentage growth in life expectancy in selected OECD countries between 1960 and 2004. There is a serious increase in all countries. Developing countries with low levels of life expectancy in the 1960s have higher annual percentage growth rates. Spain, Portugal, Japan, Mexico, Turkey, and Korea's average annual percentage growth in life expectancy is above the OECD average.

[154] Buğra and Adar, p. 9.

[155] Ibid., p. 13.

[156] Ibid.

[157] Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher and the Politics of Retrenchment* (Cambridge: Cambridge University Press, 1994), p. 5.

welfare state to power. For the first time since before World War II, political executives in Britain and the US were now openly critical of the central features of social policy. For Reagan and Thatcher, the welfare state was not simply a victim of poor economic performance, but one of its principal causes. Yet, they could not depart from the status quo, especially due to the fear of popular hostility.[158] Although the role of organized labor was shrinking the existence of client groups with a stake in welfare programs made the retrenchment difficult.

In his analysis of the responses of GB, US, Germany, and Sweden, Pierson repeats his claim that there is no retrenchment of the welfare state.[159] He warns us that retrenchment is not simply the mirror image of welfare state expansion. For him, the theories that explain the expansion of the welfare state cannot explain its retrenchment, as we are living in an environment in which welfare state has been the norm. His investigation relies on a combination of quantitative data on expenditures and qualitative analysis of welfare state reforms. Rather than emphasizing cuts in spending per se, the focus is on reforms that indicate structural shifts in the welfare state. These would include first, significant increases in reliance on means-tested benefits; second, major transfers of responsibility to the private sector; and third, dramatic changes in benefit and eligibility rules that signal a qualitative reform of a particular program.[160]

From 1974 through 1990 the expenditure patterns across the four cases are quite similar, despite widely different starting points. Social security spending and total government outlays as a percentage of GDP are relatively flat over most of the

[158] Ibid., p. 167.

[159] Paul Pierson, "The New Politics of the Welfare State." *World Politics*, 48(2) (1996): 143-179.

[160] Ibid., p. 157.

relevant period. In all cases reform has been incremental rather than revolutionary. He accepts the existence of change.

> Many programs have experienced a tightening of eligibility rules or reductions in benefits. On occasion, individual programs (such as public housing in Britain) have undergone more radical reform. In countries where budgetary pressures have been greatest, cuts have been more severe. What is striking is how hard it is to find *radical* changes in advanced welfare states. Retrenchment has been pursued cautiously: whenever possible, governments have sought all-party consensus for significant reforms and have chosen to trim existing structures rather than experiment with new programs or pursue privatization.[161]

Pierson adopts the typology developed by Esping-Andersen and distinguishes different policy challenges and political possibilities. In the liberal world, reform focuses on cost containment and re-commodification. The crucial political divide is between those advocating thoroughgoing neo-liberal retrenchment and those seeking a more consensual solution that offers compensation to vulnerable groups. In the social democratic world, the focus of reforms is on cost containment and recalibrations, which aim at rationalizing programs to enhance performance in achieving established goals. On the whole, reform has been negotiated, consensual, and incremental. In the Christian democratic world, where pressures to adjust and support for existing programs clash most intensely, reform has centered on cost containment and recalibration of "old" programs to meet new demands. Thus, there is not a single "new politics" of the welfare state, but different politics in different configurations.[162] Pierson emphasizes that neo-liberal retrenchment is not politically

[161] Ibid., p. 174.

[162] Paul Pierson, "Introduction: Investigating the Welfare State at Century's End." In *The New Politics of the Welfare State*, ed. Paul Pierson (USA: Oxford University Press, 2001), p. 14.

viable as support for the welfare state is intense as well as broad.[163] Universal health care has the broadest support, which makes it the most critical component of the welfare state that cannot be transformed easily by the governments.

We should be cautious while utilizing the social expenditure data of different countries in explaining the changing role of welfare states. As Esping-Andersen warns us, not all spending counts equally. Expenditures might be transferred to the advantageous sections of the population. Keeping this in mind, we can refer to the social expenditure data of the OECD countries, which challenge the assertion that economic globalization has diminished states' power to follow public policies. Between 1960 and 1994, total government spending in the OECD countries doubled, so that government expenditure constituted more than half of the GDP in the early 1990s. If the globalization thesis were correct, we should have witnessed that the larger the scope and the faster the rate of globalization, the smaller the percentage of GNP spent in the public and social sectors and the slower the rate of growth of both types of expenditures (as percentages of GNP). We should also have witnessed a decline in public and social expenditures (as percentages of GNP) or a decline in the rate of growth of these expenditures with the growth of the globalization process – but quite the contrary. In terms of public expenditure in percentage of GDP, the OECD average is 15.9 in 1980, 17.6 in 1985, 17.9 in 1990, 19.9 in 1995, 19.4 in 2000, 19.7 in 2001, 20.3 in 2002 and 20.7 in 2003.[164]

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[163] Paul Pierson, "Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies." In *The New Politics of the Welfare State*, ed. Paul Pierson (USA: Oxford University Press, 2001), p. 413.

[164] OECD official web site, http://stats.oecd.org/wbos/default.aspx?datasetcode=SOCX_AGG (December 2007).

Politics still matters in explaining the evolution of the welfare states. Navarro, Schmitt and Astudillo[165] reveal that political variables continue to be central in explaining how countries responded to the globalization of finance in the 1990s to protect, strengthen, or weaken their welfare states. They look at the performance of four groups of countries (social democratic, Christian democratic, liberal, and Southern European) and verify the "path-dependency" thesis. Navarro questions the dominant theoretical frame that assumes that all governments are forced to follow the same policies because of the need to be competitive in the globalized economy, where international markets (whether financial or commercial) determine what governments can and must do. He criticizes the economic determinism of this approach and puts politics at the center of the explanation.[166] The fact that social democratic countries were among the most globalized countries during the period 1974-1995 falsifies this approach. Navarro asserts that given the political will, expansionist and full employment policies are still possible.[167]

There is also the evidence that globalization can be experienced as a catalyst for the strengthening of existing welfare provision. The best examples of this are the Southern welfare states and Ireland. In the Southern welfare states, far from being a

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[165] Vicente Navarro, John Schmitt and Javier Astudillo, "Is Globalization Undermining the Welfare State? The Evolution of the Welfare State in Developed Capitalist Countries during the 1990s." *International Journal of Health Services*, 34(2) (2004): 185-222.

[166] Vicente Navarro, "The Political Economy of the Welfare State in Developed Capitalist Countries." *International Journal of Health Services*, 29(1) (1999): 1-50. Although he does not share the view that globalization automatically leads to welfare retrenchment, he is suspicious of the resilience of the welfare state. He refers to the data which show the fall in public employment and public consumption for some OECD countries between the years 1960-1994 (Ibid., p. 47). Although there was a rise in social expenditures, the rate of growth in spending on services per user and in public employment per user declined in developed capitalist countries in the 1980s and 1990s. This happened when the need for such services increased due to the growth of unemployment, demographic changes (with growth of the elderly population), growing inequalities, and increasing poverty. Other changes have also occurred, like the transformation of some universal benefits into means-tested benefits, the greater role of the private sector in the funding and provision of services, and the lessening of the intensity of care through production of employment and/or expenditures per user or beneficiary (Ibid., pp. 46-48).

[167] Vicente Navarro, "Are Pro-Welfare State and Full-Employment Policies Possible in the Era of Globalization?." *International Journal of Health Services*, 30(2) (2000): 231-251.

negative pressure leading to the retrenchment of welfare provision, globalization (qua European integration) has actually involved positive development, a "catching up" by these countries to a standard of welfare system already achieved in most of mainland Europe. In Ireland, similar developments have taken place. Neo-corporatist agreements and policies were used to compensate for the increasing social risks associated with global competitiveness. In contrast to the GB, Ireland increased social expenditure with the aim of strengthening the workforce.[168]

The developments in Asia and Latin America also challenge the thesis of retrenchment due to globalization. Wouter van Ginneken reviews examples of successful approaches and practices of the extension of social security in developing countries.

> When much of East and South-east Asia was hit by a severe financial crisis in 1997, some countries (e.g. Indonesia, Thailand and Vietnam) learned that the limitations to their social security systems –which relied on traditional family support to fill the gaps–, aggravated an already grave economic situation. Unemployment soared and millions fell through the safety net and into poverty. However, once the crisis had abated, countries in that region recognized the need to improve social security systems by covering more risks and more people".[169]

The Republic of Korea, Taiwan, China, Chile and Costa Rica achieved universal coverage in health and some middle income countries like Colombia, Tunisia, Thailand, and Vietnam are striving for it.[170]

Huck-ju Kwon analyzes the transformation in East Asia and concludes that there have been successful advances towards greater social rights, at least in Korea and Taiwan.[171] He labels the welfare states of these countries "developmental."

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[168] Prior and Sykes, pp. 205-206.

[169] Wouter van Ginneken, "Extending Social Security: Policies for Developing Countries." *International Labour Review*, 142(3) (2003): 277-294, p. 278.

[170] Ibid., p. 283.

[171] Kwon.

Welfare developmentalism has two strands: selective vs. inclusive. The key principles of the selective strand of welfare developmentalism are productivism, selective social investment and authoritarianism. Inclusive welfare development is based on productivism, universal social investment and democratic governance. The welfare state in Korea and Taiwan was selective before the Asian economic crisis of 1997. After the crisis there appeared the need for structural reform in the economy. The need for economic reform, together with democratization, created institutional space in policy-making for advocacy coalitions, which made successful advances towards greater social rights. Before the crisis, labor insurance was targeted mainly at industrial workers in large-scale firms, while state sector workers were among those first covered by the health insurance programs. A large portion of the population was devoid of any insurance. Social protection for the vulnerable in society was left to families.[172]

> The economic crisis in 1997-98 made some reform of the structural weakness of the economy inevitable. The welfare state, which has focused only on those working in the large-scale firms, now began to protect those not working, including the poor and the elderly as well as the unemployed. Within the new social protection schemes, training programs as well as unemployment benefits were major elements: in other words, the emphasis was placed on the protection of the job capability rather than the job security of workers.[173]

The extension of health insurance to cover the entire population was accomplished before the crisis, in 1988-89 in Korea and in 1995 in Taiwan.

However, the transformation in the Central and Eastern European countries has gone in the opposite direction. Zsuzsa Ferge reviews the developments in the

[172] Ibid., p. 485.

[173] Ibid., p. 493.

Central and Eastern European countries since the dissolution of the Soviet Union.[174] Most universal benefits and universal public services have been abolished. They are being transformed either into means-tested schemes (the case of family allowances or burial benefits), or into insurance schemes (the health service). Related to social insurance (pensions, sick pay, health services), she cites some major changes: First, there are attempts at its democratization, which could increase its transparency and accountability, but the process is slow and hesitant. Second, the standards of the benefits (of pension, sick pay, health services) have been continuously lowered, and conditions of access have been toughening. Third, the privatization of insurance schemes has taken different forms. In most countries, new legislation is encouraging the setting up of private pension and health insurance schemes. Means-tested social assistance –"targeting to the truly needy"- is rapidly gaining ground, either because it is replacing part of the universal or insurance-based benefits, or because it is instrumental in dealing with new needs. She questions the consequences of the withdrawal of the state from the welfare sector.[175] The transformation of health care in Central and Eastern European countries will be examined further in the following pages.

The roles of the international agencies are determinate in the transformation of the Central and Eastern European welfare states. The World Bank, the International Monetary Fund, and the World Trade Organization exert pressure on the governments of those countries, as they do to other countries, to adopt their welfare systems to the global world order. In his research on globalization and social policy Bob Deacon summarizes the global conditions that undermine equitable

[174] Zsuzsa Ferge, "The Perils of the Welfare State's Withdrawal." *Social Research*, 64(4) (1997): 1381-1402.

[175] Ibid., pp. 1387-1388.

public social provision as follows: the World Bank's preference for a safety-net and privatizing strategy for welfare; the self-interest of international non-governmental organizations (NGOs) in providing basic education, health and livelihood services that might otherwise be provided by the state; and the World Trade Organization's (WTO) push for an open global market in health services, education and social insurance.[176] This pressure, together with the neo-liberal intellectual currents, has been effective in the shaping of welfare policies. Although it is hard to talk about a one-way relation, their role in the transformation of welfare policies especially in the 1980s was important.

Is There a Retrenchment of the Health Care State?

There is a growing literature on the functioning of health sector, its effectiveness, transparency and quality. Inequalities in access, the quality of health care services, people's level of satisfaction, possible ways of organization, and public-private balance are all discussed within the context of health reform. However, the cost-containment is at the forefront of all discussions as the rise in health care costs is higher than the rise in GDPs everywhere. Across the OECD countries, the US excluded, health expenditure outpaced economic growth by 1.7 times, between the years 1997-2002. In the US this number is 2.3. Nearly all governments are under continuous pressure to reconcile economic and health concerns because the public

[176] Bob Deacon, *Globalization and Social Policy: The Threat to Equitable Welfare*, Occasional Paper 5, Geneva: UNRISD - United Nations Research Institute for Social Development, 2000.

purse funds the bulk of health spending in most countries. Why has health expenditure increased this much?[177]

The growth of health care systems is driven by an internal dynamic of what has come to seem like permanent, limitless expansion. Developments in biotechnology feed supply and demographic change feeds demand, the two operating together as medicine treats a population it has helped to grow old. In medicine, unlike other industries, the introduction of new equipment does not save money by reducing unit costs, but tends to increase the scope of, and so demand for, health care. It is not usually labor-saving, but likely to require additional investment in specialist personnel. This peculiar combination of demand and supply features in the health sector leads to a relentless increase in its size and complexity – and cost. This does not comprise a big problem when economies are growing. However, after the oil crises, in a period of recession distributional issues became acute.

The change in the traditional family structure is another reason for rising health expenditures. The care of the old was previously the task of the family. But today, with the change especially in the women's role within the household, the state is expected to provide this service via hospitals and dispensaries. Most of the growth in health spending is to be explained by rising rates of health care utilization. Access to publicly funded health care has become effectively universal, while advances in medicine mean that a greater range of treatments is possible. Chronic illness, which is less easily or readily treated than acute illness, is more prevalent than before. A more informed public had learned to express greater demand for services, coupled with higher expectations of quality and privacy. At the same time, services

[177] For the rise of health expenditure in selected OECD countries between 1960-2005, see Tables 2 (total expenditure, % GDP), 3 (total expenditure, per capita US $ PPP), 4 (public expenditure, % total health expenditure), and 5 (pharmaceutical expenditure, % total).

themselves have become more expensive because they involve more sophisticated equipment and more specialized staff.

Another reason for the rise in costs is the dominance of profit-seeking companies in the sectors of medicine and biotechnology. Health spending growth is particularly notable in the area of pharmaceuticals. Between 1992 and 2002, spending on pharmaceuticals grew, on average, 1.3 times faster per year than total health expenditure, rising to account for between 9 and 37 percent of total health spending in OECD countries in 2002.[178] Intellectual property rights make it possible for the large firms to impose the prices they determine.

In the 1970s, escalating costs, in large part fuelled by the open-ended goals of access and quality, were aggravated by the global recession and oil crisis. One result was the unmistakable shift in emphasis from access and quality to cost containment and the need to constrain health care spending. Aging populations, unbounded technological expansion and heightened public expectations solidified this goal in the 1990s. Although strategies differed, no country escaped the highly visible shift towards improving productivity, maximizing efficiency, and incorporating management procedures into health care due to the predominant goal of cost containment. However, it is hard to talk about a radical change in the health care systems. As the universalist project in health has been broadly consensual, retrenchment has been hesitant and slight. Freeman formulates this relation as follows: “But if systems had grown to limits, reform had limits, too.” Retrenchment of any kind was likely to be highly contested, and governments would risk much by

[178] OECD official web site, http://www.oecd.org/document/12/0,2340,en_2649_201185_31938380_1_1_1_1,00.html (December 2007).

embarking on it.[179] Nevertheless, there are serious changes, as it is the case in welfare, which imply a significant redefinition of the boundaries between the public and the private.

Markets were seen as a solution to many problems, framed mostly in terms of efficiency or costs, whereas public sector was denigrated as corrupt and inefficient. It was not a uniform process. The introduction or strengthening of market mechanism took many forms like injecting competition among solely public (quasi markets) or public and private providers (mixed markets), which involves moving towards the public-contract model (so-called purchaser-provider split); a renewed interest in the concept of community and the role of communities and families in health policy; introducing private finance in the form of co-pays; expanding the role of private providers in clinical as well as non-clinical services; increasing the autonomy of hospitals; and using private investment to build public facilities, etc. In both the developing and developed worlds the health care reform agenda reflects the growing influence of the neo-liberal economic theory. In its most general form, the health care agenda consisted of a mixture of following policies: increased cost-sharing for patients; the introduction of purchaser-provider split leading to creation of "internal" or "quasi" markets; establishing hospital as autonomous entities with professional managers (also called management reforms); encouraging competition among solely public or among the public and private providers for contracts; policies aimed at enhancing participation of non-state entities; decentralization etc. In the case of developing countries one can also add establishment or reorganization of health insurance systems to this list.

[179] Freeman, p. 71.

Although different in many respects, all these policies entailed selected application of various market "tools" or instruments to different parts of the health care system, ranging from the increased use of co-payments, to the expansion of private providers to areas which were previously dominated by public providers. In most cases, the market solutions also included outsourcing of many non-clinical services (cleaning, catering, security), and clinical work (support staff, some diagnostic tests or simple surgical procedures which have long waiting periods such as cataract surgery or hip replacement) as well as making use of private capital to build and operate hospitals through the famous "public-private partnerships" or "private finance initiative" (PPP or PFI).[180]

There is no consensus on the responses of health care states to the cost-containment pressures. The debate on the changing structure of the health care state is in line with the debate on the changing structure of the welfare state. For some, there is no wholesale structural reconfiguration;[181] for others a path-dependent development;[182] and for others a retreat from health care state.[183] These different positions will be explained together with the changes in health care systems of Europe, US, Southern Europe, Central Europe, and Latin America.

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[180] Ağartan, "Health Sector Reform in Turkey".

[181] Richard B. Saltman, "The Western European Experience with Health Care Reform." http://www.euro.who.int/observatory/Studies/20021223_2 (2002) (December 2007); R. B. Saltman, "Regulating Incentives: The Past and the Present Role of the State in Health Care Systems." *Social Science and Medicine*, 54 (2002): 1677-1684; Richard B. Saltman and J. Figueras, "Avrupa Ülkelerindeki Sağlık Reform Stratejilerinin Değerlendirilmesi." *Toplum ve Hekim*, 14(5) (Eylül-Ekim 1999): 384-396.

[182] Richard Freeman; Susan Giaimo; Heinz Rothgang, Mirella Cacace, Simone Grimmeisen and Claus Wendt, "The Changing Role of the State in Healthcare Systems." *European Review*, 13(1) (2005): 187-212.

[183] Pol De Vos, Harrie Dewitte and Patrick Van der Stuyft, "Unhealthy European Health Policy." *International Journal of Health Services*, 34(2) (2004): 255-269; Colin Leys, *Market-Driven Politics: Neoliberal Democracy and the Public Interest* (London: Verso, 2003); Colin Leys, "Health Care between Politics and Markets." Paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, Boğaziçi University, İstanbul, 2005; Allyson M. Pollock, *NHS plc: The Privatisation of Our Health Care* (London and New York: Verso, 2004).

No Structural Change

Richard B. Saltman thinks that the current reforms could not damage the six basic components of the Western European consensus on health care. These are first, most curative and preventive health care services are understood to be social good. No Western European society conceptualizes health care services as normal market products or commodities that should be predominantly profit-making in purpose. Pharmaceuticals and medical supplies, yes; medical care services, no. Second, the essence of solidarity is the understanding that all citizens are part of the same community. Third, all employers as well as most (social-health insurance) or all (tax-based) citizens are required by law to participate in the health care funding system. Fourth, performance is tightly controlled by national and regional authorities. Fifth, the understanding of what is "fair" is collective and need-based for most Western Europeans: if you need care, you should get it. Finally, strong accountability of health care insurers and providers to the public sector is seen as a good thing. The reforms have sought to add micro-economic (institutional level) efficiency to already achieved macro-economic (health system level) efficiency, and solutions that can combine entrepreneurial behavior with solidarity. The Netherlands and Germany have backed away from reform approaches that would instill entrepreneurial or market-like forces on the funding side of their systems. According to Saltman, reliance upon individual co-payments and other out of pocket spending is relatively low. There is no rush to private funding. There is no explicit rationing. The search for entrepreneurialism is largely inside the public sector. There has been no

substantial privatization of providers. De-centralization and re-centralization are increasing sometimes simultaneously.[184]

Saltman and Figueras analyze the European health care reform in a report prepared for the WHO. In this report they adopt a much more nuanced approach which deals with different responses. They explain the difficulty of implementing reforms with reference to dominant European values which consider health care to be a social good, in which the provision of service to each individual is also valuable to the community as a whole. Yet, several Western European states are seeking to improve their current systems by introducing a limited amount of competition among health insurance agencies and increasing personal responsibility through such means as cash benefits or user charges. Portugal, Spain, Italy, and Greece are transforming their insurance-based systems into tax-based systems, while Israel, Turkey, and the former German Democratic Republic are headed in the opposite direction. Many countries in Central and Eastern Europe have announced shifts to an insurance-based system. Change in Western Europe is largely inspired by demands for greater cost control, quality, and consumer satisfaction, while reform in the former centralized economies of Central and Eastern Europe stems from intense political pressure to replace rapidly all elements of the previous regimes.[185] The change in Southern and Eastern European countries will be discussed in the following pages.

Path-Dependent Change

The existing systems of the countries together with the actions and preferences of payers and the state in each country determine their responses to the cost-

[184] Saltman, "The Western European Experience with Health Care Reform".

[185] Saltman and Figueras.

containment pressure. Susan Giaimo reveals this in her analysis of the reform attempts in Britain, Germany and the US. Like Saltman, she emphasizes the role of dominant European values in the resistance towards radical change in health care. She asks whether payers' and policy makers' cost-containment projects have succeeded, and if so, whether the price of success has been the sacrifice of equity and solidarity. Who carries the burden of reform? Is it the weakest members of the society or have countries found ways to share this pain in a just fashion?[186] She reaches the conclusion that Britain and Germany thus far have achieved good cost performance without surrendering the principle of universal access and without requiring the most vulnerable members of society to bear a disproportionate share of the burden of adjustment. Indeed, Britain's record on cost containment has been the best of the three cases. While the price has been explicit rationing of access to hospital care, Britain has done so in ways that address equity.

Germany represents an intermediate case between Britain and the US, spending more than the former, but without resorting to the inequities of the latter. The US has only recently enjoyed markedly slower increases in health care outlays. But the cost-containment gains have come at the expense of worsening access to care for the sicker and poorer in society. The universal health care systems of Britain and Germany blocked cost-containment strategies by payers or government actors that would have sacrificed equity, while the private, voluntary fringe benefits system of the US encouraged employers and insurers to take cost-cutting actions that worked in the direction of desolidarity.[187] So, for Giaimo, the most critical variable was whether the health care system was a universal, statutory system or not. If a country's health care system legally guaranteed a universal right to health services, then it placed

[186] Giaimo, p. 334.
[187] Ibid., p. 335.

serious constraints on unilateral cost-cutting strategies by either the state or employers. Because universal health care systems institutionalized equity and redistribution in their core design, they made efforts to shift the burden of cost containment on to those least able to shoulder it politically difficult; such attempts were viewed as morally unjust.[188]

Each country's health care system designated different actors as payers and provided them with different capacities to realize their cost-containment goals. In Britain, the state must answer to taxpayers. In Germany, it is difficult for employers or employees to take unilateral action against the other. And in the US, employers have been the pivotal players and payers in the politics of health care reform because most Americans obtain health insurance as a company-based fringe benefit. Employers are free to provide or withhold fringe benefits, since these are voluntary. And since employees and unions lack an institutionalized role in health insurance financing or administration, they have not been able to mount an effective opposition to employer's cost-cutting strategies.[189] Statutory, universal programs make the pursuit of cost containment at the expense of equity difficult, while voluntary fringe benefits systems do not. Middle-class beneficiaries find themselves in the same risk community as the poor, but their reasons for fighting to protect these programs from retrenchment may arise from simple self-interest rather than out of any sense of justice or altruism towards the less fortunate. The middle and upper classes tend to be more active in politics than the poor, then the risk of electoral retribution for major retrenchment is high. Moreover, universal programs carry legitimacy in the public eye because the majority of beneficiaries make some sort of contribution to them,

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[188] Ibid., p. 339-40.

[189] Ibid., p. 340.

either through payroll deductions to social insurance or through general revenues to finance a national health service.[190]

Giaimo asserts that the health care systems in Britain and Germany approach Marshall's ideal of social citizenship, whereby each person has a right to a decent social minimum as a necessary precondition for full participation and membership in the larger community. In both Britain and Germany, the definitions of social citizenship and a decent social minimum have been generously drawn to mean that every person has a right to the same level of quality care, based on one's medical need, not on one's financial means or past contributions. By contrast, two-tiered systems of provision based on ability to pay, which grant generous services to the wealthy and only residual benefits to the poor, violate the universality and comprehensiveness of social citizenship and their associated notions of equity. The universal health care systems of Britain and Germany equate equity with equality. Equity is defined as a broad solidarity, in which the poor and sick have the same status as the wealthy and healthy. This equation derives from the ideas of mutuality and reciprocity that underpin social insurance: people identify with each other in recognizing that they all share a risk of becoming ill or incapacitated, and respond by pooling their risks against this vulnerability.[191] Actually, universalistic tax-financed programs seem more solidaristic than the social insurance programs which segment risk pools along class, occupational, or regional lines. But Giaimo, like Freeman, does not find that much difference between them in terms of the conception of solidarity. This conception affects state actors' freedom of maneuver. However, in the US, private commercial insurers, following the dictates of profit maximization

[190] Ibid., p. 341.

[191] Ibid., p. 342.

and actuarial fairness, segment the market, "cream skim" the healthier and wealthier patients, since they are the least costly to insure, and shun the unprofitable, expensive cases, namely, the sicker and poorer. The private and voluntary nature of employee fringe benefits in the US produces serious inequities.[192] The dominant structures in these countries determine their paths of health care state adjustment. For Giaimo, there is no reason to expect countries to converge on a common path of welfare state adjustment. There are several possible options. Each country's outcome will depend not only on past "policy legacies," but also on political choice and the particular settlements that stakeholders are able to forge among themselves.[193] So, she accepts the change in health care state, but does not observe a linear path towards marketization, at least in Europe.

Freeman explains the unchanging structure of health care funding in GB, Sweden, and Italy with reference to a recognition on the part of governments that centrally funded, tax-based systems are effective in controlling costs, and the continued political legitimacy of national health services. In Sweden, equity, tax finance and an element of planning continue to be seen as non-negotiable by reform commissions. In GB, even Thatcher, the leader of conservative government bent on marketization was forced to declare that the NHS was "safe with us." In Italy, parties gain from opposing the retrenchment strategies of their opponents. Nevertheless, where the use of market mechanisms in the distribution of health care is increased or extended, the commitment to equity is to some degree undermined. Reform in these systems has promoted allocative efficiency over social justice.[194]

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[192] Ibid., p. 343.

[193] Ibid., p. 367.

[194] Freeman, p. 48.

Rothgang et.al. observe a tendency of convergence from distinct types towards mixed types of health care systems.[195] They analyze the changes in GB, Germany, and the US, which are usually taken as typical examples of different health care systems. While many authors analyzing health policy changes exclusively concentrate on finance and expenditure data, they consider financing, service provision and regulation. As far as financing is concerned, they observe a small shift from the public to the private sphere, with a tendency towards convergence in this dimension. The little data available on service provision, in contrast, show neither signs of retreat of the state nor of convergence. In the regulatory dimension they see the introduction or strengthening of those coordination mechanisms (hierarchy, markets and self-regulation) which were traditionally weak in the respective type of health care system. This means, theirs is a path-dependent approach in which the current system determines the change, but in their analysis, in the opposite direction. Checking what happens after 1975, they observe a declining share of public health care *financing* in NHS systems, a growing share of public financing in the private US system, and no clear tendency for social insurance systems. So the role of the state was strengthened where it was weakest and it was weakened where it was strongest before.[196]

Yet, the retreat of the state from health care financing is very limited. Concerning the *service* dimension of health care systems, the OECD provides a wide range of data relating to the quantitative level of health services, such as total health personnel, general practitioners, specialists, nurses, or in-patient beds. Generally, there is no sign of retreat of public services –and hence, of the state- from the

[195] Rothgang et.al.

[196] Ibid., p. 194.

provision of health care in any of the three systems.[197] Related with the changing role of the state in *regulating* health care systems, they analyze coverage, financing, remuneration, access of service providers to the health care market, access of patients to service providers, and benefit package. The role of the state in regulation decreased in GB in favor of more market coordination, while in Germany the state continues to act as a referee who intervenes whenever deemed necessary. In the US, they see some retreat of the state from direct intervention, but at the same time, a strengthening of hierarchical regulation, which is executed through the private sector.[198] So, for Rothgang et.al., it is hard to talk about dramatic changes in health care systems, but the current policies converge them under the rubric of mixed systems.

Retrenchment of the Health Care State

Those who emphasize the retreat of the state and marketization are critical of the role of international agents. De Vos et.al. analyze the role of the EU, the OECD, the WTO and the GATS in health care reforms.[199] The EU has built a strict financial and political straitjacket that forces European health systems to carry out privatization and cutbacks. The OECD supports a strategy for imposing drastic cutbacks. And through GATS, the WTO wants to force governments to open their public services, including social and health services, to market forces and foreign investors. The increase in health care expenses due to population aging, rising social security

[197] Ibid., p. 196.

[198] Ibid., p. 208.

[199] De Vos et.al.

coverage, fast-growing demand, and the expansion of profit-seeking medical-pharmaceutical industry has led the governments to be more responsive to the cost-containment proposals of international agents. Because of this increase European governments defend the "simple economic logic" that social expenses can only be as high as the available funds, and that consequently –if we want to "save" social security- drastic cutbacks cannot be avoided. For De Vos et.al., this approach leaves many questions unanswered: "Who determines the available funds? Who determines what percentage of GDP can be devoted to health care? Why does the ordinary citizen have to carry the burden of the cutbacks while the medical industry and the pharmaceutical multinationals make outrageous profits?"[200] They analyze the introduction of competition in medical care system (internal market), the state controlled competition between private health insurers (managed competition and directed competition), and market care (managed care). Competition does not enhance efficiency. On the contrary, it leads to an important increase in administrative costs. The money saved by work speed-up, subcontracting, lowered wages, and so forth, appears to be absorbed by higher administrative expenses.[201] The pressure towards cutting back social security payments and the increase in patients' contributions damage redistributive mechanisms. The share for private insurance companies increases. Health care as a right for all is replaced by health care as a commodity for those who can pay and as a minimal safety net for "the poor."[202]

Actually, the World Bank proposals in the field of social security have changed in the mid-1990s as it was realized that marketization led to polarization and

[200] Ibid., p. 261.

[201] Ibid., p. 267.

poverty. The World Bank started to emphasize the need to cover those who were excluded from the social security system. So, in the social security reform debates, there is this neo-liberal approach that promotes cost-containment together with the contribution of those who have the means, and the universalist approach that aims to cover all. A universal coverage would save people from health related anxieties. It would contribute to the welfare and life quality of the people and maintain a feeling of security. They would not postpone seeing a doctor and would not worry about the future. The idea that universal access to basic medical care is "necessary" has become the conventional wisdom guiding welfare reform. However, the content of this coverage should be analyzed in detail. In the WB reform projects there is this standard minimum package in health care which might exclude some vital services. Middle and upper middle classes are encouraged to obtain extra insurance from the private sector while lower classes are left with the minimum package. But this would result in the worsening of those services provided by the state as the upper classes who are content with private sector services would not put pressure on governments for the betterment of public services. There would be very little pressure for the improvement of the quality of services provided by the state. For example in the US, governments are not faced with a serious pressure for health reform as the rich who has political power can have high quality service while the poor do not have the means to oppose the system.

The WB proposes the application of premium-based systems rather than tax-based ones. The premium system, however, might damage social justice. It is a regressive system as both the rich and the poor pay the same percent of their income as premium. This is true also for co-payments. The insistence on premium is based

[202] Ibid., p. 268.

on the will to shape doctor-patient relation as a relation between seller and buyer. When people pay premiums from their incomes they would behave as if they are buying a service and reflect on the quality of service. In this way, there would appear a control mechanism and people would contribute to cost-containment. Health care, however, should not be thought of as a service to be bought and sold. Even in standard economics textbooks it is asserted that health care cannot be left to market forces. Markets function according to demand and supply. When demand is high and supply is low prices will increase. When prices increase, demand will fall. You cannot buy that product unless you have the necessary financial means. This logic, however, cannot be applied to health care. It is unacceptable for a society to leave a person without health care service because he does not have the means to pay for it. When health care becomes a market product there appears dramatic consequences, as is the case in the US, where sick people are denied vital treatment and condemned to death.

Colin Leys also directs our attention to the commodification in health care. He analyzes the change in health services and broadcasting which became political flashpoints in market-driven politics.[203] There is a push by market forces to narrow the "non-market spheres of life," specifically, to restrict the domain in which services are provided by the government. Capital mobility removed the "Keynesian capacity" of national governments –their ability to influence the general level of demand- and made all policy-making sensitive to "market sentiment" and the regulatory demands of transnational corporations. Governments respond to the pressure exerted by capital through narrowing non-market spheres and transforming them into markets.[204]

[203] Leys, *Market-Driven Politics*.

[204] Ibid., pp. 4, 81-83.

Health care is one of those spheres. Leys demonstrates four requirements for a non-market field to be successfully transformed into a market; i.e., for the commodification of public services. First, the services produced by public organizations must be changed into commodities –that is, they must be broken down and reconfigured as discrete units of output that can be produced and packaged in a more or less standardized way (care was replaced by treatments, which could be individuated, standardized and priced). Second, there must be a change in public understanding of the service, so that it is regarded as something the value of which is comprised only of use-value to its consumer, which is also large enough to justify its price (creating a demand for health-service commodities in place of health care; part of the appeal of commodifed health care lies in the aura of science). Third, the workforce involved in their provision must be transformed from one working for collective aims with a service ethic to one working to produce profits for owners of capital and subject to market discipline (subordinating consultants to general managers, curtailing the time allowed for consultations, limiting the time and funding available for research). Fourth, governnments will take steps to minimize the risk that is borne by private firms as they enter into newly marketized spheres perhaps through tax expenditures or direct subsidies (earmarking of 85% of the transitional funding for long-term care to the private sector via local authorities; public-private partnerships diverted substantial public funds to for-profit companies).

For Leys, the process started in GB with the contracting out of the ancillary hospital services. Then a new hierarchy of general managers was installed in the hospitals. Spending was cut back below the growth of needs. Lengthening waiting times boosted interest in private health care and led to a rapid expansion of private medical insurance in the 1980s. The number of NHS beds declined; private bed

capacity expanded. NHS hospitals became self-financing "trusts" run by government appointed boards of directors, providing services to patients in return for payments by "purchasers" (100 health authorities – GP group practices that opted to become fundholders). Responsibility for the long-term care of the chronically ill, the frail elderly and mentally handicapped was transferred from the NHS to local authorities who might charge money. Long-term care ceased to be a health-service responsibility and was no longer free, except for the very poor. For-profit long-term care industry developed.[205] Leys observes the results of this process: deprofessionalization, inequality in provision, and unduly high costs. He claims that the erosion of the non-market sector threatens to undermine social solidarity and weakens the notion of common citizenship and erodes our capacity for collective reflection and debate about the kind of society in which people want to live.[206]

Leys criticizes the Blair government for aligning itself fully with the US-led drive to open all public services, including health care, to international provider competition.[207] The British NHS, which started as an experiment in universal, comprehensive, free at the point of service, tax-funded, health service provision, is now undergoing a radical transformation. Today it is a marketized system, with regulation, but with the government withdrawing from being the provider of health services to just being the funder. For Leys, the changes began in the 1980s, when the hospital sector was re-organized internally along business lines: power was transferred from hospital doctors to general managers, and non-clinical work was outsourced. In the 1990s there was the introduction of the so-called "internal

[205] Ibid., chapter 6.

[206] Ibid., pp. 4, 213, 217.

[207] Colin Leys, "Health Care between Politics and Markets".

market," in which all hospitals became financially speaking independent "trusts," as they were called, selling their services to "purchasers," the health authorities at the district level. At the same time during the 1990s, the infrastructure began to be privatized, and this was continued by the Labor Party when it took office in 1997.[208]

In another critical account of the changes in health system in GB, Allyson M. Pollock examines the dismantling and privatization of the NHS.[209] For Pollock, chronic underfunding and persistent attacks from the Right after 1979 led to the displacement of integration and needs-based planning by market ideology. The internal market weakened the immunity of the NHS to market forces. Under New Labor, instead of the reintegration and the restoration of the NHS's founding values, a series of new market solutions were prescribed. As a result, costs were driven up, not down; the bureaucracy continued to expand, instead of decreasing; inequities of all kinds were aggravated, not reduced, and new inequities were created; more services that had been free were to be charged for, or would largely disappear from the NHS, to be provided only by the private sector, for those able to afford them.

Comprehensiveness and universality became things of the past. Inequalities of all kinds flourished.[210] Before the establishment of the NHS in 1948, doctors had to decide whether a patient could afford to pay or should go without care. The NHS ethos is based on the ideal that providing health services would be neither an opportunity to make money nor a charity.[211] The NHS aimed to make health care a right, and no longer something that could be bought or sold. However, this ideal has been destroyed and individualism and business tactics have replaced collectivism and

[208] Ibid.

[209] Pollock.

[210] Ibid., p. 33.

[211] Ibid., p. 14.

compassion. Privatization has led to the destruction of services, universality, and equality. Pollock writes about the problems created by the right of hospital doctors to exercise private practice. Those who see the doctor in his private office can bump ahead of the NHS queue,[212] a practice with which we are familiar, here in Turkey. Pollock also mentions the role of the WB, the IMF, the WTO, the WHO, and the European Commission in transforming health care into a commodity.

The Role of the WB and the IMF

The role of the WB and the IMF is much more determinate in developing countries. Especially in countries that were in economic crisis these international organizations pressed for health reforms as a condition for borrowing. The IMF required structural adjustments to reduce the huge public debts that governments had contracted in previous years and were in part responsible for the crisis. Because a large part of public expending correspond to social services (health, education, and welfare), the IMF and the WB required governments to reduce them. It was at this juncture that the WB began to have a prominent role in international health policy; by the end of the 1980s, the WB had become the major international health lender and began to assist countries to prepare health reforms based on neoliberal economic principles.

The underlying principle of the neoliberal health reforms is the belief that the private sector is more efficient than the public sector. Based on this belief, neoliberal health reforms advocate a reduction of the role of governments. In the WB's vision of a neoliberal state, the government function in public health is to regulate while the private sector provides health and medical care services. One of the objectives of the

[212] Ibid., p. 15.

reforms was to free central government funds to pay for huge public debt, and shifting the financial burden of public services from central governments to provinces was an expedite way to accomplish it. In 1993, the WB devoted the World Development Report to the health sector. In this document, in addition to reinforcing the decentralization and privatization strategies, the WB included the need to improve equity and allocative efficiency through guaranteeing universal access to a basic package of services, determined according to what each country could afford and based on cost-effectiveness principles. The WB model included the creation of third party administrators responsible for collecting and administering mandatory health insurance fees and government subsidies, and for contracting and paying service providers. Users, based on what their insurance premiums could afford, would be able to select among different types of health plans and providers. The WB's expectation was that the reforms would increase equity and efficiency, and improve quality of care and users' satisfaction.

Bob Deacon analyzes a 1997 health sector strategy paper of the World Bank as an indicator of the Bank's leaving behind some of the worst excesses of a faith in free markets and deriving some positive lessons from countries with primarily public health services.[213] In the report it says that

> this involvement by the public sector is justified on both theoretical and practical grounds to improve equity, by securing access by the population to health, nutrition and reproductive services; and efficiency, by correcting for market failure, especially where there are significant externalities (public goods) or serious information asymmetries (health insurance)...the experience in developed and middle income countries is that universal access is one of the most effective ways to provide health care for the poor.[214]

[213] Deacon.

[214] Cited in ibid., p. 8.

Although there is an emphasis on market failure in health care the conclusion is that a mix of private and public services is required, and because of presumed resource constraints, the public sector is often best to concentrate in those areas where there are large externalities, such as preventive public health services.[215] The WB promotes the availability of health care to all, but limits this available health care to a standard package. The way this standard package is defined is important. The WB imposes a social insurance model with a high degree of private sector involvement. As already mentioned, the premium system might contradict with the principles of social justice and the involvement of the private sector has many disadvantages in terms of efficiency and equity.

Homedes and Ugalde analyze the failure of the neo-liberal health reforms sponsored by the IMF and the WB in Latin America.[216] During the 1980s several Latin American countries, including Brazil, Mexico and Chile, started implementing some of the policies promoted by the WB while many others did not until the 1990s. Technical, logistic, political, and financial problems have surfaced everywhere, and most countries have implemented only some aspects of the reform, for example, decentralization or the definition of a basic package, and/or some limited privatization of medical care. The WB attempts to increase the role of the private sector in the management and delivery of health services has had limited success in Latin America.[217]

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[215] Ibid.

[216] N. Homedes and A. Ugalde, "Why Neoliberal Health Reforms Failed in Latin America." *Health Policy*, 71(1) (2005): 83-96.

[217] Ibid., p. 84.

The WB and other international agencies have been more successful in promoting the decentralization of health services.[218] Homedes and Ugalde focus on the negative results of health reform in Chile and Columbia. For them, the reforms have failed to achieve the stated objectives and have in fact caused the opposite results: increased inequity, less efficiency, and higher dissatisfaction, without improving quality of care. They observe that Latin American countries, 10 and 20 years after the implementation of neo-liberal reforms, are spending more resources on health care without corresponding improvements in efficiency; high percentages of the population do not still have access to care; in some regions inequities intensified; and often there is administrative uncertainty. The financial sustainability of the sector has been placed into question because of increased health expenditures: today there are more administrators, higher salaries, higher expenditures for medicines, and more foreign debt as a result of the WB and IDB reform loans. They assert that as the principal beneficiaries of these reforms are transnational corporations, consultant firms, and the WB's own staff, the WB has persisted in promoting these unsuccessful policies.[219]

The impact of the WB policies can be observed also in Central and Eastern European countries. Before the dissolution of the Soviet Bloc, these countries had communist national health systems, which were originated after the Russian revolution. The health care systems of communist countries were funded through the state budget, and very strongly centralized. Facilities were the property of the state and providers were state employees. Now, they have moved from tax-based systems to social insurance. This involves a transition from state provision to privatization –

[218] Ibid., p. 86.

[219] Ibid., p. 92.

the main areas of which are primary care and pharmaceutical services– and from allocated care, where patients were allocated to a specific hospital with specific qualifications, to more patient choice, and finally, from a centralized role of the government to something like shared power between insurance organizations, professionals and the government.[220]

There was no trend in the direction of NHS systems. This would have been probably a more rational option at that time because the costs of transforming the systems towards social insurance were fairly high and there were also a number of advantages to a tax-based national health service. On a negative side of their own past experience is their experience with communist state regulated health. There was also the inspiration from foreign models and support. The positive inspiration and bilateral support came from the old social insurance systems, like those in Germany and Austria. The expectation of higher incomes, especially among the health care providers, should also be noted. They expected that they would drive Mercedes cars like their counterparts in Germany. The international support came from the WB, the EU, the OECD, and the WHO.[221] In Central and Eastern Europe the trend is towards social health insurance, while it is towards national health service in Southern Europe.

Whether it was through the WB proposals or not, there has been a change towards universalization in South Korea, Taiwan, Mexico, Brasilia, and Turkey. In countries where a large portion of the population is without any insurance, health reforms carried the task of covering all. Universalization is promoted together with

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[220] Peter Groenewegen, "Health Sector Reform in Eastern Europe." Paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, Boğaziçi University, İstanbul, 2005.

[221] Ibid.

market reforms to increase efficiency. More than cost-containment the need to cover all was highlighted.

Southern European Health Care Systems

The health care systems in Southern Europe entered into a process of universalization starting from the late 1970s. It is the first time in history that mature, or pretty mature, Bismarckian health care systems were turned into national health services.[222] With the exception of Italy, which was already a democracy, the end of the dictatorships was crucial in terms of allowing this move. All these reforms were passed when left-wing parties were in office. Joining the European Community was another factor that explains this move towards national health services. Southern European countries adopted national health services to close the gaps in their protection systems.[223] It is to be noted, however, that none of the South European health systems share the tax-financing approach typically followed by the British and Scandinavian health services. Though all four countries have repeatedly stated the objective of shifting fully from contributions to taxes, none of them has (yet) accomplished this shift. The persisting occupational differentiations regarding access and treatment (especially in Portugal and Greece), the large territorial disparities and the mixed form of financing have generated quite extensive distributive distortions in the structure of health care opportunities in Southern Europe, despite their universalization endeavors and overall universalistic "rhetoric." Another significant

[222] Ana M. Guillén, "Health Sector Reform in Southern Europe." Paper presented at the *Workshop on Health Reform in Comparative Perspective*, Social Policy Forum, June 17-18, Boğaziçi University, İstanbul, 2005.

[223] Ibid.

peculiarity of South European health care regards its public/private mix. In Britain and Scandinavia, the establishment of a national health service has not only implied full universal coverage and structural standardization, but also a crowding out of private providers (especially private clinics or hospitals) from the health sector –or at least a clear separation between the spheres and roles of public and private medicine. The public/private mix has evolved in a different way in Southern Europe. Here the establishment of a national health service (Italian or Iberian style) has not promoted a strengthening of the public sphere and the crowding out of private provision, but a peculiar *collusion* of public and private –often with great advantages and profits for the latter.[224]

Guillén and Matsaganis analyze the health systems in Greece and Spain. In Greece, the national health service in operation since 1983 is universal in theory, but has failed in practice to replace social insurance, coexists with a large private sector (with which it often develops improper relationships), suffers from inefficiency and corruption, and registers very low percentages of patient satisfaction.[225] In contrast to Greece and Portugal, health care in Spain was universalized not merely in legal terms but also in practice. Education and health services are financed totally out of taxes. By implication, the degree of tax funding in the Spanish national health service (and, incidentally, in Italy) is higher than in those traditionally tax-financed ones in Britain and Scandinavia.[226]

[224] Ferrera, p. 24.

[225] Guillén and Matsaganis, p. 122.

Challenging the Commodity Status of Health Care

Health sector reform has brought to the fore a big debate on the nature of health care as a commodity. The pressure for privatization can be challenged not only with the help of citizenship and human rights literature, but also with the help of standard rules of economics. Unlike the other areas of life, where the control of market forces can still be viewed as tolerable, the control of the market over health care is literally a problem of life-and-death. In the domain of social policy, health care has a peculiar character. For example, we witness that privatization of the educational system can be supported in terms of a merit-based perspective (with scholarships granted to the successful students), without provoking public reproach. Or, people's reluctance to work can be accounted for the problem of unemployment, again without provoking reproach. In health care, however, a discrimination as to who deserves treatment would be intolerable, or blaming people for their illnesses would be utter nonsense. Even when privatization was embraced as a remedy to all, no one proposed to leave health care completely to market forces. It was the increasing role of the private sector that was advocated. There is a common sense acceptance that a complete commodity status of health care would strengthen inequalities, rise expenditures, and create an inhuman environment.

Nobel Prize-winning economist Kenneth Arrow's 1963 article, "Uncertainty and the Welfare Economics of Medical Care," has become a seminal essay in the field of health economics.[227] Its fundamental contribution is a detailed and thoughtful

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[226] Ibid., p. 128.

[227] Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care." *The American Economic Review*, 53(5) (1963): 941-973. *Journal of Health Politics, Policy and Law* published a special issue on Kenneth Arrow and the changing economics of health care (vol.26, no.5, 2001). Coming from diverse backgrounds the contributors use Arrow's article to address a range of present day health policy questions. Later on, in 2003, this volume was published as a book by Duke

comparison of the deviations between the workings of markets for medical care and the competitive ideal. As Arrow demonstrates, a variety of factors prevents the medical care market from yielding an optimal allocation of resources. He argues that while medicine is subject to the same models of competition and profit maximization as other industries, concepts of trust and morals also play key roles in understanding medicine as an economic institution and in balancing the asymmetrical relationship between medical providers and their patients. His conclusions about the medical profession's failures to "insure against uncertainties" helped initiate the reevaluation of insurance as a public and private good.

In his analysis of the health care sector, Arrow identifies several important market gaps. First, because the health care environment is particularly complex, characterized by considerable uncertainty, complete markets would imply that markets must exist for *contingent contracts*. A second type of market gap, which, along with excessive prices and moral hazard, deters insurance purchase, involves the absence from the market of certain insurance policies that would ideally be available. A third important market gap arises because many types of information are not marketable. Lack of information is central to many of Arrow's arguments. After falling ill, patients may be unaware of the various treatment options and associated probabilities of various outcomes. They may be unaware of the natural course of disease and also of the quality of their physician. In an ideal competitive environment, information would be marketable so that individuals could purchase the

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University Press with the title *Uncertain Times: Kenneth Arrow and the Changing Economics of Health Care*.

desired information. Given the marketability problems in the health care sector, Arrow contends that non-market norms and institutions arise to fill the gaps.[228]

Asymmetric information between buyers and sellers is sufficiently important here to have led to various institutional arrangements, including professional norms, licensure, and nonprofit institutions, in particular nonprofit hospitals.[229] The doctor-patient relation can never be an equal relation between a buyer and a seller as the patient does not have the necessary information. When a doctor says a patient needs a surgery, that patient has to believe in this. When the service is provided by the private sector, patients cannot be sure of this necessity. The health service providers might be trying to "sell" an unnecessary product, either in the form of a diagnosis test or a certain treatment.

Those who support the commodification of health care emphasize the merits of competition. Through the usual mechanisms of competition a "quality product" should emerge since providers will compete with each other in quality, price, and satisfaction of consumers to keep their market-share and/or profits. For their part, "consumers" and "purchasers" will be free to choose among providers selecting the best "buy" suited to their individual needs. Costs will decline, and quality will be maintained or will improve. More care will be accessible to more people on their terms, not the doctor's. The laws of competition will reduce waste, overuse, and error to everyone's advantage.

There is ample reason to question the validity of this line of reasoning even from the purely economic point of view. In the US, where health care is treated as a

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[228] Michael Chernew, "General Equilibrium and the Marketability in the Health Care Industry." *Journal of Health Politics, Policy and Law*, 26(5) (2001): 885-897, pp. 888-890.

[229] Frank A. Sloan, "Arrow's Concept of the Health Care Consumer: A Forty-Year Retrospective." *Journal of Health Politics, Policy and Law*, 26(5) (2001): 899-911, p. 900.

commodity much more than other countries, costs are rising, services being reduced, young and healthy subscribers being favored over old and sick ones, emergency rooms being closed, etc. This means competition and consumer choice do not lead to efficiency and equality.

Thomas Rice questions the belief that relying on consumer's own choices will result in better social welfare.[230] He cites three instances in which providing choice can make an individual worse off: First, when individuals do not know which choices will make them best off; second, when individuals cannot obtain and/or process the necessary information about alternative choices; and third, when the provision of choice, per se, reduces utility.[231] He cites three instances in which providing choice can make a society at large worse off: When allowing some people to have certain choices reduces the utility of others who do not have such a luxury, when spill-overs from the choices of one group negatively affects others, and when allowing choice results in societal costs that exceed benefits.[232] Health care fits these instances. Rice makes a comparison between health care systems in other countries and that in the US. The relative lack of choices in other countries, as compared to that in the US strongly reflects their concerns about equity. Universal coverage implies a lack of individual choice about whether to have coverage (and whether to pay for it through higher taxes), but makes health care services affordable to the entire population. Similarly, for most basic health care services, co-payments are low, another way of transferring incomes from the healthy to the sick. The fact that there tend to be uniform health insurance benefits is also symptomatic of less choice,

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[230] Thomas Rice, "Should Consumer Choice be Encouraged in Health Care?" In *The Social Economics of Health Care*, ed. J. B. Davis (London and New York: Routledge, 2001).

[231] Ibid., p. 11.

[232] Ibid., p. 14.

but it results in most of the population having comparable coverage. Finally, the lack of hospital competition in most countries, coupled with strong limits on the diffusion of medical technology, also reduces choice, but in doing so, puts most citizens on a relatively level playing field when seeking health services. Choice is a hallmark of the US system, but it has resulted in larger inequities than in other countries.[233] Also, European systems are much more efficient as they rely on a single buyer. So, we can conclude that in health care choice is not a virtue;[234] its limitation would not only enhance equity, but increase efficiency as well.

Edmund D. Pellegrino challenges the commodity status of health care from an ethical point of view.[235] He refers to the notion of health care as common good, a moral obligation a good society owes to all its members. Health, or at least freedom from acute or chronic pain, disability, or disease, is a condition of human flourishing. Human beings cannot attain their fullest potential without some significant measure of health. A good society is one in which each citizen is enabled to flourish, grow, and develop as a human being. A society becomes good if it provides those goods which are most closely linked to being human. Health care is surely one of the first of these goods.[236] He finds the ethical consequences of commodification –that appears to be inefficient also in economic terms- unsustainable and deleterious to

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[233] Ibid., p. 31.

[234] Zygmunt Bauman explains the negative attitude towards welfare state in the last twenty years with reference to, among other things, the advent of the consumer society and the entrenchment of consumerist culture. Consumerism puts the highest premium on choice: choosing is a value in its own right, perhaps the sole value of consumerist culture which does not call for, nor allow justification. If the marketing of products cannot operate without promoting the cult of *difference* and choice, the idea of the welfare state makes little sense without appealing to the idea of the *sameness* of the human condition, human needs and human rights. Consumerism and the welfare state are therefore at cross-purposes. For him, the odds are against the welfare state; the pressure of consumer mentality is overwhelming (Bauman, pp. 58-59).

[235] Edmund D. Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic." *Journal of Medicine and Philosophy*, 24(3) (1999): 243-266.

patients, physicians, and society. Such an ethical position shows us that the problems of escalating health care costs are not simply economic questions or questions of public policy. The management of health care resources poses moral questions as well. How a society allocates its resources is an indication of the moral commitments it holds and its moral vision.

Physical health is defined as a "basic need" together with autonomy of agency, by Doyal and Gough.[237] Appropriate health care is among the "intermediate need"s which are adequate nutritional food and water, adequate protective housing, a non-hazardous work environment, a non-hazardous physical environment, security in childhood, significant primary relationships, physical security, economic security, safe birth control and child bearing, and basic education. They think the notion that all people have basic human needs and that we can chart how far they are met or not met is central to any coherent idea of social policy and social progress. If human needs are the universal preconditions for participation in social life, then all people have a strong right to need satisfaction. This follows because membership in all social groups entails corresponding duties, yet without adequate levels of need satisfaction a person will be unable to act in accordance with those duties. It is contradictory to ask of someone that they fulfill their social duties, yet to deny them the prerequisite need satisfaction which will enable them to do so. This is why social rights of citizenship follow from an unambiguous concept of human need. Basic human needs are the universal prerequisites for successful and, if necessary, critical participation in a social form of life.[238] This is in line with Marshall's analysis of

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[236] Ibid., p. 259.

[237] Len Doyal and Ian Gough, *A Theory of Human Need* (New York, Guilford Press, 1991).

[238] Ian Gough, "What are Human Needs." In *Social Policy and Social Justice*, ed. Jane Franklin (Cambridge: Polity Press, 1998), pp. 52-53.

citizenship, which is based on the establishment of three rights (civil, political, social) for the functioning of all.

Following this framework Coote and Hunter assert that the first goal of health policy should be to promote health for all on an equitable basis, to give everyone the opportunity to enjoy as much good health as possible.[239] They emphasize the importance of these principles in the field of health care: Appropriate health services, equity, autonomy, social solidarity, democratic legitimacy, and value for money.[240] Their framework supports a national health service which is there for everyone, not merely a residual service for those unable to purchase private health care. They say we may accept that people with different levels of income drive different cars, or live in homes of different sizes, or eat different foods –because of what they can afford. But we cannot, within this framework, accept that the quality of health care should vary according to the patient's means. The idea that, in times of scarcity, the national health service can be "saved" by targeting resources on needier groups carries the seeds of its own destruction. If queuing systems or hospital conditions encourage the middle classes to opt out in significant numbers, the political base for an inclusive service will soon erode. Those who "go private" will be less and less content to pay for a national health service that they think they can do without. Starved of funds, the service will deteriorate further, lose more support and spiral into decline.[241] They give the US as a bad example where targeted services became poor services. As Richard Titmuss argues, services for the poor are always poor services. When

[239] Anna Coote and David J. Hunter, "Better Health for All." In *Social Policy and Social Justice*, ed. Jane Franklin (Cambridge: Polity Press, 1998).

[240] Ibid., p. 262-263.

[241] Ibid., p. 263.

confined to the poor part of the population notorious for its lack of political muscle and public audibility, a social service cannot improve.

Health care is defined as a basic human right by McMaster,[242] Yalnizyan,[243] and Farmer.[244] McMaster uses "capabilities approach" which was advocated by Martha Nussbaum, Hilary Putnam, Amartya Sen and David Levine. The approach rejects the notion that monetary values and "happiness" are adequate measures, or assessments, of welfare. Instead, "capabilities" refer to the abilities or freedoms to enjoy "valuable functionings." We are poor not primarily because we lack goods, but because we lack the ability to be and to do things that are essential to leading a human life. Freedom is dependent on age, social role and physical and social conditions.

It is the latter group of factors that relates most strongly to health and health care; suggesting health care is an integral part of social justice. For Nussbaum central human capabilities amount to rights of opportunity, and include life (including freedom from premature mortality) and bodily health (including reproductive health, adequate nourishment and shelter) and bodily integrity (freedom from violence, rights to mobility and choice in reproductive matters). McMaster argues that given the foundational right to life and freedom from premature mortality access to non-frivolous health care can be viewed as a basic human right. Yalnizyan emphasizes the role of the state in putting boundaries and rules around markets, to decommodify

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[242] Robert McMaster, "Global Health Policy Trends: Health Policy, Poverty and Economics as Uneasy Bedfellows?" Paper presented at the *10th International Karl Polanyi Conference: "Protecting Society and Nature from the Commodity Fiction."* Boğaziçi University, İstanbul, 13-16 October, 2005.

[243] Armine Yalnizyan, "De-commodification and Re-commodification: Thoughts on the Shifting Economics of Health Care." Paper presented at the *10th International Karl Polanyi Conference: "Protecting Society and Nature from the Commodity Fiction."* Boğaziçi University, İstanbul, 13-16 October, 2005.

[244] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, with a foreword by Amartya Sen (Berkeley, Los Angeles, London: University of California Press, 2003).

certain aspects of life. Otherwise, human rights like health care would be damaged by corporate and capital rights. Farmer proposes an agenda the central contributions of which to future progress in human rights are linked to the equitable distribution of the fruits of scientific advancement. He argues that equity is the central challenge for the future of medicine and public health. Medicine-as-commerce leads to inequalities of access and outcome in the health care arena. Farmer analyzes various cases of health right violations in different countries and warns us that it is time to take health rights as seriously as other human rights.

Inequalities in Health

If you define health care as a basic human right it must be provided to everyone on the basis of equality. However, inequalities might persist even in the absence of (absolute) material deprivation and in countries that have universal access to health care. There have always been social inequalities in health – differences in health outcomes between social groups defined by variables such as class, race, gender, and geographical location. Significant inequalities exist within and between countries. Insofar as the topic of health equity is addressed at all, the focus has been restricted to access to health care. The right to health is limited to the right to health care. However, such an approach neglects the variety of social forces that influence health. Access to medical care is certainly an important factor in the preservation and restoration of health and is one element in assessing health equity, but by no means the only one.

The distribution of ill health broadly follows the distribution of income. Those with lower incomes tend to have higher rates of morbidity and mortality, for a

number of reasons. Income is a major determinant of the standard of housing individuals and families can obtain, of where they live, of their diet, and of their ability to remain warm and well-clothed. All of these factors are significant for health. Moreover, the quality of life (and therefore of health) is increasingly influenced by access to the goods and services provided by the state. Even where these are in principle distributed on a universalistic basis, in practice they are allocated neither equally nor in terms of need. While a more egalitarian allocation of medical resources could not remove inequalities in morbidity and mortality, it is evident that present inequalities in resource allocation serve to reinforce more fundamental class differences in health and illness.[245]

British scholars prepared two very important reports which reveal the persistence of inequalities in health despite the existence of the British NHS. In 1977 the Secretary of State for Social Services of the Labor government appointed a Research Working Group to examine inequalities in health. The Working Group completed its review in 1980 (called the Black Report). It concluded that the poorer health experience of the lower occupational groups applied at all stages of life. The Working Group argued that much of the problem lay outside the scope of the NHS. Social and economic factors like income, work (or lack of it), environment, education, housing, transport and what are today called "life-styles" all affect health and all favor the better-off. Those belonging to the manual classes made less use of the health care system in a number of different respects, yet needed it more.[246]

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[245] Doyal with Pennell, p. 26.

[246] Peter Townsend, Nick Davidson and Margaret Whitehead, "Introduction to *Inequalities* in Health." In *Inequalities in Health: The Black Report* and Margaret Whitehead, *The Health Divide*, now published in a single volume, edited by Peter Townsend and Nick Davidson (England: Penguin Books, 1990), p. 2.

In January 1986 the Health Education Council's Director General, David Player, commissioned Margaret Whitehead to update the evidence on inequalities in health.[247] Improvements in the health of the poor have failed to keep up with improvements enjoyed by the prosperous.[248] Attention is drawn to all the causes of death showing a marked class gradient which does not appear to be linked to smoking, alcohol abuse or any other known risk factor.[249] There is widespread agreement on three main premises in these reports: that in absolute terms the standards of health of the population as a whole have improved since the Second World War; that despite that improvement serious social inequalities in health have persisted; and that socio-economic factors have played an important part in maintaining and even increasing these differentials.[250] So, the task of the state cannot be limited to the provision of universal health care to all. The state should take measures to provide equal opportunities of benefiting from the health services and to combat social and economic factors that maintain health inequalities.

Conclusion

From the late nineteenth century onwards, we witness the eventual transformation of medical care from a private commodity to a social service in Europe. Before, the state was held responsible for taking public health measures and left the care of the sick to private physicians and charitable institutions. Industrialization, urbanization

[247] Ibid., p. 6.

[248] Ibid., p. 9.

[249] Ibid., p. 11.

[250] Ibid., p. 13.

and democratization brought the increasing state involvement in health care, including curative services. The process started in the late nineteenth century and gained moment after the Second World War. Health care –both the preventive and curative services– became a major welfare duty of the state. It was recognized as a social right that all citizens should benefit regardless of class, status, gender, race or geographical location. Although in the developing countries health care systems were impaired with hierarchy and low coverage, its social right character was acknowledged. However, the states of both developed and developing countries are faced today with increasing pressure to expand the role of the private sector and limit the state's function with regulation. Although a full-scale privatization is never put on the agenda, the emphasis on it brings us back to the period before late nineteenth century. The broad consensus on the basic-citizenship-right character of health care engenders a serious reaction against this trend. There is no doubt that health care will keep on being a contested domain as long as costs rise due to the rise in life expectancy, rise in demand and improvement in medicine. Here in this chapter, the pressures on health care state and the responses of different systems were analyzed. Both the welfare and health care typologies were elaborated in order to get a better understanding of the individual cases. They were examined in terms of their role in bringing equality and expanding the citizenship status of people.

CHAPTER THREE

FROM THE HEALTH OF THE POPULATION TO THE HEALTH OF THE INDIVIDUAL: EARLY REPUBLICAN HEALTH CARE POLICIES AND THE RUPTURE IN THE 1950s (1920-1960)

Introduction

By the time Independence War ended, there was a greatly reduced population left which was scourged by contagious diseases such as malaria, tuberculosis, trachoma and syphilis. Before the Independence War, the Balkan and First World Wars had already decreased the population and deprived it of its health. Although public health measures had started to be taken from the mid-nineteenth century onwards, like the establishment of the Cholera Combat and Quarantine institutions, Bacteriology Laboratory, Vaccination House, or the enactment of some regulations on epidemic and contagious diseases, their functions had been interrupted by the wars. So, immediately after the foundation of the Turkish Grand National Assembly in 1920, the Ministry of Health and Social Assistance was established.

Early Republican governments faced the urgent need of increasing the population and improving its health standards. The 1920s and 1930s constituted the recovery period of the country. A new nation-state was being established and the population, which was expected to constitute the "nation," was low, composed of unhealthy and weak people. They had been worn down during the wars, struck by the epidemics. Nearly half of the population of 12 million was reported to be malaria stricken while there were around a million people suffering from tuberculosis. In addition to malaria, trachoma and tuberculosis that had spread easily due to the war

conditions, venereal diseases, and necatoriasis that spread throughout the Black Sea shores caused great damages. There were about 1 million tuberculosis patients. 250,000 people were orthopedically handicapped, 250,000 were suffering from syphilis, and another 250,000 from trachoma.[251]

Under these conditions, first priority was to be given to health issues by the state. The Kemalist governing elite were aware that able people were needed in order to realize the social and economic transformation they planned. So, the early Republican governments worked hard to create this healthy "nation" through pro-natalist policies and public health measures. These two would not only increase the population but also make it robust, which is indispensable for national defense, economic and social life, and hence, all aspects of life. Population was the most important input of national defense, and economic and social development.

Here, the primary objective of health care was not the individual, but the biological population as a whole. And health care is provided because it is perceived to be in the best interest of the nation that there exist a statistically significant number of healthy, productive, and fertile individuals. Within this context, the state took the responsibility of preventive care, which might be considered to be the "science of masses," rather than curative services, which might be considered to be the "science of individuals."[252] A holistic approach was adopted in health care and the establishment of health organization, the enactment of related legislation, and the expansion of staff were all in line with this. The population and health policies of the early Republican period were successful as can be seen from the rise in population and the improvement in health indicators; the relevant data will be given throughout

[251] Kâhya and Erdemir, p. 322.

[252] David G. Horn, *Social Bodies: Science, Reproduction, and Italian Modernity* (Princeton, New Jersey: Princeton University Press, 1994), pp. 42-44.

the text. The accomplishments of this period made it possible in the 1950s for the Democrat Party governments to adopt a more individualistic approach towards health care. During the DP era, the state took the responsibility for curative services, and more than public health, hospitals and health insurance projects were on the agenda. The DP period might be characterized not only by this shift from preventive care to curative services, but also by the rising demand for health care, the commercialization of medicine (rise in private practice and advance of patent medicine), and the consolidation of an "inegalitarian corporatist" structure in hospital services. Although the DP governments did not add that much to the social security measures of the 1940s, their commitment in the field of health care cannot be ignored.

Here in this chapter the early Republican policies and mentality related to health care and the rupture in the Democrat Party period will be presented. After giving a brief account of the early Republican policies in terms of legislation, organization and personnel I will focus on pro-natalist policies. The rupture in health care in DP period will be analyzed afterwards together with other welfare developments. Such an analysis will present a picture of welfare and health care before the coup of 27 May which brought, on the agenda, the socialization of health services.

Early Republican Health Care Policies

Starting from mid-nineteenth century the state became active in public health.[253] Especially from the rule of the Sultan Mahmud II and during the Tanzimat era, public health, social welfare, and public education applications expanded dramatically within the borders of the Empire. The roots of the Ministry of Health and Social Assistance (*Sıhhat ve İçtimai Muavenet Vekaleti*) go back to 1912, to the Ministry of Internal Affairs, Public Health Directorate (*Dahiliye Nezareti Sıhhıye Müdüriye-i Umumiyesi*). The Ministry of Interior Affairs was restructured as the Ministry of Interior and Health (*Dahiliye ve Sıhhıye Nezareti*) in 1914 and the sanitary affairs began to be carried out from one center. In 1914, the Committee of Union and Progress government changed the status of the Ministry of Health, in order to increase the feasibility of resources and services by organizing the public health issues within a central body.

The Ministry of Interior and Health had three main subsidiaries: the Public Health Directorate (*Sıhhıye Umum Müdürlüğü*), the Quarantine Administration (*Karantina İdaresi*), and Hicaz Sanitary Administration (*Hicaz Sıhhıye İdaresi*). Besides the institutions under this ministry, there were two main health

[253] Özbek considers the period that starts with the early nineteenth century Ottoman reforms and ends with World War II as a single period during which the social sphere extended gradually and the government's concern with the welfare and productive capacities of the population increased. He argues that the expansion of the social sphere and state activity towards regulating that sphere should be considered as the formation of a modern welfare system in the Ottoman-Turkish context. Inherited from the global transformation of "state" during the previous three centuries of the Ottoman Empire, the Republic of Turkey was established on the very assumptions of a modern social state. Policies towards the improvement of the physical conditions of public health and the improvement and the spread of public education were two major and vital components of the Republican regime's social policies. The purpose of increasing the legitimacy of the regime and improving the productive capacity of the population were common to both the late Ottoman and early Republican periods. Nadir Özbek, "Osmanlı'dan Günümüze Türkiye'de Sosyal Devlet." *Toplum ve Bilim*, 92 (Bahar 2002): 7-33; for his analysis of the late Ottoman welfare system within the context of the formation of the modern state, see Nadir Özbek, *Osmanlı İmparatorluğu'nda Sosyal Devlet: Siyaset, İktidar ve Meşruiyet, 1876-1914* (İstanbul: İletişim Yayınları, 2002).

organizations: the Ottoman Red Crescent Society (*Osmanlı Hilâl-i Ahmer Cemiyeti*) and the Ottoman Society for Tuberculosis Combat (*Veremle Mücadele Osmanlı Cemiyeti*).

The late Ottoman period might be characterized by the emphasis on preventive care. Curative services were left to private physicians or hospitals as beneficial foundations of sultans. From 1871 onwards, the Ottoman state appointed doctors to province and county centers with the title "country doctors" (*memleket tabibi*). They had to inform the central administration about the epidemic diseases and take necessary measures. Two days of the week they examined the poor free of charge. In 1913, local health authorities (*il sağlık müdürlüğü*) were appointed to province centers. They were administratively in charge of all health issues of the province, especially preventive care and sanitary services. The title "country doctor" was replaced by "government doctor" (*hükümet tabibi*). Government doctors executed preventive care and sanitary checks. They were responsible for inspecting work place and food sanitation, forensic medicine, death and birth records, and inspecting doctors, pharmacists, and midwives doing private business.[254] Although government doctors could perform curative services in certain times like two days in a week or every week day in the morning, their position was rather administrative. They were expected to be the "eyes of the state" in the provinces (*vilayet*) on health issues, especially on epidemics. It was in this period that the services related with epidemic diseases and environmental health could reach the countryside.

Immediately after the establishment of the Grand National Assembly, the Ministry of Health and Social Assistance (*Sıhhat ve İçtimaî Muavenet Teşkilatı*) was established in 1920. The major task of the Ministry was to reduce death rates, and the

[254] Aydın, "Cumhuriyet Döneminde Sağlık Örgütlenmesi." pp. 142-143.

social assistance department was established to deal with the problems of Turkish emigrants from Balkan countries.[255] The Minister, Adnan Adıvar, tried to collect data on the number of doctors, nurses and beds in hospitals and brought the related legislation from İstanbul. His successor Refik Saydam who was the minister for 16 years with intervals, actualized the concepts of preventive medicine and public health. During this period, the main objectives of the health care system were to establish preventive care and eradicate highly prevalent infectious diseases.

The MHSA established special service organizations that had central and provincial units (vertical organization) to combat these diseases. The government doctors fought against typhus, typhoid, smallpox and dysentery. Preventive care was given top priority and the doctors assigned to this work were given extra incentives, which secondary and tertiary doctors did not. Doctors were employed in such organizations on a full-time basis with high salaries. Doctors dealing with heavy diseases (i.e., the most widespread, the most mortal and incapacitating, and the most damaging to the labor force) were not allowed to have private offices. The reason for that was that they earned more than the members of the parliament. The salary of a physician of a malaria specialist exceeded that of a governor, the salary of the president of the battle against trachoma was three times that of a deputy. All preventive services were free of charge. The Law of Public Health (*Umumi Hıfzıssıhha Kanunu*), which is still in force with minor changes, was issued in 1930. By this law it was accepted that the protection of the health of the nation was a state mission. The law reflects the priority of the struggle against infectious diseases.

[255] Ferhunde Özbay, "Nusret Fişek ve Demografi." unpublished speech text, 1996, p. 2.

The struggle against infectious and epidemic diseases can be considered to have been successful.[256] The number of cases declined, the seats of diseases were removed and plague and cholera were eradicated. We should keep in mind the probability that not all cases were reported to the MHSA. Still, the battle against infectious diseases attained its goal, and the rise in the population attests to its success. The population of Turkey, shown in Table 7, was 13,648,000 in 1927 and reached to 27,755,000 in 1960. Early Republican governments tried to improve the health conditions of the people and establish basic practices of collective and individual hygiene. They realized that the population was the most important input of economic development and national defense.

The discourse related to public health can be observed in the primary documents of the Kemalist leadership. Thus, as early as June 1923, the Kemalists included public health issues in their declaration known as the Nine Principles (*Dokuz Umde*) prepared for the elections. Population issues occupied a more central place in the 1927 program of the RPP. In the 1931 and 1935 programs of the RPP, public health policies were clarified.

The MHSA determined its priorities in its first working program in 1925 as follows: to expand the state health organization; to train doctors, health officers (*sağlık memuru*), and midwives; to establish model hospitals (*numune hastaneleri*), maternal and child care hospitals; to combat heavy diseases like malaria, tuberculosis, trachoma, syphilis, and rabies; to prepare health legislation; to bring health and social assistance organization to the villages; and to establish a school of public health and institutes of public health.[257]

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[256] Table 6 shows the number of patients who caught an infectious disease and who died because of that disease between the years 1925 and 1962.
[257] Eren and Tanrıtanır, p. 8.

The increasing concern about the health and welfare of the population, especially for the future generations, was also marked by legislative changes. The Village Law[258] comprised detailed issues to improve the average level of health in the villages. The Municipality Law[259] designated the duties of municipalities in the field of public health. The Law of Public Health[260] arranged everything related with the public health, from maternal and child care to the general hygiene rules. The performance of medical jobs was regulated by the Law on the Application of Medicine and Its Branches.[261] The Law of Pharmacy and Medical Products[262] charged the ministry with the production, use and control of medical materials and medicines. The organizational structure of the Ministry of Health and Social Assistance was set up by the Law on the Organization and Personnel of the Ministry of Health and Social Assistance.[263] There were other laws on pharmaceuticals, the handling of narcotic substances, bacteriology and chemical laboratories, private hospitals, and radiology. The major three laws were the Law on the Application of Medicine and Its Branches, the Law of Public Health, and the Law on the Organization and Personnel of the Ministry of Health and Social Assistance.

The Law of Public Health is a general law composed of 307 articles. It brings detailed regulation on such topics as borders, quarantine, cholera, plague, smallpox, typhoid fever, typhus, malaria, trachoma, tuberculosis and venereal diseases; special

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[258] *Köy Kanunu*, no. 442, *Resmî Gazete*, 7 April 1924.

[259] *Belediye Kanunu*, no. 1580, *Resmî Gazete*, 14 April 1930.

[260] *Umumi Hıfzıssıhha Kanunu*, no. 1593, *Resmî Gazete*, 6 May 1930.

[261] *Tababet ve Şuabatı Sanatlarının Tarzı İcrasına Dair Kanun*, no. 1219, *Resmî Gazete*, 14 April 1928.

[262] *İspençiyari ve Tıbbi Müstahzarlar Kanunu*, no. 1262, *Resmî Gazete*, 26 May 1928.

[263] *Sıhhat ve İçtimai Muavenet Vekaleti Teşkilat ve Memurin Kanunu*, no. 3017, *Resmî Gazete*, 23 June 1936.

articles about women, immigrants, transportation, children, milk, nutrition, labor health, water, thermal springs, cemeteries, dwellings, sewer system, and health education. Article 3 declares the duties of the MHSA as follows: the promotion of birth and the reduction of infant mortality rates; the protection of the pre- and post natal health of mothers; the prevention of contagious diseases; the war against contagious diseases and the various negative elements that caused thousands of deaths; the observation of all therapeutics; the supervision of food, and all kinds of drugs, poisons, vaccines and serum; the protection of child and youth health, the hygiene of schools and workplaces; the hygiene of mineral and thermal waters; the inauguration and administration of all kinds of bacteriology laboratories and public health institutions; the administration and control of medical schools and certification; the establishment and administration of clinics and asylums for the mentally ill and disabled; the hygiene of immigrants; the surveillance of the sanitary conditions and hygiene in prisons; the preparation of statistics; publications and propaganda on health; and the surveillance of means of transportation and communication.

All of these are related with public health and preventive services except the one on the mentally ill and the disabled. The state took the responsibility of establishing clinics and asylums for the mentally ill and disabled. Other duties of the Ministry did not comprise the establishing of a curative service institution. The curative services were left to the municipalities and special provincial administrations.

Early Republican governments neglected curative services and did not feel responsible for providing health care for diseases which were not infectious and epidemic. The hospitals and dispensaries of the MHSA were under the responsibility

of the Social Assistance Department, not the Health Service Department. Article 12 of the Law on the Organization and Personnel of the MHSA gives the task of governing all hospitals and dispensaries of the Ministry and special provincial administrations and municipalities to the Social Assistance Office. Article 10 assigns to the Health Service Department the task of epidemic and endemic combat, and general hygiene. So, the state assumed responsibility for curative services only when it was an issue of social assistance.[264] Until 1954, all hospitals except model (*numune*) hospitals and infectious disease hospitals were administered by municipalities and special provincial administrations. The appointment of the staff, however, was carried out by the MHSA. Numune hospitals were built in Ankara, Diyarbakır, Erzurum and Sivas in 1924; in Haydarpaşa in 1936; and in Trabzon in 1946. These were supposed to function as models for the provincial administration and municipality hospitals. The definition of the primary function of the Ministry of Health as "preventive health services" and the commitment to the State's disinclination to establish institutions/hospitals for curative purposes was achieved through Refik Saydam's political determination.

As will be clarified in the sixth chapter, the treatment of the poor was left to the municipalities, like other curative services. The Municipality Law assigned the task of providing doctor and medicine for the poor, to the municipalities. Article 57 charged the municipalities with establishing pharmacy in places without any; providing free or cheap medicine to the poor, establishing clinics and dispensaries which might not charge money; and employing midwives for helping poor mothers in giving birth. In the Law of Public Health (1930) government and municipality

[264] Although these articles of Law number 3017 were in force until 1983, the social assistance task of the Ministry changed its shape and became limited with child welfare, rehabilitation and medical social services, old age services, and providing of social assistance funds to charity organizations. Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl* (Ankara: SSYB, 1973), pp. 273-284.

doctors and midwives were assigned with the task of helping poor women in giving birth (article number 153) but there is no other reference to the poor in the law.

The battle against contagious diseases was fought on all fronts. Tuberculosis, malaria, trachoma, and venereal diseases were the most widespread, the most fatal and incapacitating, and the most damaging to the labor force. The summaries below include the 1950s and 1960s since the results of the earlier measures unfolded in those years.

The first step in the battle against *tuberculosis* (TB) was the founding of the Ottoman Society for TB Combat in 1918, but it was unable to function due to the war. The second step was the founding of the İzmir Society for TB Combat in 1923 by Behçet Uz. The Balıkesir Society was founded also in 1923. The İstanbul Society was founded in 1927. The İstanbul and İzmir societies were effective in terms of raising the consciousness of the people and the rulers about the importance of fighting TB and operating health institutions. Since there were no means for therapy in those years, the main task of these societies was to console the sick, educate both healthy and sick people in order to prevent contagion and deliver spittoons and food packages. The first out-patient clinic established to recognize the growing importance of the disease was an anti-TB dispensary in İstanbul, founded in 1923 in Çemberlitaş by the İstanbul City Council with the order of the MHSA. This dispensary was the first direct engagement of "state" in the battle against TB. In 1924 Dr. Refik Saydam allocated funding from the government's annual health budget to build a sanatorium with 50 beds exclusively for TB on Heybeliada. TB checks were expanded and accelerated with the advent of this sanatorium that constituted a potent curative base for the treatment of TB patients. TB was one of the major topics in the 1925 and 1927's National Congresses of Medicine. TB checks had been "voluntary"

or "charity-based" in nature during the late Ottoman and early Republican periods. However, the MHSA did significantly support their activities. The voluntary organizations were united as the Turkish Tuberculosis Combat Association in 1948 and the Law on Tuberculosis Combat[265] was enacted in 1949. It became unified under a state body with a desire to nationalize the struggle. In 1945, the mortality rate of tuberculosis was 262 in 100,000 and fell to 20.3 in 1970. The percentage of infection was 12 in 1954 and 2 in 1968.[266]

Malaria was widespread, especially in Southern and Southeastern Anatolia. It was the main issue discussed in the First National Congress of Medicine in 1925. The principles of malaria combat were determined by the Law of Malaria Combat.[267] Malaria combat organization were to examine spleen and blood, report the infected people and treat them free of charge. The drainage and destruction of larval breeding sites were among its major tasks. In 1930s, there was a serious rise in the number of inspections of humans. Around 10% of the examined were found to be infected. However, due to the demographic movements and the difficulty in importing pharmaceuticals during the Second World War new malaria epidemics broke out and that percentage rose to 32. So in 1945 another law that provided emergency measures was enacted[268] and it was replaced by a temporary law in 1946.[269] DDT began to be used in 1948 and the results were quite effective: Among the people inspected those

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[265] *Verem Savaşı Hakkında Kanun*, no. 5368, *Resmî Gazete*, 15 April 1949.

[266] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl*, pp. 111-129. See Ferit Koçoğlu, *Verem Savaşı* (Ankara: Hacettepe Üniversitesi Tıp Fakültesi Halk Sağlığı Anabilim Dalı Yayını, 1986) for a detailed account of tuberculosis combat in Turkey; see also İlikan; and Neşeriz Yeşim Yasin, *Connect the "DOTS": A New Era in Turkish Tuberculosis Control*, MA Thesis, Boğaziçi University, Department of Sociology, 2007 for critical approaches to tuberculosis combat in Turkey.

[267] *Sıtma Mücadelesi Kanunu*, no. 839, *Resmî Gazete*, 29 May 1926.

[268] *Sıtma ile Olağanüstü Savaş Yapılmasına Dair Kanun*, no. 4707, *Resmî Gazete*, 28 March 1945.

[269] *Sıtma Savaşı Kanunu*, no. 4871, *Resmî Gazete*, 21 February 1946.

with malaria constituted 20% in 1945 and 1946, and 0.8% in 1956. The Law on the Eradication of Malaria was enacted in 1960[270] and it implied a break with the earlier laws as it was based on the complete eradication of malaria by DDT rather than keeping the number of malaria cases at a reasonable level.[271]

Trachoma, which leads to blindness, was widespread in the Southern and Southeastern provinces of the country. Due to the demographic movements in World War I the number of cases increased and expanded to Central Anatolia. In 1925, a trachoma hospital was established in Adıyaman and another in Malatya. At that time three million trachoma patients were reported. And in 1930, trachoma combat hospitals were established in Adana, Gaziantep, Kilis and Besni. Apart from these hospitals mobile teams examined people and cured the infected ones. In the cities where trachoma was widespread the percentage of those infected was nearly 70 in the early years of the combat, this rate fell to 2 in the 1970s. Until 1950 there was a serious rise in the number of trachoma hospitals and trachoma treatment houses and a serious fall after this date due to the success in the battle against this disease.[272]

İstanbul Organization of Venereal Diseases (*İstanbul Zührevive Teşkilatı*) was established in 1933. The organization consisted of the İstanbul Venereal Disease Hospital; clinics in Beyoğlu, Galata, Tophane, Kadıköy; a general dispensary called the İstanbul Dispensary; and a dispensary in Üsküdar. Apart from İstanbul, there were hospitals in Ankara, İzmir, and Samsun, and dispensaries in Ankara, İzmir and Zonguldak. The battle against syphilis was carried out in special working areas such as Sivas, Ordu, Çarşamba, Düzce, Zonguldak, İzmir, Ankara, Balıkesir, Giresun and

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[270] *Sıtmanın İmhası Hakkında Kanun*, no. 7402, *Resmî Gazete*, 11 January 1960.

[271] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl*, pp. 101-111; see Erdem Aydın, *Türkiye'de Sıtma Savaşı* (Ankara: TTB, 1998) for a detailed account of malaria combat in Turkey.

[272] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl*, pp. 129-134.

Kastamonu. After 1927, two dermatology and sexually transmitted diseases hospitals, as well as seven venereal disease hospitals were established. The tentative statistics show that 2,247,561 people were checked by the committees of syphilis combat (*frengi savaş kurulları*) between 1926 and 1947, and 86,231 were determined to be infected.[273] The number of those infected with syphilis increased during the Second World War and then declined. It was 114,739 in 1930; 170,177 in 1940; 118,169 in 1950; 47,565 in 1960 and 17,420 in 1970.[274]

The Regulation Concerning Eradication of the Contagion of Venereal Diseases (*Emrazı Zühreviye Nizamnamesi*) was issued in 1915. The Law on War against Syphilis (*Frenginin Men ve Tahdidi Sirayeti Hakkındaki Kanun*, no. 90) was put into effect in 1921. It included articles obliging couples to undergo medical check before marriage, as well as articles which banned the marriage of those who were afflicted with syphilis. Likewise, in 1925, the Regulation of War with and Treatment of Venereal Diseases (*Emrazı Zühreviye Savaş ve Tedavi Talimatnamesi*) was prepared. With the regulation, state authorities were empowered to carry out the treatment of the citizens suffering from venereal diseases, to establish syphilis examination teams, venereal disease hospitals, and dermatology and STD dispensaries. The Law of Public Health introduced strict regulations related with venereal diseases. Those who were afflicted with any sexually transmitted disease were to be examined and treated in state hospitals, official health clinics, or by the state or municipal doctors free of charge, and medical examination and treatment were to be obligatory for everybody. The law required that all cases be reported to the medical officers of health, who were endowed with the authority to apply forced

[273] Ibid., p. 93.

[274] Ibid., p. 96.

venereal disease testing of those "suspected" of having venereal disease, and also to demand a health report from these people.[275]

The battle against contagious diseases was not limited to TB, malaria, trachoma, and syphilis, which were fought through vertical organizations. Measles, whooping cough, typhus, poliomyelitis, and diphtheria were also widely reported diseases. Early Republican governments focused also on smallpox, cholera, rabies, leprosy, and plague.[276] Other contagious diseases were under the responsibility of government doctors (*hükümet tabibi*). If the epidemic could not be handled by local facilities health teams were sent from Ankara.

After the formation of the Republic, examination and treatment houses (*muayene ve tedavi evleri*) with 5-10 beds were established to provide health services to places without hospitals. They were also known as dispensaries. In 1924, the government decided to open examination and treatment houses in 150 county centers. The curative service in dispensaries was free, and the poor could receive free medicine. Not only the MHSA but also municipalities and special provincial administrations opened many dispensaries. Their numbers were 90 in 1933, 180 in 1936, 200 in 1942 and 300 in 1950. The state sent not only doctors, but engaged actively in the process of establishing health units in provinces.[277] Actually the rise in the number of these houses implies the involvement of the state in curative services.

In the early years of the Republic there was a serious shortage of health personnel. There were only 554 doctors in 1923 and the number of persons per doctor was 19,860. There was a rise in the number of health care providers and a fall

[275] For a critical analysis of the war against venereal diseases in the early years of the Republic, see Öztamur.

[276] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl*.

[277] Aydın, "Cumhuriyet Döneminde Sağlık Örgütlenmesi." pp. 147-149.

in the number of persons per health care provider, but these changes were more moderate than the ones that would happen in the 1950s and 1960s.[278] Minister of Health Refik Saydam opened a Medical Student Dormitory in İstanbul in 1924. To attract students to the İstanbul Faculty of Medicine, the Ministry provided them not only a place to stay, but also clothes and some money. After graduation, they were to work for the state for a certain period of time. This system continued until 1960, the year it was turned into a scholarship model.[279]

There was no other serious attempt to increase the number of doctors before 1960. For a long period of time, there was only one faculty of medicine, a nursing school of Kızılay, a midwifery school in the İstanbul Faculty of Medicine and three health officer (*sağlık memuru*)[280] schools of the MHSA. Refik Saydam and the ministers that followed were criticized for underestimating the importance of training auxiliary health personnel.[281] A significant step in the training of health personnel was educating village midwives and village health officers in the Village Institutes from 1943 onwards until 1949. Although the expansion of the staff was one of the major tasks together with the updating of the knowledge of medical staff and the broadening of boundaries that the health services reached, the accomplishments in these areas would be far better in the following decades.

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[278] See Table 8 for the number of health care providers in 1928-2002 and Table 9 for the number of persons per health care provider in 1928-2002.

[279] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl*, pp. 291, 293.

[280] Public health specialist Zafer Öztek prefers to translate "sağlık memuru" into English as "male nurse" since it explains the profession better. As there were difficulties in recruiting women in the early years of the Republic, men were educated as nurses. In time the job descriptions of nurses and health officers were differentiated (Zafer Öztek, interview by the author, tape recording, Ankara, Turkey, March 2006).

[281] Nusret Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, ed. Rahmi Dirican (Ankara: TTB, 1997), p. 67.

In the early Republican period, National Congresses of Medicine were organized. These congresses elucidated current problems of the health of the population, so that the necessary measures could be taken. In the first congress in 1925, the main topic was malaria. In the second congress in 1927, the main topic was trachoma. In the third one it was syphilis, cancer and scarlet fever, and in the fourth, rickets and children.

The Central Institution of Public Health was also established in this period to carry on the battle against contagious diseases in a scientific way. The Law on the Central Institution of Public Health of the Republic of Turkey[282] was enacted in 1928. Refik Saydam wanted to open an institution in line with the Pasteur Institute, in order to produce all kinds of vaccines and serums. The bacteriology laboratories (*bakteriyolojihane*) in İstanbul and Sivas and the chemistry laboratory (*kimyahane*) in Ankara were united under this institution. Tuberculosis vaccine was produced first in 1931. In 1934 the Vaccination House (*Telkihhane*) and the Rabies Institute in İstanbul were closed and vaccine and serum production was done only in Ankara. In the 1930s there was a rapid acceleration in the production of vaccines and serums. Million doses of diphtheria, tetanus, Semple-type rabies, smallpox, pneumococcal vaccines and rabies serum were produced and national and foreign pharmaceuticals were controlled.[283] The Institution was even able to produce vaccines to combat epidemics in other countries. Cholera vaccines were sold to China in 1939 and to Egypt and Syria in 1947. The Law on the Establishment of the Central Institution of Public Health[284] defined the institution as composed of two bodies, the Institute of

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[282] *TC Merkez Hıfzıssıhha Müessesesi Hakkında Kanun*, no. 1267, *Resmî Gazete*, 17 May 1928.

[283] Feride Saçaklıoğlu et.al., *Aşı Pazarı Can Pazarı: Aşı Üretiminin Perde Arkası* (Ankara: TTB, 2003).

[284] *TC Merkez Hıfzıssıhha Müessesesi Teşkiline Dair Kanun*, no. 3959, *Resmî Gazete*, 4 January 1941.

Public Health and the School of Public Health. With Law No 4288,[285] the Institution was named the Refik Saydam Central Institution of Public Health. The tasks of the Institute were defined as follows: To conduct medical and scientific research that would serve the improvement of public health conditions and struggle against all kinds of diseases; to prepare serums and vaccines and other biological and chemical materials determined by the MHSA; to check national and foreign producers' serums, vaccines, pharmaceuticals and chemical materials; and to organize conferences and make publications on public health. The tasks of the School were to organize training programs for providers of health and pharmacists and chemists, to organize conferences and seminars for sharing the new knowledge with health personnel, and to make publications on public health. Although the establishment of the school was mentioned in the Law on the Establishment of the Institute of Public Health (no. 1267, 17 May 1928), its actual opening had to wait until 1936.

Besides enacting laws, forming institutions, organizing medical conferences and expanding and educating medical staff, the state made use of propaganda to make public health services more widespread. Public health education complemented the other measures. Propaganda materials reached the People's Rooms, the army, schools, the gendarmerie, the police, industrial institutions, and villages.

Pro-natalist Policies

The Republican elite were preoccupied with the need to recover from the damage caused by long-lasting wars and recent population loss due to the shattering of families, the absence of men in the families because they had been enrolled in the

[285] *Resmî Gazete*, 10 August 1942.

army, hunger and disease, war-time losses both civil and military, and population exchanges during the previous decades of successive wars. Pro-natalist policies and policies aimed at interventionist child health and welfare as well as related discourses constituted the main pillars of the war waged in the name of so-called population problem. The Turkish elite believed that the basis of a strong nation-state was a healthy, fit and numerous population. Population was perceived as an "effective" weapon in an age of nationalism to serve as a strong "military power" during war time and an "economic power" during peace time. There was the need for a new generation which would form the loyal citizens of the Republic, the manpower for the economy, and soldiers for the army. For this, a pro-natalist policy was required together with a reform in the field of health care. Promoting birth, preventing high infant mortality rates, and securing better conditions for infant and child survival were the points on which all the doctors, intellectuals, politicians and social activists agreed in the debates on the scientific management of the population.[286]

The pro-natalist policy was enacted with a series of laws: The Penal Code of 1926,[287] adapted from the Italian code, made abortion illegal (Article 471). The Law of Public Health of 1930 (Article 152) exhorted the government to increase births and prevent deaths. It also prohibited the importation, production, and sale of contraceptives. In 1936, an amendment to the Penal Code prohibited sterilization – which was interpreted as implying that no information could be disseminated concerning birth control methods. Thus, family planning education was forbidden, affecting medical education as well as the country's citizens. The Law of Public

[286] See Frederic C. Shorter, "Turkish Population in the Great Depression." *New Perspectives on Turkey*, 23 (2000): 103-124; Kathryn Libal, "The Children's Protection Society: Nationalizing Child Welfare in Early Republian Turkey." *New Perspectives on Turkey*, 23 (2000): 53-78; Öztamur.

[287] *Türk Ceza Kanunu*, no. 576, *Resmî Gazete*, 13 March 1926.

Health also declared that birthing services were to be free of charge in state hospitals. Article 155 banned mothers from working in the first three weeks of the post-natal period unless a doctor approved otherwise.

In line with the pro-natalist policies, families with too many children were seen as eligible for state help in the public discourse. Branches of the Children's Protection Society (*Himaye-i Etfal Cemiyeti*) also shared the burden of providing for these families. Likewise, fathers with more than five children were exempt from any kind of transportation fees. The MHSA allocated funds for the investigation of small towns in order to detect the number of mothers having more than six children and gave them grants. Maternity was declared to be a national and social duty, and was to be protected by the state.

The cry for population increase was strong throughout the 1930s. In 1934, the Parliamentary Committee on Population of the Republican Party wrote, "Although the importance of the population on economic grounds is fully recognized today in Turkey, the goal of promoting the strength to defend our vast land is the most important."[288] The party committee then urged a doubling of the population as soon as possible. The military capacity was believed to be supremely important.[289]

Although there was a serious effort to improve the health institutions they were disorganized and poor. The measurements were made of a child mortality rate of 27% of births, and an average life expectancy of 35 years (1935-40). For those who survived to the age of five, the average expectation of remaining life was 50 years.[290] Even so, much was accomplished during the 1930s to generate a momentum toward better health. The battle against contagious diseases proved to be effective

[288] Cited in Shorter, "Turkish Population in the Great Depression." p. 105.

[289] Ibid.

and the annual growth rate of population increased. The Republican elite's aim of accelerated population growth for national purposes was in line with the families' goals. In most cases, ordinary citizens also wanted more offspring –to acquire more labor force for the work on land and to strengthen their own, usually extended families.[291] However, the mobilization for World War II and the harnesses it brought decreased the annual population growth rate.

Frederic Shorter analyzes the effects of the Great Depression and World War II on population and concludes that it was mostly the urban people who were affected by the former while it was the rural people who were affected by the latter. The Great Depression was a shock to the economy that encouraged people to remain in rural areas where labor-intensive agriculture could provide a living. The urbanization that would have accompanied industrialization had to wait. Yet, fertility continued to be high, as for rural people, it was important to fill the lost cadres of manpower. Setbacks came only when Turkey mobilized for World War II, which drained the resources and isolated the country – conditions that seem to have contributed to an increase in mortality rates. The rural population, dependent upon agriculture, lost its labor force to the army and suffered most. Even though there was no engagement on the battlefields, mobilization was demographically devastating. Child death rates rose and fertility dipped temporarily –a blow to the state's hopes for an increase in population.

The re-mobilization for war came just as demographic recovery was contributing to economic progress. Only after World War II did the population growth rate and the life expectancy at birth resume their upward trend. Death rate in

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[290] Ibid., p. 116.

[291] Ibid., p. 106.

İstanbul rose by 7% during the war. The infant mortality rate rose nationally from 273 to 306 per thousand births, comparing 1935-40 with 1940-45. The causes were poor economic conditions, shortages of professional care and medicines, and deterioration in public health campaigns such as the one against malaria (In 1939, 13.8 per thousand, in 1942 23.2 per thousand, deaths registered in the malaria-control provinces).[292] After the end of the war, there was a rise both in the rural and the urban populations, especially in the 1950s[293].

In the 1920s and 30s, the child question was intensified in the public discourse as an integral part of the broader question of population. The MHSA and the RPP embarked upon a variety of social policies aimed at protecting pregnant women, mothers and infants to complete the tasks in the way of solving the child question, hence the problem of population. The child was the key element in the formation of the new Turkish state, which potentially embodied military and economic strength. Concerns with child poverty and child health and welfare intensified in public discourse in the 1920s, particularly as supporters of the new, secular state began to embark upon significant social and political reforms.

According to Libal, public discourses on population and child-centered policies were fused with the notion of nation-state building. Debates regarding population and children during this period were regarded as national issues to be addressed by the larger society and the Turkish state. The child, viewed as a citizen-in-the-making, symbolized a nation-state embarked on a progressive march toward future prosperity and greatness. The state vested power in the MHSA and the

[292] Ibid., p. 121.

[293] See Table 10 for city and village population and the proportion of city and village population in total in 1927-2000.

Ministry of Education to establish infrastructural reforms and concrete services that would benefit the Republic's children.[294]

Dr. Zeki Nasır wrote in 1933, "Our approach should be towards minimizing births, encouraging birth control, and then providing healthy and long lives to the children born. Malaria, tuberculosis and syphilis should be contained".[295] For Shorter, Nasır represented a more modernist position than the state's policy of trying to block all access to birth control. In 1939 Yaşar Nabi wrote that the problem was not, at least in the villages, to promote procreation, but to help newborns survive.[296] When we take into account the very high infant mortality rates of those years (nearly one-third of every 1000 births) and high total fertility per women (more than six in 1930s and 40s[297]) it seems quite rational to develop maternal and child health care rather than blocking access to birth control.

The First Ten Year National Health Plan

The First Ten Year National Health Plan was prepared by the Minister of Health and Social Assistance Behçet Uz in 1946 when the RPP was in power. The main objectives of the First Ten Year National Health Plan were as follows: the establishment and expansion of a preventive care organization; providing health organization for the villages; training health personnel and students in accordance with the needs of the day; modernization of the existing hospitals and other health

[294] Libal, pp. 57-59.

[295] Cited in Shorter, "Turkish Population in the Great Depression." p. 116.

[296] Cited in Öztamur, p. 38.

[297] From the chart of "Total Fertility per Women" in Frederic C. Shorter, "The Crisis of Population Knowledge in Turkey." *New Perspectives on Turkey*, 12 (1995): 1-31, p. 10. In this chart total fertility per women starts to decline in 1950 when it was 6 and ends up at 2 in 2000.

institutions; the establishment of new health institutions across the country; and the establishment of a National Health Bank and health funds to finance the health expenditures.[298] For every 40 villages (approximately 20,000 people) there would be a health center. Every health center would have 10 beds for emergency patients. Two doctors and eleven auxiliary health personnel would provide preventive and curative services together. The main goal was to bring health service to the villages. The plan aimed to bring not only preventive care, but also curative services to the villages which had been available only in the cities and counties beforehand. The integration of preventive care and curative services and the population-based organization were the principles of modern health care administration. The plan could not be implemented and was substituted by the establishing of 10-bed health centers in counties. The major tasks of a health center were: Maternal and child health care and hygiene; personal hygiene; prevention of epidemics and contagious diseases; struggle against drugs and social hygiene; school and student hygiene; environmental health services; health training; and curative services by all possible means.

The plan's objectives point to the major problems related with the provision of health service. Although it was designed to solve the major problems in the field of public health and health service delivery, the plan could not be implemented. It seems that there was an unjust distribution in health services and the need to expand health care across the country became a major goal. Although Refik Saydam mentioned the need to reach the villages and educate and inform the villagers on the elements of civilization, of medicine and of society, rural Turkey was devoid of basic health services. The DP tried to change this unjust distribution by opening up new health centers in counties but the poor conditions in villages did not change that

[298] Sağlık ve Sosyal Yardım Bakanlığı, *Birinci On Yıllık Millî Sağlık Planı* (Ankara: SSYB, 1946).

much, which in turn led the military to adopt the socialization of health services in 1961.

This plan announced the coming shift in the DP period, when the state would assume the responsibility in curative services. Such a shift was possible only through the accomplishments of the early Republican period. If epidemic and contagious diseases were not taken under control there would not have been any change in this direction. Early Republican emphasis on the "science of health" (*sıhhıyecilik*) rather than the "science of disease" (*tedavicilik*) was a response to the existing situation which forced the governments to take urgent measures to combat contagious diseases. In 1930, Muhiddin Celâl wrote: "...the science of health was to be primary, whereas that of disease was secondary. The latter can be carried out by individuals whereas the former can only be achieved by the state, by the national power."[299] From the very beginning, public health has always been considered to be the duty of the state. It was such a problematic area that individual solutions could not be applied. In the early Republican period, other areas in social policy like social assistance were left to the mercy of the rich. In a period when economy and society were dominated by state intervention in all areas, "it was not the state but well-to-do citizens who were expected to take responsibility in the realm of social assistance".[300] In public health, however, it was always the state which was held responsible for the provision of services. There were some voluntary organizations and societies with which the state acted together until the late 1940s, like the Society for Tuberculosis Combat or Children's Protection Society, but they were not fully

[299] *"...yani sıhhıyecilik asli tedavicilik ferdi idi; bu sonuncusu ferdlerin iktisap edebileceği bir sanat, birincisi ise ancak Devletin yapabileceği bir vazife, bir millî kudret idi."* Cited in Öztamur, p. 46.

[300] Ayşe Buğra, "Poverty and Citizenship: An Overview of the Social-Policy Environment in Republican Turkey." *International Journal of Middle East Studies*, 39 (2007): 27-46, p. 32.

independent from the state mechanism yet. Although the responsibility of the state in public health was never questioned, the weight given to public health changed in time and was always open to discussion. After the 1950s, the criticism that the government was not paying enough attention to public health was widely voiced. Public health, or preventive care, or "science of health" was concerned about the population as a whole and covered all fields of life, from epidemics to medical statistics, while curative medicine or the "science of disease" was concerned about individuals.

Refik Saydam insisted that the doctor's duty was to preserve the health of the people, rather than to cure the disabled. In the early decades of the Republican regime, the individual was to care for himself just for the sake of society and the nation, and, in turn, society would provide medical and economic assistance to the individual for the sake of the nation. Thus the individual's responsibility for her or his own health and welfare was transformed into a social duty. Assistance to the individual was not a product of a humanistic approach or a moral obligation based on the idea that everybody had the right to a healthy and prosperous life, but the product of the anxiety to create a populous nation the individuals of which were joyful, healthy, fertile and productive. Such a humanistic approach or moral obligation perspective would become dominant in the egalitarian atmosphere of the 1960s.

So, until the end of World War II, the Republican regime applied pro-natalist policies and made a sanitary reform to increase the number of the population and to improve its health. The social policies of that era were implemented with a vision not only to achieve a quantitative success, but also to improve the quality of the population. Density of population was regarded important not only from the military's point of view, but also in terms of creating a powerful economic apparatus.

"The robust man" was the fundamental element both for national security and economic and social life.[301]

The politics of the early Republican governments which were supposed to increase the birth rate while decreasing the mortality rate, to fight against epidemics, to improve the physical conditions of health facilities, to train competent health personnel, and to inform society through an intense propaganda for health were all vital in a country wearied under the burden of wars and epidemics. The battle against contagious diseases, the establishment of health care organization, and the enactment of basic health laws were all designed to create a populous and healthy nation. And there were serious accomplishments in these areas.

The early Republican elite adopted a modern, positivist and scientific tone when constructing the political discourse about the well-being and welfare of the population. They advocated the closer monitoring and regulating of the populace in the name of the national interests. For them, population was an object of knowledge and management. Its health was decisive in the economic and social development of the nation-state.

So the objectives in the first working program of the MHSA were mostly achieved. Although the Republican governments were unable to perform that well in expanding the medical staff and bringing health and social assistance organization to the villages they were able to establish the health care organization, enact basic health laws and keep the contagious diseases under control. The policy change in the DP period, when the state took responsibility in curative services, became possible thanks to the accomplishments of this era. The DP was able to focus on curative services because there was no urgent need to provide preventive care. Before going

[301] Akın.

on with the health policy in the DP period I would like to explain the major developments in the Turkish welfare system starting from the late Ottoman period until the end of DP rule.

Turkish Welfare System before 1960

The development of social security mechanisms can be traced back to the late Ottoman era.[302] Starting from mid-nineteenth century onwards various retirement funds were established for the military and civil state officials as well as workers in the public sector. Also special funds were founded to provide assistance to civil servants, employees and their families in case of illness, invalidity and death. Specific policies and institutions were developed for widows and orphans. The Dilaver Pasha Regulation (1865) and the Regulation on Mines (1869) were carried out to bring some rules related to working conditions.

The Turkish Grand National Assembly accepted the Law on the Mine Workers of Zonguldak and Ereğli Coal Field (1921) which regulated the working conditions and the social security of mine workers. The Law on Weekly Holidays (1924) brought the right of one day-off to the employees. The Law on National and General Holidays (1935) started the weekly holiday from Saturday noon. The Law of Obligations of 1926 brought a few provisions forcing employers to provide some

[302] For the intellectual sources of social policy in Turkey, see Zafer Toprak, "İkinci Meşrutiyette Solidarist Düşünce: Halkçılık." *Toplum ve Bilim*, 1 (Bahar 1977): 92-123, Zafer Toprak, "Türkiye'de Korporatizmin Doğuşu." *Toplum ve Bilim*, 12 (Kış 1980): 41-49; and Zafer Toprak, "Osmanlı'da Toplumbilimin Doğuşu." In *Modern Türkiye'de Siyasî Düşünce, cilt 1, Tanzimat ve Meşrutiyet'in Birikimi*, ed. Mehmet Ö. Alkan (İstanbul: İletişim Yayınları, 2001). Zafer Toprak mentions the influence of the Bismarckian welfare of Germany, the solidarism of French Third Republic, and the Narodnic movement of Russia. For Toprak, 1908 is the turning point. Before that, the social policy field was dominated by waqfs and Sultan's "imperial gifts." The Constitutional regime which was established after the Young Turk Revolution of 1908 adopted a more secular and bureaucratic system of welfare.

social security measures as regards work accidents, occupational health, and the like. The Law of Public Health (1930) regulated the working conditions of pregnant women and of children. It also brought some rules on occupational safety and health.

In the same year, the Law of Military and Civil Retirement Fund brought together the earlier retirement funds founded for the military and civil servants with their widows and orphans during the late Ottoman period. Alongside this fund, various funds were established for civil servants and workers in the public sector, and some occupational groups who were not employed in the public sector. The Labor Law (1936), which was limited with certain employment areas, manual labor and workplaces with more than 10 workers, regulated industrial relations and envisaged the gradual establishment of social insurance. There were provisions regarding the working conditions of women and children as well as rights such as half paid maternity leaves and health care in case of occupational diseases.

Yet, before 1945, the social policy agenda of Turkey was marked largely by the issues of population, public health and child. After 1945, together with the process of the establishment of the Ministry of Labor this agenda started to take shape around the issues of labor and occupational safety.[303] The 1940s might be considered a turning point in terms of the establishment of a social policy agenda centered on labor market and labor relations. With the rise in the share of employment in industry, governments had to take measures to regulate labor relations and to provide basic social security to workers. The social security of civil servants was also regulated.

By the end of the Second World War, Keynesian welfare states were consolidated in many of the European countries. These developments in the West

[303] Nadir Özbek, *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar* (İstanbul: Emeklilik Gözetim Merkezi – Tarih Vakfı, 2006), pp. 159-160.

affected the social policy scene in Turkey. For example, the Beveridge Report (1942), which recommended the adoption of a contributory social security system to protect all citizens against poverty at times of sickness or unemployment and in old age, was discussed in Turkish newspapers. Social Policy Conferences were organized by İstanbul University Economics and Sociology Institute. The founding of the Ministry of Labor (1945) and the Labor Insurance Institution,[304] the reorganizing of Government Employees Retirement Fund[305] to cover civil servants of different state institutions under one roof, and the pension arrangements for the insured workers in early 1950s reveal the impact of European welfare state developments in Turkey.[306] Although the scope of these measures was very limited, the post-war "welfare regime" in Turkey followed the global patterns of the Keynesian welfare state in other parts of the world.[307]

In 1945, the Law on Industrial Accidents, Occupational Diseases and Maternal Security (no. 4772) was issued. The Labor Insurance Institution was established in 1946 (law no. 4792). The Old Age Insurance Law (no. 5417) was accepted in 1949 and the Illness and Maternal Insurance Law (no. 5502) was accepted in 1950. All these laws, together with the Disability, Old Age and Death Insurance Law (1957, law no. 6900) were regulated and put together in the Law on Social Insurance Institution (no. 506) later on in 1964. With the Illness and Maternal Insurance Law, workers, pensioners, their family members and survivors were provided free health care and medicine. They would also be given temporary disability allowance. The conditions of retirement were also regulated. Civil servants

[304] *İşçi Sigortaları Kurumu Kanunu*, no. 4792, *Resmî Gazete*, 16 July 1945.

[305] *Türkiye Cumhuriyeti Emekli Sandığı Kanunu*, no. 5434, adopted in 8 June 1949.

[306] Ayşe Buğra, "Türkiye'de Sağ ve Sosyal Politika." *Toplum ve Bilim*, 106 (2006): 43-67, p. 47.

[307] Özbek, "Osmanlı'dan Günümüze Türkiye'de Sosyal Devlet." p. 23.

had had separate funds before. The Retirement Fund Law (no. 5434), which was accepted in 1949 and put into force in 1950, united all funds under one roof. This law aimed to provide social security to civil servants and military personnel during their retirement and disability, and to their dependents in case of death. Temporary article number 139 regulated the provision of health assistance to the members of the fund. For those who were in active work life, their institutions were paying the health expenses. These were very important measures but they covered only a small portion of the population. The majority of the workers in industry and services in the cities, and the peasants, who comprised nearly 80% of the population, were not covered by any security scheme.

The Law on Sickness and Maternity Insurance (no. 5502, 1950) was applied first in İstanbul and the Trakya region and expanded to the whole country in 12 years. By 1955, health insurance was applied in 24 cities and covered two-thirds of the insured. In the beginning, there were problems concerning the quality of health care due to the lack of manpower and equipment.[308] The Labor Insurance Institution (LII) established its own health care units, as the MHSA did not have the means to serve them. The first health institution of LII, which was known as the "İstanbul Hospital" or the "Occupational Diseases Hospital," was established in Nişantaşı in 1949. The Institution decided to provide health services itself rather than buying them from the MHSA or the private sector. So it started to build up new hospitals with the sickness and maternity insurance funds collected from both the employers and the employees. Before 1960, 12 hospitals with a total of 881 beds were already put into service.

[308] Özbek, *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar*, p. 240.

There occurred no dramatic changes within the field of social security and social assistance during the Democrat Party era. It can rather be said that the "labor insurance" system established in late 1940s was consolidated. The major change during the Democrat Party era was the increase in the number of workers covered by the Labor Insurance Institution. Due to the rapid industrialization and the growth in size of the enterprises, the number of workers covered by LII increased. The number of workers under LII was 466,852 in 1955 and 577,991 in 1960. Still, these numbers comprised a very small share of the active population; 4.37 and 4.78 percents, respectively.[309] As the coverage was limited to the employees of the enterprises subject to the labor law only half million were covered in a country with a working population over 14.5 million. According to the SPO data, the ratio of those who were covered by a security scheme to the whole population was only 4% in 1950, 5.1 in 1955 and 5.8 in 1960.[310]

The rise in the revenues of the Labor Insurance Institution was the good news in the papers.[311] However, there was not any social policy vision for the majority of the population. Until then, the RPP had tried to handle the problem of urban-industrial social tensions by keeping the peasants in the villages. The DP, however, although it too focused on peasants, lifted the barriers between the cities and the villages. Those who migrated to the cities did not cut their relations with the villages and this helped the newcomers in handling the personal problems due to poor

[309] Ibid., p. 244.

[310] SPO (State Planning Organization), *Economic and Social Indicators (1950-2004)* (Ankara: SPO, 2005), p. 162. In the paper he presented in Social Policy Conferences, Cahit Talas mentioned this problem in 1955. In various presentations the need to expand insurance to all laborers including those in the agricultural sector, to rise the working standards not only of a minority but of all, and to think of social assistance mechanisms together with social insurance was emphasized. Buğra, "Türkiye'de Sağ ve Sosyal Politika." pp. 47-48.

[311] *Cumhuriyet*, 29 June 1954; 31 May 1955.

working conditions and lack of social security.[312] But this should not lead us to the conclusion that every newcomer had the means provided by the link with the village, and urban poverty did not constitute a serious problem.

On the contrary, many of the newcomers had to cope with poverty. They were living in *gecekondu*s, the Turkish version of irregular housing, that were in bad condition and without any infrastructure. Even if they could have had medical examinations free of charge either from state hospitals, dispensaries or private district doctors, medication and loss of labor due to illness constituted serious problems. Child poverty was on the agenda in terms of the problems created by homeless children. Government's focus on the problems of the rural population paved the way for the undermining of urban social problems. Yet, providing social insurance to the rural population was not on the agenda.[313] That means the DP governments did not pay attention to social security and social assistance, neither for the rural nor the urban populations. Buğra mentions the delay in the establishment of Social Service Institute despite available funds proposed by foreign organizations, as the proof of DP's lack of interest in social policy.[314] It is not that easy to criticize DP, however, in terms of its health care policies.

The Shift in Health Policies during the Democrat Party Era

The Democrat Party came to power in May 1950 following a big electoral victory against the Republican People's Party (RPP, *Cumhuriyet Halk Partisi*). The first

[312] Buğra, "Türkiye'de Sağ ve Sosyal Politika." pp. 48-9.

[313] Ibid., p. 49.

[314] Ibid., p. 50.

years of DP rule can be characterized by a radical economic transformation in line with the priority accorded to the commercialization of agriculture. Marshall grants arrived in increasing volumes. Also there were surplus reserves accumulated during the etatist years. These resources were allocated in the promotion of rapid mechanization in agriculture and in the development of a massive road network. There was an impressive economic growth between 1950 and 1953. Due to the decline in world prices for agricultural commodities and severe climate conditions, however, economic growth came to a halt. And Turkey began to experience large trade deficits.[315] The external factors, added to the poor economic vision of the Democrats which relied on a market-based mentality, led to an economic crisis. The massive investments they made proved to be ineffective as they aimed for quick and tangible results rather than long-term improvements in the productive capacity of the country, as they were allergic to anything resembling economic planning, and as investment decisions were often politically inspired.[316] So the economic policies of the DP created huge deficits, debts, inflation and a black market. At the same time, however, we witness the modernization of agriculture to a certain extent and the increase in the industrial base of the country. And through the new road network villages gained contact with the outside world which created dynamism and a sense of mobility.[317] The economic boom in the early 1950s brought an electoral victory to Democrats in the 1954 elections. However, the economic downturn began to erode support for the DP. The government could not meet the average villager's rising expectations of material improvement. But also there was a real deterioration in

[315] Vedat Milor, "The Genesis of Planning in Turkey." *New Perspectives on Turkey*, 4 (Fall 1990): 1-30, pp. 5-6.

[316] Eric J. Zürcher, *Turkey: A Modern History* (London and New York: I.B. Tauris, 1998), pp. 235-6.

[317] Ibid., p. 240.

terms of life standards. So, the Democrats started to lose support, especially on the part of the intellectuals, bureaucrats and military officers, which led them to adopt authoritarian policies.[318] Authoritarian policies against the press, the universities and the judiciary allowed for a climate in favor of a military intervention.

In the program of the first Menderes government (22 May 1950 – 9 March 1951), it was stated that health service was neglected in Turkey and there was an urgent need to meet the medical needs of peasants, and open new hospitals. A big combat program would be prepared for illnesses like malaria and tuberculosis, and preventive care would receive due consideration.[319] In the program of the second Menderes government (9 March 1951 – 17 May 1954), preventive care was defined as the task of the state and the need to establish health insurance to improve the means for curing the citizens is pronounced. It is stated that they have taken necessary measures to increase the number of hospital beds which used to be very low vis-à-vis the population.[320] In the program of the third Menderes government (17 May 1954 – 9 December 1955), the rise in the number of health centers, hospital beds, tuberculosis hospitals and beds was defined as a great accomplishment. The need to bring health services to peasants was pronounced as the condition to increase the population.[321] The programs of the fourth (9 December 1955 – 1 November 1957) and the fifth (25 November 1955 – 27 May 1960) Menderes governments emphasized similar points.

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[318] Ibid., pp. 240-1.

[319] Nuran Dağlı and Belma Aktürk (eds.), *Hükümetler ve Programları, I. cilt 1920-1960; II. Cilt 1960-1980* (Ankara: TBMM, 1988), p. 161.

[320] Ibid., p. 178.

[321] Ibid., p. 197.

These programs reveal that there was still the need to control malaria and tuberculosis and the lack of health services in villages constituted a major problem. The rise in the hospitals and health centers was cited first as an objective then as an already achieved accomplishment. Health insurance was pronounced for the first time in a government program. Therefore, the link between insurance and curative services became obvious. When it is public health which was at stake, resources other than general budget were not even mentioned because it was the major duty of the state. But when curative services were started to be provided by the state on a wider basis the need to derive sources other than general budget is expressed. In the program of the second Menderes government health insurance was proposed to improve the means for curing ill citizens, which implies that even when the state took the responsibility of curative services the contribution of people were expected. Preventive care was seen as a major duty of the state while curative services were not.

When the DP was in power, the share of the MHSA in the general budget increased above 5%, for the first time in Republican history. The share of the MHSA in the general budget was highest in 1960 (5.27). The second highest rate was in 1955 (5.18). There was an upward trend from 1923 to 1960.[322] The rise in the number of public hospitals and beds is noteworthy, so is the fall in the number of persons per bed. The highest rise in the number of hospitals is observed in the DP period. In 1950, there were 201 hospitals, 13 maternity and infant homes, and 22 health centers. They increased to 417, 17 and 181 in 1955 and to 566, 20 and 283 in

[322] See Table 11 for the share of MHSA in the general budget in 1923-2006. The rise in the share of MHSA in the general budget was small in the early Republican period because the hospitals, other than model and special branch ones, were financed by special provincial administrations and municipalities.

1960.[323] This more than two-fold increase in the number of hospitals and nearly thirty-fold increase in the number of health centers distinguishes the DP period from all other periods.

There was a continuous rise in the number of hospitals also after 1960, but not at this pace. The highest increase in the total number of beds can be observed also in the DP period; from 18,837 in 1950 to 45,807 in 1960.[324] The number of doctors rose while the number of persons per doctor declined. The highest decrease in the number of persons per doctor is also in the DP period, from 6,890 in 1950 to 2,799 in 1960. Although there was a serious decrease in the number of persons per nurse, health officer and midwife in the DP period; the following periods performed better. Of course, the rise in the number of health personnel in the 1950s cannot be explained only with reference to DP policies. Earlier manpower policies, which prioritized the need for physicians and underestimated the need for auxiliary health personnel, might have been determinate in these numbers.

It was during the DP era that the battle against epidemic diseases saw results. Due to epidemics in Iran, Iraq and Syria, 128 people were infected with smallpox and seven of them died in 1957. It was the last time smallpox was seen in Turkey. There were cholera epidemics in other countries, but Turkey was not affected. Rabies and syphilis were seen only sporadically. Rare typhus cases were observed in the mid-1960s. Malaria was retreated with DDT in cooperation with the WHO in the mid-1950s. The number of deaths due to tuberculosis fell dramatically. The Refik Saydam Institute expanded its scientific capacity. Between 1956-60, the Institute increased its production of typhus vaccination 10-fold, BCG 110-fold, smallpox 20-

[323] See Table 12 for the number of hospitals by type between the years 1940 and 2003.

[324] See Table 13 for the inpatient institutions bed capacity between the years 1940 and 2003.

fold, rabies 35-fold, and diphtheria 100-fold compared to its production in its first years. New vaccines started to be produced and serum production increased at a considerable rate.

It was in this period that the earlier epidemics left their place to cancer as the target of battle. International relations became important in the shaping and application of some health programs, especially in maternal and child health care and the battle against tuberculosis. The establishment of the Maternal and Child Health Organization within the MHSA in 1952 was due to the development in the cooperation with the WHO and UNICEF. Maternal and child health centers and branches, and village stations were established as part of the projects that were developed together with the WHO. A pasteurized milk factory in Ankara was established with a grant from the UNICEF. The cooperation with international organizations like the WHO and UNICEF and their assistance were considered to be important. In 1959, the MHSA, in cooperation with the Ministry of Education, distributed milk powder and other nutritious food to school children. Between 1955-60, the rate of population growth reached its highest level, 28.53 per thousand. The third faculty of medicine, at Ege University, was founded in 1955.[325]

The DP governments acknowledged the responsibility of the state both in preventive care and curative services. In 1954, the municipality and special provincial administration hospitals were transferred to the MHSA and started to be financed from the general budget. This would serve the rise of the standard of curative services, the provision of health services to all provinces on the basis of equality, and the integration of preventive care and curative services.[326] New

[325] Soyer, *Sanayi Devriminden Küreselleşmeye Darbeden AK Partiye Sağlığın Öyküsü*, pp. 93-94.

[326] Nusret Fişek, *Halk Sağlığına Giriş* (Ankara: Çağ Matbaası, 1983), pp. 162-163.

hospitals were built to provide curative services. However, this led to the concentration of health personnel in hospitals in urban areas, which in turn weakened the health service delivery in rural areas. This constituted one of the main reasons for the socialization of health services. When priority is given to curative services there is the risk of unjust distribution of health facilities because the hospitals usually concentrate in cities as they necessitate a strong infrastructure. Yet, the government's acceptance that curative service was its task together with preventive care was a turning point in the history of health care in Republican period.[327] This acceptance, however, does not imply a model of national health service in which all types of health services are covered from the general budget. Starting from the expansion of curative services there appeared the search for ways to have people contribute and in 1955 the Regulation on Hospitals brought the practice of payment in state hospitals. The change characterizing the DP period should be regarded for the shift from preventive care to curative services, from the "science of masses" to the "science of individuals." The nation-state was consolidated and the target of a larger and healthier population was reached. This allowed the DP to focus on curing individuals although there was still the need to expand basic preventive care to the villages.

[327] This was not an easy transformation. Years after the transfer of hospitals, even after the socialization of health services, in a meeting on the integration of curative services in 1966, the undersecretary of MHSA Faruk İlker restricted the responsibilities of the Ministry to preventive care and social assistance. For him, curative services had been left to the MHSA without its consent ("The Ministry of Health is responsible for the task of preventive care and social aid. Curative services have become a de facto task of the Ministry by constant imposing" (*Sağlık Bakanlığı'nın kendisine mevdu vazife koruyucu hizmetler ve sosyal yardımdır. Tedavi edici hizmetler Sağlık Bakanlığı'nın üzerine mütemadiyen yığılarak kalmıştır.*) Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde Tedavi Edici Sağlık Hizmetlerinin Bir Elden İdaresi Konusunda Yapılan Seminer Çalışmaları* (Ankara: SSYB, 1966), p. 40. In our interview, former head of Etimesgut Training and Research Region Doğan Benli described a visit of President Turgut Özal. After showing him round the health post Doğan Benli invited him to the hospital and Özal said "It is not my job". Benli recounted this anecdote with appreciation as he also thinks that state is responsible for primary care (Doğan Benli, interview by the author, tape recording, Ankara, Turkey, August 2006).

The Democrats opened new health centers with wider terms of reference. Among them were: Maternal and child health care and hygiene, personal hygiene, the prevention of infectious and epidemic diseases, narcotic control, school and school children hygiene, environmental sanitation, health education, and curative services where possible.[328] Medicine for preventive care, child birth, and emergency were free as well as medicine for the poor.[329]

New hospitals were built and annexes were added to existing ones. A brief look at the newspapers reveals the interest of the government in providing hospital services. An annex was added to the Baltalimanı Bone and Knuckle Tuberculosis Hospital,[330] another was added to the Bakırköy Psychiatry Hospital,[331] an oncology institute was planned to be established in Ankara[332] and an annex was planned to be added to Şişli Child Hospital for children with tuberculosis.[333] Despite these efforts, the hospitals were unable to meet the rising demand and were always crowded. *Cumhuriyet* reports on the capacity of tuberculosis hospital services with the heading "Awful Statistics": Only 6,210 of 10,887 tuberculosis patients were able to be hospitalized in İstanbul.[334] Patients sharing beds or lying down on mattresses became common scenes in hospitals.[335] When Minister of HSA Behçet Uz inspected some hospitals in İstanbul he observed problems related to hygiene (there were many flies)

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[328] Aydın, "Cumhuriyet Döneminde Sağlık Örgütlenmesi." p. 156.

[329] Ibid., p. 158.

[330] *Cumhuriyet*, 17 April 1954.

[331] *Cumhuriyet*, 18 April 1954.

[332] *Cumhuriyet*, 8 September 1954.

[333] *Cumhuriyet*, 18 July 1954.

[334] *Cumhuriyet*, 28 May 1954.

[335] *Cumhuriyet*, 28 March 1952.

and absenteeism of the doctors.[336] Doctors were not observing the rule of working hours. When the budget of the MHSA was discussed in the National Assembly in February 1955, deputies from both parties emphasized the squalor and insufficiency of the hospitals. The need to build less costly big hospitals rather than luxurious ones was emphasized, together with the need to train health personnel and to provide preventive care to peasants. The Minister of HSA Behçet Uz acknowledged the squalor and insufficiency of the hospitals, but demanded that the deputies realize the great accomplishments such as tuberculosis combat, newly built county health centers, and the rise in the number of health personnel. He thought that the new regulation on hospitals would be applied in March would prevent complaints about hospitals. In the same meeting, Bilecik deputy Doctor Talât Oran mentioned the need for 85,000 hospital beds, which would cost 456 million liras. For him, this amount could not be provided by the government so it was necessary to take money from patients: "This is the new system in all civilized countries. They pay a lot of money to buy a tie but when it comes to hospital service they do not want to pay any money. They abstain from treatment which is subject to payment. This is unacceptable."[337] In accordance with the mentality of Talât Oran, the regulation on hospitals introduced the practice of payment in state hospitals.

The Regulation on Hospitals was accepted by the council of ministers on 25 February 1955 and was published in the Official Gazette in 4 April 1955 (*Hastaneler Talimatnamesi*). It was a very detailed regulation that consisted of nine chapters and 287 articles. It aimed to regulate everything related with the operations of a hospital. Article 4 made a distinction between those who would be examined and treated free

[336] *Cumhuriyet*, 18 July 1954.

[337] *Cumhuriyet*, 26 February 1955.

of charge and those who would not. Those who would be examined and treated free of charge were as follows: Women who needed maternity grants in accordance with the Law of Public Health article number 153 and those who had problems in giving birth (hospitals might provide swaddling clothes for the babies of poor and deserving women); those with infectious diseases who had to be quarantined according to the Law of Public Health; those with poverty record (if the patient did not have a poverty record and could not afford the costs, the head doctor had the right to allow their free treatment); those whose need for free treatment was approved by the MHSA or the highest administrator of the region; all the army officers, privates (*er*) and civil servants who retired with physical disabilities and their dependents; all members of the practice of medicine and medical sciences and their dependents; those who needed to be cured before conscription; and those under arrest or convicted whose poverty was approved by the public prosecutor. According to article number 5, money would be charged in accordance with the tariff prepared by the MHSA from all those who fell outside the above categories. The tariff would determine the prices for beds, care, operations, x-rays, physical therapy and laboratory in hospitals and examination, treatment, small operations, x-ray and laboratory work in policlinics. The charges for the examination and treatment of civil servants were regulated in article number 12. Civil servants were required to bring a note (*tezkere*) from the state institutions, State Economic Enterprises, banks, insurances and trade unions they worked for, to be examined and treated free of charge.[338] Hospitals could have four categories of rooms: private, first, second and third class (article number 9). Bed sharing was banned in article number 15.

[338] *İktisadi Devlet Teşekkülleri, banka, sigorta ve sendika mensup ve memurları –hastanelere yazılmış birer tezkere getirmek şartiyle- yatırılır.*

This regulation can be considered to be one of the initial steps in the consolidation of "inegalitarian corporatism," where both the rural population and urban informal sector employees are excluded from the formal social security system. Those who benefited from medical coverage, in this case from hospital services, were workers in the formal sector and civil servants. In time, the former would benefit more from its own hospitals that would be established throughout the country, while the latter would always have the advantage of benefiting from state and university hospitals. Another important factor in terms of differences in access to health care was the economic status of the people. The affluent had always been, and remained, advantageous in receiving qualified health care. Apart from security coverage the financial strength of the people had always been decisive in the quality of health service they received.

In the 1950s there was a serious rise in the number of doctor's offices in big cities. The newspapers of those years are full of advertisements of specialist doctors in İstanbul. There were stories of doctors who used middlemen (*simsar*) to bring patients in return for commissions. The discipline committee of the İstanbul Union of Medical Chambers debarred six doctors who had used brokers from practicing medicine for a period of one week to six months.[339] The commercialization of medicine resulted in such stories and articles were published to change the negative image of doctors. In his article "Hostility towards Doctors," Professor Rasim Adasal criticizes the unfair accusations which classify doctors as a separate rich and egoistic class.[340] Starting from the late Ottoman practice of appointing country doctors to province and county centers in 1871, the doctors who worked for the state always

[339] *Cumhuriyet*, 15 July 1954.

[340] *Cumhuriyet*, 9 April 1954.

had the right to private practice. They resisted being civil servants and tried to earn money from private practice. What was new in the 1950s which multiplied these stories, was the rise in urban population, progress in medicine and medication, the rise in the number of specialists, the rise in expectations, and thereby the rise in demand for health care. The number of people who applied to doctors increased, as did the number of doctors. Unethical behaviours appeared where private practice expanded.

Another problem of the period was related with the trade regime. Limits that were put on the imports of consumer goods resulted in a shortage of medicine. For example, there was a shortage of x-ray film.[341] Even when there was no limit on the importation of consumer goods, it was not possible to find every type of medicine on the market. For example, the Ministry of Economy and Trade allocated money for the importation of insulin and infant food which could not be found in the market[342] or the Minister of HSA assigned the inspectors the task of finding the lacking medicine in the pharmaceutical warehouses and pharmacies in İstanbul.[343] Adnan Adıvar criticized the doctors for prescribing medicine which could not be found unless sought throughout the city or brought from foreign countries if the patient had the connections. He said that, doctors should consider the economic situation of their patients.[344] Before, the pharmacists had prepared medicine by mixing the required ingredients, but with the advance of patent medicine, the availability of medicine had become a problem.

[341] *Cumhuriyet*, 21 April 1955.

[342] *Cumhuriyet*, 7 July 1954.

[343] *Cumhuriyet*, 17 July 1954.

[344] *Cumhuriyet*, 25 September 1954.

The Minister of Health and Social Assistance Behçet Uz always mentioned the need to increase the number of hospital beds and their balanced distribution. For him, Turkey was lagging fifty years behind in child illnesses. So he prepared a program that covered the establishment of health centers and hospitals, the equipment of hospitals with modern sanitary conveniences, the expanding of opportunities to combat infectious diseases, the production of infant food and the modernization of thermal waters. This program would be implemented within 10 years and would cost one billion and a hundred million liras. The MHSA sent booklets of this program to health directorates and doctors to get their opinion.[345]

The final version of the program was designed to expand health centers throughout the country. Turkey was divided into 16 regions and health services would be organized according to this scheme. Health centers with 10 beds in small counties and 25 beds in big counties would be established. They would provide curative services and preventive care together. The National Health Bank existed also within this program but there was something original, i.e., the health insurance.[346] The Bank would set up and operate health insurance.[347] The National Health Program was sent to Doctor Bridgman from the WHO for assessment. He was an expert who visited Turkey several times and prepared a report on hospitals. Bridgman found it unrealistic to apply health insurance in a country like Turkey. He gave the examples of Britain, France, and the USA, i.e., countries with high urban and industrial populations where the establishment of insurance was possible. However, Turkey had a large rural population, so it was much more proper to make

[345] *Cumhuriyet*, 13 January 1955.

[346] The need to establish health insurance was already declared in the program of second Menderes government. Dağlı and Aktürk (eds.), p. 178.

[347] Aydın, *Türkiye'de Sağlık Teşkilatlanması Tarihi*, pp. 69-74.

insurance compulsory for some and discretionary for others.[348] The National Health Program could not be implemented and the government reconciled itself to the opening of new health centers.

The plan of establishing health insurance has been on the agenda since the 1950s. But the basic fact that was emphasized by Doctor Bridgman, that of Turkey's being an agricultural country, made the realization of this plan impossible. Social insurance systems had been established in European countries in the late nineteenth and early twentieth centuries when industrialization had transformed the peasants into factory workers. Insurance came on to the agenda as a workers' right. In countries like Turkey, where the rural population constituted the majority until the last twenty years, insurance has not been, and still is not, a realistic option. Unlike the industrial workers, peasants are not regular wage earners to whom the social insurance principle can be applied. In the following discussions related to the financing of health care, insurance will always be proposed by the governments but meet with the argument that in a country with such a large rural population an insurance system will not work.

Major Problems in the Field of Health Care

Although there were serious accomplishments in health care throughout the first half of the twentieth century people faced difficulties in accessing health services especially in rural areas and epidemics could still be observed. The written accounts on that period like memoirs and interviews reveal that transportation and the availability of medicine were the main problems. Until 1955, if you were able to

[348] *Cumhuriyet*, 20 April 1955.

reach a state hospital you were provided free health service. For the majority of the population, however, it was hard to meet the costs of transportation and medicine.

In his memoir *Kasaba Doktoru* (Small Town Doctor), Muzaffer Sertabiboğlu exemplifies the difficulties people faced like the high cost of taking patients to Fethiye State Hospital. Sertabiboğlu fulfilled his compulsory service as government doctor in Hekimhan, Güngörmüş, Kaş and Mersin between 1948 and 1952.[349] Compulsory service was required for doctors, who had been provided free accommodation and scholarships while studying at the Faculty of Medicine. Sertabiboğlu started working at Kaş in 1948. At that time Kaş had no land connection to Fethiye or Antalya. All the transportation was done by a State Maritime Lines boat that came from İstanbul once a week. One day he was called by the midwife of a village who was unable to help a woman giving birth. The woman had not given birth although she had been in labor for three days. Upon examination, the doctor found that the baby had died and it had to be evacuated in order to save the mother's life. So an operation was necessary which could be done by the surgeon in Fethiye State Hospital:

> ... I told the husband to take his wife to Fethiye with a motorboat, and save her life. The man knew that the motorboat would cost 200 liras. He said 'I am poor, I only have a horse. If I sell it I can get only 100 liras. I cannot take my wife there'. This man, who had four children from his first wife, did not care for her life.[350]

So, Sertabiboğlu took the risk, did the operation and saved the woman's life.

He faced similar cases many times. In another case, there occurred the need to get a child to Fethiye, but the child's poor grandfather said he did not have enough

[349] Muzaffer Sertabiboğlu, *Kasaba Doktoru: Anılar – Acılar* (İstanbul: İstanbul Tabip Odası, 2000).

[350] Ibid., p. 57.

money for the motorboat. So, Sertabiboğlu made the operation by going through his medicine books and saved the child.[351]

After he became a specialist he started working in Edirne State Hospital. In 1956, to solve the problem of the foreign exchange bottleneck, the government applied a selective import restriction. The medicine used in tuberculosis treatment could not be imported and became an item found only on the black-market of İstanbul. Those who could afford the medicine could be saved while those who could not were doomed to death. In his memoirs, Sertabiboğlu describes this situation with great anger and rebellious feelings towards the "welfare state" (*sosyal devlet*) in Turkey.[352]

It seems that in the 1950s, the costs of transportation and medication were more decisive compared to the cost of examination. Specialist health care was not accessible to those who lived outside the cities and county centers. The spatial exclusion constituted a serious problem especially for the poor who did not have the means to cover transportation costs. Considering the poor road network system in the country and the economic condition of the peasants in that period, we can say that the majority of the population was unable to receive any specialist care, or any kind of basic health care. At that time, a great majority of the villages did not have proper road access.

When transportation was not a problem, in the case of the poor who lived in İstanbul, medication and loss of income due to disability for service comprised the main problems. In a series of interviews conducted by well-known men of letters with poor families in İstanbul for the journal *Akşam* in 1956, the people reported that

[351] Ibid., p. 64.

[352] Ibid., p. 89-91.

they had access to doctors, but medication and loss of income due to disability for service worried them greatly.[353] Oktay Rifat talked to Şükriye Özçelebi, who lived in a one-room house with her 11 children. He asked whether they saw the doctor when the children get sick. She said they did. She and her neighbors started talking: "-Certainly the hospital is free. -But medicine is not. -They cannot buy all the medicine. -By getting into debt."[354] Orhan Kemal talked to Pakize Erün with 9 children in their one-room house in Sultanahmet. She complained to the writer about her illnesses and those of her husband: "... He has an ulcer in his stomach and a hernia in his groin. He always faints. Sometimes I tell him to go to the hospital and have operation. He looks at my face hopelessly and says 'If I lie down for operation what will the children eat and drink; what will they do if I die?'"[355] Another poor woman with seven children said she was afraid of seeing the doctor as he might recommend her to rest.[356] Another woman with eight children complained about the prices of drugs: "We cannot buy a box of drugs for 300 kuruş."[357]

Rahmi Dirican was one of the public health specialists who worked together with Nusret Fişek in the socialization of health services. In his memoir, *Bir Hekimin Anıları* (Memoir of a Doctor), he described the difficulties people face in Tunceli Hozat.[358] In 1953 he started working in Hozat as a gendarmerie legion doctor. He wanted to conduct private business after his work hours. The circumstances allowed

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[353] Orhan Kemal, Oktay Rifat, Melih Cevdet Anday, İsmet Yenisey and Remzi Tozanoğlu, *Roman Kokan Evlerde Gezinti* (İstanbul: Yaba Yayınları, to be published).

[354] Ibid., p. 28.

[355] Ibid., p. 54-55.

[356] Ibid., p. 60.

[357] Ibid., p. 105.

[358] M. Rahmi Dirican, *Bir Hekimin Anıları* (Ankara: Selvi Yayınevi, 1998); Rahmi Dirican, interview by the author, tape recording, Erdek, Ortaklar village, Turkey, July 2006.

for this since the Ministry could not assign someone to the position of government doctor. Still, no one came to see him. When he asked why, people said "... here, if someone is not seriously ill they do not see a doctor because people are really poor. 10 liras for examination, and medicine and injection added, it will cost 25 liras. Very few can afford this. The well-off take their patients to Elazığ".[359] So Dirican fixed the examination fee as 1 lira and people started to see him. He had his private office while he was working in Tokat Erbaa health center between 1956 and 1958. One morning an old peasant woman came to his office and accused him of yearning for money and neglecting them: "Infidel, the village is struck by pestilence! You sit here and bucket money. Who will take care of us?".[360] She was coming from a village struck by measles epidemic. Dirican remembers that the traveling health officer had informed him about the situation and he settled for making suggestions. He had not gone and seen by himself. Then he went to the village together with that woman and treated the patients there. He regretted his attitude and thought that people would not have died if he had gone there earlier.[361] He realized that he was developing an itch for money. One night a poor man requested that he see his ill son. He told him to bring his son to the office in the morning. He knew that he could not take money from this man. If the father were rich, he would have gone. Early in the morning he learnt that the boy had died. At that moment he swore he would not work in a system which commercialized the doctor-patient relation. He went to a public health course at the Ankara School of Public Health (*Hıfzıssıhha Okulu*).[362] These stories show that the state health services were not sufficient and people did not have the means to

[359] Dirican, *Bir Hekimin Anıları*, p. 50.

[360] Ibid., p. 90.

[361] Ibid., p. 91.

[362] Ibid., pp. 94-95.

receive health care that is subject to payment. They also show us that the state doctors' privilege of practicing privately after hours created problems of equity.

The DP period can be characterized by a rising demand for health care, the commercialization of medicine together with increasing state involvement in curative services, the undermining of public health, and the consolidation of an "inegalitarian corporatist" structure in hospital services. The most important change was the transfer of municipality and special provincial administration hospitals to the MHSA, which implies the acceptance of the responsibility of the state in the field of curative services. The expenses of the hospitals would be met from the general budget. There were serious improvements in health care, but the rising expectations of the people could not be met. The process of urbanization, the rise in transportation facilities and the improvements in health technologies were the reasons for the change in people's expectations. Also, the post-war period was characterized by the rising demands of citizens from the state. That was why the growth rate in the field of health always lagged behind the rising demand.[363]

In the 1950s, the governments gave importance to the training of health personnel and by 1960, there were three faculties of medicine (İstanbul, Ankara, İzmir), nine nursing and health officer schools, and 14 midwifery schools. The number of auxiliary health personnel could not be raised to the desired level. The real rise occurred after 1960. The rise in health service expenditures led the DP governments to designate new resources like health insurance, but they did not prepare comprehensive plans for this. As the expert from the WHO asserted, as already mentioned, the application of health insurance in an agricultural society was difficult. They tried to cope with the rising expenditures by charging money for

[363] Gençay Gürsoy, "Sağlık." *Cumhuriyet Dönemi Türkiye Ansiklopedisi*, cilt 7 (İstanbul: İletişim Yayınları, 1983), p. 1724.

hospital services. Improvements in medical technology, the prioritizing of curative service, and the rise in expectations were not peculiar to the DP period. The DP period might be considered as the initial phase of this process, which led many of the politicians, health bureaucrats and doctors to conclude that "the state cannot meet all expenditures related with health; people's contribution is a must at least for curative services" - a view that would be emphasized more strongly even after the socialization of health services.

Conclusion

The leap in public health services in the late Ottoman period was unable to develop due to the wars and the dissolution of the Empire. The new Republic inherited some Ottoman institutions, but had to establish a new health care organization, enact the related legislation, and fight against infectious diseases. After decades of war and epidemics, the country had lost a large number of people and those left were worn with diseases. The nation-state was going to be established, but the population which was expected to constitute the "nation" was low, composed of unhealthy and weak people. There was the need to create a healthy and productive nation, otherwise the military security and economic and social development goals could not be achieved. So the early Republican governments adopted pro-natalist policies and introduced a sanitary reform to increase the population and improve its health. Birth control was prohibited and people were encouraged to have many children. The child question was an integral part of the broader question of population. The population started to increase during the Great Depression, but the mobilization for World War II brought a halt to this increase. The struggle against infectious diseases like tuberculosis,

malaria, trachoma, and syphilis was quite successful. However, there was not much improvement in terms of expanding the staff or extending the health and social assistance to the villages.

In the early Republican period, the state took the responsibility of preventive care and left the curative services to the local authorities and private practitioners. The emphasis was on the "science of health" rather than the "science of disease", i.e., on the health of the population rather than the health of the individual. This holistic approach changed during the DP period. The accomplishments of the Republican governments made it possible for the DP to concentrate on curative services. The municipality and special provincial administration hospitals were transferred to the MHSA and new hospitals were founded.

This change in the 1950s was not peculiar to Turkey. Prior to World War II, health care was predominantly primary care and public health-oriented, partly because curative capacities had been limited and often ineffective at best. Through the early decades of the twentieth century, health care was normally limited to performing public health functions. Hospitals were primarily designed to protect the public health, often by appealing to quarantine rather than treating, and largely served only patients who could not afford a private physician. During the 1950s and 1960s, the emphasis in health care shifted perceptibly towards curative medicine. The modern medical profession developed primarily around the search for finding cures rather than promoting health, preventing disease and protecting public health.

The growth of high-tech medical centers, the expectation of ever more sophisticated diagnostic capacity, and expansion of dramatic life-saving procedures changed the nature of medical care. This global change raised the expectations of people and their demand for health care. Although the DP invested in curative

services and allocated a large share to the MHSA in the general budget, the rising demand for health care could not be met. The emphasis on curative services caused concentration in cities, which left the rural population devoid of any health services. Transportation was a major problem for the large rural population while for those in the cities, the availability of medicine and loss of income due to disability for service constituted the main problems.

The DP period might be characterized by a rising demand for health care, the commercialization of medicine, increasing state involvement in curative services, the undermining of public health, and the consolidation of "inegalitarian corporatist" structure in hospital services. With the 1955 Regulation on Hospitals, the DP introduced payment in hospitals for those outside the formal sector. The expenses of the workers would be covered by LII and those of civil servants by their public offices. Workers in the formal sector constituted a very small portion of the working population. Yet the number of the members of the LII and its revenues were rising. Starting from 1949 LII established its own hospitals and in ten years time their number reached 12. LII established a separate health insurance system and adopted the role of financier, provider and administrator.

Health insurance came onto the agenda during the DP period. There is a coincidence between the emphasis on curative services and the search for the possibility of establishing an insurance system. However, it was realized that in an agricultural society, insurance was not a realistic option. This study reveals that the state took the responsibility of curative services but unlike preventive care it was not considered to be the major duty of the state. From the very beginning there was no debate related to the financing of public health. But for curative services there was always a search for the contribution of the people. This was related also to the rising

expectations, demand and expenditures. Due to the accomplishments in the field of preventive care the government could now focus on curing illnesses, but curing has always been an expensive service and governments had to find ways to finance it. The search for insurance system reveals that curative service was not considered to be a basic citizenship right and providing of it to those who had paid premiums was approved.

In the DP period, the rise in the number of hospitals, hospital beds, and health centers meant a serious rise in expenditures. The DP governments tried to find ways to cover these expenditures. Also the example of LII might have been influential. The institution was collecting health premiums from its members and establishing new hospitals and providing quality care. However, at that time, this model seemed impossible to apply to the whole population, but it was applied to a certain portion of it. Civil servants paid premiums for health services in their retirement. Their expenses were covered from the general budget when they were working. So, inequalities started to appear in terms of receiving health care between those in the formal sector and those outside of it. As the former constituted a small portion of the population and the health services were not that expensive then, the inequalities between those inside and those outside the formal sector were less decisive than other inequalities. The inequalities between the rural and the urban persisted although the DP tried to diminish them by opening new health centers in counties. The inequalities between the rich and the poor became much more apparent with the rise in doctors running private practices, the developments in medicine, and health technologies.

Although we can talk about the consolidation of “labor insurance” during the DP era, there was not that much change in terms of social policy. In the field of

health care, however, there was a serious change, some aspects of which led the military after the coup of 27 May to adopt the socialization of health services. The emphasis on curative services which increased the inequality between the rural and the urban population, the undermining of public health and the commercialization of medicine were among the reasons for the socialization of health services.

CHAPTER FOUR

THE MILITARY TAKEOVER AND THE ATTEMPT TO ESTABLISH A NATIONAL HEALTH SERVICE: THE SOCIALIZATION OF HEALTH SERVICES (1961)

Introduction

The coup of 27 May 1960 might be considered as a turning point in the history of Republican Turkey. The 1961 Constitution and the State Planning Organization (SPO, *Devlet Planlama Teşkilatı*) were the two main products of the coup. The first charged the state with the task of providing social welfare to its citizens, and the second designated the development strategy and five-year plans of the country. In line with the welfare responsibility of the state and the new strategy of planned development, a radical reform measure was taken in the field of health care: The Socialization of Health Services.[364]

Basically, it was the establishment of a system which ensured that everyone would benefit equally from health services, that to benefit from such service was not conditioned upon the financial means of the person in need of such service, that these services were administered by the state and that they were developed according to a well-determined program. Actually, the concept of "socialization" (*sosyalleştirme*) caused confusion, "nationalization" (*millileştirme*) was a more proper concept to explain this new policy. As will be clarified later on, "socialization" can be read as

[364] *Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun*, no. 224, *Resmî Gazete*, 12 January 1961, see Appendices.

the definition of the “national health services”. The verb “to socialize” is used to explain the application of the law in a particular region.

The Socialization Law envisaged a gradual transition. The new system would be applied throughout the country over a period of fifteen years. So, the provinces would be socialized one after another. In places where the socialization was applied, i.e., the places which were socialized, health stations and health posts were established that were responsible for the well-being of a certain population. They were connected to the health center in the county and hospital in the province, among which the referral chain worked. The law’s objective was to extend health care, including preventive and environmental services and health education, to the whole country, and to make it easily and equally accessible to everyone.

In this chapter the socialization model will be analyzed as an attempt to bring universal health coverage to all citizens based on the principle of equality. The early Republican emphasis on population and public health had been weakened during the Democrat Party era and hospitals had started to gain weight. The state, which had not taken the responsibility of curative services beforehand, adopted the role of main provider, financier and administrator of health care. Yet, the existing health services were unable to meet the rising expectations of people, and peasants, who constituted nearly 70% of the population, were devoid of basic health care. Especially the Kurds living in South Eastern Anatolia were devoid of major services. Although epidemics like trachoma that were generally seen in those regions were taken under control, there was a serious inequality between the East and the West in terms of health services. Especially for the military officers, the integration of the Kurds required radical measures and in this way Kurdish nationalism, which had started to gain a political dimension in the late 1950s, would lose its ground. Also there was a kind of

commercialization of medicine which revealed itself in the rising number of specialist offices in big cities and the introduction of patent medicine. The military officers, who were influenced by the welfare state developments in Europe, wished to provide health service to all. The unjust distribution of health services, the lack of basic health care in the rural areas, and the difficulties poor people faced in receiving medical care led the officers to assign the undersecretary of the Ministry of Health and Social Assistance (MHSA) Nusret Fişek the task of preparing a national health program.

For the officers the major problem of the country was social justice. Not only health, but also education, tax and distribution of land were going to be handled within a comprehensive planning vision. It was the period when national developmentalism was the dominant ideology and planning was the dominant paradigm.[365] Military rulers and early planners conceived economic growth and social justice as inseparable components of a democratic development. The SPO was expected to designate a comprehensive development strategy which promoted social justice. Therefore, the planning of not only economic growth but also population, health and education were the responsibility of the SPO. Social issues were handled in functional unity with the economic structure. For example, education was planned based on a strategy which aimed at reaching general social development and equal opportunity together, and its being functional for the economic and technological progress of the country.[366] The same was true for population and health.

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[365] Keyder, *Ulusal Kalkınmacılığın İflası*.

[366] Necat Erder, Attila Karaosmanoğlu, Ayhan Çilingiroğlu, Attila Sönmez, *Plânlı Kalkınma Serüveni: 1960'larda Türkiye'de Plânlama Deneyimi* (İstanbul: Bilgi Üniversitesi Yayınları, 2003), p. xiii.

The SPO prepared a development strategy which was based on land reform, progressive agricultural tax, and the reorganization of the State Economic Enterprises (SEEs). However, civilian governments rejected their radical reform proposals, which in turn left the objective of development devoid of its resources. Early planners resigned and the SPO lost its initial power. I explain this process as it indicates the problems in the designation and application of radical reforms. This process left the socialization of health services, among other social policy measures, without any resources and strong planner support. It was not only the objective of industrialization, but also of social justice that was at stake. I will then try to analyze the role of the Kurdish question both in the planning leap and the health program. Although in the original program socialization was planned to be activated first in the big cities in the West, the military insisted on its application first in the East and this was precisely the point which related the program to the Kurdish question. After presenting a brief account of the Kurdish nationalist movement in the Republican period, I will look at the major themes of the Turkish state discourse on the Kurdish question to locate the 27 May practices, including socialization, within them.

The simplistic pro-natalism of the 1930s left its place to anti-natalism in the 1960s as the rapid population growth started to create so many developmental problems and public health issues. The annual growth rate of population which had fallen during the World War II years due to mobilization, rose to 28.53 per thousand in the second half of the 1950s. The early planners insisted on the need to control this population growth as it was very high with respect to the existing economic resources of the country and the anticipated annual economic growth rate of 7%. Nusret Fişek worked on the population section of the First Five Year Development Plan and prepared the Population Planning Law together with the early planners

although there was a difference in their priorities. The former emphasized the health and human rights dimension of birth control while the latter was more interested in its economic dimension. The anti-natalist policies of the 1960s constituted a serious rupture with the pro-natalist policies of the 1930s not only in terms of its orientation, but also in terms of its ideological shift. The anti-natalist policies of the 1960s were marked both by economic concerns and a human rights perspective. The change in the population policy and its ideological implications will also be analyzed in this chapter.

After portraying the conditions that generated the need to formulate a new health care system, the intentions of the military officers, and the discussions around a new model, I will focus on the main principles of socialization. I will explain these principles mainly with reference to the writings of Nusret Fişek, the architect of the model. The socialization of health services was a radical step towards covering the whole population based on the principle of equality. It was influenced by the welfare and health care developments in Europe. These developments were complemented by the Universal Declaration of Human Rights (1946) and the Constitution of the World Health Organization (1948). The Constitution of the WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, and puts the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being irrespective of race, religion, political belief, economic or social condition. Defining health as a fundamental right amounts to assigning the task of providing it to the state. This approach was adopted in Turkey and article 49 of the 1961 Constitution assigned the state the task of providing physically and mentally healthy lives and medical care to

all its citizens.[367] The socialization of health services was a way of accomplishing this ideal.

Similar to the DP period, socialization accepted the responsibility of state in curative services, but emphasized preventive care. In this sense, it exhibits continuity with the early Republican period. However, preventive care in socialization was not limited to environmental hygiene and combat against epidemics and included educating people on health, and early diagnosis and treatment through the periodical examination of healthy people. The socialization of health services did not share the holistic approach of the 1930s although it emphasized public health. It was clearly stated that citizens had the right to live healthy lives and that the state was responsible for this. Everyone would benefit from preventive care and curative services on an equal basis. In the early Republican period, health care provision was not a product of a welfare state approach because everybody had the right to a healthy and prosperous life, but the product of the anxiety to create a populous nation with healthy and productive individuals. But in the 1960s, social policies like health care were adopted to make people feel like citizens. Both the population policy and health care were determined within a planning vision for the promotion of equality and social justice. The rupture in the 1960s was very important in terms of adopting health care as a basic citizenship right. However, the socialization could not be applied properly and the ideal of providing health care to all citizens based on equality was not accomplished. The following chapter will analyze the application process and the "failure" of socialization.

[367] "The state is obliged to provide maintenance of physical and mental health as well as medical treatment for all." (*Devlet, herkesin beden ve ruh sağlığı içinde yaşayabilmesi ve tıbbi bakım görmesini sağlamakla ödevlidir.*)

Throughout this study I will make reference to the writings of Nusret Fişek, the architect of both the socialization of health services and the population planning. He was the most prominent figure in the field of public health in Turkey. Born in 1914 in İstanbul, he graduated from the İstanbul University Faculty of Medicine in 1938. He received his Ph.D. in bacteriology and immunology from Harvard University in 1954. He obtained the academic title of associate professor at Ankara University in the field of microbiology in 1955 and was appointed as the director of Ankara School of Public Health (*Hıfzıssıhha Okulu*) in 1958. In 1960, he became undersecretary of state in the MHSA. He was appointed to the School of Public Health to be removed from his position in the Ministry. Fişek decided to return to the university and became a public health professor at Hacettepe University in 1966. He worked at the Hacettepe Faculty of Medicine until he retired in 1983. His last position there was the chairmanship of the public health department. He founded the Hacettepe University Institute of Population Studies and presided there between the years 1966-72. He was the head of the Turkish Medical Association between 1984-1990. He was the founding member of many associations, such as the Human Rights Association, the Human Rights Foundation, the Association of Doctors Against Nuclear War, the Turkish Family Health and Planning Foundation, the Ataturkist Thought Association, the Turkish Microbiology Association, and the Ankara Microbiology Association. He was elected as the honorary member of the Royal College of Physicians, the Faculty of Community Medicine (GB), and the American Medical Association. He was a member of many foreign associations such as the New York Academy of Sciences, the American Public Health Association and the Liverpool School of Tropical Medicine. He participated in many international gatherings and received many awards. He wrote many articles and trained hundreds

of medical students. He introduced notions like public health, community medicine and family planning to medical training and tried to put them in political practice. He died in 1990 at the age of 76. The TMA offers awards in his honor: the TMA Nusret Fişek Public Health Award, the TMA Nusret Fişek Service Award and the TMA Nusret Fişek General Practitioners Research Award.[368] His son Gürhan Fişek established an institute in his name: Fişek Enstitüsü.[369]

The Military Takeover of 27 May 1960 and the Establishment of the State Planning Organization

Due to some internal and external factors, the second half of the 1950s was not that bright for the DP governments. Huge budget deficits, debt, and inflation began to erode support for the party and the party responded to the loss of support and any kind of opposition with anti-democratic policies. During the DP era, the influence of the army officers lost weight and their life standards declined. The DP slighted and even disdained the military. Due to the inflationist policy of the party, not only the army officers', but also the civil servants' life standards deteriorated. The salaries of civil servants were fixed between the years 1948 and 1959. That means there was a fall in the salaries in the same amount of the rise in prices. The government made a 100 % raise in the salaries of the civil servants in 1959, but it lagged behind the rise in the index of wholesale prices, which was 142.48% that year.[370]

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[368] Mehmet Cemil Uğurlu, "Bir Toplumsal Hekimlik Önderi Prof. Dr. Nusret H. Fişek (1914-1990)." *Ankara Üniversitesi Tıp Fakültesi Mecmuası*, 45(2) (1992): 367-410.

[369] http://fisek.org.tr.

[370] Figen Altuğ, "Devlet memurlarının mali durumlarındaki gelişmeler (1948-1960 Dönemi)." *Toplum ve Bilim*, 13 (1981): 67-75, p. 73.

In the early 1960s, civil servants constituted 2.82% of the working population and the share they took from national income was 15% which meant 9430 TL per capita in a year. The commercial sector constituted 67 per thousand of the working population and the share they took from national income was 24.9% which meant 129,900 TL per capita in a year. So the commercial sector grew with great earnings, which led the military and civil bureaucracy who, in the 1950 elections, had to hand over their power to oppose the government.[371] This decline in life standards of the army officers and civil servants, together with the anti-democratic policies of the DP, paved the way for the coup. Young army officers assumed power in the name of the military.

On 27 May 1960, the military announced that power was now in the hands of a National Unity Committee (NUC, *Milli Birlik Komitesi*). A cabinet of technocrats was installed by the military, but it was a purely executive organ. All important policy decisions were made by the NUC itself. The officers in the NUC were convinced that a simple change of government was insufficient. University professors were given the task of drawing up a new constitution and the State Planning Organization was established for a planned and coordinated development. These were expected to change the anti-democratic and uncoordinated trajectory taken up by the DP.

There are various concepts used for 27 May coup, among them insurrection (*ihtilal*), reform (*inkılap*), revolution (*devrim*), coup d'etat (*darbe*). It was not an insurrection, reform or revolution. It was a coup, but not an ordinary one. It was supported by many and it was done against a government which had lost its legitimacy as it exerted repressive policies like investigatory commissions with

[371] Hikmet Özdemir, "Siyasal Tarih 1960-1980." In *Türkiye Tarihi, vol. 4, Çağdaş Türkiye 1908-1980*, ed. Sina Akşin (İstanbul: Cem Yayınevi, 1990), p. 193.

judicial powers within the assembly (*tahkikat komisyonu*). It was different from Latin American coups, which resulted in long-term dictatorships. Also it was different from the following coups of 12 March 1971 and 12 September 1980. 27 May was not organized within the military hierarchy. It was against the DP rule, but also against the military hierarchy. But more importantly, the political change it brought served the democratization of the country.

The 1961 Constitution brought democratic principles through which dissenting groups could be organized and heard. Public rights and freedoms were defined and secured. 27 May brought freedom of association, freedom of unionization, the right to strike and collective bargaining, freedom of press; the principle of planning, the autonomous position of universities, radio-television, and judicial bodies; and the founding of supreme judicial bodies like Council of State and the Constitutional Court to check the legislative and executive bodies. In the Constitution, the Turkish Republic was defined as a democratic, secular, welfare state (*sosyal devlet*) governed by the rule of law. This emphasis on rights and freedoms and on welfare created sympathy towards the military among the workers and intellectuals. However, 27 May increased the power of the military within the political sphere and started a tradition of coups. 27 May legitimized the exceptional role of military and secured its position through the establishment of National Security Council, which functioned like a state party. The military obtained a right of representation within this semi-military committee headed by the President of the Republic, outside the parliament and above the government.

The 27 May military government functioned for 1.5 years until the first meeting of the parliament which was elected on 25 October 1961 through the new

proportional representation system. This 1.5 years might be periodized in three stages:

First, 27 May 1960 – 12 June 1960: In this short period, which might be labeled "de facto power," there was no constitution. The military established a government composed mostly of civilians, and a council of professors was given the task of preparing the new constitution.

Second, 12 June 1960 – 6 January 1961: Through the passing of the new constitution and its putting into effect from 27 May onwards, the "de facto regime" was based on a legal ground. The State Planning Organization was founded in this period and the Law of Socialization of Health Services was enacted in the last day of this period.

The third period was 6 January 1961 – 25 October 1961: In this period the executive power was shared by the NUC and the Chamber of Deputies.[372]

The idea of planning can be traced back to the early Republican period. A group of young Kemalist writers who published the journal *Kadro* in 1932-34 had advocated state planning in all areas of social, economic and cultural life. They saw statism as a viable alternative to communism and capitalism, a sort of "third way." However, their wider visions were not taken up by the leadership, which limited planning to the economic field.[373]

The first Turkish five-year industrial plan was announced in 1933. It was based on a Soviet report which recommended the concentration on textiles, iron and steel, paper, cement, glass and chemicals.[374] It aimed to raise the production of consumer goods which had been imported before. Although a large amount was

[372] Ibid., p. 197.

[373] Zürcher, p. 206.

spent on the application it failed in the production of some intermediate and producer-goods and some factories were not established.[375]

The second five-year industrial plan was announced in 1936. The main objective was to increase exports to finance budget deficit and meet the rise in exports necessary for industrialization. The third industrial plan, which was announced in 1938, could not be applied due to the Second World War.[376] Unlike earlier plans, the Turkish Development Plan of 1947 emphasized agricultural development. Turkey was expected to increase its agricultural production and meet Europe's demand for agricultural products to benefit from Marshall grants.[377] For Günçe, while the former plans had been "collections of projects," the 1947 plan was a product of the new development ideology.[378] It was accepted that Turkey had a comparative advantage in the field of agriculture, and 57.7 % of the investments was allocated to the projects related directly or indirectly to agricultural development.[379] It emphasized free enterprise, the development of agriculture and agriculture-based industry (instead of heavy industry), roads instead of railways and the development of the energy sector (oil).[380] Although they adopted the logic of this plan, the DP was against the idea of planning, which they associated with communism and the evils of statism. Menderes identified planning with communism and single-party rule: "The rule of DP rejects the development of the economy as a guided economy which can

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[374] Ibid.

[375] Ergin Günçe, "Türkiye'de Planlamanın 'Dünü – Bugünü – Yarını'." *ODTÜ Gelişme Dergisi*, Planlama Özel Sayısı (1981): 117-132, p. 119.

[376] İlhan Tekeli and Selim İlkin, "Türkiye'de Planlama: Ülkesel, Bölgesel, Kentsel." *Cumhuriyet Dönemi Türkiye Ansiklopedisi*, cilt 6 (İstanbul: İletişim Yayınları, 1983), p. 1604.

[377] Ibid., p. 1605.

[378] Günçe, p. 121.

[379] Ibid., p. 123.

be governed from above centrally by plans and projects. All the countries in the world base their economies not on the five-year plans specific to totalitarian states, but on free enterprise and the wisdom of their citizens."[381] Menderes declared that their plan was their budget.[382]

In the late 1950s, the political reactions against the DP were expressed within the RPP. There was a fierce intellectual opposition in universities and other milieus. The demands of the opposition and comprehensive projects about the new order were expressed within publications like *Forum*. The consolidation of democracy by the establishment of a Constitutional Court and the formation of a Keynesian order were among the major suggestions. One of the outcomes of this intellectual opposition was the Declaration of Primary Targets (*İlk Hedefler Beyannamesi*) by the RPP in 1959. This declaration which formed the basis of the 1961 Constitution emphasized basic freedoms and social justice. The demands of the opposition were consistent with those of the international institutions of world capitalism like the IMF and the World Bank. The need for a "planned development" was pronounced not only by the opposition, but also by these institutions. "Planned development" was the dominant paradigm of capitalism for underdeveloped countries. The military was influenced by all these debates and played an active role in the shaping of the planning leap.[383]

The NUC and the RPP blamed the Democrats' lack of planning for the economic and financial chaos at the end of the 1950s. The wish for planned and coordinated development found its expression in the establishment of the State Planning Organization. It was established by Law 91 of September 1960 and then

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[380] Zürcher, p. 226.

[381] Cited in Tunç Tayanç, *Sanayileşme Sürecinde 50 Yıl* (İstanbul: Milliyet Yayınları, 1973), p. 137.

[382] Cited in Tekeli and İlkin, p. 1606.

[383] Erder et.al., pp. x-xi.

obtained the status of a constitutional organ (articles 41 and 129 of the 1961 Constitution). The SPO was given extensive powers in the fields of economic, social and cultural planning. It was designed as an undersecretariat of the prime ministry. The central organization would be composed of three offices (economic planning, social planning, and coordination) and a secretariat.

The highest organ of SPO was High Planning Council. The council consisted of three ministers who were chosen by the council of ministers, undersecretary of SPO, and heads of three offices. The prime minister or the deputy prime minister would chair the council. The main task of the council was to determine the major economic and social objectives and the strategy of the plan. The SPO bureaucrats who were the technical members of the council submitted the choices, and the council made the final decision. This strategy was given final shape in the council of ministers.[384]

General Secretary of the Land Forces Şinasi Orel was given the task of establishing the SPO. Orel gathered young planners and worked with them both in the establishment of the organization and the preparation of the first plan. In the beginning Şinasi Orel was the undersecretary of the organization, Osman Nuri Torun was the head of Coordination Office, Attila Karaosmanoğlu was the head of Economic Planning Office, and Necat Erder was the head of Social Planning Office. After Şinasi Orel, Osman Nuri Torun became the undersecretary and Ayhan Çilingiroğlu was appointed to the presidency of the Coordination Office. The members of the team were brilliant idealist young men whose prestige was as high as army officers at that time. They were highly trusted and provided with the means to prepare the strategy document and the First Five Year Plan. Unlike earlier industrial

[384] Mehmet Kabasakal, "Devlet Planlama Teşkilatı." *Cumhuriyet Dönemi Türkiye Ansiklopedisi*, cilt 6 (İstanbul: İletişim Yayınları, 1983), p. 1617.

plans, the development plans would have a comprehensive vision of the development of the country in its economic, technological, social and cultural aspects. The inequalities in terms of region and class were going to be abolished through development plans. Economic growth and social justice could be reached at the same time through a rational functioning of capitalism.[385]

The founders of the SPO were motivated by the urge to initiate major structural reforms. Only through these reforms the 7% average annual growth rate aimed for the planned 1963-67 period could be accomplished. However, these reforms appeared only in the strategy document of the first five-year development plan, which was approved by the Council of Ministers on June 19, 1961 before the elections. But in the final text of the plan approved by the civilian coalition government[386] these reforms were retained. Discrepancies between the strategy document and the plan pertain to three fields where structural problems that hinder the accumulation of capital were diagnosed: agricultural reforms, the reorganization of State Economic Enterprises, and tax reform.

The agricultural reform proposal was based on a report prepared by an expert from the Food and Agricultural Organization (FAO), E. H. Jacoby. It foresaw a maximum limit to land holdings although this limit would vary according to regions, irrigation possibilities, and other characteristics of the land. The aim was to distribute the lands of big landowners to transform them into rational enterprises. It was not designed particularly for the Southeastern region. The vast lands from every region

[385] Erder et.al., pp. xii-xiii.

[386] The parliamentary elections were held on 15 October 1961. The Republican People's Party (RPP, *Cumhuriyet Halk Partisi*) gained 36.7 % of the votes (173 seats), the Justice Party (JP, *Adalet Partisi*) 34.7 % (158 seats), the New Turkey Party (NTP, *Yeni Türkiye Partisi*) 13.9 %, and the Republican Peasants National Party (RPNP, *Cumhuriyetçi Köylü Millet Partisi*) 13.4 %. On 20 November 1961, a RPP-JP coalition was built and it left its place to a coalition of the RPP-NTP-RPNP in June 1962. The rejection of reform proposals and the resignation of planners was when the latter coalition was in power.

would be distributed, which would in turn diminish the political weight of the agricultural sector.[387] Technocrats supported this reform on the grounds that the existing situation caused absenteeism, the neglect of land holdings, and low agricultural surplus. However, the project pertaining to land reform was not even discussed by the High Planning Council of the coalition government because the government members of the committee opposed it.[388]

The efficiency of the State Economic Enterprises was very important for the success of the development plan since they were responsible for more than 60% of the industrial investments in Turkey. The SEEs had no autonomy and politicians relied on them for welfare distribution measures and favoritism in order to obtain local political support. The SEEs were forced to borrow from the Central Bank to meet their deficits, which resulted either in increased inflation or the curtailment of productive investments. As governments used them to decrease unemployment their overall productivity was very low.[389] So the planners proposed a kind of "holding company" model which would provide autonomy to the SEEs.[390] They wanted to apply rational market criteria and make public managers accountable to the public at large. However, the principle of reorganization was refused by the High Planning Council and deleted from the text.

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[387] Necat Erder, interview by the author, tape recording, Ankara, Turkey, February 2007. Necat Erder was one of the founders of the SPO. After getting his Ph.D. from Paris University Faculty of Law and doing his post-doc study at Columbia University he worked as the head of Social Planning Office. Later on, he held posts at the OECD and the World Bank and then became a faculty member at Middle East Technical University. As the head of the Social Planning Office he was the major figure who designated the health and population policies within the First Five Year Development Plan, together with Nusret Fişek. His accounts are valuable in figuring out the early planning debates.

[388] Milor, p. 22.

[389] Ibid., p. 22-3.

[390] Erder, interview by the author.

Tax reform was necessary for the financing of investments. Planners estimated that in order to attain the 7% average annual growth rate aimed for 1963-67 period, the ratio of total investments to the GNP would have to reach 18.3%. Available foreign aid and internal resources would not be enough and it was necessary to increase public savings through new taxes.[391] Planners invited a famous professor, Nicholas Kaldor of Cambridge, for a report on tax reform. Kaldor was an appropriate figure as he had contributed to the reorganization of the tax systems of many underdeveloped countries and worked in the preparation of the Beveridge Report.[392] He came up with an agricultural taxation reform proposal that aimed to introduce incentives for increasing agricultural output. In his report, he referred to the remarkable data to demonstrate the need for a tax reform:

> Although the net income of the agricultural sector, 17.6 billion liras, constitute the 42.5% of the 41.3 billion liras gross national product, it provides only 0.8% of all indirect taxes and an amount less than the sector's share in national income of direct taxes. (...) When we take direct and indirect taxes together we see that the contribution of the agricultural sector to total state income does not exceed ratios of 1/10 or at most 1/8. When we take all tax income together, the tax burden of the non-agricultural sector –industry, trade, services and etc.- is around 20-25% while that of the agricultural sector is around 4-5%.[393]

He did not find it proper for a country like Turkey to collect income tax from the agricultural sector. He proposed instead a land and "potential" product tax to finance industrial investments without leading to inflation.[394] Revenues would not be based on the market value of the land or its gross product, but on the potential product,

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[391] Milor, p. 24.

[392] İzzettin Önder, "Nicholas Kaldor." *Toplum ve Bilim*, 15-16 (Güz 1981-82): 90-93.

[393] Nicholas Kaldor, "Türk Vergi Sistemi Üzerine Rapor." *Toplum ve Bilim*, 15-16 (Güz 1981-82): 94-115, p. 97.

[394] Ibid., p. 98.

which implied a penalty for unproductive landowners while promoting the productive ones.[395] That is to say, the new reform would exert pressure on landowners to operate their plots efficiently through rationalizing production. It was a progressive tax in the sense that an average net product would be calculated for each particular region and type of land. Because farmers would not pay taxes for their products above this average, they would be motivated to mechanize their production and avoid the underutilization of land.[396] So through this progressive tax, not only agricultural development would be accelerated by improving labor productivity but also new funds would be used for industrialization.

In the High Planning Council technocrats had to face the opposition of ministers. The Minister of Finance Ferit Melen (RPP), the Minister of Industry Fethi Çelikbaş (RPP), deputy prime minister Ekrem Alican (head of New Turkey Party – NTP, *Yeni Türkiye Partisi*), and deputy prime minister Hasan Dinçer (head of Republican Peasants National Party – RPNP, *Cumhuriyetçi Köylü Millet Partisi*) opposed the structural reforms. The most harshest disputes took place on the agricultural tax. The ministers accused the planners for having adopted leftist policies. Ferit Melen opposed the proposal with the claim that "There is no *kulag* (Russian landlords) in Turkey." Prime minister İnönü was convinced that these reforms were necessary, but he had to consider political balances. He also had to deal with the coup attempts of Colonel Talat Aydemir.[397] He had to consider the political feasibility of these reforms.

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[395] Ibid., p. 99.

[396] Milor, p. 24.

[397] Among the highest-ranking officers there was the fear of future independent action by junior officers. That fear was not completely unfounded. Colonel Talat Aydemir, commander of the war academy in Ankara, executed two abortive *coup d'état*s on 22 February 1962 and 21 May 1963. The first time he was granted a pardon; the second time he was executed.

Another tax reform proposal which had a conventional character was being prepared by the Ministry of Finance. İnönü asked the Dutch advisor of SPO, Jan Tinbergen, in what ways this plan was distinguished from the Kaldor plan, and Tinbergen replied, "the former lags hundred years behind the latter." He emphasized the modern character of the Kaldor plan.[398] But İnönü's and Turhan Feyzioğlu's supports for reforms did not suffice for their adoption. According to Erder, the ministers and deputies did not want to lose electoral support, especially from big landowners. They considered everything that would transform the system as a threat. They did not want to take risks. They did not accept the rationalization of the existing system, like the reorganization of the SEEs, let alone the major reforms, for fear of losing their political annuities.[399]

The planners asked the government to diminish the 7% growth rate in the strategy document as it would be impossible to reach such a rate without structural reforms. The government refused to revise the strategy while the means necessary to achieve this objective were all rejected. The insistence of the government that planners should declare to the public that the GNP would grow by an estimated 7.6% (even higher than the 7% in the strategy document) for the first year of the plan resulted in the resignation of the planners. In accordance with their self-image as "honorable technicians," they were left only with the choice of resignation.[400] The founders of Turkish planning resigned in October 1962 when the RPP-NTP-RPNP coalition was in power. Necat Erder asserts that the "failure" of planning was a result of the unwillingness of the Turkish political class to put its short-term interests

[398] Erder, interview by the author.

[399] Ibid.

[400] Ibid.

within the confines of a plan discipline that requires a vision of long-term perspective.[401] The plan would benefit those who would gain from industrialization and the following transformations. For Erder, the capitalist class which was forming at that time lacked foresight and did not make rational decisions.[402] So the planners learned that what was optimum for rapid economic growth might not have been politically feasible.

The elected politicians could not take the risk of losing support from the big landowners who made a coalition with industrial businessmen against the reformist bureaucratic cadres. The big landowners were much stronger and they got on their side the group of industrial businessmen who had just started to crystallize. The discourse of social justice seemed to disturb them. The following paragraph is taken from a report prepared by the Union of Trade Chambers, The Industrial Chambers and Trade Stock Markets, on the views and wills of the private sector on development plan:[403]

> We have to limit and clarify the notion of "social justice" which is referred to frequently in the plan and is open to all kind of interpretations. This notion is usually used by the advocates of socialist and welfare states to express the redistribution of wealth, the prevention of the earnings of entrepreneurs, taking of the whole or a large part of their income, and the distribution of existing sources with a criterion which is neither economic nor moral. It should be stated clearly that we oppose such a notion of social justice.[404]

[401] Erder et.al., p. 11.

[402] Erder, interview by the author.

[403] Türkiye Ticaret Odaları, Sanayi Odaları ve Ticaret Borsaları Birliği, *Kalkınma Planı Hakkında Özel Sektörün Görüş ve Dilekleri* (Ankara, 1962).

[404] Cited in Zafer Ülger, *27 Mayıs İhtilali'nde Kalkınma Tartışmaları*, Yüksek Lisans, Marmara Üniversitesi, İktisat ABD, Kalkınma İktisadı ve İktisadi Büyüme Bilim Dalı, 2006, p. 74.

Agricultural reform would accelerate the migration from the villages to the cities by dissolving the small peasantry and ruining the balances between those who migrated and those who stayed, a mechanism that kept poverty under control. The fear of facing modern urban poverty overbore the objectives of planned development and industrialization. The measures taken to keep the peasants in their villages dominated the institutional vision of the single party era. The single party policy of not facing poor peasants in the cities through preventing the dissolution of the villages maintained its role in the early planning discussions.

Buğra observes that the Turkish political authorities managed to resist the major poverty increasing tendency of capitalist development associated with changing rural structures by keeping agriculture practically outside the tax system and supporting it by different policies favorable to small farmers.[405] The peasantist discourse of the early Republican period, which could be observed in the activities and publications of the People's Houses, in the Village Institutes experience and in the ideological debates concerning the attempts at land reform during the interwar era, aimed to keep peasants in their villages.[406] Such projects were designed to prevent the dissolution of the village economy and social relations it sustained. The desire for industrialization could not resist the anxiety related with the formation of a class society and rising urban poverty, and the "failure" of planning can be considered as another example of this. This "failure" left the two social planning projects, the population planning and the socialization of health services, devoid of strong planner support and resources.

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[405] Ayşe Buğra, "Devletçi Dönemde Yoksulluğa Bakış ve Sosyal Politika: 'Zenginlerimiz Nerede?'" *Toplum ve Bilim*, 99 (2003-04): 75-97; Buğra "Türkiye'de Sağ ve Sosyal Politika."; Buğra, "Poverty and Citizenship."

[406] Asım Karaömerlioğlu, *Orada Bir Köy Var Uzakta: Erken Cumhuriyet Döneminde Köycü Söylem* (İstanbul: İletişim Yayınları, 2006).

The socialization of health services was going to start with the big cities in the West.[407] According to Nusret Fişek, in this way, it would be easier to find doctors who wanted to work within the Socialization; the doctors who did not want to join the system would loose their customers and would be forced to move their offices to the periphery; the more powerful segments of the population would support the project and it would be easier to build up the infrastructure in big cities.[408] However, the military insisted on the project's application first in the remotest villages of the East. This insistence implies that they saw it also as a project for national integration. By providing free health care to Kurdish citizens, the military aimed to win their loyalty to the Turkish state. However, this constituted one of the reasons of the failure of the Socialization project; a topic I will analyze in the following chapter.

The military's sensitivity on the priority of the development of the East revealed itself in the discussions on the need to separate "social" from "economic" planning by establishing two different units in the SPO. According to Milor, "The military supported the idea of the separate administrative existence of the "social" planning unit -for which no precedent existed in other countries- on the grounds that this was a mechanism for solving the "Eastern problem" by making it possible to co-

[407] In 1 December 1960, *Cumhuriyet* announced that the "nationalization of medicine" (*hekimliğin devletleştirilmesi*) would start from Trakya region and a budget of 130 million liras was allocated for this project. In another newspaper account, it was announced that the socialization of medicine would start in Trakya within a month and 655 health personnel would work in the pilot region (*Cumhuriyet*, 6 December 1960). However, the military changed the project and had it start in Muş, a remote Eastern province.

[408] Gürhan A. Fişek, Şerife Türcan Özsuca and Mehmet Ali Şuğle, *Sosyal Sigortalar Kurumu Tarihi 1946-1996* (Ankara: SSK – Tarih Vakfı, 1997), p. 62; Gürhan Fişek, interview by the author, tape recording, Ankara, Turkey, March 2006.

opt disgruntled residents of Turkey's Eastern region."[409] Milor analyzes the unpublished documents of the June, 1961 meetings, designed to discuss the "strategy" of the first five-year plan, that were held among planners and the fifteen members of the ruling committee together with some invited university professors, to measure the differences of opinion and convergences between planners and military bureaucrats. He reveals the contrast between the planners' liberal-productivist conception of the state and the military bureaucrats' etatist-patrimonial one. The etatist-patrimonial tradition holds the state responsible for the welfare of its citizens by giving priority to social justice and full-employment over economic growth and efficiency.[410] So, the planners' emphasis on adopting capital intensive production methods, perhaps at the expense of employment, was not embraced by the military bureaucrats.

> And in turn military officers' emphasis on social planning to decrease the income gap among social classes and perhaps to minimize ethnic tensions between geographical regions -although this was never publicly confessed- was not readily embraced, though neither was it objected to by planners who seemed to be preoccupied with the productivity of investments rather than their distributive effects.[411]

The military viewed the provision of health care as an important tool for social justice and social integration.

In comparison with the early planners, the military was more interested in the social development of the Southeast. Right after the coup of 27 May, Cemal Gürsel expressed his desire to establish a department of social planning to solve the "Kurdish problem." His hometown was Erzurum and he had worked in the Eastern

[409] Milor, p. 17, footnote 23.

[410] Ibid., p. 19.

[411] Ibid.

provinces for many years. He assigned colonel Türkeş to recruit a staff for this task. Türkeş wanted Nur Yalman to prepare a proposal and Yalman asked Attila Karaosmanoğlu and Necat Erder to work together. At the beginning they rejected the offer with the claim that it was unacceptable to establish two separate planning institutions, and that planning should be viewed with all its aspects. According to them, the Kurdish problem could be solved within a framework of comprehensive development plan and through decreasing regional differences and making regional plans. But Yalman insisted and they started working on the establishment of the SPO.[412] This story reveals the priorities of the military and their conception of social planning. Of course the "Kurdish problem" was not the only determinant in the planning leap characterizing the period, but it seems to have been an important one.[413]

When confronted with the military's will to make the SPO an Eastern project, the head of the Social Planning Office Necat Erder decided to resign because he did not want to serve the transformation of the big ideal of planning into the simple task of Eastern development and national security. The planners bargained seriously with the military and convinced them to limit the project with the establishment of an Eastern Group within the SPO. According to Erder, the military was concerned with the security dimension of the issue and the early planners with development. He resisted the use of the SPO by the military as an active agent in the security issue. He

[412] Günal Kansu, *Planlı Yıllar: Anılarla DPT'nin Öyküsü* (İstanbul: İş Bankası Yayınları, 2004), p. 55.

[413] Even today, the military bureaucrats are preoccupied with the health care provision to the Eastern provinces. In a newspaper account, it was announced that the National Security Council (a 27 May institution) was working for the closing of the doctor gap: "A solution with award to the biggest national security problem" (*En büyük milli güvenlik sorununa ödüllü çözüm*) (*Radikal*, 1 July 2006). The National Security Council suggested the government to give incentive premiums to the doctors working in areas of multiple deprivations which would be four times of their salaries. But the Turkish Medical Association found it insufficient and expressed the need to provide infrastructure. The persistence of the regional inequalities and the persistence of the military's involvement in the political decisions can be observed quite clearly also in the field of health care.

thinks the military and the police were not qualified to handle the Eastern question in terms of social integration. Rather they were more concerned with the security dimension and did not have grand projects related with the East. Their vision was limited to the exiling of tribal leaders to cities in the Western part of the country. He views the military's insistence on the starting of the socialization of health services in the East as a practical choice: There was not any health service there and it would be easier to convince the government if it started in regions of multiple deprivation. The early planners discussed the Eastern problem within the context of regional planning. They aimed to eradicate the inequalities among regions and income groups, but they never discussed the problem on an ethnic base.[414]

The denial of the ethnic base of the Kurdish question dominated the Turkish state discourse throughout the Republican period. Mesut Yeğen analyzes the Turkish state discourse and asserts that the state, for a long time, consistently has avoided recognizing the Kurdishness of the Kurdish question.[415] Whenever the Kurdish question was mentioned in the Turkish state discourse, it appeared as an issue of either political reaction, tribal resistance or regional backwardness, but never as an ethno-political question. Yeğen opposes the view that the state discourse misrepresents the Kurdish question, and reveals that Kurdish question is reconstituted within this discourse.[416] He analyzes six different themes in the Turkish state discourse: First, the denial of the separate ethnic identity of Kurds; second, the Kurdish question as the remnant of the old order, as a religious resurrection; third, as

[414] Erder, interview by the author.

[415] Mesut Yeğen, *Devlet Söyleminde Kürt Sorunu* (İstanbul: İletişim Yayınları, 1999); Mesut Yeğen, "The Kurdish Question in Turkish State Discourse." *Journal of Contemporary History*, 34(4) (1999): 555-568; Mesut Yeğen, "Türk Milliyetçiliği ve Kürt Sorunu." In *Modern Türkiye'de Siyasî Düşünce, cilt 4, Milliyetçilik*, ed. Tanıl Bora (İstanbul: İletişim Yayınları, 2002).

[416] Yeğen, "The Kurdish Question in Turkish State Discourse." p. 555.

the resistance of pre-modern forms of society, tribal relations and banditry; fourth, as the plot of foreign countries; fifth, Kurds as enemies; and sixth, the Kurdish question as a question of economical integration, regional backwardness.[417] He emphasizes that the issue of the consolidation of state power was playing a considerable role in the formation of the contemporary Turkish state discourse.

> However, by the 1950s, a shift had taken place in the nature of the problem of consolidation and integration in Turkey. It seems that while the Turkish state was engaged predominantly in military and political consolidation during the 1920s and 1930s, it began to engage in economic consolidation after the 1950s. It was in this context that the question became reconstituted as an issue of "regional backwardness."[418]

It was by this discourse of regional backwardness that the Kurdish question was reconstituted as something to be solved and not something to be repressed. So it carries a critique of the traditional discourse which reconstitutes the Kurdish question as a question of pre-modernity, political reaction or banditry, all of which must be eliminated. However, it is a continuation of the traditional discourse as it was also silent on the ethno-political aspect of the Kurdish question.[419] Yeğen analyzes the presence of the discourse of regional backwardness between 1950-1990.[420] He links this discourse with the aim of integrating the Kurdish regions with the Turkish market. However, we can interpret this aim of economic integration as a tool for social and political integration.

The discourse of regional backwardness has become dominant after the 1950s, but this does not mean that the other discourses disappeared. The military's

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[417] Yeğen, *Devlet Söyleminde Kürt Sorunu*.

[418] Yeğen, "The Kurdish Question in Turkish State Discourse." p. 564.

[419] Ibid., p. 565.

[420] Yeğen, *Devlet Söyleminde Kürt Sorunu*, pp. 159-170.

insistence on using the SPO as an office of national security related with the Eastern question,[421] the exiling of 55 Kurdish tribal leaders and the imprisonment of 485 prominent Kurdish figures in a camp in Sivas immediately after the coup,[422] and a ban on a Kurdish language course for health personnel who would work in the socialized regions all reveal that earlier discourses had not disappeared. There was an attempt to establish a language course for the health personnel but it was blocked by a state institution.[423] The name of the institution is not given in the book. Probably it was the military which blocked the language course. Actually, language constituted a big problem in the socialization of health services in the East as the doctors and patients had difficulties in communicating.

The denial of the existence of the Kurds (hence, the Kurdish language), and the conception of the Kurdish question as the resistance of pre-modern forms of society and tribal relations can be observed in these 27 May practices. The socialization of health services was also a project for struggling against the backwardness of Kurds. The "enlightened" doctors would not only cure them, but also equip them with basic knowledge of hygiene, which was an indicator of "civilization." The doctors, together with the teachers, would be the models of modern life for the Kurdish peasants.

Kurdish nationalism radicalized when the promises of Turkish – Kurdish equality and the defense of the Caliphate were left after the declaration of the establishment of the Republic. Kurdish opposition to Kemalism found expression in a series of upheavals like the one in 1925 known as the Şeyh Sait Rebellion, 1927-30

[421] Erder, interview by the author.

[422] *Nokta*, 18-24 Ocak 2007, no. 12.

[423] Gürhan A. Fişek et.al., p. 62.

in Ağrı and 1936-38 in Dersim. In the first two decades of the Republic the Kurdish regions were completely militarized and administered by general inspectorships (*umumi müfettişlikler*). In this period, the Kurds were literally ruled out in the state discourse. In periods of upheaval, Kurdishness was defined as a negative atavism, a feudal ethnos which had to be destroyed as it represented savagery and conservatism in opposition to the Turkish ethnos which represented civilization, honesty and revolution.[424]

After fifteen years of turbulence, the following 20 years (1938-59) might be defined as the years of exhaustion. The Kurds did not have the means for a new rebellion or any other strategy. Turkification in Kurdish cities formed a new intelligentsia which found its references in Republican Turkey's political culture. Also, the transition to the multi-party system reduced the pressure on rural Kurdish elite and tribes and made it possible for the tribes and religious orders to establish a privileged patron-client relation with the center by integrating with the political system.[425] However, Kurdish nationalism did not lose its ground and started to gain a political dimension in the late 1950s.

In the chaotic years of the DP rule, 49 prominent figures of Kurdish nationalism were arrested (*49'lar*). When military forces came to power, they sent 55 Kurdish tribal leaders into exile and imprisoned 485 prominent Kurdish figures in a camp in Sivas. Cemal Gürsel threatened the Kurds with the words "If the mountain Turks do not stand still there will be blood bath...".[426] In his speech to the Kurds in

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[424] Hamit Bozarslan, "Kürd Milliyetçiliği ve Kürd Hareketi (1898-2000)." In *Modern Türkiye'de Siyasî Düşünce, cilt 4, Milliyetçilik*, ed. Tanıl Bora (İstanbul: İletişim Yayınları, 2002), p. 848.

[425] Ibid., p. 850.

[426] *Dağlı Türkler rahat durmazlarsa öyle bir kan banyosu...* (Cited in Oran, Baskın "Kürt Milliyetçiliğinin Diyalektiği." In *Modern Türkiye'de Siyasî Düşünce, cilt 4, Milliyetçilik*, ed. Tanıl Bora (İstanbul: İletişim Yayınları, 2002), p. 876.

Diyarbakır, he urged them to spit at those who called them Kurd. Regional boarding schools were built, and the names of villages were systematically changed.[427] But the 1961 coup made it possible for an opposite process to run; the 1961 Constitution expanded the freedom of speech and association, which made it possible to discuss the "Eastern" question, and provided new means of expression to Kurdish intellectuals.[428]

The Kurdish nationalist movement shed doubts on the political integration of Kurds on the part of the military. The officers of 27 May handled this issue both by coercive measures and by providing basic health care. This was the first time that health service was put clearly as a tool of national integration. However, starting socialization from the East, in a region where it was difficult to employ health personnel and construct infrastructure, made the application of the project very difficult. Fişek was a pragmatic man and did not insist on the application in the West as he wanted the project to survive.[429] This divergence of opinion between the military and Fişek reveals not only the priorities of the military, but also their lack of interest in the proper incentive structures. Fişek was much more engaged in the feasibility of the project.

[427] Ibid.

[428] Bozarslan, p. 853.

[429] Gürhan Fişek, interview by the author.

From a Pro-natalist Policy to an Anti-natalist One:

Population, Planning, and Human Rights

The early Republican governments were preoccupied with the need to recover from population loss. Wars and diseases virtually emptied the country's vast lands, and those left were mostly sick and weak. For national security, and for social and economic development, there was the need to expand population in the shortest time possible. So, pro-natalist policies were applied which prohibited birth control and promoted big families. The improvement in health institutions, especially in the field of maternal and child care, would also serve the rise in population. Due to the improvements in health care the annual growth rate of population rose, except in the mobilization years of World War II, but its pace started to create developmental problems and public health issues in the 1960s. There was the need for a dramatic policy revision. The founders of the SPO wanted to counteract the effects of rapid population growth on economic development. So, the Social Planning Office of the SPO[430] worked on the new policy together with Nusret Fişek, and this policy is still applied in Turkey with some revisions.

The annual growth rate of population was high between the years 1927 and 1935 (21.10 per thousand). It was around 17 between 1935 and 1940. However, it fell to 10.59 during the Second World War. After the war it began to rise and reached 28.53 per thousand in the second half of the 1950s.[431] This was due to the success of combat against the highly prevalent infectious diseases, the use of antibiotics, vaccination against tuberculosis, and the development in the health institutions. But

[430] The early planners considered the planning of the population more important than the planning of health care. They saw health more like a sub-section of population (Erder, interview by the author).

[431] See Table 7, for population and annual growth rate of population between the years 1927 and 2005.

such a rate has become a heavy burden on the Turkish economy. Moreover, illegal abortions increased as a result of the economic pressures on family budgets. The first move to legalize contraception came from obstetricians and the Ministry of Health.[432] Zekai Tahir Burak and Naşit Erez informed the MHSA about the rise of maternal deaths due to traditional abortion methods. Ankara Maternity Hospital conducted a study and examined 5000 women in 1953-54. It was found that 30% of pregnancies ended in abortion and 26.9 of the women in this 30% became infertile. The maternal death rate was 1.3 per thousand in births and 5.7 per thousand in abortions.[433] The Ministry requested the Ministry of Justice to invalidate the articles which forbid birth control in 1958. But a serious attempt had to wait the formation of the SPO after the 27 May coup.

In November 1960, the SPO decided to add family planning to the First Five Year Development Plan. Then in December 1960, Nusret Fişek organized a meeting on the rise in population, in the School of Public Health. There was a consensus in that meeting that both the import of contraceptives, and abortion should be permitted. The head doctor of Ankara Maternal Hospital Zekai Tahir Burak proposed the invalidating of articles forbidding birth control because of the damage the traditional methods were causing: "today in various parts of Anatolia, some primitive materials, and especially dope (*çiriş*), are used. Due to this, only in the Maternity Hospital 14 mothers are disabled per day. Article 152 of the Law of Public Health and the second clause of article 471 of the Turkish Penal Code should be invalidated. If these clauses were applied each woman would have 14-16 children by the age of 32." In that

[432] Nusret Fişek, "Problems in Starting a Program." In *Family Planning and Population Programs: A Review of World Developments*, ed. B. Berelson (Chicago: University of Chicago Press, 1966), pp. 299-300.

[433] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl*, p. 196.

meeting, the number of women who died due to primitive methods of abortion was declared to be 15,000 annually.[434] High fertility and abortion were causing anemia and inanition, which paved the way for other illnesses. Birth control became an issue of public debate. In a country where pro-natalist policies had been applied for the last forty years it was not that easy to make radical changes. Although the new population policy was stated in the First Five Year Development Plan, the Population Planning Law had to wait until 1965.

The plan envisaged a forceful implementation of this new anti-natalist policy. Although the dimension of the economic development of the new population policy was emphasized, the beneficial effects of low fertility on the health of mothers and children were not mentioned. The planners were interested more in the economic dimension of the issue. They thought they had to control the serious population rise, otherwise the economic resources of the country would be exhausted. Fişek was concerned more with the health and human rights dimension of the issue. He prepared the law and worked hard for its adoption in the Parliament. He knew that traditional abortion methods resulted in women's deaths and infertility. He thought it was a basic human right to decide whether or not to have a child. Governments could not interfere with people's choice on this matter. He pointed out that population planning was implemented in all developing countries.[435] He responded to the criticisms of those who opposed population planning. Those who were against it argued that there was the need to determine an optimum population number, population planning programs were expensive and did not work, and it was an intervention into family privacy. Fişek supported such a program to improve

[434] *Cumhuriyet*, 17 December 1960.

[435] Nusret Fişek, "Nüfus Plânlamasında Hükümetlerin Sorumluluğu." *Sağlık Dergisi*, 38 (11-12) (Kasım-Aralık 1964): 3-8, pp. 5-6.

maternal and child health. He argued that those who were well-off and the intellectuals who lived in cities used birth control.[436] Thus, the banning of birth control constituted a burden on the poor, who would have difficulties in raising their children. The number of children in need was rising due to the ban on birth control. There could be no optimum population; the important thing was the rate of economic development.

The number of unproductive population should be controlled; a system in which one person fed another was unsustainable. Population planning was not expensive. The rate of literacy was high in Turkey compared to that of other developing countries, so the population planning program could be successful. The clauses which banned birth control limited the freedom of choice of the people as to when and how many children they would have. This ban was a violation of human rights. Population planning would not be seen as an intervention to family privacy, nobody would be forced to anything.[437] In this way, Fişek used economic arguments together with a human rights perspective. He was concerned with the health of the population, which had a close connection with basic human rights. He even emphasized the relation between women's rights and population planning. He wrote that "the struggle for women's rights and education should be considered a significant part of any population control program."[438] His emphasis on human rights

[436] Alan Duben and Cem Behar reveal that the inhabitants of İstanbul had known the methods of birth control and used them even in late nineteenth and early twentieth centuries. The Islamic religion had not forbid those methods. So, the inhabitants of İstanbul who did not need many children, unlike those in rural Turkey, had low fertility and small families. In the interviews that were conducted by Duben and Behar, women talk about withdrawal (coitus interruptus), vaginal ovule, douche, and even condom. Alan Duben and Cem Behar, *İstanbul Haneleri: Evlilik, Aile ve Doğurganlık 1880-1940*, 2nd edition (İstanbul: İletişim Yayınları, 1998), pp. 190-204.

[437] Fişek, "Türkiyede Nüfus Meselelerinin Ele Alınış Tarzı ve Plânlar." pp. 14-15.

[438] Fişek, "Problems in Starting a Program." p. 299.

reveals that the new policy was not simply a change in the direction of the population policy.

It is possible to talk about a rupture, as was the case in health policies, with the early Republican mentality. The early Republican policies had been concerned with the population as a totality. It had not been the individuals' rights, but the development of the country that had been at stake. The pro-natalist policies or health measures had been designed to create a strong population which would allow for the social and economic development of the country. The founders of the Republic had not established a connection between the development of the country and the individual rights and welfare of the people.

The 1960s constituted a rupture in the sense that this period was marked by an awareness of basic human rights and the acknowledgement that their application would contribute to the welfare of the country. Although the maternal health dimension of population planning was not mentioned in the First Five Year Plan, a rights-based approach found a ground. Fişek's emphasis on the difficulties poor people faced due to the ban on birth control is an important indicator of the egalitarian concerns. Both the socialization of health services and the population planning policy aimed to improve the living conditions of the rural poor who lacked basic services. Teaching them the modern ways of birth control would protect poor women from the hazards of using traditional methods.

But how would such a program be implemented? Fişek proposes using integrated service. For him,

> there are three main reasons in favor of an integrated service. First, population control is a continuous operation and requires confidence and close relations between the public and the workers for satisfactory results. Second, women, especially in conservative countries, are shy and do not like to be seen taking an interest in birth control as such. It

> is much easier for them to apply to a multipurpose clinic or worker for advice on birth control. Third, since the type of personnel and equipment necessary to run a population control program would duplicate those of a maternal and child health clinic, an independent organization for population control would be an unnecessary and wasteful use of resources.[439]

The socialization of health services thus would allow for the implementation of the population control policy. The health stations, health posts, and health centers within the organizational scheme of the socialization would be used also for population planning. In terms of reaching the remotest villages and teaching people modern birth control methods, the socialization of health services was the most proper model of organization.

The Plan was accepted in the Parliament in 1962 despite the opposition of the members of the Justice Party to the section on population planning. The Justice Party kept opposing, but the Population Planning Law[440] was accepted in April 1965 with the votes of RPP deputies and senators. The Law specified the essentials of the new anti-natalist policy: Families could have as many children as they wished and whenever they wished, through measures preventing pregnancy. Sterilization and abortion could not be performed except in cases of medical necessity.[441] The government would carry out educational programs to disseminate knowledge of contraception and to motivate people to use birth control. The government would provide family planning services throughout the country and, if necessary, subsidize the cost of contraceptive materials and services.

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[439] Ibid., p. 302.

[440] *Nüfus Planlaması Hakkında Kanun*, no. 557, *Resmî Gazete*, 1 April 1965.

[441] Abortion, except in case of medical necessity, was illegal until 1983. The Law on Population Planning (*Nüfus Planlaması Hakkında Kanun*, no. 2827; *Resmî Gazete*, 27 May 1983) which replaced the former law (no. 557), legalized abortion within 10 weeks of pregnancy. Abortion was practiced also when it was illegal, either secretly or by the consent of two doctors who declared the medical necessity although there was no such necessity.

The Need to Socialize Health Services

The military officers of 27 May gave full weight to social justice. Influenced by the welfare state developments in Europe and the conditions of deprivation of the villages, they proposed radical measures. In the interviews conducted by Yaşar Kemal, Cevat Fehmi Başkurt and Ecvet Güresin with the NUC officers in *Cumhuriyet*, education, land, tax and health were cited as the most important problems of the country. Orhan Erkanlı said he could not forget the pale-faced, malaria-stricken people out there in those steps.[442] Numan Esin emphasized the need for a comprehensive health program to maintain preventive care. He said he believed that Turkish doctors had the desire to serve rather than greed for money, but there was the need for radical revisions for the doctors to fulfill their desires. He proposed the establishment of a health system like the one in Britain and in this way doctors could obtain the opportunity to work for the people.[443] Mehmet Özgüneş emphasized the need for health insurance: all citizens should have the opportunity of treatment when they became ill.[444]

Sami Küçük was one of those who cited the British health system as the ideal model. For him, the most important problems of the country were education, land and health. He told the story of a poor peasant who had had to sell his ox to get medical treatment for his wife and said, "No one should die because of not having money... because of not obtaining medicine, not seeing the doctor. That is why I admire the health insurance council (he means the NHS) established in Britain very

[442] *Cumhuriyet*, 20 July 1960.

[443] *Cumhuriyet*, 26 July 1960.

much and it would make me happy to see a similar system in my country." His words reflected the basic ideology of the Beveridge Report: "In this country everybody should have land to plow, and the people on this land should cultivate it with the most modern vehicles. Everyone should have a job and a home to live in. And everybody should be confident in their future. They should not think 'what if I lose my job'. Everbody should have confidence in justice and social justice".[445]

The officers knew the conditions of the villages well, either because their origins were rural or because they had visited them as part of their job. Some of them had been to Western countries on duty and had had the opportunity to observe the welfare state practices there. The British health system (NHS) impressed them most. They were concerned mostly with rural poverty. It was quite natural that they emphasized the problems of the peasants when nearly 70% of the population lived in the villages. For them, the DP rule had greatly damaged social justice and there was an urgent need to restore it through radical measures like tax reform, land reform, education campaigns and health reform. While demanding general social justice they criticized not only the big landlords but all capital owners. In one of these interviews, Orhan Erkanlı made precise statements about the relation between capital and labor:

> We should build up social justice. We hate the same old story of "Fifteen millionaires on every street and a thousand and hundred hungry people in every village." I liken the national wealth to the water in communicating vessels. We should establish the absolute balance between capital and labor. No one should exploit others.[446]

But the military's emphasis on social justice and need for radical transformations was not enough to create a completely different order. The civilian governments

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[444] *Cumhuriyet*, 2 August 1960.

[445] *Cumhuriyet*, 19 July 1960.

[446] *Cumhuriyet*, 20 July 1960.

were not convinced that such reforms could and should be done and they settled for minor changes. Land and tax reforms could not be implemented, which in turn left the governments without enough resource for an onset in the fields of health and education.

In the interview conducted with him for the 40th anniversary of the Socialization Law, former NUC member colonel Suphi Gürsoytrak described a scene from his secondary school days in the 1930s:

> On the way to school I used to look at the back side of Numune Hospital where there was the morgue. Peasants -I reckoned that they were peasants by their colorful clothes- came there to take their dead. I used to say to myself that if one day I got the power, I would try to create means to save these people from crawling in front of hospital doors. Of course after 27 May, such an opportunity appeared.[447]

In the same series of interviews another NUC member colonel, Sami Küçük, told an anecdote dating back to his days in Mardin Midyat as an officer in 1939-1943:

> One New Year's Eve I have a terrible toothache. There was no dentist. The nearest city was Mardin, but I was not sure whether there was any dentist there. Besides it was impossible to get there because we would go there on horse and it was a hundred kilometers. I had to have it out. Guess who did it? The barber! Without any anesthetic... with a pair of pincers.

Then in 1949 he went to the British Military Academy. The Labor Party was in power: "They were applying that famous 'welfare', i.e. the plan based on the principle of social state. With this plan the British focused on the big problem of health. But they improved so much that all of Northern Ireland was coming to Britain because it was free." Then he recounted a scene witnessed by one of his friends. A peasant was trying to sell his ox for a good price to get medical treatment for his

[447] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü* (Ankara: TTB, 2001), p. 30.

wife. With all these in mind, colonel Küçük talked about the need to change the health system of Turkey and raise its standards to the level of the British, in the interview published in *Cumhuriyet*.[448]

In the journal published by the MHSA, *Sağlık Dergisi*, the health policy of the National Revolution Government was declared immediately after the coup, in an article entitled "Our Revolution."[449] The most important policy was declared as providing basic health service to peasant citizens.[450] It was stated that 75% of the population was peasant, so it was not difficult to guess that the majority of the population, including those living at counties (*ilçe*), were unable to obtain basic medical care.[451] Also, the existence of areas of multiple deprivations was accepted and sending of doctors to those districts was put as an urgent task. This would be accomplished not by force, but by incentive. The program of the MHSA was summarized as giving priority to preventive care, the amendment of the conditions of the health personnel and determining the principles of rural health. Also the struggle against infectious diseases like malaria, tuberculosis, trachoma, syphilis and leprosy would continue.[452] Here the peasants are emphasized as citizens to denote their right to receive basic health services which had not been provided to them before. The state was responsible for the well-being of its citizens and peasants were not excluded.

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[448] Ibid., p. 42.

[449] "İnkılabımız", *Sağlık Dergisi*, 34(5-6) (Mayıs-Haziran 1960): 196-7.

[450] *Hizmetlerin köylü vatandaşın ayağına götürülmesi.*This phrase of "peasant citizen" would be used by the Minister of Health and Social Assistance Faruk Sükan in his speech in the Ankara Chamber of Medicine in March 1965. He said it was a must to bring health services to the peasant citizens and this could be accomplished only by socialization (*Cumhuriyet*, 8 March 1965). The association between rural Turkey and socialization, which constituted one of the reasons for the "failure" of socialization in the long run, will be elaborated further in the following chapter.

[451] Ibid., p. 196.

[452] Ibid., p. 197.

The emphasis on the citizenship status of the peasants in this context implies that there was a "citizenship gap" between the rural and the urban inhabitants of Turkey and that health service was an important component of this status. There is the acceptance that state has to provide basic health care to all its citizens regardless of their residence. Unlike the early Republican governments, the DP created opportunities of social integration available to the peasant population. After World War II, due to the mechanization of farming, people had started to migrate to cities without severing ties with the villages. The new road network connected the villages to the outside world. Yet, in the first half of the 1960s, 60% of Turkish villages lacked drinkable water resources, 98% lacked electricity, and 90% did not have proper road access.[453] The DP opened nearly 250 new health centers in the counties and came closer to the villages, but their number was not sufficient and it was not that easy for peasants to reach the counties. So, people in the cities and some counties had access to health care in one way or another while those in the villages did not. This difference was intolerable if all are considered as citizens which necessitates the provision of social services on the basis of equality.

Cemal Gürsel emphasized similar points in the opening speech he made at the 16th National Medical Congress.[454] He said justice, education and health were the three pillars on which a society was built. For him, doctors should work in every corner of the country altruistically, like judges and teachers. To live in the best places of the country with a shop owner mentality contradicted the honored position of the

[453] From the first Demirel government program; cited in Ayşe Buğra, "Poverty and Citizenship", p. 37.

[454] Cemal Gürsel, "Devlet Başkanı ve Başbakanımız Sayın Org. Cemâl Gürsel'in 26-29 Eylül 1960 Tarihinde Yapılan XVI. Millî Türk Tıp Kongresi Münasebetiyle Yaptığı Açış Konuşması." *Sağlık Dergisi*, 34(9-10) (Eylül-Ekim 1960): 386-7.

doctor within the community. He painted a very pessimistic picture of the health conditions of the country:

> There are 10,000 beds for tuberculosis patients and 21,000 beds for other patients in hospitals. In a country with a population of 30 million, 250,000 of which suffer from tuberculosis, these numbers are really low and they can just respond partly to the needs of the cities. 40,000 villages and 18 million peasants are abandoned to their fate. Also there are at least 100,000 street boys. In every 1000 birth, 5 mothers and 165 babies die. And we should not think that these numbers apply to the whole country. 40.000 villages live on their own and we do not know what is happening there. There are 47,000 syphilis patients and 146,000 trachoma patients in the country. Again, I do not think these numbers reflect the reality. Because villages which comprise the majority of our population have been abandoned.[455]

The migration of doctors to Western countries and their unjust distribution within the country are the other important components of this negative picture: "We have 12,000 doctors 1000 of which are in the US, 6,500 in İstanbul, İzmir, Ankara, Adana and Bursa. The remaining 5,000 are dispersed among 62 cities. So, for the 4 million people living in cities, there are only 6,500 practicing doctors and for the 25 million in Anatolia there are 5,000. And these 5,000 work in the big cities".[456] Gürsel warned the audience sternly that things could not go on like this: "The villages are not the colonies of the cities."[457] By using this notion of "colony," he went beyond the simple fact of inequality between the cities and the villages.

During the same congress, Minister of HSA Ragıp Üner mentioned the unreliability of the health statistics and the urgent need to collect reliable information. He said a new law was being prepared to expand basic health services

[455] Ibid., p. 386.

[456] Ibid.

[457] *Köyler, şehirlerin müstemlekesi değildir.* Ibid., p. 387.

throughout the country.[458] Only ten days before this congress the minister had made the opening speech of a meeting on the socialization of health services in Turkey.[459] He explained the aim of the law as to carry health services to the remotest parts of the country to make people live a socially just life in accordance with the Universal Declaration of Human Rights.[460] For him, the reasons behind the unsatisfactory condition of health services were, the opportunity of the state-employed doctors to have their own offices, the undermining of public health as a science and the lack of personnel to be employed in this field, financial constraints, the unjust distribution of the doctors throughout the country, the tendency of the doctors to become specialists, and the lack of a primary care network which raised the workload of hospitals.[461] Üner described the condition of hospitals in İstanbul as deplorable.[462] There was thus the need to improve primary care to reduce the pressure on hospitals.

It was not only the hospitals, but also the living environments that lacked basic hygiene requirements. The struggle against epidemics like malaria, tuberculosis, syphilis and trachoma was widespread and efficient, but the struggle against other epidemics like polio, pneumonia, typhoid fever, measles and diarrhea was not as effective in those years. The Minister of Health and Social Assistance Yusuf Azizoğlu warned the citizens about the polio threat and said that only in the

[458] Ragıp Üner, "Sağlık ve Sosyal Yardım Bakanı Prof. Dr. Ragıp Üner'in 26-29 Eylül 1960 Tarihinde Ankara'da Toplanan XVI. Millî Türk Tıp Kongresi'nde Yaptığı Konuşma ." *Sağlık Dergisi*, Eylül-Ekim, 34(9-10) (1960): 387-389.

[459] Ragıp Üner, "Sağlık ve Sosyal Yardım Bakanı Prof. Dr. Ragıp Üner'in Türkiye'de Tababetin Sosyalleştirilmesi Konusunda 16-17 Eylül 1960 Tarihlerinde Ankara Hıfzıssıhha Okulu'nda Yapılan Çalışmaları Açış Konuşması." *Sağlık Dergisi*, Eylül-Ekim, 34(9-10) (1960): 389-392.

[460] Ibid., p. 389.

[461] Ibid., pp. 390-1.

[462] *Cumhuriyet*, 18 March 1960.

last one month 145 children had caught the disease.[463] The March 1963 issues of *Cumhuriyet* reports news about a typhoid fever epidemic in Sağmalcılar which was the second outbreak in one year. A measles epidemic had become a threat in İzmir in April 1963.[464] All these epidemics could be prevented through environmental hygiene measures and vaccination.

Fişek depicted the situation of health organization and services following the coup of 27 May 1960 as follows:

> ... investment and manpower were lost because each establishment and organization of the public sector had instituted its own separate health services. Even the MHSA had established, for every significant health problem, completely separate health service organizations that reached the very confines of the various districts and villages. The health personnel were not equitably distributed throughout the land, and institutions had been established where medical treatment and care was very expensive because of the limited number of beds. The new generation of doctors was not trained in accordance with the socializing view of modern medicine. Home-care services had not been organized with a plan, and general care services and other most important services, such as mother and child health care had not been introduced as far as the villages. The central organization of the MHSA was in no state to administer the health service in the best possible way, and the health services were very much handicapped because of the centralized administrative system.[465]

So, there was the need

> to concentrate the health services in one administration and to eliminate the causes which prevented the distribution of health personnel throughout the country, give up the construction of health care establishments with limited number of beds and construct instead operationally profitable institutions, set up a home-care organization

[463] *Cumhuriyet*, 13 January 1963.

[464] *Cumhuriyet*, 2 April 1963.

[465] Nusret Fişek, *Efforts to Socialize Health Services in Turkey* (Washington: Joint Publications Research Service, 1966), p. 4. [Translation of "Türkiye'de Sağlık Hizmetlerinin Sosyalleştirilmesi Üzerinde Çalışmalar." *Sağlık Dergisi*, 37(3-4) (Mart-Nisan 1963): 9-22].

> that would reach into the villages, and decentralize the administrative system.[466]

In another article, he gave details of the situation and the major problems of the health system. He criticized ministers and other administrators, people and doctors for thinking and prioritizing patients and hospitals when health service was considered. Starting from the ministry of Refik Saydam, although preventive care was said to be prioritized, that was not the case. Preventive care was limited to malaria prevention and vaccination campaigns. However, preventive care involves educating people and making them change their attitudes, improving environmental conditions, and providing the conditions of a well-balanced and sufficient diet. Fişek recommended the application of a "community medicine" perspective, which implies the enforcement of preventive and curative services by one organization through team work.[467] He analyzed the major problems of labor power. Those related to the doctors had to do with the employment structure rather than the numbers. These were the unjust distribution of the doctors (61% in three big cities, 25% in province centers and 14% in counties and villages; 40% in European Turkey, 26% in Central Anatolia, 15% in Marmara and Aegean, and 19% in other regions), the rise in the number of specialists instead of general practitioners (24% general practitioner, 76% specialist), the conflict between the public work and the private business of the doctors, the migration of doctors to foreign countries (18% of the doctors were in other countries), the lack of doctors who would organize and execute preventive health services, and the insufficiency of education on preventive care and community care in faculties of medicine. Fişek finds the quantity and the quality of other health

[466] Ibid., p. 5.

[467] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 129.

personnel grave. There were not enough health officers, nurses or midwives. They had not been given sufficient educations. Their work could not be inspected closely and they were not subject to in-service training.[468]

Fişek criticized the Provincial Administration Law (*İller İdaresi Yasası*) which made the functioning of health administration inefficient. The doctors in the counties could get in touch with the doctors in districts (*bucak*) through the *kaymakam* (official charged with governing a provincial district) and *nahiye müdürü* (official charged with governing a provincial subdistrict), while provincial health directors (*il sağlık müdürü*) could get in touch with doctors in the counties through the governor and the *kaymakam*. Health units could not work as cooperating teams. Establishing separate organizations for different diseases had been a necessity in the early years of the Republic, but to maintain health services with such an organizational structure meant losing labor power and money. Hospital services were costly. To prevent the rise in hospital investments and costs it was better to develop home-care organization. Fişek put the financial aspect as follows: The Turkish Republic was among the states that spent the minimum amount on health services. The per capita health expenditure was 400 liras in Britain, 135 in Israel, 29 in Ceylon and only 19 in Turkey.[469] Although the share of the MHSA in the general budget had exceeded 5% during the DP governments, the total amount spent on health was low.

He explained the health status of the country. The death rate per thousand was 18, the birth rate 44, and infant mortality rate 165.[470] These were high rates for a

[468] Ibid., p. 129-130.

[469] Ibid., pp. 130-131.

[470] As the article was written in 1967, these are the numbers for the first half of 1965, which can be controlled from the relevant data: According to OECD data, in 1960, OECD average for infant mortality rate was 36.1 while it was 189.5 in Turkey. These numbers were 30.6 and 163.5 for 1965. See Table 14 for the infant mortality rates in selected OECD countries between 1960 and 1998. In Turkey, the birth rate was 47 in 1955-60, and 43.2 in 1960-65 and the crude death rate was 19.8 in

country with such a development level. This showed that Turkey did not attach enough importance to health problems. Maternal and child care, tuberculosis prevention, population planning and parasite prevention were not given enough attention. Those living in villages tried to solve their health problems themselves. They could go to cities only if their condition became serious and only if they had the financial means. Patients were unable to benefit from the hospitals equally. Good health infrastructure was needed in rural areas for the eradication of malaria. Turkey needed to establish such an infrastructure, otherwise it would be obliged to spend 50-60 million liras every year and faced the threat of malaria epidemic.[471]

The existence of separate primary care units implied the inefficient use of personnel and resources. Before the socialization of health services there might be a government doctor, a malaria-tuberculosis-syphilis-trachoma prevention organization and a health center in one district. Secondary and tertiary health care were also provided by separate units. The MHSA, the Ministry of Defense, some State Economic Enterprises, universities, the Labor Insurance Institution and the private sector provided secondary and tertiary health care services. The MHSA was the largest health service provider, but not the only one. Among these providers the Labor Insurance Institution would have a larger share in health services and coverage for a short period. The existence of separate units both in primary care and in secondary and tertiary care created organizational and financial problems. The Socialization Law was an attempt to integrate all. The integration of health services was one of the objectives of the socialization.

1955-60, and 16.4 in 1960-65. Türk Tabipleri Birliği, *Türkiye Sağlık İstatistikleri 2006*, edited by Onur Hamzaoğlu and Umut Özcan (Ankara: TTB, 2006), pp. 30,49.

[471] Ibid., p. 131.

The Coming of a New Health System

The members of the NUC were thinking of a radical transformation in the health system. Influenced by the development of the Keynesian welfare state in Europe, the officers wanted to change the inegalitarian and insufficient structure of health service provision in Turkey. In an interview published in *Cumhuriyet*,[472] NUC member colonel Sami Küçük, then the president of the Social Commission,[473] declared that they wanted to work for the development of health service provision in Turkey. The Turkish health system would be parallel to the health systems of developed countries, especially Britain. After reading this, the undersecretary of Ministry of Health and Social Assistance (MHSA) Nusret Fişek wrote him a letter requesting a meeting on this issue. Then the Social Commission of the NUC sent a communiqué to the MHSA saying that a report be prepared with a view of transforming health services in Turkey into public services. Fişek arranged a meeting with NUC member Muzaffer Özdağ and warned him that for such a dramatic change they needed to determine political principles as to whether there would be private medicine or not, whether doctors would have the right to choose patients, and how the system would be financed. For him, making such decisions was not the task of the MHSA, but of the political authority. He wrote a report on the development of health services in Turkey.[474]

In this report, Fişek analyzed the health care systems of the USA, Sweden, Great Britain and the USSR. Health service in Turkey was widely socialized in terms

[472] This is the interview I have already mentioned (*Cumhuriyet*, 19 July 1960).

[473] NUC was composed of commissions that were responsible from economic, social, and security issues.

[474] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, pp. 7-8.

of legislation but it was not applied properly. The reasons behind this were: First, doctors working for the state had the right to make private business and earn money. Many of the doctors in state hospitals had their own offices. Second, public health was not recognized as a science and there were no personnel of health management and collective health measures. Third, financial constraints. While developed countries were spending 10% of their budgets for public health measures, 5% of Turkey's budget was going to public health, curative medicine and social assistance.

Despite these facts, there were many socialized health services that had been executed like the struggle against malaria, syphilis and trachoma. Also, maternal and child health organization was making progress. According to him, health services provided by the Labor Insurance Institution (İSK), the State Railways (TCDD), the State Post (PTT), the State Economic Enterprises and other public and private institutions for their own personnel should also be considered within socialized health. Here, by "socialized health", he referred to all kinds of health care, both public health and health service delivery, that were provided by the state. Fişek emphasized the importance of the referral chain and proposed the establishment of regional offices to prevent people from applying directly to medical specialists in hospitals. He did not see the banning of private medicine as a solution and suggested the banning of private business to doctors working in state institutions. They could give up their private businesses, however, only if their salaries were adjusted. He found it impossible to establish a premium-based system because of the social and economic conditions of the country. He argued that the practice of revolving funds, which had started in 1955 (a certain amount of money was taken only from the well-

off),[475] should be improved. Totally free health service could only be realized in rich countries.[476]

Then the Social Commission of the NUC requested a more detailed plan from Fişek. He sent to the commission three alternative plans and they started working on the most comprehensive one. The working group was composed of officers, health officials and representatives from the ministries of Public Works, Finance, Labor and Education. One of the doctors in this working group, Doğan Benli, then a medical specialist in the Directorate General of Malaria Combat, described the discipline and diligence of the officers in the working group with great admiration.[477] Staff officers were sent to the embassies of different countries like Great Britain, Sweden, Germany, the USA, the USSR and Czechoslovakia to collect information on their health systems. All this information was brought together and discussed to give shape to an ideal plan for Turkey.

They summarized their decisions in ten articles with budget and personnel allocation tables. These decisions formed the basis of the Socialization Law: Health stations were the first step of the organization; health centers were the second; health centers with a hundred beds would have specialists; doctors and other health personnel would receive extra allowance; people would be given free medicine that cost 25 TL every year; it is better for the pilot region to have a population of around 1.5 million; doctors in preventive services should also receive extra allowance; the construction of regional hospitals would be discussed in a separate plan; an expert

[475] He is referring to the regulation I have already mentioned. Although the regulation did not limit the charging of money only from the well-off, from Fişek's words we understand that it was interpreted this way. Maybe in practice, the criteria of poverty was loosely defined.

[476] Ragıp Üner and Nusret Fişek, *Sağlık Hizmetlerinin Sosyalleştirilmesi ve Uygulama Plânı Üzerinde Çalışmalar* (Ankara: SSYB, 1961), pp. 19-29.

[477] Benli, interview by the author.

from GB would be invited; foreign assistance would be sought for.[478] Actually, these decisions did not comprise a detailed plan with clear reference to the financial resources of the transformation. However, the basic principles of the Socialization Law, i.e., the setting up of primary care services and extra allowance for the health personnel, were pronounced. The referral chain system encouraging people's application to a primary care unit before going to a hospital was taken from the British model. In Britain, the citizens applied to the general practitioners with whom they were registered, but there was no conception of district and everybody was free in choosing his/her practitioner. The idea of allocating personnel to health units in separate districts was borrowed from the Swedish model. In Sweden there was a rural district model and health service was provided to a population of 6000 by a team composed of a doctor and two public health nurses.[479]

Various project-drafts were prepared and the sixth one was discussed in a consultative conference attended by well-known doctors, representatives of the Turkish Medical Association and the Turkish Pharmacists' Association.[480] The most prominent figure in the meeting was Tevfik Sağlam.[481] He rejected full-time employment for doctors. He said, "there cannot be a doctor without his own office, otherwise all of you will turn into civil servants."[482] Doctors' resistance to becoming civil servants had always been decisive in the shaping and application of health policies. When the Turkish Medical Association had been established in 1953,

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[478] Üner and Fişek, pp. 14-18.

[479] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, pp. 12-13.

[480] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 15.

[481] He was the first president of İstanbul Chamber of Medicine and the organizer of the First National Congress of Medicine. He was the founder of the Tuberculosis Combat Association. He was the rector of İstanbul University between 1943-52.

[482] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, p. 13.

council member Sıtkı Alıçlı had complained about the attitudes of the former health ministries. The ministers had wanted to destroy the autonomy of the doctors; they had expected them to run for the position when there was a need in Çemişkezek. So, they had ignored the material and spiritual welfare of the doctors, which in turn damaged the health of the country.[483]

Actually, Nusret Fişek did not think of the prohibition of private medicine even for a moment. He thought it was an anti-democratic practice and a violation of human rights.[484] That was because he reacted against the word "nationalization" (*devletleştirme*), saying that it was the practice of communist regimes. So the new system would prohibit private medicine only for doctors working in state institutions in socialized regions. They would be promoted with extra allowances. In the draft bill there was also an article regulating the paying of premiums to the doctors from the fees paid by patients. Only on specific occasions would examination and treatment be subject to payment.

The article regulating the paying of premiums to doctors (article 30) was removed from the draft bill with the objections of the NUC members. They objected also to the contractual employment of doctors as it contradicted with the general system. However, NUC member Suphi Karaman persuaded them that it was not possible to make doctors work with civil servant salaries.[485] In the same bill, the collection of premiums from the people was also regulated (article 32).[486] That article was developed in the next draft bill.

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[483] Cited in Füsun Sayek, *Türk Tabipleri Birliği: Tarihe Giriş* (Ankara: TTB, 1998), p. 14.

[484] Üner and Fişek, p. 23.

[485] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, pp. 11-12.

[486] Ibid., p. 60.

Article 32 in the next draft bill specified the financial resources of the socialized health services: Annual health insurance premium of 25 *lira*s from everyone over 12 in the socialized regions; health tax of 5 *kuruş* from every kilogram of salt, a health tax of five *kuruş* from every letter, post card and greetings card posted within the country by the Post Office; money collected as health insurance premium, revenues and etc., by the Labor Insurance Institution (*İşçi Sigortaları Kurumu*) and other institutions in socialized regions; 5% of the revenue of Special Provincial Administrations (*Özel İdareler*) from the previous year; allocation from General Balance Account (*Umumi Muvazene*); fees collected by the socialized health services organization; and a health tax of 25 liras taken from radio receiver machine owners every year.[487]

The official from the Ministry of Finance rejected this proposal. Fişek says, this bureaucrat shaped the financial policy of the socialization. This bureaucrat said, "even though its labeled as health premium, this is a tax. As it will be collected by force, people will react. Service-specific tax is out of date." And "If you establish insurance you need to build up an organization to collect premiums. The most experienced organization on this issue is the Ministry of Finance. This is its task." He also said, "If this is not a service specific tax we find where to collect it from. If the government makes a political decision and orders us to collect 500 million liras, we collect this money."[488] However, the financial aspect of the law was not clarified and it constituted the main topic of discussion in the general assembly meeting of the NUC. For medical historian Erdem Aydın, this lack of clarification and the latter

[487] Ibid., p. 106.

[488] Ibid., p. 57.

omission of premium collection implied the stillbirth of socialization.[489] The head of the Social Planning Office of the SPO Necat Erder said they introduced this premium to provide the participation of the people. It was not expected to supply large resources or to take the place of tax. It was rather designed to make people a component of the service. It was not a question of resource, but a question of participation. However, they were unable to explain this to the finance officers, who did not have a vision outside the existing tax system. For Erder, this premium was one of the original dimensions of the socialization and its rejection constituted one of the reasons for its "failure".[490]

The Socialization Law (no. 224) passed in the NUC on 5 January 1961 just a few hours before the officers left their place to the Constituent Assembly. In the Constituent Assembly, the NUC was to share the task of legislation with the Chamber of Deputies composed of representatives elected by occupational groups. Before this devolution of power, the NUC passed some major laws taking into account that it would be difficult to do this in the Constituent Assembly, that the precedence would be given to the Constitution and the electoral law.[491] As there were several laws that had to be passed, there was not enough time to discuss the Socialization. Still, the financial aspect of the project and the role of the State Planning Organization were interrogated. On 5 May 1961, in the general assembly meeting of the NUC, the Socialization Law was discussed and put into force. The undersecretary of the MHSA, Nusret Fişek, also attended the meeting and together with colonel Suphi Gürsoytrak defended the law.

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[489] Aydın, "Sosyalleştirme Yasasındaki Teknik Hatalar ve 32. Madde Olayı."; Aydın, "Sağlık Hizmetlerinde Sosyalleştirmenin Tarihsel Yönü."; Aydın, "Türkiye'de Taşra ve Kırsal Kesim Sağlık Hizmetleri Örgütlenmesi Tarihi."

[490] Erder, interview by the author.

[491] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, p. 57.

Suphi Gürsoytrak presented the law to the NUC members: "... the High Committee that has held power since 27 May and its President, have promised the Turkish Nation and thereby the world that it would provide this service, which has been neglected for centuries, to the citizens through socializing medicine."[492] He explained the main principles of the law and said that they were planning to collect premiums beginning from 1962. Every year citizens would be given medicine which did not cost more than 25 liras. Kadri Kaplan asked whether this bill had been analyzed by the Social Planning Office of the SPO and how the expression "premiums might be collected" should be interpreted. Suphi Gürsoytrak answered the first question and said that they cooperated with the SPO. Nusret Fişek answered the second question and said that article number 32 had been removed from the bill on the request of the Ministry of Finance. Gürsoytrak emphasized the possibility of collecting a premium of 25 liras from each family, but not for the time being.[493] Fişek explained the collaboration with British and their and Americans' offer of financial help.[494]

The "planning of the East" is an important theme in Nusret Fişek's speech which reveals the kind of role they ascribed to the socialization of health services: "All the ministries accepted that the most important service is health in the planning of the East. The easiest way to win the hearts of people, to affect them, is to bring health services to them. Even the colonizers in the world are bringing health services to the colonized by building up dispensaries there. They affect them in this way."[495]

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[492] Republic of Turkey. *TC MBK Genel Kurul Toplantısı*, Session 71, vol 5, 5 January 1961 (71. Birleşim, cilt 5, 5 Ocak 1961).

[493] Ibid., p. 16.

[494] Necat Erder says the organizations that offered financial help might be USAID and Biritish Ministry of Development (Erder, interview by the author).

[495] Republic of Turkey. *TC MBK Genel Kurul Toplantısı*, p. 17.

Gürsoytrak answered all the objections related to the financial resources by saying that they did not bind the following governments financially. A separate law would be brought to the cabinet and it would determine the amount to be allocated to socialization. So he wanted the NUC members to focus not on the budget but on the main principles.[496]

While discussing the articles Vehbi Ersü objected to the removal of "premiums." Nusret Fişek answered that the removed "premiums" were the premiums that would have been paid to the doctors. The "premiums" that would be collected from the people had not been removed. Only the collection was postponed. Here we can see the confusion on the financial aspect of the socialization. By looking over the discussions one cannot understand whether it was to be a premium-based system or a tax-based one. Vehbi Ersü stated the need to collect premiums from the people. The expenditure of socializing medicine cannot be met from the general budget. He suggested collecting a small amount of premiums: "This would not be a great expense for the people. This amount would not be taken from those who proved their poverty."[497] The objection related to the budget was expressed again while discussing the issue of free quarters (*lojman*) and vehicles.

Article 27, which regulates the extra allowances for the doctors and other health personnel, was also challenged. Haydar Tunçkanat drew attention to the harsh working conditions of the military officers. It would be unjust and the resources would not be sufficient if the doctors received much more. Nusret Fişek responded to this objection by referring to the spirit of the era. People did not behave according to

[496] Ibid., p. 20.

[497] Ibid., p. 21.

ideals.[498] Doctors needed to be paid the amount that they could earn if they were self-employed. Otherwise it would be impossible to find doctors to employ and all the investment made would be wasted: "You invest 100 million liras in the Trakya region and give 6 million of it as compensation. What happens if you withhold this 6 million? 94 million liras would be wasted."[499] He then said there were many Turkish doctors in foreign countries. In the United States alone there were 1200 doctors. This was very costly for the Turkish economy. Training a student for medical service cost 500,000 liras and that meant they were giving away 600 million liras to the US with no return.[500]

The officers, however, insisted on the self-sacrificing attitudes of military personnel and teachers. Also, the undersecretary of Ministry of Finance opposed the special treatment of doctors. So Fişek changed that detailed article with a much more general one, which said that the wages would be proposed by the MHSA in accordance with the principles fixed by the State Personnel Office and finally would be set by the cabinet. In determining the wages, points that would be taken into account were: personnel's possible earnings if they were self-employed, duration of service, specialization, the importance of their position, the weight of their job and the deprivation conditions they confront in the regions they work.[501] The law passed but the wages of health personnel and other controversial issues related to finance continued to be matters of concern throughout the application process. The Law on the Socialization of Health Services was published in the Official Gazette and came into force on 12 January 1961.

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[498] Ibid., p. 32.

[499] Ibid., p. 33.

[500] Ibid., p. 33.

[501] Ibid., pp. 40-41.

Actually, there was continuity between the earlier plans (the First Ten Year National Health Plan – 1946, the National Health Program – 1954) and the Socialization in terms of their aims of providing health service for all and expanding preventive care. But the Socialization was part of the planning leap characterizing the period and that made it possible to take on health service within a totality. The SPO focused on economic development at first hand, but then cultivated new concepts and methods in the sphere of societal and cultural development. For example, the concept of "investment in man" (*insana yatırım*) was used to refer to the objectives in the fields of education, health and social security. The relations of the social variables among themselves and with the economic variables were exposed.[502] Fişek was highly trusted by the early planners because of his competence, productivity and political views. So, they prepared the Socialization Law and the health service section of the First Five Year Plan together.

The link between health and development was determinate in the planning of socialization. Military rulers and early planners conceived economic growth and social justice as inseparable components of a democratic development. The connection between health and socio-economic issues was always pronounced. In an SPO document, it is stated that the interconnectedness of economic and social sectors revealed itself in the field of health: "Health is one of the instruments of development. One of the goals of economic development is to maintain good health. Economic development is an instrument for maintaining good health."[503] The socialization of health services might be seen also as a modernization project that aimed to change the ways of living and the mentalities of the villagers. The doctors,

[502] Kansu, p. 95.

[503] Parla Kişmir, *Sağlık Planlamasında Ekonomik ve Sosyal Kriterler* (Ankara: DPT, 1967), p. 6.

as educated state officials, were expected to train people in basic public health conditions and influence them. In the free housing of the doctors in the villages, the teachers would also stay. So, the existence of a teacher and a doctor in the remotest villages of the country was expected to accelerate the societal development.

The Main Principles of the Socialization

Nusret Fişek defined the socialization of health services as follows:

> the establishment of a system or order of things that ensures that the rendering of such services is no longer a source of personal gain for those rendering such services, that everyone may benefit on an equal basis from available health services, that to benefit from such service or services is not conditioned upon or limited by the financial means of the person in need of such services, that these services are administered by the State and that they are developed according to a well-determined program.[504]

The word "socialization" causes confusion as it means the process by which human beings or animals learn to adopt the behavior patterns of the community in which they live. It is the process whereby people acquire social identities and learn the ways of life within their society. Fişek admitted that it was not a proper concept to express the change in the health system. In an interview, he referred to the confusing of "socialization" with "socialism" and said they would rather call it "nationalization" (*millileştirme*). With the notion of "socialization" he wanted to denote the adaptation of the health system to society like the adaptation of the child to the community.[505]

In 1963, an expert from Great Britain came to analyze the socialization in Muş. Neville Goodman was the assistant of Sir John Charles, who had been invited

[504] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 1.

[505] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, p. 61.

in 1961 to discuss the socialization program. Charles was the chief medical officer in the formation of the British NHS. He prepared a report focusing on the planning and organization of this transition and this report was published in Turkish.[506] In this report he emphasizes the importance of planning and organization, the need to promote health personnel to work in less appealing regions, and the need to establish an advisory mechanism between the MHSA and health personnel. His assistant Goodman wrote an article on the application of socialization in Muş which was published in the British medical journal *Lancet* on 4 January 1964. The article was translated and published in *Sağlık Dergisi*.[507] In a footnote, Goodman said the word "socialization" in Turkish health system was different from the word they used in Britain. "Socialization" was used in Turkey to express the health services for the whole population. So, the word "national health services" would be used as an accurate translation.[508] Likewise, Fişek explains the opposition of Goodman to the term "socialization." Goodman told him that "socialized medicine" denoted the system in Russia in which the patient did not have the right to choose the doctor and vice versa. So, an accurate translation would be the "national health services."[509] Fişek's definition of "socialization" can be read as the definition of the "national health services."

Fişek summarized the important provisions of the law socializing the health services in 15 articles:

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[506] Üner and Fişek. pp. 119-134.

[507] Neville M. Goodman et.al., "Tababetin Sosyalleştirilmesi İçin Türkiye'de Yapılan Tatbikat." *Sağlık Dergisi*, Mayıs-Haziran, 38(5-6) (1964): 61-69.

[508] Ibid., p. 62.

[509] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, p. 26.

> 1. There will be a program for health services (Article 1 to 17 and Article 21). This Law requires the preparation of a health plan, and it also stipulates that the plan prepared in accordance with the provision in Article 17 should not be put into effect without previously securing the conditions necessary for said plan's execution.[510]

Health services were to be socialized in accordance with a plan which would be in line with the five-year plans of the SPO. Issues such as which province would be socialized and when, the required personnel and infrastructure, the quality and quantity of the health institutions would all be determined beforehand.

> 2. Everyone will benefit from the health services on the basis of equality (Article 2). Today nobody can claim that the villagers benefit from the health services as much as the town and city people, that the Eastern provinces benefit from such services as much as the Western provinces. Neither have we seen any radical action in the expenditures of our health budget till now that would ensure such equality. This provision in Article 2 will in the coming years compel governments when preparing their budgets to think how to ensure equal service with limited means and compel them also to find a way, a solution to this matter of equality in service.[511]

The question of equality was decisive from the very beginning. The great gap between cities and villages, East and West, rich and poor in terms of receiving health care was the main concern of the military, the early planners and Fişek, who shared the vision of a socially just development.

> 3. The organization of the health services within a Province will not correspond to that of the Province's administrative division and sub-divisions and the authority to employ health personnel will be transferred from administrative directors to directors of the health services (Articles 2 and 25). In Turkey, the administrative organization was rather set up with a security perspective, namely the maintenance of law and order. The above-mentioned rule with reference to the transfer of authority was conceived with a view to establish the competence and jurisdiction of the health directors over

[510] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 6.

[511] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 6.

> their personnel who in fact are called upon to perform a distinctly technical service to the community, and to see to it that the organization of health services be in essence based upon population, the health personnel being an important factor in the application and performance of this service to the people.[512]

As mentioned above, because of the Provincial Administration Law, the doctors in the counties could get in touch with the doctors in districts (*bucak*) through *kaymakam* and *nahiye müdürü* while provincial health directors (*il sağlık müdürü*) could get in touch with doctors in the counties through the governor and the *kaymakam*. This administrative structure was increasing the bureaucratic burden on doctors and health authorities. They were unable to move quickly because of the administrative directors to whom they were held subject. With the socialization, health posts (*sağlık ocağı*) were held subject directly to the provincial health director and the governor.

> 4. The basic health service units, named the health posts have been accepted as the fundamental nuclei of the organization of the health services, and the "government doctor" have been abolished (Articles 2 to 10 and Article 23). In order to achieve minimum cost for health services, it is a must to unify the health organizations. (...) With the above mentioned rule it is possible to revert to an organization based on population which is more compatible with modern principles abandoning thus the conception of a health organization not corresponding to administrative division and subdivisions.[513]

According to the Socialization Law, health services become unified within a province. That means, in determining the regions of health posts county borders were not taken into account. That is, villages attached to the same health post might have been within the borders of different counties. In the establishment of health posts and the determining of the regions, not the administrative divisions but the efficiency in

[512] Ibid., pp. 6-7.

[513] Ibid., p. 7.

health service provision was taken into account.[514] Some villages had no connection with the county to which they were attached. There might be ethnic or sectarian gaps or some geographical barriers. So, the health organization would be established by neglecting these administrative deficiencies.

> 5. Personnel working for the organization of the health services will not be allowed to exercise their profession for their own account, in return the Government will engage their services with a contract, and (the Government) will be free to determine their contractual service fees (Articles 3 to 19 and Article 26). Harmony in the organization of the health services would mean the ensuring of the distribution of doctors throughout the land in proportionally appropriate (averages) numbers; and in order to be able to operate available health facilities profitably the way out (the solution) would be to end the double-status of the doctor of being both a functionary of the government and a private practitioner of a liberal profession.[515]

Although there was a rise in the number of the health personnel, their distribution throughout the country was always a problem. Doctors and other health personnel always concentrated in big cities and in the Western provinces. Living conditions were decisive in this choice. Doctors did not want to work in regions of multiple deprivations. Earning money from private practice was easier in the economically developed regions. They also did not abandon their positions in state and university hospitals which in turn guaranteed them regular income, social security and status. For a doctor with a private practice it was advantageous to hold a position in a state hospital. Patients who demanded a qualified hospital service visited the doctor first in his office. This practice is still widespread and it damages not only the principle of equality, but also the doctors' public image. Through socialization Fişek aimed to break this commercial relation and employ health personnel throughout the country.

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[514] Öztek, *Sağlık Hizmetlerinin Sosyalleştirilmesi ve Sağlık Ocağı Yönetimi*, p. 292.

[515] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 7.

In an SPO report published in 1966, the reactions against socialization were mentioned and criticized.[516] One of the reactions was related to the damaging of private medicine as free health service was expanded even to the villages. The report argued that private medicine would not be damaged because private practitioners would keep on earning more than state and university hospital doctors. Another reaction was related with the regression of Turkish medicine. The report answered this criticism stating that a doctor who was not preoccupied with earning money would spend more time on scientific research. In this report the doctors' resistance to losing the advantage of private practice and becoming civil servants is clear.

> 6. For the doctor who does not wish to take up service in the public sector, the Law recognizes his right to private practice; equally the Law recognizes the patient's right to attend to any private doctor on the condition that he pays for the services he receives (Articles 4 and 5). With this provision the freedoms of the individual are protected against being unnecessarily infringed upon during the process of socializing.[517]

Fişek did not want to adopt the Soviet model, in which people had to go to the regional clinic and doctors had to examine whoever came.[518] Although the expression "the nationalization of medicine" (*hekimliğin devletleştirilmesi*) was used in the newspapers to explain the preparations of the Socialization Law, the abandoning of private practice did not come up at any point. Starting from the report on the development of health services in Turkey presented to the NUC, not private practice but the possibility of being both a private practitioner and a civil servant was challenged. In that report it was stated that the prohibition of private medicine was an

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[516] Samira Berksan, *Sağlık Hizmetlerinin Sosyalleştirilmesi Üzerine Bir Not* (Ankara: DPT, Sosyal Planlama Dairesi Araştırma Şubesi, 1966).

[517] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 7.

[518] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, p. 26.

anti-democratic practice and a violation of human rights. That carried the danger of a decrease in the quality of service as it abandoned competition and incentive.[519]

> 7. In the health organization it has been accepted to form regions composed of several Provinces (Article 9). Today, there is need to abandon the conception of centralization in administration, need to divide the country into service regions each being composed of four to five Provinces, and need to transfer many of the powers of the MHSA to the regional directories.[520]

Article 9 defined the socialized health organization. It was composed of health stations (*sağlık evi*), health posts (*sağlık ocağı*), health centers (*sağlık merkezi*), hospitals, various preventive care organizations, health authorities, regional hospitals, regional laboratories, institutions that train health personnel, the central organization of the MHSA, and departments that had been established to cooperate with the MHSA. Health stations were responsible for a population of 2500-3000. They consisted of a midwife who took care of maternal and child health. Health posts were responsible for a population of 5-10,000 in rural areas and 15-35,000 in urban areas. They consisted of a general practitioner, a nurse, a midwife, a health officer, a medical secretary, a driver and a janitor. They were responsible for both preventive care and curative services.

There would be a health center in counties, and a hospital in provincial and regional centers. Turkey was divided into 16 regions and the salaries of the health personnel, for example, was determined according to the region's level of development. The regions were: 1. İstanbul, Edirne, Kırklareli, Tekirdağ (later on Yalova would be added); 2. Sakarya, Bolu, Kocaeli, Zonguldak (later on Karabük

[519] Üner and Fişek, p. 23.

[520] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 8.

and Bartın would be added); 3. Bursa, Balıkesir, Çanakkale; 4. İzmir, Manisa, Aydın, Denizli, Muğla; 5. Eskişehir, Bilecik, Kütahya, Afyon, Uşak; 6. Antalya, Burdur, Isparta; 7. Ankara, Kastamonu, Çankırı, Yozgat, Kırşehir, Nevşehir (later on Kırıkkale would be added); 8. Konya, Niğde (later on Karaman and Aksaray would be added); 9. Samsun, Sinop, Ordu, Çorum, Amasya, Tokat; 10. Sivas, Kayseri; 11. Adana, İçel, Hatay, Maraş, Gaziantep (later on Kilis would be added); 12. Trabzon, Giresun, Gümüşhane, Rize, Artvin (later on Bayburt would be added); 13. Elazığ, Adıyaman, Malatya, Tunceli, Bingöl; 14. Diyarbakır, Urfa, Mardin, Siirt (later on Batman and Şırnak would be added); 15. Erzurum, Erzincan, Kars, Ağrı (later on Ardahan and Iğdır would be added); 16. Van, Muş, Bitlis, Hakkari.[521] The socialization of health services started from the Eastern provinces. The course of the socialization corresponds more or less to this regional division, started from the less developed regions and continued with the more developed ones.

> 8. Possibilities have been prepared to develop the cooperation between the people and the health organization (Article 23). In a service rendered to the people it is important to obtain their cooperation and understanding, it is also vital that the people accept as their own an organization that renders such service to the community; unfortunately this psychological aspect of the matter had been neglected so far. In this new Law when socializing the health service it has been sought to inject new ideas into the administration taking into account the creation of organisms where people and the members of the health establishments may meet.[522]

In Article 23, it was stated that health councils would be established in health posts, health centers and provinces to provide the connection between the socialized health service organization and the people. These councils would inform the administrators

[521] Devlet Planlama Teşkilatı, *Yataklı Tedavi Kurumları Ana Planı* (Ankara: DPT, Sosyal Planlama Dairesi, 1975).

[522] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 8.

on the expectations of the people from the health organization. According to the regulation on health councils,[523] the doctor of the health post would preside over the council composed of the *muhtar* (village headman), the *imam* (prayer leader), the teacher and the elected members of the villages to which the health post was responsible. They were to meet quarterly and discuss the health problems of the region. For example, if the students attending a village school had hepatitis or parasites, the measures would be discussed to provide the school hygiene. Participation of the people to the health services was to be provided through these councils.[524] This emphasis on participation reflects the democratic mentality of the period. In socialization there was both the modernizationist approach of the 1930s, which reveals itself in the aim to change the ways of living and the mentalities of the villagers with the help of educated health personnel, and there is this democratic approach of the 1960s of including the people within the system.

> 9. The administration has been given permission to establish a study region in one part of the country to carry out experimental work (Article 18).[525]

Fişek explained the risks of applying comprehensive and costly projects without doing experimental work. The decisions taken by experts in offices might be defective when applied in the field. So, the socialization of health services was going to be applied in a pilot region and Muş was chosen for this in 1962. It was an area of multiple deprivations, people were poor and the health services were really insufficient. The roads connecting the villages to the province center were blocked

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[523] *Sosyalleştirilmiş Sağlık Hizmetlerinin Sağlık Kurulları Yönetmeliği*, *Resmî Gazete*, 15 March 1969.

[524] Öztek, *Sağlık Hizmetlerinin Sosyalleştirilmesi ve Sağlık Ocağı Yönetimi*, p. 298, Öztek, interview by the author, March 2006.

[525] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 8.

during winters and people could not reach the hospital. Muş was thus viewed as a challenge and the government chose it with the assertion that "if we succeed in Muş we will succeed anywhere".

Construction of health stations for a population of 5-10,000 and health posts for a population of 2-3000 started. Midwives were sent to the health stations in the remotest villages. The number of beds in the Muş hospital was increased from 70 to 200 and 15 specialist doctors were employed there. Then on 8 August 1963, the socialization practice started.

In this report, Goodman appreciated the practice, but asserted that it was difficult to find a sufficient number of health personnel for the expansion of the project to other provinces. He explained the new health post and free residential buildings in detail. The doctors and other health personnel attended a preliminary course for two months at the School of Public Health. Doctors signed contracts for three years to work there in return for very high salaries. Except for nurses, all the permanent staff was full in the twenty health posts in Muş.

The biggest change in the hospitals (there were two hospitals, one in Muş city center and one in Bulanık) was the appointment of 15 medical specialists to the central hospital and the practice of not accepting patients to the hospitals who had not been referred from the health post. Personal health records were kept and a new system for the collection of health statistics was established. Immunization was the task of the health officer who spent most of his time with vaccination, environmental hygiene and public health education. The patients did not pay any money to the doctors in the health posts. Only those who saw the doctor outside the working hours paid money. Life-saving drugs were free, but others were not. Those who attended directly to the hospitals had to pay a fixed amount of money unless they held a

poverty record approved by the *muhtar*. Goodman estimated that nearly 99% of the people did not pay any money because the elected *muhtar*s gave poverty records to whoever requested. The hospital provided every kind of health service other than eye glasses and dental plates.[526] The report shares the optimism and the enthusiasm of the health personnel and the health authorities.

> 10. The health services of establishments within the public sector in Turkey have all been unified (in one hand); and the MHSA has been given the power to control the health personnel cadres of the other establishments (Articles 7 and 8). Today, the fact that every State organism has its own separate health services organization causes an economic loss. As we are compelled to use everyone at hand with consideration for economy, the fact mentioned above must be viewed as detrimental.[527]

Article 7 gave the task of determining the number of health personnel who would work in state institutions to the Council of Ministers that should consider the proposal of the MHSA (the article was amended in 1988 and the task was taken from the Council of Ministers and given to the Prime Ministry). Article 8 put it very clearly that in the regions where health services were socialized (they were planning to socialize the whole country in 15 years time, but it took 22) all the state health institutions except those of the Ministry of Defense were to be governed by the MHSA. In the public sector, the MHSA, the Ministry of Defense, the Labor Insurance Institute, faculties of medicine, the Ministry of Education, the State Post (PTT), the State Railways (TCDD), municipalities and state economic enterprises were providing health services. Various institutions were trying to produce health service without any coordination, which implied a waste of resources. Through the unification of these institutions people would benefit from a wider capacity of health

[526] Goodman et.al.

[527] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 8.

service. Also article 30 regulated the transfer of the buildings, medicine, equipment and furniture of the public sector health institutions in the socialized regions to the MHSA. However, temporary article number 3 allowed for the postponement of the transfer of public sector health institutions to the MHSA until the socialization of the whole country had been completed. The public sector health institutions and especially the Social Insurance Institution (the Labor Insurance Institution was turned into SII in 1965 with law no. 506) referred to this article in resisting the transfer of their health institutions.

> 11. The Law also provides that prior to the gradual socializing process personnel for the health services be trained, and that with a view to securing possibilities to lower the cost of services conducive to the development of the preventive services health personnel outside the regions of application be also completely attached to government service (Article 19).[528]

All the health personnel had to attend a two-month course at the School of Public Health in Ankara. Not only in faculties of medicine but also in health training schools, health personnel were trained to be employed in hospitals. So, there was a need to train them, especially on public health and preventive care. The course for general practitioners was on preventive care and health management (60 days); for specialists on the same subject (30 days); for nurses and health officers on service in socialized regions and preventive care (60 days); and for midwives on service in socialized regions, assisting at childbirth, maternal and child care, nurturing and food control (60 days).[529] This was announced also in the newspapers with the information

[528] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 8.

[529] Devlet Planlama Teşkilatı, *Sağlık Hizmetlerinin Sosyalleştirilmesi* (Ankara: DPT, Sosyal Planlama Dairesi, 1965), p. 13.

that 3-year contracts would be signed with the trainees to be employed in the socialized health services.[530]

> 12. The Law gives the MHSA the right and power to determine which drugs (medicines) are to be given free of charge (Article 16). In socialized health services the matter of medicine waste is a big problem. The Law aims at preventing such waste (...).[531]

Nusret Fişek adopted the "life-saving drug" model from the Australian health system. In this model, life-saving drugs were free but the others were not.[532] The general practitioners in health posts might be flexible in determining the life-saving drugs. Adrenaline injected to the heart of a patient was life-saving, but penicillin for a baby with pneumonia was also life-saving. Zafer Öztek said in the health post at which he had worked they had considered all kinds of drugs for babies as life-saving. The MHSA had sent the drugs in bottles and they had given them to the patients in paper cones.[533] Every year the MHSA determined and sent the drugs to be given freely at the health posts. According to the Law on Pharmacists and Pharmacies,[534] if there was no pharmacist or pharmacy in a district, doctors in the public or private sector might have a medicine chest. So, some health post doctors were given the right to buy and sell drugs.

> 13. The Law reduces the health service responsibilities of the Municipalities, leaving them only a local responsibility (Article 33).[535]

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[530] *Cumhuriyet*, 7 March 1963.

[531] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 9.

[532] Nusret Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları 3: Eğitim, Tıp Eğitimi, Uzmanlık, Sürekli Eğitim ve Diğer Konulardaki Yazıları*, ed. Rahmi Dirican (Ankara: TTB, 1999), p. 141.

[533] Öztek, interview by the author, March 2006.

[534] *Eczacılar ve Eczaneler Hakkında Kanun*, no. 6197, *Resmî Gazete*, 24 December 1953.

[535] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 9.

The municipalities would be responsible for environmental hygiene like cleaning, food control, public places and public transport control, disinfecting, water supply, sewer clearance, garbage collection and cemeteries. The remaining health services, the services of the government doctor, and the inspection of the municipality's environmental hygiene practice would be executed by the health post doctor.

> 14. Care and preventive medical establishments have been considered as complementary institutions (Articles 11 and 12).[536]

The long-lasting wars had damaged the health of the population and infectious diseases like malaria, tuberculosis, trachoma, syphilis and leprosy were widespread. The MHSA established special service organizations that had central and provincial units to combat these diseases. Maternal and child care was also organized in this way in 1952. These unipurpose institutions served the whole population in a wide district (vertical organization). The urgency to combat these diseases with the limited resources at hand forced the governments to adopt this model, as was the case in other countries. This, however, implied a complexity in organization, duplications in services, and waste of resources. To prevent these and to take on individuals and families within a totality the integration of health services was required. Both the curative and preventive services would be provided by a single institution. This multipurpose institution would serve a certain population in a narrow district (horizontal organization). It was easier for the people to use integrated services because there was one certain institution that could be referred to for every kind of health problem.[537]

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[536] Ibid.

[537] Öztek, *Sağlık Hizmetlerinin Sosyalleştirilmesi ve Sağlık Ocağı Yönetimi*, p. 94.

Fişek thought Turkey had gone beyond the unipurpose organization model and now had the means to establish a multipurpose one. He criticized those who do not accept curative service to be a responsibility of the state. Until the Second World War, preventive care had been thought to be a task of the state while curative service was left to private doctors supported by insurance. This had lost its validity and now both of these services were thought to be the state's responsibility. To think of these two services separately while organizing health services was impossible especially in underdeveloped countries. Because preventive care encompassed not only environmental hygiene and the control of epidemics but also the education of people about health, early diagnosis and treatment through the periodical examination of healthy people, and the control of excessive fertility; none of these could be separated from curative services. If a country established separate organizations for preventive care and curative services it would waste financial and personnel resources.[538] He referred to the analogy in the World Health Organization documents: Preventive care was like a bitter drug. To make people adopt it, it had to be covered by sugar, i.e., by curative services.[539]

> 15. The procedure of applying to the health establishments for service and of taking advantage of services given free of charge is set in a regulation to that effect (Articles 13, 14 and 27). Thus, profitable working possibilities are being prepared, and in hospitals only medical services are to be rendered free of charge and dispositions are such that the patients are to pay for their bed and food. Otherwise room and board expenditures in the hospital budgets will be a big problem.[540]

[538] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 137.

[539] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları 3: Eğitim, Tıp Eğitimi*, p. 149.

[540] Fişek, *Efforts to Socialize Health Services in Turkey*, p. 9.

In the preliminary reports on the Socialization Law, Fişek mentioned the risk of abuse that would follow if all the health services were provided free of charge. To prevent unnecessary applications a certain amount of money might be taken. Also it was beyond the capabilities of a state to provide all kinds of health services free. At that time Fişek defended the insurance system, a point that will be discussed below. Maybe not all the health services were provided free in the socialization program, but a large number of them were. According to the regulation on the execution of health service in socialized regions,[541] all kinds of services given in the health post within working hours were free. But if the application was made outside the working hours, the patient had to pay fee: if it was in the health post building this amount was 5 liras, if it was in the patient's house it was 15, and if the doctor was brought to a village it was 50. This money was added to the revolving fund of the hospital with which the health post was affiliated. Also the money from the sale of drugs in the medicine chest of the health post was transferred to the revolving fund. Those who come from the not-yet-socialized regions and whose settlement in the socialized region had not exceeded 90 days -except civil servants and their families, and the poor- paid the same amount as those who applied outside the working hours. If a patient was referred to a hospital from a health post, the hospital service was free of charge. Those who went to a hospital directly -except for in emergency cases- paid 10 liras. Laboratory, x-rays and prosthesis services were also out of pocket. If a specialist doctor went to a patient's house with the invitation of the health post doctor, this service was free during the working hours. The examination and cure fees of insured patients would be paid by the insurance institution. Staying in private, first and second class rooms was subject to fee. Those who stayed at the hospital -except the

[541] *Sağlık Hizmetlerinin Sosyalleştirildiği Bölgelerde Hizmetin Yürütülmesi Hakkında Yönetmelik*, decree number 6/3470, *Resmî Gazete*, 9 September 1964.

poor- paid a daily amount of seven liras for food and bed.[542] Here we can see the aim of establishing the referral chain. People were encouraged to go to the health posts first and to hospitals only when necessary. The expansion of primary care units everywhere which would prevent crowding in the hospitals was the most important aim of socialization. The health posts would function as filters and nearly 90% of the patients would be treated there. In this way, hospitals would function much more efficiently and health costs would decline. In primary care units the patients would be treated within their environment and their cure would be much more efficient.

The expansion of primary care units would reduce demand on hospital care, but the main concern was to provide basic health service to everyone, at all times and everywhere. The principle of availability requires the organization of health services in such a way that all the citizens can reach them whenever and wherever they need. When the health unit is close to their houses people have access to a doctor in the early phase of their illnesses. They would not postpone the treatment. The treatment of a disease after it has progressed is much more difficult and costly. There are many factors acting upon people's use of the health services and remoteness is a very important one.[543] I have already mentioned that the lack of availability of health services especially in rural and Eastern Turkey and the difficulty of taking patients to county and province centers created many problems. The military bureaucrats decided to execute this new health program mainly to provide health services to all.

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[542] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesi ile İlgili Kanun, Kararname, Yönetmelik ve Protokoller (1962-1972)* (Ankara: SSYB Sosyalleştirme Dairesi Başkanlığı, 1972), pp. 41-42.

[543] A research on the determinants of utilization from the health post in Kazan reveals that the closer the villages to the health post the more use is. Kâzım Toprak, "Köylük Bölgelerde Tedavi Hizmetlerinden Yararlanmada Mesafenin Etkisi." *Sağlık Dergisi*, 45 (5-6) (1971): 59-66. A research on the determinants of utilization from the health posts in Çubuk Training and Research Region reveals that remoteness, ease of transportation, economic status, length of illness and quality of the service effect the application (Öztürk and Bilir).

This widespread basic health service would be given by primary care units, i.e., the health posts.

Three separate health post types were designated: village type (for a population of 5-10,000), county type (D-1) (for a population of 10-20,000), and province type (A-1) (for a population of more than 20,000). They differed not only in their architecture but also their personnel. The village type consisted of general practitioner, nurse, midwife, health officer, medical secretary, driver and janitor. (Every health post had a jeep to be used in village visits and emergency situations. The causalities due to the difficulty of taking patients to the hospitals would be hindered.) The province type consisted of head doctor, general practitioner, dentist, psychologist, social worker, dental technician, nurse, four health officers (x-ray, community health, laboratory, and environmental hygiene), midwife, medical secretary, driver and janitor. The province type consisted of the same personnel. Health stations that were in charge of a population of 2.500-3.000 would be attached to health posts. They would have a midwife.

The main tasks of health stations were maternal and child care, vaccination, educating people on personal and social hygiene, and training mothers. The main tasks of health posts were outpatient and home-care, emergency, epidemics combat, household records, environmental hygiene, maternal and child care, laboratory service where possible, measures to treat nutrition disorders, referral of patients to hospitals if necessary, education on personal and social hygiene, provision of medicine in places 10 km far away from a pharmacy, all preventive vaccination, and public health education.[544] Twenty-four different types of statistical records would be kept to have an accurate picture of people's health and the functioning of the system.

[544] Devlet Planlama Teşkilatı, *Sağlık Hizmetlerinin Sosyalleştirilmesi*, pp. 9-10.

The main records were household detection, distribution of population according to age groups, personal health, pregnancy watch and treatment, child care and treatment, working of the personnel, vaccination, epidemics, diseases, referral, environmental hygiene control, and public health education.[545] From 1963 onwards there was a hustle to expand this model throughout Turkey, which implied a new role for the state in the provision of health care.

In 1978, the WHO and UNICEF cosponsored the International Conference on Primary Health Care (PHC) in Alma-Ata, at which the international development community adopted PHC as the key to attaining the goal of Health for All by the year 2000. PHC, as defined at the Alma-Ata conference, called for a revolutionary redefinition of health care. Instead of the traditional "from-the-top-down" approach to medical service, it embraced the principles of social justice, equity, self-reliance, appropriate technology, decentralization, community involvement, intersectoral collaboration, and affordable cost. The Alma-Ata Declaration on PHC envisaged a minimum package of eight elements: (1) education concerning prevailing health problems and the methods of preventing and controlling them; (2) promotion of food supply and proper nutrition; (3) an adequate supply of safe water and basic sanitation; (4) maternal and child health, including family planning; (5) immunization against the major infectious diseases; (6) prevention and control of locally endemic diseases; (7) appropriate treatment of common diseases and injuries; and (8) provision of essential drugs.[546] Years before this conference, the

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[545] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirildiği Bölgelerde Uygulanan İstatistik Formları ile İlgili Açıklama* (Ankara: SSYB Sosyalleştirme Özel Daire Başkanlığı, 1967).

[546] *Declaration of Alma-Ata: International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (December 2007)

Socialization Law had adopted these principles. The Turkish delegation explained the socialization of health services and it was appreciated by the audience.[547]

Conclusion

The socialization of health services was designed by Nusret Fişek, the SPO, and the military to extend health care, including preventive and curative services, to the whole country, and to make them easily and equally accessible to everyone. Although there had been significant accomplishments in the field of health care before 1960, some problems persisted, like the lack of health care in villages, the unjust distribution of health personnel, small number of auxiliary health personnel, high infant mortality rate, and the sporadic appearance of epidemics. The DP tried to solve these problems and took big steps in the field of hospital care. Also, the acceptance of the curative service as a responsibility of the state was an important turning point. However, new problems were added to the persistent ones in the DP period. The emphasis on curative services led to the undermining of public health and brought concentration of health services in cities, which left the rural population without basic health care. The opportunity of the state employed doctors to have their own offices, the tendency of doctors to become specialists, the lack of a primary care network which increased the workload of hospitals constituted other problems.

The existence of separate health care units (apart from the MHSA, the Ministry of Education, the Ministry of Defence, the State Economic Enterprises, the Labor Insurance Institution, the State Post, the State Railways and universities had their own health institutions) prevented the efficient use of already scarce resources.

[547] Dirican, interview by the author. Dirican was a member of Turkish delegation.

The vertical organization model of the 1920s became ineffective in time as separate organizations for separate diseases meant loss of resource and manpower when epidemics were not that widespread. Although the share of the MHSA in the general budget increased, the existing health services were unable to meet the rising expectations of the people. The socialization of health services was a response to all these problems. It was based on the dominant ideology of the 1960s which considered economic growth and social justice as inseparable components of a democratic development.

The military coup of 27 May brought dramatic changes to Turkish politics. The 1961 Constitution charged the state with the task of providing social welfare to its citizens while the SPO was to designate the development strategy of the country. However, the development strategy of the early planners, which was based on land reform, progressive agricultural tax, and reorganization of the State Economic Enterprises, was rejected by the civilian governments and the SPO lost its initial power. This process left the socialization of health services without any resources and strong planner support.

The military wanted the socialization to start from the East, which implied that they saw it also as a project of national integration. They wanted to suppress Kurdish nationalism, which had started to gain a political dimension in the late 1950s through regional social development, and health service was an important component of this. It was the first time that health service was viewed clearly as a tool of national integration.

Another dramatic change was in the field of population policy. The pro-natalism of the 1920s and 1930s left its place to the anti-natalism of 1960s. Although economic considerations were decisive in this shift health and human rights played

important roles in the lifting of the ban on birth control. The organizational units of socialization were to be used in population planning.

The socialization of health services brought a new organizational structure which would be much more efficient and egalitarian than the existing system. The primary concern of the military, early planners and Fişek was the inequality between the cities and the villages. There were serious inequalities between rural and urban population, East and West, and rich and poor in terms of receiving health care. As it was the initial phase of the consolidation of inegalitarian corporatism, the primary inequality was not the one between those in the formal sector and those outside of it. The LII (SII, after 1965) had just started to establish its health facilities and the number of those covered by a security scheme was very low. Hospital services were not that expensive and poor people were treated free of charge. So, more than the status at work it was the rural-urban divide that was decisive in health care inequalities. Yet the existence of separate health units, which was an indicator of corporatist system started to create problems and socialization attempted to integrate those units for an effective functioning.

CHAPTER FIVE

HOW THE SOCIALIZATION OF HEALTH SERVICES WORKED AND DID NOT WORK? (1961-1980)

Introduction

The Socialization Law (no. 224), which is still in force today, was an attempt to abolish all kinds of discriminations and provide health services on an equal basis, but it was not applied in the proper sense. Although the results of the proper application were noteworthy, both in terms of improving health indicators and falling expenditures, the socialization of health services could not be established as the health system of Turkey due to various reasons which will be analyzed in this chapter.

Although the number of those covered by a security scheme increased,[548] a large number of people were not covered by any medical scheme while insured workers, civil servants, and their dependents benefited from health services. Civil servants, retired civil servants, and their dependents could directly benefit from university hospitals. Insured workers, retired workers, and their dependents had their own hospitals. So, free curative services were provided to those who had paid premiums. This corporatist structuring of the system, together with other factors,

[548] See Tables 15-18 for the number and ratio of the population covered by RF, SII, Bağ-Kur and private funds, and Table 19 for the total population covered by security schemes, the ratio of insured population and the ratio of population covered by health services. The difference between the ratio of insured population and the ratio of population covered by health services should have diminished after 1985 when Bağ-Kur started to include health insurance. The gap closed in the late 1990s, which might have been due to the rise in Green Card holders.

prevented the development of socialization which aimed to cover all citizens on the basis of equality. Since the insured could directly go to hospitals, health posts were unable to develop. This proves that a service confined to the poor parts of the population is doomed to regression.

The main argument of this chapter is that efforts to establish a universal health care system failed in Turkey due to many factors, the most important being the corporatist structuring of the welfare regime. Esping-Andersen defines the universalist system as one in which all individual risks are pooled under one umbrella whereas in the corporatist system all individual risks are pooled by status membership.[549] The Turkish welfare system can be defined as inegalitarian corporatist. The label "inegalitarian corporatist" is intended to draw attention to both the corporatist element (with claims depending upon the membership of occupationally-defined corporate groups, as in the European conservative or corporatist welfare regimes) and the fundamentally inegalitarian character marked by the exclusion of quite a large portion of the population, those in the informal and agricultural sector.[550]

Health insurance was provided to government employees by the Retirement Fund (est. 1949), to formal employees by the Social Insurance Institution (est. 1945) and to the self-employed by the Bağ-Kur (Social Security Institution of Craftsmen, Tradesmen and Other Self-Employed; est. 1971; health insurance was applied starting from 1985). Although there was a hierarchy of access and accordingly citizenship among the members of these schemes, they were all protected in one way or another. This structuring of the health care system might be considered an

[549] Esping-Andersen, *Social Foundations of Postindustrial Economies*, pp. 40-41.

[550] Jeremy Seekings; Buğra and Keyder, "The Turkish Welfare Regime in Transformation."

indication of the alliance among the bourgeoisie, the bureaucracy and the workers of the formal sector which developed in the 1960s and 70s, which was analyzed by Keyder.[551] The socialization of health services was unable to provide universal coverage and the need to cover all still persists.

Apart from the consolidation of the inegalitarian corporatist system, the governments' reluctance to allocate enough resources for the socialization, the problem of unjust distribution of doctors, the unwillingness on the doctors' part to work in health posts, encouraging of specialization in medical training, and the problems due to the initialization of the program in the East constituted the reasons for the failure of socialization.

The socialization of health services started in Muş in 1963. Although the program had certain achievements, especially in places where it was properly applied, it was unable to become the national health service of Turkey. Even in the field it was limited to, i.e., the establishment of a primary care network, there were many problems. The pressure on hospitals continued to grow and the referral chain did not function. The number of health posts failed to reach the expected levels and the existing institutions were underfunded and understaffed. Of course, the existence of a health post in a village improved the health condition of that village. People would feel confident as there was a doctor nearby to whom they could go on an unconditional basis.

In the second section of this chapter, I will analyze these achievements and failures with reference to the reports of the SPO and the MHSA, the interviews, and the two general assemblies on the socialization of health services – one in June 1969 and the other in June 1978. Then I will give an outline of the population planning

[551] Keyder, *State and Class in Turkey*.

practice, the other grand project of the early 1960s. The third section will discuss the reasons behind the "failure" of socialization. Before looking over the achievements and the failures, and the reasons behind the failure, I will present a general overview of the approaches to health policy of successive governments between 1961-1980 and the way health policy was dealt with in government programs and health sector expertise commission reports of five year development plans.

The Approaches to Health Policy of Successive Governments in 1961-1980

After the military takeover of 27 May 1960, a cabinet of technocrats was installed by the military. The first Cemal Gürsel government was in power from 30 May 1960 to 5. January 1961 and the second one from 5 January 1961 to 20 November 1961. After taking radical steps like the passing of a new constitution and the establishment of the SPO, the military left its place to the civilian governments, although its influence on Turkish politics remained decisive. 27 May paved the way for other coups (12 March 1971, 12 September 1980) and installed the National Security Council, which extended its influence over government policies. Nevertheless, it was not the military but the civilian governments that shaped the welfare and health care policies. They were the ones who would implement the laws formulated by the military, including the socialization of health services.

On 15 October 1961, parliamentary elections were held. It was a real shock for İnönü's Republican People's Party (RPP) to receive only 36.7% of the votes (173 seats), which was slightly ahead of the Justice Party (JP), which polled 34.7% (158 seats). The New Turkey Party (NTP), the Republican Peasants National Party (RPNP) and the Workers Party of Turkey (WPT, *Türkiye İşçi Partisi*) gained seats in

the parliament. The RPP and JP had to form a coalition headed by İnönü, but it did not last long (20 November 1961 - 22 June 1962). Then İnönü formed a new cabinet, this time based on a coalition of the RPP with the two smaller parties, the NTP and the RPNP (25 June 1962 - 25 December 1963). The RPP-NTP-RPNP coalition could not work due to many conflicts, like that over the issue of land tax reform, and İnönü had to resign when the two smaller parties withdrew their ministers from the cabinet.

President Gürsel asked the Justice Party leader Ragıp Gümüşpala to form a government but he failed in his attempt. For the last time, İnönü was charged with forming a government. On 25 December 1963 the third İnönü coalition, this time a minority one of the RPP and independents, took office. It was not a strong government either (25 December 1963 - 20 February 1965). On 13 February 1965 İnönü resigned when he failed to get his budget approved in the parliament. A caretaker cabinet ruled the country (20 February 1965 - 27 October 1965) until parliamentary elections were held in October. It was headed by a former diplomat and independent deputy Suat Hayri Ürgüplü.[552]

The programs of all these governments were marked by common goals in the field of health: the development of preventive care, the improvement in the working conditions of health personnel, the expansion of health manpower, the provision of health care to peasants, the promotion of national pharmaceutical industry and private hospitals. It was clearly stated in the programs of both the tenth İnönü government (RPP and independents) and the Ürgüplü government that the socialization of health services, which aimed to bring health services to the peasants in the remotest parts of the country, would be applied. This was necessary to provide social justice in the distribution of health services. In both of these programs a

[552] Zürcher, pp. 253-63.

gradual health insurance was pronounced together with the socialization of health services.[553]

The policy target that put socialization as an organizational model and health insurance as a financial institution dominated all the debates related to health care throughout the 1960s and 1970s. Not only in government programs but also in the SPO Special Commission Reports, the aim of expanding health insurance to all segments of the population was mentioned together with the socialization model. The socialization of health services was narrowly defined as the providing of preventive care and basic health service to peasants and the urban poor. It was not considered to be the health system of Turkey with all its institutions including hospitals, but was rather limited to preventive care. The socialization of health services, the expansion of health insurance, and the integration of health institutions were the three major goals specified in the SPO Special Commission Reports. The Health Sector Expertise Commission Report of the First Five Year Plan (1963-67) was no exception.

In the Health Sector Expertise Commission Report of the First Five Year Plan (1963-67, published in July 1962, during the ninth İnönü government), preventive care was promoted to increase the health standards in Turkey.[554] The notion of "comprehensive medicine" was used to denote the role of health service delivery in societal development. Health posts were expected to improve peasants' health conditions and doctors would be the motors of development in rural areas. Family planning was required to raise per capita income, to reduce infant mortality rate and to raise physically and psychologically strong young people. There was the need to increase the number of health personnel and to provide their just distribution.

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[553] Dağlı and Aktürk (eds.).

[554] Devlet Planlama Teşkilatı, *1963-1967 Planı Hazırlık Çalışmaları Sektör Programları: Sağlık Hizmetleri* (Ankara: DPT, 1962).

Although there were great accomplishments in the struggle against epidemic diseases, there was still much to do, especially for regional epidemics like trachoma in the Southeast, leprosy in the East and hookworm in the Eastern Black Sea region. Hospitals lacked in bed capacity (21 beds for a population of 10,000) and their regional distribution was unjust. But as hospital services were expensive it was much more efficient to apply a health post program. This would reduce costs, bring health service to peasants, provide societal development, and expand family planning and malaria combat services. There was the need to establish 580 health posts in the cities within a period of 15 years. In this report, the establishment of health insurance was not explained in detail, but only specified as a goal.

The Justice Party, now led by Süleyman Demirel, won a landslide victory in the elections of October 1965. The party gained an absolute majority of the votes cast (52.9%) and of seats in the assembly. The RPP had 28.7% of the votes. Demirel was able to obtain a vote of confidence easily for his cabinet. For the next five years, he dominated Turkish politics. In the mid- and late 1960s economic growth was high and real incomes went up continually, by an average of 20% in the years 1963-69.[555] In the program of first Demirel government (27 October 1965 - 3 November 1969), preventive care, the integration of health services, the provision of health care to all, an increase in the number of hospital beds, the promotion of private hospitals, the gradual inclusion of people into health insurance, an increase in the number of doctors and other health personnel, their balanced distribution, and the protection of the national pharmaceutical industry were specified as the major goals.

What is noteworthy about this program is its emphasis on social justice. When we read the sections on social security we realize that Demirel had the

[555] Zürcher, p. 263.

European welfare state as an ideal in his mind. He talked about saving the citizens from the anxiety of the future, the establishment of unemployment insurance, the protection of deprived children, widows, pensioners, orphans, and old aged and disabled people. Everybody should receive a just share from the rising income and expanding welfare:

> The establishment of social justice through abolishing private property, hostile behavior towards wealth, and distributing the accumulated income and capital among the people by State force has been abandoned today even in most doctrinaire countries. To establish social justice, the modern state has the means of progressive taxes, public facilities that expand for the benefit of people, the fixing of wages and taking of share from the profit through free trade unions and collective bargaining.[556]

The second Demirel government (3 November 1969 – 6 March 1970) was established after the JP's victory in the 1969 elections. Demirel formed a new cabinet, slightly more centralist than the former.[557] In its program, preventive care, equal health care benefits, struggle against epidemics, environmental hygiene, maternal health, educating people in basic health care, the establishment of oncology and mental illness hospitals, the training of doctors and auxiliary health personnel, the protection of the national pharmaceutical industry and the development of a gradual health insurance were mentioned. However, the notion of "socialization" was not pronounced although the aims of preventive care, bringing health service to all citizens, improving the awareness of the people about health issues, and giving priority to preventive care were the components of the socialization.

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[556] (*Mülkiyeti ortadan kaldırarak, servet düşmanlığı yaparak, biriken gelir ve sermayeyi Devlet zoruyla ferdler arasında bölmeğe kalkarak, sosyal adaleti sağlama çabaları, bugün en doktriner ülkelerde bile terkedilmiştir. Sosyal adaleti gerçekleştirmek için modern devletin elinde müterakki vergiler, halk kitleleri yararına genişleyen kamu faaliyetleri, hür sendikacılık ve kolektif pazarlıkla ücretlerin tespiti ve kârdan pay alınması gibi birçok vasıtalar mevcuttur.*) Cited in Dağlı and Aktürk (eds.), pp. 103-4.

[557] Zürcher, p. 265.

In the program of the third Demirel government, the socialization of health services was noted as one of the special measures for the development of the East (6 March 1970 – 12 March 1971). Demirel had to establish this new cabinet as the right wing of his own party had voted with the opposition and forced him to resign. To set opportunities of free examination and treatment for the needy was specified as a goal in both the second and third Demirel government programs. The latter mentions the need to fix problems in the application of the socialization specifically for the development of the East. All the other goals, such as giving priority to preventive care, bringing health service to all, and the establishment of a gradual health insurance, also appeared in this program.

The emphasis on economic development was one of the defining characteristics of the Justice Party. Demirel described his project as to meet basic needs like electricity, water, sewerage and health, but also to redouble production, construct widest roads, harbours, airports, dams and irrigation systems. In his ideal of "Great Turkey" regional inbalances were minimized through necessary measures.[558] Looking at the programs of the successive Demirel governments, we can say that socialization was seen as one of these measures. The Justice Party had a

[558] Tanel Demirel, *Adalet Partisi: İdeoloji ve Politika* (İstanbul: İletişim Yayınları, 2004), pp. 282, 295. Demirel's ideal of "Great Turkey" in terms of welfare is as follows: "We yearn for an affluent Turkey. A Turkey where anyone who is willing to work can be employed, can maintain his and his family's living without being dependant upon anyone; a Turkey that has overcome poverty, unemployment, and despair, whose individuals are free of the fear of the present and the future, thereby of any kind of fear, who gained a political, economic and social personality; where every family resides in places honoring human dignity, who own everything that people of the civilized nations own, and who live their lives without depending on anyone in standards in accordance with human dignity; whose patients can have doctors and medication to cure them; whose disabled, old-aged, widow, or unemployed is not abandoned to the mercy of the streets; and a Turkey that has achieved the goal of social insurance and social solidarity." (*Müreffeh bir Türkiye istiyoruz. Çalışmak isteyen herkesin iş bulabildiği, kimseye muhtaç olmadan kendisini ve ailesini besleyebildiği, fukaralığı, işsizliği, çaresizliği yenmiş, fertleri bugün korkusundan yarın korkusundan ve gelecek korkusundan; velhasıl her türlü korkudan kurtulmuş, siyasî, iktisadî, sosyal kişiliğini kazanmış, her ailenin insan haysiyetine yaraşır bir evde oturduğu, ileri memleketlerin insanlarının sahip olduğu her şeye sahip olan, kimseye muhtaç olmadan, insan haysiyetine yaraşır bir seviyede yaşayan; hastası doktor ve ilaç bulan, sakatı, ihtiyarı, dulu, yetimi, işsizi sokak ortasında kalmayan; sosyal güvenlik ve sosyal dayanışmayı başarmış bir Türkiye istiyoruz.*) Cited in ibid., pp. 273-74.

comprehensive perception of social justice. Demirel himself emphasized the transition from a security state to a welfare state.[559] His views had a social-liberal outlook within which the welfare state was the "modern" and the "current" state form.[560] However, the Demirel governments did not adopt socialization as the ideal model for a welfare state. They limited its function to regional development and advocated the establishment of general health insurance. General health insurance, unemployment insurance, and agricultural insurance which envisaged direct subsidy were the major goals of the Demirel governments in the field of welfare.[561] New health posts were established to bring health care to the rural population, but socialization was not applied in the proper sense.

The third Demirel government was in power until the military memorandum of 12 March 1971. Nihat Erim, a member of the right wing of the RPP, formed a cabinet (26 March 1971 – 11 December 1972) which consisted largely of technocrats from outside the political establishment. He announced that his government would restore law and order and enact a number of socio-economic reforms like land reform, land tax and the nationalization of the mineral industry. But he failed to apply the reform program. When he approved some of Demirel's old ministers in his cabinet, 11 of his reformist technocrats resigned from the cabinet in December, so, Erim had to form a new cabinet (11 December 1972 – 22 May 1972). He was succeeded by Ferit Melen, one of the leaders of the Reliance Party (RP, *Güven Partisi*) (22 May 1972 – 15 April 1973).

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[559] "... a period marked by the global tendency towards the vision of welfare state from that of security state." (*Dünyanın jandarma devlet telakkisinden sosyal devlet telakkisine doğru yönelen yeni bir döneme girdiği...*) Cited in Tanıl Bora, "Süleyman Demirel." In *Modern Türkiye'de Siyasî Düşünce, cilt 7, Liberalizm*, ed. Murat Yılmaz (İstanbul: İletişim Yayınları, 2005), p. 573.

[560] Bora, p. 571.

[561] Tanel Demirel, "Adalet Partisi." In *Modern Türkiye'de Siyasî Düşünce, cilt 7, Liberalizm*, ed. Murat Yılmaz (İstanbul: İletişim Yayınları, 2005).

The program of the Melen government mentioned the same goals, like giving priority to preventive care, environmental hygiene, maternal health, the national pharmaceutical industry, and the expansion of health manpower and the establishment of a gradual health insurance. The difference was the commitment that the dependents of insured workers would receive health benefits in all the cities within the year 1972.[562] Economist Naim Talu was appointed by the president to lead a caretaker government to take the country to the first free elections after the coup of 12 March, those of October 1973 (15 April 1973 – 26 January 1974).

The Health Sector Expertise Commission Report of the Second Five Year Plan (1968-72) was prepared during the first Demirel government. Public health and preventive care were given priority.[563] The socialization of health services would be accomplished in 15 years if the share of the MHSA in the general budget were increased to 6%. It was accepted that there was no improvement in the integration of health services. The application of the socialization of health services was analyzed in the report. The rise in the number of personnel, vaccination, examination and notices of epidemics was mentioned. The expansion in the scope of health service, the balance in the regional per capita service, and the fall in the per capita and per service expenses were the results of socialization. However, there was not that much improvement in terms of roads, drinking water and telephone infrastructure in the villages where health posts are established.

In this report the relation between the socialization of health services and the Social Insurance Institution was analyzed under a separate heading. It was stated that

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[562] Actually, the Social Insurance Law (no. 506, 1964) regulated the health benefits of spouses and children in article number 35. But the application of this all over Turkey became possible in 1 April 1973 (Özbek, *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar*, p. 284).

[563] Devlet Planlama Teşkilatı, *İkinci Beş Yıllık Kalkınma Planı (1968-1972) Sağlık Sektör Özel Komisyon Raporu* (Ankara: DPT, 1966).

if there was a contradiction between the socialization of health services and the bill on Social Insurance Institution there should be a change in the legislation to provide the integration of health services. The financial resources required for the socialization of health services could not be obtained as the expected tax revenues could not be acquired and the national defence expenses were higher than the presumed level. Goals such as providing all drugs free of charge and raising the standarts of hospital services to the level of those of Western countries could only be accomplished through new financial resources like insurance. For the time being, it was difficult to establish a nation-wide insurance system, however, a partial one could be established that covered civil servants, the self-employed and those who were subject to income tax, i.e., those from whom it was easy to collect premiums. The SII was assigned the task of organizing the insurance. Peasants were excluded from this coverage since they did not have enough material means and it was difficult to determine their income levels. Inpatient and preventive care could be financed from the general budget and insurance could finance drugs, prothesis and hospital expenses.

Beginning with the second Menderes government program, the establishment of general health insurance had always been a major goal in government programs. Although it was accepted that it was difficult to establish insurance in an agricultural society, this did not lead to the adoption of the British NHS as the ideal model. The contribution of the people was considered to be necessary and there was always the problem of determining from whom premiums would be collected as it was obvious that some would not make regular contributions. If they were collected from certain groups would it lead to a discrimination in terms of the quality of service they

received? Actually, this was the case, but more than the inequalities in health service provision the premium-based development of SII was emphasized.

The report was positive about the application of the socialization of health services. It asserted that the service was beneficial to people and the people had embraced the program. The need to revise the education in faculties of medicine which was based on curative services was mentioned. In the report it was proposed that the people in socialized regions should be trained in the field of language to facilitate the working of health personnel. The word "Kurdish" was not used in the report, and teaching Turkish to the people rather than teaching Kurdish to the health personnel was considered as a solution. In the report the establishment of new hospitals, which was something very expensive, was criticized for absorbing large amounts of money from the budget to the disadvantage of preventive care.

The Health Sector Expertise Commission Report of the Third Five Year Plan (1973-77) was not that positive about the application of socialization.[564] The reform of the socialization of health services was seen as the condition necessary to provide health service to all on the basis of equality. To relinquish socialization was contrary to the principle of equality in the Constitution. However, there were problems related with financial and human resources. Preventive care, the socialization of health services, the integration of health services, the principle that doctors working for public institutions could not practice private business, a just rotation system and an improvement in the level of wages were the main causes. The principle that health expenses should be met from the general budget was accepted but if it was viewed as necessary for the maintenance of minimum standards additional financial resources might be inquired.

[564] Devlet Planlama Teşkilatı, *Üçüncü Beş Yıllık Kalkınma Planı (1973-77) Sağlık Sektör Özel Komisyon Raporu* (Ankara: DPT, 1972).

The difference in these two reports related to the application of socialization might be explained with reference to the deterioration of the program. From the very beginning there were problems related with the application. However, in the initial phases when enough resource was allocated, the system functioned properly. Health bureaucrats and other health personnel had faith in the system and worked hard for its functioning. But the new cadres, the bureaucrats within the MHSA, were not convinced of the applicability of the system. Also the consolidation of the inegalitarian corporatist structure left the program devoid of resources. There was no owner of it. So the financial and manpower resources decreased and the system failed. The reasons for the failure will be elaborated in the following pages.

The results of the elections of October 1973 were a surprise. Ecevit's left of centre RPP came out of the elections as the biggest party, polling 33.5% against the 29.5% won by Demirel's JP. None of the parties had an absolute majority, so a coalition or minority governments were inevitable. This situation continued throughout the 1970s. In January 1974, a short-lived cabinet was formed by the RPP and the National Salvation Party (NSP, *Milli Selamet Partisi*) (26 January 1974 – 17 November 1974). His successful treatment of the crisis in Cyprus allowed Ecevit to be embraced as a hero and he sought to use his new popularity to gain an absolute majority in early elections. The other party leaders avoided the early elections. Sadi Irmak formed a caretaker cabinet (17 November 1974 – 31 March 1975). Then Demirel put together a coalition of the JP, the NSP, the Nationalist Action Party (NAP, *Milliyetçi Hareket Partisi*), the Republican Reliance Party (RRP, *Cumhuriyetçi Güven Partisi*) and a number of defectors from the DP, which declared itself to the public as the "Nationalist Front" (31 March 1975 – 21 June 1977). The coalition held together until the elections of 1977. These elections were held in a

climate of increasing violence and economic crisis. The RPP, profiting from Ecevit's personal popularity, received 41.4% of the votes while the JP received 36.9%. An attempt by Ecevit to form a coalition of his party and independents soon failed (21 June 1977 – 21 July 1977). Demirel then formed a second "Nationalist Front" coalition. Defections by JP representatives brought about its fall in December (21 July 1977 – 5 January 1978). Then in January 1978 Ecevit formed a cabinet of RPP and the independents, which survived until October 1979 (5 January 1978 – 12 November 1979). Demirel returned to power and established a minority government supported by his own party and the independents (12 November 1979 – 12 September 1980). The coalition governments of 1973-80 were weak. The political system became paralysed, because the two major parties, the JP and the RPP, were unable to cooperate. Governments could not take effective measures to combat the two overwhelming problems of the country, political violence and economic crisis.[565]

The program of the first Ecevit government emphasized social justice in the distribution of health service. The main goal was the benefiting of all, especially those who lacked financial strength, from health services. Preventive care would be given priority and the imbalances in hospital services would be removed. The establishment of general health insurance would be worked upon. The program of Irmak government specifies the same goals. Additionally, this program declared the need to bring all the social security institutions under one roof. And it made a commitment for the application of the socialization program.

The fourth Demirel government's (first Nationalist Front) program affirmed that the work for the socialization of health services would be accelerated. Those

[565] Zürcher, pp. 274-76.

who were incapable of affording the service would be provided free treatment. The program of the second Ecevit government which could not receive a vote of confidence emphasized the public service characteristic of health care. In the program of the fifth Demirel government (the second Nationalist Front), it was stated that not only those who were employed but all citizens would have social security. Health insurance would also be provided to all. Health services would be distributed justly throughout the country. And socialization of health services would be re-evaluated and necessary measures would be taken to make it effective. Health personnel would be encouraged through various measures to work in places of multiple deprivation. The program of the third Ecevit government repeats the public service characteristic of health care and the need to expand insurance. The just distribution of health institutions and personnel throughout the country, preventive care, and the rise in the number of doctors who work full-time in public institutions were the major goals. The deficiencies of the socialization of health services would be detected and a new arrangement in line with the existing conditions would be settled. The criticism of full-time law (no. 2162, 1978), which will be analyzed later, marked the program of the sixth Demirel government. The law was criticized for leaving the patients without doctors and the commitment to provide citizens with all kinds of free health services was declared.

The Health Sector Expertise Commission Report of the Fourth Five Year Plan (1978-82) was prepared in 1976 when the first Nationalist Front was in power.[566] The head of the commission was Nusret Fişek and his influence was apparent in the policy framework of the report. The main principles of the former three five year plans were accepted. It was stated in the report that the commission

[566] Devlet Planlama Teşkilatı, *Dördüncü Beş Yıllık Kalkınma Planı (1978-82) Özel İhtisas Komisyonu Raporu: Sağlık Sektörü* (Ankara: DPT, 1976).

did not find the development of the preventive care and the socialization program that predicted the provision of every kind of health services to low income people in rural and urban areas satisfactory.[567]

The governments brought high-level curative services to a certain minority and neglected preventive care and the rural areas. This was due to the pressure of the minority who was used to receive high-level service and the attitude of some doctors. A balance between the investments and current expenditures could not be achieved as the Ministry of Finance resists covering the expenditures that the investments required in the following years. The commission did not adopt general health insurance. However, given the determinance of the government on this issue, if the law was accepted the commission proposes its application in a way that improved the socialized health services, that insurance would only be a finance institution, had nothing to do with the operating of the system, and be applied mainly to support the hospital services.[568] So, insurance was accepted only as a finance institution but not a service provision one.

The optimistic tone of the earlier health sector expertise commission reports related to socialization left its place to a pessimistic one. Before, the accomplishments had been explained but then the problems. The limits in financial

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[567] "As an examination of the report will reveal, the committee does not find satisfactory the development of preventive services and the program of socialization of health services which aims to provide all kinds of services in the rural area and in cities especially to people with limited financial means." (*Rapor incelendiğinde görüleceği gibi, komisyon koruyucu hekimlik hizmetlerinin ve özellikle kırsal bölgelerde ve şehirlerde dar gelirli halka her çeşit hizmeti götürmeği öngören sağlık hizmetlerinin sosyalleştirilmesi programının gelişmesini tatmin edici bulmamıştır.*) Ibid., p. 4.

[568] "The committee has not approved general health insurance. However, it has advised that, regarding the determinacy of the government on this issue, in case the law is passed it should be applied in such a way as to assist the development of socialized health services, the insurance should be responsible for finance and not be involved with management, and the insurance should be primarily applied in a way to support hospital services." (*Komisyon genel sağlık sigortasını benimsememiştir. Ancak hükümetin bu hususta kararlı tutumunu göz önüne alarak bu kanun kabul edilirse sosyalleştirilmiş sağlık hizmetlerini geliştirecek şekilde uygulanmasını, sigortanın finansman kurumu olması ve işletme ile ilişkisi olmaması, sigortanın öncelikle hastane hizmetini destekleyecek biçimde uygulanmasını önermiştir.*) Ibid., p. 6.

and human resources, the lack of integration of health services, and the structure of medical education were the main barriers against the socialization.

Throughout the 1960s and 1970s, the unjust distribution of health services among regions (West-East, urban-rural) and the inequality of access to health care among people (those who benefit from medical coverage – those who do not, rich-poor) constituted the main problems for the governments. In all government programs there was a clear commitment that everyone would benefit from medical coverage. And insurance was pronounced in almost all, despite the reserved tone in the early 1960s. Everybody would pay premiums and benefit from the system on the basis of equality. They did not propose a premium-based corporatist system in which citizens would benefit from health care depending on their employment status. But they did not propose a tax-based NHS system in which citizens would benefit from health care depending on their citizenship status, either. While general health insurance was proposed to finance health services and to include everyone within the system the integration of health services was not emphasized that strongly in the government programs.

The transfer of SII, SEE or municipality hospitals to the MHSA was not mentioned clearly. The socialization of health services was viewed more as an organizational scheme. It was nowhere referred to as the health system of Turkey, but rather as a public health measure brought to rural areas for societal development, or as it is the case in the third Demirel government program, specifically for the development of the East. The socialization of health services was emphasized much more in the health sector expertise commission reports of the SPO, which might be due to the presence of Nusret Fişek and other public health specialists in the commissions. Not only the socialization of health services, but also their integration

(which is a vital component of socialization) was expressed as the main causes. Unlike the government programs, and also some internal SPO reports,[569] insurance was not viewed as the cure for problems related with coverage and finance. This can also be explained with the influence of Fişek and other public health specialists, who held the state responsible for primary care. For them, insurance could be established to finance drugs and hospital services which were too expensive for the state to meet.[570] It should only be a finance institution which did not engage in the management or the provision of services. Otherwise, inequalities might occur, as it was the case in Turkey. The SII and SEE hospitals produced further inequalities by employing health personnel with high wages in city centers and by spending too much on every patient. So, the insurance institution had to buy the service from outside. The programs of Ecevit governments emphasized more the public character of health service but this did not lead to great accomplishments in the socialization program.

The Achievements and Failures of the Socialization Program

The socialization of health services got its start in an Eastern province, Muş. In August 1963, the program started with 19 health posts and 35 health stations. As

[569] In an SPO report prepared by Kişmir and Berksan, the integration of health services, the establishment of a nation-wide insurance system, and the socialization are proposed together. Parla Kişmir and Samira Berksan, *Sağlık Özel İhtisas Komisyonu Raporu Üzerine Düşünceler* (Ankara: DPT, 1966). In an SPO report that promotes the transfer of SII hospitals to MHSA, the same three causes are defended. Devlet Planlama Teşkilatı, *Kamu Sektörüne Ait Sağlık Tesislerinin Tek Elden İdaresi* (Ankara: DPT, 1967).

[570] If insurance is established to finance drugs and hospital services how would the premiums be collected? Would they be collected from all? If not, would the services be provided on the basis of equality? The services in health posts were already free of charge. The problem of access was more in the field of secondary and tertiary institutions, and medication. So, to limit insurance with the financing of drugs and hospital services would not solve the problems related with the premium system.

underdeveloped regions were given priority, it continued with Ağrı, Bitlis, Hakkari, Kars, Van (1964), Diyarbakır, Erzincan, Erzurum, Mardin, Siirt, Urfa (1965), Adıyaman, Bingöl, Elazığ, Malatya, Tunceli (1967), Artvin, Giresun, Gümüşhane, Rize, Trabzon (1968), Maraş, Edirne (1969) and Nevşehir (1970). Also, Ankara-Etimesgut (1964), Ankara-Abidinpaşa (1967) and İzmir-Torbalı (1968) started to function as health research and training districts.

Table 20 shows the number of health stations and health posts, the population of the socialized provinces, and the proportion of the population to health stations and health posts in 1963-1970. Table 21 shows the planned and realized numbers of health personnel in health posts in 1963-1975. Table 20 reveals that both the health posts and the health stations were in charge of a very high population and the upper limits (3000 for health stations and 10,000 for health posts) were exceeded. Table 21 reveals that the existing number of doctors and nurses did not meet the required numbers.

These figures indicate the great difficulty of appointing doctors in the socialized regions, which was one of the reasons of the "failure" of socialization. Still, health posts were active, as can be seen from the figures in Table 22. There is a rise in the number of operations like examination of the patients, laboratory examinations and small surgical interventions. This rise until 1970 and the fall in 1971 and 1972 are due to the changes in the number of doctors. When there is a fall in the number of doctors the health post services shrink.[571] Although there were promotional mechanisms like high wages and free quarters to encourage doctors to work in socialized regions, there was always a gap between the numbers of required and existing personnels. For example in late 1975, the existing number of doctors in

[571] Seher Savaş, *Sağlık Hizmetlerinin Sosyalleştirilmesi Programının Değerlendirilmesi Üzerine Bir İnceleme*, Uzmanlık Tezi, Mali ve Hukuki Tedbirler Şubesi (Ankara: DPT, 1977), p.46.

26 socialized provinces and four training regions met only to 36 % of the required number.[572]

Still, there was a serious improvement in the number of health personnel in socialized regions. In 1965, in socialized regions before the socialization, there was one doctor for 17,800 persons, one health officer for 12,000, one nurse for 51,600 and one village midwife for 10,000. After the application of the socialization program, for example in 1974, these numbers were 9,920; 6,777; 10,261 and 3,018 respectively.[573] There was also a rise in the number of preventive care measures, like vaccination and environmental hygiene control. Table 22 shows the number of various vaccines applied between 1964-1974 and the number of environmental hygiene controls between the same years. Another important indicator of this health care leap was the rise in the number of births assisted by the health personnel which increased from 4,576 in 1964 to 143,296 in 1974 (see Table 22).[574] Table 23 shows the number of health stations, health posts, training regions and the socialized provinces between 1963-2001.

The MHSA prepared an annual report (September 1963 – September 1964) on the socialization practice in Muş. The total number of people who were treated in the health posts in one year was 105,883. Only 6,782 were sent to hospitals. Service

[572] Ömür Sevin, *Sayılarla Sağlık Sektörü* (Ankara: DPT Sosyal Planlama Dairesi, 1976), p.2.

[573] Cited in Savaş., p. 7.

[574] The number of births with assistance of health personnel is taken from the table on births and deaths in the socialized regions in 1964-1974 (Savaş, p. 56). In this table there is a rise in stillborn cases and infant mortality which can be explained with reference to the rise in the number of socialized provinces and the keeping of the records which had not been done properly before. Between these years the number of socialized provinces rose to 25, a fact that has to be kept in mind while reading the relevant data.

was provided mostly by health posts. Before the socialization only 13,000 patients had been treated in 1962.[575]

In an SPO report, the problems related to the application in Muş were summarized as follows: difficulties in the provision of fixtures, medicine, and other supplies; a delay in the selection, education and supply of the personnel; former conventions on working hours, education and coordination between the personnel and the local health authorities were protected; salary differentiation between the health personnel and other civil servants created tensions; the determination of the places of the health posts and the health stations.[576] Of course, determining a test region and proceeding in accordance with the experiences gained there would allow for a more efficiently functioning system. However, Muş was more like the province where socialization was initialized rather than a pilot region. According to Öztek, the practice of socialization in Muş should have been assessed by an impartial group.[577]

The First General Assembly on the Socialization of Health Services (16-19 June 1969)

An assembly on the socialization of health services would gather every year in accordance with the article 22 of the Law. It would inform and give advice to the MHSA on the execution and evaluation of socialization, and establish cooperation among the people and various institutions. The members of the assembly would consist of representatives from the MHSA, universities, ministries, the SPO, the Labor Insurance Institution, the Turkish Medical Association, the Turkish

[575] Cited in Devlet Planlama Teşkilatı, *Sağlık Hizmetlerinin Sosyalleştirilmesi*, pp. 43-44.

[576] Ibid., pp. 25-26.

Pharmacists' Association, the Turkish Union of Chambers of Veterinarians, and a member from each provincial health council. However, the assembly only gathered two times, once on 16-19 June 1969 and the other on 19-20 June 1978. This reveals the indifference of the MHSA cadres who were responsible from the organisation of these assemblies towards the socialization. The minutes of these assemblies together with the other sources will reveal both the functioning of the socialization and the reasons for its "failure."

The first general assembly was held six years after the beginning of socialization and the second one after 15 years. Common problems were expressed in both. Although the people were content with the existence of health personnel in their villages and costs were not that high, there were problems in manpower, finance, administration, education, and organisation. Personnel shortage, financial and infrastructural problems, lack of integration of health services, priorities in medical training, contradiction with the insurance system made the application difficult. Although insurance was promoted by some in both assemblies, the view of socialization as a tax-based national health service system was dominant. It was seen as a stage coming after the insurance system. In the second general assembly even the nationalization of medication was promoted to prevent health from being subject to trade. Within the social democratic atmosphere of the second assembly the state was attributed an important role in the financing, providing, and organization of health services. Despite this social democratic discourse Ecevit governments were unable to take radical steps in the socialization of health services due to the instability in the political and economic spheres.

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[577] Öztek, interview by the author, March 2006.

Before the first general assembly a report that contained both the program details of the meeting and the operating of the socialization was published by the MHSA.[578] In this report, six years of socialization were analyzed with reference to both the accomplishments and the problems. The main goals of the socialization were specified first (to improve the health standards of the society, to develop public health services, to provide home-care and inpatient care instead of costly hospital services, to decrease the infant and maternal mortality rates, to combat infectious diseases, and to increase life expectancy) and then the reasons for the adoption of the program (the unjust distribution of the doctors, the low number of auxiliary health personnel, the inability of the citizens to pay for health expenses, the problems in working conditions of the personnel, the negative impact of the practice of private business on patient-doctor relations, the lack of personnel aware of the requirements of the concept of public health and preventive care were enumerated).[579]

The serious rise in the number of health personnel and so the fall in the population per one health personnel after socialization are presented in tables (see Table 24). There is a large discrepancy between the numbers of existing and required personnels, especially for doctors, pharmacists, and nurses as already mentioned with reference to Table 21. The wage schedule applied to the health personnel in the socialized regions is also presented.[580] From this schedule we see that the health personnel in the socialized regions received 3-4 times of the wages they would have received in not-yet-socialized regions. The socialized regions were regions of multiple deprivations. In this report the condition of the villages with health stations,

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[578] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 16-19/6/1969 Günlerinde Yapılacak Genel Kurul Çalışmaları* (Ankara: SSYB Sosyalleştirme Dairesi Başkanlığı, 1969).

[579] Ibid., pp. 8-10.

[580] Ibid., pp. 17a, 17b.

in terms of transportational, communicative and educational services is also revealed.[581]

There was a serious rise in the number of examinations, vaccinations, small surgical interventions, injections, laboratory services, midwifery services, and notices of epidemics. The personnel and their spouses were involved in societal development tasks like courses on literacy, sewing and nutrition. In this report, additional benefits of socialization are also presented such as the employment of peasants, economic development of the villages, and the modern life style introduced by the health personnel whom the peasants were expected to take up as models.[582]

The main difficulties in the application of the socialization were listed in detail. The first one was the difficulty concerning the employment of personnel. Socialized regions were not appealing working places since it was difficult to find a place to stay either for rent or as free quarter; the high salary advantage assumed for promotion declined,[583] a just assigment system could not be established, the period of contracts was limited to three years, and there was the problem of schooling the employees' children. The other difficulties were related mostly to finance and infrastructure. Also the lack of cooperation with other institutions, and the conflict

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[581] Only 60% of the villages with health stations had road, 39% had water, and 9% had electricity. And 98% of them had school while 45% had telephone services (Ibid., pp. 18b, 18c).

[582] Ibid., p. 25.

[583] "Since the gap between salaries in socialized regions and in regions not yet socialized is closed due to the differential payment systems applied by the Minister of Health and other ministries (Compensation Law no.472, Full-Time Law no. 641, Social Insurance Law no. 672, State Economic Enterprises Law no. 708), since the socialization services have been slow and mobile, and applied in regions of deprivation where they expand to villages, and the health units of other institutions concentrate in city centers and big county centers…" (*Bakanlık içi ve diğer Bakanlıklarca uygulanan çeşitli ücret sistemleri yüzünden sosyalizasyon bölgelerinde ödenmekte olan ücretle sosyalizasyon bölgesi dışında kalan bölgelerde uygulanan ücret arasında fark kalmadığından (472 sayılı tazminat kanunu, 641 sayılı tam gün kanunu, 672 sayılı sosyal sigortalar kanunu, 708 sayılı İktisadî Devlet Teşekkülleri Kanunu) sosyalizasyon hizmetlerinin seyyar ve ağır oluşu, mahrumiyet bölgelerinde bulunuşu ve bu bölgelerde de köylere kadar yayılmış olması, diğer kuruluşların sağlık ünitelerinin il merkezlerinde, en çok büyük ilçe merkezlerinde bulunması ve...*) Ibid., p. 26.

between the socialization law (no. 224) and the provincial administration law (no. 5442) were cited as the major difficulties. The medical training, which was not sufficient on providing the basics of community medicine and preventive care, constituted another problem.[584] Various solutions were formulated, but the one related to financial resources is worth mentioning. For the operating of curative services the launching of health insurance was proposed.[585] Here, we see the differentiation in terms of the financing of preventive care and curative services. Preventive care was seen as the task of the state while curative services necessitated the contribution of the people. Even Nusret Fişek himself accepted the application of insurance for drugs and hospital services.

By the time the assembly gathered, socialization had been applied in 23 provinces, which meant that one-third of the country was socialized. The Minister of HSA Vedat Âli Özkan defended the program in the opening speech of the assembly. He was a member of the JP and he held this position successively in three Demirel governments. He mentioned the need to introduce health service to the remotest villages. He talked about the problems related to the lack of health personnel, which was a problem both for socialized and other regions. The number of medical specialists constituted 20-30% of the required number, general practitioners 40-50%, nurses 70%, midwives 70% and health officers 80%. But new medical faculties had been opened and the gap was expected to be filled in time. Özkan responded to the criticisms about the costliness of socialization and said that in six years time only 570 million liras had been spent which was a moderate amount.[586]

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[584] Ibid., p. 26-27.

[585] Ibid., p. 29.

[586] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu, 16-19 Haziran 1969* (Ankara: SSYB Sosyalleştirme Dairesi Başkanlığı, 1969), pp. 12-13.

The undersecretary of the MHSA Faruk İlker summarized the problems which led to the deviation of such a perfect public health project from its way: the practice was not evaluated properly, medical students were not trained sufficiently in the field of public health, the wage scales forced the doctors to work in private sector, people's demand for curative services causes pressure, and there are ideological and attitudinal changes in the technical and political echelons.[587] He reminded them of article 30 of the Law, which required the transfer of all public sector health institutions to the MHSA and asserted that the continuation of the operating of the health facilities and the services of other public institutions damaged the spirit of socialization.[588] He was completely right in blaming the existence of separate health institutions which contradicted with the holistic approach of socialization. It was not possible to provide health service to all on the basis of equality when some segments of the population had their exclusive health institutions. Socialization required the integration of all health services and people would benefit from them through following the referral chain. But the integration could not be accomplished and some kept their advantageous positions. Also, the existence of separate institutions created problems in health manpower distribution. When the SII employed doctors with high salaries it became difficult to recruit doctors for the socialized regions.

Both the minister and the undersecretary supported the socialization and explained the problems with reference to the application not the inefficiency of the

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[587] Ibid., p. 16.

[588] "I believe that the fact that the article no 30 of the health law (224) has not been operative for various reasons and that the health facilities and services under different health institutions function in terms of their own status damaged the spirit of the practice of socialization of health services." (*224 sayılı kanunun 30uncu maddesinin muhtelif sebeplerle işleyememiş olması ve diğer kamu kuruluşlarına ait sağlık tesislerinin ve hizmetlerinin kendi statüleri içerisinde faaliyette bulunmaları kanaatimce sağlık hizmetlerinin sosyalleştirilmesi tatbikatının ruhunu ve esprisini rahnedar etmiştir.*) Ibid., p. 18.

system itself. However, there was not always such a support of high level administrators and its lack was determinate in the failure of socialization. For example, in a seminar organized by the MHSA on the integration of health services (*sağlık hizmetlerinin tek elden idaresi*) in October 1966,[589] both the Minister of Interior Faruk Sükan and the Minister of Health Edip Somunoğlu[590] took positions against the socialization. Sükan explained his impressions of the socialized regions and said that health posts worked at 25% capacity. He could empathize with the doctors' unwillingness to work in places devoid of infrastructure and social benefits.[591] He listed some cases of abuse, like recording vaccines as if they had been applied or the failure in reporting some epidemics.[592] For him, the socialization of health services was an adoption of exported ideas and was designed in the offices. So, it contradicted with the existing realities and means of Turkey. In a similar way,

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[589] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde*.

[590] Zafer Öztek tells that Edip Somunoğlu offered Demirel to abolish the Socialization Law. Demirel asked him whether they had any other alternative. As they said they did not Demirel ordered them to continue with the existing one. Öztek, interview by the author, March 2006.

[591] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde*, p. 93.

[592] The undersecretary of SII Refik Erer gives similar examples in the first general assembly and quotes the expression of his friend "Vaccine need not be done to the skin, it can be done to the paper" to explain the high percentage of vaccination in a socialized village. Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, p. 72. Also there were stories of not declaring the epidemics to the MHSA. Not to risk their positions doctors and provincial health directors might conceal the cases. The statistical reports were gilded because if a provincial health director was taken out of socialization his wage would be cut by one-third or one-fourth of the existing one. Ömer Ertürk, *Sosyalizasyon ve Doğu* (Ankara: Hacettepe Üniversitesi Tıp Fakültesi Öğrenci Derneği, 1970), p. 47. Of course this was not peculiar to socialization. Also before the socialization of health services the epidemics and the performances of the personnel had to be reported to the MHSA. Rahmi Dirican told me about an event he had experienced. He had worked in Erbaa Health Center between 1956-58. He was going to report 23 cases of typhus fever. The provincial health director wanted him to change the numbers otherwise he would loose his directorate position (Rahmi Dirican, interview by the author). There is a similar story in the memoirs of Lütfü Köselioğlu. While he was working in Malaria Prevention in the beginning of 1950s, a health officer had given him a lesson when he wanted the filling of statistical charts with accurate information. The officer told him: "Doctor, statistics means writing made up numbers. To those who do not know how to lie we ask 'Haven't you ever made statistics?'" (*Doktor bey istatistik demek atmasyon rakam yazmak demektir. Biz yalan söylemesini bilmeyenlere 'hiç mi istatistik yapmadın?' deriz*) Lütfü Köselioğlu, *Kaf Dağı'nın Ötesi* (İstanbul: İletişim Yayınları, 2000), p. 123.

Edip Somunoğlu criticized the socialization on the grounds that it required a doctor for a population of 7,000, while it was impossible to find a doctor for a population of 100,000. Students of medicine did not receive sufficient training to allow them to work as health post doctors.[593]

In the First General Assembly on the Socialization of Health Services, there were presentations related with the public health duties of the health posts. Socialization was not limited to providing public health to the rural population, but it was given priority. Abdullah Özer made a presentation as a member of the UNESCO Public Health Education Turkish Committee. He had the audience listen to the accounts of peasants from villages in socialized provinces like Urfa, Mardin, Diyarbakır and Bitlis. For example a man from Urfa Çaykara village expressed his gratitude with these words: "The doctor made a speech, showed a film and explained the advantages of toilets. They told us that we were getting sick because we did not have any toilets. We built many toilets. Now we are very pleased." A man from Mardin Yeşilli told that after the speech of the health post doctor they made canals of waste water and toilet for each house which resulted with a decline in diseases. A woman from Urfa Halfeti explained the radical change in an established practice: "We used to give birth standing up. Three of my babies died while I was giving birth. They warned us and now the midwife is helping us. God bless them." A woman from Diyarbakır Kesentaş expressed her pleasure about the lessons given by the midwives:

> We have learned new lessons and our ills have lessened. If we become ill we go to the health post right away. Formerly, for a difficult birth rich people would bring a jeep and take the woman to the hospital in Diyarbakır. The birth of the poor would die in the village and could

[593] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde*, p. 98.

> not go to Diyarbakır. Now the health post jeep takes us right away and our patients are saved. God bless the government.

A man from Bitlis Gülkırı told that formerly they had been afraid of vaccine but now they all went willingly to be vaccinated and to see the doctor.[594]

These reveal the public health and modernization aspect of the socialization. Environmental hygiene (housing, settlements, working environment, sanitation, and water and air quality), maternal care and vaccination were the major tasks of the health posts. In the following speeches this presentation was criticized for being overly optimistic.

From the very beginning, the connection between health posts and modernization was established. Socialization was not designed as only a health care, but also an integration and modernization program. The educated personnel were expected to train the villagers not only in the field of health, but also in other areas, like literacy. In an article on the socialized health services in Muş, the societal development mission of health posts was emphasized and the training courses especially for women were praised.[595] In the assembly, İrfan Özer from Atatürk University Faculty of Medicine also emphasized the modernizing mission of health posts. For him, they should be seen as development units brought to the villages. Many young doctors had to deal with issues not related to health and help peasants in establishing of cooperatives, introducing new agricultural techniques and giving education to women. Although he saw the health posts as units for development he thought these should be the tasks of the Ministry of Rural Affairs.[596]

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[594] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, pp. 26-28.

[595] *Cumhuriyet*, 13 May 1964.

[596] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, pp. 75-76.

In the assembly, a film on socialization was shown at the beginning. Both this film and the speeches of the peasants drew a positive picture of socialization. However, criticisms were made especially on the lack of health personnel and the insufficiency of the existing personnel in terms of training and experience. Hakkari provincial health director Zekeriya Taşdelen mentioned the lack of personnel with reference to numbers: "According to the average of four years, 44.9% of general practitioners, 1.25% of specialist doctors, 7.7% of nurses, 41.9% of health officers, and 56.2% of midwives could be provided. In the year 1968, the manpower provided was 38.2%."[597] Another important problem was related to the doctors' training. The Faculties of Medicine prioritized curative services rather than preventive care. Although this was the case, young doctors were not experienced in methods of early diagnosis and treatment. They could not make laboratory examinations of feces, urine or blood. They were worse in the field of preventive care. They did not have the basic information to determine the physical, biological, social and other factors of the region they work. They did not take into account the attitudes and behaviors of the people. They could not evaluate the priorities, targets, resources, means, and positive and negative qualifications of the people. They lacked the potential to determine the health problems of the region. They were not well equipped with information on epidemiological research, public health education, and health statistics.[598]

Another criticism about the application of socialization was related to the workload on the health posts. Erdal Atabek, the head of TMA,[599] expressed the

[597] Ibid., p. 37.

[598] Ibid., pp. 37-38.

[599] He held this position for a long period of time: 1966-1984. He was a charismatic leader whose name was associated with the TMA.

difficulty of dealing with so many and various tasks like environmental hygiene, maternal and child health, epidemics combat, and clinic work.[600] As the Ministry was unable to appoint doctors for many of the health posts, the existing doctors were in charge of a population of 35-40,000 instead of 7,000.[601] The workload of health posts included health services provided for SII members. Health authorities of various provinces complained about the rise in workload because of the applications of the insured which kept the doctors from doing their field service.[602] While the health bureaucrats complained about the pressure of the SII, the undersecretary of SII Refik Erer complained about the insufficiency of health posts. He said that they had annulled the contracts they had made with the doctors, after the socialization of the five provinces and the patients were aggrieved as the health posts were not ready.[603] He opposed the expansion of socialization at least for a period of time.[604] While the citizens did not pay anything in the health posts and the hospitals, the SII paid a certain amount of money for its members. It gave five liras for each health post visit. Erer did not oppose this but offered the sharing of this money among the doctors. The undersecretary of the MHSA Faruk İlker answered him by saying that if the SII gave up taking premiums from the workers they would accept to provide health service free.[605] The SII was criticized for not providing preventive care services.

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[600] Ibid., p. 63.

[601] During their East Anatolia visit, members of Hacettepe University Faculty of Medicine Student Association listened to the complaints of health post doctors who had to examine 150 patients in a day. They said they could perform only curative services and write prescriptions only by looking at the faces of the patients (Ertürk, *Sosyalizasyon ve Doğu*).

[602] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, pp. 47, 51.

[603] Ibid., p. 73.

[604] Ibid., p. 100.

[605] Ibid., p. 134.

The SII had established its own health institutions beginning from 1949. Usually insurance institutions did not provide health service but bought it instead from public or private institutions. But as the MHSA did not have enough health facilities the SII established its own, and in places without its own facilities made contracts with providers. Actually, the existence of a corporatist institution together with the socialization was a contradiction in terms which became obvious in this discussion. After the expansion of SII health facilities the insured would attend them rather than the health posts and this would prevent the development of socialization.

Erdal Atabek referred to the status of contracts signed by the health personnel. He wanted a guarantee that the MHSA keep its promises.[606] These promises were usually related with the appointment after the fulfilling of service in the socialized region. This was seen as one of the reasons of the "failure" of socialization. The doctors lost confidence in the Ministry and did not want to go to regions of multiple deprivation as they would not be appointed to a big city after the expiration of the contract period, as they might be "forgotten" there.

Fişek talked about a clash of principles:

> Until the enacting of the Socialization Law we saw health services as services to make profit. We accepted them to be services that only the rich and only the ones who could afford could benefit from. We opened the hospitals to the poor only when their condition was serious. In theory the hospital services are free, but we cannot claim that all the citizens in the remote villages of Turkey are treated on an equal basis.

For him, the health insurance system was based on the same logic. Only those who could have insurance benefited from the health service. "Thus, if we are facing problems in the socialization of health services it is because two systems which fundamentally contradict exist in Turkey." He said a system which provided health

service to all on the basis of equality should be promoted and the insurance should be abolished gradually or kept as a finance institution. This was a must regarding the demand for personnel. The SII and banks employed health personnel at higher wages and the MHSA had difficulty in recruiting personnel.[607] This revealed itself in the number of doctors per 1000 in SII facilities and MHSA institutions.

The head of the SII Health Department Esat Eğilmez answered this and said that SII was not against the Ministry, but beside it. If the MHSA had provided health service to all citizens, the SII would not have intervened in health services and would have settled for performing other insurance services. At that time the SII had 61 health stations, 45 general hospitals, 34 dispensaries, three sanatoriums and three birth clinics.[608] Refik Erer proposed the postponement of the transfer of SII health institutions to the MHSA for the latter to provide what was necessary.[609]

In the finance sector report of the assembly it was accepted that a desirable wage level would allow meeting the lack of personnel to a great extent. At the beginning the wages were high enough to recruit personnel. However, in six years time the change in the economic conjuncture had damaged the satisfactory character of the wages.[610] According to the report, the possible rise in the health expenditures due to the rise in people's expectations and the improvements in medicine should be kept in mind. But for the time being there was the need to focus on the provision of health care throughout the country on the basis of equality in accordance with the

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[606] Ibid., p. 143.

[607] Ibid., p. 53-54. In the same speech he accuses the Ministry of Finance for not allocating the necessary resources (ibid., p. 56) and the representative from the Ministry of Finance rejects this accusation (ibid., p. 80).

[608] Ibid., p. 68.

[609] Ibid., p. 74.

[610] Ibid., p. 153.

principle of social justice. At this point the socialization of health services had so far been successful. In 1968, the annual health expenditure per person was 25 liras in socialized regions and 24 liras in the remaining regions. But in the SII, the annual health expenditure per person was 300 liras in 1967. And this did not include preventive care.[611] The SII provided only curative services. But this was precisely the reason behind the high costs. Curing was always more expensive than preventing illnesses. More importantly, the availability of curative services for those who had already paid premiums would increase the utilization of services. People's contribution to the investments in health was seen as unrealistic considering the distribution of national income and per capita GNP. The contribution of people to curative services was formulated as follows: People's contribution to policlinic, laboratory and medicine expenses with a percentage of 20-25; a premium-based system which had a long history. Benevolent societies, voluntary health insurances and compulsory health insurances, i.e., social security, were examples of this system. But all these belonged to earlier periods before the nationalization of health services. Chronologically, voluntary insurance, social security and national health service followed each other, the typical example being Great Britain. The return from national health service to premium-based insurance would be met with opposition.[612]

This was a linear development model of health systems. It was only here that the socialization was clearly stated to be a tax-based national health service model which was thought to be the ultimate destination of health systems. Mostly, socialization was considered to be an organizational model that is based on providing public health and primary care to the rural population and the poor. That was why

[611] Ibid., p. 155.

[612] Ibid., p. 157.

establishing a general health insurance was always on the agenda. Here, the socialization of health services was considered to be an NHS system in which everyone was provided all kinds of health services on the basis of equality and the expenditures were met from the general budget. The British model was regarded as an ideal to be reached along a linear path. Actually, there was no such universal path. It was true that the British had transformed their insurance system into the NHS but other European countries had not followed this pattern and had expanded the coverage of their insurance systems. In terms of coverage the social insurance systems in Europe and the NHS in GB did not differ; both were universal as no one fell outside the system.

In the discussion section of the report the head of TMA Erdal Atabek defended the premium-based model. For him the ideal model was the one in which the state provides the service with the share in general budget. However, the state could not provide enough service with the allocated share. So, there was the need to get people's contribution. This could be done in two ways: One was the revolving fund and the other was health insurance. People might pay some money when applying to a health institution but this had certain disadvantages. They might apply less or postpone their application which might lead to a regression in the patient's condition. The health insurance did not carry these disadvantages. As people did not pay any money, they would not have any reservations to apply in time. As everybody gave a share of his/her income insurance was compatible with social justice. The premiums of those who could not pay would be paid by the state. It was easier to make projections on health service as the total amount of premiums could be determined on an annual basis. The insurance system was advantageous and this could be seen in the difference of development rates of MHSA services and SII

services. Atabek did not see any contradiction between the insurance system and the socialization of health services. For him, they complemented each other and the socialization of health services could be accomplished with the financial resource of general health insurance.[613] This was exactly the same vision he defended in the meeting on integration in 1966.[614] So, he shared the same position with the SPO which suggested the socialization together with the general health insurance.[615]

Fişek did not share Atabek's position. For him, there was a contradiction between the insurance system and the socialization: In the Constitution health service was defined as a task of the state while insurance service was not. Social security need not contain health insurance. It could contain unemployment insurance and pensions. As it was the task of the state to provide health care the financing of this service was the task of the government. If the government did this through compulsory insurance and collect premiums then this had to be defined as compulsory insurance premium tax. That is why it was not proper to establish insurance to support the socialization. The Ministry of Finance could find ways to increase its income with the demand of the government. The establishment of insurance in Turkey had been on the agenda of successive governments since 1946 but none of them could accomplish it. And it would not be accomplished until the

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[613] Ibid., p. 165-167.

[614] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde*, pp. 18, 117.

[615] The position of Erdal Atabek was the position of the TMA for years. He was defending the premium-based system also to guarantee the income of doctors. But at the 1970 Medical Congress he offered insurance system only as an additional financial resource. Erdal Atabek, "Sağlık Hizmetlerinden Halkın ve Hekimlerin Bekledikleri." *21. Milli Türk Tıp Kongresi, 20-26 Eylül 1970, Bursa* (İstanbul: Çelikcilt Matbaası, 1970), p. 13. By the late 1970s TMA adopted a leftist position and started to defend socialization with all its principles. Since then, the TMA has insisted on the application of a tax-based national health service model. The socialization should be financed with progressive taxes. They have defended the right to health for all citizens. But sometimes this political determination has created tensions in a professional organization which also has had to defend the benefits of doctors both in private and public institutions. The benefits of doctors might contradict with the benefits of the people.

national income of Turkey rises to the required level. With the national income level at hand compulsory insurance could not be established.[616] Fişek's estimation proved to be right; none of the governments could establish general health insurance although it was in their programs. The tax-based national health service model was supported only by him and some other public health specialists who constituted a minority. Throughout the 1960s and 1970s it was the premium-based insurance system which was widely supported.

The Second General Assembly on the Socialization of Health Services (19-20 June 1978)

The Second General Assembly was held when Bülent Ecevit was the prime minister of the government which was composed of RPP members and independents. There were many participants from the ministries, provincial health directorates, hospitals, and faculties of medicine, the SPO, the SII, the TMA and the TPA. But as the minutes of this assembly were not drawn up we only have a summary of the meeting, which leaves the position of the parties obscure. Still, we can obtain a picture of the problems and the widely pronounced formulas.

In his opening speech the Minister of Health Mete Tan emphasized the importance of the full-time law that they had brought to the Turkish Grand National Assembly for the functioning of the socialization. It was usually stated by public health specialists that the socialization was an ideal plan for Turkey and had effective principles but could not be implemented properly. Mete Tan repeated this and

[616] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, pp. 168-169.

claimed that if a full-time law had been enacted before, the socialization would have worked.[617]

The summary of the general assembly began in the tone of a manifesto. After explaining the need to provide health service to all on equal basis and for free, there came a criticism of Turkish capitalism: "In countries like Turkey where capitalism functions poorly, you cannot leave the bread and water of the people to the rules of supply and demand, let alone the right of living, right to health, the right to doctor and medicine. Sadly, the health of people in Turkey is left to this rule."[618] Nobody should be left devoid of health service because of being poor. Those who opposed socialization support the continuation of the utilizing of health services as tools of exploitation. The social democratic perspective of the RPP revealed itself in this summary.

These were the main arguments that were expressed in the assembly: When the medical specialists in the hospitals of the socialized regions were given the right to open private offices, the implementing of the law became much more difficult. Even in 1965, the Minister of Health declared that the doctors did not need to close their offices. In the short run, it was necessary to provide a just distribution of doctors. Especially in the East and Southeast Turkey there were hospitals without doctors. The allowing of doctors in the public sector to practice medicine privately had negative consequences. The wages of the doctors in socialized regions should be regulated.

In the training region Etimesgut both the preventive care and curative services were provided in full and the annual cost of a patient was 100 liras. This

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[617] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesi, İkinci Genel Kurul Toplantısı, 19-20 Haziran 1978* (Ankara: SSYB Sosyalleştirme Dairesi Başkanlığı, 1978), pp. 8-9.

[618] Ibid., p. 12.

shows the rise in service quality and the fall in cost, in the socialization. Socialization was a team service but this could not be implemented. The principle of 16 regions could not be applied either. The division of labor within the Ministry was problematic as the departments of socialization and of curative services were under separate assistant undersecretaries. The organizational structure of the MHSA should be adapted to the socialization model.[619] The most important principle of socialization, that is the integration of health services, could not be accomplished. Temporary article 3 created a contradiction within itself.

The general health insurance that was recommended as an alternative to the socialization could have been useful in finding resources, but it is doubtful whether the premiums collected would be spent for health services. It would not bring any benefit to the rural area. For the socialization to function, the share of health in the general budget should be 10-15. The appointments should be carried out by computer and the subjective factor should be abolished. A just appointment system should be brought. Although the integration of health services is required to prevent the wasting of resources and to provide their just distribution the faculties of medicine and SII hospitals should be left outside of this. The former had been established and were run for educational purposes and the latter had been established with the premiums collected from employers and employees. (But in the same summary, the integration of all health institutions of the public and an equal wage policy among them were proposed.)

[619] Through socialization, health services were going to be integrated horizontally on the basis of population, and vertical organization would be abolished. The health posts were going to be responsible from malaria prevention, tuberculosis prevention or maternal and child health care that were the tasks of separate directorates of the Ministry. But these directorates could not be closed because the administrators did not want to loose their positions. So, in the same village the health post and the Maternal and Child Care would perform exactly the same tasks which meant the waste of resources (Öztek, interview by the author, March 2006; Dirican, interview by the author). This bureaucratic fragmentation constituted a problem in the implementation of the socialization program.

The health services in Ankara, İstanbul and İzmir should be socialized. The practice of compulsory service should be brought. The personnel in the regions of multiple deprivation should have some rights related with promotion and salary indicator. The personnel should be subject to a training program before going to the socialized region. More faculties of medicine were needed, 16-17 was not enough. All the hospitals of the faculties of medicine should be within the scope of full-time law. Cases of discrimination were reported within the hospitals. The patients could not be treated with respect to their race, language, religion, sect and party. 30% of the general budget was allocated to defense expenses and only 2.9% to health. This should change and the socialization of health services should be applied in the proper sense. For this, the state should be the producer and the distributor of medicine and medical equipment, and personnel should be trained in accordance with the requirements of the law. Socialization could be summarized with the motto: People's health could not be the subject of trade. There were doctors and pharmacists who wanted to earn too much money from the illnesses of people. Socialization was the nationalization of health services and the doctors, ancillary health personnel and medicine needed to be nationalized. Social assistance should be the task of the Ministry of Social Security rather than the MHSA. General health insurance was not a solution. Money could not be taken from the people to whom health service had not been provided. This would be robbery on the part of the state. The health of the citizens was the responsibility of the state. The budget had to be arranged in accordance to this.

These were the problems that were emphasized before in various meetings including the First General Assembly and health sector expertise commission reports. However, the solutions for these problems differed from those proposed earlier.

Here, the emphasis was made on nationalization of health services, personnel and medicine which brings socialization in line with the British NHS. The responsibility of the state in health care provision was accepted without any reservation or condition.

At the last meeting of the assembly a proposal drawn up by 30 members was presented and accepted as a request. These are from the proposal: The meetings revealed that the practice of the socialization has bottlenecks mainly in five fields: manpower, finance, administration, education, and organization. In the field of manpower, full-time law should be enacted and the appointment and transfer of health personnel should be reorganized. In the field of finance, health services should be financed from the general budget in accordance with the Constitution; the percentage of health in the general budget should be increased at least to 10 in order to build up the infrastructure of the socialization; the wages of the health personnel should be increased to a desirable level. In the field of administration, health institutions should be integrated; the MHSA Central Organization should be rearranged in accordance with the multipurpose service principle of the socialization; measures should be taken to prevent the concentration of curative services in big cities and bank or office medicine should be abolished. In the field of education; the training of doctors and other health personnel should be rearranged in accordance with the realities of the country; in-service training should be applied for all health personnel; the practice of general practition should be encouraged rather than medical specialisation. In the field of organization, health services should be socialized in the three big cities; socialization should cover the whole country by 1981; general hospitals should be established in 16 regions.

Although this is an unsorted account of what was said in the general assembly we can recognize the social democratic approach dominant in the meeting. Health care was clearly defined as a basic right which should be financed from the general budget. Insurance was not adopted although it appears in the programs of the Ecevit governments. The terms “trade” and “exploitation” echoed the sensitivities of the period. Here, socialization was not limited to public health and primary care for the rural population and the poor. It was rather considered as the health system of Turkey, with all its institutions. The proposal of socializing three big cities was an indication of this.

Population Planning

Before analyzing the reasons for the failure of socialization I would like to present a picture of the population planning practice, the other grand project of the early 1960s. Similar to the socialization, no radical steps were ever taken to translate the policy stated in the Population Planning Law into state actions. Despite the belief apparent in the discourses of the political, intellectual, and public cadres that the too high fertility rates constituted a serious problem for Turkey, the state did very little through its own facilities to encourage the use of medical methods of birth control. The MHSA would facilitate voluntary family planning by investigating and approving methods, and offering methods through its own clinics and hospitals. In 1983 the state took a further step and removed the criminal sanctions against abortion and supported voluntary surgical sterilization for married couples. It also ordered more training and allowed midwives and nurses to insert intrauterine devices (IUDs).

Nevertheless, birth control has received rather limited assistance from the state up to the present time though more so in the 1980s than in the 1960s and 1970s.[620]

In 1973, Fişek analyzed the application of the Law and criticized the reluctance of the governments and the lower priority given on the control of population growth in the Second and Third Plans.

> The implementation of family planning programs by the government has always been slow and results have lagged far behind both goals set in the plans and public demand. It is encouraging that the public attitude continues to be favorable, in spite of slow government action, and that the level of contraceptive use is increasing. In fact, the small family norm is accepted by the majority of families in Turkey. Knowledge of modern contraception is being rapidly disseminated, though no modern means has yet displaced coitus interruptus as the most frequently used method.[621]

A Hacettepe Population Studies Institute study dated 1968 revealed that more than half of the women in their fertile years did not know that they could prevent pregnancy. That means the governments could not inform people about the possibility of preventing pregnancy, let alone bringing this service to them. Fişek explained this failure with the reluctance of governments in acknowledging the population rise as a problem and in promoting the health personnel.[622] He criticized the MHSA for not being determinate in implementing the program. There was still a limited use of modern birth control methods and withdrawal was becoming widespread.[623]

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[620] Shorter, "The Crisis of Population Knowledge in Turkey."

[621] Nusret Fişek, "Population Planning in Turkey: National and Foreign Priorities." *International Journal of Health Services*, 3(4) (1973): 791-796, p. 791.

[622] Nusret Fişek, "Nüfus Artış Hızı ve Hükümetin Sorumluluğu." unpublished article, n.d, p. 4.

[623] Nusret Fişek, "Türkiye'de Aile Planlaması Program Stratejisi." *Toplum ve Hekim*, 41 (1986): 37-39, p. 37.

Although "modern" methods like IUDs, pills and condoms did not become widespread, there was a serious decline in the total fertility per woman. The fertility decline began in the 1950s, gained speed in the 1970s, and has continued up to the present time. In the 1950s, the total fertility per woman was 6.6; it fell to 3.3 in 1988, and 2.7 children in 1994.[624] Despite the state's reluctance to encourage the use of medical methods of control, low fertility levels could be maintained by withdrawal, which was described as the "traditional" method. Therefore, the main demographic change that created the high rate of population growth in Turkey, reaching almost 3% per year in the 1950s, was improved health and a rising life expectancy; i.e., reduced death rates, not increased birth rates, though they had a small contribution.[625]

Life expectancy increased excessively worldwide in the last century. It was 35 years before World War II. According to OECD data, the life expectancy figures in Turkey since 1960 are as follows: 1960 (50.3 for females and 46.3 for males), 1970 (56.3 and 52.0), 1980 (60.3 and 55.8), 1990 (68.3 and 63.8), 2000 (72.8 and 68.1), 2004 (73.6 and 68.8), 2007 (75.4 and 70.4). Among the OECD countries Turkey is above the average in terms of the average annual percentage growth in life expectancy between the years 1960-2004, together with Spain, Portugal, Japan, Mexico and Korea. It is 0.90 for men and 0.87 for women.

Death rates for infants and two or three-year olds play a major role in the life expectancy at birth. In the early Republican period, more than one-third of the children died in the first years of their lives. When death rates are so high among children, their years of life contribute very little to the calculation of the average expectation of remaining years of life at birth. So the reduction of infant and early

[624] Shorter, "The Crisis of Population Knowledge in Turkey." p. 7.

[625] Ibid., p. 9.

childhood mortality played a major role in raising the average expectation of life at birth. There were other factors as well. For example, the decrease in childbearing during the last 30 years meant that many fewer women died in childbirth or complications of pregnancy as compared with the early years. Improvements in diet, living conditions, and medical assistance also contributed.[626] Infant mortality rate per 1000 births since 1960 are as follows: 1960 (189.5), 1965 (163.5), 1970 (145), 1975 (132.5), 1980 (117.5), 1985 (88), 1990 (55.4), 1998 (36.5), 2005 (24).[627] The present situation is one of low fertility and low mortality. The decline of mortality (improvement in survival rates at all ages) caused rapid population growth.

The Reasons for the "Failure" of Socialization

The discussions and the policy proposals in general assemblies give us an idea about the functioning of socialization. The information on functioning also informs us about the reasons for the failure of socialization. By "failure" I do not mean the irrelevancy of its principles or the negative consequences of application. On the contrary, all the principles of socialization were compatible to the economic, social and geographic conditions of the country. Only the ambiguous character of the financing system and the postponing of the integration of health services can be considered as deficiencies within the law. It would be unrealistic to expect the application of a premium-based system in such a low-income country with a large

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[626] Ibid., p. 10.

[627] OECD official web site, http://masetto.sourceoecd.org/vl=1665055/cl=38/nw=1/rpsv/factbook_fre/data/11-01-02-T01.xls (December 2007). The last number is from OECD official web site, http://www.oecd.org/dataoecd/46/5/38980477.pdf (December 2007).

rural population. But there is also no clear clause that the expenses would be covered from the general budget. So, there were always discussions on the financing of the system and complaints about underfunding. Although the system proved to be inexpensive, the governments' reluctance to allocate sufficient budgets hindered its development. Socialization functioned well in the mid 1960s when the percentages of health in general budget were high. The improvement in the health status indicators in places where it functioned properly is noteworthy. For example, the health status of Ankara Etimesgut Health Research and Training District, Ankara Çubuk[628] and Bursa Gemlik was higher than those of the cities.[629] In Etimesgut, infant mortality rate fell from 142 in 1967 to 93 in 1973, and the crude death rate fell from 10.3 in 1967 to 7.0 in 1973.[630] In Etimesgut infant mortality and fertility rates decreased faster compared to those of the whole country due to the significant rise in maternal and child care services.[631] In research and training districts, vaccination percentages rose to 99% and the number of deaths due to infectious diseases,

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[628] Kırcalıoğlu et. al. examined the maternal and child health indicators in Çubuk Health Research and Training District and compared them with that of Turkey (Kırcalıoğlu, Özcebe and Akın Dervişoğlu). Çubuk district was run by Ministry of Health and Hacettepe University. Due to the protocol signed by Ministry of Health and Hacettepe University Department of Public Health in 1974, socialized health service was provided to the people in Çubuk. There were seven health posts, one occupational health center, Çubuk Health Group responsible from the administration, in-service training and control, Çubuk District Hospital, and a family planning training center within the hospital. In Çubuk district, fertility rate declined 46.9% between 1977 and 1989, death rate 32.3%, and infant mortality rate 71.9%. There was a rise in the regular checks for pregnant women, the births in hospital, the use of modern birth control methods, and immunization. All these indicators were better than the indicators of Turkey between the same years. Although maternal and child health indicators were similar with the indicators of Turkey at the beginning, after a ten year period, the improvement of maternal and child health level in Çubuk district was far better than that in Turkey. The type of services delivered at the Çubuk district and the utilization of these services by the public had been more effective and far above the overall level of Turkey. This shows us that, when applied in the proper sense the socialization of health services served both the improvement in health indicators and the population planning.

[629] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 171.

[630] Ibid., p. 39.

[631] Bülent Kılıç and Gazanfer Aksakoğlu, "Eğitim Araştırma ve Sağlık Bölgeleri." *Toplum Hekimliği Bülteni*, 25 (3) (2006): 7-14.

epidemics, and preventable reasons was reduced. In Narlıdere Health Research and Training District, in ten years time life expectancy for both sexes increased by ten years.[632] These districts were in advantageous positions thanks to the commitment of the universities. There was no deficiency in required health personnel who were trained beforehand and in-service, and there was a close collaboration between the health posts and hospitals. So, their conditions were much better than that of other socialized regions. They had the means to apply socialization with all its requirements.

The first research and training district was established in 1964 by a protocol between the MHSA and Hacettepe University as the Etimesgut Research and Training District. The regulation on the execution of health services in socialized regions[633] defined districts and brought the rule that services would be provided on the basis of a "protocol." Following Etimesgut, six districts were established in Erzurum (1967 - Atatürk University), Torbalı (1968 - Ege University), Diyarbakır (1969 - There was a faculty of medicine established by Ankara University), Abidinpaşa (1971 - Ankara University), Çubuk (1974 - Hacettepe University) and Silivri (İstanbul University - 1974). New districts were established in Halkalı/Avcılar, Gemlik,[634] Doğankent, Ulaş, Bornova and Gölbaşı between 1979 and 1980, and in Narlıdere in 1982. They were established by protocols signed between the MHSA and the public health departments or community medicine institutes of the faculties of medicine.[635]

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[632] Ibid.

[633] *Sağlık Hizmetlerinin Sosyalleştirildiği Bölgelerde Hizmetin Yürütülmesi Hakkında Yönetmelik*, decree number 6/3470, *Resmî Gazete*, 9 September 1964.

[634] For Gemlik see Pala and Aytekin.

[635] For protocols see Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesi ile İlgili Kanun*.

In these districts, the socialization of health services was applied in the proper sense and students were provided with opportunities of practicing. They served as regions of socialization where the medical students gained experience on community medicine.[636] The socialization of health services was going to be applied in the proper sense including the referral chain. All the patients referred from health posts were provided free health service in the regional hospitals.[637] Although they improved the basic health indicators of these places they remained as isolated cases. When it was applied in the proper sense people were satisfied with the services, health indicators improve, and costs were controlled. Even without the support of a faculty of medicine a health post would change a lot in the health of a certain population.

So, by "failure" I do not refer to the principles or the proper practice. The socialization of health services was designed as the health system of Turkey. It was meant to cover everyone on the basis of equality and all health service institutions would be integrated under the direction of the MHSA. Socialization is the name of the health organization of Turkey. This included not only the health stations and

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[636] Ayşen Bulut, a public health specialist involved in maternal and child health from İstanbul University, who was trained and worked in Çubuk region between 1977-83 has some doubts about the effects of this practice on the students. Those regions were ideal places governed by the universities with all necessary resources and qualified administrators but the conditions were different in other places. She thinks rather than establishing such special regions it might be better to encourage and convince students to work in socialized regions (Ayşen Bulut, interview by the author, tape recording, İstanbul, Turkey, January 2007).

[637] However, there were problems in referring to university hospitals. Aksakoğlu explained the practice in İzmir Narlıdere. When he was the assistant head doctor of Ege University Hospital he was also responsible from three health posts. The poor patients referred from these health posts were taken care of even in the university hospital. According to the regulation on the execution of health service in socialized regions (*Resmî Gazete*, 9 September 1964, decree number 6/3470) those who were referred from health posts to hospitals did not pay any money. It was not limited to poor patients. But this regulation could not be applied and Aksakoğlu had to limit the practice with poor patients. Yet, they could not keep on doing this because of the financial dependency on revolving funds. Still, İzmir was portrayed by public health specialists as a town in which socialization functioned well. The health post personnel made home visits and filled the required forms and not only the uninsured poor but also the members of SII, RF and Bağ-Kur applied health posts in their districts (Aslı Davas, Gazanfer Aksakoğlu, Feride Saçaklıoğlu and Ata Soyer; interviews by the author, tape recording, İzmir, Turkey, March 2006).

health posts but also the hospitals, dispensaries and laboratories. Unfortunately, it was limited to the opening of health posts and could not become the health organization of Turkey. The ideal of covering everyone could not be accomplished, which is a topic I will analyze below. Although the Socialization Law was not repealed, it was not applied either.[638] Health reform proposals that assume a premium-based insurance model covering everyone have always been, and still are, on the agenda. The main reasons behind the failure of socialization give us clues about the shaping of Turkey's welfare regime and health care system.

The Consolidation of Inegalitarian Corporatism and the Development of Hospitals

The socialization did not become the NHS of Turkey and was limited to the provision of primary care to the Eastern, rural and poor segments of the population. It did not develop due to this limitation –services for the poor are poor services– but it was precisely for this reason that it could not be abolished either. The need to provide basic health care to the Eastern, rural and poor segments of the population was accepted by all. No one could question the state's duty to bring health care to the villages and the poor. But this health service was limited to primary care. Secondary and tertiary care was provided to those in the formal sector. So the state expanded the provision but kept its level at the minimum. Hence, a distinction occurred between "the people" and "the citizens" in the field of health care, and "the people" were provided public health while "the citizens" were provided medical care. Although the socialization emphasized public health, it was not restricted to "the people." Those

[638] The title of the article written by public health specialist Gazanfer Aksakoğlu is "Denenmeyen Model: Sosyalleştirme" (The Model that was not Tried: The Socialization). See also Gürsoy, p. 1726.

who were devoid of any service would be provided primary care but this was not based on the assumption that Eastern, rural, poor segments of the population would benefit only from primary care. They had the right to utilize services of hospitals free of charge, which were going to be built in every district. Those in the formal sector were not given the right to directly apply to hospitals. They also had to apply to health posts first, which registered and monitored them as was the case for the people in villages. However, the system did not work and the poor segments of the population had to settle for basic health care provided in health posts while those in the formal sector benefited from hospital facilities. This is related also to the late coming of the socialization to the big cities in the West. It was hard to establish a universal system based on a primary care network when a corporatist system based on the utilisation of hospitals by those in the formal sector was consolidating.

The Legislation of the Health Coverage for Those in the Formal Sector

The Social Insurance Law[639] and the Civil Servants Law[640] regulated the health insurance of workers and civil servants.[641] Although they were adopted after the initializing of the socialization program neither contained any reference to it.[642] It was as if the socialization was introduced as a public health program for rural Turkey and the need to establish insurance for workers and civil servants prevailed. Actually

[639] *Sosyal Sigortalar Kanunu*, no. 506, *Resmî Gazete*, 29, 30, 31 July and 1 August 1964.

[640] *Devlet Memurları Kanunu*, no. 657, *Resmî Gazete*, 23 July 1965.

[641] The Retirement Fund Law (no. 5434) which was accepted in 1949 and put into force in 1950, already regulated health assistance to civil servants and military personnel during their retirement and disability, and to their dependents in case of death.

[642] There are two temporary articles in Civil Servants Law on the right of seniority and financial provisions that would be applied to personnel employed in the socialization of health services (temporary articles 12 and 13). But this is related with personnel management, not with medical coverage.

this was the reason behind the "failure" of socialization: the simultaneous development of the inegalitarian corporatist system which provided medical coverage to those in the formal sector. The Social Insurance Law defined the basic rights of the insured and their dependents: in cases of industrial accident, occupational disease, illness, maternity, disability, old age and death, social security benefit would be provided. All these cases and the benefit for each one were defined in detail. The third section on illness insurance defined the scope of health benefit: examination, clinical and laboratory examination, treatment, medicine and other curing equipment (article 33). The spouse and children of the insured benefited from the same rights, but in cases of outpatient care they had to pay 20% of the medicine cost (article 35). This law endowed the spouses and children of the insured with the right of health benefit, but its application throughout the whole country could be realized on 1 April 1973. The health insurance premium was 8 % of the income of the insured, half of which would be paid by the insured and the other half by the employer (article 73).

The dependents of the insured are defined as the wife; or the husband whose maintenance was supported by his wife (certification was required); children until 18 or 25 years of age depending on the level of education and disabled children regardless of age; and parents who are maintained by the insured person. Daughters of the insured persons had been entitled to health care insurance regardless of age unless they were married and employed. Sons had been subjected to age limits in parallel to the education status and were exempted from these conditions only in case of disability which hindered the ability to work.[643]

[643] See Azer Kılıç for a well-written analysis of the gender regime of social security system in Turkey. She asks whether gendered policies can be seen as positive discrimination for women to satisfy specific needs and to compensate the disadvantaged position or as a reinforcement of a female second-class status through the strengthening of unfair gender norms and relations.

The Social Insurance Law integrated separate laws. It expanded the application area of social insurance almost for all employees except those in agriculture. Even if there was only one employee in a workplace he/she would to be insured. But this expansion was going to be gradual. By 1971, it was applied everywhere. The limit of 20 months for disability for service benefits in cases of industrial accidents and occupational diseases was lifted. Health benefit would be provided as long as the condition of the insured necessitated. For general sickness, the length of temporary disability for service benefit was increased to 18 months. The Advocacy Law (1969) included lawyers within social insurance coverage. With the Law no. 2100 (1977) those who worked in agriculture with permanent contract of service and those who did housework permanently with a salary were included within the Social Insurance Law. But in practice, only a small portion of those in agriculture (16,647 in 1981 and 165,268 in 2003) were included.[644]

Article 123 endowed the SII with the right to establish health institutions and make contracts with the existing ones. It was clearly stated that the SII had the right to establish and manage hospitals, sanatoriums, preventoriums, dispensaries with or without bed, health stations, pharmacies and the like or make contracts with hospitals, doctors, pharmacists, midviwes and other natural and legal persons to accomplish the tasks ascribed to it with this law and to provide health benefits. The SII could set up pharmacies in all health institutions with bed and if there was no private pharmacy in the district in all health institutions without bed, with the condition of employing a pharmacist and holding a licence. If there were private pharmacies in the district the SII could not set up pharmacy in health institutions without beds, so it made contracts with one or few of the private pharmacies.

[644] Özbek, *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar*, pp. 284-86.

In the discussions of Social Insurance Law in the Parliament, the setting up of pharmacies was the most controversial issue along with the article putting a limit to the number of examinations (10,000) a SII doctor could make in a year (article 118).[645] From these discussions we learn that the SII could not employ enough doctors with the existing level of salaries especially for places like Tunçbilek, where there was a large worker population. This prevented doctors from sparing enough time for each patient. It was stated that the SII could increase the level of salaries with the premiums collected from workers. The Institution had enough money, but it spent it on excessive equipment rather than allocating it to the doctors. The debate on setting up of pharmacies was even harsher. It led the members of the parliament to discuss the limits of social insurance and public service. The pressure of private pharmacists on the Parliament was strongly criticized by some deputies. According to Şeref Bakşık, the expansion of SII health services would be disadvantageous for private hospitals, practitioners, laboratories and insurance firms, but this was inevitable when the state fulfilled its public duties. He asked why it was only the pharmacists that howl. Those who emphasized the welfare character of the Turkish Republic, and so the requirement to provide health service in its totality - examination, laboratory, x-ray and medicine together- were confronted by the criticism that it was not a socialist state which would socialize everything bit by bit.

This debate was typical in terms of revealing the tension between those who emphasize the public character of health and those who believed in the strength of private initiative. Starting from the late Ottoman period onwards private medicine always had a significant place in the system although it lost its strength especially

[645] Republic of Turkey, *Millet Meclisi Tutanak Dergisi*, Session 126, 14 July 1964, Term 1, vol 32, meeting 3 (126. Birleşim, 14 Temmuz 1964, Dönem 1, cilt 32, toplantı 3) and Session 127, 15 July 1964, Term 1, vol 32, meeting 3 (127. Birleşim, 15 Temmuz 1964, Dönem 1, cilt 32, toplantı 3).

after 1960s. But even in socialization, private practice was not prohibited and state monopoly on pharmaceuticals was not even mentioned. Although the role of the state expanded there was always a sphere left for private initiative. The significant rupture in terms of the role of private initiative would occur in the early 1980s.

The health benefits of civil servants and their dependents were regulated in the fourth section of the Civil Servants Law. It said in article 138 that the necessary social insurance benefits would be provided to civil servants in cases of illness, maternity, and accident and disease due to mission; illness and maternity of civil servants' spouses and dependents; illness and maternity of the old aged or disability pension based on a law, and illness and maternity of their family members; illness and maternity of those who get widow's and orphans' pension based on a law. Article 209 regulated the health and transportation benefits for civil servants and their dependents in case they became sick within or outside the country.

The health expenditures of active civil servants and their dependents were met by the institutions for which they worked for. Those of pensioners and their dependents were met by the Retirement Fund. The Retirement Fund Law (no. 5434, 1949) united all funds under one roof. This law provided social insurance to civil servants in public and military sector in their retirement and disability, and to their dependents in case of their death. In the beginning only civil servants and military personnel were covered by the Retirement Fund; later on, mayors, permanent counsellors, deputies, military school students and contractual based employees in some institutions were added. With Law no. 1101 (1969) the pension rates were increased significantly and the differences among retired, widow and orphan pensions were lifted.[646]

[646] Özbek, *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar*, p. 251.

The income of the Fund is derived from deductions from the salaries of civil servants, designated funds (*karşılık*) from the institutions, and investment revenues. Those who received retirement pay, disability, widows' and orphans' pension; the spouses and the children (under 18, if in secondary education under 20, if in university under 25, unmarried sons and daughters; unmarried daughters who would be deserving if they received no other benefit; and disabled and deserving sons) of those who received retirement pay or disability pension had the right to receive health benefits from the Retirement Fund. They could apply public hospitals, sanatoriums, preventoriums, rehabilitation centers, examination and treatment houses, government and municipality doctors, and health posts. Health benefits included treatment, clinical and laboratory examinations, hospitalization, and the necessary medicine and curing equipment. The health benefit of dependents was regulated in 8 July 1971 with law number 1425.

Following the civil servants and workers in the formal sector the self-employed were also covered by a security scheme. Bağ-Kur (Social Security Institution of Craftsmen, Tradesmen and Other Self Employed) was established in 2 September 1971[647] to provide social security for the self-employed through collecting premiums. Self-employed, craftsmen, and artisans would benefit from old age and disability pensions and death insurance. Health insurance was added to Bağ-Kur Law, later in 1985 (additional article 13: 5 November 1985, 3235/1 md.). Those who could benefit from health insurance were compulsory insured subject to 1479, their dependent spouses and children, mothers and fathers, those who received old age and disability pensions and their dependent spouses and children, mothers and fathers, and those who received death pension.

[647] *Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu Kanunu*, no. 1479, *Resmî Gazete*, 14 September 1971.

The state did not make any contribution to the premiums of the insured except those of civil servants. The revenues of the Retirement Fund were a 25% entrance deduction, a 16% old age deduction, a 20% institution provision and a 4% additional institutional provision. In Bağ-Kur the health insurance premium was 20%. Those with premium debt cannot benefit from health services. In the SII, 6% of the health insurance premium was paid by the employer and 5% by the employee.

In all government programs and development plans, medical coverage for all citizens was specified as the major goal. Actually after the change in Bağ-Kur Law in 1985, those who were excluded from medical coverage became limited to the rural population and urban informal sector employees and they constituted a considerable portion of the population. There were attempts to include those in the agricultural sector especially after the 1980s, but their success was partial. The inclusion of agricultural sector within social security was late as it was the case in other countries. Turkey had also some peculiar characteristics, like the irregular character of employment, low level of income, and the ambivalence of borders among the categories of employee, sharecropper and employed.

The Resistance to the Transfer of SII Hospitals

As mentioned in the previous chapter, article 8 of the Socialization Law required the transfer of all public sector health institutions, except those of the Ministry of Defense, to the MHSA in the regions where health services were socialized. Article 30 regulated the transfer of the buildings, medicine, equipment and furniture of the public sector health institutions in the socialized regions to the MHSA. But temporary article 3 allowed that the transfer of public sector health institutions to the

MHSA could be postponed until the socialization of the whole country was completed. In resisting the transfer of its health institutions, the SII referred to this temporary article. Neither article 8 nor temporary article 3 were executed even when the socialization of the whole country was completed in 1984.

From 1949 on the Labor Insurance Institution (then the Social Insurance Institution in 1965) established its own health institutions. The MHSA did not have enough health facilities and this led the organization to establish its own. In premium-based insurance systems health services are bought from the public and the private sectors. The organization itself is not the provider, but the financier of the service. But in the Turkish case, the insurance organization established its own hospitals and dispensaries with the premiums collected from the employers and the employees, only for the utilization of its members. The organization made contracts with the doctors who ran private offices in places where it could not establish its own institutions. Beginning with the 1950s the SII had the fastest growth rate in health facilities and services (see Table 25). And SII facilities were providing high quality services.[648]

Fişek emphasized that this growth was to the disadvantage of the uninsured citizens and caused staff shortages in the MHSA.[649] In 1976, the number of people per physician in Turkey was 2000, while it was 700 in the health institutions of

[648] But throughout the 1980s and 1990s, governments used the accumulated funds of the Institution irresponsibly and newspapers started to report the queues and apathy of the doctors in SII hospitals. Of course the irresponsible use of the accumulated funds was not the only reason of the deterioration in actuarial balance and the rise in budget deficit. The fall in age limits for pension right, the practice of debts which are not in return for premiums (*prim karşılığı olmayan borçlar*), and the restriction of the areas in which the funds of the institution could be utilized deteriorated the actuarial balances of the system (Özbek, *Cumhuriyet Türkiyesi'nde Sosyal Güvenlik ve Sosyal Politikalar*, pp. 294-96). Because of the large share of informal sector and the large number of dependents, the budget deficit was unavoidable. This deficit could come into being later on but the irresponsible use of the acumulated funds quickened the process. Buğra, "AKP Döneminde Sosyal Politika ve Vatandaşlık." p. 154.

[649] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 70

SII.[650] Fişek said the most important reason behind the difficulty to recruit medical specialists for the hospitals in the East was the job opportunities the SII had created in the West.[651] While preparing the Socialization Law he offered the formation of a premium-based system. But it was for all citizens within the socialized regions. The employment position was not determinate.

Later on, he changed his idea and started to defend national health service model as the peak point of the "linear" development process: first, voluntary insurance; then, social security; and last, national health service. He defended this position with reference to the 1961 Constitution, the Universal Declaration of Human Rights and the WHO documents. Also it was unrealistic for him to establish a premium-based system within such a low-income country. The same argument would be used by the ministers and the TMA to defend the insurance system. They would argue that there was the need to establish insurance as Turkey was a poor country, as it did not have enough resource to finance the health services. But when there was too much pressure from the government on deriving resources for health services, as was the case in the Health Sector Expertise Commission Meeting of the Fourth Five Year Plan (1979-83), Fişek accepted the insurance but only as a finance institution, not a service provision one. He accepted it for the improvement of socialized health services, which in a way contradicted the insurance model. He

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[650] In the Health Sector Expertise Commission Report of the Third Five Year Plan (1973-77) it is reported that there are 83 beds for 10,000 insured and their dependents in SII hospitals, while for the remaning population this number is only 18. And in the Health Sector Expertise Commission Report of the Fourth Five Year Plan (1979-83) the distribution of doctors among the institutions is reported as follows: While there is one specialist for 27 beds and 13,000 people, and one nurse for 12 beds in MHSA hospitals, there is one specialist for seven beds and 3,600 people, and one nurse for seven beds in SII hospitals, and one specialist for 11 beds and one nurse for 14 beds in municipality hospitals. In MHSA hospitals there is one bed for 600 persons, in SII hospitals it is one bed for 480.
When hospitals were administered by the special provincial administrations and the municipalities before 1954, the authority of appointment was at MHSA. This was not the case for SII hospitals and it affected the distribution of health personnel negatively. Fişek, *Halk Sağlığına Giriş*, p. 162.

[651] Cited in G. Fişek, Özsuca and Şuğle, p. 90.

usually blamed the Ministry of Finance for the lack of resources. For him, it was the task of finance officers to find the required resources. The ideal method was the national health service in which everybody, regardless of their employment status, had access to all kinds of health services that were financed from the general budget. Fişek criticized the growth of insurance system for damaging the egalitarian spirit of socialization. He criticized insurance model also on the grounds that it was much more expensive. For 1973, when the MHSA spent 57 liras per person, the SII spent 717 liras, while in the ideal socialized region of Etimesgut it was only 88 liras including both the health posts and the hospital.[652] Despite all his oppositions, however, the insurance system co-existed with the socialization program and hindered its development.

In a meeting organized by the Turkish Medical Association in 27-30 April 1965, Erdal Atabek from the TMA supported the establishment of insurance rather than revolving funds and general budget, as the realistic option. But Fişek criticized this approach as it encouraged the finance officers who were unwilling to allocate money to the socialization of health services. For him, if 6% of the budget was allocated to the MHSA, there would not be any problem in the application of socialization.[653] He accepted the need to establish insurance only for the provision of drugs free of charge and the improvement of hospital services. SII consultant Refik

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[652] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 75. It is possible to observe the increasing gap in expenditures of the socialized regions and the SII. Fişek provided some figures: In 1964, per capita expenditure was 32 liras in socialized regions and 150 in SII. Türk Tabipleri Birliği Merkez Konseyi, *Türk Hekiminin Dünü, Bugünü, Yarını* (İstanbul: Yaşar Matbaası, 1965), p. 89. It was 25 liras in socialized regions in 1968, while it was 300 in SII in 1967. Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, p. 155. And in 1973, it was 88 liras in Etimesgut and 717 in SII. Such a comparison is meaningful if socialized health services include hospital care. That's why the last comparison is more reliable. Yet, if SII expenditures include medication and the socialization does not, it becomes hard to compare these two figures. Because in socialization only life-saving drugs were provided free of charge. Nevertheless, we might talk about an increasing gap.

[653] Türk Tabipleri Birliği Merkez Konseyi, *Türk Hekiminin Dünü, Bugünü, Yarını*, p. 84. The share of MHSA in the general budget will never reach this required level.

Erer rejected Fişek's claim that it was not possible to apply insurance in Turkey. He opposed the expansion of socialization on the grounds that it was very costly. After all, the insurance system had an 18 year past and had progressed suddenly and quickly. Orhan Alpyörük from the İzmir Medical Association and Saim Aksan from the SII İstanbul Hospital defended the application of both the socialization and the insurance. For Aksan, as much as it was a must to apply the socialization to the poor it was just to apply insurance to those with financial benefits.[654] Such a statement reveals that socialization was not seen as the health system of Turkey even when it functioned well. Here it was limited to primary care for the poor. Whether there would be differences in terms of quality of the service the poor and the others received is questionable.

This approach should be reflected upon since it dominated the debates related to health care throughout the 1960s and 1970s. When it came to coverage, every party agreed upon a universal system. But only primary care was provided to all. Curative services were to be provided upon payment, to those who "deserved" it. A universal health care system providing all kinds of health services financed by public resources did not find support, except from Fişek and some public health specialists. This approach also viewed socialization more or less as the extension of the practice of "country doctors" of the late Ottoman period where doctors were expected to treat the poor free of charge. This implies the limiting of the health care duty of the state with social assistance.

At the beginning, in the six socialized provinces the SII abrogated the contracts it had with doctors with private offices. The undersecretary of SII Refik

[654] "As much as it is a must to apply the socialization to the poor, it is just to apply social insurance to those with financial means." (*Sosyalizasyonu malî kudreti düşük olan vatandaşa uygulamak ne kadar zaruri ise, sosyal sigortaları da, malî kudreti buna müsait vatandaşa uygulamak o kadar adaletlidir.*) Ibid., p. 167.

Erer complained about this during the First General Assembly of the Socialization of Health Services. After the abrogation of contracts the trade unions started sending telegrams complaining that nobody took care of them. Then SII appealed to the MHSA and inquired about the situation there. The MHSA responded that everybody was taken care of in accordance with the Socialization Law. The health posts, however, were not ready then. And the first impression was very important. Erer said that they were trying to send the insured to the health posts but the insured did not want to go to the health posts, although the SII had contracts with, and although the charges were paid.[655]

This experience led the SII to develop its own health service institutions. Actually, this shows the complex relation between the socialization and the insurance system. The development of insurance model prevented the development of socialization on the one hand, and the troubles within the socialization encouraged the expansion of the insurance-based health system on the other. The SII established its own health facilities and as they developed the connection with the socialization was damaged. The insured workers did not embrace socialization. There occurred a duality in the system relating to beneficiaries, providers, and bureaucrats. Those who benefited from socialized health services and the SII hospitals were separated, doctors prefered to work at the SII hospitals and did not work at the health posts, and the SII bureaucrats opposed the MHSA bureaucrats who supported integration.

The SII wanted to benefit from the curative services of the socialized health like the health posts. Two protocols were signed between the SII and the MHSA, one

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[655] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, pp. 72-73.

in 1967 and the other in 1979.[656] In the first protocol, payments that would be made by the SII to the MHSA in return for the examination, treatment, medicine and etc. were regulated.[657] The second protocol set the rules of cooperation between the health institutions of the SII and the MHSA. To free the staff in the health posts from the burden of paper work, related with the examination and treatment of the insured, the SII would appoint civil servants there.[658] Despite these protocols, health posts were not widely visited by the workers. Various researches conducted at different times reveal that it was usually the uninsured poor who applied to the health posts. The SII members preferred to apply directly to their dispensaries and hospitals.

In his study on Etimesgut region, Gazanfer Aksakoğlu analyzed the roles of various variants in the selection of health institutes such as family type, age and sex, economic status, cultural level, distance, and illness type. He found out that both the members of the SII and others applied to health posts. But members of the SII declared that they would apply to a SII clinic if there were one in the vicinity. The major factor that determined the application to health posts was economic status. The well-off did not apply to the health posts.[659] Öztürk and Bilir found out that in the Çubuk region, the insured workers did not apply to the health posts.[660]

In a recent study conducted by Hür Hassoy in İzmir Gülyaka, those who applied to the health posts were found to be people without any social insurance. Poor people with low educational levels, who lived in *gecekondu*s, and whose

[656] G. Fişek, Özsuca and Şuğle, p. 63.

[657] Ibid., p. 245.

[658] Ibid., p. 246.

[659] Aksakoğlu, *Sağlık Hizmetlerinin Sosyalleştirildiği Bir Bölgede*.

[660] Öztürk and Bilir.

mother tongue was not Turkish applied to the health posts more often. Those who had insurance and who had higher income levels preferred institutions other than the health posts.[661] Çiçeklioğlu's research in the Akçay region reaches similar results. Those who used the health posts were the poor and the people without any insurance.[662] Other researches conducted in Edirne, Örnekköy and Gemlik confirm that upper classes and insured sections of the population did not apply to the health posts while the lower classes without any insurance did.[663]

Both the number and the geographical scope of the SII hospitals expanded, as can be seen from Tables 26 and 27.[664] The highest amount of investment in hospitals by SII is observed between 1965-75. It is the period when SII did not yet pay large amounts of old-age insurances and had enough accumulation of funds.[665] It was also the period when efforts to establish the socialization of health services were made. But as the workers in the formal sector and their dependents enjoyed the advantage of directly attending to the SII hospitals through bypassing the referral chain, the health posts did not develop. As the health posts could not develop due to many factors, the SII assumed the task of health service delivery, which in turn damaged the development of a universalistic system.

The trade unions struggled against the transfer of the SII hospitals to the Ministry of Health throughout the 1960s and 1970s. For example, in the 22nd General Assembly of the Social Insurance Institution in 1967, the head of Yol-İş (road construction workers) Federation Halit Mısırlıoğlu said that their concerns

[661] Hassoy; Hassoy and Çiçeklioğlu.

[662] Cited in Hassoy, p. 118.

[663] Cited in Hassoy and Çiçeklioğlu, p. 369.

[664] G. Fişek, Özsuca and Şuğle, pp. 109-110.

[665] Ibid., p. 109.

about the hospitals would persist as long as the Socialization Law existed.[666] In the same general assembly it was expressed that operating of the health policy by a single organization was one thing and the transfer of the hospitals was another. Of course, they favored the benefiting of the poor peasants from the health services, but socialization could not be applied properly with the means at hand. Refik Baydur defined the transfer of health facilities which were established with the premiums collected from the employers and the employees as a violation of property right.[667] The Minister of Health Vedat Âli Özkan assured them that the SII hospitals would not be transferred and this would be abrogated from the law.[668] Former Minister of Labor Bülent Ecevit supported the cause of workers and proposed the expansion of insurance system at least to cover all tax payers.[669]

It was during the Import Substituting Industrialization (ISI) period that domestic industry was protected through the production of the very manufactures hitherto imported. There was an alliance among the manufacturing bourgeoisie, the working class and a certain stratum of the bureaucracy. The Turkish working class was in a better condition compared with its counterparts in other equally less developed societies. In 1963 they acquired the right to strike and the real wages increased 5-7% annually in the following decade. It was not only the right to collective bargaining and strike or the relatively high wages, but also social rights

[666] Ibid., p. 64.

[667] Ibid.

[668] Ibid., p. 65.

[669] Ibid.

like advanced pensions and health insurance which distinguished the position of the Turkish working class from that of its counterparts.[670]

Within the "selective welfare developmentalism" of the 1960s and 70s[671] workers had the power to maintain their advantageous position. So, the resistance of the SII and trade unions played an important role in impeding the integration of the SII hospitals. However, the universalist system could not have developed still if some groups had had advantageous position in receiving health services. Without the reaction against the transfer of health facilities, the formation of a universalist system might again have been hindered if some citizens had been offered access to health care delivery while others had been left out. The advantegeous position of workers and their dependents might have continued after the transfer had been realized. Actually the SII health services regressed in time and the workers and their dependents' advantageous position was wounded. Still, they were provided health services and medicine with a small amount of co-payment. After the transfer of the SII hospitals in 2005, they did not lose this right and had the benefit of attending to all MHSA hospitals. Here, I will not get into the details of the transfer process and the problems related with it. I just want to note that whether the hospitals gave exclusive service or not, the SII members would not embrace the socialization as long as they had direct access to hospitals; as it is the case for the members of the Government Employees Retirement Fund (ES, est. 1949) and the Social Security Institution of Craftsmen, Tradesmen and Other Self-Employed (Bağ-Kur, est. 1971).

[670] Keyder, *State and Class in Turkey*.

[671] Kwon.

The SII's resistance can be traced in the minutes of the meeting on the integration of health services which was held in 10-12 October 1966;[672] it was so strong that the members of the cabinet had to retreat. The meeting brought together the representatives of the MHSA, the SII, the TMA, the Turkish Pharmacists Association and faculties of medicine.

Edip Somunoğlu, the Minister of HSA of the first Demirel government which was in power then, noted that the integration of health services was mentioned not only in the Socialization Law (no. 224, article 30), but also in the First Five Year Plan and the Health Sector Expertise Commission Report of the Second Five Year Plan. To solve the problem of the unjust distribution of health services there was the need to integrate various types of treatment institutions. The difficulty was in the transfer of the hospitals of the Ministry of Defense and the SII.[673] Refik Erer, then President of the Health Affairs of SII, argued that the real owners of the SII hospitals were the workers and their transfer was financially and legally impossible.[674] Nezih Ulagay from the TPA, criticized Erer and said that the SII hospitals were owned by both the employers and the employees. He found the existing situation against social justice since the peasants were deprived of health services while the working class was in a good condition.[675] Similarly, Cemal Üner from the İstanbul and Environs Civil Servant Doctors Trade Union[676] asked the fate of the 20 million peasants. For him, the SII should make sacrifices.[677] Necip Danişoğlu from the law section of the

[672] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 10-12 Ekim 1966 Günlerinde*.

[673] Ibid., pp. 11-12.

[674] Ibid., p. 29.

[675] Ibid., p. 45.

[676] İstanbul ve Civarı Memur Hekimler Sendikası

[677] Ibid., p. 46-47.

meeting said the workers could not be considered to be the owners of the SII hospitals as the SII had come into existence with the money of the state. According to him, the premiums collected until then had covered the services provided until then.[678] Erer became angry and opposed the view that the state made financial assistance to the SII. On the contrary, the SII contributed to the general budget. And it was not possible to tell the workers who had already paid three billion liras "you have been served and it is over."[679]

The members of the cabinet in this meeting were not determinate about the transfer of the hospitals. The Minister of Interior Faruk Sükan said there was not enough money in budget for this. And the Minister of Health Edip Somunoğlu, by the end of the meeting, concluded that the integration of health services should not be considered as a process of transfer. Rather a separate institution was imagined which would rely on the resources of insurance, the general budget, the assistance of municipalities and special provincial administrations.[680] So he shifted his position in terms of the issue of "transfer." And related to the problem of resources, not only the ministers but also the other participants defended the application of insurance. The undersecretary of MHSA Faruk İlker, talked about the need to increase the number of beds from 30-40,000 to 300-350,000. According to him, the financial resources of the country were not sufficient to meet this growth and so insurance was a must.[681]

Fişek argued that in such a low income country it was difficult to establish insurance and collect premiums. Here the same argument was used by other bureaucrats to defend the necessity of insurance. So, parallel views contradicted each

[678] Ibid., p. 71.

[679] Ibid., p. 72.

[680] Ibid., p. 130.

[681] Ibid., p. 28.

other and co-existed together. Erdal Atabek from the TMA repeated his view on insurance and claimed that even when the share of health in the general budget was increased a quality health service could not be maintained. The citizens had to contribute to health expenses in the form of insurance. The premiums of those who could not afford would be paid by the state.[682] Rüknettin Tözüm from the İstanbul Faculty of Medicine also defended a nation-wide health insurance system. Only in this way, could the freeloading mentality (*bedavacılık zihniyeti*) be prevented and the patients receive health care not through the compassion of the doctor, but through insurance.[683] The difficulty of collecting premiums from the peasants was discussed also in this meeting. The formula of collecting premiums from those who could afford them was widely accepted. The Minister of Interior Faruk Sükan declared that premiums could be collected from civil servants, artisans, self-employed and agriculture tax payers.[684] However, the status of those who did not pay any premiums was not clarified. Would they receive the same service? Or would they receive less? The Dean of Ege University Faculty of Medicine İsmail Ulutaş said treating the patients who paid premiums and those who did not on the basis of equality would be legally unjust.[685] Actually, this mentality clarified the future status of those who did not pay any premiums. The principle of equality which forms the basis of socialization was not advocated.

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[682] Ibid., p. 18.

[683] Ibid., p. 54.

[684] Ibid., p. 93.

[685] "I believe that providing medical service equally to those who expect this service in return of their previous payments and to those who have not paid anything would be unjust at least in legal terms." (*Evvelâ birtakım para ödeme yükümlülüğü altında tedavi bekleyen kişilerle, hiç para vermemiş kişileri aynı ölçüler dahilinde tedaviye kalkmak, hiç değilse hukukî bakımdan da adaletsizlik olur zannederim.*) Ibid., p. 21.

Sadık Baykaner from the School of Public Health (*Hıfzıssıhha Okulu*) opposed the collection of premiums from the peasants before bringing health service to the villages. It was not possible to apply insurance when the majority of the population lived in rural areas.[686] Baykaner emphasized the relation between the provision of the service and the collecting of the premiums. However, when an insurance system was proposed it was usually not the peasants but the civil servants and the tax-payers who were going to pay premiums. That meant the collection process would take start with the urban population.

In the debates related with the insurance system the emphasis was on the hospital services which had been gathered in the cities. So, the distinction started to crystallize between socialization for the rural population and insurance for the urban one.

Although socialization was designed as the general health system of Turkey with all its institutions including hospitals it functioned more as a primary care program for the peasants. As the socialization of health services was not considered to be the national health system of Turkey, the project of establishing a general health insurance was always on the agenda. For example, at the end of this meeting on the integration of health services, the report of the finance and economy section proposed the application of a gradual insurance system. In this system, not only the population covered but also the health services provided would expand in time. Such an approach was based on the assumption that the number of people with a certain level of income, thereby the ability to pay for premiums, would increase in time.[687]

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[686] Ibid., p. 33.

[687] Minister Faruk Sükan formulated the resources of the nationwide health insurance: allowance from the general budget; revolving funds of hospitals; shares in the budgets of local administrations, municipalities, special provincial administrations and villages; grants, contributions, interests; premiums paid by the insured. There would be a gradual expansion both in the number of people insured and the scope of guaranteed services. The premiums of those who could not afford would be

According to this developmentalist assumption -which prevailed through the 1960s and 1970s– informal sector and agricultural employment would decline in time. There was this very optimistic notion that the process of development would eventually involve everyone in the formal sector, and the transformation process would unfold by itself and the population would end up being covered by a health scheme, either through the government functionaries and state employees, or through being formal workers in the formal sector. In the 1980s, people started realizing that that was not going to be the case.[688]

Here in this meeting there was a clear opposition to collecting of premiums from those who were not provided any health service. But later on, the insurance system was more easily promoted. This might have been due to the rise in expenditures, but also due to the rise in health institutions. In the later debates on insurance, the problem was defined not as the lack of service but as the impossibility of collecting premiums from the people. Not the collecting itself but its feasibility was challenged. So, while at first the collection of premiums was questioned in terms of its legitimacy, it was now questioned whether or not it was applicable.

The SPO was one of the parties in the debate on the integration of health services. In all health sector expertise commission reports, five year development plans and the other SPO documents the integration was promoted. Although there was an inconsistency among the SPO reports on the issue of insurance, and the

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paid by special provincial administrations, municipalities and charities (ibid., p. 115). It is typical that local authorities and charities were held responsible for the poor. See Buğra, "Devletçi Dönemde Yoksulluğa Bakış ve Sosyal Politika." Buğra analyzes the ways in which poverty was perceived and confronted in early Republican Turkey. Poverty alleviation was not seem to be considered as a responsibility of the state. In official ideology and public opinion, poverty appears as a problem with which voluntary initiatives should deal, through donations by the rich. Here, charging the local authorities and the charities, but not the state, with the duty of paying the premiums of the poor is a continuation of this early Republican mentality.

[688] Keyder, "Health Sector Reform in the Context of Turkish Political Economy."

weight of socialization, the integration of health services of public institutions was a common goal. In an SPO report on the integration of the administration of the health institutions of the public, the variety in structure, personnel, equipment and wage policy was specified as a problem.[689] The provision of service to certain groups through public institutions was a remnant of the efforts of each institution to provide a better service to its members when a certain level of health service could not be provided to the whole population. Such a practice contradicted with the modern state principle of providing public services to all, not to a certain group.[690] The integration of the services, together with the socialization, the insurance and personnel policy would increase people's use of the health services as a whole.[691] The integration would make it possible for the people to benefit from a wider capacity of health institutions and the functional connection among the health posts, hospitals and other institutions would operate and their services would complement each other.[692]

The report reminded the reader that insurance was a finance institution. The transfer of the SII hospitals could not be seen as usurpation because their current price would be paid. As the facilities of other institutions were built up through budget funds they could directly be transferred to the central administration. The funds used in the financing of SII health institutions were public funds composed of compulsory premiums paid by the employers and the employees. So they could not be considered as volunteer savings. The transfer of a service run by public funds of a public institution to another institution did not run counter to the principles of public

[689] Devlet Planlama Teşkilatı, *Kamu Sektörüne Ait Sağlık Tesislerinin Tek Elden İdaresi*.

[690] Ibid., p. 1.

[691] Ibid., p. 5.

[692] Ibid., p. 6.

administration.[693] Despite the clear position of the SPO on the integration of health services this policy could not be implemented for years.

The problem of the incompatibility of insurance with the socialization cannot be limited to the existence of separate SII health facilities. Even if the SII did not have any health facilities but collected premiums for health benefits, the contradiction would persist. There would be a duality between those who paid premiums and those who did not, and the former would oppose receiving the same health benefits. So, the integration of health services itself would not solve the problem although it would help a lot in eliminating certain inequalities, especially those related to the distribution of health personnel. When those in the formal sector paid premiums for health insurance and had the right to apply directly to hospitals health posts would not develop and serve only the uninsured rural population. It did not matter whether the hospitals were owned by the institution or not.

The Independent Development of the Hospital System

Throughout the 1960s and 1970s health posts did not become the primary care institutions for the whole population and hospitals in cities grew in terms of both quality and quantity (see Tables 12 and 13 for the rise in the number of hospitals and their bed capacity). It was not only that the SII hospitals could not be transferred to the MHSA, but that the other hospitals could not be integrated into the system either. Partly due to the late inclusion of big cities within the socialization, hospitals followed an independent path.

[693] Ibid., p. 8.

Primary care is important both in NHS and social insurance systems. To prevent needless aggregation in hospitals patients are treated and cured in primary care institutions where a very high percent of the applications can be dealt with. Although the rising demand for curative services is not peculiar to Turkey, it is distinguished from the developed countries by the weakness of its primary care system. During the 1950s and 1960s, the emphasis in health care shifted perceptibly towards curative medicine. The modern medical profession has developed primarily around the search for finding cures rather than promoting health, preventing disease and protecting public health. Despite this shift, the developed countries established gatekeeping institutions of primary care to diminish the pressure on hospitals and control the expenditures.

The system was not adopted in its totality and the hospitals operated independently.[694] The coordination between the health posts and the hospitals could not be established especially due to the neglect of hospital doctors, and the referral chain did not work. With the rising urbanization, demand for hospitals increased. Those living in cities did not want to go to health posts lacking specialists and laboratories and the system was not adapted to the expectations of the people[695]

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[694] Years later on June 3, 1998, in the First General Assembly on Health Posts and Preventive Care which was held in Ankara, public health specialist Zafer Öztek criticizes the heading of the assembly as it excludes hospitals. For him, it should have been "the socialization of health services". Because socialization does not mean the establishment of new health posts. It is the major law which determines the health policy of Turkey including the health stations, health posts, health centers, hospitals, regional hospitals and other institutions. If the secondary care institutions do not adopt the socialization practice, it will not operate. Sağlık Bakanlığı, *1. Sağlık Ocakları ve Koruyucu Hekimlik Kurultayı*, Sağlık Bakanlığı Temel Sağlık Hizmetleri Genel Müdürlüğü, 3 Haziran 1998 (Ankara: AÇSAP Genel Müdürlüğü Basımevi, 1998), p. 46. In the opening speech of this assembly President Demirel appreciates the socialization program as it brought health care to those who could have access to it previously only when they went to cities. For him, it is a program of unification and integration. Through socialization, doctor who graduated from faculty of medicine took the place of medical corpsman who became needleman. He emphasizes the continuing imbalance in the distribution of health personnel and the need to set up the coordination between the hospital system and the health posts.

[695] *Sağlık Hizmetlerinin Sosyalleştirildiği Bölgelerde Hizmetin Yürütülmesi Hakkında Yönetmelik*, decree number 6/3470, *Resmî Gazete*, 9 September 1964.

although it was flexible enough for this. And as there was not any barrier against the direct application to hospitals people did not abide to the referral chain. Those who had medical coverage could benefit directly from hospitals and this prevented the development of health posts.

Actually, it was clearly stated in the regulation on the execution of health service in socialized regions that those who were referred from health posts to hospitals did not pay any money. Those who went to a hospital directly -except for emergency cases- pay 10 liras. And laboratory, x-ray and prosthesis services were also out of pocket. If a specialist doctor visited a patient at his/her home with the invitation of the health post doctor, this service was free in the working hours. The examination and cure fees of the insured patients would be paid by the insurance. Staying in a private, first or second class room was subject to fee. Those who stayed in hospital -except the poor- paid a daily amount of seven liras for food and bed. Those who applied for examination and treatment outside the working hours paid five liras if they were in the health post building, 10 liras if they were at home and 50 liras if the doctor was brought to a village.

The fees of civil servants, other personnel who work in public sector and insured workers would be charged from the relevant institutes later on. Those who came from the not-yet-socialized regions and whose settlement in the socialized region did not exceed 90 days -except civil servants and their families, and the poor- paid the same amount as those who applied outside the working hours.[696] Here we see that registration at a health post was important. According to the plan, everyone would be registered at a health post and their condition would be monitored by the health post throughout their lives. According to the accounts of public health

[696] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesi ile İlgili Kanun*, pp. 41-43.

specialists, this regulation was applied properly in health research and training districts. However, it is not clear whether this regulation was applied properly in all socialized regions. Medication was also an important problem. Although the patient was treated free in the health post or in the hospital, the cost of drugs, laboratory, x-ray and prosthesis constituted a heavy burden.[697]

Furthermore, 26 cities and four training regions had been socialized by the year 1975, which means that 41 cities including the three metropolitan centers were not subject to this regulation. In these cities the regulation on hospitals, which was accepted during the DP government in 1955, should have been in practice until 1973. On 26 November 1973, a new regulation on the management of hospitals was published in the *Official Gazette*[698] when the caretaker government of Naim Talu was in power. It was a very detailed regulation which defined the medical services, the tasks of departments and the personnel, and the bureaucratic procedures related with the using of services. Similar to the 1955 regulation it made a distinction between those who would be examined and treated free of charge and those who would not. Those who would be examined and treated free of charge were as follows: Women who needed maternity grant in accordance with the Law of Public

[697] While working as a village health post doctor, public health specialist Kayıhan Pala started to operate a medicine chest to save people from the obligation of going to the pharmacy in the city. But he could not keep on doing this because he was giving drugs free to the poor and lost an amount of two salaries in three months time (Kayıhan Pala, interview by the author, tape recording, Bursa, Turkey, July 2006). Life-saving drugs and vaccines were provided by the MHSA but other medicine was always a problem. In his book *Arin Mektupları* (Letters from Arin), Oryal Gökdemir complains about the lack of drugs in the letters he wrote from Arin, a village of Bitlis Adilcevaz, where he worked as a health post doctor. In a letter dated 31.10.1964 he talks about his feeling of absurdity due to the lack of drugs: "What we are doing here is not a doctorate. Who is saved is lucky, who dies is not" (*Burada doktorluk falan yaptığımız yok. Kurtulan şansına, ölen bahtına*). In the notes he has written on the letters, decades later in 1990s, he clarifies this situation. He was filling prescriptions but the nearest pharmacy was in Erciş, 60 km away from the village. And the people did not trust drugs other than injection shots. Then drugs were sent from the Ministry; some free and some subject to payment. But this time, as the people felt skeptical about the state they needed to be convinced to take these drugs. Oryal Gökdemir, *Arin Mektupları* (İstanbul: Arkın Kitabevi, 1998), pp. 53-54.

[698] *Yataklı Tedavi Kurumları İşletme Yönetmeliği*, *Resmî Gazete*, 26 November 1973.

Health article 153 and those who had problems in giving birth (hospitals might provide swaddling clothes for the babies of poor and deserving women); those with infectious diseases who had to be quarantined according to the Law of Public Health; those whose need for free treatment had been approved by the MHSA or the highest administrator of the region; the policemen who were subject to the article 89 of the Security General Directorate Law (no. 3201); those who were injured or got sick in forest fires according to the article 71 of the Forestry Law (no. 6831); those who would get in free boarding schools or would be educated with scholarship at the public expense and those subject to article 25 of the Labor Law (no. 1475); those who went to free boarding schools at the public expense; those who were subject to Law no. 1005; those who needed to be cured before conscription; those whose need for free treatment had been confirmed by the MHSA document; those under arrest or convicted who had the above-mentioned document. The same as 1955 regulation, 1973 regulation also gave the right to determine those who would be exempt from payment to the head doctor of the hospital.

What is new in this regulation was the establishment of "social service" in hospitals. The "medical social service" was defined as the economic, social, educational and supportive services that would be provided by social workers to all inpatients with the aim of their benefiting from the treatment in the most effective way, the regulation of the relations of the patient with his/her milieu and family, and the solving of personal and familial problems that the patient would confront after leaving the hospital (article 33). Article 131 defined the task of social workers in social service. Social workers cooperate with the patient's family and milieu in solving the personal and familial problems. If it was necessary, through investigating the socio-economic condition of patients they determined whether the patient would

make contributions towards the costs. They looked for permanent or temporary support for the patients from outside institutions.[699] The situation of poor patients who were not covered by any security scheme will be analyzed in the following chapter.

Like the 1955 regulation, there was a section on the treatment and examination fees of civil servants and insured. Article 62 regulated the procedure for those whose expenses would be covered by the offices and institutions they were bound to. Civil servants and insured workers had to bring a document from the institutions for which they worked and declared that all the expenses of the patient would be paid by them.

This regulation shows us that a separate hospital system was developing in the cities. There is no reference to "socialization," "health posts" or "referral chain," which is an indicator of the rupture between the rural and urban health care systems. As there is no reference to socialization within the text we can say that it applies to every hospital in Turkey, not only those in not-yet-socialized regions. If this was so, it contradicted the regulation on the execution of health service in socialized regions which brought free medical treatment in hospitals to all citizens who were referred from health posts. This system did not work and the hospitals provided free medical care to the members of social security schemes and the deserving poor. Throughout the 1960s and 1970s, the social rights of civil servants, workers, self-employed (they had medical coverage later on, in 1985), and their dependents were regulated and the

[699] For medical social service in Turkey, see Veli Duyan and İshak Aydemir, "Sağlık Alanında Sosyal Hizmet Uzmanlarının Mesleki Çalışmaları." *Sağlık ve Toplum*, Ekim-Aralık, 4(4) (2004): 19-27. In his article on the medical social service practice at Ankara Hospital, Veli Duyan asserts that it is mostly the economic problems that social workers in hospitals usually deal with. The fee of entering the hospital, medicine, supplies, fee of leaving the hospital, and medicine after leaving the hospital constitute major problems for the poor patients. And although their task is defined much wider social workers usually deal with economic problems. For Duyan, the profession of social work is ascribed low prestige in the hospitals.Veli Duyan, "Ankara Hastanesinde Tıbbi Sosyal Hizmet Uygulamaları." *Sağlık Dergisi*, Mart, 65(1) (1993): 85-90.

rules according to which they would benefit from medical services were formulated. The consolidation of this inegalitarian corporatist structure thwarted the development of socialization as a universal system. The right to health care, including all kinds of curative services and medication, of the workers and civil servants were guaranteed by basic laws.

Health Manpower and the Structure of Medical Training

No other component of health services is as important as health manpower. Their quantity, quality, distribution and attitude play an important role in the shaping and functioning of health systems. Even though they do not act as a monolithic bloc, doctors' attitude towards public and private service is very important. Their resistance to becoming civil servants, their reluctance to work in provinces despite the incentives, and their inclination towards specialization partly due to the structure of medical training constituted barriers against the development of an egalitarian health care system.

The Difficulties in Recruiting Health Personnel

The dual-employment of doctors created problems within the health service provision. Doctors working for the state had the right to practice private business. They spent very little time in the public institution and they had to examine too many patients. After their working hours, they accepted patients in their private offices. This was a waste of resource, especially in a period of shortage of doctors. It also was creating ethical problems. The patients who wanted to be taken care of in the

hospital knew that they first had to visit the doctor in his private office and pay money. For hospital facilities, doctors and especially the surgeons moved into a mixed medical practice. Many doctors started their professional work from the slim security of a government position.

This right of dual-employment was one of the reasons behind the unjust geographic distribution of the doctors. As a doctor with private office could earn money in highly populated and relatively developed regions, there occurred a concentration in big cities. Also, cities were more appealing for doctors, who were mostly raised and educated in such places. Their social status was high and they sought for socially, culturally and economically developed environments. Therefore in order to end this unjust distribution and to solve the ethical and economical problems, socialization brought a ban on private practice for the state employed health personnel in socialized regions. Health personnel working for the state would be promoted by high salaries. Three-year contracts which regulated the contractual service fees and the possible placement after the termination of service were signed by the health personnel.

Recruiting the health personnel did not constitute a problem at the outset. The salaries were high[700] and it was guaranteed that they would be placed in a more developed region after the termination of service.[701] However, the State Personnel Law (23 July 1965, no. 657) which was designed by the RPP (and the independents) government but enacted by JP (and NTP, RPNP, NP) government abolished the employment of state personnel with contracts, except on some special occasions.

[700] A monthly compensation of 1.600-2.700 liras was added to the civil servant salary in 1963-64. Usually the wages in regions of multiple deprivations were around three or four times of those in the big cities. A couple would buy a flat in a big city after two years of service.

[701] The high wages of the health personnel disturbed the other government employees, like the military officers and the kaymakams.

Fişek defined this as the most important reason behind the failure of the application of socialization.[702] The abolishing of contracts, however, does not imply a decline in salaries. However, depending on the economic conditions of the country and the financial restraints on socialization, the salaries lost their relative highness.

Another mistake related to the employment of doctors was made by the Minister of Health Yusuf Azizoğlu. He made a visit to Muş in 1963 and appreciated the practice there: "It is excellent that government doctors do not have private practice. Our friends spend all their time on public service. Let's expand this everywhere. Let's enact a law. Let's apply this system to those who demand it in the West".[703] Fişek warned him that such an attempt would harm socialization. If the doctors in the East earned the same amount as those in the West, they would have no reason to work in the East and involve in the system.[704] Despite Fişek's opposition, Azizoğlu prepared a draft bill. It was enacted two years later by the JP (and NTP, RPNP, NP) government. This full-time law (no. 641), which was applied in the training hospitals (11 hospitals in three big cities) of the MHSA, had a negative effect on the geographic distribution of health personnel. The specialists were given extra allowances that were nearly three times of their salaries. The chiefs and assistant chiefs of the training hospitals were allowed to conduct private practice in the hospitals after 16:00. Seventy percent of the charges would be transferred to the doctors. This led to the concentration of examinations and treatments, even the operations, outside of the working hours. The full-time principle was degenerated.[705]

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[702] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 60.

[703] Cited in Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları 3*, p. 144.

[704] Ibid., p. 144.

[705] Tonguç Görker, "Tam Gün Yasası Zorunlu." *Hekimden Hekime (Ankara Tabip Odası Dergisi)*, Nisan-Mayıs-Haziran, http://www.ato.org.tr/dergi/1999_2/dosya3.html (1999) (December 2007), pp. 1-2. In the First General Assembly on the Socialization of Health Services former Minister of HSA

Fişek traced the historical roots of this reaction against becoming civil servants: The involvement of the government in health services started with the 1871 regulation on health. In accordance with this regulation country doctors were appointed. Doctors started to receive salaries from the state in return for examining poor patients free of charge. In time, they were charged with additional tasks but the doctors never considered themselves to be civil servants and this created problems in their attitudes towards state service.[706] Although Fişek detected the traces of this reaction in late Ottoman period, it was not peculiar to Turkey. Everywhere doctors enjoyed considerable power and tried to preserve their professional autonomy. They were in a key position regarding the allocation of health care resources. As mentioned in the second chapter, British Minister of Health Aneurin Bevan, while establishing the NHS, had to pay a significant amount to hospital doctors although they kept their privilege of treating private patients. Considering the reaction of doctors against being civil servants, the socialization treated them not as civil servants but as self-employed professionals who would be taken into service on

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Fahrettin Kerim Gökay criticizes this full-time practice on the grounds that it closed the doors of hospitals to the poor. Efforts were made to meet the overtime premiums of the doctors from the revolving funds, which in turn led to the refusal of poor patients. Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetleri'nin Sosyalleştirilmesi Tatbikatı, 1inci Genel Kurulu*, pp. 82-83.

[706] Türk Tabipleri Birliği Merkez Konseyi, *Türk Hekiminin Dünü, Bugünü, Yarını*, p. 81. "In Turkey, doctors today define their work as a liberal profession, whether or not they are civil servants. This has a traditional background. In Turkey, the involvement of the government in health services began with the code of general health management of 1871. This code introduced the practice of 'country doctors.' These doctors received salaries from the government in return for their service to the poor, and they became servants of the state in this way. And in time, they were assigned other tasks too on the grounds that they received salaries. But the doctors never considered themselves to be civil servants despite the fact that they were paid by the state, and this psychology led to certain problems in their attitude towards service to the state." (*Türkiye'de bugün hekim, memur olsa da olmasa da, kendisini serbest meslek sahibi addeder. Bunun bir geleneksel sebebi vardır. Türkiye'de hükümetin sivil idarede sağlık hizmetlerine karışması 1871 senesinde neşredilen idareî umumiyeî sıhhiye nizamnamesi ile başlar. Bu nizamnameye göre memleket tabipleri ihdas edilmiştir. Hekimler bu nizamname ile fakir hastalara bakmak üzere devletten maaş almışlar ve devlet hizmetine böyle girmişlerdir. Zamanla para veriliyor diye başka vazifeler de yüklenmiştir bu hekimlere. Fakat hekim devletten para aldığı halde hiçbir zaman kendini memur olarak görmemiş ve bu psikolojik etkinin altında devlet hizmetine karşı tutumunda aksaklıklar olmuştur.*)

contract. First the contract system was abolished then the salaries lost their relative highness, which left the system with the problem of staff shortage.

When Muş was socialized 12 specialists went there on their own will, then to Bitlis, Ağrı and Van. They went there although it was not compulsory. The doctors working in the socialized regions were assured that after the termination of three-year contracts they would have the privilege to be placed in the next socialized region. In this way, a young specialist would have the chance to be placed in İstanbul in 15 years time. Fişek recognized that this assurance was important in convincing the doctors to work in the East especially, when he faced the complaints of the doctors who were not placed in the West after the end of three years. A neurologist working in Muş visited him and said "You told us that we would be placed in the following socialized regions. I applied for my appointment to Malatya but they did not approve it. The undersecretary of MHSA rejected my request by asking how he could find a neurologist for Muş." Fişek shared this as an example of the disrespect of the MHSA towards its own personnel.[707] For example, Oryal Gökdemir was sent to the health post in Bitlis Adilcevaz Arin with the guarantee that he would enter specialization wherever he wanted after three years of service. The same bureaucrat in the Ministry who gave him this guarantee made things difficult when he wanted a formal approval to start specialization in the university.[708] Such stories ruined doctors' trust in the MHSA. Doğan Benli was the last head of department of socialization within the MHSA. He resigned from office because he could not stand the Minister's arbitrary decisions of appointment. Doctors and ancillary health

[707] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları 3*, p. 143.

[708] Gökdemir, p. 12.

personnel with serious connections were appointed not to the places they were needed most but to the places they wanted.[709]

The underlying factor of the lack of human resource in the socialized regions was not the scarcity of doctors, but their unbalanced distribution. Fişek opposed those who find the application of socialization unrealistic with respect to the existing amount of health personnel:

> In the Etimesgut region eight health post doctors serve a population of 56,000. As the population of Turkey is 35 million today [1976], if all the health posts required are opened we need 4800 doctors and 3200 of them would work in the villages. According to the 1970 fiscal year report of the MHSA, in Turkey more than 15,000 doctors practice their profession. And the numbers of graduates from the faculties of medicine is 700-800 annually.[710]

He repeated his objection in another article: "if you provide a doctor for a population of 7000 in rural areas and 5000 in cities, the required number of doctors in villages and cities would be 7000. In 1976, the number of doctors in Turkey was 22,943."[711] So, the problem was not scarcity, but the unbalanced distribution, as revealed in Table 28.

The resistance of doctors with private practices was decisive in the "failure" of socialization. Fişek put the blame on doctors with private practices and advantageous groups in society. The former were afraid to lose their earnings although they worked in public sector health institutions. The socialization of health services would hinder their earnings. People would go to health posts and hospitals instead of these private offices. If they chose to work within the socialization

[709] Benli, interview by the author.

[710] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 89.

[711] Ibid., p. 135.

program then they had to close their private offices. The expansion of preventive care and health care delivery through public institutions was a threat to the private sector. The latter group was composed of those who were used to benefitting from the public sector health institutions easily through their social or economic status. They could not accept waiting with others for an examination or staying in hospital.[712] Fişek himself witnessed the complaints of advantageous groups: "Before, the doctor was coming to us, now we are waiting together with the people." Another group which was criticized by Fişek was the specialists in socialized regions as they did not work in collaboration with the health post doctors.[713]

A General Picture of Health Manpower in the Early 1960s

Health manpower has always been a problem in the provision of health services in Turkey. Whether the number of doctors is sufficient or not is questionable but the problem of distribution has always been obvious. One of the reasons for the "failure" of socialization is the rejection of doctors to be employed in regions of multiple deprivation. When the salaries for health personnel in socialized regions lost their comparatively high status due to the improvement in salaries in the MHSA training hospitals, SII and SEE hospitals which were usually located in city and town centers, a personnel shortage occurred. Of course, it was not only the pecuniary factors that

[712] Ibid., p. 29; Fişek, Nusret. "Sağlık İdaresinde Modern Eğilimler." In *20. Milli Türk Tıp Kongresi, 23-27 Eylül 1968, İstanbul* (İstanbul: Çelikcilt Matbaası, 1968), p. 10.

[713] A patient had to be referred from a health post with a form (019) filled out by the health post doctor. After seeing the patient the specialist in the hospital was to control the form and send it back to the health post doctor. In this way, the health post doctor would learn whether his diagnosis had been right or wrong. But the specialists did not give importance to this practice. Also, the monthly meetings of health post doctors and specialists could not be arranged.

determined the decisions of the doctors. The working and living conditions in the socialized regions also played an important role. Furthermore, the quality of medical training did not encourage young medical graduates to undertake responsibilities in rural health services. All these factors were analyzed in detail in the Turkish Health Manpower Study, which was conducted by the Ankara School of Public Health under the MHSA of Turkey and the Division of International Health of the School of Hygiene and Public Health of the Johns Hopkins University starting from July 1963.[714] It presents a picture of health manpower in Turkey in the early 1960s. As the research was conducted after the initializing of socialization it contains valuable information on the application of socialization and its manpower dimension.

The research states the number of available doctors for 1963 was 10,027.[715] The distribution of Turkish doctors and population by region is also provided for the year 1964 which reveals the regional inequalities.[716] The researchers sent questionnaires to all the doctors they could reach and from the 7,418 respondents to questionnaires 1,944 (26.2%) were general practitioners, 4,542 (61.2%) were specialists, and 910 (12.3%) were in specialty training. This reveals the trend toward specialization.[717] So, the unjust distribution was not only between the rural and the

[714] Carl E. Taylor, Rahmi Dirican and Kurt W. Deuschle, *Health Manpower Planning in Turkey: An International Research Case Study* (Baltimore, Maryland: The Johns Hopkins Press, 1968).

[715] Ibid., p.36.

[716] The number of doctors was 3,948 in Turkey in Europe, 555 in Black Sea Coast, 1,462 in Marmara and Aegean Sea Coasts, 473 in Mediterranean Sea Coast, 391 in West Anatolia, 2,561 in Central Anatolia, 159 in Southeast Anatolia and 451 in East Anatolia. Number of persons per doctor was 3,063 in total while it was 761 in Turkey in Europe, 8,841 in Black Sea Coast, 3,373 in Marmara and Aegean Sea Coast, 2,965 in Central Anatolia, and 8,749 in East Anatolia (ibid., p. 38).

[717] Unfortunately this inbalance persisted. According to the Health Sector Expertise Commission Report of the Fourth Five Year Plan (1978-82), 36% of doctors worked in İstanbul, while 46% in 15 big cities, and 18% in the remaining 51 cities. There was an imbalance between the specialists and general practitioners. Including assistants 72% of the doctors were specialists. The number of specialists (12,400) exceeded the necessary amount (7,350).

urban districts or the East and the West, but also between the specialists and the general practitioners.[718]

According to the research almost two-thirds of all doctors in Turkey were located in the three metropolitan areas. An additional one-fourth were in smaller cities and only one-eighth were in villages and towns. Only 5% of the total population lived in the three big cities where 61% of the doctors worked.[719] If the doctor had received a medical scholarship, he was more apt to be practicing in a rural community.[720] The distribution of specialists was even more biased toward metropolitan areas.[721]

The problem of human resources was not limited to doctors. The need to increase the number of auxiliary health personnel was always on the agenda. No other category of health personnel was in shorter supply than trained nurses. There were at least five doctors for every registered nurse. Even in the better hospitals, direct patient care was provided mainly by patient helpers who have had little or no education, and only on-the-job training. The costly scientific education of doctors was often wasted because they must supervise patient care provided by auxiliaries, undertake nursing care of the critically ill and deal with details of nursing administration.[722] As the doctors in state hospitals went to their private offices after 14:00 nurses had to take heavy responsibilities for decisions regarding patient care. Long hours of work, unclearly defined responsibilities, and the low prestige attributed to nursing prevented the graduates of nursing schools from practicing their

[718] See Table 29 for the number and percentages in total number of doctors of specialists and general practitioners in Turkey between 1950 and 2002.

[719] Taylor, Dirican and Deuschle, p. 51.

[720] Ibid., p. 52.

[721] Ibid., p. 53.

profession. That was why in the last four decades the handful of active nurses per 100,000 population had only doubled while the number of nursing schools increased 12-fold and the average number of female nurses graduating annually increased eight-fold.[723]

The doctors also were asked about the socialization program. The overwhelming majority of doctors in the sample approved the plan for the socialization of health services. 69% were entirely in accord and 16% were at least partly in favor of the plan.[724] Among those 245 doctors who were against or partly in favor, 31 felt it might put an end to private practice, 48 found the salary insufficient, 15 objected to the harsh working conditions, eight felt that special skills would be lost, and four objected to the specified obligatory period.[725]

In the research the attitudes of Turkish doctors towards rural service were also analyzed. Doctors generally did not prefer to work in rural areas and they had many good reasons for it. A rank order of factors having unfavorable influence on doctors' attitudes towards rural health units is given in Table 30.[726] The table reveals that not only professional factors but also social and financial ones contributed to the negative attitude towards rural service. Tests were conducted to measure the altruistic and humanitarian feelings of doctors from different groups in the table and those in the socialization program ranked highest.[727]

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[722] Ibid., p. 127.

[723] Ibid., p. 157.

[724] Ibid., p. 57.

[725] Ibid.

[726] Ibid., p. 92-93.

[727] Ibid., p. 104.

In the early 1960s there was a growing dissatisfaction among the doctors which was mostly due to economic considerations. The median monthly income for all doctors was 2381 ($ 264) for the year 1964. A doctor's starting salary was 675 TL/month ($ 75). After 30 years of service this amount was 2900 TL/month ($ 322). The UN estimate was that the average Turkish wage earner received an income of 420 TL per month in 1964 for a six-day week.[728] The doctors in the sample survey were asked to indicate what they considered a reasonable minimum income and what they indicated was three and four times the present government scale. This was consistent with the 1963 experience in recruitment for the socialization program. "The salary was four to five times the government standards and doctors applied in adequate numbers even though the assignments were in primitive rural areas."[729] However, these high standards could not be maintained and it became much more difficult to employ doctors in socialized regions.

An important claim of this report was that the main point of focus should be not increasing the number of doctors, but rather improving their utilization, altering their distribution to equalize care for all population segments, improving the conditions of practice, relieving the doctors' present financial insecurity, and ameliorating other negative factors affecting their morale.[730] Also not the opening of new medical schools but improving the utilization and output of the existing ones was suggested.[731]

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[728] Ibid., p. 47-48.

[729] Ibid., p. 49.

[730] Ibid., p. 274.

[731] Ibid., p. 279. There has always been a debate whether the number of doctors is sufficient or not. In early 1960s the existing number was found to be sufficient to apply the program of socialization. Erder, interview by the author; Taylor, Dirican and Deuschle, p. 259.

The latest debate on this problem increased the tension between the Justice and Development Party government and the TMA. JDP government adopted a law in February 2007 which provided the

Since the establishment of the MHSA, one of the main objectives has been to increase the number of health personnel, especially the doctors. With the formation of the SPO, this was going to be achieved within a certain plan.[732] Although there is an improvement in the number of doctors and other health personnel as already seen in Tables 8 and 9, the unjust geographic distribution has persisted.[733]

The Full-time Law of 1978

The persistence of this unbalanced distribution and dual employment of doctors created problems within the health system. Governments had been searching for methods that would convince doctors to work for state institutions in places where they were needed most. A radical step was taken in 1978 when Ecevit was in power. The Law on the Principles of the Full-Time Work of the Health Personnel[734] was enacted to make doctors spend all their energy and time in public service. In the current situation patients lost their trust in doctors who expected them to visit their private office before going to the hospital. This law would end such confrontations

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opportunity for foreign doctors to be employed in Turkey. President Sezer sent back the law to the parliament and the JDP had to omit the article on "import doctors." The government does not find the existing number of doctors (105,000) sufficient and emphasizes the rank of Turkey among 53 WHO member countries in its region. In WHO Europe region countries, the number of doctors per 100,000 population is 338 while it is 149 in Turkey. Turkey is at 52nd tier among 53 countries. The TMA opposes this criteria as it does not take into account the application frequency of people to the doctor which is low in Turkey. For TMA, the aim of the government is to develop cheap labor power for health market and to create reserve army of unemployed doctors.

[732] Güven Özdem, "Türkiye'de Planlı Dönem Boyunca (1963-2000) Doktor ve Tıp Fakültesi Öğrenci Sayılarında Gelişmeler." *Toplum ve Hekim*, 20(5) (2005): 372-380.

[733] See Table 31 for the number of doctors and population per doctor in health regions in 1966 and 2000.

[734] *Sağlık Personelinin Tam Süre Çalışma Esaslarına Dair Kanun*, no. 2162, *Resmî Gazete*, 9 July 1978.

and the professional dignity of doctors would be protected. The patients would not have to queue up in the hospitals. The traffic in personnel would slow down.[735]

The undersecretary of the MHSA Tonguç Görker was the architect of this law. He invited assistant general director of the SII Engin Tonguç to discuss the proposal. Görker explained the main goals of the MHSA to Tonguç as follows:

> The Full-time Law was the first law of a set of laws to regulate health services. With this law the working conditions and the wage system would be improved, all the work of doctors would be utilized in public institutions, the hospital-private office relation would end. (…) The MHSA would be reorganized, the number of general directorates would be decreased, the MHSA would be responsible only from preventive care, all the public sector health institutions except those of Ministry of Defense and the universities would be integrated, and they would be governed by a new semi-autonomous general directorate which has health departments of SII at its core.[736]

Before coming to the other steps they fluffed at the first one.

Although this law brought some improvements, like the increase in the working hours of health personnel, efficiency in hospitals, placement of doctors to health posts (doctor occupancy rate rose from 30 to 90) and to hospitals in undeveloped regions, a better order in attendance and emergency services, the efficiency in use of health personnel and a rise in the status of general practitioners, it was not applied in the proper sense.[737] The party in power was alarmed when some problems appeared, like the resignation of specialists from state hospitals. Of course some doctors were going to choose private business. But this problem could be solved by appointing new doctors. However, fearing to lose votes the RPP did not

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[735] Nevzat Eren, "Tam Gün Yasası ile Yaşananlar." *Hekimden Hekime (Ankara Tabip Odası Dergisi)*, Nisan-Mayıs-Haziran, http://www.ato.org.tr/dergi/1999_1/tamgun.html (1999) (December 2007), p. 1.

[736] Engin Tonguç, *Bir Tutam Umut İçin: SSK Anıları*, 2nd ed. (Ankara: Güldikeni Yayınları, 1999), pp. 64-65.

[737] Görker, p. 3.

apply the law in the proper sense. The Minister of HSA, who had made fervid speeches about the full-time law (like the one he did in the Second General Assembly of the Socialization of Health Services), shifted his position. The government was not determined enough to apply such a big reform in a period marked by economic problems.[738] Also the opposition of the deans of the medicine faculties and dual-employed doctors was decisive. The government changed and the JP came to power. The Minister of HSA Münif İslamoğlu was against the law and let the doctors to work both in private and public. The law was abolished later, however, by the coup of 1980.

The Incompatibility of the Medical Training with the Socialization

The education given in faculties of medicine was also a barrier to the socialization. Students were trained to become doctors in hospitals and private offices. After six years of education in faculty hospitals with advanced technological facilities and with a focus on curative services they could not be satisfied in the limited environment of the health posts. They could not be satisfied with saving the lives of hundreds of children through vaccination or curing their pneumonia and diarrhea. Fişek talked about a bitter letter from a general practitioner from a health post of a village in Van. As the roads were closed they could not take a patient to hospital. They could not make the appendectomy there and the patient died. The doctor asked Fişek whether they had sent doctors there to watch the patients die. Fişek wrote him back and asked whether he thought how many lives he had saved by being there. He visited him in the health post and repeated the same question. The doctor said if he

[738] Tonguç, p. 85.

had not been there 30-40 patients would have died. Fişek then asked whether his cardiology professor could save 30-40 patients in a year.[739]

This story reflects the mentality of doctors towards primary care. They did not attach value to being general practitioners and wanted to be specialists and this led to the high proportion of specialists to practitioners.[740] So, the problem with doctors could not be solved only by increasing their salaries. It was not only pecuniary interests but also professional considerations which determined their choices. According to a study conducted among health post doctors, practitioners wanted to become specialists because they wanted to increase their level of knowledge and their level of income, they liked the area in which they wanted to specialize, they did not want to live in small towns and the prestige of being a specialist was higher.[741] This research refers to former researches conducted in various years (1964, 1977, 1978)[742] which reveal that the majority of health post doctors thought that the education they had received was not sufficient to serve at the health posts.[743] This research itself reaches similar conclusions. The Faculties of

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[739] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, p. 68.

[740] Nusret Fişek, *Nusret Fişek ve Hekimlik* (Ankara: TTB, 1991), p. 65. In his memoirs *Arin Mektupları*, Oryal Gökdemir describes the difficulties he faced in providing the environmental hygiene in the village. Sometimes he had a feeling of absurdity but he accepted that after the establishment of the health post many epidemics like measles were prevented and together with other health personnel they saved the lives of hundreds of children in year. Oryal Gökdemir, pp. 38, 54. He was 24 when he left home to work in Eastern Anatolia in the region of Socialization of Health Services. He writes that this expression affected him as if socialism was on the way to Turkey (ibid., p. 7). Complaints of the health post doctors and their unwillingness to work in the socialized regions were heard much more. But of course there were thousands of doctors who worked with great enthusiasm. Public health specialist Zafer Öztek explained that as health post doctors they were competing among themselves to improve health status indicators, like a fall in the infant mortality rate, in their regions. Öztek, interview by the author, March 2006.

[741] Polat, Koçoğlu, Özgür and Koçoğlu, p. 51.

[740] A study by Nusret Fişek and Uğur Cilasun (1987) might be added: Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları 3*, pp. 35-45.

[743] Polat, Koçoğlu, Özgür and Koçoğlu, p. 49.

Medicine did not prepare their students even in primary care. Students felt they would acquire real practice if they chose specialisation.

Throughout the 1960s and 70s nearly in all discussions related with health policy, the need to change the medical training in accordance with the needs of the country was mentioned. The structure of medical training which equipped students for curative services in secondary and tertiary care institutions and not for preventive care was criticized. In addition, the education for curative services did not prepare the students to practice medicine immediately upon graduation. Insufficient practical training made them lack confidence. This feeling of inadequacy was one of the reasons behind the choice of specialization. The other was the poor condition of primary care institutions.

When the Health Manpower Study was conducted, there were four faculties of medicine (İstanbul, Ankara, Ege, Hacettepe). At that time, the pattern of medical training in Turkey was still strongly influenced by the German educational system of the past century.[744] That didactic system was compatible with the relatively static medical knowledge, but it started to have serious limitations after the changes in medical knowledge: innovative and research thinking would stagnate; theoretical learning would predominate; the students did not have the chance to practice.[745] So, to meet modern demands specific changes in medical education were required: the emphasis should be on what is practical and convenient in medical practice; the premedical and preclinical elements of medical training should include basic sciences which were devoted especially to understanding groups rather than concentrating only on individuals; clinical preparation must focus on the whole

[744] Taylor, Dirican and Deuschle, p. 124.

[745] Ibid., p. 124.

patient; rural teaching should emphasize the team approach and show how a doctor could expand his capacity for service by working through auxiliaries; and permeating the new approach to medical education should be a much greater emphasis on preventive services.[746]

The researchers appreciated the experiments in some institutions and departments. They probably refer to the community medicine approach that Fişek tried to implement at Hacettepe University. Unfortunately, this approach did not last long and Hacettepe did not train general practitioners despite its initial commitment. Many faculties of medicine was established between 1963 and 1980 (Trakya, Gazi, On Dokuz Mayıs, Fırat, Cerrahpaşa, Karadeniz Teknik, Dicle, Cumhuriyet, Çukurova, Erciyes, Uludağ, Atatürk, Akdeniz), but the problem of the dominance of curative medicine persisted. In some universities community medicine institutions were established and protocols were signed with the MHSA to apply socialization program and to provide opportunities of practice to the students in health research and training districts.[747] Medical students learned community medicine there, but its application remained restricted to those districts.

Today, the medical education paradigm is accused of surrendering to the biomedical perspective of medical science.[748] The basic sciences are taught without relating them to clinical practices, and clinical practices are taught without relating them to basic health problems of the country. The medical science is improving at an abnormal speed and becoming more and more technical and expensive. The medical training which adapted itself to this development has lost its humanitarian

[746] Ibid., p. 125-6.

[747] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesi ile İlgili Kanun*.

[748] Cem Terzi, *Toplum Sağlığına Bir Köprü: Tıp Eğitimi* (İstanbul: İletişim Yayınları, 2001).

perspective.[749] Although it is obvious that preventing an illness is much cheaper than curing it, medical science and medical education are conditioned on curing, because curing illnesses is much more "profitable" than preventing them. The faculties of medicine reflect their choice of curative medicine in their curriculums.[750] Terzi proposes a change in medical training in accordance with the needs of society. Such a change requires the permeation of public health, medical ethics, social sciences and health policies into the medical training. Otherwise, it will not be possible to train good doctors and combat the inequalities in health.

As there has not been that much change in the proposals made in the 1960s and 2000s, we can conclude that there has not been that much change in the general structure of medical training. Two months of public health internship and some theoretical courses in the third and fourth classes are not enough to change the whole structure.

Fişek defended the "community medicine" approach, which is based on preventive and primary care, and criticized the "traditional" one. In community medicine, an individual is not isolated from his physical, biological or social environment. Health services should be brought to everyone. People should be served not only when they are ill, but also when they are healthy. Preventive care, treatment and rehabilitation are integral components of the service. Preventive care is prioritized. The causes of illnesses are viewed to be both biological and social. Limited resources are used in protecting people from the widely seen and highly damaging illnesses. In traditional medicine, however, an individual who is served is the one who goes to a private office or the hospital. Health services are provided to

[749] Ibid., p. 11.

[750] Ibid., p. 21.

those who apply to health institutions. People are served only when they are ill. Service is composed of treatment and rehabilitation. Preventive care has a limited application. The reasons for illnesses are viewed to be only biological. High-quality personnel are trained and high-technology is provided to cure the illnesses which are difficult to diagnose and treat.[751] However, the community medicine approach was unable to predominate in the universities or in the health bureaucracy and the governments spent their resources in establishing new hospitals rather than bringing health services to all.

Financial Problems and the Attempts to Establish General Health Insurance

The financial feasibility of the socialization of health services was not analyzed at the beginning and the resources of the program were not clarified in the law text. There was a proposal of collecting premiums from the people living in socialized regions but this was removed from the text with the intervention of an official from the Ministry of Finance. However, removal of the term "premium" from the text was forgotten. There was not a clear statement that all the expenses related to the socialization of health services would be met from the general budget. Throughout the 1960s and 1970s the financial feasibility of the socialization was questioned. Fişek had to struggle against the accusations that the financial resources of the country could not meet the program. He complained about the attitude of the officials from the Ministry of Finance who did not want to allocate the required amount to the MHSA.

[751] Fişek, *Halk Sağlığına Giriş*, p. 47.

When he was the undersecretary of MHSA he had to convince the Minister of Finance for the current budget. The consolidated budget was composed of investment, current budget, and transfers. The investments were planned by the SPO while the others were planned by the Ministry of Finance. In the beginning, the SPO allocated the necessary amount for investments, like the construction of health stations and health posts, but the Ministry of Finance did not for the operating of the program. Health posts were established with the money planned by the SPO (investment), but their annual expenses like salaries, equipment and drugs (current budget) were not provided by the Ministry of Finance. Foreseeing the resistance of the officials from the Ministry of Finance, Fişek put the current budget of MHSA in the First Development Plan although it was not the task of the SPO.[752] When ninth İnönü government was in power Fişek had to convince Ministry of Finance Ferit Melen for the current budget. The officials from the Ministry of Finance criticized the existence of current budget in the plan as the SPO did not have the right to determine the current budget. In the meeting of the Council of Ministers on the MHSA budget, Fişek tried to convince the bureaucrats from the Ministry of Finance and the ministers that money was required to operate the investments otherwise there was no need to make investments. He proposed the transfer of money from investments to the current budget. Ekrem Alican rejected this as the investment budget had a balance and requested from the Ministry of Finance to allocate money. Then the other ministers convinced Melen to allocate 10 million, and an additional allowance during the course of the year. Although the Minister of HSA Fahrettin

[752] In the Health Sector Expertise Commission Report of the First Five Year Plan, there is a table of current budget health expenses for the MHSA (health posts, malaria eradication, tuberculosis combat, trachoma combat, leprosy combat, public health institutes, occupational health dispensaries, depots and maintenance halls, hospitals), Labor Insurance Institution, and other public institutions for the years 1963, 1964, 1965, 1966, 1967, 1963-67 total, 1972 and 1977. Devlet Planlama Teşkilatı, *1963-1967 Planı Hazırlık Çalışmaları*, p. 63.

Kerim Gökay accepted this, Nusret Fişek did not as he was sure that the additional allowance would not be allocated. He turned out to be right. Fişek relates this story in response to the questions on the main difficulties the socialization program had to confront.[753] He clearly states that the main reason for the "failure" (*yürümemesi*) of socialization was the limits put by the Ministry of Finance on the expenses. This struggle on the current budget between MHSA and the Ministry of Finance continued at least when Fişek was the undersecretary of the MHSA between 1960-66 with intervals.

The financial feasability of the socialization program was not analyzed in detail while the law was being prepared, but later on the School of Public Health conducted a study on the expenses and the financing in relation to the projected government budgets.[754] The first section on the expenses necessary for the socialization of health services and the financing of the program was written by Nusret Fişek and an expert from the Planning and Coordination Department, Rıza Köksoy, while the second section on the projected government budgets between 1965-77 was written by Aslan Başer. In the preface, the Minister of HSA Kemal Demir explained the reason for conducting such a study as the need to answer the criticisms related with the financial feasability of the socialization program. In the negotiations of the 1964 budget in the parliament and the senate, socialization was approved as an ideal plan for Turkey especially with its role in bringing health services to the villages. However, there were doubts as to whether the application of the program was beyond the financial capacity of the governments.

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[753] Türk Tabipleri Birliği Merkez Konseyi, *Söyleşilerle Sosyalleştirme Yasasının Öyküsü*, pp. 20-21; 62-63.

[754] Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesinin Gerektirdiği Harcamalar ve Program Finansmanı* (Ankara: SSYB, Hıfzıssıhha Okulu Yayınlarından, no. 14, 1964).

The study thus was a response to the objections of the members of the parliament and the intellectuals. Demir summarized the findings as follows: To accomplish the socialization program in 15 years 6% of the budget needed to be allocated to health expenses including the investments. Currently 4% was allocated, but in the following years the income budget would rise and some important expenses would keep firm, allowing for the allocation. Both in developed and undeveloped countries 8-20% of the budget was allocated to health expenses. The concurrent development of social insurance in 15 years would be the guarantee of the improvement of the program.[755] Although he mentions insurance the report is based on projections of general budget.

In the first section of the report there was reference to the First Five Year Development Plan where the socialization program was viewed as possible. Now as there were data for the years 1963 and 1964, the projections would be much more reliable. They used three different methods in the projection of the government budget: one based on the GNP increase in forecast; one based on the projection of government expenses; and one based on the assumption that in comparison to the development level the government budgets would rise by 10% every year. They forecast three different budgets based on the three different methods for the years 1965-77.

These projections were detailed in the second section of the report. In that section, projections were made with the assumptions that the GNP would rise by 7%, the birth rate would fall, and the connections between the budget and the public sector would not change.[756] Fişek and Köksoy took the amount reached through the

[755] Ibid., p. 3.

[756] The possible maximum amount of health expenditures for socialization based on 1962 prices, for the years 1965-1977, is given in a table (ibid., pp.52-53).

first method (33 billion liras for 1977) as the most reliable one and used it in the projections for health expenses. If 6% of the government budget was allocated to the MHSA the socialization program could be financed by the state without resorting to supplementary resources. Other countries allocated more than this. For example, the share of health is 10.7% in Israel, which had to allocate a large amount for its defense expenses like Turkey, 20.4 in Sweden, and 15.4 in Ceylon.[757] Those who did not find the socialization financially feasible expected a level of service as in England and Sweden. Fişek and Köksoy opposed this expectation as the aim was not to reach their level in 15 years time. This was not possible because in those countries the number of health personnel and their wages were much higher like the number of hospital beds; also all the medicine, drugs and prostheses were free of charge. Turkey could not reach their level in 15 years time but there would be a great improvement in the health services if 6% of the budget was allocated for the application of the socialization program.[758]

Fişek and Köksoy presented their budget projections with tables and charts (see Tables 32 and 33). The report was very detailed and all the expenses were calculated one by one. The numbers, locations and dates of establishment of health posts, tuberculosis dispensaries, public health institutes, depots and maintenance halls, health schools, health museums, rehabilitation centers, day nurseries, maternal health centers and branches; the numbers and locations of hospital beds to be put into service; and the numbers and locations of government doctor offices and nursing homes (*bakımevi*) to be closed were all projected for every year between 1963 an

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[757] Ibid., pp. 10-11.

[758] Ibid., p. 11-12.

1977 (see Tables 34 and 35 for the health post and hospital program of 15 years).[759] And the standard costs and expenditures of all these health services were projected in detail. So, the costs of both the establishment of the institutes and programs and their operating were taken into account. However, factors like progress in medicine, the trend towards hospital services, and the rise in life expectancy were not taken into account, which would determine the debates on financial resources. The share of the MHSA in general budget was insufficient to reach the required level and the resources allocated for socialization diminished.[760]

In various articles Fişek repeated the argument that with a slight increase in the share of health in general budget it would be possible to operate an efficient health system in the whole country.[761] He wrote:

> In Etimesgut Training Region the average per capita health expenditure was 26 liras. Considering this, when health services are socialized everywhere and all the required vehicles and personnel are provided the total expenditure of health posts would be 910 liras. In our country, the 1969 health expenditure of the public sector - including the hospitals- is 1.5 billion liras. And the 900 million liras of it is derived from the MHSA budget. In this case, (…) by increasing the share of the MHSA budget from 3.9 to 5.9 it would be possible to

[759] When we compare the number of health posts in the program with the actual situation we see that in the initial phases they were very close. In 1965 projected one was 443 while the actual was 416. But in 1970, projected one is 1558 while the actual is 851, and in 1975 these numbers are 2865 and 995 respectively. This reveals the rising discrepancy in the projected objectives and the actual achievements. The aim of socializing the whole country in 15 years time could not be accomplished either. It took 21 years to expand the program to the whole country.

[760] According to the Health Sector Expertise Commission Report of the Third Five Year Plan (1973-77), the distribution of the MHSA budget among the directorates was given in which the biggest share was that of General Directorate of Curative Services. While it took 38.29% of the budget the Department of Socialization took only 11.61%. So, increasing the share of the MHSA in the general budget would not be enough. The distribution within the MHSA was also important.

[761] He believed in the feasibility of the socialization because health services were not that expensive then. The change in the widely seen illnesses due to the rise in life expectancy escalated the costs. There was an epidemiological turn in the middle of the twentieth century. In the developed industrialized countries chronic illnesses like cancer, kidney failure and heart disease replaced the epidemics and acute illnesses and this increased the demand for more expensive secondary and tertiary care institutions. Developing countries like Turkey did not complete the epidemiological turn and chronic illnesses can still be seen together with epidemics.

> establish an organization and provide health care as in Etimesgut region.[762]

But the governments did not show the political will to expand the share of health in the general budget and finance the primary care. Yet, health expenditures rose continuously due to the rise in population, the proportion of urban population, population covered by a security scheme, and expectations of people, and the developments in health technologies and medication. The per capita real health expenditure in lira was 17.33 in 1965, 27.27 in 1975 and 24.62 in 1983, with 1983 prices.[763] The need to find additional resources led the politicians to formulate bills of General Health Insurance.

Starting from the People Sickness Insurance bill (*Halk Hastalık Sigortası Kanunu Teklifi*) prepared by Reşit Ülker and introduced to the assembly when Demirel was in power on 26 April 1970, there were serious attempts to establish general health insurance in Turkey. Various bills I found in the archives of the Turkish Grand National Assembly that were introduced between the years 1970-76 were not even discussed in the General Assembly. These bills aimed to find resources for the health expenditures, but also to expand the coverage to the whole population. In the legal grounds of these bills it was stated that a "welfare state" (*sosyal devlet*) was obliged to provide health care to all, not only to the insured, who constituted around 25% of the whole population at that time. This could be accomplished only with the contributions of the people. Except the needy, everybody should pay a certain amount of their monthly incomes (%3 in one, %4 in others) as health premiums. The socialization of health services aimed to cover the whole population and provide them basic health care. But it could not be applied in the

[762] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 90.
[763] Gürsoy, p. 1726. See Table 3 for per capita health expenditure; Turkish data is available from 1975 onwards.

proper sense due to various reasons and there occurred the need to establish a general health insurance. However, the political instabilities and the low level of per capita GNP made the enacting of the law impossible.[764]

While these bills were on the agenda Fişek expressed his objections in various articles: When insurance was extended to a wider population, those who were outside the system would receive less health care; people who were paying premiums would benefit more from the health service which would increase the expenditures; a health insurance system which had established its own health organization would undermine preventive care. He thought insurance could not be applied in underdeveloped countries like Turkey as it was costly and required more health personnel to serve the insured. Those who were covered would use the existing resources more, which would leave those excluded much more deprived. This was exactly the case in Turkey; the SII was employing a significant number of doctors.[765] Fişek referred to those excluded from the system as the bills promoted a gradual expansion.

The discussions of that period show that the need for people's contribution to health was widely accepted. It was usually claimed that the state could not carry all the burden of health service delivery, particularly the curative services and medicine. More than any other social policy field, health care provision was seen as an important task of the state that could not be left to the commercial sector or to the charities. Health is very important for feeling secure and it is a subject which cannot be dealt with personally. So, at least until the 1980s, health service delivery was seen

[764] In a meeting Zafer Öztek asked Demirel why they could not apply GHI and he answered, "You cannot collect premiums in a country where per capita GNP is below 5,000 dollars. I realized this and retracted the bill" (Öztek, interview by the author, March 2006).

[765] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, pp. 151-159; Fişek, *Halk Sağlığına Giriş*, pp. 145-147.

as the task of the state but its financial resource has always been controversial. At the discursive level, the need to cover the whole population was accepted but in practice only the members of the SII, the Government Employees Retirement Fund (est. 1949) and Bağ-Kur (est. 1971; health insurance was applied from 1985 onwards) could be covered.

The Association of the Program with the East

Although the peasants in the villages were very pleased to have doctors, initializing the socialization program in the East proved to be disadvantagous. A peasant from a village of Muş expressed his pleasure with these words: "God in the heavens, socialization on earth" (*Gökte Allah, yerde sosyalizo*). He told this to a journalist from *Milliyet* who carried it to the headline.[766] The harsh climatic and geographic conditions and the lack of infrastructure, however, created many problems, including staff shortage. Language was also a big problem. As already mentioned, there was an attempt to establish a language course for health personnel, but it was blocked by a state institution.[767] The state recognized the health care delivery need of the Kurds, but not their language. This created negative confrontations. While Rahmi Dirican was inspecting the personnel of the health posts in Muş in 1964, a health post doctor protested the program, saying "Why are you sending us here, what they need is not a doctor but a veterinarian, because all of them are animals (…) they can neither express their complaints nor understand what I say. They only say 'you are the doctor, so you have to find it' and want me to make injections. How can I serve these

[766] Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, p. 173.

[767] G. Fişek, Özsuca and Şuğle, p. 62.

animals?"[768] Dirican informed the Ministry about this confrontation and the doctor was removed from the office. Of course, not all encounters were like this. Some doctors learnt some Kurdish or were helped by a local interpreter in some cases.[769]

As mentioned earlier, the socialization of health services aimed at the integration of the Kurds although it was never publicly expressed. It is obvious that the integration of Kurds could not be accomplished but the socialization was an important step in approaching them through the means of welfare state, not coercion.

The socialization of health services was limited to the Eastern and Southeastern regions for a long period. This led to the association of the program with the East, with the underdeveloped rural Turkey. Province-type versions of health posts could not be established although they had been set in the initial program. The county- and province-type health posts would consist of more health personnel and laboratories. With such a structuring they would meet the expectations of the rising urban population. But they could not be established and people applied to hospitals directly without following the referral chain. Public health specialists state that 90% of all illnesses can be cured in primary care institutions, and only 10% require a specialist and hospital care. But there was not any deterrent effect that would detain people from directly going to hospitals and this increased the health expenditures as hospital services were much more expensive. Instead of an organization that provided the best possible service to the whole population, hospitals were established to serve a small portion of the population in the big

[768] Dirican, *Bir Hekimin Anıları*, p. 118.

[769] In a recent report published by TESEV, the employment of Kurdish speaking health personnel in all steps of health service is proposed as middle aged and elderly women, and preschool aged children cannot speak Turkish (TESEV, *Doğu ve Güneydoğu Anadolu'da Sosyal ve Ekonomik Öncelikler*, İstanbul: TESEV Yayınları, 2006, p. 94).

cities.[770] All governments considered establishing new hospitals much more useful in gaining popular support.

Conclusion

The socialization of health services aimed to provide health care to all citizens irrespective of need or labor force participation. Although it emphasized public health and preventive care, it was not limited to their provision. The aim of bringing universal health coverage to all citizens on the basis of equality could not be accomplished and there were problems even in the limited sphere of providing public health and primary care for the rural population and the poor. There were always discrepancies between the required number of health posts and personnel and the existing ones. When enough resources were allocated, the system functioned well. There was a significant rise in the health services and so an improvement in the health indicators in socialized regions. This was true especially for the health research and training districts which were run by faculties of medicine and the MHSA together. Although it is hard to estimate the role of socialization in the overall improvement of health indicators of Turkey we might assert that the establishment of health posts in places where no health facilities had existed beforehand made significant differences.

The improvements are observed not only in the sphere of service provision but also in the sphere of expectations. The establishment of health stations and health posts in the villages changed the expectations of the people. The expansion of the system made people think that the state had to send doctors to the villages. However,

[770] Rahmi Dirican, "Türkiye'de Sağlık Hizmetlerinin Örgütlenmesine Genel Bir Bakış." In *21. Milli Türk Tıp Kongresi, 20-26 Eylül 1970, Bursa* (İstanbul: Çelikcilt Matbaası, 1970), p. 13.

this was a limited expectation as the service provided at the health posts remained limited. The state was held responsible for public health and preventive care but when it came to curative services it was usually asserted that these could not be financed by public resources and people's contribution was a must. So, starting from the program of the second Menderes government the project of establishing general health insurance was set as a goal.

In all government programs, the SPO reports and some health sector expertise commission reports, the establishment of general health insurance was mentioned. Throughout the 1960s and 70s insurance was the main theme of discussion in all meetings related with health care policies. This fact itself is an indicator that the socialization was not considered to be the health system of Turkey. It was limited to an organizational model or a public health program for the Eastern, rural, and poor segments of the population. These segments of the population -the "people"- were provided public health while those in the formal sector -the "citizens"- were provided medical care. The policy makers and the health professionals did not believe in the possibility of establishing a universal health care system which would be financed from the general budget. They searched for ways of establishing general health insurance but were unable to actualize it due to the large share of agricultural and informal sector. The insurance system was promoted also to cover everyone as the exclusion of some people from the system was unacceptable. Especially in the field of health care it is hard to justify the existence of inequalities. So, when socialization was not adopted as a tax-based national health service model, social insurance was promoted. Actually in terms of coverage, both might be universal and in terms of finance both might be progressive. As Richard Freeman argues, the difference

between these two systems is not as great as it is often made to seem.[771] Taxation may be thought of as a form of compulsory insurance and insurance premiums are normally levied as a compulsory payroll tax. When there is equity in the collection of taxes or premiums and when there is equity in access, there is not that much difference in terms of citizenship status. However, in a country like Turkey with a large number of informally or self-employed people such an egalitarian insurance system was unable to function.

The socialization did not become the health system of Turkey due to various reasons, the most important being the simultaneous development of the inegalitarian corporatist system. In Turkey, as in the conservative systems of Europe, social rights are dependent on employment status. Unlike those conservative systems, quite a large portion of the population, those in the informal and agricultural sectors are excluded. The relation between the universalist socialization system and the corporatist model should be considered as a two-way relation. As the universalist system was unable to provide the necessary health care to all citizens despite its original claim, the corporatist system had to create its own means. And as the corporatist system created its own means the universalist system could not find enough resources and support to consolidate itself. Actually, the emphasis on rural Turkey and primary care prevented the adoption of socialization as the new universal health care system. The ambiguous character of its financial basis contributed to this development. Primary care units could not be developed because of the changing expectations of people related to health care, but mostly because of the lower status of its attendants. As rich people and the members of SII, RF and Bağ-Kur did not use

[771] Freeman, pp. 6-7.

health posts and had the advantage of directly going to private offices and private hospitals or state hospitals, the primary care units could not develop.

As Richard Titmuss suggests, services for the poor are poor services. When a service is confined to the poor parts of the population which lack public audibility and political strength, it is doomed to regression.[772] When segments of the population with economic power or social insurance have some advantages there would be little pressure on the state to improve the quality of the services it provides for the general public. If those who would control the public services and demand higher quality leave the system and enjoy their advantages, the quality of those public services diminishes. This was what had happened in the case of the health posts. The health posts were unable to develop also because of the rising expectations of people. Especially the urban population, which exploded from the 1950s onwards, was not content with the primary care provided at the health posts that lacked specialist care, laboratory and x-ray machine. There was a rising demand for hospital care. Because the socialization did not cover the big cities for a long time hospitals followed an independent path. They could not be integrated into the system and the referral chain did not work.

The attitude of doctors was also decisive in the "failure" of socialization. Their resistance to becoming civil servants, their reluctance to work in provinces despite the incentives, and their inclination towards specialization partly due to the structure of medical training constituted barriers against the development of an egalitarian health care system. The other major reason was the limits put by the Ministry of Finance on health care expenses. These limits might be explained partly by the economic conjuncture of the country; but the priorities and the political will

[772] Titmuss.

were much more decisive. Those in the formal sector benefited from curative services including medication while the others could not. If the basic consideration of the policy makers had been equity they would have spent less on the health care services provided for the former.

All of these reasons for the "failure" of socialization give us an idea about the shaping of the Turkish welfare regime. When we come to the 1980s, a universal health care system was not established, and although there was a rise in the percentage of those covered by a security scheme a large portion of the population was without any health insurance. There was a hierarchy of access and accordingly, citizenship among the insured related to their closeness to the state and employment status, but more importantly around 60% of the population was not covered by any security scheme. The socialization lost its effectiveness and started to be promoted only by a small group of public health specialists and the TMA. The failure to establish a universal and comprehensive system combined with the marketization trends of the 1980s and this had devastating consequences especially for the poor. The marketization trends of the 1980s, health reform proposals of the 1990s, the Green Card, and the universalization and privatization trends of the early 2000s will be analyzed in the following chapter.

CHAPTER SIX

HEALTH REFORM IN A NEO-LIBERAL CONTEXT (1980-2007)

Introduction

The socialization of health services aimed to cover all on the basis of equality. However, this could not be accomplished due to various reasons, the most important being the corporatist structuring of the welfare regime. The system could not cover the whole country after two decades of its initiation, and it was limited to the providing of primary care to the poor and the peasants. After the military coup in 1980 the whole country was socialized, but the system already had proved to be ineffective. The problems of the 1950s that the socialization of health services was meant to solve persisted: financial constraints, lack of a primary care network which raised the workload of hospitals, lack of integration and coordination, lack of health services in rural areas, unjust distribution of doctors, doctors' tendency to become specialists, and the private practice of state-employed doctors. The socialization could not solve these problems although it provided basic health care in rural areas and brought about a change in people's expectations with the acknowledgement that the state had to send doctors even to the remotest villages. As it was not interpreted and applied as the national health service system of Turkey the need to cover everyone through establishing a general health insurance was always on the agenda and in the late 1970s, although draft bills were prepared, they could not be legislated. The coverage of social insurance schemes was expanding, but there was still a large

portion left outside, especially those in the agricultural and informal sectors.[773] Apart from the inequality between those within and outside the system, there were inequalities among the members of different security schemes in terms of the rights and services provided. Low coverage, the weakness of the primary care network, the unjust distribution of services and personnel, the inefficiency of hospitals, the resistance of doctors to becoming civil servants, the lack of integration, and the inequality of access to health care were recurrent problems. The rise in urbanization and the rise in percentage and number of those covered by a security scheme increased the demand, together with the developments in medicine, which in turn intensified the problems.

In the 1980s, governments faced the same problems. However, the emphasis shifted from bringing basic health care to the "peasant citizens" to providing hospital services to the increasing urban population. The problems were recurrent but not the solutions, except that of general health insurance for financing the health sector and including everyone within the system. Other solutions like decentralization in health services, autonomization of hospitals towards their privatization, family medicine and promoting of private sector were peculiar to the 1980s and after. The health reforms in the 1980s and after are usually explained with reference to the need to contain costs which escalated with population aging, rising rates of health care

[773] See Table 19. However, the given percentages of those covered by health insurance might be higher than the actual amount. Bağ-Kur and SII members who have premium debts cannot use health benefits. Also there are cases of double or false countings (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed). According to the State Planning Organization the ratio of insured population covered by health services was 36.3% in 1980, 60.6 in 1990, 81.0 in 2000 and 88.8 in 2004. SPO, p. 163. The World Bank estimates that over one-third (36 to 37%) of the population does not have access to health insurance, including the Green Card program, based on 2001 Household Consumption Survey and 2002 Household Budget Survey. World Bank, *Turkey: Joint Poverty Assessment Report*, p. 72. While the SPO declared one-fifth of the population to be without any health insurance in the early 2000s, the WB estimated this amount to be over one-third. The WB estimate might be higher than the actual amount, but the official number is probably lower.

utilization, and developments in medicine and biotechnology. The neo-liberal transformation, which promoted market mechanisms as a panacea to the problems of inefficiency, also shaped reform proposals. The World Bank and the IMF dictated the requirements of this transformation to the developing countries. The increasing budget deficits in social insurance put the reform as an urgent task before the governments. That was the case also in Turkey. However, the need to reform health care cannot be explained only with the neo-liberal transformation and the budget deficits in insurance. Throughout the 1960s and the 1970s, same problems were discussed, but the solutions proposed were different, except that of general health insurance.

The Motherland Party (MP, *Anavatan Partisi*), symbolized the transition from national developmentalism to neo-liberal capitalism. The former restrictions for the markets were lifted and the private sector was promoted in many fields, including health care. Competition was viewed as the best way to achieve efficiency and efforts were made to limit the provider role of the state. Regional and statutory inequalities, infrastructural problems and poor quality service to people with no financial means became salient in this period. Public resources were used to support the private health sector and preventive care was neglected. The share of health in the state budget declined and the hospitals were forced to generate their own resources. The privatization of health involves the administering of the hospitals as if they are business enterprises and the practice of revolving funds based on the distribution of the profit to the doctors and other health personnel. So, the state hospitals started to accept only those who were covered by a security scheme or had the necessary means. By the 1990s the health system was in a big crisis and newspapers were full of stories of poor people who could not pay for health expenses and were held in

pledge by the hospital administrations. This will be documented in the following pages. The failure of socialization in establishing a universal health care system, combined with the marketization trends of the 1980s, resulted in many negative outcomes especially for the poor. The following government tried to solve these by initiating the Green Card scheme.

The health reform which was supported by the World Bank came onto the public agenda in the late 1980s when the Motherland Party (MP, *Anavatan Partisi*) was in power. But it was the following True Path Party – Social Democratic People's Party coalition (TPP-SDPP, *Doğru Yol Partisi – Sosyal Demokrat Halkçı Parti*) that worked harder to implement this. The reform project was in line with the WB proposals based on the restructuring of social security systems, the separation of provision and finance, the promotion of the inclusion of non-public institutions and actors, the increasing use of market mechanisms, and decentralization. The World Bank promoted decentralization and privatization strategies and emphasized the need to improve equity and allocative efficiency through guaranteeing universal access to a basic package of services. The WB shaped the reform proposals of the governments starting from the late 1980s onwards. The TPP-SDPP coalition designed a national health program which covered decentralization in health services, the autonomization of public hospitals, and the transition to general health insurance (GHI). The abolition of regional inequalities and the establishment of the Green Card Scheme for the poor were the other two major targets. Among these targets only the Green Card could be actualized. The developmentalist assumption that everyone would become a part of the formal sector and thereby would be covered by insurance had turned out to be wrong. It was clear that new measures were needed and various governments tried to find new ways of providing citizenship-based coverage, rather

than coverage based on employment, or status in employment. The Green Card was a citizenship-based right which provided health care to those who were not covered by any social security institution, and whose monthly income was less than one-third of the net minimum wage for a person in a household. It might be analyzed as an improvement in citizenship status despite the fact that it is a means-tested mechanism.

One important objective of the socialization was to address regional and rural-urban disparities. However, the failure in its proper realization hindered the abolition of these inequalities. Key health indicators varied markedly across regions and across rural and urban Turkey. Infant mortality, under-five mortality, maternal mortality, and immunization are health indicators related to the availability and adequacy of primary care. The low level of these health indicators reveals the inadequacy of primary care in the period under study. They were worse in rural areas and the eastern part of Turkey. There were also inequalities among the regions in terms of the quantity and the quality of hospitals. The problem of recruiting health personnel to be employed in the East could not be solved. So, every government was faced with the crucial task of abolishing regional inequalities. The persistence of regional inequalities will be documented in the following pages.

The following weak coalition governments were unable to take radical steps in the field of health care due to economic crises and the armed conflict. The single party government of the Justice and Development Party (JDP, *Adalet ve Kalkınma Partisi*) undertook drastic changes in the system which abolished the inequalities among the members of different security schemes. The Social Insurance Institution hospitals were transferred to the Ministry of Health (MoH) and members of the SII started to benefit from the MoH hospitals. Then members of different security

schemes gained the right to apply to every hospital, both public and private. SII members started to get their drugs from private pharmacies while the Green Card began covering inpatient medication. All these implied an equalization in citizenship status, although Green Card is a means-tested mechanism. The central objective of the reform was declared as establishing a high quality and effective health system to which everybody could have access on an equal basis.

The reform project of the JDP was much more comprehensive than those of the former governments, but the major components like GHI, family medicine, and autonomization of hospitals were exactly the same. What distinguishes JDP is its determinate attitude in changing the system. It was the first government to enforce the necessary legislation for the integration of the different security schemes and GHI although the Constitutional Court annulled some of its articles. Also, the scale of the use of market mechanisms and buying services from private providers distinguish the JDP government from the earlier ones. On the one hand, there was a serious concern for universalization, but on the other hand there were all kinds of problems associated with markets and privatization. The JDP's policies towards universalization and privatization were found to be successful. This had an impact on the voting behaviour of the people in the 2007 elections. This chapter analyzes these developments starting from the coup of September 12, 1980 and sets up connections with the socialization.

The Coup of September 12 and Its Aftermath

The armed forces seized political power on September 12, 1980 on the grounds that the state organs had stopped functioning. The parliament was dissolved, the cabinet

was deposed and the immunity of the members of the National Assembly was lifted. All political parties and the two radical trade unions confederations were suspended. A state of emergency was declared throughout the country and no one was allowed to leave. The military envisaged an eventual return to a democratic system and intended to enforce radical changes in the political system before handing power back to the civilians. The coup of September 12 was also a reaction against the liberal mentality of the coup of May 27, as can be observed from the abolition of May 27 as a national holiday, along with May 1.[774]

All power was concentrated in the hands of the military, more specifically in those of the National Security Council (NSC) headed by the chief of staff, General Kenan Evren, who was officially declared head of state on September 14. The NSC appointed a 27-member cabinet under retired admiral Bülent Ulusu. Thousands of people were arrested, tortured or sentenced to death. All kinds of opposition were suppressed brutally.

A consultative assembly was established by the military. It elected a 15-member constitutional committee which produced a first draft for a new constitution on July 17, 1982. It was a reversal of the constitutional developments of 1960. It concentrated power in the hands of the executive and increased the powers of the president and National Security Council. It also limited the freedom of press, the freedom of trade unions and the rights and liberties of the individual. The usual rights and liberties were included in the constitution, but it was declared that they could be annulled, suspended or limited on the grounds of a whole series of considerations,

[774] Zürcher, p. 292.

including national interest, public order, national security, welfare of the republican order and public health.[775]

The 1982 Constitution replaced article 49 of the 1961 Constitution, which had assigned the state the task of providing a physically and mentally healthy life and medical care to all its citizens, with article 56, which emphasized the duty of the citizen in protecting environmental health. Although the state was still responsible for the health of its citizens, its role in regulation, rather than provision, was more at the forefront. For the first time in a constitution, the "private sector" and "general health insurance" were emphasized.[776] The promotion of the private sector and the establishment of a general health insurance had existed in government programs and five-year development plans before, but their existence in the Constitution strengthened their legitimacy. In the program of the Ulusu government (20 September 1980 – 13 December 1983) established after the coup of September 12, general health insurance was specified as a goal together with egalitarian distribution.[777]

Although the promotion of the private sector had been emphasized before the 1980s, its actualization in the proper sense had to wait the transition from national

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[775] Ibid., p. 295.

[776] Article 56: Everyone has the right to live a healthy life in a stable environment. It is the duty of the state and the citizens to maintain, to preserve and to improve the environment and take measures against pollution. The state plans and organizes the service of health institutions with the aim of providing everyone a mentally and physically healthy life and improving efficiency in terms of manpower and resource. The state fulfills this duty by getting assistance from and controlling the public and private health institutions and social aid institutions. A general health insurance can be enforced by law in order to expand the coverage of health services. (*Madde 56: Herkes, sağlıklı ve dengeli bir çevrede yaşamak hakkına sahiptir. Çevreyi geliştirmek, çevre sağlığını korumak ve çevre kirlenmesini önlemek Devletin ve vatandaşların ödevidir. Devlet, herkesin hayatını, beden ve ruh sağlığı içinde sürdürmesini sağlamak; insan ve madde gücünde tasarruf ve verimi artırarak, işbirliğini gerçekleştirmek amacıyla sağlık kuruluşlarını tek elden planlayıp hizmet vermesini düzenler. Devlet, bu görevini kamu ve özel kesimlerdeki sağlık ve sosyal yardım kurumlarından yararlanarak, onları denetleyerek yerine getirir. Sağlık hizmetlerinin yaygın bir şekilde yerine getirilmesi için kanunla genel sağlık sigortası kurulabilir.*)

[777] Dağlı and Aktürk (eds.).

developmentalism to neo-liberal capitalism. Within the context of this transition in the late twentieth century, efforts were made to diminish the role of the state and the public sector was found inefficient due to the lack of competition. The market was seen as a panacea to many problems, framed mostly in terms of efficiency or costs, whereas the public sector was denigrated as corrupt and inefficient. Neo-liberal ideology, which became hegemonic in the last quarter of the twentieth century, constituted a rupture with the interventionist and distributionist practices of the welfare state, which integrated the aim of social justice with the aim of economic development. There was a shift in economics from the Keynesian approach that had been dominant since the Great Depression towards an approach that endorsed the supremacy of markets free from distortions introduced by the states. The trust in Keynesian macroeconomic policies was damaged and the tacit class alliances were dissolved. The social consensus which was based on the sharing of the benefactions of development by the representatives of both labor and capital was dissolved. In a similar way, the optimistic atmosphere in post-independence Third World countries disappeared and all the development models, whether planned or not, became unsustainable. In the late 1970s developing countries faced foreign debt crises. The new development doctrine was now structural adjustment policies.

The development of consumer society, the strengthening of a service sector based economy, and the breaking of traditional solidarity structures like party, trade union and family by individualistic values were also effective in the hegemony of neo-liberal ideology. All these contributed to the adoption of neo-liberal values by the middle classes which had claimed ownership of the welfare state before. This was complemented by the fall of the Soviet Union and the subsequent retreat of the imagery of a socialist society.

Neo-liberal doctrine attracted the middle classes with its consumer freedom and tax reductions, but it served most the interests of big industrial capital and finance capital groups. These groups claimed that capitalism should be restructured, that the Keynesian system was out of date, that the barriers against the market economy should be lifted and its entrepreneur spirit should be reactivated. Neo-liberal ideology made an economic-social recommendation package of the demands of these groups and politicized it.[778]

In the post-war period, most developing countries followed a path of planned economic development that could be described as "statist," "protectionist" and "inward-looking.". In the aftermath of the wave of crises that started with the Mexican debt crisis of 1982 and hit many other developing countries thereafter, such inward-looking policies became subject to heavy criticisms by many scholars and by the international financial institutions. The inward-looking import-substitution policies were questioned because they made the developing countries depend heavily on imports of certain capital goods, and, therefore, on foreign exchange. The oil crisis of the 1970s and the subsequent abundance of OPEC dollars decreased the price of foreign exchange and made it possible for the developing countries to borrow easily from the world markets. Thus, the developing countries in need of foreign currency to import capital goods borrowed from banks holding too much of these currencies.

"Excessive borrowing" led to balance of payments crises in many developing countries. When these countries could not provide enough foreign currency to continue importing, or more importantly, pay their debt installments, the situation became alarming both for the developing countries and for the international financial

[778] Ahmet İnsel, *Neo-Liberalizm: Hegemonyanın Yeni Dili* (İstanbul: Birikim Yayınları, 2004).

community. As a result, those developing countries that could not pay their debt installments had to apply to the IMF for loans. The IMF funding came with conditionalities that aimed to resolve short-term problems such as unsustainable public deficits and balance of payments. Funds and guidance from its twin institution, the World Bank, aimed to make a shift in the structure of the developing country economies from their protectionist and inward-looking state towards a more liberal and market oriented one.

Turkey suffered a crisis between 1977 and 1980. The restructuring of its economy was prompted by the World Bank and the IMF. It represents only one case among many other developing countries. The Turkish crisis hit before the wave of crises that started with Mexico in 1982. Turkey and Kenya were the first countries that received structural adjustment loans from the World Bank to restructure the role of the state in their economies.[779]

On January 24, 1980, the Turkish government declared a new economic stabilization program. The intention was to alleviate its foreign exchange crisis to receive loans from the World Bank and the IMF. The program declared its objectives as reducing state involvement in productive activities, increasing reliance on market forces, replacing inward-looking strategy with an export-oriented strategy, and attracting foreign investment.

It was in this neo-liberal atmosphere that the expansion of the socialization of health services throughout the whole country was completed. Article 20 of the Socialization Law declared that the whole country would be socialized in 15 years time. However, this could not be accomplished and the period was extended several times. The socialization of health services had been enacted by the military after a

[779] Ziya Öniş, *State and Market: The Political Economy of Turkey in Comparative Perspective*, (İstanbul: Boğaziçi University Press, 1998).

coup and its expansion was completed by the military after another coup, although the two had completely different visions.

Zafer Öztek, a public health specialist from Hacettepe University, was appointed as the general manager of the Department of Basic Health Services in the Ministry of Health in 1982. At that time 47 of 67 provinces were socialized. His major purpose was to socialize the whole country. He had worked with Nusret Fişek and he was an ardent supporter of socialization like many other public health specialists. The Department of Socialization was responsible for 47 provinces while the Department of Basic Health Services was for the remaining 20. The Minister of Health Kaya Kılıçturgay, the undersecretary and the personnel manager were all members of the military and they did not have any familiarity about the socialization. Öztek held that post for 1.5 years and for six months during this service he worked hard to convince the minister for the socialization of the remaining 20 provinces. He said "If we do not socialize the whole country now, it will never be socialized in the future. We should do it when the military is in power. Otherwise the civilian governments will not realize this".

Öztek was set on doing this and convinced the minister. He established teams and sent them to the provinces to be socialized. They looked for buildings and sometimes converted public buildings like gendarmerie or *imam* residences, general registry offices, or the entrance floors of health centers. They had problems in facilities but not in equipment. It was difficult in the metropols and especially in İstanbul. The Department of Socialization was charged with the starting of the program in the new provinces. Its task would be accomplished when everywhere was socialized. So, it was closed at the beginning of 1984 as the whole country, including

the big cities, were socialized. From 1984 onwards the Department of Basic Health Services would be responsible for health stations and health posts.[780]

Öztek had convinced the minister by saying that the civilians would not accomplish this goal. When the socialization was initiated Nusret Fişek had used the same argument. He said the military should enact the law before the civilians came to power, otherwise it would not be enacted. Both the initiation of the socialization and its expansion were accomplished by the military and idealist public health specialists who did not trust the civilian governments. This top-down approach left the socialization without political support. It is ironic that the socialization of health services which reflected the welfare mentality of the 1960s was completed in the neo-liberal period. But in the 1980s, the socialization was already devoid of strength. It was not adopted as the national health service of Turkey and was limited to the sphere of primary care provision to the poor and the peasants. When it was limited to the opening of new health posts no government would oppose the system. There was a serious rise in the number of health stations and health posts after 1980. The initial rise was due to the socialization of all provinces at the end of 1983 but the steady increase in the number of health posts has continued to the present (see Table 23). After 1980, it would primarily be the TMA and public health specialists who would support the socialization not as the opening of new health posts, but as the health system of Turkey.

The expansion of socialization was not the only radical measure adopted by the NSC. It abolished the full-time law on the grounds that it constituted a financial burden for the state and it did not meet the needs. With this change the health personnel lost their financial privileges. In August 1981 compulsory service was

[780] Zafer Öztek, interview by the author, tape recording, Ankara, Turkey, February 2007.

adopted for the doctors. There were some partial regulations for promoting the private sector. In November 1981, the private health sector started to benefit from state incentives. And in September 1983, the practice of revolving funds was extended to the Ministry of Health hospitals. A commission within the NSC evaluated the general health insurance project and found it unrealistic as it would increase the demand for outpatient care which would not be met with the existing personnel and health posts, and the premiums collected from the well-off would not cover the rising expenditures.

The Motherland Party in Power (1984-1992)

After the adoption of the constitution and Evren's installation as president, elections were held under the close control of the military. Three parties were allowed to take part in the elections of November 6, 1983: The Party of Nationalist Democracy (PNP, *Miliyetçi Demokrasi Partisi*), the Populist Party (PP, *Halkçı Parti*), and the Motherland Party. In the elections the MP scored an overwhelming victory, polling over 45% of the votes. The 45% gave the MP an absolute majority in the new assembly. Özal was the leader of Motherland Party and, like his contemporaries Reagan and Thatcher, advocated neo-liberal policies for an effective functioning of the economy. He defended less government involvement and more reliance on market forces. He challenged the role of the state in welfare as it implied intervention to the free market. He found the private sector rather than the public to be more efficient in providing welfare services. When intervention was required for the very poor, charity mechanisms would be operated. Health policies were also shaped by this mentality.

In the programs of first and second Özal governments (13 December 1983 – 21 December 1987 and 21 December 1987 – 9 November 1989) general health insurance was promoted together with the equal distribution of health personnel, preventive care, and a rise in the number of hospitals and health posts. What distinguished Özal government programs from the earlier ones was their emphasis on the promotion of private sector. It was clearly stated that the establishment of the private health institutions would be supported. Competition within the pharmaceutical sector was promoted. And the pressure on the SII and the Ministry of Health hospitals would be diminished by buying health services from the private sector.[781]

Among the objectives of the MP governments, promoting hospital medicine and buying services or employing personnel on a contractual basis were highlighted. In the field of medication, free market requirements were going to be covered. During the first MP government five million children were vaccinated in a big campaign, new maternal and child health programs were started, Population Planning Clinics were established within hospitals and maternity hospitals, Public Health Centers (*Kamu Sağlığı Merkezleri*) were established in metropols, county hospitals were promoted, and Emergency Services (*Hızır Acil Merkezi Hizmetleri*) were set up.[782]

The MP period was marked by the commercialization of health services. Under the slogan "The New System in Health," public hospitals were managed by a five-person board of trustees, all the personnel and the other expenses of hospitals were covered by revolving funds, primarily medical specialists were satisfied, and

[781] Dağlı and Aktürk (eds.).

[782] Ata Soyer, "Türkiye'de Sağlık Hizmetleri: 1980-1995." *Yüzyıl Biterken Cumhuriyet Dönemi Türkiye Ansiklopedisi*, cilt 14 (İstanbul: İletişim Yayınları, 1996), p. 1115.

full-time doctors took share from the revolving funds. The major document which reflected the MP mentality was the Basic Law on Health Services,[783] which was accepted in May 1987. It symbolizes the retreat of the state from the field of health care. The law was criticized for undermining preventive care, bringing the curative services to the market, increasing the use and cost of health expenses, covering the expenses with the money collected from the wage earners, and creating a disorganized community of employees.[784] In temporary article 3, it was stated that the citizens would be recorded in the health register (*kütük*) and pay premiums until the transition to general health insurance. The health expenditures of those who were not registered would be covered by the individuals or by the private insurance firms. The health expenditures of those without financial means would be covered partially or completely by funds or associations established for the purpose of social solidarity. This emphasis on funds reflected the MP mentality which left the task of poverty alleviation to charity, a point to which I will come back later. The Social Democratic People's Party appealed to the Constitutional Court and some of the crucial articles of the Law were annulled: the collection of premiums in one place to integrate the health insurance; the transformation of public health institutions into health enterprises; the employment of health personnel on a contractual basis; and the transition to a general health insurance model.[785] The government did not bring new regulations to substitute for the annulled articles and the law could not be applied.

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[783] *Sağlık Hizmetleri Temel Kanunu*, no. 3359, *Resmî Gazete*, 15 May 1987.

[784] Ibid., p. 1116.

[785] Semih Şemin, "Ülkemiz Sağlık Mevzuatı ve Sağlıkla İlgili Politikaların Genel Değişim Dinamikleri." *Toplum ve Hekim*, 53 (Şubat 1993): 2-10, p. 3.

We might assume that the major laws on health care reflect the ideological outlook and the priorities of the era in which they were enacted. The Law of Public Health (1930) emphasized the role of the state in preventive care and left the curative services to local authorities and private doctors. Epidemic combat and pro-natalism were at the forefront. The Law on the Socialization of Health Services (1961) aimed to cover all on the basis of equality and to provide preventive and curative services together. Improving the health of people even in the remotest villages of the country was a prerequisite to be qualified as a welfare state. The Basic Law on Health Services (1987) tried to restrict the role of the state with the field of regulation and increase the use of private mechanisms. It was claimed that only through such mechanisms could efficiency be accomplished.

In 1990 another major law was prepared by the MP government, the Law on Health Insurance Institution which was known as *Sağ-Kur*. This draft envisaged the establishment of a Health Insurance Institution. Citizens would be classified based on their income; the premiums of the poor would be paid partly or fully by the Institution; it was compulsory for the remaining population to pay their premiums; everyone would benefit from basic health services but had to make additional payments if they wanted additional service. But the government withdrew the proposal like the former governments which had been unable to take the further step in legislation. Similar to the earlier bills on the premium system, it could not be legislated as it required a dramatic change which might be hard to accomplish. Later reform proposals of the premium system would have the same faith, except the one legislated by the JDP in 2006.

When the Özal governments were in power in 1983-1989 the share of the MHSA (after 1988 only Ministry of Health) was very low compared to the earlier

periods. There was a rise in 1990 when Yıldırım Akbulut was the prime minister. This high share was sustained when Mesut Yılmaz headed the cabinet (see Table 11). This change in 1990 can be observed also in the share of public health expenditure in total health expenditure. It was around 45-50% until 1989, and then it did not fall beneath 60% after 1990. This is also valid for per capita expenditure, which was 41.3 dollars in 1983 and rose to 66.5 in 1989 and 95.1 in 1990 (see Table 36). The rise in public expenditures in the late 1980s might be explained with reference to the rise in the share of the Ministry of Health in the general budget, but mostly to the rise in funds, premiums, contribution rates, and revolving funds.

Out of pocket payments constituted a big share in health expenditures. In 1980, the share of out of pocket payments was 43.6% in total health expenditures. It was higher than 50% in 1984 and 1985 and then fell to 28.2 % in 1992. In 1980 prices there was a 51% rise in out of pocket payments between 1980 and 1992. The budget of the Ministry of Health was at the second order in total health expenditures. The SII was at the third order and its share rose from 10.6% in 1980 to 17.7% in 1992. The share of other public institutions fell from 11% to 5%. And the share of universities remained almost the same in 1980-92.[786]

The importance of revolving funds for the hospitals becomes obvious when we consider the fact that the largest share of the budget of the Department of Curative Services was allocated to personnel salaries. In 1988, revolving funds constituted 128% of expenditures, salaries not included, and in 1993 this figure increased to 271. And revolving funds became much more important in university

[786] Soyer, "Türkiye'de Sağlık Hizmetleri: 1980-1995." p. 1122.

hospitals. In 1991, the share of revolving funds of all university hospitals in their total budget was 47%.[787]

There was a fall in public investments in health. The share of investments in the Ministry of Health budget was around 15% between 1980 and 1993. The investments of Ministry of Health in the consolidated budget were around 2-3%. The SII investments in health were even less. Due to the establishment of new universities, their investment share was around 25-40%.[788] Public investments decreased while private investments rose. Private sector investments increased from 800 million TL in 1980 to 1,339 billion TL in 1992, and their share in total health investments increased from 9.7% to 34.5%.[789] The number of inpatient institutions under the Ministry of Health was 604 in 1980 and it increased only to 634 in 1992 while the number of private inpatient institutions increased from 90 in 1980 to 143 in 1992. This rapid pace in the establishment of private institutions would continue and would accelerate in late 1990s.[790] The plan to attract private sector investment in health services was successful largely due to generous government subsidies. Government incentives for private hospital investments resulted in the building of many private hospitals, especially with the support of other incentives, such as the subsidy of imported equipment. The private institutions concentrated in wealthier areas and advantageous areas. Most of the private institutions were in İstanbul, İzmir, Ankara, Adana, and Bursa. They gave health services in specialized fields like ophthalmology, dental health, obstetrics and gynecology, microchirurgia, and

[787] Ibid., p. 1123.

[788] Ibid.

[789] Ibid., p. 1124.

[790] The number of beds in private institutions increased from 3,868 in 1980 to 6,230 in 1990, and to 14,257 in 2000 (TURKSTAT, p. 44).

transplantation. In this way, these institutions could become the first-comers in their specialty fields, could bring together the specialists and become a monopoly.[791]

Private investments in health are expensive and they depend upon imports. Between the years 1980-93 the share of medical imports in total imports rose from 1.3% to 4.2%. And the share of medical devices in total medical imports rose from 10.9% to 17.8%, while the share of medical supplies rose from 4.3% to 7.5%. The share of medical imports in total health expenditures rose from 5.4% to 18.2%. The number of computerized tomography devices only exceeded the required amount by 483%.[792]

In terms of manpower, there were serious improvements between 1980 and 1995. The number of doctors rose from 27,241 to 69,349 in 1995, nurses from 26,880 to 64,243, and health officers from 11,664 to 34,342 (see Table 8). The fall in the number of patients per doctor, nurse and health officer was remarkable while the fall in the number of patients per dentist and pharmacist was moderate (see Table 9). The problem of inequality in regional distribution persisted. Although there was an improvement in the number of health personnel, the number of patients per health provider varied among the regions.

After the coup of 1980, the real wages of doctors fell down dramatically. It was 622.5 dollars in 1979, 213.7 in 1983, and 306.7 in 1986. The real wages of doctors approached their earlier level in 1990, i.e. 565.1.[793] The Turkish Medical Association organized "white protests" in 1989 for a better health system. The Association expressed its criticisms in an open letter to the people: Per capita health

[791] Ibid., p. 1127.

[792] Ibid.

[793] These numbers are taken from a series published in *Milliyet* in January 1992: "Hastalar, Doktorlar, Hastaneler" (7 January 1992). The main theme of the series was the collapse of health system after the military coup in 1980.

expenditure should be increased from 50 to 200 dollars; the share of the Ministry of Health budget should be doubled; the means to encourage general practitioners should be developed for a better primary health care in health posts; the number of medical faculties (it was 17 in 1980 and 25 in 1990) and the number of medical students increased without allocating enough resources; the wages of doctors were really low and they should be doubled; compulsory service, which had been in effect since 1982, could not solve the problem of inegalitarian distribution, it should be abolished and a new employment policy should be applied; and coordination should be established among health policy institutions.[794]

The State Planning Organization had a report made by Price Waterhouse in 1989-90. This Health Sector Master Plan was prepared for an accessible, available and efficient health care system. In the report, four strategy options were proposed: Making improvements in the current condition, applying the national health service strategy, the free market strategy, or the intermediate option. The SPO selected the last one and made suggestions in accordance with this. However, there were problems related to the reliability of data and the plan became ineffective.[795]

The Ministry of Health published "Turkish National Health Policy" in 1990.[796] The establishment of general health insurance was put as an urgent task to cover the excluded 24 million. The improvement in regional and specialist/general practitioner distribution, the establishment of a family medicine system, the establishment of a health insurance system, and the use of proper technology were among the other goals. The importance of expanding basic health services was

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[794] Şükrü Hatun, *Türk Tabipleri Birliği'nde On Yıl* (Ankara: TTB, 1999), pp. 161-162.

[795] A. Erdal Sargutan, *Karşılaştırmalı Sağlık Sistemleri* (Ankara: Hacettepe Üniversitesi Yayınları, 2006), p. 224.

[796] Sağlık Bakanlığı, *"2000 Yılında Herkese Sağlık": Türkiye Milli Sağlık Politikası* (Ankara: Sağlık Bakanlığı, 1990).

accepted, and health stations and health posts were held responsible for providing these services only in the rural areas. In county centers public health centers would be responsible. The referral chain should be strictly applied. The hospitals would be autonomous institutions. These aims would be repeated in the health reform programs of the following governments. General health insurance, family medicine, and autonomization of hospitals constituted the major components of the reform projects.

The first health project agreement was signed by the World Bank and Turkish government in 1990. The World Bank gave loans for the First Health Project. Within this context the Project Coordination Unit, the Project Coordination Committee and Committees were established. The first project started in 1991 and ended in 1998. The aim was to increase the accessibility of basic health services in the project region, to take necessary measures that would increase the efficiency in provision and management of health services, and to improve the technical and administrative capacity of the Ministry of Health. The long-term objective was the establishment of a new health care system. The second health project agreement was signed in 1994 with similar concerns. Both of these projects had two components: the strengthening of basic health services and the strengthening of health policy and administration.[797] Within this context, the Health Project Coordination Unit published a study on reform under the title "Mega Project in Health."[798] The problems were specified as the weakness of primary care, the unjust distribution of personnel and institutions, and finance. The solutions to these problems were in line with the World Bank

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[797] İlker Belek, "Sağlık Reformları, Kriz ve Sağlık Paradigmasında Liberal Yeniden Yapılanma." *Toplum ve Hekim*, 16(6) (Kasım-Aralık 2001): 438-441.

[798] Sağlık Bakanlığı, *Türkiye Sağlık Reformu: Sağlıkta Mega Proje*, Sağlık Projesi Genel Koordinatörlüğü (Ankara: Sağlık Bakanlığı Yayınları, 1992).

proposals for the developing countries: Family medicine (together with health posts), the autonomization and privatization of hospitals, and general health insurance. The role of the Ministry of Health in service provision was limited. The establishment of a health information system and a national health academy was part of the project. Throughout the 1990s and the 2000s these solutions would come on to the agenda more or less in the same form. The need to cover everyone has been the major objective. The establishment of a general health insurance has been discussed as a way of achieving this goal since the 1950s. However, family medicine and privatization of hospitals are recent proposals, as is the limiting the role of the Ministry of Health in service provision.

In 1989, the term of the President Kenan Evren, who was the leader of the coup of 1980, would be over, and according to the constitution the President could not be reelected for a second term. Although the votes of the MP fell to 36% in the general elections of 1987, and to 21% in the local elections of 1989, and despite a high level of opposition from the political parties and the media, Özal stood as candidate for presidency and was elected by the members of the parliament, who were predominantly from his own party, the MP. The Motherland Party governments were in power until November 1991. The MP shaped the social, political and economic scene throughout the 1980s. It put its mark on Turkish history and symbolized the transition from national developmentalism to neo-liberal capitalism. When the MP was in power, state involvement in economic and social fields was challenged and a technicist understanding of politics was promoted.

The problems in health services that were expressed when the MP was in power did not differ from those that had been expressed before. Low rates of coverage, the inefficiency of hospital services, the unequal distribution of personnel

and services, the weakness of primary care institutions, the failure in the application of the referral chain had all been handled by the former governments. However, the solutions were different, except for the general health insurance. Family medicine, the autonomization of hospitals, and the promotion of the private sector were peculiar to the post-1980 period. Unlike the earlier period, more state involvement was not seen as a cure to all. The MP was unable to solve the recurrent problems and even intensified them through reliance on market mechanisms. It was during the MP governments,that health care became highly commercialized and expensive, increasing the existing inequalities. The solutions that were proposed by the MP governments did not differ from those of the following governments which all reflected the World Bank health reform proposals. The following TPP-SDPP (DYP-SHP) coalition would defend the same solutions of GHI, family medicine and autonomization of hospitals, but unlike the MP, it would give priority to the condition of poor people and establish a fourth security scheme, i.e., the Green Card. This reflects the difference in ideological outlook. The TPP-SDPP coalition was against the Reagan-Thatcher type neo-liberalism of the MP. Demirel would emphasize the rising inequalities among the people and the welfare duties of the state. Although they would defend similar solutions in terms of health reform, the following governments would not leave the health of people to the market forces as much as the MP governments.

The Era of Coalition Governments and Health Reform Projects

The True Path Party, headed by Süleyman Demirel, who had been banned from politics until 1988 by the leaders of the coup of 1980, gained the majority of the seats

and formed a coalition government with the partnership of the Social Democratic People's Party in the general elections of 1991. Özal and his party lost the popular support they had enjoyed due to the high inflation and the erosion in purchasing power that had occurred during their term. The average wage-earner's purchasing power had declined by 47% since 1980. Another reason was the nepotism and corruption that surrounded the regime. Like his contemporaries in office, Reagan and Thatcher, Özal believed in an unrestricted capitalist free-for-all. This resulted in a number of scandals.[799] The neo-liberal policies of the MP governments increased the poverty and polarization in society. It was during the MP governments that hospitals were forced to cover their expenses primarily from revolving funds as if they were business enterprises. As the personnel received share from the revolving funds the amount charged to the patients rose. It became difficult for the state hospitals to accept patients without insurance or money. The health system was in a big crisis and newspapers were full of stories of poor people who could not pay for health expenses and were held in pledge by the hospital administrations. Demirel emphasized these problems in his election campaign together with the scandals of pledge stories in hospitals and this played an important role in his success.

In an interview before the elections, Demirel said, "The state has lost its welfare dimension, it will gain it again. Only 8% of the GNP is allocated to education, health and social insurance. This percentage is 30 in the West. Today, hospitals serve the well-off, there is no equality of opportunity in education. We will open the doors of the hospitals to all and provide equality of opportunity in education."[800] He emphasized the welfare duty of the state:

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[799] Zürcher, p. 301.

[800] *Milliyet*, 10 September 1991.

> People are subject to a social solidarity created by a social charter. In this social charter, the state is responsible for protecting the helpless and needy. When are people helpless? In illness, old-age or accident. The state should help those in need. Those without any social insurance comprise nearly the half of the population. For years, general health insurance has been discussed in Turkey. We will bring a system in which those without the means will be protected by the state.[801]

Throughout the election campaign he criticized the polarization created by the MP governments: "They divided the country into two. Some of the citizens live in the plenty and welfare of Denmark, some live in the poverty of Pakistan. Those who say, 'I do not like the poor,' listen, we like the poor. Everybody will have everything."[802]

In the election advert of the TPP, free health services to all were promised. The Green Card was announced to be coming for the poor. There would not be any turning of people out of hospitals. In another advert, it was promised that free examination, diagnosis, and treatment in all hospitals, and medicine would be provided to all without health insurance.

The program of the TPP-SDPP coalition had a detailed health section. Unlike the MP programs there was reference to socialization: Preventive and basic health services like maternal and child health, nutrition, environmental health, and health training which had been integrated under the socialization program would be expanded throughout the country, their efficiency would be increased, and the excessive demand on curative services would diminish in this way. Within this context, primary health care institutions would be strengthened in terms of infrastructure, manpower and equipment and would be expanded. This would

[801] *Milliyet*, 23 September 1991.

[802] *Milliyet*, 30 September 1991.

diminish the excessive and needless aggregation in inpatient institutions. In this context the practice of family medicine would be applied.

The health services would be provided within a referral chain that started from the health stations in the remotest villages and extended to specialist hospitals and university hospitals. The personnel needs of the public institutions would be met by determining the wages of the personnel based on performance, and the conditions and the location of the institution in which they worked, and by contractual employment. General health insurance would be expanded gradually and no citizen would be left outside the general health system. The insurance premiums of the citizens who did not have financial capacity would be covered by the state. Within this framework, "Green cards" would be given to all to provide the opportunity of treatment.

In January 1992, the government declared an economic package and set more substantial goals: The "Green Card" program; the expansion of social insurance; land allocation in some regions, corporate tax privilege, and privileges in investment good imports, and flexibility in pricing to promote the private health sector; and encouraging foreign investment in health sector. These were more or less in line with the National Health Policy aims of the MP governments. General health insurance, family medicine, and promotion of the private sector were expressed also in the MP period. What was new here was the introduction of the Green Card which provided health insurance to the poor.

Before getting into the details of the process of health reform in Turkey which accelerated in the 1990s it is better to remember the general outline of the global process, which was explained in the second chapter. The targets of health reforms are stated as follows: to improve the health status of the population, to

develop the satisfaction of the service users, to diminish the inequalities in the advantage of the disadvantaged, and control the costs in an efficient way. Health sector reforms involve a paradigmatic shift in the funding, organization and provision of health care services. Since the 1980s, particularly in the developed world, they are posed as responses to the "crisis" in health care, which has generally been defined in terms of inability to absorb growing costs of medical care in an economic context marked by recession. In the developing world, not cost-containment but universalism is the main target: to expand coverage and increase access of previously excluded populations to basic medical care.

Since the late 1980s, the WHO and the WB have been actively promoting public health and policies aimed at achieving universal access to basic health care, and they generally have explained their interest on the grounds that healthy populations and access to health care are integral to economic and social advancement. The idea that universal access to basic medical care is "necessary" has become the conventional wisdom guiding welfare reform.

Almost all reform programs have been marked by the priority given to preventive measures and primary care services for immediate improvement of the health outcomes. Social insurance systems that offer a basic package of services financed through contributions have been promoted. This type of insurance allows the state to ensure a "basic" package of health services to the whole population, i.e., those who pay their contributions and the rest of the population who are exempt from contributions as a result of rigorous means-testing, while at the same time allowing the development of a "voluntary" private insurance system to satisfy the needs of better-off citizens for higher quality care. In other words, this type of financing

seemed to be the best way to achieve a minimum level of health as well as expand the role of markets in health systems.[803]

The global reform package includes the restructuring of social security systems, the separation of provision and finance, the promotion of the inclusion of non-public institutions and actors, the increasing use of market mechanisms, and decentralization. The public insurance institution should buy services from both public and private providers. Public health and primary health care should be improved to decrease the demand on secondary and tertiary institutions. The providers' practices should be monitored. This process expands the role of the state in terms of finance and regulation while diminishing it in provision. The splitting of finance and service, the autonomization of hospitals, appointing professional managers to hospitals, redefining the tasks of Ministry of Health, the transfer of some tasks to local authorities are common traits. So, the state retreats and leaves its place to private sector or contract-based doctors in terms of provision, and limits its role with regulation and control.[804]

The major sources of these reforms are World Bank documents. In *Financing Health Services in Developing Countries: An Agenda for Reform*,[805] the three major problems of health sector in developing countries are defined as allocation / insufficient spending on cost-effective health activities; internal inefficiency of public programs; and inequity in the distribution of benefits from health services. And four policy reforms were proposed: The first was to charge users of government health facilities and to institute charges at government facilities, especially for drugs

[803] Ağartan, "Health Sector Reform in Turkey".

[804] Ağartan, "Sağlıkta Reform Salgını."

[805] World Bank, *Financing Health Services in Developing Countries: An Agenda for Reform* (Washington D.C.: The World Bank, 1987).

and curative care. This would increase the resources available to the government health sector, allow more spending on underfunded programs, encourage better quality and more efficiency, and increase access for the poor. Use differential fees to protect the poor. The second reform involved providing insurance or other risk coverage: Insurance was necessary to relieve the government budget of the high costs of curative care; governments cannot raise government hospital charges close to costs until insurance is widely available. The third reform involved using non-government resources effectively: The non-government sector (including nonprofit groups, private physicians, pharmacists, and other health practitioners) would be encouraged to provide health services for which consumers are willing to pay. This will allow the government to focus its resources on programs that benefit whole communities rather than individuals. Decentralization of the government health services was the fourth reform: Decentralize planning, budgeting, and purchasing for government health services, particularly the services offering private benefits for which users are charged. When setting national policies and programs, use market incentives where possible to better motivate staff and allocate resources. Allow revenues to be collected and retained as close as possible to the point of service delivery. This will improve both the collection of fees and the efficiency of the service.[806]

And the *World Development Report 1993: Investing in Health* advocates a threefold approach to health policy for governments in developing countries and in the former socialist countries.[807] First, foster an economic environment that will enable households to improve their own health. Policies for economic growth that

[806] Ibid., p. 3-6.

[807] World Bank, *World Development Report 1993: Investing in Health* (Washington D.C.: The World Bank, 1993).

ensure income gains for the poor are essential. Second, redirect government spending away from specialized care and toward low-cost and highly effective activities such as immunization, programs to combat micronutrient deficiencies, and control and treatment of infectious diseases. By adopting the packages of public health measures and essential clinical care described in the report, developing countries could reduce their burden of disease by 25%. And third, encourage greater diversity and competition in the provision of health services by decentralizing government services, promoting competitive procurement practices, fostering greater involvement by nongovernmental and other private organizations, and regulating insurance markets.

Here, the concern with poverty is obvious. The neo-liberalism of the 1980s caused great turbulences especially in Latin America. IMF led policies challenged the legitimacy of the states and the regimes, unemployment rates rose, and income distribution deteriorated. The neo-liberal policies which created higher polarization and poverty started to be challenged. Even the WB and the IMF had to change their policies. The WB focused on poverty to provide basic insurance to people so as to allow them to become actors in the market game.[808] In the case of health services, the poor were going to be protected through the basic insurance package and the well-off would have the chance to use additional services through private insurance. The WB proposed premium systems. People would behave like responsible consumers and control the services in such systems. The insurance fund would purchase the service from private doctors, clinics, laboratories, and autonomized hospitals. The referral chain should work to keep the 80% of the patients in primary care. It is assumed that

[808] Çağlar Keyder, "Giriş." In *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar*, eds. Çağlar Keyder, Nazan Üstündağ, Tuba Ağartan and Çağrı Yoltar (İstanbul: İletişim Yayınları, 2007), p. 22.

variety of opportunities would increase competition and this would improve the quality of service. So, a less decentralized and more competitive system was proposed together with a contribution based private and general health insurance.[809]

The reform project of the TPP-SDPP coalition government was in line with that of the World Bank. To discuss this reform project, the MoH organized the First National Health Congress in 23-27 March 1992. Health related subjects were discussed in 34 working groups with 500 participants from all relevant institutions, sectors, universities, professional associations and the press. Each group prepared a report at the end of the Congress. After the Congress, all group reports were published in a volume and a health policy draft document was assembled by a group of editors. The draft document was opened to public discussion and sent to the participants of the Congress as well as to all relevant individuals and institutions and to the World Health Organization, and the comments received were published. The draft document was revised and the National Health Policy Document was developed. The final document was presented at the Second National Health Congress in 1993.[810]

Before the First National Health Congress, the Ministry of Health expressed its major targets: Family medicine, general health insurance and the autonomization of hospitals on the way to their privatization. Actually, in the group discussions family medicine was rejected, general health insurance was accepted, and the autonomization but not the privatization of hospitals was accepted. Family medicine was discussed and rejected in the working group of basic health services. The members of the group made suggestions for the improvement of the socialization.

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[809] Ibid., pp. 23-25.

[810] Ministry of Health of the Republic of Turkey, *Health Sector Reforms in Turkey, 1997*, Health Project General Coordination Unit (Ankara: Ministry of Health, 1997), p. 27.

They were public health specialists who were active in the socialization. They explained the "failure" of the socialization with the errors in its application not with its theoretical structure. They rejected the family medicine system as it was a "retreat" and as it was contrary to "modern health care approach." Family doctors should be trained for employment in basic health services which would be provided at health posts and neighborhood policlinics.

The working group on financing health services was composed of officers from the Ministry of Health, social insurance institutions and private insurance firms. The TMA, which had defended the national health service model since late 1970s, was not represented. The working group on finance adopted a premium-based general insurance system, in line with the draft document of the Ministry of Health. The working group on hospitals proposed an autonomous and enterprise-type hospital structure. The hospitals would be administered by local authorities, and controlled by the center. Their internal management structure would be democratic. However, there was no reference to privatization in the report. The draft document prepared by the Ministry of Health after the Congress claimed to be based on the working group reports. But this was not the case. The document reflected the initial targets of the Ministry of Health. This attitude of the Ministry of Health was criticized by the participants of the Congress and the TMA published a report about the process. In this report the Ministry of Health was criticized for adopting the free market ideology. A tax-based national health service model was proposed together with the socialization. The TMA was defending the socialization instead of family medicine. It was against privatization and autonomization.[811] The TMA would maintain this ideological position and challenge the more or less similar reform

[811] İlker Belek, "Türkiye Sağlık Reformları." *Toplum ve Hekim*, 16(6) (Kasım-Aralık 2001): 438-447, p. 444.

projects of the following governments. Until the late 1970s, the TMA advocated general health insurance and criticized the socialization on the grounds that it was unrealistic. In the highly politically polarized atmosphere of the late 1970s and the early 1980s the TMA adopted a leftist position and started to challenge reform proposals of various governments which were based on GHI, family medicine, and privatization. It became the ardent supporter of socialization.

Some of the participants of the Congress, public health specialists Gazanfer Aksakoğlu, Gürhan Fişek and Necati Dedeoğlu, sent letters to the Ministry of Health protesting the attitude of the Ministry and proposing the application of the socialization in the proper sense. They explained the possible negative outcomes of family medicine, general health insurance, and privatization. In his letter to the Minister of Health, Aksakoğlu expressed his views on the Basic Health Services section of the draft document of National Health Policy. He explained the reasons of their opposition to family medicine: First, there already existed a health organization with its legislation, infrastructure and personnel. Second, the state could not abandon its public duty of providing health; family medicine would create a health market for private practitioners. Third, private and personal medicine had always been the most expensive; competition would increase excessive use of technology and unethical behaviors. Finally, preventive, curative, and rehabilitative components of health service could not be separated; if all these services were not provided by a team only curative services would be provided.[812] The contrast between socialization and family medicine would always be expressed in these terms and the opposition of public health specialists and the TMA would intensify when the pilot project for

[812] Letter of Aksakoğlu to Yıldırım Aktuna, 1 April 1993.

implementing the system got initialized in the summer of 2005 as a step of the Transformation in Health Program, a point I will analyze later on.

The process created tensions and the relations between the Ministry of Health, and the TMA and health syndicates went sour. The Second National Health Congress was organized in April 1993 in such an environment. The TMA and health syndicates declared that if the National Health Policy document was not changed, they would walk out of the congress. Their voices were suppressed and they walked out of the congress. Right after the congress, health reform legislation drafts and their rationale were declared by the Ministry of Health. In these drafts health posts and family medicine were put down together;[813] public health institutions were becoming social health enterprises; premium-based general health insurance was established to cover basic benefits package.[814] People were classified based on their income and each group would pay a different amount of actuarial premium. Those in the first degree, i.e., people earning 1.2 times or less of minimum wage, would not pay any premium.[815] Every insured person would benefit from the health services included in the basic benefits package equally regardless of the premium they paid. The content of the package was not clarified in the law and said to be regulated by the Health Coordination High Council.[816] The financing of the health care services was separated from the service provision. This separation was expected to promote the efficient use of funds spent for health through consciousness of costs and control of

[813] The existence of both family medicine and health posts is based on the prediction that contract-based family doctors would not prefer to work in rural Turkey. So, health posts were kept to provide service to the peasants. However, this would create a dual structure in which family doctors served the urban population and health posts served the rural.

[814] Sağlık Bakanlığı, *Sağlık Reformu Kanunları (Tasarı Taslakları)*, Sağlık Projesi Genel Koordinatörlüğü (Ankara: Sağlık Bakanlığı Yayınları, 1993).

[815] Ibid., p. 82-83.

[816] Ibid., p. 57.

expenses from the insurance point of view and promote quality by introducing competition in service provision.[817]

The rationale for health sector reforms was explained with reference to factors which were relevant for all countries: "...population growth, demographic changes, predominance today of a more expensive disease pattern, expectations of the people, and technological innovation and development are increasing pressure on health-care resources." The shortage of funds, instability in the quality of services, a decline in the standards of the medical profession, wasting of resources despite short supply and low efficiency of health care systems in Turkey, provide the main reasons for the rationale of the Health Reform Activities in Turkey.[818] Also, the unsatisfactory health indicators, given the country's level of socio-economic development, necessitates a change in the system. The socialization of health services was not found to be proper for a rapidly ageing and urbanizing population.[819] "The current health system also suffers from problems concerning equity. Although all MoH service delivery institutions are subsidized to the 60% of the actual costs, only insured people are entitled to free access at the point of use".[820]

A Health Services Utilization Survey (1992) revealed these equity problems: The rate of application to doctors was lower in Eastern and rural Turkey. For all age groups the application to doctor in urban areas was 1.6 times more than the rural areas. Those without any health insurance utilize medical services (1.6) less than the others (3.3). 48.7% of the population preferred hospitals as the first place of contact. This percentage was 57.6 in urban areas. All groups in rural areas, regardless of their

[817] Ministry of Health of the Republic of Turkey, *Health Sector Reforms in Turkey, 1997*, p. 33.

[818] Ibid., p. 22.

[819] Ibid.

[820] Ibid.

level of education, utilized health posts more often.[821] As already mentioned in the previous chapter, health posts were used by the poor and rural segments of the population. These people were devoid of financial means and insurance which made it difficult for them to apply to secondary and tertiary institutions. People tried to solve their problems in the nearby health posts unless their condition got serious.

As is the case in other countries going through a reform process, it was not only efficiency (which usually implies the provision of the necessary service with minimum cost), but also improvement in terms of access and quality that constituted the major targets. In the Turkish context, the pressure for cost-containment started to be taken seriously in the 1990s, although the real increase in health expenditures was not that fast as revealed in the finance report prepared by Tokat and his working group.[822] In nominal terms there was a serious rise in public health expenditures between 1992-1996, but in real terms that was not the case. Also in the SPO's calculations the share of total health expenditures in GNP, the share of public health expenditures in the GNP, and per capita health expenditures did not show that much difference between 1992-1996. A fast rate of acceleration in all these would occur in the late 1990s and the early 2000s (see Table 36). The economic crisis of 1995 may account for this slow pace of increase between 1992-96. Health spending was directly related to the economic situation of the country. Not only the total amount spent on health care but also its share in the GDP tend to rise with income. So, the harsh economic conditions might have diminished health spending although the demand for health care continued to rise.

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[821] Sağlık Bakanlığı, *Birinci Sağlık Projesi: İnsangücü Geliştirme*, Sağlık Projesi Genel Koordinatörlüğü (Ankara: Sağlık Bakanlığı Yayınları, 1999), pp. 12-13.

[822] Sağlık Bakanlığı, *Türkiye Sağlık Harcamaları ve Finansmanı: 1992-1996*, Mehmet Tokat et.al, Sağlık Projesi Genel Koordinatörlüğü (Ankara: Sağlık Bakanlığı Yayınları, 1997).

The drastic stabilization program announced by the Çiller government in April 5, 1995 brought containment of costs in the field of health care. The program consisted of immediate short-term measures (tax raises, cuts in expenditure, rises in interest rates, and sharp price increases for government services and state products) and in part also of plans for tax reform, an independent central bank, increased exports and a faster rate of privatization.[823] After April 5, hospitals and health posts had difficulties in providing even the basic pharmaceuticals and medical equipment. Those who were covered by a security scheme had problems in buying pharmaceuticals as they were unable to pay the 20% contribution rate. The Ministry of Health, far from giving any support to the hospitals, became indebted to them.

Maybe the rise in health expenditures was not that pressing in the 1990s due to the economic situation, but it was obvious that it would be pressing in the future. The problems were related not only to the need to contain costs. The most urgent task was to cover everyone and make health services available and accessible to all. Although there was a constant rise in the percentage of population covered by health insurance there was still a large portion left outside. When health reform legislation drafts were prepared in 1993, only 61.6% of the population was covered by an insurance scheme. The remaining one-third should also have been covered. The other problems within the system were summarized by the Ministry of Health in a health reform document: There was no long-term, consistent and stable health policy. Primary health care had not developed and health services had become hospital-centered. The referral chain system did not work. The hospitals were managed and used inefficiently. Hospital management was very centralized. There was difficulty in accessing hospital services in terms of geographic distance and service quality.

[823] Zürcher, p. 323.

The resources allocated to the health services were too low compared to other countries. Almost half of the health expenditures were derived from out of pocket payments. There was no adequate allocation for preventive and health promotion services. In the public sector, service providing and financing duties were usually provided within the same body, with no incentive for efficient and effective use of resources. The geographic distribution of health personnel was unbalanced. The functional composition of health personnel according to their specialty fields was inappropriate. The basic training of health personnel did not meet the requirements of the health services, and the continuous training was inadequate and irregular. Health professionals had various occupational problems regarding the issues of employment, remuneration, and benefits. The management of health services was very centralized. The central MoH organization was complicated and organized vertically, with some units responsible for certain types of services, some for serving specific population groups, and some dealing with specific diseases. This resulted in coordination problems even among the divisions of the central MoH. The current health legislation was out of date, reflecting the conditions and mentality of the late 1920s and the early 1930s. There was a lack of information concerning health and health services, including epidemiological data and data on services and service costs.[824]

All these problems were expressed in the five year development plans and the general assemblies of socialization that were analyzed in the previous chapter. Throughout the 1960s and 1970s the same problems were discussed as problems that needed urgent solutions. Yet we might assume that they intensified due to the rise in demand. The rise in both the number and the proportion of insured and urban

[824] Ministry of Health of the Republic of Turkey, *Health Sector Reforms in Turkey, 1997*, pp. 23-24.

population increased the demand for health care which was reinforced by the developments in medicine.

Starting from the late 1980s, the Turkish governments tended to solve the problems of the health care system with the support and guidance of the World Bank. The major problems of low coverage, poor health status, complexity and lack of regulation in health service provision, loss of confidence in public health services, and inequalities in the geographical distribution of health care personnel and facilities were going to be solved through health reform projects. The major components of these projects were the establishment of a GHI, the restructuring of the health care delivery system, the decentralization of health care services, and the enhancement of the information systems. However, the weak coalition governments failed to come up with radical measures. High inflation, fiscal crises, and armed conflict did not allow the governments to apply any real project. Throughout the 1980s and the 1990s, health reform was discussed most intensely during the TPP-SDPP government. The government declared its goals as the application of national health policy (decentralization in health services, the autonomization of public hospitals, and the transition to GHI), the abolition of regional inequalities, and the enforcement of Green Card.[825] Among these, only Green Card could be actualized.

The Green Card Scheme

The Green Card was an important promise of the TPP in its election campaign in 1991. Newspapers were full of stories of poor people who could not pay health

[825] Republic of Turkey, *TBMM Tutanak Dergisi*, Term 1, Volume 12, Legislation Year 19, Session 84, 17 June 1992 (Dönem 1, Cilt 12, Yasama Yılı 19, 84. Birleşim, 17 Haziran 1992).

expenses and were held in pledge by the hospital administrations. The TPP referred to these stories and promised to open all hospitals to the poor.

Among these stories, one finds the story of a new born baby who was smuggled out of Muğla State Hospital in a plastic bag by his aunt as his family could not pay for the expenses of birth in April 1991. Two days later he died and his family accused the hospital personnel for not caring and feeding the baby while he was held in pledge.[826] Another story was about a shepherd who died at Çukurova University Hospital due to the out of date rabies vaccination. His wife gave birth in the same hospital. The shepherd's body was held in pledge in the morgue and his daughter in the birth clinic as the family could not pay the expenses.[827] Another story was about a boy who was struck by lightning and held in pledge at Çukurova University Hospital as his poor father could not pay the treatment fees in June 1991. His father was able to find some money from Solidarity Fund and the municipality, but had to sign a bill of exchange for the remaining amount.[828] In another case, the twin sons of Kürekli family were held in pledge at the Kayseri Faculty of Medicine Hospital for 28 days and were saved with the money provided by the Nevşehir governor and charitable citizens.[829] Escaping was the only way to not be held in pledge: "The simplest dressing is 25,000 liras and bed is 150,000 liras in the public hospitals. So, the poor patients escape from the hospitals in which they could not pay the examination, treatment and bed expenses so as not to be held in pledge."[830]

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[826] "Rehin kalan bebeği poşette kaçırdılar" (Pledged baby abducted in a bag), *Hürriyet*, 1 April 1991; "Rehin Bebek Sabri öldü" (Pledged Baby Sabri Has Died), *Hürriyet*, 3 April 1991.

[827] *Hürriyet*, 1 March 1991.

[828] "Önce yıldırıma, sonra yoksulluğa çarptı" (Struck first by lightening, then by poverty), *Hürriyet*, 10 June 1991 and "Rehin kaldığı hastaneden 10 milyonluk senetle kurtuldu" (Freed from pledge in hospital by a debenture of 10 million pounds), *Hürriyet*, 27 June 1991.

[829] *Hürriyet*, 29 August 1991.

[830] *Hürriyet*, 10 July 1991.

After the elections, the Minister of Health Yıldırım Aktuna sent notice to governors and head doctors for the free treatment of poor patients.[831] He asked "Was there any pledge case before 1980? Was there any complaint about this?" He criticized the former government for having forced everyone to pay to increase the revolving funds. The amount transferred from the Treasury to the health services had decreased and the government had tried to finance health services from the people. Aktuna said it was natural to charge people who had the means, but the poor should be protected.[832] There was no uniformity in the application, however, and the news on the application of the notice was given in a very pessimistic tone: "Long patient queues, useless bureaucracy, wrong diagnosis, fatal delays in operations, the requirement of going first to the private offices to find a hospital bed, and prescriptions costing millions of liras have made the health services inaccessible for those without health insurance and these problems cannot be solved with a notice."[833]

The notice could not be applied at Diyarbakır State Hospital as the hospital did not have the means to cover the expenses:

> The largest health institution of the Southeastern Anatolia region is nearly bankrupt. As more than 90% of the patients come with poverty records and are treated for free the revolving fund is drained. The debt of the Diyarbakır State Hospital to public and private institutions exceeds 1 billion liras... The head doctor of the hospitals says, 'The amount sent by the Minister of Health is very little. It is a symbolic amount. It is impossible to cover the expenses with the revolving funds. We have started to refuse the patients. There is a threat of closure'.

[831] *Milliyet*, 3 December 1991.

[832] *Milliyet*, 23 November 1991.

[833] *Milliyet*, 5 December 1991.

When the treatment of the son of Münevver Özkan with a poverty record was refused she said, "They said when Demirel came to power hospitals would be free. Green cards would be given. But now we are refused. If my son will not be treated he will die."[834] In the underdeveloped East, due to the small share of formal sector, the proportion of the insured and well-off was small. Although the hospitals in the Western cities had financial problems the situation of those in the East were much more difficult. When the Green Card was introduced, the majority of Green Card holders would be from the Eastern regions.

The TPP-SDPP coalition introduced the Green Card scheme in 1992 as a social assistance mechanism for the poor citizens who were excluded from the health care coverage provided under public insurance mechanisms. At that time it was essentially designed as a provisional arrangement to sustain citizens who were not covered by any of the public insurance schemes and who were below a definite level of income, until a more general and universal health insurance system would be established. To understand the peculiarity of the Green Card scheme we might elaborate earlier legislation on the treatment of poor patients. When the issue of the treatment of the poor in related legislation throughout the Republican period is examined it is seen that there has always been a concern to protect patients without financial means. The state took the responsibility of providing preventive and curative services for the poor. Yet, the Green Card implied a rupture with the earlier legislation as it introduced criteria to define poverty and the services that would be provided for the poor. The earlier legislation could not guarantee service provision while the Green Card started to function as the fourth security scheme.

[834] *Milliyet*, 17 December 1991.

From 1871 onwards, the Ottoman state had appointed doctors to province and county centers with the title "country doctors" (*memleket tabibi*). These doctors were examining the poor free of charge two days of the week. After the establishment of the Republic, examination and treatment houses (*muayene ve tedavi evleri*) with 5-10 beds were built to carry health service to places without hospitals. They were known also as dispensaries. The curative service in dispensaries was free, and the poor could receive free medicine. The First National Health Plan (1946) regulated the establishment of health centers. In health centers medicine for preventive care, child birth, and emergency was free as well as medicine for poor patients.

In the Municipality Law[835] article 15/34, these are regulated as the duties of a municipality: To help the children of poor families, orphan, poor, and destitute children by providing money, doctor, medicine, food, cloth, shelter, education and training; to treat poor patients free of charge, provide medicine, bury the poor free of charge, and to look after those who are destitute and incapable of work. Article 57 clarifies the role of the municipality in health care: To establish pharmacies in places without any; to provide free or cheap medicine to the poor, to establish clinics and dispensaries which might not charge money; and to employ midwives for helping poor mothers in giving birth.

The poverty record, which is still used today in application for social assistance, was first regulated in the Law on the Establishment of *Muhtar* and Village Councils in Cities and Towns.[836] Article 3/15 assigns the *muhtar* and the Village Councils the task of giving poverty records to those in need of assistance.

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[835] *Belediye Kanunu*, no. 1580, *Resmî Gazete*, 14 April 1930.

[836] *Şehir ve Kasabalarda Mahalle Muhtar ve İhtiyar Heyetleri Teşkiline Dair Kanun*, no. 4541, *Resmî Gazete*, 15 April 1944.

Before the Green Card, people had applied to hospitals with poverty records but there was no guarantee that they would receive free health service.

In the Law of Public Health (1930) there was no specific regulation for the treatment of the poor. The central government left the provision of curative services to the municipalities and special provincial administrations. The treatment of the poor was not an exception. Government and municipality doctors and midwives were assigned the task of helping poor women in giving birth (article 153), but there is no other reference to the poor in the law.

Articles 31 and 32 of the Law of Private Hospitals[837] regulated the application of poor patients in emergency cases: When poor patients applied in emergency cases they would be examined and treated free of charge and put in the free of charge department of the hospital and if there was no such department the expenses until their transfer would be covered by the municipality.

This early legislation reveals that municipalities were charged with the duty of protecting poor patients. This is in line with the early Republican mentality, which limited the role of the central government to public health and left curative services to local authorities.

In the Socialization of Health Services maybe not all the health services were provided free but a large amount of them were. According to the regulation on the execution of health service in socialized regions,[838] all kinds of services given in the health post within working hours were free. Diagnosis and life-saving medicine in centers would be free of charge. If a patient was referred to a hospital from a health centre, then hospital services would also be free of charge. In the regulation, poor

[837] *Hususi Hastaneler Kanunu*, no. 2219, *Resmî Gazete*, 5 June 1933.

[838] *Sağlık Hizmetlerinin Sosyalleştirildiği Bölgelerde Hizmetin Yürütülmesi Hakkında Yönetmelik*, decree number 6/3470, *Resmî Gazete*, 9 September 1964.

were exempted from the daily amount of seven liras for food and bed in hospitals, and health post fee which was taken in cases of applications outside the working hour. The priority of the socialization was to provide health services to the peasants and the poor.

The Regulation on Hospitals (1955) exempted those with poverty records from paying the expenses. If the patient did not have a poverty record and could not afford the costs, the head doctor had the right to allow their free treatment. The latter Regulation on Hospitals (1973) exempted those whose need for free treatment was approved by the MHSA or the highest administrator of the region. Like the 1955 regulation, the 1973 regulation held the head doctor in charge of determining those who would be exempted from payment.

The Law on Social Disability and Old Age Pensions[839] defined beneficiaries as those who were not covered by any other social security institution, without income generating poverty and any other sources of revenue, and without close relatives to take care of them. Those who were covered by this scheme were to receive free health service from public hospitals. However, they had to pay for the medication. With an amendment to article 7 on 21 April 2005 (law no. 5335), they were provided Green Cards which allowed them to get free medication.[840]

The Law on the Encouragement of Social Cooperation and Solidarity[841] was accepted to provide social assistance to the poor. It was meant to provide the services regulated in the law through the Fund for the Encouragement of Social Cooperation

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[839] *65 Yaşını Doldurmuş, Muhtaç, Güçsüz ve Kimsesiz Türk Vatandaşlarına Aylık Bağlanması Hakkında Kanun*, no. 2022, *Resmî Gazete*, 10 July 1976.

[840] The number of those who receive pension (old-age, disability and handicapped) in 31 June 2007 is 1,254,530. The old-age pension is monthly 73.53 YTL while handicapped pension is 147.06 (for 40-69 % handicapped) and 220.59 (for more than 70 % handicapped) YTL after 30.6.2007 (sgk.gov.tr).

and Solidarity. The Fund was conceived as an umbrella organization covering local foundations (today the number of foundations is 933) managed by representatives of the central government at the district level. Before the Green Card Law, people had applied to the Fund for their health expenditures. The coverage of the Green Card law was limited to the expenses of the inpatient health services of Turkish citizens residing in Turkey who were not covered by any social security institution, and whose monthly income was less than one-third of net minimum wage for a person in a household. An amendment was made in this regard with a government notice published on 25 January 2002, which extended coverage to include the expenses of outpatient medical examination, while the coverage of the medical expenses of outpatient care by the scheme was initiated in January 2005 with law no. 5222 (14 July 2004). So, before the amendment in 2002 Green Card holders had applied to the Fund for outpatient care and medication, and after that only for medication until the enactment of law no. 5222. With a regulation published in the Official Gazette (22 December 2004) it was declared that all the expenses of Green Card holders would be covered by the Ministry of Health budget. Today, no health benefit is provided by the Fund to any insured, including Green Card holders. However, in article 11 of the Green Card Law it is asserted that for those who do not qualify for the Green Card and yet cannot afford health services, the clauses of the Law on the Encouragement of Social Cooperation and Solidarity will be applied.[842]

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[841] *Sosyal Yardımlaşma ve Dayanışmayı Teşvik Kanunu*, no. 3294, *Resmî Gazete*, 14 June 1986.

[842] "The clauses of the Law number 3294 on the Encouragement of Social Cooperation and Solidarity will be applied for the payment of health services which are beyond the financial capacity of those who do not qualify for the Green Card, and which are not covered by this law." (*Yeşil Kart alacak durumda olmayanların ödeme gücünü aşan sağlık hizmetleri ile bu Kanun kapsamında olmayan sağlık hizmetleri ile bu Kanun kapsamında olmayan sağlık hizmetlerinin ücret ve bedellerinin karşılanmasında 3294 sayılı Sosyal Yardımlaşma ve Dayanışma Teşvik Kanununun hükümleri uygulanmaya devam edilir.*)

The Basic Law on Health Services brought the register until the establishment of general health insurance. The health expenditures of the recorded citizens would be covered by the health insurance register and those of the poor by the solidarity funds.

The Law on the Covering of the Treatment Expenses of the Poor Citizens by the State through a Green Card[843] constituted a rupture with the earlier legislation. The parliamentary discussion on the Green Card is important in terms of revealing the position of the parties and the peculiarity of the law.

When the TPP-SDPP coalition brought this law to the general assembly the harshest critiques came from the members of the MP. Yaşar Eryılmaz from the MP said that in the law the MP had enacted (he meant the Solidarity Fund Law), the declaration of poverty was sufficient for free treatment whereas this new law necessitated official registration which was an affront to human dignity. The opposition found the income limit very low and submitted a motion for the minimum wage to be the limit. The covering of the outpatient services and medication was also proposed in the motion. But it was rejected. The Green Card was criticized for increasing the burden of bureaucracy.

Other than the opposition, the criticisms of a TPP member, Münif İslamoğlu, are also important. His major concern was the dignity of citizens. When he was the head doctor of Numune Hospital, Demirel had told him that "we are asking for poverty record... There is no need! Why do you push my citizen to come to heel in front of the *muhtar* and say that he is poor and needs a record? Accept all citizens who declare their poverty. Even if Koç says that he is poor, do not charge him." İslamoğlu said he had applied this and it had worked. For him, the poverty record

[843] *Ödeme Gücü Olmayan Vatandaşları Tedavi Giderlerinin Yeşil Kart Verilerek Devlet Tarafından Karşılanması Hakkında Kanun*, no. 3816, *Resmî Gazete*, 3 July 1992.

degraded the citizens and people should not be discouraged to apply to the hospitals by being stamped based on their income. “This citizen serves for us in the army, he/she pays taxes; and his/her major problem is sickness and he/she should trust his state in this case.” İslamoğlu accused Özal of transforming hospitals into enterprises and bringing the premium system in which doctors were paid in accordance with the number of patients they examined as it led to the refusal of poor patients. That is why people appreciated their catchphrase of “we will abolish the mentality of ‘pay or die.’” He opposed the bringing of a criteria of poverty because no Turkish citizen would lose his dignity and say that he was poor although he was not. But İslamoğlu’s motion for the abolition of criteria was not brought to the proceeding. Minister of Health Yıldırım Aktuna said it was a must to bring a criteria otherwise people had to declare their poverty each time they went to a hospital which was much more humiliating. For him, this card would give people back their pride. He explained the necessity of defining those who lacked the capacity to pay as follows: “If you do not define the criteria of those who lack the capacity to pay there will be problems in the council, which will make this assessment or you introduce subjectivity. The poverty of the people cannot be determined by their attitudes, clothes, ways of cutting a poor figure, or ways of talking.” He said these criteria would lift the burden of the councils. He thought that the criteria would prevent the partial distribution of the resources of the fund as it was the case in the MP goverment. He said the Fund would help people who could not get Green Cards but who still lacked the capacity to pay. The Green Card would be applied until the transition to general health insurance was completed. It was necessary because citizens would not have to obtain poverty records from the *muhtar*s or be subject to the compassion of the head doctors until the transition. He predicted that 2,907,000 people would be given Green Cards

in the urban areas and 7,261,800 in the rural.[844] This was a realistic estimate based on official statistics on poverty. By the late 1990s the actual outcome came close to these numbers.

Although there have been serious changes in terms of health policies there has always been a concern for protecting the poor patients. Whether this has been accomplished or not is another question. But, when we look over the legislations starting from the late Ottoman period we realize that the state accepted the responsibility of covering the poor in the field of health care. Governments did not take radical measures to alleviate poverty and chose to leave the poor to the discretion of charitable people. However, in the field of health care state protection was guaranteed in the laws. Of course, this did not provide full security to the poor. Even when they were examined freely in one way or another the medication was always a problem. Or if they had chronic illnesses which required long-term health care and medication they had to apply voluntary initiatives. Yet, in legal terms it was the responsibility of the state to provide health care to the poor. This responsibility of the state might be explained with reference to the specificity of health care. This is a field which cannot be left to personal solutions. It is hard to justify the lack of health care for some people. The inequalities in health and health care are the most intolerable. Also the feeling of threat might have a role; in the case of epidemics the poor patients must be treated to protect the society at large.

The Green Card Law constituted a break with the former legislation as it brought criteria in the definition of the poor and the services they would receive. Although the former legislation seemed to guarantee state protection, it never was the case and people had to apply informal mechanisms. The novelty of the Green Card

[844] *TBMM Tutanak Dergisi*, Term 1, Volume 12, Legislation Year 19, Session 84, 17 June 1992.

Law is the detailed rules and regulations which would bring standardization to the functioning of the system.

The Green Card Law was accepted when the need to respond to emerging forms of poverty became urgent. In the late 1980s the conditions leading to poverty were no longer transitory and the extended family and social support mechanisms could not provide support.[845] It became harder to be employed in state owned enterprises, and the modern private sector was now faced with the imperative of competitiveness. Many of the programs of agricultural input subsidy and output price support were revoked in conformity with principles of market rationality. The survival of peasant agriculture became increasingly difficult and the capacity of the rural hinterland to support family strategies was seriously undermined. For the newcomers in the cities, the support of the rural hinterland was crucial. Urban livelihood came under pressure with the changing place of irregular settlements in the urban environment. With the geographic expansion of cities and the new popularity of suburban middle-class residences, new immigrants had to compete over urban peripheral land and it became nearly impossible to build up *gecekondu*s.

The violent conflict between the Turkish army and Kurdish separatist forces, which started in the mid-1980s and continued through most of the 1990s, forced many Kurdish people to leave their villages under threat of violence or simply because of total loss of livelihood. Unlike the previous migrants, Kurdish people arrived in the city without assurances provided by existing networks formed by family members or co-locals.[846] A considerable portion of the population was living below the food and non-food poverty line (local cost of basic needs basket including

[845] Ayşe Buğra and Çağlar Keyder, *New Poverty and the Changing Welfare Regime of Turkey*, Report Prepared for the United Nations Development Programme (Ankara: UNDP, 2003).

[846] Buğra, "Poverty and Citizenship," pp. 39-40.

non-food): 28.3% in 1994. The proportion of the population living on less than one dollar a day per capita at PPP prices was 1.1% in 1994 while the proportion of those living below the food poverty line (local cost of minimum food basket) was 2.9%.[847] Although Turkey did not have a considerable amount of extreme poverty the proportion of food and non-food poverty (nearly one-third of the population) necessitated drastic measures.

Access to the Green Card scheme is based on investigation and verification of a person's level of income, hence the poverty of the applicant. According to the Green Card law and related decrees, the sources of income that are considered in calculating the monthly income of a household are: in-cash payments for services; in-cash agricultural revenues; rent from estates or interests; in-cash transfers or grants from public, private institutions or other people; and in-kind income in any form above. The total income of the household is calculated by adding up all revenues from these sources. If the monthly income per household member is lower than one-third of the net minimum wage and the applicant is not covered by any of the public health insurance schemes, he/she is entitled to receive a Green Card.

The Green Card is a means-tested benefit as it is conditional upon low level of income and lack of insurance. In social policy literature, means-tested benefits are seen as part of a "residualist" approach and often regarded as being incompatible with social citizenship rights that should be realized through benefits that are in line with "universalist" approaches. Universal old age and health benefits are more in line with equal citizenship rights than means-tested schemes. Means-tested benefits are criticized as they easily provoke stigma and dualisms, while universal programs deliberately aim to eliminate any kind of status distinction.

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[847] World Bank, *Turkey: Joint Poverty Assessment Report*.

As discussed in chapter two, Esping-Andersen defines three distinct models of welfare state solidarity: residual, corporatist, universalistic. A residual approach to risk pooling divides society into them and us: on one side, a self-reliant majority of citizens who can obtain adequate insurance through private means; on the other side, a minority of dependent welfare state clientele. Residual programs are typically needs-tested and generally destined to be ungenerous since the median voter is unlikely to extend much support to benefits of scarce personal relevance.[848] A means-tested benefit cannot provide a social right of citizenship because it threatens the integrity of the "self." This is because the processes of approval designed to determine whether one deserves the means-tested benefits are processes of social exclusion. The stigma attached to means-testing threatens not only the applicants' sense of 'self', but also their ability to function as normal human beings.[849]

Zygmunt Bauman warns us about the division and exclusion means-test benefits would bring. Only when social services are aimed at the community as a whole and so are seen as benefiting everybody, are they able to foster social integration and a sense of community. Confine the provision of services to a means-test and the community is immediately split into those who give without getting anything in exchange, and those who get without giving. The overall effect of means-testing is division instead of integration; exclusion instead of inclusion.[850] Vicente Navarro shows how means-test programs, as a percentage of all social (including health) programs, declined most substantially during periods in which socialist parties that gave paramount importance to the principle of universality were in power

[848] Esping-Andersen, *Social Foundations of Postindustrial Economies*, p. 40.

[849] Fred Twine, *Citizenship and Social Rights: The Interdependence of Self and Society* (London, Thousand Oaks, New Delhi: Sage Publications, 1994), p. 97.

[850] Bauman, pp. 49-50.

in those countries.[851] Alan Deacon and Jonathan Bradshaw point out in their excellent history of the means-test that it was indeed to the promise to abolish the means-test that the Beveridge Report owed its "tremendous popularity."[852] And as mentioned in the second chapter, Paul Pierson cites the reforms that indicate structural shifts in the welfare state as first, significant increases in reliance on means-tested benefits; second, major transfers of responsibility to the private sector; and third, dramatic changes in benefit and eligibility rules that signal a qualitative reform of a particular program.[853] So, means-testing is an indicator of a shift towards the neo-liberal approach and it contradicts the universalistic welfare.

However, we should not ignore the historical context while analyzing a means-tested mechanism. In the developed welfare countries of the West, means-test might be considered as a retreat but in the developing countries it could serve the improvement in citizenship status. Jeremy Seekings explains the pro-poor welfare reforms in countries across the South in the last two decades as components of a more egalitarian welfare system. Seekings asserts that there would be resistance to citizenship based rights in corporatist systems. People who are covered by the existing system would oppose the universalization of some rights.[854] But in the case of health, this opposition is expected to be weaker as it is hard to deny health service to some portions of the population.

In Europe, initial social policy measures were means-tested. In developing countries, such measures came late. The developmentalist assumption that everyone

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[851] Vicente Navarro, "Why Some Countries Have National Health Insurance, Others Have National Health Services, and the U.S. Has Neither." In *Why the United States Does Not Have a National Health Program*, ed. Vicente Navarro (Amityville, New York: Baywood Publishing, 1992), p. 138.

[852] Alan Deacon and Jonathan Bradshaw, *Reserved for the Poor: The Means Test in British Social Policy* (London: Martin Robertson & Co Ltd, 1983).

[853] Pierson, "The New Politics of the Welfare State." p. 157.

would be integrated in the formal sector and so would have insurance proved to be invalid. The governments of the developing countries tried to find new ways of providing citizenship based coverage, rather than coverage based on employment, or status in employment. Although means-tested in character, the Green Card implies the acceptance that state is responsible for providing health services to the poor and cannot leave them to the discretion of hospital head doctors, charitable institutions, or solidarity funds. The measures like the Green Card imply a transformation of the poor relief from an issue of charity to an issue of citizenship.[855]

The Green Card might be considered an improvement in citizenship status especially when we think of the former situation. I have already illustrated the pledge stories. Before the Green Card people had great difficulties in receiving health care. Every time they went to a hospital they had to beg for free service and prove their poverty. There was no guarantee of receiving free health care although the legislation seemed to protect the poor. The regulations were open to interpretation and poor patients had to convince the health personnel. They might receive free health care, but this did not mean that they were treated equally. The interviews I conducted with various health personnel reveal the problems of the former situation.

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[854] Seekings.

[855] Michael Ignatieff explains this relation as follows: "The language of citizenship is not properly about compassion at all, since compassion is a private virtue which cannot be legislated or enforced. The practice of citizenship is about ensuring everyone the entitlements necessary to the exercise of their liberty. As a political question, welfare is about rights, not caring, and the history of citizenship has been the struggle to make freedom real, not to tie us all in the leading strings of therapeutic good intentions." Michael Ignatieff, "Citizenship and Moral Narcissism." *The Political Quarterly*, 60(1) (1989): 63-74, p. 72. For the relation between justice and charity see Allen Buchanan, "Justice and Charity." *Ethics*, 97 (1987): 558-575. Although he accepts the limitations of voluntarism and the strengths of collectivism Geoffrey Finlayson takes the former as an important component of the "mixed economy of welfare". For the role of voluntarism/charity in the development of welfare state in Britain between the years 1830 and 1990, see Geoffrey Finlayson, *Citizen, State, and Social Welfare in Britain, 1830-1990* (Oxford: Clarendon Press, 1994).

Turhan Temuçin, the head doctor of Numune Hospital between 1978-80, explained the procedure as follows:

> When I was the head doctor I requested from the patients to apply directly to me if they did not have money. Those who could not pay would come and see me. I asked them questions, some of which were tricky. I asked them about their income, whether they paid rents, whether they had any property, and etc. I repeated the same questions to be sure whether they were telling me the truth. When I said 'this patient will not be charged any money,' all the health expenses including bed, medication and other materials would be free. The expenses were covered from the revolving fund. Numune had enough resources. Around 5-10% were treated free of charge. The income from remaining 90% was enough. I did not ask for poverty record. I was sure I took right decisions.[856]

In that period, health costs were not that high and it was easier to provide free health service to the poor.

Social workers assisted the head doctors in means-testing. Kezban Çelik, a social worker in Sami Ulus Maternal and Child Health Hospital told me about a form sent from the Ministry of Health. "We were asking whether the patient had a house, a job, how much his rent was, how many children he had. It was more or less like a socio-economic scaling. After filling out this form we would decide whether the patient should or should not pay, or pay a certain amount. Ours was a suggestion. The head doctor or assistant head doctor would give the final decision." She mentioned that the health personnel showed ways of escaping to the poor, like writing down wrong addresses to the bill.[857] The solidarity network among the patients, doctors and other health personnel was mentioned also by other social workers I had interviewed.

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[856] Turhan Temuçin, interview by the author, tape recording, Ankara, Turkey, March 2006.

[857] Kezban Çelik, interview by the author, tape recording, Ankara, Turkey, March 2006.

The difficulty of receiving free health service intensified in cases of chronic illness. When there was the need for long-term treatment and medication, hospitals directed the patients to charitable institutions. Kayıhan Pala, who used to work as a head doctor, mentioned the situation of dialysis patients who had to apply dialysis associations.[858] Zafer Öztek said, "the situation was really bad before the Green Card, especially in case of chronic illnesses. We were sending people to special provincial administrations, municipality, Solidarity Fund, charitable organizations, various associations, Kızılay and etc." His account reveals the unequal treatment of poor patients: "In training hospitals the cases of poor patients were labeled as 'training cases' and it was the head doctor who decided it. But their operations were done by assistants as they were labeled as 'training.'"[859] The clinics in Yedikule Hospital told me that they had to give cheaper medicine with more side effects to poor patients who were not covered by any security scheme. Medication was always a problem even after the application of the Green Card. As it covered only inpatient medication before 2005, poor patients had to stay at the hospital to be able to obtain free medicine.

The Green Card solved these problems to a considerable extent. Although it might be criticized for being a means-tested mechanism that created stigma, the practice before the Green Card was much more stigmatizing. Having to prove your poverty every time you received some kind of service was humiliating. And even if you proved it, there was no guarantee that you would not be forced to find the money from Solidarity Fund associations, municipalities or charitable societies. A formal scheme like the Green Card made people feel much more secure and provided a kind

[858] Kayıhan Pala, interview by the author.

[859] Öztek, interview by the author, March 2006.

of “freedom from fear.” Another effect of the principle of means-testing is the steady deterioration of the quality of welfare services. But this criticism cannot be applied to the Green Card Scheme either because the holders receive health services in state hospitals together with other citizens. There are no separate hospitals or health packages for Green Card holders. It functions as a life saving mechanism for poor citizens who are excluded from the health system by the corporatist structuring of the welfare regime. The Green Card Scheme was established on the basis of the assumption that it was the responsibility of the state, not the funds, associations or charitable societies, to provide health services to the poor. It is a modern scheme of social assistance financed by public resources.

After the foundation of the Social Cooperation and Solidarity Fund in 1986, poor patients were directed to local funds for health expenditures. Fund for the Encouragement of Social Cooperation and Solidarity, which had been established when Özal was in power, was presented as an adaptation of the historical tradition of Ottoman charity. The aim was to mobilize private donations with the initiative and under the guidance of the state and alleviate the burden of welfare provision on the budget. Özal had had a conservative liberal approach which aimed to support the market with traditional solidarity. Buğra compares this approach with that of Demirel’s, which was shaped by the notion of citizenship. She considers two legislations -social disability and old age pensions (1976) and the Green Card (1992)- which were adopted when Demirel was in power as steps in the development of citizenship status. Both are means-tested that target the poor, yet they did not separate poverty alleviation from citizenship rights. Demirel emphasized the role of the state in social policy while Özal tried to deal with poverty through the country’s

traditional ethos of charity. The latter's approach was in line with the postmodern neo-liberal environment.

The TPP was against the use of extra budgetary funds and donations in poverty alleviation. The Green Card was a step in the transition from the notion of "compassion to the deserving" to the notion of "citizenship rights." The TPP saw Green Card as a practice that would replace the humiliating processes of obtaining a poverty record or attempts to prove poverty in hospitals. It would be a much more formal practice in line with social rights.[860]

There was a large difference in the percentage of the health service use of the insured and uninsured before the application of the Green Card, which also reveals the necessity for such a scheme. According to the 1992 Ministry of Health Research on Use of Health Services the inpatient treatment of the uninsured is 36% below the national average and for outpatient treatment it is 29% below. The annual average of application to a doctor is 3.04 for a SII member and 1.32 for the uninsured. Annual average of inpatient treatment is 4.7 for the general population but only 0.8 for the uninsured in the East. The uninsured cover around 60% of their health expenses. The 50.4% of the uninsured had difficulties in covering the expenses, 37% borrowed, 7.4% sold furniture and 2.7% executed a deed.[861] A survey on Green Card holders in Gölbaşı – Ankara in 1994 reveals that before the Green Card 90% of the holders

[860] Buğra, "Türkiye'de Sağ ve Sosyal Politika.". The Justice Party, which accepted the old age pensions in 1976, did not welcome the Thatcher-Reagan type liberal economy policies. The party emphasized social justice and social welfare. Demirel was well aware of the need to maintain social rights for the other rights to be realized. If a person was devoid of basic income resources necessary for a living then classical freedoms lost their meaning. He promoted progressive taxation for a just income distribution. The old, destitute, disabled, helpless and unemployed should be free from the fear of tomorrow. The Justice Party aimed to establish general health insurance to cover everyone, unemployment insurance, agricultural insurance, and social disability and old age pensions but could actualize only the last one (see Demirel, *Adalet Partisi*, chapter 6 for a well-written analysis of the welfare conception of Justice Party; also see Demirel, "Adalet Partisi."; Tanıl Bora).

[861] Oğuz Engiz, "Türkiye'de Sağlık Güvencesi Olmayan Kesim." *Toplum ve Hekim*, 11(73) (Mayıs-Haziran 1996): 57-59.

were covering health expenses from out of pocket payments, 2% from other insurance institutions, 2% from the Solidarity Fund and 6% from other sources.[862] Both this survey and another on Green Card holders in the Gemlik Health Training and Research District[863] emphasize the people's satisfaction with having Green Cards.

Nevertheless, it is not devoid of problems.[864] Although it brought criteria of poverty it did not put an end to disturbing confrontations - this time with the local authorities. The main measures of application regarding the key question who would be eligible for a Green Card, are set at the local level, especially by the varying practices and understandings of local Green Card Governing Committees. The very procedures of applying for a Green Card and going through a renewal, requires the "poor citizens" to constantly perform and narrate their poverty. The rumors and news in the Turkish media about Green Card holders running in Mercedeses, owning apartment buildings, being relatives of politicians, etc. contribute to the production of an "organized suspicion" towards Green Card holders. This "organized suspicion" leads the public opinion to demand more control over the system, and it legitimizes the Green Card bureaucrats' desire to have more control over who will be eligible for a Green Card.[865]

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[862] Işıl Maral, Sefer Aycan, Ayşegül Saraç and Ali Bumin, "Yeşil Kart Alan Kişilerin Bazı Özellikleri ve Yeşil Kart Kullanımı." *Toplum ve Hekim*, 11(71) (Ocak-Şubat 1996): 15-19.

[863] Cemal Hüseyin Güvercin, *Gemlik Eğitim ve Araştırma Bölgesi'nde Yeşil Kart Sahiplerinin Bazı Özellikleri, Yeşil Kartların Kullanımı ve Bunu Etkileyen Etmenler*, Uzmanlık Tezi, Uludağ Üniversitesi Halk Sağlığı Anabilim Dalı, 2000.

[864] For an analysis of Green Card as a violation of the ideal of equal citizenship, on the grounds that the poor people's access to the constitutional citizenship right of a healthy life is provided – and at the same time restricted – by means testing, see Çağrı Yoltar, *The Green Card Scheme: An Ethnography of the State and its 'Poor Citizens' in Adıyaman*, MA Thesis, Boğaziçi University, Department of Sociology, 2007.

[865] Ibid.

The bureaucratic procedures necessary to obtain a card are of a complexity, beyond the social skills of the potential beneficiaries. The most basic and apparently the most concrete criterion of Green Card is the maximum level of income. It was set by law as one-third of the net minimum wage. Between 1 July 2007 – 31 December 2007, net minimum wage is 419.15 YTL, and one-third of this amount is 139.71 YTL. For a family of four persons the so-called "level of hunger" declared by Türk-İş is 627.65 YTL, and the "level of poverty" is 2,044.47 YTL in August 2007. Green Card provides a security net only for the poorest of the poor. In other words, those whose income is above this criterion, but still lower than the "level of poverty" cannot get the Green Card, hence they have to pay for their expenses of health services. The data provided by a Household Budget Survey (2002) reveal that problems persist even in the case of the poorest of the poor: 58% of those who live below the poverty line, and 68% of the extremely poor remain without any insurance including Green Card.[866]

Data on the number of Green Card holders is not that reliable as it would become obvious in its reduction after the cancellation of 4.5 million due to repetitions or abuses in 2005. The number fell from 12.5 million to 9,843,271.[867] From the table on the Ministry of Health web site we learn the number of given Green Cards and total expenditures between the years 1992-2002 (see Table 37). Although the total amount of Green Card holders is not given in this table we can find approximate numbers for each year: 2.2 million in 1993, 5.7 in 1996, 8.7 in 1999, and 13 in 2002. In April 2006 there were 11,148,375 Green Card holders (15.08% of the population) and in September 2007 it fell to 9,052,509 (12.07% of the

[866] World Bank, *Turkey: Joint Poverty Assessment Report*, p. 73.

[867] *Radikal*, 20 September 2005.

population).[868] The rise in health expenditures especially after 2005 will be analyzed in the following section.

Both the socialization and the Green Card emphasized the protection of the disadvantaged groups. They tried to integrate people by providing them health services. Although the Green Card did not target directly the East, it benefited mostly the inhabitants of that region as was the case in socialization. In Eastern and Southeastern Anatolian cities, one-third or half of the population have Green Cards. The Eastern problem has been considered as a problem of economic development. It was thought that the Southeastern Anatolia Project (GAP), economic incentives and public investments would solve the problem. However, this assumption turned out to be false and measures like socialization and the Green Card proved to be much more effective in "winning the hearts of the people." People in the East experience underdevelopment as a citizenship gap and the closing of this gap through citizenship rights would improve their sense of community.[869]

Actually, the Green Card implies the acknowledgement of the failure in turning socialization into the national health service of Turkey. Efforts to establish a universal health system have failed and there arose the need to integrate the excluded. It also implies the acknowledgement of the rise in demand for hospital services and the insufficiency of primary care. The health posts could not meet the demands of the people. We might consider the socialization as a response to the needs of rural Turkey and the Green Card as a response to the demands of an urban population for hospital care. The Green Card was an attempt to integrate the poor

[868] Ministry of Health official web site, http://sbu.saglik.gov.tr/yesil/ (December 2007).

[869] See TESEV for the impact of Green Card in the East and Southeast. By November 2005, total amount of GC holders in Turkey was 10,212,872 while it was 3,921,613 in the region. Such an amount constituted 38% of the population of the region and it is higher than the percentage of GC holders in the whole country, which is 14%. Despite this fact, 30% of the population in the region does not have any health insurance (Ibid., p. 124).

who were excluded by the inegalitarian corporatist system. It was an attempt to abolish the inequalities between those who were covered by security schemes and those who were not. However, the inequalities among the citizens who were covered by different security schemes in terms of the rights and services provided persisted, and Justice and Development Party government would handle this issue through radical measures.

Justice and Development Party and the Program of Transformation in Health

When Özal died in 1993, Demirel became the president, leaving his prime ministry to Tansu Çiller of the TPP. Çiller governments were in power for the following three years. In the 1995 elections, the Welfare Party (WP, *Refah Partisi*), an Islamic-based party, gained the plurality of the seats in the parliament. As it did not have enough seats to come to power alone, it had to have a coalition partner. Political tradition calls for the president to ask the leader of the largest party in parliament to form the coalition government, however, the other political parties were convinced that the RP would have hard time in finding a coalition partner given the fact that the Kemalist leaders of the Turkish state led by the military were against a government headed by an Islamist party. In fact, negotiations between the TPP, MP and the Democratic Left Party (DLP, *Demokratik Sol Parti*) started right after the election results became available with the intention of excluding the WP from the government. A TPP-MP coalition was the only other possibility if the WP would be excluded. But this required that a third party such as the DLP or the Republican People's Party (*CHP*, the social democratic party that merged with the SDPP, which changed its name to the RPP in 1995) supported this center-right coalition. As a result, the WP was

unable to form a government and a TPP-MP coalition (6 March 1996 – 28 June 1996) was formed. However, the coalition could not last long with the WP in opposition, and in the end gave way to a TPP-WP coalition (28 June 1996 – 30 June 1997).

When the WP leader Necmettin Erbakan became the prime minister in 1996, the military was disturbed by his actions, which led to what was referred by the media as a "post-modern coup." On February 28, 1997, the military leaders explicitly threatened the government led by the WP with a coup on the grounds that it had taken actions against the secular nature of the Turkish state. This forced Prime Minister Erbakan to resign. Approximately a year later, the Constitutional Court closed the WP. After the collapse of the WP government with Erbakan's resignation, another coalition government headed by the MP was formed in 1997 (30 June 1997 – 11 January 1999). When this government was overthrown by the parliament in 1999, another government, headed by the DLP, was established to lead the country to the elections in four months. A fortunate event happened for the DLP government during its short term (11 January 1999 – 28 May 1999). The leader of the PKK was captured with the aid of the Israeli and American intelligence agencies. After the capture of its influential leader in 1999 and his call to end the insurgency in 2000, the Kurdish movement subsided substantially. This "triumph" against the Kurdish insurgents brought forth another coalition government headed by the DLP with the partnership of the Nationalist Action Party (NAP, *Milliyetçi Hareket Partisi*) and the MP out of the elections of 1999 (28 May 1999 – 18 November 2002).

The DLP experienced another fortunate event early in its term, which was the candidacy status that Turkey was given for membership in the EU. Probably inspired by this, the coalition government adopted an inflation stabilization program under the

guidance and support of the IMF and the World Bank. Unfortunately, the program ended with a serious crisis in 2001, which led to a 9.5% contraction in the economy. In 2002, disagreement between the coalition partners along with the problems that the DLP had within the party structure led to early elections once more. The elections brought the current JDP government to power. The 58th government was headed by Abdullah Gül, the vice president of the JDP (18 November 2002 – 11 March 2003). The political ban on Tayyip Erdoğan was lifted and he was able to enter the parliament with the renewed elections in Siirt. He became prime minister of the 59th government (14 March 2003 – 22 July 2007).

In the aftermath of the 2001 crisis, Turkey has taken major measures towards dealing with the problem of public sector imbalances. There are various factors at work which explain why these measures were taken in this period and not before. First, the Turkish politicians have realized that something had to be done to deal with the public sector debts and borrowing requirements if they were to avoid the bankruptcy of the Treasury and a consequent economic crisis. Second, the politicians in charge of the economic issues requested financial and technical support from the IMF and the World Bank in order to solve this problem. This meant that these institutions would be more involved than before in managing the Turkish economy. Therefore, their conditionalities had to be met, and their policy suggestions had to be taken seriously. Otherwise, the attempt to solve the problem of public sector imbalances would be short-lived again. Third, the export of Kemal Derviş from the World Bank to the post "the minister in charge of the economy" in order to respond to the 2001 crisis contributed further to the support Turkey received from the Fund and the Bank. Hence, the future looked positive for the managers of the Turkish economy. The credits were generously flowing from the International Financial

Institutions. Furthermore, the world economic conjuncture allowed the flow of foreign funds to the country as long as the financial community remained confident about Turkey's prospects and the "green light" signal was being received from the institutions of world economic governance.

The single party government of the JDP came to power within such an economic environment and followed the policies that were initiated by the previous Ecevit government. The crisis suffered was overcome under the guidance and support of the IMF and the World Bank, and the economic policies followed have been strictly in line with the demands of these financial institutions. So, there was an environment conducive for the JDP to take radical steps in the field of health care. The popular support for the party was another factor of its determination. The people who voted for the JDP were the disadvantaged sections of the population who were devoid of health insurance and complained most about health services. The JDP was expected to improve the functioning of the state at the advantage of the lower classes. It was not sharing the government with another party which also made it easier to implement changes.

In the health section of the 58th government program, the problems and targets were defined in accordance with the earlier government programs and health sector reform proposals: The existing system could not meet the demands. 19% of the population did not have any health insurance. The target was an effective, accessible and qualified health system. The state had to meet health needs of all in cooperation with the private sector. The existing system was not modern, costs were high, access was difficult, and there was no standard unity among social insurance organizations. Health services should be accessible to all. The involvement of social insurance institutions in health care prevented them from fulfilling their essential

tasks. All hospitals would be autonomized. The MoH would be restructured. Competition would be brought to health sector. Provision and finance would be separated. Health insurance would be separated from long-term insurances. General health insurance would be established. Family medicine would be applied. Referral chain would be applied properly. An information system would be set up. Patient rights would be protected.

All the reform proposals dating from the late 1980s onwards specified these same problems and solutions. However, the weak coalition governments had been unable to come up with anything radical. It was also a period of armed conflict which made it difficult to focus on health care. There was high inflation and fiscal crises. All these translated into an inability to formulate any real projects. So, the real reform project had to wait for the 59th government. The whole social security system would be transformed for a more egalitarian system.

The JDP seemed to be determined to solve the problems that had persisted for decades. Coverage was the most urgent problem. Although the number of Green Card holders reached 13 million in 2002, around one fifth of the population was still without any health insurance. The employment structure in Turkey, i.e., a large traditional sector and unpaid family employment leading to growing informalization, was pointed as one of the major reasons for this persistent problem of coverage. Also the members of Bağ-Kur who could not pay their premiums on a regular basis (around 60% of the members) were not covered.

A large portion of the population was left outside the system, but those included were not satisfied with their situation. There was a serious hierarchy among the members of different security schemes which reflected the conservative corporatist nature of the system. This system ended up creating a four-tiered structure

in which the civil servants were at the top, with the highest levels of satisfaction with the services, as they were able to receive high quality service in a comparatively short time.[870] Active and retired civil servants (RF) and their dependents had the right to apply to university hospitals which were equipped with high technology, better educated personnel, modern facilities and higher quality care; active and retired workers and their dependents had access to crowded, low-technology SII hospitals providing low quality health services. The members of Bağ-Kur and holders of the Green Card could apply to MoH hospitals, which were in no better situation. There were significant inequalities in terms of both the quality and quantity of the services provided.[871] The inequality reveals itself also in the health expenditures per insured person covered: In 2000, it was 111.1 dollars for SII members, 147.9 for Bağ-Kur, 289.8 for RF, 210.5 for active civil servants, and 56.0 for Green Card. Pharmaceutical expenditures per insured were: 31.2 for SII, 92.0 for Bağ-Kur, 165.0 for RF, and 97.4 for active civil servants.[872]

The levels of satisfaction of the members of different security schemes reflected these inequalities. Üstündağ and Yoltar analyzed health care from the perspective of citizens. Although everybody complained about the system, members

[870] Üstündağ, "Health and Health Care from the Perspective of Citizens."

[871] Ibid.

[872] TIBA (Turkish Industrialists' and Businessmen's Association - Türk Sanayicileri ve İşadamları Derneği / TÜSİAD), *Charting the Way Forward: Health Care Reform in Turkey* (İstanbul: TIBA, 2005), p. 54. Calculations based on the data in TURKSTAT tables on population covered by security schemes result in these percentages: In 1980, those covered by SII constituted 23.85% of the population, RF 12.12%, and Bağ-Kur 10.14%. These figures are 34.50, 11.65, and 20.06 in 1990, and 50.30, 14.40, and 22.53 in 2000 respectively (TURKSTAT, pp. 107-112). Bağ-Kur started to cover health after 1985. In Bağ-Kur health coverage is optional. This means that not all Bağ-Kur members have health coverage either because it is not preferred or premiums cannot be paid. This is also valid for the SII members. Those who have premium debts cannot use health benefits. When we take these into account, together with the cases of double or false countings (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed), the actual number of people with health coverage becomes smaller.

of the RF complained less.[873] Green Card holders also complained less as they viewed it as a favor of the paternalistic state although they had problems in having outpatient medicine then. Members of the SII complained most since they saw free health care as their right due to the premiums they paid. The common problems were the bureaucratic procedures that were involved in receiving health care, the inadequacy of the system in delivering the care it promised, and the financial leak involved in the system. The poor quality of doctors, the little time they spared for diagnosis and treatment and the lack of technological equipment of the hospitals were the most-cited reasons for the inadequacy of the system. People were dissatisfied with the state delivered health care system due to the fact that they were forced to pay money at every level if they wished to get timely and adequate care. Stories about doctors employed in state hospitals who forced patients to visit their private office if they wanted to receive timely and comprehensive care were widespread. People complained about "knife money," the money doctors asked to pay them out of record if they wanted their operations to be conducted without waiting.[874]

Huge gaps were reported in the distribution of health personnel among the provinces and regions; in particular, there was a concentration of physicians in the big cities and towns and rural areas were significantly understaffed. According to the MoH data, 13% of health posts lacked a GP whereas three-fourth of all health stations lacked a midwife.[875] As a result, primary care, particularly in crowded urban areas, failed to serve as point of first contact and was unable to carry out the "gate-keeping" function. All these problems at the primary care level naturally placed

[873] Üstündağ and Yoltar.

[874] Ibid.

additional burden on hospital outpatient facilities, which in turn increased waiting times and lowered the quality of care.

Health outcomes in Turkey were poorer than would be expected in a country with Turkey's income level. Despite considerable progress achieved in the recent past, Turkey continued to rank far behind most middle-income and EU accession countries on key health indicators.[876] Key health outcome indicators varied markedly across urban and rural Turkey and across regions, reflecting the uneven supply of and access to health care across regions.[877] Infant and child mortality rates were 40 % above the national average in rural areas and in Eastern Turkey. Vaccination coverage of infants and pregnant women was significantly lower in the poorer Eastern and Southeastern provinces than in the rest of the country. The Turkish health system faced a dual challenge. Significant parts of the country and the population continue to be afflicted by a high burden of disease from preventable infectious diseases, and high maternal and infant mortality rates typical of developing countries. At the same time, a growing share of the population was affected by non-communicable diseases prevalent in developed countries. Heart disease and cerebrovascular problems and cancer increased to a considerable extent.[878]

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[875] TIBA, p. 62.

[876] World Bank, *Turkey: Joint Poverty Assessment Report*, p. 74. For a comparison of Turkey with OECD-European countries in terms of various health indicators, see Table 38.

[877] For a comparison of regions in terms of various health indicators, see Table 39. Eastern and Southeastern Anatolia lag behind other regions. Also, epidemics such as dysentery, typhus, and brucella are widespread (TESEV, p. 119). Çağlar Keyder uses the notion of "citizenship gap" to explain the people's experience of the socio-economic underdevelopment of the region. Social policy measures should be implemented to close this gap and make people reconcile with the state and the remaining population. Social Policy Forum web site, http://www.spf.boun.edu.tr/docs/acikradyo2006/AcikRadyo-SPF-29.11.2006.pdf (December 2007).

[878] World Bank, *Turkey: Joint Poverty Assessment Report*, p.75.

The regional inequalities can be observed in the distribution of secondary and tertiary care institutions. Both the quantity and the quality of these institutions were lower in the East and Southeast. While there were 27.4 hospital beds for 10,000 population in the Marmara region there were only 13.1 in the Southeast (see Table 40). The State Planning Organization divided Turkey into six regions in terms of the development levels of the provinces. There were 27.6 hospital beds for 10,000 population in the first region and 12.5 in the sixth (see Table 41).

Those with insurance, including a Green Card, were significantly more likely to seek health care when ill than those without insurance, underlining the importance of insurance to improving access to health care. The share of hospitalization among those without any insurance was lower by 26 % than among those with insurance or a Green Card. The most important reason for not seeking outpatient care when sick, and not for seeking hospital admission when required, was the lack of affordability.[879]

The share of the population that had to pay for outpatient treatment, drugs, and hospitalization is consistently higher among the lowest-income quintile than among the upper-income groups, which reflects the lower insurance coverage among low-income households. Among those who paid for outpatient care, total payments (covering consultation, drugs, and gifts to staff) were highest among the lowest-income group, and dropped with rising income and associated increased insurance coverage. The situation is less marked in the case of hospital treatments; while the share of those who had to pay for hospital treatment was higher in the lowest-income groups, the average amount paid for inpatient care was lower among the lowest-

[879] Ibid., p. 77-79.

income groups.[880] This difference can be explained with reference to the coverage of Green Card. It started to cover outpatient care after 2002 and outpatient medication after 2005.

The main public financiers were the Central Government (48% in 2003), and the social security institutions (50% in 2003). The Central Government spending was distributed across four major areas, including health care programs and service delivery through the MoH, the Green Card scheme, civil servants health benefits, and government financing of social health insurance schemes, when the latter run deficits.[881] Budgetary funds were not particularly well targeted towards assuring equitable access of the entire population. Less than one-tenth of Central Government funding goes toward the Green Card system while over one-fifth goes toward providing civil servants with health care benefits, a population which was traditionally not among the lowest-income groups. Another one fifth went in subsidies to Bağ-Kur and RF, neither of which was specifically targeted toward lower income groups. Thus, overall, the relatively important public subsidies to health care benefited middle- and upper-income households more than the poor, who continued to face significant access barriers to health care.[882]

The JDP argued both in its election manifesto and later in the 58th and 59th government programs that the existing health system had become inaccessible, inefficient and irresponsive to the growing needs, and the costs had been increased due to corruptions within the system. Claiming that effective, accessible and high quality health system was indispensable for a vigorous society and that the

[880] Ibid., p. 80.

[881] Ibid., p. 86.

[882] Ibid., p. 88.

satisfaction of the basic health needs of everybody (with co-operation of the private sector, when necessary) was one of the basic responsibilities of the state, the JDP government announced its reform program, "Transformation in Health" (*Sağlıkta Dönüşüm Programı*), in December 2003.[883]

Announcing the central objective of the reform as "establishing a high quality and effective health system which everybody can access," the program listed as its main principles 'human centrism, sustainability, continuous quality improvement, participation (of all stakeholders), reconcilement, volunteerism, division of power, decentralization and competition in service'.[884] In comparison to the previous reform attempts, the program represented a very comprehensive plan which envisioned changes in the organization, financing and delivery of health services. The main components of the program were: Restructuring the Ministry of Health to enhance its core functions of setting priorities, developing policies, defining standards, controlling and ensuring quality and managing public health processes, including preventive services; introducing compulsory statutory health insurance for the whole population, with the possibility of supplementary voluntary health insurance operated by private insurers; increasing access to health care by making use of private facilities where necessary, strengthening primary care services and family medicine, improving the referral system and giving institutions more administrative and financial autonomy; improved and more appropriate training for doctors, nurses and administrators and better incentives to encourage a more even distribution of personnel across the country; establishing a school of public health and a national

[883] Sağlık Bakanlığı, *Sağlıkta Dönüşüm Projesi*, Sağlık Projesi Genel Koordinatörlüğü (Ankara: Sağlık Bakanlığı Yayınları, 2003).

[884] Ministry of Health of the Republic of Turkey, *Transformation in Health* (Ankara: Ministry of Health, 2003), pp. 25-26.

quality and accreditation agency; and supporting more rational use of drugs and medical devices through the establishment of a national drug agency and a medical device agency; and improving health information systems.

Quite similar to the social health insurance reforms proposed in other national contexts Transformation in Health envisions the separation of financing of care from its provision, creating an independent agency for managing the health insurance fund and financing a basic package of services through a dedicated payroll tax. Besides the content, the Turkish government also seems to be sharing the objectives of reforms with many developing country governments, namely improving the equity and efficiency of health care resource use. In many instances, social health insurance has been viewed as a mechanism to improve access (and ensure universal coverage) and to control the growth rate of health care expenditure. The latter is not a major concern in the Turkish case as the Turkish health care system already suffers from underfunding and public spending on health lags behind the OECD average. Turkish reformers seem to be more interested in increasing efficiency and effectiveness in delivery, funding and organization of health services.[885]

General Health Insurance which was the first component of the social security reform would be activated in accordance and interaction with the Transformation in Health Program. In the proposal for reform in the social security system[886] the creation of GHI was proposed to finance the provision of a high quality health service for all population, which was equitable, equal, protective and curative. It was declared in the proposal that: Public health insurance services which were currently provided in five different qualities and standards as SII, Bağ-Kur, RF, public workers

[885] Ağartan, "Health Sector Reform in Turkey".

[886] Ministry of Labor and Social Security, *Proposal for Reform in the Social Security System*, Draft Text, Ankara, http://www.calisma.gov.tr/projeler/sos_guv_reform.pdf (2004) (December 2007).

and those who have Green Cards, would be integrated and transformed into a structure where all the citizens would be provided with health insurance services in equal scope and quality. An obligatory, premium-based health insurance system would be established. Health insurance premiums for the poor would be provided by the state. The mixed model implemented both in terms of institutions and financial methods displayed an inefficient and complicated structure. There were different schemes which were based on social insurance (SII, SII Agriculture, RF, Special Funds), the National Health Services (Civil Servants, Green Card Owners, Citizens in need above the age of 65), or private health systems (private health insurance,[887] out of pocket payments). All the citizens would be covered within the scope of the GHI. The notion of "dependent population" would be defined as the spouse and children. There would be a basic security package. A premium at the rate of 12.5% would be taken for the insured and his/her family after which s/he is obliged to look. With the aim of preventing misuses and unnecessary utilizations, a contribution share at specific rates would be taken for all health services. Services would be purchased from Family Doctors through contracts, in order for the protective health services to be prioritized and implemented. Citizens would be given the right to choose their doctors and health facilities both from the public and the private services.

The Ministry of Labor and Social Security started to work on the reform in November 2002. Four major components of the reform proposal were general health insurance, social benefits and services, retirement insurance, and institutional structuring. It took four and a half years to prepare the draft bill in cooperation with

[887] Private health insurance is a fast growing sector in Turkey but currently is limited to about one percent of the population. Private health insurance was permitted in Turkey starting in the 1990s. There were 36 companies covering 704,545 people at the end of 2003, and this figure rose just from 25,000 in 1991 (TIBA, p. 59).

various institutions. Social Security Institution was established,[888] but the application of Social Security and General Health Insurance Law[889] was postponed first to 1 July 2007 and then to 1 January 2008 due to the annulment of some of its articles by the Constitutional Court in 15 December 2006. The reasoned decision of the Constitutional Court is significant since it reveals the bureaucratic resistance to an egalitarian sharing of social risks. Although President Sezer brought the law to the Constitutional Court to be examined in terms of the principles of welfare state (*sosyal devlet*), equality and right to social security,[890] the Constitutional Court did not mention any of these and annulled some articles to protect the advantageous position of the civil servants. The Court emphasized the need to regulate the social security of civil servants separately, while approving the major articles of the law for workers and self-employed, some of which were highly criticized by the opposition party, labor unions and professional associations. The rise in the minimum age and the number of working days required for receiving pension, the fall in the amount of pension, and general health insurance based on premiums were approved by the Court for all, except civil servants.

This decision allowed for separate regulations for civil servants. The Court's insistence on the preservation of the existing inegalitarian system led to incoherent decisions. According to the law, dental prosthesis expenses of those over 18 and those under 45 would not be covered by the Social Security Institution. The Court annulled this article only for civil servants, which implied that it was not viewed as a

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[888] *Sosyal Güvenlik Kurumu Kanunu*, no. 5502, *Resmî Gazete*, 20 May 2006.

[889] *Sosyal Güvenlik ve Genel Sağlık Sigortası Kanunu*, no. 5510, *Resmî Gazete*, 16 June 2006.

[890] President Sezer sent the law back to the Parliament on the grounds that it contradicted with the welfare character of the state. He stated that social security could not be handled only with reference to actuarial calculations and the state should take an affirmative role in the field of social security. The Parliament did not take the notice into account and passed the law without any amendment, which led to the appeal of the President and the opposition party to the Constitutional Court.

violation of the Constitution in principle, unless applied to the civil servants.[891] The annulment of the proposed increase in the period of contributions to the pension fund before the retirement (from 7000 to 9000 days), for civil servants, was also hard to grasp. Civil servants were regular full-time employees with job security. It was the workers who were faced with the constant threat of unemployment for extended periods and who, in many cases, had no chance of employment as manual workers when they were in their 40s.[892] In the age of flexible and unregulated production it was hard for the workers, especially the seasonal and part-time workers, to fulfill the number of days required for receiving pension. The Court decision protected the acquired rights of civil servants and consolidated the existing inequalities among employees.

Both the integration of the different schemes and the establishment of a GHI aimed to abolish differences among the citizens who were covered by the social security system in terms of the rights and services provided. By covering all, the differences between the members of insurance schemes and the others would also be abolished. The financial deficits of the different insurance schemes since 1994 damaged the sustainability of both the system and the economy. The reform was expected to solve this problem too. The Social Security Institute prepared a report which might be considered as a response to the decision of the Constitutional Court (May 2007). In that report the problems were defined as low coverage, differences in the quality and content of the services people received, waste of resources due to the patchy structure, misuse of resources due to the lack of competitiveness, inefficiency

[891] For a well-written critique of the decision of the Constitutional Court see the articles of Aziz Çelik in *Birgün* (15,16,17 January 2007). For him, the Court's approach is "elitist-statist" that ignores the principle of welfare state.

[892] Buğra and Adar, pp. 30-31.

of the referral chain which increased the applications to much more expensive secondary and tertiary care institutions, and the undermining of preventive care which increased the expenditures. So, the reform involved a premium-based system, referral chain, receiving health service from both public and private sector in competition, and the separation of provision and finance to solve these recurrent problems.[893]

In the report, the Institute gave comparative data showing the advantageous position of the civil servants in Turkey. The comparisons made among the OECD countries revealed that Turkey was among the countries where pensions were paid for longer periods of time. The difference between the security schemes in terms of replacement rates was also noteworthy. The replacement rate, which is defined as the ratio of the pension to the net earning base for premium were 90% in the Social Insurance Institute, 127% in Bağ-Kur and 106% in the Retirement Fund.[894] There were serious differences among the rate of the sum of premiums to the pensions, in different security schemes. If we take as model a 50 year old retailer, a teacher, a head of department and a general manager whose life expectancies are 76, we reach different results. For example, for the retailer these rates were 65% (RF), 66% (SII) and 58% (Bağ-Kur), while they were 54, 78, and 61% for the teacher. They were 39, 78, and 61 for the head of department while they were 25, 103, and 64 for the general manager. These numbers revealed that civil servants had an advantageous position and among them high level bureaucrats were the most privileged. That was why the

[893] SGK (Sosyal Güvenlik Kurumu), *Sosyal Güvenlik Reformu: Uygulama Öncesi Yeni Yaklaşım*, Sosyal Güvenlik Kurumu, http://www.sgk.gov.tr/doc/SosyalGuvenlikReformu_UygulamaOncesiYeniYaklasim.pdf (December 2007).

[894] Ibid., p. 37.

daily newspaper *Radikal* published the news on this report with the following heading: "Social Insurance Works for the Bureaucrats."[895]

Law no. 5510 regulated the use of health services: Those who were covered were defined as all citizens, foreigners who had stayed in Turkey more than one year, heimatlos and refugees. The health services covered were, illness, maternity, work accident, occupational illness, preventive care services for individuals, dental care, laboratory examination and analyses and other diagnosis services and emergency services, examination and treatment abroad to those who went with permanent or temporary duty and to all in case the treatment could not be provided in Turkey, transportation costs and essential charges, and companion expenses. The uncovered health services were all services with aesthetic purposes, including orthodontics in case of aesthetic purposes, and other services which were not defined as health service by the Ministry of Health. The notion of "basic benefits package" was removed from the law after the criticisms.[896] The condition of benefiting was 30 days of insurance. Those who paid their premiums themselves should not be indebted. The exceptions in benefiting were children under 18, those who depended on others for medical care, emergency situations, epidemics, preventive care services for individuals, maternity, work accident and occupational illness, and cases of disaster and war. No condition was required in these situations. There was co-payment in outpatient doctor and dentist examination, orthesis, prothesis, and other curing

[895] "Sosyal güvenlik bürokratlara çalışıyor: Kamuda çalışan genel müdür sosyal güvenlik sistemine yatırdığı primin dört katı kadar emekli aylığı alırken, SSK'lının emekli aylığı yatırdığı primin ancak yüzde 97'si" (Social insurance works for the bureaucrats: Whereas the general manager in public office receives a pension four times the premium he has paid to the social insurance system, the member of SII receives only %97 of the premium), *Radikal*, 22 May 2007.

[896] There was the suspicion that basic benefits package would include a small variety of service which in turn would lead the middle and upper middle classes to have private complementary insurance. If this was the case, middle classes would not claim and support the system which would cause its weakening. Also the inegalitarian structure of the system would persist, this time the inequality being between those with additional insurance and those without it.

equipment, and drugs in outpatient care.[897] If a person applied to a contract health institution without obeying the referral chain, except in cases of work accident, occupational health, disaster and war situation and emergency cases, the institution paid 70% of the costs. If a person under GHI applied to a contract institution and wanted to benefit from upper level rooms, hotel services, and professor service that were not with contract then he paid the difference. If a person applied to a health institution with no contract, in case he followed the referral chain the Social Security Institution would pay 70% of the costs, in case he did not follow the chain, this amount was 50%. Cases in which there was no co-payment were chronic illnesses, inpatient treatment, work accident and occupational illnesses, disaster and war situation, preventive care services for individuals, control examinations, those who took honor wages (*şeref aylığı alanlar*), terror victims, and children under protection.[898]

Premium-Based System

The government was aware of the possible rise in expenditures after the application of GHI. Social Insurance Institution estimates that when applied together with Transformation in Health Program total cost of GHI will be covered by 6.6% of national income in 2025 and GHI finance deficit will be 3.7 %. It seems the reform

[897] Article 68: Co-payment will be applied in these health services: Doctor and dentist examination in outpatient care (2 YTL). Orthesis, prothesis, and other curing equipment, and drugs in outpatient care (will be around 10%-20% and determined by the institution). Co-payment is brought to prevent needless applications. This logic is problematical as it is based on the assumption that people will apply health institutions although they do not have any health problem. The risk of postponing the application due to co-payment and premium debt is much higher. When some illnesses are postponed, then they require more expensive treatment. People should feel comfortable in applying health institutions. The contribution of such a comfort to the quality of life is remarkable.

[898] SGK (Sosyal Güvenlik Kurumu), p. 64.

would be accomplished with an additional 0.5% public deficit. The premium system was preferred as it would guarantee that collected amount would be used in health care. For the reformers, tax income would not be enough to finance health expenditures. Article 81/f regulated the payment of premiums: GHI premium would be 12.5% of people's monthly income. 5% of this premium would be paid by the insured, and 7.5% by the employer. Those who would be subject only to general health insurance would pay 12% of their income.

The law put a base and a ceiling in the determination of the amount of minimum revenue that formed the basis of contribution (*prime esas kazanç*). Base was minimum wage and ceiling was 6.5 times of minimum wage. People who earned less than minimum wage but more than one-third of minimum wage would pay their premiums as if they earned minimum wage and those who earned 10 times of minimum wage would pay their premiums as if they earned 6.5 times of minimum wage. This is unjust. Both the premium system and the co-payment practice are regressive. When you get the same percentage of premium and co-payment from different income groups this would be at the disadvantage of lower income groups.

Article number 81/g defined the contribution of the state: The state makes 5% contribution in disability, old age and death insurance, and 3% contribution for general health insurance. The contribution of the state was a positive step in the reform proposal as it implies the acceptance of the responsibility of the state in social insurance. Before, the state did not make any contribution to the premiums but covered the expenses of active civil servants and Green Card holders.

The law did not allow anyone to opt out of the system. Although private insurance was promoted with the regulation that those who had private health or pension insurance can exempt their private insurance premiums which did not exceed

monthly 30% of minimum wage from their minimum revenue that formed the basis of contribution, they were not allowed to be covered only by private insurance. GHI was mandatory for everyone. This would make the system much more egalitarian since when middle and upper classes opt out of the system and prefer private insurance, public services could not develop. In the health care reform proposal of the Turkish Industrialists' and Businessmen's Association (2004), which was more or less the same as that of the World Bank and the government, opting-out was allowed after an initial period during which universal coverage was clearly established. It was recommended that the GHI considered an option for beneficiaries above a specific income level (to be defined) to opt out of the public insurance system and purchase private insurance as their principal coverage.[899] But such a recommendation was highly problematical as it ignored the long-term consequences of limiting the public insurance to the lower classes.

Both the opting-out and the basic benefits package was rejected by the government. These were the two important components of the WB and TIBA (Turkish Industrialists' and Businessmen's Association - Türk Sanayicileri ve İşadamları Derneği / TÜSİAD) proposals. Although the standardized benefits package proposed by TIBA covered a wide range of services,[900] the existence of the term "package" carried risks in itself as already mentioned. So, the JDP government admitted the long-term consequences of basic benefits package and opting-out to be at the disadvantage of the lower classes and did not include them in the law.

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[899] TIBA, p. 22.

[900] Physician visits, obstetrical and gynecological care, pregnancy and family planning services, deliveries, well baby visits, immunizations, emergency room visits, general ward hospital stays, surgeries, chemotherapy and radiation therapy, post-acute home health care, mental health and substance abuse, routine eye exams, hearing aids, laboratory services, X-rays, and prescription drugs (generics where available) (Ibid., p. 20).

However, it did not give a similar response in the premium system which would also create inequality among the citizens.

According to the General Health Insurance law all citizens in Turkey would contribute to the scheme based on their financial capacities. Those who were "unable to contribute" -because of their lack of means- would continue to be covered by the Green Card scheme, until another new legislation titled the Law on Social Security Provision without Premium Payments was passed by the parliament. If the current reform proposals were implemented as planned, the existing three separate public insurance schemes would be united under one "General Health Insurance" scheme and the Green Card scheme would be replaced by the "Without Premium Payments Law" framework in the following years.

The establishment of a premium-based General Health Insurance has been on the agenda since the 1950s. But it could not be realized due to the existence of a large agricultural sector and informal employment. It was proposed again and again but, found to be unrealistic within such a socio-economic structure. So, has this structure changed in such a way as to allow for the application of the current proposal? It is true that there has been a decline in the share of agricultural economy and rural population, but the rural population still constitutes one-third of the population and half of the population is in the informal economy. Although a premium-based GHI was viewed to be unrealistic, it was the only solution that gained public audience. Also in the 1960s and 1970s, apart from a small circle of public health specialists and Nusret Fişek, no one believed in the possibility of establishing a universal health system financed by the general budget. Today only the TMA and health syndicates defend this option. As discussed in the second chapter, Mediterranean countries replaced their social insurance systems with national health

services in late 1970s and the early 1980s. Although its welfare regime has common traits with those of the Mediterranean countries, Turkey follows the path of Central and Eastern European countries which has also been designed by the World Bank.

Premium might be thought of as the Achilles' heel of the new system. In a country where half of the working population is in the informal sector it is impossible to collect premiums from all. The current functioning of Bağ-Kur gives us an idea for the possible functioning of GHI. Bağ-Kur members are supposed to pay premiums to benefit from health services. However, they cannot pay their monthly premiums and cannot benefit from health services. In 2006, this was the case for 60% of Bağ-Kur members. This percentage was 75% in the East and Southeast. They are stigmatized and forced to establish a relation of indebtedness with the state. Bağ-Kur system does not work due to the fluctuations of income. People do not earn regular incomes and have problems in paying their premiums. Those who are not poor enough to warrant government coverage, and who are not steadily employed to be able to pay into the fund will again be excluded from the system. Those in the informal sector, the poor, people living in the East and Southeast will be affected more. In the East and Southeast 60% of the population is poor but only 30% hold Green Cards. The remaining 30% will always be indebted and stigmatized. What will happen to people who cannot get Green Cards but who do not have the means to cover their health expenses? People will not be able to pay their premiums when they lose their jobs or their incomes diminish. If a crisis occurs budget problems will arise. In the new proposal those who cannot pay their premiums will be punished so to speak by the fact that they will not receive health service until they pay their premiums. It will be unacceptable by the wider public that some people are denied health care.

In the former inegalitarian corporatist system the inequality occurred between those who were covered by a security scheme and those were not, and among the members of different schemes in terms of the rights and the services provided. Now, a new inequality will be established between those who pay their premiums themselves and those whose premiums are paid by the state. The most privileged of those who can pay their premiums will be those who are aware of which illnesses are covered, make calculations on the fee differences between private and public hospitals, and connect the system with private insurance. This means that women, the poor, informal sector workers and rural population will be disadvantaged.[901] Premium system will force some to declare their poverty as it was the case in Green Card. It is much easier to collect taxes than premiums when income sources are diversified, the share of formal wages is diminished, and employment is not regular. The premium system is based on the assumption that paying premiums makes people claim the system and control its functioning. This assumption constitutes the relation between the citizens and the health service providers as a relation between a customer and a seller. As discussed in the second chapter, health care cannot be visioned in these terms. It should be seen as an essential responsibility of the state towards its citizens, as it is the case in education.[902]

The Transfer of SII Hospitals

The members of the SII had an advantageous position in terms of receiving health services. As discussed in the previous chapter the SII had had enough resources to

[901] Üstündağ and Yoltar.

[902] Keyder, "Giriş." In *Avrupa'da ve Türkiye'de Sağlık Politikaları*; Üstündağ and Yoltar.

provide high quality service and SII institutions could employ necessary amount of health personnel at the disadvantage of others. Per capita health expenditures were always higher than the Turkish average. However, the actuarial balance of the institution deteriorated and the budget deficit increased due to the irresponsible use of accumulated funds, the fall in age limits for pension right, and the practice of debts which were not in return for premiums. Also, the large share of informal sector and the large number of dependents contributed to the downturn. In 1990, 19,487,970 people were covered by the SII, which was nearly one-third of the population. And in 2000, this number was 34,110,202, nearly half of the population. The health services provided for such a large share of population was far from meeting the demands and newspapers were full of stories about the state of disarray in the SII hospitals.[903]

Between 1979-93 the number of those covered by SII increased 145%, the number of patients who applied to a SII health facility increased 98%, inpatients 90%, operations 64%, and births 77% while inpatient institutions increased 43 %, dispensaries 62%, health stations 15%, total number of beds 53% and total health personnel 11%.[904] Before the 1990s there had been surplus income from health care contributions, but it was used to subsidize the activity of other branches, such as pensions. In 1994 and 1995, health care expenditure surpassed health care contributions. The inefficient provision of health services, poor control over

[903] A typical heading from *Milliyet* (9 February 1992): "Examination and medication queues are lengthening. Patients are desolate. Health deadlock in SII: SII is serving one-third of the country's population but has only 7% of health personnel. SII data reveals that 20% of specialist cadres and 14% of general practitioner cadres are empty". In another newspaper account it is said that the debt of SII to pharmaceutical firms would leave the members of the institution devoid of necessary medication (*Milliyet*, 28 January 1992).

[904] Soyer, "Türkiye'de Sağlık Hizmetleri: 1980-1995." p. 1130. See Nejat Yazıcıoğlu, " 'Genel Sağlık Reformu' Kime Karşı." *Toplum ve Hekim*, 53 (Şubat 1993): 23-27, p. 25 for the rates of health personnel shortage in SII in the late 1980s.

contracted health services and the absence of a proper management information system caused this deficit. Since 1995, the SII has suffered from an overemphasis on cost containment at the expense of quality.[905]

The transfer of SII hospitals to the MoH was part of the reform project of the JDP which aimed to abolish the inefficient and complicated structure of the health care system. The provider role of the SII was criticized as it created organizational inefficiency within the system. The transfer was promoted on the grounds that the burden on the SII hospitals would be shared. The integration of health services was always on the agenda but due to the resistance of trade unions and the SII itself, the transfer could not be accomplished. In January 2005 with Law no. 5283,[906] 148 hospitals, 212 dispensaries, 202 health stations, three dental care hospitals, six dental care dispensaries, two hemodialysis dispensaries of SII, and three hospitals of State Post, Ziraat Bank and Police Organization were transferred to the MoH. The door plates of SII hospitals were replaced with MoH plates on 19 February 2005. There was a rush to MoH hospitals on 21 February 2005. There were long lines and pharmacies could not supply drugs. SII started to buy health services from the MoH and private hospitals.[907]

Trade unions opposed the transfer, referring to the days when the SII was a model in terms of health service and pharmaceutical expenditures. They promoted the improvement of the system rather than the transfer. They explained the loss of quality with the fall in SII's resources and corruption cases. It served millions of workers, pensioners and their dependents and exerting the duties of the "welfare

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[905] B. Serdar Savaş, Ömer Karahan and R. Ömer Saka, *Health Care Systems in Transition: Turkey* http://www.euro.who.int/document/E79838.pdf (2002) (December 2007), p. 44.

[906] *Bazı Kamu Kurum ve Kuruluşlarına Ait Sağlık Birimlerinin Sağlık Bakanlığına Devredilmesine Dair Kanun*, no. 5283, *Resmî Gazete*, 19 January 2005.

[907] Türk Tabipleri Birliği, *Devrin 1. Yılında SSK: Tespitler – Görüşler* (Ankara: TTB, 2006).

state" alone. The unions viewed the confiscation of the SII hospitals as part of the World Bank led Transformation in Health Program which required the transformation of all health institutions into health enterprises.[908]

Those who opposed the transfer emphasized the efficiency of SII with reference to the different per capita health expenditures: It was $ 317 for RF, $ 224 for Bağ-Kur and $ 134 for the SII. The SII had 17% of hospital beds and 8% of health personnel while it was serving 50% of the population.[909] But this line of thinking is problematical as it equates efficiency with per capita health expenditure. Of course, cost containment is an important component of efficiency, but the quality of health services provided by the SII was really low. SII members complained a lot about the inadequacy of hospitals, long queues and the apathy of doctors. Also the insufficiency of beds and health personnel vis-à-vis the number of people served may be a justification for, rather than a challenge to, the transfer. Half of the population was devoid of services, and this might be solved by opening other health facilities to SII members. Another criticism was related to the autonomy of the SII, which was claimed to have been lost after the transfer. The property status of the hospitals was recalled: SII hospitals were the property of workers and their transfer would be a deforcement.[910] The transfer of SII hospitals to the MoH was seen as a deforcement. The trade unions and the TMA saw this transfer as the first step towards privatization. They claimed that SII hospitals would be transferred to special provincial administrations first and privatized later on. They asked how the state

[908] Ibid., p. 32.

[909] Aziz Çelik, "Başbakan SSK'da yanılttı" (The Prime Minister surprises in SSK), *Radikal*, 9 November 2004.

[910] Aziz Çelik, "SSK özerk olmalı" (SSK should be autonomous), *Birgün*, 16 November 2004. Çelik warns about the possible rise in costs when SII starts buying the services from the MoH. Costs were low in SII as it was providing its own health services. He mentioned that SII did not have budget

would pay the price. They argued that the state would solve the problems of going to all hospitals and medication without making the transfer.

The integration of health services was a major component of the socialization. Law no. 224 regulated the transfer of the SII and the SEE hospitals to the MoH but postponed it until the socialization of the whole country would be completed. So, by early 1984 the SII hospitals should have been transferred to the MoH. As discussed in the previous chapter, the trade unions and SII resisted the transfer of their health facilities, which constituted one of the reasons of the failure of socialization. The SII provided favorable conditions to the health personnel, which led to a concentration in hospitals in big cities. The transfer was difficult then as the services provided by the SII hospitals were high in quality and the people who utilized them did not want to give up their advantages. But when we come to the 1990s and 2000s the system was in such disarray that people did not react to the transfer. On the contrary, they were content with the opportunity of going to other public hospitals. The TMA and trade unions opposed the transfer, but their opposition did not find any ground. In the process the government excluded the trade unions and did not clarify the payment schedule. The way the transfer was realized might be criticized but the transfer itself was reasonable. The TMA resisted the transfer although it supported the socialization. Actually, these two positions contradict each other.

There was great chaos in the beginning, especially in receiving medicine from private pharmacies. There were long queues for changing the insurance cards and taking medicine. However, SII members were content with this transfer as they could apply to other hospitals and receive their medicine from any private pharmacy. Before, they had had to wait in long queues for treatment in a SII hospital and get

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deficit in health expenditures but in pensions. It did not have any problem in pensions before, but the state squandered its resources.

their medicine from the SII hospital pharmacy. A large group of people started to utilize all hospitals. The pharmaceutical factory of the Institution which produced lower quality drugs was closed and SII members started to get drugs like the members of other security schemes. Simultaneously, SII, RF and Bağ-Kur members started to benefit from private hospitals. And in summer 2007, the declaration of the Health Application prepared by the Social Security Institute and the declaration of the Health Care Benefit Application prepared by the Ministry of Finance abrogated the differences among the members of different security schemes in terms of the health institutes to which they could apply. This challenged the corporatist hierarchy and brought equality among insurance schemes.

The opportunity to go to private hospitals for RF, SII and Bağ-Kur members promoted the private sector and increased costs.[911] Another factor that increased costs was the changes in the application of Green Card. A government notice published in January 25, 2002, extended coverage to include the expenses of outpatient medical examination. It was stated in the 1992 decree that Green Card holders, in order to obtain health care services, were to go to public health centers, public hospitals in their districts and in their provinces, respectively. If they broke this chain of referral, their health expenses would not be covered by the Green Card scheme, except in cases of emergency. However, with the regulation published on March 17, 2004 in the *Official Gazette*, Green Card holders were granted the right to get services directly from public health centers or hospitals as well as SII hospitals,

[911] The private hospitals were applying higher prices and the Prime Minister warned them not to exploit the citizens. In the same speech he sets the connection between citizenship and welfare: "Welfare state means the citizen feel himself as a citizen. Health is one of the fields in which state-society relations are injured most. A citizen understands whether the state is a welfare state or not when he goes to a hospital" (*Radikal*, 14 August 2005). (*Sosyal devlet vatandaşın vatandaş olduğunu hissetmesi anlamına gelir. Sağlık Türkiye'de devlet ile toplum ilişkilerinin en çok yara aldığı alanlardan biri. Vatandaş devletin ne kadar sosyal devlet olduğunu hastane kapısına gittiği zaman anlar.*)

either with or without referral from a lower level service provider. And with law number 5222, the coverage of the medical expenses of outpatient care by the scheme was initiated (14.7.2004). This law brought about a considerable relief for Green Card holders in getting medicine, who had to apply Solidarity Funds for outpatient medicine before. As the rate of GC holders was high in Eastern and Southeastern Anatolia, an extension in its coverage would serve the diminishing of regional inequalities.

All these changes contributed to the "citizenship status" of the people but led to a considerable increase in health expenditures. In May 2006, health expenditures increased 151.5% compared to the same period of the previous year. This increase was 295% in Green Card allocations. 57% of total health expenditures of 2006 budget was used in the first 4 months. This percentage had been 22.1 in 2005 and 14.3 in 2004. 76 % of Green Card allocations and 65% of curative service expenditures were used in the first four months.[912] SII health expenditure rose from 6.5 quadrillion YTL in 2004 to 9.5 quadrillion YTL in 2006, while SII pharmaceutical expenditures rose from 2.7 quadrillion YTL to 4.8 quadrillion YTL. Per capita expenditure increased from $ 124 to $ 316.[913] Since the initiation of the program in 1992, Green Card expenditures showed a steady increase but the rises in 2005 and 2006 are remarkable.[914] The number of uninsured patients including Green Card holders who were treated in MoH institutions increased five times between

[912] *Sağlık Harcamalarında Büyük Artış*, May 2006, http://www.tepav.org.tr/tur/admin/maliupload/haber/saglikharcamalarindakibuyukartis.pdf (December 2007).

[913] Ata Soyer, *AKP'nin Sağlık Raporu* (İstanbul: Evrensel Basım Yayın, 2007), p. 105.

[914] The Green Card expenditure was 5,992 thousand YTL in 1995; 202,080 in 2000; 884,108 in 2003; 1,257,500 in 2004; 1,950,300 in 2005; and 2,910,500 in 2006 (Hakan Yılmaz, personal correspondance).

2004 and 2005, and 2.5 times between 2005 and 2006.[915] The amendments which allowed SII members and Green Card holders to apply all MoH hospitals increased the number of applications (see Table 42 for the rise in inpatient and outpatient cases between 2002-2006 in the MoH, university, private, SII and other public hospitals). Actually, this rise in health service utilization from public institutions is ironic when the state was planning to diminish its role in provision.[916] The same table reveals the serious rise in inpatient and outpatient cases in private hospitals after the expansion of contracts signed between the private hospitals and social security institutions that opened the private hospitals to SII, RF and Bağ-Kur members.[917] According to National Health Accounts (2000), 24% of health expenditures were used in the private sector. This share is 39% in 2003 in the World Bank Health Report and 47% in 2005 in SPO accounts.[918]

Total health spending accounted for 7.6% of GDP in Turkey in 2005, below the average of 9.0% across OECD countries. Health spending tends to rise with

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[915] The number of treated patients without social insurance was 5,051,312 in 2004; 25,037,347 in 2005; and 64,438,776 in 2006. Ministry of Health official web site, http://www.saglik.gov.tr/TR/BelgeGoster.aspx?F6E10F8892433CFFAC8287D72AD903BEFFB31DDACD1CE3B0 (9.10.2007).

[916] On a TV program before the July 2007 elections the Minister of Health Recep Akdağ was explaining the expansion in public services: "Money allocated for preventive services was approximately 570 million dollars in the former government's term. We allocated 1 billion 720 million dollars for preventive services in 2006. For instance, whereas money allocated for vaccinating was 14 million YTL in 2002, it is 156 million in 2006. In public hospitals, if we count former SII hospitals and state hospitals together, the number of MRs were nearly 18, whereas this number is 65 today. There were 500 ultrasonography devices, and now we have 1500. In the former periods the number of new hospital beds was nearly 5000, and we added 19.000 beds 80% of which have toilets and showers. In the former government's term 39.000 health personnel were employed in the public, whereas we employ 100.000 –yes 100.000– health personnel". NTV Neden web site, http://www.candundar.com.tr/index.php?Did=5121 (December 2007).

[917] In Eastern and Southeastern Anatolia, after the opening of private hospitals to the members of security schemes, public hospitals started to serve almost only the Green Card holders. In Van and Diyarbakır MoH hospitals nearly half of the patients who were treated were Greed Card holders. This practice seems to offer a solution to the pressure on public hospitals but in the long-run middle classes might relinquish applying these institutions. Such a development would deteriorate the public hospitals (TESEV, p. 123). This might happen in other regions. When a service is not claimed by the middle classes it is doomed to regression.

[918] Soyer, *AKP'nin Sağlık Raporu*, p. 86.

income. Given that Turkey has the lowest GDP per capita among OECD countries, it is not surprising that it also has the lowest health spending per capita among them, spending $ 586 in 2005 (adjusted for PPP), compared with and OECD average of $ 2759. However, health spending per capita in Turkey grew, in real terms, by 5.8% per year on average between 2000 and 2005, one of the fastest growth rates in OECD countries and significantly higher than the OECD average of 4.3 % per year. In Turkey, 71.4% of health spending was funded by public sources in 2005, slightly below the average of 72.5% in OECD countries. The share of public spending in Turkey, however, has increased significantly over the past five years, up from 62.9% in 2000.[919]

Although there has been a serious rise in the share of public spending, the share of consolidated budget in total health expenditures is falling. It is falling also in real terms. This results with the underfunding of preventive care. The existing system promotes curative services and drug consumption. The share of consolidated budget in total health expenditures was 40% in 1996 and it fell to 22% in 2004. The share of the MoH was 30% in 1996 and became 16% in 2002. But the share of social insurance institutions increased steadily. It was 35% in 1996 and became 48% in 2003.[920] Although there has been a rise in the share of the MoH in the general budget, the budget of MoH decreased in real terms. If we calculate the budget of the MoH adding the funds and subtracting the Green Card spending, we realize the fall in real terms between 1997-2006. The share of the budget of MoH in GDP was 0.99 in 2002 and it decreased to 0.86 in 2004. There was a rise in 2005 due to the transfer

[919] OECD official web site, http://www.oecd.org/dataoecd/46/5/38980477.pdf (December 2007).

[920] *Mali İzleme Raporu, Kasım 2005 Bütçe Sonuçları, Ek Analiz, Sağlık Harcamalarında Neler Oluyor?* http://www.tepav.org.tr/tur/admin/maliupload/2005_11_TEPAV_Mali_Izleme_Raporu_Kasim%5BAnarapor%5D.pdf (December 2007).

of SII hospitals but if we subtract it we see that the MoH spending went below the 1997 level.[921] The rise in the health expenditures of social insurance institutions was noteworthy.[922] A natural component of this process was the explosion in pharmaceutical and medical technology expenditures. Total pharmaceutical expenditures rose from 4.1 billion dollars in 2004 to 9 billion dollars in 2005. The share of public in these expenditures is high. Public expenditure for pharmaceuticals was 1 billion YTL in 1999, and 10 billion YTL in 2006.[923]

While health spending increased by 40% in real terms between 1996-2006, the share of preventive care in public health expenditures remained very little.[924] Turkey allocates a very little amount to public health. The increase in public health expenditures did not have any effect on health service production. State health investments came to a halt. The share of investments in the budget of Department of Basic Health Services was 3.9% in 2001, 3.2% in 2002, 2.4% in 2003, 2.8% in 2004 and 2.2% in 2005.[925]

There is a direct correlation between the status of being insured and the use of health services. According to the National Household Health Expenditure Survey 2002-03,[926] population without any health insurance was 45.4% in rural and 29.9% in

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[921] Hakan Yılmaz, "Sağlıkta Harcama Politikaları." Paper presented at *Sağlığa Erişimde Sivil Toplum ve Harcama Politikaları Konferansı*, Ankara, 2006.

[922] See Table 43 for the rise in health expenditures -total and per capita- of RF, Table 44 for the rise in health expenditures of Bağ-Kur, and Table 45 for the rise in health expenditures of SII. Also see Table 46 for the budget transfers to social insurance institutions.

[923] Soyer, *AKP'nin Sağlık Raporu*, p. 105.

[924] The share of preventive care expenditures in total public health expenditures was 1.11 in 2005 and 1.22 in 2006. Per capita preventive care expenditure was $160 in Netherlands, $151 in Germany, $19 in Spain, $216 in US, $9 in Korea, $12 in Mexico and $4.8 in Turkey in 2003 (Yılmaz, "Sağlıkta Harcama Politikaları").

[925] Soyer, *AKP'nin Sağlık Raporu*, p. 105.

[926] Sağlık Bakanlığı, Refik Saydam Hıfzıssıhha Merkezi Başkanlığı, Hıfzıssıhha Mektebi Müdürlüğü, *Türkiye Ulusal Sağlık Hesapları Hane Halkı Sağlık Harcamaları 2002-2003* (Ankara: Sağlık

urban, 31.6 in the West and 47.5 in the East and Southeast. The percentage of hospitalization for 1000 was 81.8 in the West and 66.3 in the East and Southeast, 95.3 for the insured and 42.2 for uninsured. The percentage of those who applied to a health institution after facing a health problem in the previous two weeks was 80.79% for the insured and %19.21 for the uninsured. This shows that having access to health services encouraged people to get immediate treatment instead of postponing application or getting medication themselves. So, the increase in coverage directly was reflected to the health expenditures as an increase. But the latest rise in expenditures was less due to the rise in the percentage of the people covered by a security scheme than the rise in the availability of services. The opening of MoH hospitals to SII members and Green Card holders, the opening of private hospitals to SII, RF and Bağ-Kur members, the opening of private pharmacies to SII members, and the inclusion of outpatient medicine within the Green Card coverage increased the utilization of health services. The universal reasons of the increase in health expenditures like the aging of the population, developments in medicine and biotechnology, rising expectations, and the profit-seeking companies' control over medical technology and medicine continued to play their role.

Another factor that increased the availability of the health services was the introduction of performance-based revolving fund system to the MoH hospitals in 2004. Doctors in MoH hospitals started to take share from the revolving funds based on the tasks they fulfilled. Doctors were content with this system. In 2002, 89% of the doctors were working both in private and public, in 2007 this fell to 38%. A specialist earned around 5500 YTL in a month. The urge to earn more money

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Bakanlığı, http://www.hm.saglik.gov.tr/pdf/kitaplar/USHHaneHalkiSaglikHarcamalari.pdf, 2006 [December 2007]).

increased the services.[927] The TMA was against the performance-based revolving fund system as it increased the costs and led to unjust distribution of income and ethical problems. It was also criticized for leading to competition among the doctors.[928] There was a serious fall in the appointments that were given for later periods, but all the health personnel I have interviewed talked about the rise in unnecessary treatments and diagnostic tests since all kind of services, including the request for a test, contributed to the income of doctors. Such a suspicion is relevant also for private hospitals. There is a widespread belief that private hospitals lead the patients to unnecessary treatments and tests, for profit-maximization. They might do this also for "consumer satisfaction," which usually increases with the use of high technology and excessive medication. All these factors contributed to the rise in health expenditures.

The IMF warned about the rise in public health expenditures, especially in Green Card and pharmaceuticals. As a response, the government decided to control the rise in health expenditures by applying a package price for every treatment. With a notice on 1 July 2006, the Ministry of Finance declared the package prices.[929] Emergency cases and inpatient treatments were not included in the package, which would lead the hospitals to the informal way of registering outpatient treatments as emergency and inpatient. The declared prices of diagnostic tests were very low, for example 70 kuruş for tomography and 80 kuruş for MRI. This notice was criticized

[927] *Radikal*, 13 September 2007.

[928] Another measure that was adopted by the MoH to solve the problem of personnel was compulsory service. It was abolished in 2003, but legislated again in 2005. Compulsory service had always been opposed by the TMA as a violation of basic freedoms. The TMA advocated incentives rather than force. However, after abolishing compulsory service in 2003, the MoH could not find doctors to employ in the East and had to re-legislate it. This made improvements in the distribution. For example in Hakkari the number of specialists increased from 12 to 60 and general practitioners from 56 to 74 (*Radikal*, 20 August 2007).

[929] *Radikal*, 2 July 2006.

by the health personnel and TMA as it would lead to informal mechanisms and lack of resources. The TMA opposed the mentality which treated the patients as cases and the treatment process as package. The notice could not be applied and the Council of State repealed it.[930]

After this notice on package prices, the Ministry of Finance omitted 116 drugs, and later on 35 new drugs, from refund list to control the rising pharmaceutical expenditures.[931] The rise in drug consumption was tried to be controlled by limiting the types of drugs that could be prescribed by general practitioners or by limiting the number of drugs that could be prescribed on one visit. The Council of State repealed the limits put on the amount of drugs that could be prescribed by the doctors in inpatient care.[932] The public hospitals which served especially the members of SII, RF and Bağ-Kur could not take the service fees from these institutions. The government cancelled RF, SII and Bağ-Kur debts to public hospitals, which amounted to 3.5 billion YTL. Hospitals were stranded.[933] The dean of the Ankara Faculty of Medicine complained that they were unable to pay their debts since they could not get their receivables from the state. Whereas they had difficulties in even paying the salaries, resources were transferred to the private sector.[934] Then the Ministry of Finance started to pay the receivables of hospitals.[935]

It is hard to criticize the rise in health expenditures in itself. As Turkey had a very low per capita health expenditure compared to other OECD countries, a rise is

[930] *Radikal*, 18 October 2006.

[931] *Radikal*, 5 July 2006 and 14 September 2006.

[932] *Radikal*, 14 November 2006.

[933] *Radikal*, 3 February 2006.

[934] *Radikal*, 2 March 2006.

[935] *Radikal*, 3 March 2006.

justified for a more widespread and higher quality service. Part of the increase can be explained with the equalization project. People who had not had access to some services started to have access to them. The increase in the utilization of health services is also a positive outcome. However, the rise in the share of the private sector should be criticized as it might have increased unnecessary services. Although Green Card holders were granted equal rights, the distribution of health expenditures on the basis of equality can still be questioned. People who do not qualify for Green Card but who are not covered by a security scheme either are still denied health care. Also the fall in primary care expenditures might have negatively affected the disadvantaged.

Family Medicine vs. Health Posts

Family medicine was an important component of Transformation in Health Program. It was asserted in the program that the prerequisite for establishing an effective referral system was to obtain primary service from the doctor that the patient chooses and trusts. This depended on the consolidation of primary health care services and the quality of the service delivered by the family doctor. The system relied on the practice of family medicine aiming at the satisfaction of the patient.[936]

The need to establish a strong primary care network both to improve the health status of the people and to diminish the pressure on secondary and tertiary care institutions had been expressed as the rationale of the socialization in 1961. Health stations and health posts would be in charge of a certain population and provide them primary care services. They would function as gatekeepers. However,

[936] Ministry of Health of the Republic of Turkey, *Transformation in Health*, p. 31.

the system did not work and health posts which were established later on in the cities and the West were used mostly by the poor and uninsured segments of the population and the peasants. The pressure on hospitals continued to rise and the need for a strong primary care network persisted.

Almost 90% of the MoH General Directorate of Primary Health Care budget was used to pay staff salaries, leaving insufficient funding for operating costs, pharmaceuticals and other supplies, the purchase and maintenance of equipment, or for providing a means of transportation so that health care staff can visit rural areas and the health post assigned to them for supervision. The services provided by health centers and health posts, including essential drugs, had been free of charge; since 2002, however, official fees were charged which are assigned to the centers' revolving funds.[937] Health stations and health posts had always been underfunded and understaffed.[938]

The inadequacies of health stations and health posts had resulted in the utilization of other providers as the point of entry to the health care system. In urban areas, MoH hospital outpatient departments were used extensively for first contacts with the health care system, while many SII beneficiaries use its hospital polyclinics for first contact care. Growth in the number of university hospitals over the previous two decades also resulted in heavy use of their outpatient departments for first contact care.[939]

The health indicators related to the availability and adequacy of primary care –including infant mortality, under-five mortality, maternal mortality, and

[937] TIBA, p. 63.

[938] See Table 47, for health posts and health stations unattended by doctors and midwives.

[939] Ibid., p. 63.

immunizations – were low in Turkey. As would be anticipated given the state of the public health infrastructure, these health indicators were worse in rural areas and the eastern part of Turkey in general.[940] The inadequacy of primary care and the inequality in health services partially explain the rank of Turkey in the UN Human Development Index:[941] The Human Development Index for Turkey is 0.757, which gives Turkey a rank of 92nd out of 177 countries with data (2006 Human Development Report which refers to 2004). According to the 2006 Human Development Report, 88% of one-year-olds were fully immunized against tuberculosis in 2004, and 81% against measles. Children with diarrhea receiving oral rehydration and continued feeding (under age 5) was 19% in 1996-2004. Contraceptive prevalence rate (of married women ages 15-49) was 64%. The rate of births assisted by skilled health personnel in 1996-2004 was 83%. The number of physicians per 100,000 was 135. Population undernourished (% of total) was <2.5 in 1990-92 and 3 in 2001-03. The rate of children under weight for age (% under age 5) was 4 in 1996-2004 and 16 in 1996-2004. The percentage of infants with low birth weight in 1996-2004 was 16. Although Turkey's GDP was higher than those of other countries in lower ranks, its performance in health and other fields pushed it to the higher ranks.

The Transformation in Health Program represents a comprehensive attempt to restructure all levels of health care provision, establishing new institutions where

[940] Ibid. See Table 48, for regional differences in health outcomes.

[941] Each year since 1990 the Human Development Report has published the human development index (HDI) that looks beyond GDP to a broader definition of well-being. The HDI provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and enrolment at the primary, secondary and tertiary level) and having a decent standard of living (measured by purchasing power parity, PPP, income). Each year since 1990 the Human Development Report has published the human development index (HDI) that looks beyond GDP to a broader definition of well-being. Human Development Reports web site, http://hdr.undp.org (December 2007).

necessary. Primary care, in this model, was assigned a significant role in terms of both improving the access of the population to essential clinical and preventive care and relieving the pressure on secondary and tertiary levels. This implied a significant reorganization in terms of dismantling health centers and posts and substituting them with family doctors, who would act as gatekeepers of the health care system. In the provision of primary care services, family doctors would also be accompanied by public health centers (*toplum sağlığı merkezleri*).

While family doctors are synonymous with general practitioners in most countries, they have a distinct position in Turkey. All medical school graduates can work as general practitioners, who are not regarded as specialists. These doctors usually work in health posts providing preventive and primary health care. Family doctors are specialists, receiving an additional three years of training with a largely curative focus. They are eligible to fill any post, although they mainly work in mother and child health care and family planning units. The number of family doctors increases every year despite strong opposition to the family doctor scheme, particularly from some public health professionals who fear that primary health care will be adversely affected by further expansion of the scheme.[942]

The first family medicine department was established in Gazi University Faculty of Medicine in 1984. Specialized training in family medicine started in MoH training hospitals in Ankara, İstanbul and İzmir in 1985. The training is three years, nine months being on internal medicine, nine months on child health, eight months on obstetrics and gynecology, six months on emergency, and four months on psychiatry. Today, family doctors and general practitioners have separate

[942] Savaş, Karahan and Saka, p. 21.

organizations and the TMA's opposition to family medicine system alienates the family doctors.

With the Family Practice Pilot Project Bylaw,[943] the pilot project for implementing the system of family doctors began in the summer of 2005 in Düzce. Under the new system the FPs would be self-employed practitioners who were paid by the state a capitation fee, or a fee per enrolled patient, and additional payments for special qualifications, such as serving in undeveloped regions where there was a shortage of physicians; length of service; whether or not they carried out the public health services such as screening and immunization, whether or not they did home visits, etc. The payment schemes were designed to include performance criteria: For those FPs who did not meet these requirements there would be serious consequences in terms of income. For instance, if the FPs exceeded the predetermined referral targets or if they failed to provide immunization services or to make home visits, a certain amount would be deduced from their payments.

The family doctor model, however, has been controversial. The TMA has interpreted this strategy as promoting solo, office-based physicians who are likely to focus on curative services, and whose integration into a unified primary health care network will be difficult. This approach, they believe, will be detrimental to preventive services and community outreach, as well as for a multidisciplinary team approach to primary care, regular record keeping for patients, and establishing necessary priorities for planning health services on a provincial basis. They argue that individual physician practices will each need to be furnished and equipped, leading to both duplication in medical equipment and higher overall expenditures. Further, they believe that paying these independent physicians on a contractual basis,

[943] *Aile Hekimliği Pilot Uygulaması Hakkında Yönetmelik*, *Resmî Gazete*, 6 July 2005.

rather than as salaried government employees, will lead to decreased job security and social rights, as well as poorer working conditions since cross-coverage is less likely to be unavailable.[944]

TMA and General Practitioners Association claim that when doctors have the chance to choose their patients they will tend to exclude those with chronic illnesses, cancer, those who have to apply frequently, mentally handicapped, and etc. If payments will be per capita, doctors will prefer easy cases. When there is competition among doctors they will try to satisfy their patients more, and patient satisfaction is based on referral to a higher level institution, prescribing many drugs, demanding various examinations, and giving report. Family doctors may decide to refer the patients to specialist practitioners and they might take this decision together with their patients. Specialist practitioners and family doctors might sign contracts. This would cause unethical situations and referrals would increase.[945] The projected application number in one year to a family doctor is 4.1. If a family doctor works 50 weeks in a year and 40 hours in a week, he can spare only 9.8 minutes to a patient. This is not enough and there is no time left for preventive care services.[946]

In family medicine, not only doctors will have the chance to choose their patients but patients will also have the chance to choose their doctors. This is based on the assumption that people's opportunity to choose their provider will lead to competition which will in turn increase efficiency. But as discussed in the second chapter, choice in health care damages not only equity but also efficiency. Doctor-patient relationship is not an equal relationship between a buyer and a seller as the

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[944] TIBA, pp. 64-65.

[945] Bülent Kılıç, "AKP, Aile Doktorluğu ve Sağlıkta 'Dönüş'üm Programı." *Toplum ve Hekim*, 18(2) (Mart-Nisan 2003): 120-122.

[946] Pratisyen Hekimlik Derneği, *Düzce Aile Hekimliği Pilot Bölge Uygulaması Çalışma Grubu - Düzce Raporu* (İstanbul: Pratisyen Hekimlik Derneği, 2006), p. 29.

patient does not have the necessary information. The asymmetry in terms of information makes the application of market rules in health care very problematical.

After an investigation trip to Düzce pilot region, the TMA Public Health Branch, The Association of Public Health Specialists, and representatives from public health departments made a press statement (11 March 2006). It was asserted that preventive care had lost its priority and was limited with only those who had applied. There was no planned maternal and child health monitoring system. Due to competition doctors employed other health personnel informally. Team work, which constituted one of the main characteristics of the socialization, was damaged. Contractual work abolished social insurance rights. Mobile services could not be provided. The referral chain was not working. There was a rise in health expenditures. The pharmaceutical expenditures increased 40-50% in the last year. The public institutions were utilized for private use. A meeting was organized after this trip and in that meeting the system was challenged as it undermined preventive care and public health. With such a model it would be hard to implement national programs. The family medicine model was contrary to the principles of socialization.[947]

The TMA accused the JDP for planning to abrogate health posts. The TMA, the TDA and other syndicates organized White Demonstrations in March 2007 to claim the health posts (*Sağlık ocaklarına sahip çıkalım*). They asserted that health posts were owned by society but the government was trying to turn them into private clinics with the practice of family medicine. They advocated the promotion of health personnel in primary care with compensation and the functioning of the referral chain.

[947] TTB, *Halk Sağlıkçılar Sağlıkta Dönüşümü Tartışıyor*, 11 March 2006.

The socialization came onto the public agenda in the context of the debates on family medicine. Health posts were defended with the concern of social justice while the family medicine was criticized for being a step towards the commercialization of health care. The logic of socialization was appreciated and its proper application was recalled with nostalgia. For example, Türkan Saylan wrote about the "different Anatolia" which had been created by socialization. She emphasized the importance of primary care and preventive services.[948] She said, "We would not have these problems if primary care was developed. We should apply the socialization with the efficiency of its initial phases. The health posts, household monitor cards...".[949] In her memoirs she referred to the proper functioning of health posts and promoted both the socialization and the compulsory service.[950] For her, only through socialization could the health system be improved.[951]

Şükrü Hatun expressed his wish to return to those good old days when he used to work hard in a health post in Adıyaman to diminish the infant mortality rate from 200 to 140. He wrote "Millions of people benefited from health posts. They applied health posts as if they were sending their children to school. What will happen to the health stations in remote villages and fields? Family medicine contradicts with the principles of socialization."[952]

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[948] *Radikal*, 9 March 2006.

[949] *Radikal*, 3 July 2006.

[950] Türkan Saylan, *Güneş Umuttan Şimdi Doğar: Türkan Saylan Kitabı*, Söyleşi: Mehmet Zaman Saçlıoğlu, 5th edition (İstanbul: Türkiye İş Bankası Kültür Yayınları, 2005), pp. 244-5.

[951] Ibid., p. 256.

[952] *Radikal 2*, 11 March 2007.

The Purchaser-Provider Split

The autonomization of hospitals has been a major component of health reform proposals since the 1980s together with family medicine and GHI. The reform program envisages a system in which public hospitals, which will gain the status of independent trusts or foundations, compete with each other and with private hospitals and clinics for contracts with the General Health Insurance Organization. This implies a fundamental shift in the culture of service provision, as contracting formalizes the relationship between purchasers and providers, which in the long-run undermines the pre-existing non-contractual relations and incentives.

A significant component of purchaser-provider split has been the recognition of the administrative and financial autonomy of public hospitals. In most instances, autonomization has been associated with changing the legal status to public benefit corporations to be run as non-profit but nonetheless commercial bodies. This involves determining their own priorities, setting their own pay scales, borrowing on the private market or entering into contracts with other private and public agencies to buy some services, or contract out others. One of the first and fundamental steps in providing "autonomy" to public hospitals is replacing the senior hospital specialists with chief executives or managers in the management of hospitals.

In the reform program of the Turkish government, public hospitals are redesigned to act as equal players with private providers in a market, operating more efficiently as they are now concerned with capturing the market share, minimizing costs and maximizing returns.[953] The scale of the use of market mechanisms and

[953] Ağartan, "Health Sector Reform in Turkey".

buying of services from private providers distinguish the JDP government from the former ones. On the one hand there is a serious concern for universalization but on the other hand, there are all kinds of problems associated with markets and privatization. Neither the idea of universal health insurance nor the idea of social pensions had been discussed as seriously as they are being discussed today. The fact that the debate takes place with reference to the situation of those hitherto excluded from the social security system is also significant in the sense that it points towards a shift from an inegalitarian corporatism to a universalistic tendency.[954] But the uncritical belief in the efficiency of private sector and competition should be problematized. As seen in the second chapter, competition has negative consequences in the case of health care. The US health system is a good example of this.

The negative effects of the market logic reveal themselves in poor areas where it is difficult to derive profit. If the role of the state is limited to regulation and control, how will the number of hospitals in poor regions increase? Or how will their capacity expand, their equipment be modernized? In Eastern and Southeastern Anatolia where 30% of the people are not covered by a security scheme and where 75% of Bağ-Kur members are in debt, how will a competitive atmosphere be established?[955]

[954] Buğra and Keyder, "The Turkish Welfare Regime in Transformation." p. 227.

[955] Üstündağ and Yoltar.

Conclusion

When we compare the post-1980 period with the 1960s and the 70s in terms of health care, we see that there are certain shifts as well as some recurrent elements. Low level of coverage, weakness of primary care network, unjust distribution of services and personnel, inefficiency of hospitals, resistance of doctors to become civil servants, lack of integration, and inequality of access to health care are the persistent problems. We might talk about the intensification of these problems due to the rise in urbanization and the rise in percentage and number of those covered by a security scheme which increased the demand, together with the developments in medicine. Other recurrent themes appear in terms of a solution proposed. Post-1980 governments tried to enact General Health Insurance. It had been on the agenda since the 1950s, but had not been accomplished since the socio-economic structure of the country was not convenient. In the late 1980s, the World Bank began to assist countries in implementing health reforms based on neo-liberal economic principles. General Health Insurance was among the proposals of the WB, and the post-1980 governments adopted this proposal, which has already appeared in earlier government programs. It was promoted both to finance the health sector and include everyone within the system. We can observe continuity with the pre-1980 period in the definition of problems and in the appeal to GHI as a solution. However, there is a great rupture in terms of application and the other proposals. We see that the private sector was encouraged and market mechanisms were adopted with the assumption that the state was cumbersome and inefficient. Private hospitals and clinics were established formerly too, but their share in the general health services was not so great. Abolishing the private sector in health had not been envisioned even as part of

the socialization, but the state had assumed the essential tasks and it was the state that financed, provided and regulated the health service. However, with the neo-liberal climate of the post-1980, state's retreat from its provider role and autonomization of the hospitals came to the agenda. It was thought that competition would increase efficiency.

Another rupture was in the field of public health. No one ever mentioned public health anymore, and the debate was all about the hospitals. The share of public health and primary care declined increasingly, which resulted with the worsening of the conditions of the disadvantaged who benefited from these services most. Urban and rural inequalities as well as regional inequalities which were hoped to be abolished by the socialization persisted. And encouraging the private sector further intensified these inequalities. Those who had the necessary financial means could have easier access to health services before too, but the disparity between the services the poor and the rich received was not so great. The developments in medical technology and the pharmaceutical science made health services increasingly costlier, and this resulted with the exclusive access of high classes to the most improved services. A wide portion of the population who had neither the financial means nor any kind of social insurance came to be excluded from the system. The inequalities among those who had social insurance also intensified, especially with the plunder of the resources of the SII. The harsh market mechanisms adopted by successive MP governments made the hospitals dependent upon revolving funds and the practice of accepting patients free of charge became nearly impossible. By the 1990s, public health services deteriorated considerably and stories of people held pledge in hospitals became widespread. The TPP-SDPP coalition which assumed power in such a climate made efforts towards recovering from the

damages of the brutal neo-liberal politics of the MP. Demirel highlighted the welfare dimension of the state, its role in public services, and equity. Although they too, following the path of the World Bank, supported the GHI, family medicine and the autonomization of the hospitals, never applied marketism *a la* MP. They acknowledged state's responsibility towards its citizens in the field of health, thereby introduced the Green Card scheme designed for the uninsured poor. Although a means-tested mechanism, the Green Card, held today by the 12% of the population, is an important step towards universal coverage.

The aim of abolishing inequalities among the existing security schemes in terms of access to services has been on the agenda of the TPP-SDPP coalition as well as the following coalitions. It was aimed both to abolish the existing hierarchies and to include those who fell out of the system notwithstanding the Green Card. But the economic crises and the armed conflict hindered radical steps towards these aims. The JDP, which assumed power alone after the period of recovery from the crisis of 2001, initiated efforts for a system of universal coverage and, taking a step that none of its precedents dared, legalized the GHI. The JDP is distinguished from former governments with its determinacy in health reforms and the steps it took towards equalization. We may argue that the JDP, which adopted the idea that the state has social responsibilities towards everyone, made serious interventions in terms of the "people/citizen" distinction, which I mentioned when discussing the failure of socialization.

The JDP won a landslide victory in the elections of July 2007 and gained 46.58% of the votes. Various analyses have been made about the reasons for this success. Health policies were among these reasons. The 59th government opened all public and private hospitals to the members of different security schemes, provided

the opportunity of getting medicine from private pharmacies for SII members, included the outpatient medication in Green Card coverage, abolished fee in health posts, and sent doctors to the East and Southeast. All these measures contributed to the success of the JDP.[956] These were steps in the direction of equality and the JDP referred to them frequently in its election campaign: One of the slogans of the party was "I get treatment in any hospital I choose," and "Every newborn will have health insurance" was a promise from the same campaign. The JDP faced the opposition of the trade unions, professional associations, the bureaucracy and the opposition parties but did not retreat.

Of course, policies envisioned in favor of a more universalistic system should be supported. Only through such a system those who live with the constant threat of social exclusion can be included and a comprehensive notion of community based on Marshall's idea of social citizenship can be established. However, the unconditional belief of the JDP in the efficiency of market mechanisms challenged this ideal of equal citizenship. The 59th government promoted the private sector much more than the earlier governments. Market mechanisms were advocated both in the hospitals and primary care units. In a climate hegemonized by the neo-liberal market ideology, the JDP succumbs too readily to pressures towards the limiting of public expenditures and the shrinking of the state. The premium-based general health insurance, family medicine, purchaser-provider split and the buying of services from the private sector are all components of this marketization process.

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[956] On a TV program where the results of the election were debated, Ersin Kalaycıoğlu told about a field research they conducted between 23.06–16.07.2007. They had specified several problematic areas and asked people which party could offer a cure for which. 50% answered that the JDP could solve the problems in the health system. That was the highest percentage among all the specified areas. NTV Neden web site, http://www.candundar.com.tr/index.php?Did=5201#this (December 2007).

CHAPTER SEVEN

CONCLUSION

In this thesis I have analyzed the health policies of the Republican period, with a special focus on the attempt at the socialization of health services undertaken in 1961, after the military intervention of 27th May 1960. In the study, I have drawn on three theoretical approaches in examining the health policies of the Republican period in terms of state-citizen relations. The first reveals the connection of welfare and citizenship, and argues that social rights reduce the existing class differences in society and endow all with a sense of communal belonging. The approach in T. H. Marshall's now classic essay helps us to understand the debate on social rights in Turkey. It is possible to adjust his approach to the context of the socialization of health services. Apart from class differences, the establishment of social rights can allow for the waning of others, such as regional, ethnical, and urban/rural differences.

Esping-Andersen, who criticizes Marshall for discussing all social rights solely in terms of equalization, draws attention to the potential stratification implied in the welfare state. This potential is particularly important in understanding the Turkish case, since the state builds hierarchies through welfare. The civil servants whose affinity with the state is most marked are placed at the top of the pyramid, followed by workers in the formal sector and the self-employed. This distinction becomes all too crystallized in the field of health. The Turkish welfare system displays a character akin to those defined as "conservative" by Esping-Andersen, but with a significant difference: Although European conservative systems build

hierarchies among those covered, everyone is included in the system one way or another. In Turkey, as is the case in many of the developing countries, a large portion of the population falls outside the system. The term "inegalitarian corporatist" is much more fitting for the peculiarity of this system.

The second approach I have drawn from concerns the health care typologies. The basic categorization here is national health service, social insurance and private insurance. The first represents a health system established by the state and financed through the general taxes, where the state assumes the roles of the financier, the provider and the regulator. The second represents a system where premiums collected from the employees are utilized in buying the services provided by the state, or by private or non-profit institutes. In the third, the provision and financing of the service is left to the private sector. The system that was intended in 1961 in Turkey fits in the first, but there were (and still are) attempts to establish the second system throughout the 1960s and the 1970s. The responses of diverse welfare and health care systems discussed within the framework of the second theoretical approach towards the pressures emerging from global competition, technological development, de-ruralization, changes in the traditional family structure, women's increasing participation in employment, and aging population also helped to understand the reform process in Turkey.

The third approach is represented by Heper's analysis of the bureaucratic ruling tradition of Turkey and Keyder's analysis of the alliance between the bureaucracy, bourgeoisie and the formal workers within the ISI-based economy of the 1960s and the 1970s. Both these analyses provide insights for the failure of the establishment of a universal health system in Turkey, as well as helping us to understand the process of exclusion/inclusion and the current shifts.

In the thesis, the historical development of the Turkish care system was studied by using the following the periodization: The period between the establishment of the Ministry of Health in 1920 and the DP's assumption of power in 1950 can be characterized by health policies intended towards recovering a population devastated by the wars and epidemics. The DP took charge of curative services, for which the state did not take any responsibility before, relying on the achievements of the public health and pro-natalist policies. This meant a shift from a population based approach in health to an individual based one. The rupture in 1961 was related to the state's acknowledgement of its function as a welfare state. It was aimed to provide all with both preventive and curative services on the basis of equality through the socialization of health services. The system did not work due to various reasons throughout the 1960s and the 1970s and a new break occurs in 1980. The neo-liberal wave from which no country in the world could escape influenced Turkey as well. We can characterize the period from 1980 to the present with health reforms in a neo-liberal context. However, this period also had ruptures in itself. The introduction of the Green Card in 1992 and the attempts towards universalization made after the JDP assumes power constituted the main lines of rupture.

The problems within the current health care system and the recent attempts at its modification constitute the starting point of the thesis. The current fragmented health care system creates a hierarchy in terms of access and accordingly citizenship among the members of different security schemes. This system creates a dual inequality, one being within the system itself by virtue of differential benefits provided under different schemes, the other being between the people covered and uncovered. Rural population and urban informal sector employees, who together constitute a large segment of the population, are excluded from the system. To be

able to locate this inegalitarian corporatist structure and the recent attempts at its modification within their historical context, I looked at the former welfare and health care policies.

It was at this point that I discovered an attempt to establish a universal, egalitarian, and comprehensive national health service system in 1961. Although I was aware of the establishment of health posts, it was not known to me that they constituted the primary care stand of the health system of Turkey as defined by the Law on the Socialization of Health Services. The law was, and still is, in force but was not applied and the socialization did not become the health system of Turkey. If it were applied in the proper sense not only the health posts, but all public health institutions would be responsible for providing medical care to all citizens on the basis of equality. Neither the financial means nor the status in employment would be determinate in people's access to health care. There would be no discrepancy between the East and the West, the city and the village.

The attempt at the socialization of health services became the major topic of this thesis as the formulation, application, and the failure of such a system would provide insights about the shaping of the welfare and health care system of Turkey. The main argument of the thesis is that the socialization of health services could not be established as the health system of Turkey mainly due to the simultaneous development of inegalitarian corporatist system which provided medical coverage to those in the formal sector. Two systems that contradict with each other –the tax-based universalist system of socialization and the premium-based corporatist system of social insurance- existed together and the development of the latter prevented the application of the former. The goal of covering all on the basis of equality and bringing health service, at least at the level of primary care, all over Turkey could not

be accomplished. The reasons behind this failure indicate the structuring of state-citizen relations in Turkey. Rather than providing health care to all, the state used the resources at hand to protect those in the formal sector with respect to their status in employment.

Health care has a peculiar place within the field of social policy. It is widely accepted as a social right which would be provided to all on the basis of equality. Freedom from anxiety, which is acquired through the relief of access to health care, contributes a great deal to the quality of life. It is important to examine health care as it embodies a particular set of overtly political assumptions about the state, its responsibilities and the rights of citizenship. It is especially through health policies that citizens conceive their relationship to the broader society around them as well as to the state. So, the consolidation of an inegalitarian corporatist system through the repression of an egalitarian universalist system reveals the position of the state before its citizens. Even in the field of health care, where inequalities are most intolerable, the policies served to the enhancement of the existing inequalities rather than curtailing them.

The socialization of health services was formulated by the military officers, the health bureaucrats and the early planners who were influenced from the welfare state developments in the West. They adjusted the universal national health service systems of Britain and Sweden to the Turkish context. There were many problems related with the provision of health care: the unjust distribution of health services, the lack of basic health care in the rural area, and the difficulties poor people faced in receiving medical care. Actually, there were serious achievements in the field of health care after the formation of the Republic. There was a serious population loss and the remaining population was unhealthy and weak. The country, worn out by the

long-lasting wars and epidemics, recovered with the commitment of the early Republican governments in the field of health care.

Creating a healthy "nation" through pro-natalist policies and public health measures was the priority of the Kemalist governing elite. A robust population was deemed indispensable for national defense, and the development of economic and social life. The population and health policies of the early Republican period were successful, as can be seen from the rise in population and the improvement in health indicators. The state assumed only the task of preventive care and left curative services to local authorities, charities and private physicians. This indicates that the state approached the people not as citizens with rights, but as a population who needed to be strengthened. It was not the individuals' but the population's health that the state felt the need to protect.

The combat against epidemics and endemics, the establishment of health organization, the enactment of related legislation, and the expansion of staff were all in line with this holistic approach. These achievements allowed the Democrat Party to adopt a more individualistic approach towards health care in the 1950s. There was a rupture in the DP period as the state took the responsibility in curative services and actively involved in the provision of hospital care. While the combat against epidemics and endemics continued to be waged, the emphasis in health care shifted perceptibly towards curative medicine, as was the case in many other countries in those years. Whenever the shift occurred there appeared a search for financing health care through general insurance, which at that time was found out to be unrealistic in an agricultural society. But the insurance system was developing independently and the Social Insurance Institution started to establish its own health institutions in the early 1950s.

It was in the DP period that the members of the SII and the Retirement Fund were endowed with the right to benefit free of charge from the services in hospitals. It was the initial phase of the consolidation of inegalitarian corporatism in which civil servants and workers in the formal sector, who constituted a very small portion of the population then, gained an advantageous position. The inequalities between the rural and the urban regions, the East and the West were much poignant than those between the people covered and uncovered. The peasants who constituted nearly 70% of the population were devoid of basic health care. The rise in private practice, the developments in medicine, and health technologies sharpened the inequalities between the rich and the poor. While state involvement in hospital services increased on the one hand, the rise in private practice and advance of patent medicine led to a certain commercialization in medicine, particularly in big cities on the other. The emphasis on hospital services weakened the health service delivery in rural areas because hospitals usually concentrated in cities as they require a strong infrastructure. It was in such an environment that the socialization of health services came onto the agenda.

The abolition of inequalities and the provision of health care to all within a certain plan constituted the starting point of the socialization. The Constitution of 1961 charged the state with the task of providing social welfare to its citizens. And the State Planning Organization would designate the development strategy of the country. Health care was an important component of the development strategy of the period which promoted social justice. Through the socialization of health services everyone, without any distinction in terms of economic power, status in employment, region, ethnicity, and rural/urban divide would be provided health service, both preventive and curative. Everywhere health stations and health posts would be

established to maintain the well-being of a certain population, both in cases of illness and health. Hospital services would also be available to all as secondary care institutions. Through such a comprehensive program the problems in the field of health care -financial constraints, lack of a primary care network which raised the workload of hospitals, lack of integration and coordination, lack of health services in rural areas, unjust distribution of doctors, the private practice of state-employed doctors, doctors' tendency to become specialists- would be solved.

This rupture in the 1960s was very important in the sense that health care was adopted as a basic citizenship right. The role of social rights in the improvement of people's sense of equal worth and belonging to the wider community was accepted and the socialization gave priority to the provision of health care to the peasants, Kurds and the poor. The program started in the East, which indicates the aim of national integration. The military officers tried to cope with the Kurdish nationalism, which started to display a political character in the late 1950s, by bringing health service even to the remotest villages of the East. Aside from the initial application of the socialization efforts were made to solve the Eastern question through economic measures. Actually, the improvement in social rights would be much more effective in "winning the hearts of the people," a phrase used by Nusret Fişek who prepared the Socialization Law and the Population Planning Law.

Another issue which was handled by Fişek and early planners within the context of societal development was population. Rapid population growth had to be controlled as it started to create developmental problems and public health issues. So, the pro-natalism of the 1930s left its place to the anti-natalism of the 1960s. Although the early planners handled the issues of population and health within the context of their importance in economic development, the perspective of human

rights and social justice also had an important role in the shaping of the laws related with these.

The Socialization Law was not applied in the proper sense by any of the governments. Except for the second half of the 1960s, the two decades after the coup of May 27 can be characterized by political and economic instabilities which were partly due to insecure coalition governments. Such circumstances were unfavorable for radical policies in welfare and health care. None of the governments could implement the socialization of health services as a national health service system which is defined by the providing of health care to all citizens regardless of their status in employment. Rather, they limited the function of socialization to public health services for the rural population and the poor, which was expected to support the development of the East. New health posts were established in villages, but the system was not considered in its totality with all the health institutions including hospitals. The socialization was not limited to public health and primary care for rural population and the poor, but this happened to be the case in practice, especially throughout the 1960s and the 70s when socialization was wedged in this area.

Although the socialization gave special weight on primary care units (health stations and health posts) all health institutions were supposed to be taken in a totality. A patient referred from a health post to a hospital would be examined free of charge. But in practice, due to the failure in integrating the hospitals with the system, socialization remained limited to primary care services provided in health posts in rural areas. And even this limited area, i.e., the establishment of a primary care network, was not devoid of problems. The pressure on hospitals continued to rise and the referral chain did not function. The number of health posts could not reach the expected levels and the existing institutions suffered from lack of funds and staff.

Infant mortality, under-five mortality, maternal mortality, and immunization are health indicators related to the availability and adequacy of primary care. The low level of these health indicators reveals the inadequacy of primary care. They continued to be worse in rural areas and the eastern part of Turkey.

The scope of a change in expectations brought by the socialization of health services remained limited. Lack of a complete change in this regard could be seen as a failure in itself. It was a widely acknowledged duty of the state that doctors should be appointed in villages. However, the view that the state had to provide all kinds of health services to its citizens by means of public resources did not gain wide support. It was usually argued instead that health services could not be financed through public resources and there was the need to establish an insurance system. So, while the state assumed the responsibility of providing health care to the remotest villages, the quality of that care were always low. The expensive modern curative services were available for the rich and the insured in the cities. That means, the state provided public health for "the people" and medical care for "the citizens". Both the welfare and the health care systems were shaped in accordance with the alliance among the bureaucracy, bourgeoisie and the workers in the formal sector –citizens- in the Import Substituting Industrialization period.

The initialization of the program in rural areas and the East can be accounted for the "failure" of socialization, among other reasons. In places of multiple deprivation, the poor infrastructure and the employment of health personnel constituted great problems. The efficiency of the system could not be declared due to the problems in application. We nevertheless observe that in the initial period when there was relatively low pressure in terms of resource, the program functioned properly. It also functioned well in health training and research districts where

faculties of medicine executed the program together with the MHSA. The results of the proper application were noteworthy, both in terms of improving health indicators and falling expenditures.

Big cities were not covered by the program until 1984. The urban population was growing and their expectations became much more decisive in the shaping of health policies. This led to an inevitable duality, where a separate hospital system developed in cities along with the socialization in rural and undeveloped areas. Although the socialization of health services aimed to integrate all health institutions and make the referral chain work, it was unable to prevent this duality. The progress in medical science led the urban settlers to demand increasingly more expensive hospital and specialist care. So, the rising expectations of the rising urban population together with the increasing costs due to progress in medicine led the governments to search for ways of financing health expenditures. The state would not abandon its role of financier in public health, but the rising costs of curative services necessitated a search for new resources. Throughout the 1960s and 1970s, all the parties involved in health policy including the governments, the SPO and the Turkish Medical Association supported the establishment of a premium-based general health insurance. It was widely accepted that people's contribution to health expenses was a must. Those who argued for the application of socialization as a tax-based national health service system could not gain enough support.

The policy makers of the period did not welcome the idea of a universal health care system financed by public resources. Although they acknowledged the need to cover everyone, they believed that the only way to achieve this was to establish a premium system. However, even this wide consensus could not allow the unstable governments of the period to take this step. It was not only the need to raise

funds for health expenditures, but also the aim to cover all that led the governments to engage with general health insurance. This effort *per se* reveals that the socialization was not considered as the tax-based national health service model of Turkey. This was partly due to the ambiguous financial basis of socialization. Socialization was not clearly defined as a tax-based system at the beginning. Despite the fact that in the late 1960s and 1970s Nusret Fişek started to defend it as a tax-based system, it was treated more as an organizational model.

When a certain section of the population was covered by health insurance which guaranteed access to hospital services primary care units would not develop. Members of the Retirement Fund -civil servants, retired civil servants, and their dependents- could directly benefit from university hospitals. Members of the SII -insured workers, retired workers, and their dependents- had their own hospitals. Free curative service was provided to those who had paid premiums. Since the insured could directly attend to hospitals, health posts could not develop. This proves that a service confined to the poor parts of the population is doomed to regression.

The socialization entailed the integration of all health institutions. That means hospitals of the SII would be transferred to the Ministry of Health and Social Assistance. However, both the Institute itself and the trade unions opposed this transfer although it was explicitly stated in the law. The workers and their dependants under SII could benefit from the organization's clinics and hospitals which were established from 1950s onwards with the premiums collected from the employers and the employees. Since they had the opportunity to utilize the SII health services, workers in the formal sector did not embrace the socialization system. This corporatist structuring was also problematic in terms of health manpower. Doctors

preferred to be employed in the SII hospitals located in town and city centers where they were provided with relatively appealing working conditions.

Apart from the consolidation of the inegalitarian corporatist system, the governments' reluctance to allocate enough resources for the socialization; the problem of unjust distribution of doctors; the unwillingness on the doctors' part to work in health posts; encouraging of specialization in medical training; and the problems due to the initialization of the program in the East constituted the reasons of the failure of socialization.

The socialization of health services could not be the health system of Turkey and the bills to establish general health insurance could not be legislated. When we come to the 1980s, we still see that a considerable portion of the population did not have any health coverage and the regional and urban-rural inequalities persisted. The 1980s was another turning point in the Republican history. After the coup of September 12, 1980 the Motherland Party took successive offices which symbolized the transition from national developmentalism to neo-liberal capitalism. Regional and statutory inequalities, infrastructural problems and poor quality service to people with no financial means have become salient in this period. Public resources were used to support private health sector and preventive care was neglected. The share of health in state budget declined and the hospitals were forced to generate their own resources.

By the 1990s the health system was in a deep crisis and newspapers were full of stories of poor people who could not pay for health expenses and were held in pledge by the hospital administrations. The failure of socialization in establishing a universal health care system, combined with the marketization trends of the 1980s, resulted with many negative outcomes especially for the poor. The following

government tried to solve these by initiating the Green Card scheme. The True Path Party – Social Democratic People's Party coalition enacted the Green Card Law to provide health insurance to those who were not covered by any social security institution, and whose monthly income was less than one-third of net minimum wage for a person in a household. It might be analyzed as an improvement in citizenship status despite the fact that it is a means-tested mechanism. It functioned as a life saving mechanism for the poor citizens who were excluded from the health system by the corporatist structuring of the welfare regime.

The application of such citizenship-based social policy measures implied that the developmentalist assumption was abandoned, which had been dominant until the 1980s. According to this assumption, industrialization would allow everyone to get a regular job in the formal sector and everyone would be covered under a security scheme. This assumption lost its validity both in the developed and the developing countries. Today, it is a commonplace fact that economic development does not necessarily provide employment and employment does not guarantee insurance and reduce poverty. So, citizenship-based rights had to be implemented in order to cover those outside the system.

Low coverage, weakness of primary care network, unjust distribution of services and personnel, inefficiency of hospitals, resistance of doctors to become civil servants, lack of integration, and inequality of access to health care were the problems that the governments had to handle both before and after the coup. The rise in urbanization and the rise in percentage and number of those covered by a security scheme increased the demand, together with the developments in medicine, which in turn intensified the problems. The socialization of the 1960s emphasized the bringing of basic health care to the "peasant citizens" while the health sector reform attempts

of the 1980s and after focused on providing hospital services to the increasing urban population. Health reforms are usually explained with reference to the need to contain costs which escalated with population aging, rising rates of health care utilization, and developments in medicine and biotechnology. The neo-liberal transformation which promoted market mechanisms as a panacea to the problems of inefficiency also shaped reform proposals. The prerequisites of this transformation were dictated to the developing countries by the World Bank and the IMF. The increasing budget deficits in social insurance put the reform as an urgent task before the governments. That was also the case in Turkey. However, the need to reform health care cannot be explained only with the neo-liberal transformation and the budget deficits in insurance. Throughout the 1960s and the 1970s, same problems were discussed but, the solutions proposed were different, except that of general health insurance. Other solutions like decentralization in health services, the autonomization of hospitals towards their privatization, family medicine and the promotion of private sector were peculiar to the 1980s and after.

All the post-1980 governments tried to implement health sector reform but it was the 59th government of the Justice and Development Party that was able to take radical steps. It is the first government to enforce the necessary legislation for the integration of different security schemes and general health insurance although the Constitutional Court annulled some of its articles. Universal health insurance is discussed seriously with reference to the situation of those hitherto excluded from the system. Also the scale of the use of market mechanisms and buying services from private providers distinguish the JDP government from the earlier ones. On the one hand, there is a serious concern for universalization, but on the other hand there are all kinds of problems associated with markets and privatization. The measures that

abolish inequalities among the members of different security schemes including the Green Card scheme and the inclusion of the private sector within the health service provision for the insured have been found to be successful by the people, a fact that reflected in the electoral victory of the Party in the 2007 elections. The 59th government wanted to abolish the inequalities among the "citizens," the insured in the formal sector, but faced the resistance of the bureaucracy which tried to maintain the advantageous position of the civil servants. It also wanted to abolish the inequalities between the "citizens" and the "people" by covering all through the establishment of general health insurance. However, the application of a premium-based system in a country like Turkey where the rural population still constitutes one-third of the population and half of the working population is in the informal sector, would exclude some from the system and create stigma and dualisms. In many developing countries the universalist programs are designed to provide social insurance to those who were hitherto excluded from the system.

The JDP government advocated premium-based general health insurance, family medicine, purchaser-provider split and the buying of services from the private sector which constituted the components of the marketization process. Such a process is promoted by the IMF and the World Bank. Although neither the JDP government nor the international organizations proposed an absolute commodity status of health care, they supported the increasing role of the private sector on the grounds that efficiency would be maintained through competition. However, the dominance of the market in the health sector has always engendered negative consequences, in terms not of only equality but also of efficiency. When the market dominates the sector, costs rise, equality disappears, and the welfare of the whole society gets damaged. If the JDP turns patients into consumers and health facilities

into enterprises, the consequences will be damaging for all. Although the health reform packages presuppose the opposite, equity and market rationality are not compatible. The results of the privatization might be examined in a further research.

Health care is one of the fields that have the most bearing upon the definition of citizenship, perhaps the most important one. I tried to examine the health care developments in Turkey from a historical perspective, taking into account ruptures and continuities. I tried to reveal the extent to which the provision of health services serve for inclusion and equalization on the one hand, and differentiation on the other. I would thus be able to illustrate in detail the rights and privileges provided through social security institutions. I could only show the privileges in the field of health as revealed in laws and in the growth figures of SII hospitals since data on expenditures and service provision before 1980 were hard to access.

The framework of this dissertation provides a path for further detailed studies in this field. For instance, in order to illustrate the inegalitarian corporatist structure, the historical development of privileges in various areas such as retirement might be examined. Another point which I left aside in this study is the position of military officers in terms of access to health care. The Ministry of Defense has always had exclusive hospitals, and their integration with the Ministry of Health has never been brought onto the agenda. While the transfer of public hospitals has been the object of vehement debates for years, the hospitals belonging to the Ministry of Defense have always been excluded. In the hierarchy of access to health care, one of the most advantageous groups is the military.

I also left the minorities out of the study, an issue which by an examination would give us clues on state's distinctive attitude as to who deserves citizenship and who does not. It would be quite interesting to reveal the attitude of the state towards

endowment hospitals. The role of doctors in health care policies is a subject matter in its own right. I examined the role of this privileged group of profession in terms of the failure of the socialization, but a study on the attitude of doctors towards the health policies throughout the Republican era will reveal the specificity of the field of health as well as of the doctors as a professional group. No other group of profession has been such decisive and influential in the application of policies, if not their formulation. No other component of health services is as important as health manpower.

I illustrated the changing attitude of the Turkish Medical Association with respect to socialization and general health insurance, but it should also be examined in terms of its position in various matters and its history as a professional organization. Another point of further study is the progress in the field of health and its impact on people's expectations. Yet another is the role of international agencies in the shaping of health policies. In Turkey, international agencies have implemented several programs since the 1950s; UNICEF and the WHO contributed in the malaria combat and maternal-child health programs. And today, the IMF and the WB, apart from implementing programs, are trying to shape the health care policy of the nation.

Comparative analyses can also be made. I have tried to locate Turkey's position in welfare and health care typologies, highlighting particularly its common traits with Southern Europe. But further comparisons can be made more specifically with the developments in other countries. For instance, whether health was brought to the agenda as part of a project of integration as in Turkey can be examined, or the programs developed for providing health care to rural areas can be compared with the ones here.

The role of the private sector in health is yet another subject matter. I discussed its role within the context of the rupture in the DP period and the neo-liberalism of the 1980s, but it also deserves to be probed further in terms of pharmaceuticals, medical technology and private hospitals, especially in the current conjuncture.

Today, welfare and health care systems are faced with the pressure to change all over the world. Turkey does not escape this pressure. The direction of this change, which will directly affect people's lives, will reveal the new dimension the state-citizen relations will acquire. It is not enough to locate this change within its global context; its historical context should also be examined. How was the system in Turkey shaped, who was included and who was excluded, what were its areas of priority? The answers to these questions are essential for an understanding of the present. This is the main contribution of this dissertation. In a field rarely receiving any attention outside public health circles, it looks over the historical trajectory in Turkey with a brand new perspective, drawing from the theoretical and conceptual framework set by the literature on welfare, health care and citizenship. This trajectory, derived from first and second hand sources, thus becomes more comprehensible in terms of both its affinity-distance to the systems in other countries and the ruptures and continuities it embodies. Further studies on health and other areas of social policy in Turkey can draw from the periodization and analysis in this dissertation. The study of health policies throughout the Republican era in terms of state-citizen relations is a novel contribution in its own right. Discussing the socialization of health services, which is almost left to oblivion in present, as an attempt to establish a universal, egalitarian and comprehensive system, and revealing

the consolidation of an inegalitarian corporatist structure built on its failure will no doubt enrich the literature on social policy.

APPENDICES

A. List of Abbreviations

B. Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun, no. 224, *Resmî Gazete,* 12 January 1961 (The Law on the Socialization of Health Services, no. 224, *Official Gazette*, 12 January 1961)

C. List of Tables

D. Tables

LIST OF ABBREVIATIONS

Bağ-Kur - Social Security Institution of Craftsmen, Tradesmen and Other Self Employed (*Esnaf ve Sanatkarlar ve Diğer Bağımsız Çalışanlar Sosyal Sigortalar Kurumu*)

DLP - Democratic Left Party (*Demokratik Sol Parti - DSP*)

DP - Democrat Party (*Demokrat Parti - DP*)

EU - European Union

FAO - Food and Agriculture Organization of the United Nations

GATS - General Agreement on Trade in Services

GDP - Gross Domestic Product

GHI - General Health Insurance

GNP - Gross National Product

IDB - International Development Bank

IMF - International Monetary Fund

ISI - Import Substituting Industrialization

IUD - Intrauterine device

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

JP - Justice Party (*Adalet Partisi - AP*)

LII - Labor Insurance Institution (*İşçi Sigortaları Kurumu - İSK*)

MHSA - Ministry of Health and Social Assistance (*Sağlık ve Sosyal Yardım Bakanlığı - SSYB*)

MoH - Ministry of Health (*Sağlık Bakanlığı - SB*)

MP - Motherland Party (*Anavatan Partisi - ANAP*)

NAP - Nationalist Action Party (*Milliyetçi Hareket Partisi - MHP*)

NGO - Non-governmental organization

NHS - National Health Service

NP - Nation Party (*Millet Partisi - MP*)

NSC - National Security Council (*Milli Güvenlik Kurulu - MGK*)

NSP - National Salvation Party (*Milli Selamet Partisi - MSP*)

NTP - New Turkey Party (*Yeni Türkiye Partisi - YTP*)

NUC - National Unity Committee (*Milli Birlik Komitesi - MBK*)

OECD - Organization for Economic Co-operation and Development

PFI - Private finance initiative

PHC - Primary Health Care

PNP - Party of Nationalist Democracy (*Milliyetçi Demokrasi Partisi - MDP*)

PP - Populist Party (*Halkçı Parti - HP*)

PPP - Public-private partnership

RF - Retirement Fund (*Emekli Sandığı - ES*)

RP - Reliance Party (*Güven Partisi - GP*)

RPNP - Republican Peasants National Party (*Cumhuriyetçi Köylü Millet Partisi - CKMP*)

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

RRP - Republican Reliance Party (*Cumhuriyetçi Güven Partisi - CGP*)

SDPP - Social Democratic People's Party (*Sosyal Demokrat Halkçı Parti - SHP*)

SEEs - State Economic Enterprises (*Kamu İktisadi Teşekkülleri - KİT*)

SII - Social Insurance Institution (*Sosyal Sigortalar Kurumu - SSK*)

SPO - State Planning Organization (*Devlet Planlama Teşkilatı - DPT*)

STD - Sexually transmitted disease

TB - Tuberculosis

TIBA - Turkish Industrialists' and Businessmen's Association (*Türk Sanayicileri ve İşadamları Derneği - TÜSİAD*)

TMA - Turkish Medical Association (*Türk Tabipleri Birliği - TTB*)

TPA - Turkish Pharmacists Association (*Türk Eczacıları Birliği - TEB*)

TPP - True Path Party (*Doğru Yol Partisi - DYP*)

TURKSTAT - Turkish Statistical Institute (*Türkiye İstatistik Kurumu – TÜİK*)

UNICEF - United Nations Children's Fund

WB - World Bank

WHO - World Health Organization

WP - Welfare Party (*Refah Partisi - RP*)

WPT - Workers Party of Turkey (*Türkiye İşçi Partisi - TİP*)

WTO - World Trade Organization

nunun 17 nci maddesi mucibince vergiye mukabil alınacak teminat tasarruf bonosu tevkifatına tabidir.

Veraset ve İntikal Vergisi Kanununa göre beyan olunan matrahlar tasarruf bonosu tevdiatına tabi tutulur. Ancak, Veraset ve İntikal Vergisi Kanununun 17 nci maddesi gereğince alınacak teminatlar bu fıkraya göre yapılacak tevdiatın matrahından indirilir.

C - Tevkifat ve tevdiat nispetleri :

Madde 8 — Bu kanunun 4, 5, 6 ve 7 nci maddelerinde sözü geçen tevkifat ve tevdiatın nispeti, % 3 den yukarı olmamak üzere Maliye Bakanlığınca her mali yıl başında memleketin iktisadi ve mali durumu nazara alınarak tesbit ve ilân olunur.

D - İstisnalar :

Madde 9 — Aşağıda yazılı ödemeler, tasarruf bonoları tevkifat ve tevdiatından müstesnadır :

1) 500 lirayı aşmayan ödemeler (Hizmet erbabı için bu had yıllık itibariyle ve 3600 liradır);

2) Avanslar (Gelir Vergisi tevkifatına tabi avanslar hariç);

E - Tevkifat ve tevdiatın fona yatırılması :

Madde 10 — Bu kanun gereğince her ay içinde yapılacak tevkifat ve tevdiat en geç mütaakıp ayın 15 inci gününe kadar müfredatlı bordrolara müsteniden 1 inci maddede sözü geçen fon hesabına yatırılır.

III - Çeşitli hükümler

A - Muafiyetler :

Madde 11 — Fon muameleleri ile tasarruf bonoları faizleri ve bonoları ilişkin her türlü muameleler bilcümle vergi, resim ve harçtan müstesnadır.

B - Tahsil ve Ceza hükümleri :

Madde 12 — Bu kanunla konulan mükellefiyetlerin yerine getirilmemesi veya geç yerine getirilmesi hallerinde alâkalılar hakkında Âmme Alacaklarının Tahsil Usulü hakkındaki 6183 sayılı Kanun hükümleri uygulanır.

C - Fon muameleleri ve bono ihracı işlemleri :

Madde 13 — Fon muameleleri ve bonoların ihracı işlemleri 1050 ve 2490 sayılı kanun hükümlerine tabi değildir.

Madde 14 — Yapılan tevkifat veya tevdiatın miktarı 5 liradan az olursa nazara alınmaz. 5 liradan fazla 10 liradan az olursa 10 liraya iblâğ edilir. Tevkifat ve tevdiatın zamanı, şekli ve bonolara tahvilinde uygulanacak esaslar ve bu kanunun diğer hükümlerinin tatbik tarzı tüzükle tesbit olunur.

Madde 15 — Bu kanun gereğince nama yazılı olarak ihraç edilecek tasarruf bonoları ihraçlarını takip eden yıldan itibaren beş yıl sonunda hamiline yazılı bono ad ve itibar olunur.

Ancak Maliye Bakanı bidayetten itibaren tasarruf bonolarını hamiline yazılı olarak ihraca veya nama yazılı tasarruf bonolarını hamiline yazılı bonolarla değiştirmeğe yetkilidir.

Her iki çeşit tasarruf bonolarının kuponları hamiline yazılı tahvil kuponu gibi muameleye tabi tutulur.

Nama yazılı bonoların ihracına kadar muvakkat borç senedi vermeğe Maliye Bakanı mezundur.

Madde 16 — Fonda biriken paraları, bir taraftan gelir bütçesinde (Tasarruf bonoları hasılatı) adı altında açılacak özel bir fasla gelir ve mukabilini de gider bütçesinin Maliye Bakanlığı kısmında açılacak özel bir tertibine (Sarf ve tevzi tarzı 1 inci maddedeki esaslar dahilinde Bakanlar Kurulu Kararı ile tesbit edilmek üzere) tahsisat kaydetmeğe veya her mali yıl için fonun muhtemel gelirini bidayeten tahmin edip gelir bütçesinde toplu olarak göstermeğe Maliye Bakanı mezundur.

Madde 17 — Bu kanun gereğince, çıkarılacak bonoların faiz ve bedelleri ile diğer giderlerini karşılayacak ödenek her yıl Devlet Borçları bütçesine konulur.

Bonolara ait faizler, ödenmeleri gerekli tarihten itibaren beş yıl; bono bedelleri ödenmeleri gerektiği tarihten itibaren on yıl sonra Hazine lehine zamanaşımına uğrar.

Geçici Madde — Bu kanun gereğince çıkarılacak bonoların muvakkat borç senetlerinin ihraç giderleri Devlet Borçları Bütçesinde açılacak ayrı bir bölüme Maliye Bakanı tarafından ödenek kaydı suretiyle ödenir.

Madde 18 — Bu kanunun geçici maddesi kanunun yayımı tarihinden, diğer hükümleri 1/3/1961 tarihinden itibaren yürürlüğe girer.

Madde 19 — Bu kanunu Bakanlar Kurulu yürütür.

7/1/1961

No.	Başlık		Düstur Tertip	Cilt	Sahife	Resmî Gazete Sayı
	Sözü geçen Kanunlar :					
797	Veraset ve İntikal Vergisi hakkında Kanun	17/4/1926	3	7	1116/701	348
1050	Muhasebei Umumiye Kanunu	14/6/1927	3	8	1373/628	667
2490	Artırma, Eksiltme ve İhale Kanunu	10/6/1934	3	15	1057/396	2723
6183	Âmme Alacaklarının Tahsil Usulü hakkında Kanun	28/7/1953	3	34	1658	8469

Sağlık hizmetlerinin sosyalleştirilmesi hakkında Kanun

Kanun No : 224 *Kabul tarihi : 5/1/1961*

GENEL HÜKÜMLER

Kanunun gayesi

Madde 1 — İnsan Hakları Evrensel Beyannamesinde bir hak olarak tanınan sağlık hizmetlerinden faydalanmanın sosyal adalete uygun bir şekilde ifasını sağlamak maksadiyle tababet ve tababetle ilgili hizmetler bu kanun çerçevesinde hazırlanacak bir grogram dâhilinde sosyalleştirilecektir.

Terimler

Madde 2 — Bu kanunda kullanılan terimlerin delâlet ettiği mânalar aşağıda gösterilmiştir :

Sağlık : Sağlık, yalnız hastalık ve mâlûliyetin yokluğu olmayıp bedenen, ruhen ve sosyal bakımdan tam bir iyilik halidir.

Sağlık hizmetleri : İnsan sağlığına zarar veren çeşitli faktörlerin yokedilmesi ve toplumun bu faktörlerin tesirinden korunması, hastaların tedavi edilmesi, bedeni ve ruhi kabiliyet ve melekeleri azalmış olanların işe alıştırılması (Rehabilitasyon) için yapılan tıbbi faaliyetler sağlık hizmetidir.

Âmme sektörü : Umumi ve mülhak bütçeli idarelerle hususi idareler ve belediyeler ve bunlara bağlı teşekküller, sermayesinin tamamı Devlet tarafından verilmek suretiyle kurulan iktisadi teşekküller, idare ve murakabeleri 3460 sayılı kanun hükümlerine tabi teşekkül ve müesseseler, hususi kanunlarla kurulan bankalar ve diğer teşekküller, sermayesinin yarısından fazlası Devletin veya yukarıda yazılı müesseselerin elinde bulunan teşekküller ve bunların aynı nispetle iştirakleri ile vücut bulan kurumlar âmme sektörünü teşkil ederler.

Sağlık personeli : Sağlık personeli, sağlık hizmetlerinde maaş, ücret, yevmiye ve mukavele ile istihdam edilen ve bu sahada mesleki eğitim görerek yetişmiş olanlardır.

Bu hizmet sahasında çalışan ve yüksek eğitim yapmamış olanlar yardımcı sağlık personelidir.

Sosyalleştirme : Sağlık hizmetlerinin sosyalleştirilmesi vatandaşların sağlık hizmetleri için ödedikleri prim ile âmme sektörüne ait müesseselerin bütçelerinden ayrılan tahsisat karşılığı her çeşit sağlık hizmetlerinden ücretsiz veya kendisine yapılan masrafın bir kısmına iştirak suretiyle eşit şekilde faydalanmalarıdır.

Sağlık ocağı : Takriben 5000 - 10 000 kişinin köyler grupu veya bir kasaba veya şehir ve büyük kasabalardaki mahalle grupları bir sağlık ocağını teşkil eder. Bunların il içinde idari taksimata uyması icabetmez.

Temel prensipler

Madde 3 — Sağlık hizmetlerinin sosyalleştirildiği bölge veya kurumlarda çalışan âmme sektörünün sağlık personeli ücret mukabilinde veya her hangi bir şekilde menfaat sağlıyarak serbest meslek icra edemezler. Telif ve tercüme hakları, konferans ücretleri, ilmi mükâfatlar gibi doğrudan doğruya hasta muayenesiyle alâkalı olmıyan kazançlar bu kayıttan müstesnadır.

Madde 4 — Âmme sektörüne dâhil kurumlardan maaş veya ücret almıyan ve hiç bir şekilde ayni ve nakdi menfaat sağlamayan hekim ve

ıet şubeleri mensupları, - mer'i kanunların hükümleri dairesinde - eklerini serbestçe icraya ve hususi sağlık müesseseleri ve eczane ıağa mezundurlar.

Madde 5 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde yaşa- arın - ücretini şahsen ödemek şartiyle - sağlık hizmetlerini gördür- üzere istedikleri sağlık personelini veya müessese ve eczaneyi seç- hakları mahfuzdur.

Madde 6 — Türkiye Cumhuriyeti hudutları içinde yaşayan yabancı ıklu şahıslar Sağlık ve Sosyal Yardım Bakanlığı tarafından hazır- ın bir yönetmelik hükümleri çerçevesinde ücret mukabili sosyalleş- miş sağlık hizmetlerinden faydalanabilirler.

4772 ve 5502 sayılı kanunlara tabi yabancı uyruklu sigortalılar sos- leştirilmiş sağlık hizmetlerinden faydalanırlar.

Madde 7 — Âmme sektörüne dâhil kurumlarda çalıştırılacak sağ- personeli miktarı bu kurumların tabi bulundukları kanunların hüküm esasları dairesinde alınan kadroları aşmamak şartiyle Sağlık ve Sos- Yardım Bakanlığı tarafından ilgili bakanlıkların da mütalâası alı- rak yapılacak teklif üzerine Bakanlar Kurulu tarafından tesbit edilir.

Madde 8 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde, Milli vunma Bakanlığına bağlı teşekküller hariç âmme sektörüne dâhil ku- mlara ait sağlık hizmetleri ilgili Bakanlıklarca müştereken hazırlana- k tüzükte gösterilen esaslar dairesinde Sağlık ve Sosyal Yardım Ba- ınlığı tarafından yürütülür.

Sosyal sigorta kanunları gereğince sigorta muameleleri için lü- ımlu belgeler, Çalışma ve Sağlık ve Sosyal Yardım Bakanlığı tara- ndan müştereken tesbit olunan esaslar dâhilinde, sosyalleştirilmiş sağ- k hizmetleri teşkilâtınca tanzim edilerek İşçi Sigortaları Kurumuna erilir

Sosyalleştirme

Sağlık teşkilâtının kuruluş ve vazifeleri

Madde 9 — Sosyalleştirilmiş sağlık hizmeti teşkilâtı : Sağlık evleri. ağlık ocakları, sağlık merkezleri ile hastaneleri, çeşitli koruyucu he- kimlik teşekkülleri, sağlık hizmeti hususiyet arzeden yerler için kurul- muş sağlık teşekkülleri, sağlık müdürlükleri, bölge hastaneleri, bölge laboratuvarları, sağlık personeli yetiştiren eğitim müesseseleri, Sağlık ve Sosyal Yardım Bakanlığı merkez teşkilâtı ve diğer Bakanlık ve kurum- larda Sağlık ve Sosyal Yardım Bakanlığı ile işbirliği yapmak üzere kurulmuş olan dairelerden teşekkül eder.

Madde 10 — Bir sağlık ocağının hizmeti en az bir hekim ve yeter sayıda yardımcı sağlık personelinden teşekkül eden bir ekip tarafın- dan yürütülür. Köylerde bu ekibe yardımcı olarak tesis edilen sağlık evlerinde yardımcı sağlık personeli vazifelendirilir.

Sağlık ocakları ve evleri her türlü koruyucu hekimlik hizmetleri, hastaların muayene ve tedavisi ile, sağlık ocağına kayıtlı şahısların sağlık sicillerini tutmakla mükelleftir. Ocak hekimleri yalnız kendi ocak- ları içinde adlî tabiplik vazifesi görürler.

Her ekibe sağlık hizmetlerini kifayetli bir şekilde yapacak mo- torlu veya gerekirse canlı nakil vasıtası, malzeme ve nüfusu 5000 den az olan yerlerde ikamet eden personele kira mukabili lojman tahsis edi- lir. Bu kira miktarı Maliye ve Sağlık ve Sosyal Yardım Bakanlığı tara- fından hazırlanacak bir yönetmelikle tesbit edilir.

Madde 11 — Sağlık hizmetlerinin sosyalleştirildiği yerlerdeki her ilcede en az bir sağlık ocağı bulunur.

Sağlık merkezlerindeki sağlık personeli, ocaklarda çalışan perso- nelin her türlü koruyucu hekimlik ve tedavi hekimliği hizmetlerinde on- lara rehber ve yardımcıdır. Bu hizmetlerden kendi uhdelerine verilenleri de bizzat ifa ederler. Sağlık merkezleri başhekimi kendisine bağlı sağ- lık ocaklarında çalışan personelin faaliyetlerini de denetler.

Sağlık merkezlerinin personel kadrosu ihtiyaca göre Sağlık ve Sos- yal Yardım Bakanlığınca tesbit edilir. Her sağlık merkezinde kadrola- rında yazılı sayıda motorlü vasıta, sağlık hizmetlerini kifayetli bir şe- kilde yapacak malzeme ve nüfusu 5000 den az olan yerlerde personele lojman verebilirler.

Madde 12 — Hastaneler, sağlık ocaklarından veya sağlık merkez- lerinden veya diğer hastanelerden gönderilen veya durumları âcil mü- dahaleyi icabettiren veya 13 üncü madde hükümlerine göre müracaat eden hastaları ayakta veya yatarak tedavi etmek ve uhdelerine verilen koruyucu ve sosyal sağlık hizmetlerini yapmakla mükelleftirler. Hasta- nelerdeki sağlık personeli sağlık ocakları ve sağlık merkezleri persone- linin mesleki tekamülüne de yardım ederler.

Sağlık hizmetlerinin yürütülmesi

Madde 13 — Sosyalleştirilmiş sağlık hizmetlerinden faydalanmak istiyen, âcil vakalar hariç, evvelâ sağlık evine veya sağlık ocağına baş- vururlar. Köylük bölgelerde sağlık ocağı hekimleri tedavi edemedikleri vakaları, güç olması muhakkak bulunan doğumları sağlık merkezine, hastaneye sevki gereken âcil vakaları hastaneye yollarlar. Sağlık oca- ğında hekim bulunmadığı hallerde yardımcı sağlık personeli hastaları - kendi selâhiyetleri dahilinde olan müdahaleyi mütaakıp gerekirse - sağ- lık merkezine veya hastaneye sevkedebilir. Sağlık merkezinde tedavisi mümkün olmıyan hastalar veya mütehassıs müdahalesini icabettiren do- ğumlar hastanelere veya doğumevlerine sevkedilir.

Sağlık hizmetlerinin sosyalleştirildiği bölgelerde sağlık ocağı sağlık merkezi ve hastanelerde hizmetin nasıl yürütüleceği Sağlık ve Sosyal Yardım Bakanlığınca hazırlanan bir yönetmelikle tesbit edilir.

Madde 14 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde hasta muayene ve tedavisi bu kanunun 16 ncı maddesi hükümleri dairesinde ücrete tabi olan ilâç bedelleri ve aşağıda zikredilen haller hariç para- sızdır.

a) Sağlık ocağı tarafından sevkedilmedikleri halde sağlık mer- kezlerine veya hastanelere veya sağlık merkezi ve bir hastaneden diğer bir hastaneye sevkedilmeden hastanelere müracaat edenler (Âcil vaka- lar hariç),

b) Sağlık hizmetlerinin sosyalleştirilmediği bir bölgeden gelip de müracaat ettiği ocak bölgesinde ikametleri 90 günü aşmamış olanlar (Mahallin mülki âmirlerinden fakirlik belgesi alanlar hariç),

c) Bölgede yaşayan halkın çalışma saatleri nazarı itibara alına- rak tâyin edilen mesai saatleri dışında ve tatil günlerinde nöbetçi olma- yan hekim ve yardımcı sağlık personeline muayene ve tedavi olmak istiyenler,

Sosyalleşmiş bölgelerden herhangi bir sebeple geçici olarak ayrılan ve kendi ocak hekimleri tarafından verilen sağlık fişlerini ibraz edenle- rin muayenesi bulundukları yerlerdeki ocak hekimleri veya bunların hastayı sevkettikleri müesseselerde veya şahıs sağlık hizmetlerinin sos- yalleştirilmediği bir bölgeye gittiği takdirde orada Sağlık ve Sosyal Yardım Bakanlığınca tâyin edilen müesseselerde ücrete tabi değildir.

Madde 15 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde has- taların muhtaç olduğu ilâç ve tedavi vasıtaları köylerde ve serbest ecza- nesi bulunmayan yerlerde sağlık teşkilâtı veya Sağlık ve Sosyal Yardım Bakanlığı tarafından işletilen eczaneler tarafından temin edilir. Bu ecza- ne ve teşekküller serbest eczane bulunmayan yerlerde serbest meslek icra eden hekimlerin muayene ve tedavi ettikleri hastalara da ilâç sa- tarlar.

Bir yerde serbest eczane bulunduğu halde bu eczanede bulunmayan ilâçlar da Sağlık ve Sosyal Yardım Bakanlığı teşkilâtı tarafından temin edilebilir.

Madde 16 — Sosyalleştirilmiş sağlık hizmetleri gören teşekküller tarafından parasız veya bedelinin bir kısmı veya tamamı hastalar tara- fından ödenerek alınacak ilâç ve tedavi vasıtalarının listeleri her yılın ilk ayında Sağlık ve Sosyal Yardım Bakanlığı tarafından ilân edilir. Liste harici ilâç ve tedavi araçları bedeli hastalar tarafından ödenmek suretiyle alınır.

Sosyalleştirmenin tatbik ve teşmili

Madde 17 — Bir bölgede sağlık hizmetlerinin iyi bir şekilde yürü- tülmesi için gereken tesisler, lojmanlar, malzeme, araçlar ve personel temin edilmeden o bölgede sosyalleştirme planı tatbik edilemez.

Madde 18 — Sağlık hizmetlerinin sosyalleştirilmesi hususundaki planın tatbikatına rehber olmak üzere gereken kılavuz bölgelerin nere- lerde kurulacağı Sağlık ve Sosyal Yardım Bakanlığının teklifi üzerine Bakanlar Kurulunca kararlaştırılır.

Sosyalleştirme planı bütün yurda kademeli surette teşmil edilirken sağlık hizmetlerinin hangi bölgelerde ve ne zaman sosyalleştirileceği de Sağlık ve Sosyal Yardım Bakanlığının teklifi ve Bakanlar Kurulunun kararı ile tesbit edilir.

Madde 19 — Âmme sektörüne dâhil kurumlara bağlı sağlık idare ve teşkilâtında yardımcı sağlık personeli yetiştiren okullarda ve kendi mensuplarına veya muayyen meslek gruplarına sağlık hizmeti yapan kurumlarda çalışan personele bu kanunun 3 ve 26 ncı maddelerinin hü- kümlerinin ne zaman tatbik edileceği bağlı oldukları bakanlıkların, aynı hükümlerin Tıp Fakültelerinde tatbik tarihi, üniversite senatosunun ka- rarı ve Millî Eğitim Bakanlığının teklifi üzerine Bakanlar Kurulu tara- fından kararlaştırılır.

Madde 20 — Sosyalleştirme bu kanunun neşri tarihinden itibaren en geç 15 yıl içinde bütün memlekete teşmil edilecek ve 19 uncu maddede yazılı teşekküllerde çalışan sağlık personeli de bu müddetin bitmesinden önce bu kanun hükümlerine tabi olacaktır.

Özel daire, genel kurul ve mahallî sağlık kurulları

Madde 21 — Sağlık hizmetlerinin sosyalleştirilmesi işlerini plânlamak ve Bakanlığın diğer daireleri ile işbirliği yaparak yürütmek üzere Sağlık ve Sosyal Yardım Bakanlığında bir (Özel daire) kurulur.

Madde 22 — Sağlık hizmetlerinin sosyalleştirilmesi faaliyetlerinin yürütülmesi ve değerlendirilmesi konusunda Sağlık ve Sosyal Yardım Bakanlığına görüşlerini bildirecek, tavsiyelerde bulunacak ve bu konuda halk ve çeşitli kurumlar arasında işbirliği sağlayacak bir Genel Kurul teşkil edilir. Bu Kurul Sağlık ve Sosyal Yardım Bakanlığından tâyin edilecek veya vazifelendirilecek yeter sayıda mütehassıs ile Üniversitelerin, Bakanlıkların, Devlet Plânlama Teşkilâtının, İşçi Sigortaları Kurumunun, Türk Tabipleri Birliğinin ,Türk Eczacılar Birliğinin, Türk Veteriner Hekimleri Odaları Birliğinin göndereceği salâhiyetli temsilcilerle il sağlık kurullarının göndereceği birer temsilciden teşekkül eder. Sağlık ve Sosyal Yardım Bakanlığının talebi üzerine yukarıda adı zikredilmeyen kurumlar da Genel Kurula daimî veya muvakkat temsilci gönderir.

Genel Kurul mûtat olarak yılda bir kere toplanır. Kurulun Başkanı Sağlık ve Sosyal Yardım Bakanı veya görevlendireceği bir zattır. Sağlık ve Sosyal Yardım Bakanı, Genel Kurulu veya Genel Kurulun bazı üyelerinden teşkil edeceği istişare kurullarını toplantıya çağırmağa salâhiyetlidir.

Genel Kurul üyelerinden 3656 ve 3659 sayılı kanunlara tabi olup da toplantılara Ankara dışından geleceklere kanuni yollukları Sağlık ve Sosyal Yardım Bakanlığı tarafından, bunların dışında kalanlara yollukları Maliye ve Sağlık ve Sosyal Yardım Bakanlıkları tarafından tesbit edilen esaslar dahilinde ödenir.

Madde 23 — Sosyalleştirilmiş sağlık hizmetleri teşkilâtı ile halk arasındaki münasebeti temin maksadiyle sağlık ocaklarında, Sağlık merkezlerinde ve illerde, sağlık kurulları kurulur. Bu kurulların kuruluşu, çalışma tarzları ve toplantı zamanları Sağlık ve Sosyal Yardım Bakanlığı tarafından hazırlanan bir yönetmelikle tâyin edilir.

Bu kurullar halkın sağlık teşkilâtından istediği hususları ilgililere duyurur. Hizmetlerin başarı ile yürütülmesi için halkın eğitilmesine ve teşkilât ile maddî ve mânevî işbirliği yapmalarına yardım ederler.

Personele dair hükümler

Madde 24 — Sosyalleştirilmiş sağlık hizmetlerinde vazife alanlar vazifeye başladıkları günden itibaren 3 yıl hizmete mecburdurlar. Bu müddet zarfında ilgili kurumları bunları herhangi bir mahalle ve herhangi bir sağlık vazifesine nakledebilirler.

3 yıllık müddetin hitamından en geç üç ay evvel istifa edeceğini bildirmeyen sağlık personelinin hizmet müddetleri 3 er yıllık devreler için uzatılmış sayılır.

Sağlık personelinin nakil ve tâyinleri; istekleri, bir bölgede muayyen bir süre hizmet etmiş olmaları, kadro durumları, sağlık halleri, çocuklarının tahsil durumları, vazifede gösterdikleri başarı gibi hususlar gözönüne alınarak Sağlık ve Sosyal Yardım Bakanlığı tarafından hazırlanacak bir tüzük ile tesbit edilir.

Sosyalleştirilmiş sağlık hizmetlerinde 3 yıllık vazifeyi tamamlayanlar bu müddetin hitamından itibaren üç ay içinde istifa etmedikleri veya kurumlarınca sosyalleştirilmiş sağlık hizmetlerinden gayri bir vazifeye tâyin edilmedikleri takdirde yeniden 3 yıl - yukarıda zikredilen hükümler dairesinde - istihdam edilirler. Personelin 3 yıllık devreler sonunda hizmetlerinin temdidi emekliye ayrılıncaya kadar aynı şekilde devam eder.

Tâyin edildikleri yere gitmeyenler veya vazifesini terk edenler hizmetten çıkarılırlar. Bu suretle hizmetten ayrılanlar 1 yıl müddetle âmme sektöründe herhangi bir vazifeye tâyin edilemezler ve çalışmakta oldukları il dahilinde bir yıl müddetle serbest sanat icra edemezler.

Madde 25 — Sağlık hizmetleri sosyalleştirilmiş illerde çalıştırılan hekimlerin istihdam yetkisi Sağlık ve Sosyal Yardım Bakanlığına, yardımcı personelin istihdam yetkisi ise il Sağlık Müdürlerine aittir. Sosyalleştirilmiş sağlık hizmetleri personeli tâyin edildikleri vazife dışında, tâyin makamı tarafından uygun görüldüğü hallerde âmme sektörüne ait başka bir sağlık hizmetini de günlük resmî mesai süresini aşmamak şartiyle ek ücret veya maaş almadan ifa ederler. Mahallin sağlık âmiri, sağlık personeline zaruret halinde kısa süreli geçici vazifeler verebilir.

Madde 26 — Sağlık ve Sosyal Yardım Bakanlığı veya ilgili Bakanlık Sağlık hizmetlerinin sosyalleştirilmiş olduğu bölgelerde kadro mevzuu olan hizmetlerinde mukavele ile sağlık personeli istihdam eder.

Sağlık personeline mukavele ile verilecek ücret miktarları bu meslek mensuplarının umumi serbest kazanç seviyeleri, hizmet süreleri, ihtisasları, işgal ettikleri mevkiin önemi, yaptıkları vazifenin ağırlığı ve çalıştıkları bölgelerde maruz kaldıkları mahrumiyet şartları göz önüne alınarak Sağlık ve Sosyal Yardım Bakanlığının teklifi ve Devlet Personel Dairesinin tesbit ettiği esaslara göre Bakanlar Kurulunca tâyin olunur.

2847, 3656 ve 3659 sayılı kanunlara tabi daire ve teşekküllerde istihdam edilen personelden sosyalleştirilmiş bölgelerde istihdam edilenlerin istihdamları müddetince emeklilik, kıdem ve terfi hakları mahfuzdur. Bu gibi kimseler sosyalleştirilmiş bölgelerden ayrıldıkları zaman iktisap etmiş oldukları emeklilik ve terfi dereceleri nazarı itibara alınarak nakil ve tâyinleri yapılır.

Madde 27 — Ücret mukabili muayene ve tedavi edilen hastalardan ücret, hizmeti yapan sağlık personeli tarafından, makbuz mukabilinde tahsil edilir.

Madde 28 — Sosyalleştirilmiş hizmetlerde çalıştırılan karı veya kocanın aynı mahalde ayrı iki teşekkülde çalıştırılmaları mümkün değilse bunlar aynı hizmet yerine tâyin edilebilirler.

Malî hükümler

Madde 29 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerdeki inşaat, Bayındırlık Bakanlığınca tercihan yapılır.

Madde 30 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde âmme sektörüne dâhil kurumların sağlık teşekküllerine ait binalar, malzeme, ilâç ve eşya Sağlık ve Sosyal Yardım Bakanlığının lüzum gösterdiği ve iş emniyetini tehdit etmediği takdirde aşağıdaki esaslar dairesinde Sağlık ve Sosyal Yardım Bakanlığına devrolunur :

a) Devlete ait binalar Maliye Bakanlığınca Sağlık ve Sosyal Yardım Bakanlığı emrine tahsis olunur.

b) Sermayesinin tamamı Devlete ait iktisadî teşekküllerden Hazineye devredilecek binaların iktisap bedellerinden amortisman bedelleri çıkarıldıktan sonra geri kalan bakiye bu teşekkülün sermayesinden tenzil edilir. Binalar Hazine adına tescil edildikten sonra Sağlık ve Sosyal Yardım Bakanlığı emrine verilir.

c) Bir kısım sermayesi hakikî veya hükmî şahıslara ait olan âmme sektörü müesseselerinin malı olan binaların devrinde Devlet hissesine düşen kısım hakkında (b) fıkrasındaki gibi muamele yapılır. Hakikî ve hükmî şahısların hissesi kendilerine ödenir.

d) İşçi Sigortaları Kurumuna ait sağlık tesisleri, binaları, tıbbî malzeme, eşya ve ilâçlar, iktisap bedeli verilmek suretiyle, Sağlık ve Sosyal Yardım ve Çalışma Bakanlıkları tarafından müştereken tesbit edilecek esaslar dairesinde Sağlık ve Sosyal Yardım Bakanlığına devredilir.

(a), (b) ve (c) fıkralarında yazılı binalarla eşya, malzeme ve ilâçların devrine ait diğer hususat Maliye, Sağlık ve Sosyal Yardım ve ilgili Bakanlıklar arasında müştereken tesbit edilecek esaslara göre yürütülür.

Madde 31 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde hususi tababet icra edenlerin - istedikleri takdirde - sanatlarını icra için kullandıkları alet, makine, cihaz ve malzemeden işe yarar olanlar Sağlık ve Sosyal Yardım Bakanlığı tarafından satın alınabilir.

Satın alma bedeli; malzemenin maliyeti, amortismanı, satın alındığı tarihteki rayiç fiyatı gözönünde tutularak Maliye, Sağlık ve Sosyal Yardım Bakanlıkları tarafından kurulacak bir komisyon kararı ile tâyin olunur.

Madde 32 — Sosyalleştirilmiş sağlık hizmetlerinde ücretli olarak muayene ve tedaviye tabi şahıslardan alınacak ücretlerin miktarı Maliye ve Sağlık ve Sosyal Yardım Bakanlıkları tarafından müştereken tesbit ve ilân olunur.

Madde 33 — Sağlık hizmetlerinin sosyalleştirildiği bölgelerde belediye sağlık hizmetlerinden olan su, lâğım, mezbaha ve temizlik işleri, umumi yerlerin, taşıtların ve meskenlerin teftişi, haşarat ve gıda kontrolu, mezarlıklar gibi çevre sağlığı hizmetleri belediyeler tarafından yürütülür.

Sağlık hizmetlerinin sosyalleştirildiği bölgelerde belediyelerin çevre sağlığı hizmetleri dışında kalan sağlık hizmetleri, hükümet tabipliği vazifeleri ve belediyenin çevre sağlığı hizmetlerinin murakabesi sağlık ocakları hekimleri tarafından ifa edilir ve bu bölgelere ayrıca hükümet tabibi tâyin edilmez.

Geçici Madde 1 — Bakanlar Kurulu tarafından tesbit edilecek bir kılavuz bölgelerde sağlık hizmetlerinin sosyalleştirilmesi için hazırlıklara 1 Mart 1962 de ve tatbikata Bakanlar Kurulunun tesbit edeceği tarihte başlanır.

Sosyalleştirme, Kılavuz bölgelerde elde edilen neticeler gözönüne alınarak - en geç 1 Mart 1964 den itibaren kademeli olarak yurda teşmile başlanır.

Geçici Madde 2 — Sağlık hizmetlerinin sosyalleştirilmediği bölgelerde âmme sektörüne bağlı kurumlarda sağlık hizmetleri kendi usul ve mevzuatına göre yürütülür.

Geçici Madde 3 — Âmme sektörüne dâhil kurumların, sağlık hizmetlerinin sosyalleştirildiği bölgeler dahilinde bulunmakla beraber sosyalleştirmenin henüz teşmil edilmediği bölgelerdeki mensuplarının hizmetine de cevap veren Sağlık müesseselerinin 35 inci madde hükümleri gereğince Sağlık ve Sosyal Yardım Bakanlığına devri, kurumu talep etmediği takdirde sosyalleştirmenin bu kurumun teşkilâtı olan her yere teşmil edilinceye kadar tehir edilir.

Madde 34 — Bu kanun neşri tarihinden itibaren yürürlüğe girer.

Madde 35 — Bu kanunu yürütmeğe Bakanlar Kurulu yetkilidir.

7/1/1961

No.	Başlık	Düstur Tertip	Cilt	Sahife	Resmî Gazete Sayı
	Sözü geçen Kanunlar :				
2247	Devlet Demiryolları ve Limanları İşletme Umum Müdürlüğü Memur ve Müstahdemlerinin ücretlerine dair Kanun 22/11/1935	3	17	15/12	316
3460	Sermayesinin tamamı Devlet tarafından verilmek suretiyle kurulan iktisadi teşekküllerin teşkilâtiyle idare ve murakabeleri hakkında Kanun 4/7/1938	3	19	1306/329	3950
3656	Devlet Memurları Aylıklarının Tevhit ve Teadülüne dair Kanun 8/7/1939	3	20	1397/657	4252
3659	Bankalar ve Devlet Müesseseleri Memurları Aylıklarının Tevhit ve Teadülü hakkında Kanun 11/7/1939	3	20	1539/770	4255
4772	İş Kazalariyle Meslek Hastalıkları ve Analık Sigortaları Kanunu 7/7/1945	3	26	1262	6051
5502	Hastalık ve Analık Sigortası Kanunu 10/1/1950	3	31	515	7407

1960 Mali yılı Muvazenei Umumiye Kanununa bağlı cetvellerde değişiklik yapılması hakkında Kanun

Kanun No : 225 *Kabul tarihi : 5/1/1961*

Madde 1 — 129 sayılı kanunla 1960 Mali Yılı Muvazenei Umumiye Kanununa bağlı (A/1) işaretli cetvelin Tarım Bakanlığı kısmının 427 nci (6893 sayılı kanun gereğince verilecek prim ve para mükâfatı) faslından, Dışişleri Bakanlığı kısmının 459 uncu (Dış memleketlerde Türk kültür varlığını koruma ve tanıtma masrafları) faslına yapılmış olan (187 000) liralık aktarma iptal edilmiştir.

Madde 2 — 1960 Mali Yılı Muvazenei Umumiye Kanununa bağlı (A/1) ve (A/2) işaretli cetvellerin ilişik cetvelde yazılı tertipleri arasında (2 231 034) liralık aktarma yapılmıştır.

Madde 3 — Bu kanun yayımı tarihinde yürürlüğe girer.

Madde 4 — Bu kanunu Maliye Bakanı yürütür.

7/1/1961

CETVEL

F.	M.	Tahsisatın nev'i	Tenzil	Zam
		A/1		
		BAŞBAKANLIK		
307		Harcırahlar		
	50	Ecnebi uzman ve hizmetlilerle bunlara yardımcı personelin harcırah ve başka masrafları	10 000	
401		Matbaa masrafları		
	20	İşçi gündelikleri		10 000
	30	Diğer işletme ve yönetim masrafları		15 000
		Fasıl yekûnu		25 000
		ADALET BAKANLIĞI		
419		Ceza ve tevkif evleri masrafları		
	10	Yiyecek masrafları	636 034	
421		Yüsek Soruşturma Kurulu ve Yüksek Adalet Divanı her türlü masrafları		700 000
422		Devrilen iktidar zamanında suç işleyen yüksek dereceli memurlar hakkında yapılacak soruşturmalar için kurulacak tahkik heyetlerinde çalışanlara verilecek yevmiye ve yolluklarla suçun açığa çıkarılması için yapılacak her türlü masraflar		400 000
505		Geçen ve eski yıllar karşılıksız borçları		636 034
		JANDARMA GENEL KOMUTANLIĞI		
305		Kira bedeli		120 000
409		Muayyenat		
	10	Tayinat	120 000	
		DIŞİŞLERİ BAKANLIĞI		
307		Harcırahlar		
	10	Daimî vazife harcırahı		350 000
		TARIM BAKANLIĞI		
427		6893 sayılı kanun gereğince verilecek prim ve para mükâfatı	187 000	
		A/1 yekûnu	953 034	2 231 034

CETVEL

F.	M.	Tahsisatın nev'i	Tenzil	Zam
		A/2		
		BAŞBAKANLIK		
711		Matbaada mevcut makina, alet ve malzeme onarımı	11 000	
751		Matbaa için alınacak makina, alet ve malzeme	4 000	
		BAYINDIRLIK BAKANLIĞI		
776		Demiryolları yapım masrafları		
	40	İstikşaf, etüd, aplikasyon, proje ihzarı, istimlâk ve diğer masraflar	1 263 000	
		A/2 yekûnu	1 278 000	
		A/1 ve A/2 yekûnu	2 231 034	2 231 034

42 sayılı kanun gereğince emekliye ayrılan subaylardan isteklilerin öğretmenliğe alınması hakkındaki 125 sayılı kanuna bir madde eklenmesine dair Kanun

Kanun No : 226 *Kabul tarihi : 5/1/1961*

Madde 1 — 42 sayılı kanun gereğince emekliye ayrılan subaylardan isteklilerin öğretmenliğe alınması hakkındaki 125 sayılı kanuna aşağıdaki madde eklenmiştir :

LIST OF TABLES

Table 1.

Life expectancy and average annual percentage growth in life expectancy in selected OECD countries, 1960-2004.

	Life expectancy						Average annual percentage growth in life expectancy	
	1960	1970	1980	1990	2000	2004	Men	Women
Norway	73.6	74.2	75.8	76.6	78.7	79.9	0.19	0.19
Sweden	73.1	74.7	75.8	77.6	79.7	80.6	0.22	0.23
Netherlands	73.5	73.7	75.9	77.0	78.0	79.2	0.17	0.17
Germany	69.6	70.4	72.9	75.2	78.0	78.6	0.28	0.27
UK	70.8	71.9	73.2	75.7	77.8	78.4	0.26	0.21
Spain	69.8	72.0	75.6	76.8	79.2	80.5	0.31	0.34
Greece	69.9	72.0	74.5	77.1	78.1	79.0	0.29	0.27
US	69.9	70.9	73.7	75.3	76.8	77.4	0.26	0.21
Korea	52.4	62.6	65.4	71.0	75.5	77.3	0.84	0.93
Mexico	57.5	60.9	67.2	71.2	74.1	75.2	0.60	0.62
Turkey	48.3	54.2	58.1	66.1	70.5	71.2	0.90	0.87

Sources: OECD official web site, http://www.oecd.org/dataoecd/7/42/35530071.xls and http://www.oecd.org/dataoecd/22/38/38181989.xls (December 2007).

Table 2.

Health expenditures; total expenditure, % GDP in selected OECD countries, 1960-2005.

	1960	1970	1980	1990	2000	2005
Norway	2.9	4.4	7.0	7.6	8.4	9.1
Sweden	--	6.8	9.0	8.3	8.4	9.1
Netherlands	--	--	7.5	8.0	8.0	--
Germany	--	6.0	8.4	8.3	10.3	10.7
UK	3.9	4.5	5.6	6.0	7.3	8.3
Spain	1.5	3.5	5.3	6.5	7.2	8.2
Greece	--	4.7	5.1	5.8	9.3	10.1
United States	5.1	7.0	8.8	11.9	13.2	15.3
Korea	--	--	--	4.3	4.8	6.0
Mexico	--	--	--	4.8	5.6	6.4
Turkey	--	--	3.3	3.6	6.6	7.6

Source: OECD official web site, http://www.oecd.org/dataoecd/46/36/38979632.xls (December 2007)

Table 3.

Health expenditures; total expenditure, per capita US $ PPP in selected OECD countries, 1960-2005.

	1960	1970	1980	1990	2000	2005
Norway	49	145	676	1392	3082	4364
Sweden	--	310	938	1581	2272	2918
Netherlands	--	--	755	1434	2258	--
Germany	--	264	950	1730	2634	3287
UK	84	165	482	989	1859	2724
Spain	16	95	363	872	1520	2255
Greece	--	159	486	843	1950	2981
United States	147	351	1068	2738	4569	6401
Korea	--	--	--	356	780	1318
Mexico	--	--	--	306	506	675
Turkey	--	--	76	168	451	586

Source: OECD official web site, http://www.oecd.org/dataoecd/46/36/38979632.xls (December 2007)

Table 4.

Health expenditures; public expenditure, % total health expenditure in selected OECD countries, 1960-2005.

	1960	1970	1980	1990	2000	2005
Norway	77.8	91.6	85.1	82.8	82.5	83.6
Sweden	--	86.0	92.5	89.9	84.9	84.6
Netherlands	--	--	69.4	67.1	63.1	--
Germany	--	72.8	78.7	76.2	79.7	76.9
UK	85.2	87.0	89.4	83.6	80.9	87.1
Spain	58.7	65.4	79.9	78.7	71.6	71.4
Greece	--	42.6	55.6	53.7	44.2	42.8
United States	23.3	36.3	41.1	39.4	43.7	45.1
Korea	--	--	--	36.6	46.8	53.0
Mexico	--	--	--	40.4	46.6	45.5
Turkey	--	--	29.4	61.0	62.9	71.4

Source: OECD official web site, http://www.oecd.org/dataoecd/46/36/38979632.xls (December 2007)

Table 5.

Health expenditures; pharmaceutical expenditure, % total health expenditure in selected OECD countries, 1960-2005.

	1960	1970	1980	1990	2000	2005
Norway	--	7.8	8.7	7.2	9.5	9.1
Sweden	--	6.6	6.5	8.0	13.8	12.0
Netherlands	--	--	8.0	9.6	11.7	--
Germany	--	16.2	13.4	14.3	13.6	15.2
UK	--	14.7	12.8	13.5	--	--
Spain	--	--	21.0	17.8	21.3	22.9
Greece	--	25.5	18.8	14.3	--	--
United States	16.2	12.3	9.0	9.2	11.7	12.4
Korea	--	--	--	36.5	29.5	27.3
Mexico	--	--	--	--	19.4	21.3
Turkey	--	--	--	20.4	24.8	--

Source: OECD official web site, http://www.oecd.org/dataoecd/46/36/38979632.xls (December 2007)

Table 6.

The number of patients who caught an infectious disease and who died because of that disease, 1925-1962.

	Encephalitis		Whooping cough		Brucellosis		Smallpox		Diphtheria		Dysentery		Relapsing fever		Measles		Scarlet fever	
Years	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**
1925	5		239	25			483	69	336	56	110	10	33		2,778	163	971	245
1930	3	1	261	14	3		906	160	1,311	204	420	58			2,033	72	1,630	239
1935	3		5		9		106	15	1,335	182	732	86	1	1	4,227	273	917	79
1940			9	2	9	1	987	129	929	112	364	11	2		3,711	203	462	5
1945			40	3	8		34	13	834	69	634	38	1		4,950	334	384	9
1950	3	1	9,118	70	36		7		1,242	170	335	7	7		13,531	269	2,406	8
1955			7,469	71	31				3,460	405	350	11			18,036	472	225	
1960	5		6,691	67	45				3,532	366	130	3			15,926	281	709	5
1961	1		5,997	47	70				4,573	415	118	3			16,604	158	3,544	10
1962			6,372	24	112	1			4,279	475	118	2			10,347	82	2,215	6

	Rabies		Puerperal malaria		Paratyphoid fever		Poliomyelitis		Glanders		Epidemic encephalitis		Anthrax		Typhoid fever		Typhus fever		Plague	
Years	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**	**C**	**D**
1925	5	5	48	11	25	1			5	3	34	11	18	1	607	59	333	26	10	6
1930	11	11	62	20	73	7			2	5	220	91	337	39	1,319	143	254	31		
1935	31	31	134	47	268	16			5	2	494	167	680	46	3,813	462	420	57		
1940	13	13	158	33	212	17					664	225	691	46	3,043	329	799	100		
1945	5	5	57	19	155	5	1		1	1	398	64	1,013	106	4,173	251	2,618	139		
1950	24	24	33	9	324	20	12	1	3	1	154	58	1,547	48	4,284	325	225	15		
1955	37	37	28	8	702	16	43	2	5		261	42	1,343	16	7,629	397	24	1		
1960	59	59	20	5	382	8	456	15			336	32	958	17	6,884	289	10			
1961	54	54	20	5	320	5	361	7	2	1	291	36	1,156	13	5,425	221	5			
1962	45	45	10	2	328	2	1,193	45	2	1	267	31	1,133	21	5,817	224	10			

C: Caught; D: Died

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Çalışmalarında 40 Yıl (1922-1962)* (Ankara: SSYB, 1964), pp. 36-39.

Table 7.

Population and annual growth rate of population, 1927-2005.

Year	Population (thousand)		Years	Annual growth rate of population – per thousand
1927	13,648		1927-1935	21.10
1935	16,158		1935-1940	17.24
1940	17,821		1940-1945	10.59
1945	18,790		1945-1950	21.73
1950	20,947		1950-1955	27.75
1955	24,065		1955-1960	28.53
1960	27,755		1960-1965	24.63
1965	31,391		1965-1970	25.19
1970	35,605		1970-1975	25.01
1975	40,348		1975-1980	20.65
1980	44,737		1980-1985	24.88
1985	50,664		1985-1990	21.71
1990	56,473		1990-2000	18.28
2000	67,804			
2005	72,844*			

* This is an estimated figure. According to the latest address-based registration system, the population of Turkey is 70,586,256 on 31 December 2007 (Turkish Statistical Institute official web site, http://www.tuik.gov.tr/PreHaberBultenleri.do?id=3894, January 2008).
Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 1.1, p.5.

Table 8.

Health care providers, 1928-2002.

Year	Physician	Dentist	Nurse	Health officer	Midwife
1928	1,078		130	1,059	377
1930	1,182		202	1,268	400
1935	1,243		325	1,365	451
1940	1,500		405	1,493	616
1945	1,945		409	1,632	806
1950	3,020		721	4,018	1,285
1955	7,077	958	1,525	3,927	1,993
1960	8,214	1,367	1,658	3,550	1,998
1965	10,895	1,932	4,592	4,676	4,329
1970	13,843	3,245	8,796	9,954	11,321
1975	21,714	5,046	14,806	11,021	12,975
1980	27,241	7,077	26,880	11,664	15,872
1985	36,427	8,305	30,854	10,525	17,987
1990	50,639	10,514	44,984	21,547	30,415
1995	69,349	11,717	64,243	34,342	39,551
2000	85,116	16,002	71,600	46,528	41,590
2002	95,190	17,108	79,059	49,324	41,513

Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 3.2, p.45.

Table 9.

Number of persons per health care provider, 1928-2002.

Year	Physician	Dentist	Nurse	Health officer	Midwife	Pharmacist
1928	12,841		106,485	13,072	36,719	108,148
1930	12,217		71,485	11,388	36,100	113,701
1935	12,909		49,372	11,755	35,579	128,368
1940	11,819		43,773	11,874	28,779	137,426
1945	9,626		45,792	11,476	23,237	161,457
1950	6,890		28,859	5,178	16,192	160,054
1955	3,371	24,903	15,644	6,075	11,923	18,994
1960	2,799	19,718	11,366	7,071	8,799	19,563
1965	2,859	16,123	6,783	6,661	7,179	17,588
1970	2,228	10,885	4,016	3,548	3,120	11,731
1975	1,843	7,932	2,703	3,632	3,085	5,716
1980	1,631	6,279	1,653	3,810	2,798	3,685
1985	1,381	6,057	1,630	4,780	2,797	4,336
1990	1,108	5,336	1,247	2,604	1,844	3,552
1995	887	5,252	958	1,564	1,556	3,223
2000	792	4,213	942	1,449	1,621	2,898
2002	731	4,070	881	1,412	1,677	3,119

Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 3.8, p.51.

Table 10.

City and village population, 1927-2000.

				Proportion of city and village population in total (%)	
Years	Total	City population	Village population	City	Village
1927	13,648,270	3,305,879	10,342,391	24.22	75.78
1935	16,158,018	3,802,642	12,355,376	23.53	76.47
1940	17,820,950	4,346,249	13,474,701	24.39	75.61
1945	18,790,174	4,687,102	14,103,072	24.94	75.06
1950	20,947,188	5,244,337	15,702,851	25.04	74.96
1955	24,064,763	6,927,343	17,137,420	28.79	71.21
1960	27,754,820	8,859,731	18,895,089	31.92	68.08
1965	31,391,421	10,805,817	20,585,604	34.42	65.58
1970	35,605,176	13,691,101	21,914,075	38.45	61.55
1975	40,347,719	16,869,068	23,478,651	41.81	58.19
1980	44,736,957	19,645,007	25,091,950	43.91	56.09
1985	50,664,458	26,865,757	23,798,701	53.03	46.97
1990	56,473,035	33,326,351	23,146,684	59.01	40.99
2000	67,803,927	44,006,274	23,797,653	64.90	35.10
2007*	70,586,256	49,747,859	20,838,397	70.50	29.50

* 2007 figures are based on the latest address-based registration system (Turkish Statistical Institute official web site, http://www.tuik.gov.tr/PreHaberBultenleri.do?id=3894, January 2008).
Source: Turkish Statistical Institute official web site, http://www.tuik.gov.tr/VeriBilgi.do (December 2007)

Table 11.

The share of Ministry of Health and Social Assistance in the general budget, %, 1923-2006.

Years	Share		Years	Share
1923	2.21		1982	2.81
1925	2.64		1984	3.11
1930	2.02		1986	2.71
1935	2.54		1988	2.73
1940	3.05		1990	4.12
1945	3.12		1992	4.71
1950	4.08		1994	3.72
1955	5.18		1996	2.76
1960	5.27		1998	2.65
1965	4.10		2000	2.26
1970	3.08		2002	2.40
1975	3.54		2004	3.19
1980	4.21		2006	4.3

Source: Türk Tabipleri Birliği, *Türkiye Sağlık İstatistikleri 2006*, edited by Onur Hamzaoğlu and Umut Özcan (Ankara: TTB, 2006), table 68, p.98.

Note: It might appear contradictory that the share is decreasing after the enactment of Green Card Law in 1992. But, it was by December 2004 that all the expenses of Green Card holders were started to be covered by the Ministry of Health budget. Before that, outpatient care and medication expenses were covered by Social Cooperation and Solidarity Fund.

Table 12.

Number of hospitals by type, 1940-2003.

Year	Total of hospitals	Maternity and infant homes	Mental and neurological hospital	Health center
1940	154	10	3	1
1945	153	14	3	8
1950	201	13	3	22
1955	417	17	3	181
1960	566	20	3	283
1965	626	31	4	264
1970	743	30	4	291
1975	798	31	8	300
1980	827	49	12	291
1985	736	29	8	121
1990	857	36	7	142
1995	1,009	44	8	156
2000	1,184	52	8	141
2003	1,130	57	8	

Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 3.3, p.46.

Table 13.

Inpatient institutions bed capacity, 1940-2003.

Year	Total number of beds	Maternity and infant homes	Mental and neurological hospital	Health center
1940	11,883	265	2,100	10
1945	13,633	345	2,500	80
1950	18,837	1,083	2,800	220
1955	34,526	1,716	3,460	2,060
1960	45,807	2,095	4,300	3,767
1965	55,451	2,809	4,700	3,428
1970	71,486	4,565	5,150	3,679
1975	81,264	4,770	6,035	3,665
1980	99,117	6,067	7,026	3,760
1985	103,918	5,312	6,486	1,935
1990	120,738	6,751	6,416	2,125
1995	136,072	7,797	6,196	2,200
2000	156,549	8,637	6,146	1,930
2003	164,897	9,591	6,075	

Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 3.4, p.47.

Table 14.
Infant mortality rate per thousand live births in selected OECD countries, 1960-1998.

	1960	1965	1970	1975	1980	1985	1990	1998
Norway	18.9	16.8	12.7	11.1	8.1	8.5	6.9	4
Sweden	16.6	13.3	11	8.6	6.9	6.8	6	3.6
Netherlands	17.9	14.4	12.7	10.6	8.6	8	7.1	5.2
Germany	35	24.1	22.5	18.9	12.4	9.1	7	4.7
UK	22.5	19.6	18.5	16	12.1	9.4	7.9	5.7
Spain	43.7	37.8	28.1	18.9	12.3	8.9	7.6	4.9
Greece	40.1	34.3	29.6	24	17.9	14.1	9.7	6.7
United States	26	24.7	20	16.1	12.6	10.6	9.2	7.2
Korea	--	--	45	--	--	13	--	--
Mexico	--	--	79.4	63.1	51	41.2	36.2	25.3
Turkey	189.5	163.5	145	132.5	117.5	88	55.4	36.5
OECD average (31 countries)	36.1	30.6	28.1	22.9	17.9	14.2	11	7.2

Source: OECD official web site,
http://masetto.sourceoecd.org/vl=1665055/cl=38/nw=1/rpsv/factbook_fre/data/11-01-02-T01.xls
(December 2007)

Table 15.

Population covered by the Retirement Fund, 1950-2003.

Year	Total	Active insured	Pensioners*	Dependents	RF members in total number of insured (%)	RF members in total population (%)
1950	821,418	199,825	9,302	612,291	100.0	3.9
1955	1,200,447	281,426	34,375	884,646	100.0	4.9
1960	1,560,345	359,303	61,862	1,139,180	100.0	5.6
1965	2,353,291	548,383	96,286	1,708,622	37.7	7.4
1970	3,578,508	823,829	180,895	2,573,784	37.8	10.0
1975	4,715,939	1,092,000	340,699	3,283,240	28.7	11.6
1980	5,426,273	1,325,000	495,669	3,605,604	26.0	12.1
1985	5,878,582	1,400,000	680,142	3,798,440	21.1	11.6
1990	6,583,141	1,560,000	843,443	4,179,698	17.4	11.6
1995	8,123,887	1,880,437	952,360	5,291,090	16.6	13.2
2000	9,765,851	2,163,698	1,296,935	6,305,218	16.4	14.4
2003	9,556,291	2,508,741	1,466,679	5,580,871	15.7	13.5

* Retired, invalid, widow, widower, orphan.
Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 6.1, p.107.
The last two columns are calculated based on table 6.1 (p.111) and table 1.1 (p.5) in the same source.
Note: As the total number of insured might be overestimated due to cases of double or false countings in SII and Bağ-Kur (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed), we should be cautious about the calculated percentage of RF members in total number of insured.

Table 16.

Population covered by the Social Insurance Institution, 1965-2003.

Year	Total	Active insured	Voluntary active insured	Active insured in agriculture	Pensioners*	Dependents	SII members in total number of insured (%)	SII members in total population (%)
1965	3,835,055	895,802			54,590	2,884,663	61.4	12.2
1970	5,783,854	1,313,500			145,446	4,324,908	61.2	16.2
1975	8,236,422	1,823,338			289,870	6,123,214	50.1	20.4
1980	10,674,172	2,204,807			635,815	7,833,550	51.2	23.8
1985	13,576,258	2,607,865		18,300	1,070,681	9,879,412	48.9	26.7
1990	19,487,970	3,286,929	300,000	74,407	1,596,634	14,230,000	51.6	34.5
1995	28,523,960	4,208,761	980,841	253,463	2,337,755	20,743,140	58.3	46.3
2000	34,110,202	5,254,125	843,957	184,675	3,339,327	24,488,118	57.3	50.3
2003	35,024,356	5,615,238	697,630	165,268	3,935,523	24,610,697	57.6	49.5

* Retired, invalid, widow, widower, orphan.
Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 6.1, p.108.
The last two columns are calculated based on table 6.1 (p.111) and table 1.1 (p.5) in the same source.
Note: As the total number of insured might be overestimated due to cases of double or false countings in SII and Bağ-Kur (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed), we should be cautious about the total numbers and the calculated percentages.

Table 17.

Population covered by the Social Security Institution of Craftsmen, Tradesmen and Other Self Employed (Bağ-Kur), 1975-2003.

Year	Total	Active insured	Voluntary active insured	Active insured in agriculture	Pensioners*	Dependents	Bağ-Kur members in total number of insured (%)	Bağ-Kur members in total population (%)
1975	3,360,420	816,555			4,379	2,539,486	20.4	8.3
1980	4,540,317	1,100,500			138,317	3,301,500	21.7	10.1
1985	8,000,756	1,681,747		244,818	294,496	5,779,695	28.8	15.7
1990	11,332,686	1,967,379	106,019	752,075	595,889	7,911,324	31.5	20.0
1995	11,909,578	1,870,219	76,864	799,132	880,820	8,282,543	24.3	19.3
2000	15,278,781	2,424,049	242,463	888,645	1,277,444	10,446,180	25.6	22.5
2003	15,883,249	2,450,408	226,161	933,441	1,446,804	10,826,435	26.1	22.4

* Retired, invalid, widow, widower, orphan.

Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 6.1, p.109.

The last two columns are calculated based on table 6.1 (p.111) and table 1.1 (p.5) in the same source.

Note: As the total number of insured might be overestimated due to cases of double or false countings in SII and Bağ-Kur (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed), we should be cautious about the total numbers and the calculated percentages.

Table 18.

Population covered by private funds, 1965-2003.

Year	Total	Active insured	Pensioners*	Dependents	Private fund members in total number of insured (%)	Private fund members in total population (%)
1965	48,280	20,000		28,280	0.7	0.1
1970	84,490	35,000		49,490	0.8	0.2
1975	115,872	48,000		67,872	0.7	0.2
1980	196,130	77,737	11,943	106,450	0.9	0.4
1985	288,977	76,778	21,230	190,969	1.0	0.5
1990	312,186	84,072	32,409	195,705	0.8	0.5
1995	291,247	70,854	51,948	168,445	0.5	0.4
2000	323,569	78,495	71,266	173,808	0.5	0.4
2003	295,653	70,925	71,715	153,013	0.4	0.4

* Retired, invalid, widow, widower, orphan.
Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 6.1, p.110.
The last two columns are calculated based on table 6.1 (p.111) and table 1.1 (p.5) in the same source.
Note: As the total number of insured might be overestimated due to cases of double or false countings in SII and Bağ-Kur (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed), we should be cautious about the calculated percentages of private fund members in total number of insured.

Table 19.

Population covered by social security schemes, general total, 1950-2002; ratio of insured population and ratio of population covered by health services, 1950-2002.

Years	Total	Ratio of insured population (%)	Ratio of population covered by health services (%)
1950	821,418	3.9	3.9
1955	1,200,447	5.1	5.1
1960	1,560,345	5.8	5.8
1965	6,236,626	20.2	20.2
1970	9,446,852	26.9	26.9
1975	16,428,653	41.7	33.6
1980	20,836,892	48.9	38.4
1985	27,744,573	59.0	42.1
1990	37,715,983	72.7	54.4
1995	48,848,672	81.3	64.3
2000	59,478,403	87.2	83.2
2002	62,026,565	88.1	83.8

Source: TURKSTAT (Turkish Statistical Institute), *Statistical Indicators, 1923-2004*, in cd format (Ankara: TURKSTAT, 2006), table 6.1, pp.111-112.

Note: The given percentages of those covered by health insurance might be higher than the actual amount. Bağ-Kur and SII members who have premium debts cannot use health benefits. Also there are cases of double or false countings (those who abandon their schemes to be registered into another may be listed in both, or those who abandon the system totally may continue to be listed). According to the State Planning Organization the ratio of insured population covered by health services was 36.3% in 1980, 60.6 in 1990, 81.0 in 2000 and 88.8 in 2004. SPO, p. 163. The World Bank estimates that over one-third (36 to 37%) of the population does not have access to health insurance, including the Green Card program, based on 2001 Household Consumption Survey and 2002 Household Budget Survey. World Bank, *Turkey: Joint Poverty Assessment Report*, p. 72. While the SPO declared one-fifth of the population to be without any health insurance in the early 2000s, the WB estimated this amount to be over one-third. The WB estimate might be higher than the actual amount, but the official number is probably lower.

Table 20.

The number of health stations and health posts, the population of the socialized provinces, and the proportion of the population to health stations and health posts, 1963-1970.

Province	The year it was socialized	Population	Active health posts	Population per health post	Active health stations	Population per health station
Total		9,108,700	851	10,700	2,231	4,080
Muş	1963	238,100	19	12,720	51	4,570
Ağrı	1964	281,100	32	8,780	60	4,680
Bitlis	1964	182,000	14	13,000	40	4,550
Hakkari	1964	102,700	8	12,840	15	6,850
Kars	1964	671,600	71	9,460	160	4,200
Van	1964	320,500	28	11,450	57	5,620
Diyarbakır	1965	557,700	45	12,390	120	4,650
Erzincan	1965	274,800	31	8,860	69	3,980
Erzurum	1965	684,900	72	9,510	161	4,250
Mardin	1965	444,600	46	9,660	105	4,230
Siirt	1965	310,000	27	11,480	64	4,840
Urfa	1965	502,000	43	11,670	112	4,480
Adıyaman	1967	303,600	28	10,840	69	4,400
Bingöl	1967	174,600	17	10,270	46	3,790
Elazığ	1967	370,300	32	11,570	81	4,570
Malatya	1967	512,300	42	12,200	133	3,850
Tunceli	1967	168,800	19	8,890	46	3,670
Artvin	1968	223,800	28	7,990	88	2,540
Giresun	1968	476,800	44	10,840	139	3,430
Gümüşhane	1968	282,700	30	9,420	74	3,820
Rize	1968	315,000	27	11,670	48	6,560
Trabzon	1968	661,400	55	12,020	163	4,060
Edirne	1969	331,500	19	17,450	105	3,160
Maraş	1969	497,500	51	9,750	131	3,800
Nevşehir	1970	225,400	23	9,800	94	2,400

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl* (Ankara: SSYB, 1973), p.239.

Table 21.

The planned and realized numbers of health personnel in health posts, 1963-1975.

		Doctor			Health officer			Nurse			Midwife		
Year	Number of provinces	Pla. staff	Realized number of personnel	Ratio of planned numbers to the realized (%)	Pla. staff	Realized number of personnel	Ratio of planned numbers to the realized (%)	Pla. staff	Realized number of personnel	Ratio of planned numbers to the realized (%)	Pla. staff	Realized number of personnel	Ratio of planned numbers to the realized (%)
1963	1	20	18	90.0	20	18	90.0	20	13	65.0	60	54	90.0
1964	6	179	143	79.8	174	207	118.9	173	50	28.9	508	309	60.8
1965	12	486	276	56.7	401	399	99.5	459	142	30.9	1,346	622	46.2
1966	12	486	284	58.4	461	468	101.5	459	129	28.1	1,346	746	55.4
1967	17	635	315	49.6	603	597	99.0	599	179	29.8	1,755	1,146	65.2
1968	22	832	324	38.9	801	739	92.2	787	185	23.5	2,309	1,547	66.9
1969	24	902	342	37.9	871	929	106.6	857	235	27.4	2,512	2,062	82.0
1970	25	946	331	34.9	914	910	99.5	892	194	21.7	2,893	2,515	86.9
1971	25	946	309	32.6	914	915	100.1	892	239	26.7	2,893	2,439	84.3
1972	25	946	283	29.9	914	1,488	162.8	892	256	28.6	2,893	3,023	104.4
1975*	26	1,069	389	36.3	1,119	868	77.5	990	504	50.9	4,509	3,897	86.4

Sources: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinde 50 Yıl* (Ankara: SSYB, 1973), p.241;
(*) Ömür Sevin, *Sayılarla Sağlık Sektörü* (Ankara: DPT Sosyal Planlama Dairesi, 1976), p.2.

Table 22. Various activities in health posts, 1963-1974.

Year	Number of provinces	Examined patients (a)	Laboratory examination (a)	Small surgical intervention (a)	Forensic examination (a)	Judicial autopsy (a)	Marriage permission (a)	Vaccines (b)	Environmental hygiene controls (c)	Births with assistance of health personnel (d)
1963	1	38,751	78	332	--	--	--	--	--	--
1964	6	216,926	1,260	2,165	3,019	97	1,002	1,657,559	102,887	4,576
1965	12	604,996	10,063	10,338	15,909	781	3,815	3,182,549	255,406	16,043
1966	12	1,235,061	24,951	24,579	33,620	2,075	9,108	9,689,078	820,278	39,117
1967	17	1,132,880	24,986	31,617	34,175	1,843	12,352	9,860,557	659,779	48,296
1968	22	1,519,122	22,267	42,681	40,606	2,759	22,597	6,176,118	785,741	84,774
1969	24	1,657,647	35,249	73,033	46,120	2,913	30,150	5,756,917	2,111,180	98,808
1970	25	1,620,007	26,211	72,208	50,288	2,752	43,786	6,833,599	1,250,947	115,323
1971	25	1,379,710	26,709	51,955	48,945	2,835	58,900	7,484,139	1,557,839	126,448
1972	25	1,269,174	34,283	68,958	46,342	2,962	61,849	8,308,388	1,506,372	135,272
1973	25	--	--	--	--	--	--	5,174,088	1,447,723	142,913
1974	25	---	--	--	--	--	--	5,130,602	1,535,917	143,296

Sources: (a) Sağlık ve Sosyal Yardım Bakanlığı. *Sağlık Hizmetlerinde 50 Yıl* (Ankara: SSYB, 1973), p.242;
(b) Seher Savaş, *Sağlık Hizmetlerinin Sosyalleştirilmesi Programının Değerlendirilmesi Üzerine Bir İnceleme*, Uzmanlık Tezi, Mali ve Hukuki Tedbirler Şubesi (Ankara: DPT, 1977), p.52;
(c) Ibid., p.49.
(d) Ibid., p.56.

Table 23.

Number of health posts and health stations by years, 1963-2001.

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

Source: Ministry of Health official web site,
http://www.saglik.gov.tr/extras/istatistikler/apk2001/063.htm (December 2007)

Table 24.

The number of personnel and population per personnel before and after the socialization, 1968.

The number of personnel in 22 provinces and 3 training regions:

	Before the socialization	After the socialization
Specialist	168	267
GP	224	460
Dentist	17	34
Pharmacist	0	11
Health officer	579	1,430
Nurse and assistant nurse	408	1,005
Midwife	642	1,991

Population per personnel in 22 provinces and 3 training regions:

	Before the socialization	After the socialization
Doctor	19,700	10,000
Health officer	14,500	5,100
Nurse and assistant nurse	19,000	7,300
Midwife	12,000	3,600

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık ve Sosyal Yardım Bakanlığında 16-19/6/1969 Günlerinde Yapılacak Genel Kurul Çalışmaları* (Ankara: SSYB Sosyalleştirme Dairesi Başkanlığı, 1969), p.16.

Table 25.

The health institutions and the health services of SII, 1952, 1962, 1971.

	1952	1962	1971
Number of doctors	152	599	2,453
Insured per doctor	2.947	1.135	939
Hospital beds	1,065	3,416	11,780
Insured per bed	421	199	194
Health expenditure (million TL)	13.2	158.6	1,007,5
Health investment (million TL)	9.2	84.0	252.9
Per capita health expenditure	38.7	233.1	440.8
Per capita investment	20.5	123.5	110.6
Number of inpatients	16,973	96,000	296,000
Number of examined patients	626,500	3,940,000	11,909,000
Rate of inpatients	3.8	14.1	12.9
Rate of examined	36.3	57.9	52.1

Source: Nusret Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, ed. Rahmi Dirican (Ankara: TTB, 1997), p.70.

Table 26.
New hospitals of the Labor Insurance Institution and SII, increase in total number of beds, 1950-1996.

Years	Number of hospitals	Number of beds
1950-54	9	416
1955-59	3	465
1960-64	12	2,153
1965-69	22	2,519
1970-74	15	3,219
1975-79	9	799
1980-84	10	1,068
1985-89	10	831
1990-95	22	2,455
1995-96	3	915

Source: Gürhan A. Fişek, Şerife Türcan Özsuca and Mehmet Ali Şuğle, *Sosyal Sigortalar Kurumu Tarihi 1946-1996* (Ankara: SSK – Tarih Vakfı, 1997), p.109.

Table 27.

New special branch hospitals of the SII, and increase in total number of beds, 1950-1996.

Years	Number of hospitals	Number of beds
1950-54	1	100
1955-59	-	-
1960-64	-	-
1965-69	3	612
1970-74	-	-
1975-79	2	169
1980-84	3	489
1985-89	3	966
1990-95	6	882
1995-96	1	400

Special branch hospitals of the SII and the years of their establishment

Süreyyapaşa Göğüs ve Kalp Damar Hastalıkları Eğitim Hastanesi	1951
Ballıdağ Sanatoryumu	1965
Ankara Doğumevi	1966
Ege Doğumevi ve Kadın Hastalıkları Eğitim Hastanesi	1969
Erenköy Ruh Sağlığı ve Hastalıkları Hastanesi	1978
Ankara Meslek Hastalıkları Hastaneleri	1979
İstanbul Meslek Hastalıkları Hastanesi	1980
Erenköy (İstanbul) Geriatri Hastanesi	1981
Karamürsel Kadın Göğüs Hastalıkları Hastanesi	1983
Çayeli Doğum ve Çocuk Hastalıkları Hastanesi	1985
Bakırköy (İstanbul) Doğumevi ve Çocuk Hastalıkları Hastanesi	1986
Konya Doğumevi ve Çocuk Hastalıkları Hastanesi	1989
Hidroterapi ve Fizik Tedavi (Yoncalı) Hastanesi	1991
Ünye Psikiyatri Hastanesi	1991
Erzurum Doğum ve Çocuk Hastalıkları Hastanesi	1992
Ankara Çocuk Hastalıkları Eğitim Hastanesi	1993
Adana Doğumevi Kadın ve Çocuk Hastalıkları Hastanesi	1994
Zonguldak Göğüs ve Meslek Hastalıkları Hastanesi	1994
İhtisas (Ankara) Hastanesi	1995

Source: Gürhan A. Fişek, Şerife Türcan Özsuca and Mehmet Ali Şuğle, *Sosyal Sigortalar Kurumu Tarihi 1946-1996* (Ankara: SSK – Tarih Vakfı, 1997), p.110.

Table 28.

The distribution of doctors according to various population categories, 1965.

Population of the settlement	Number of settlements	Total population (million)	Number of doctors	Population per doctor
0-10,000	36,059	22.1	956	23,063
10,001-25,000	122	1.9	725	2,592
25,001-100,000	63	2.8	1495	1,843
100,001-over	14	4.7	7335	642
Total	36,258	34.5	10,511	2,968

Source: Nusret Fişek, *Prof. Dr. Nusret Fişek'in Kitaplaşmamış Yazıları: Sağlık Yönetimi*, ed. Rahmi Dirican (Ankara: TTB, 1997), p.99.

Table 29.

The number and percentages in total number of doctors of specialists and general practitioners, 1950-2002.

Year	Total	Specialist		GP	
		Number	%	Number	%
1950	6,895	3,647	53	3,248	47
1960	8,214	4,181	51	4,033	49
1965	10,895	6,657	61	4,238	39
1970	13,843	8,818	64	5,025	36
1975	21,714	12,698	58	9,016	42
1980	27,241	16,699	61	10,542	39
1985	36,427	20,878	57	15,549	43
1990	50,639	24,900	49	25,739	51
1995	69,349	29,846	43	39,503	57
2000	85,117	38,064	45	47,053	55
2002	95,190	43,660	46	51,530	54

Source: Türk Tabipleri Birliği, *Türkiye Sağlık İstatistikleri 2006*, edited by Onur Hamzaoğlu and Umut Özcan (Ankara: TTB, 2006), table 40, p.67.

Table 30.

Rank order of factors having unfavourable influence on doctors' attitudes toward rural health units.

	Rank order of importance			
	Health unit doctor			
Factors	Recent graduates	Socialization service doctors	Rural practitioners	Hospital residents
Interference with plans for specialization	11	17	22	16
Problems maintaining personal cleanliness and grooming of clothes	16	11	17	19
Lack of proper housing	6	8	10	8
No chance for professional advancement	9	14	20	7
Inadequate instruments and equipment	6	14	11	8
Objections of wife, husband, or fiance	25	21	25	24
Objections of other family members	27	27	27	27
Inadequate health unit buildings	11	11	12	16
Lack of professional meetings and stimulating professional contacts	2	6	7	13
Inadequate transportation and postal services	5	2	5	4
Inadequate medicine and supplies	1	4	3	1
Lack of library research facilities	2	9	2	4
Insufficient social life and lack of recreational opportunities	23	23	18	22
Insufficient income	20	22	15	11
Unqualified assistant staff	4	3	1	3
Lack of variety in clinical work	14	11	18	18
Lack of educational facilities for doctor's children	15	4	4	11
Lack of experienced specialist consultation for clinical problems	10	9	8	6
Health hazards for doctor's family	11	7	9	15
Supervision by nonprofessional persons (*kaymakam*, *nahiye müdürü*, *muhtar*, etc.)	8	1	5	2
Too many patients	26	25	24	26
Fear of losing clinical skills	17	17	21	23
Too few patients	19	26	23	25
Fear of personal safety	24	23	26	21
Political interference	22	16	16	14
Difficulties created by medico-legal cases	17	19	13	8
Personal problems of living in village	21	20	13	19

Source: Carl E. Taylor, Rahmi Dirican and Kurt W. Deuschle, *Health Manpower Planning in Turkey: An International Research Case Study* (Baltimore, Maryland: The Johns Hopkins Press, 1968), pp.92-93.

Table 31.

The number of doctors and the population per doctor in health regions, 1966, 2000.

Region	Provinces	Number of doctors (1966)	Population per doctor (1966)	Number of doctors (2000)	Population per doctor (2000)
Region 1	Kırklareli, Edirne, İstanbul, Tekirdağ	4,651	701	19,204	592
Region 4	Manisa, İzmir, Aydın, Denizli, Muğla	1,326	2,552	11,937	599
Region 7	Kastamonu, Çankırı, Ankara, Kırşehir, Yozgat, Nevşehir	1,658	1,964	13,599	434
Region 14	Diyarbakır, Siirt, Mardin, Urfa	254	6,429	1,942	1,943
Region 15	Kars, Ağrı, Erzurum, Erzincan	386	4,601	1,654	1,052
Region 16	Muş, Bitlis, Van, Hakkari	125	5,885	677	2,889

Source: Güven Özdem, "Türkiye'de Planlı Dönem Boyunca (1963-2000) Doktor ve Tıp Fakültesi Öğrenci Sayılarında Gelişmeler." *Toplum ve Hekim*, 20(5) (2005): 372-380, p.380.

Table 32.

The planned budget of the MHSA in 1963-1977 (thousand Turkish liras).

Years	Total expenditures	Investments			Capital and transfer			Current expenditure			
		Construction	Equipment	Total	Expropriation	Transfer	Total	Initial expenditures	Personnel exp.	Other current exp.	Total
1963*	591,266 758,387	91,335	28,898	118,554 120,233	4,786	22,476	15,000 27,262	17,488	402,059	191,345	457,711 610,892
1964	681,626 853,918	140,510	28,750	147,989 169,260	11,950	15,567	24,711 27,517	29,037	442,095	186,009	508,926 657,141
1965	1,045,994	149,625	37,666	187,291	9,800	25,305	35,105	24,296	568,869	230,433	823,598
1966	1,121,684	121,381	39,734	161,115	8,350	29,750	38,100	26,981	641,051	254,437	922,469
1967	1,172,510	103,003	32,464	135,467	9,300	30,250	39,550	26,173	701,482	269,838	997,493
1968	1,245,219	101,855	31,999	133,854	8,200	32,500	40,700	21,360	761,997	287,308	1,070,665
1969	1,347,925	125,481	31,693	157,174	11,250	33,000	44,250	31,534	815,847	299,120	1,146,501
1970	1,442,799	117,278	36,168	153,446	9,800	33,500	43,300	29,749	897,655	318,649	1,246,053
1971	1,515,474	106,610	29,839	136,449	11,300	34,000	45,300	26,104	972,157	335,464	1,333,725
1972	1,624,532	110,870	33,795	144,665	9,100	34,500	43,600	27,196	1,057,717	351,354	1,436,267
1973	1,712,459	108,936	31,740	140,676	10,550	37,000	47,550	27,355	1,130,484	366,394	1,524,233
1974	1,827,134	119,000	44,421	163,421	11,300	37,500	48,800	32,365	1,200,543	382,005	1,614,913
1975	1,876,825	76,870	44,577	121,447	4,900	38,000	42,900	22,883	1,289,693	399,902	1,712,478
1976	1,946,769	65,555	45,641	111,196	8,400	38,000	46,400	22,569	1,352,474	414,130	1,789,173
1977	1,998,143	3,600	38,272	41,872	500	38,500	39,000	3,380	1,484,446	429,445	1,917,271

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesinin Gerektirdiği Harcamalar ve Program Finansmanı* (Ankara: SSYB, Hıfzıssıhha Okulu Yayınlarından, no. 14, 1964), p.14.

* The numbers in the upper side for the years 1963 and 1964 are the real budget numbers.

Table 33.

The planned distribution of health investments to various programs in1963-1977.

Health programs	The total investments within 15 years (thousand Turkish liras)	The share within the MHSA budget %
Health posts	972,520	47.0
Hospitals	696,244	33.5
TB combat dispensaries	74,965	3.6
Public Health institutes	45,752	3.2
Stores and maintenance halls	83,572	4.0
Health schools	127,839	6.1
Health museums	2,848	0.1
Health service institutions	27,653	1.3
Infectious diseases and other services	45,289	2.2
Total	2,076,682	100

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesinin Gerektirdiği Harcamalar ve Program Finansmanı* (Ankara: SSYB, Hıfzıssıhha Okulu Yayınlarından, no. 14, 1964), p.15.

Table 34.

The planned health post program in 1963-1977.

Years	Health posts that would be in service		Health posts that would be built		The provinces where new health posts would be put into service
	Village type	City type	Village type	City type	
1963	20	-	144	9	Muş
1964	164	9	249	21	Hakkari, Bitlis, Van, Ağrı, Kars
1965	413	30	179	13	Erzurum, Erzincan, Diyarbakır, Siirt, Mardin, Urfa
1966	592	43	198	10	Tunceli, Bingöl, Elazığ, Adıyaman, Malatya, Artvin, Gümüşhane
1967	790	53	182	23	Rize, Giresun, Trabzon, Maraş
1968	972	76	198	14	Tokat, Sivas, Kayseri, Amasya
1969	1,170	90	268	30	Çorum, Yozgat, Kırşehir, Nevşehir, Niğde
1970	1,438	120	226	34	Ordu, Samsun, Sinop, Gaziantep, Hatay
1971	1,664	154	207	37	Adana, İçel, Konya
1972	1,871	191	226	27	Çankırı, Kastamonu, Ankara, Bolu
1973	2,097	218	233	22	Eskişehir, Afyon, Bilecik, Kütahya, Uşak, Isparta, Burdur
1974	2,330	240	246	49	Antalya, Muğla, Zonguldak, Sakarya, Kocaeli
1975	2,576	289	183	25	Denizli, Aydın, Manisa, İzmir
1976	2,579	314	109	78	Bursa, Balıkesir, Çanakkale
1977	2,868	392	-	-	İstanbul, Edirne, Kırklareli, Tekirdağ

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesinin Gerektirdiği Harcamalar ve Program Finansmanı* (Ankara: SSYB, Hıfzıssıhha Okulu Yayınlarından, no. 14, 1964), p.55.

Table 35.

The planned inpatient institution program in 1963-1977.

Years	The number of beds	The number of beds to be added	The cities where new hospitals would be built
1963	38,400	--	Ankara, Erzincan, Gaziantep, Giresun, Isparta, Kars, Kastamonu, Kayseri, Konya, Mardin, Muş, Samsun, Siirt, Sinop, Urfa, Van, Yozgat
1964	39,700	1,300	Ankara, Adana, Antalya, Aydın, Bursa, Erzurum, Eskişehir, İzmir, Manisa, Sakarya, Samsun, Tunceli
1965	41,000	1,300	Ağrı, Denizli, Diyarbakır, Erzurum, Edirne, Hakkari, İstanbul, Kars, Muş, Urfa, Trabzon, Zonguldak, Artvin, Adıyaman, Bingöl, Elazığ, Erzincan, Gümüşhane, Malatya
1966	42,300	1,300	Çanakkale, Diyarbakır, Elazığ, İstanbul, Maraş, Siirt, Tekirdağ
1967	44,305	2,005	Adana, Ağrı, Artvin, Elazığ, Giresun, İzmir, Maraş, Rize, Siirt, Trabzon
1968	44,900	595	Artvin, Amasya, Elazığ, İstanbul, Kars, Kayseri, Muğla, Mardin, Sivas, Tokat, Trabzon
1969	46,200	1,300	Amasya, Bursa, Çorum, Kırşehir, Nevşehir, Rize, Van, Yozgat
1970	47,920	1,720	Adana, Balıkesir, Çanakkale, Çorum, Denizli, Erzincan, Gaziantep, İstanbul, Manisa, Niğde, Ordu, Samsun, Sinop
1971	49,015	1,095	Adana, Bolu, İçel, Kastamonu, Kayseri, Konya, Ordu, Sinop, Trabzon, Zonguldak
1972	50,100	1,085	Afyon, Ankara, Aydın, Bilecik, Bolu, Burdur, Bursa, Çankırı, Edirne, Isparta, Kastamonu, Kırklareli
1973	51,400	1,300	Adana, Ankara, Antalya, Eskişehir, Kocaeli, Kütahya, Muğla, Sakarya, Van, Zonguldak
1974	52,700	1,300	Aydın, Antalya, Balıkesir, Bursa, Çanakkale, Denizli, Diyarbakır, İzmir, Samsun, Trabzon, Manisa
1975	54,000	1,300	İstanbul, Kırklareli
1976	55,300	1,300	Will be determined
1977	56,600	1,300	No construction

Source: Sağlık ve Sosyal Yardım Bakanlığı, *Sağlık Hizmetlerinin Sosyalleştirilmesinin Gerektirdiği Harcamalar ve Program Finansmanı* (Ankara: SSYB, Hıfzıssıhha Okulu Yayınlarından, no. 14, 1964), p.56.

Table 36.

Health expenditures, 1980-2004.

(at current prices)

Years	GNP (Billions TL)	Consolidated budget (Billions TL)	Health expenditures (Billions TL)			Total health exp. / GNP (%)	Public health exp. / GNP (%)	Public health exp. / Total health exp. (%)	Public health exp. / Consolidated budget (%)	Per capita health exp. (Thousand TL)	Per capita health exp. ($)	Per capita health exp. (PPP)
			Public	Private	Total							
1980	5,303	1,078	96	91	187	3.5	1.8	51.4	8.9	4.2	55.5	82.3
1981	8,023	1,516	116	135	252	3.1	1.4	46.2	7.7	5.5	50.1	81.9
1982	10,612	1,602	149	177	326	3.1	1.4	45.6	9.3	7.0	43.3	85.5
1983	13,933	2,613	204	239	443	3.2	1.5	46.0	7.8	9.3	41.3	93.5
1984	22,168	3,784	300	384	684	3.1	1.4	43.9	7.9	13.9	38.2	98.5
1985	35,350	5,313	461	573	1,034	2.9	1.3	44.6	8.7	20.6	39.7	97.8
1986	51,185	8,165	680	783	1,463	2.9	1.3	46.5	8.3	28.4	42.5	101.7
1987	75,019	12,696	1,115	1,125	2,240	3.0	1.5	49.8	8.8	42.6	49.8	117.2
1988	129,175	21,006	2,033	1,862	3,895	3.0	1.6	52.2	9.7	72.5	51.0	121.8
1989	230,370	38,051	4,530	3,213	7,744	3.4	2.0	58.5	11.9	141.1	66.5	140.2
1990	397,178	67,193	8,622	5,298	13,920	3.5	2.2	61.9	12.8	247.9	95.1	161.7
1991	634,393	130,263	14,847	8,532	23,379	3.7	2.3	63.5	11.4	408.3	97.9	173.5
1992	1,103,605	221,658	28,616	14,584	43,200	3.9	2.6	66.2	12.9	740.0	107.4	196.6
1993	1,997,323	485,249	58,000	27,000	85,000	4.3	2.9	68.2	12.0	1,428.8	130.1	231.4
1994	3,887,903	897,296	103,500	56,500	160,000	4.1	2.7	64.7	11.5	2,639.7	88.9	211.4
1995	7,854,887	1,710,646	193,000	107,000	300,000	3.8	2.5	64.3	11.3	4,859.3	106.4	212.2
1996	14,978,067	3,940,162	352,000	198,000	550,000	3.7	2.4	64.0	8.9	8,747.8	107.8	220.5
1997	29,393,262	7,990,748	655,000	385,000	1,040,000	3.5	2.2	63.0	8.2	16,246.2	107.3	227.3
1998	53,518,332	15,601,363	1,479,673	719,576	2,199,249	4.1	2.8	67.3	9.5	33,753.1	129.8	271.9
1999	78,282,967	28,094,057	2,567,369	642,000	3,209,369	4.1	3.3	80.0	9.1	48,411.9	115.9	252.4
2000	125,596,129	46,705,028	4,359,145	1,089,000	5,448,145	4.3	3.5	80.0	9.3	80,809.0	129.6	298.2
2001	175,483,953	80,579,065	7,607,184	1,229,733	8,836,917	5.0	4.3	86.1	9.4	129,181.5	105.6	304.7
2002	275,032,366	115,682,350	13,114,705	2,189,070	15,303,775	5.6	4.8	85.7	11.3	220,553.6	146.6	360.7
2003	356,680,888	140,454,842	17,099,880	3,045,803	20,145,683	5.6	4.8	84.9	12.2	286,310.7	191.5	390.9
2004	428,932,343	151,357,207	22,637,501	4,264,124	26,901,625	6.3	5.3	86.1	15.0	377,132.6	265.1	483.4

Source: SPO (State Planning Organization), *Economic and Social Indicators (1950-2004)* (Ankara: SPO, 2005), p.172.

Table 37.

Given Green Cards and total expenditures, 1992/93-2002.

Years	Number of those who applied for Green Card	Given Green Cards	Money allocated (million TL)	Money spent (million TL)
Total	16,535,217		376,069,266	1,162,511,311
1992/93	2,971,722	2,211,341	889,625	745,430
1994	1,498,213	1,460,111	1,351,992	2,046,954
1995	1,674,712	1,325,276	3,718,465	5,977,284
1996	970,889	716,338	10,251,763	9,695,274
1997	1,298,526	953,912	18,998,950	23,242,378
1998	1,345,953	1,093,465	30,000,000	53,579,962
1999	1,352,148	961,186	36,970,000	111,880,334
2000	1,610,828	1,404,677	90,000,000	167,091,891
2001	1,674,706	1,372,419	85,634,921	304,471,251
2002	2,137,520	1,502,452	98,253,550	483,780,553

Source: Ministry of Health official web site,
http://www.saglik.gov.tr/TR/dosyagoster.aspx?DIL=1&BELGEANAH=9407&DOSY (September 2006)

Table 38.

The comparison of Turkey with OECD-European countries in terms of various health indicators, 2003.

OECD-European countries	Total health expenditures / GNP (%)	Public health expenditures / GNP (%)	Infant mortality rate	Life exp.	Doctor per 1000	Inpatient bed per 1000
Austria	7.6	5.3	4.8	78.6	3.4	6.0
Belgium	9.6	-	4.8	78.1	3.9	4.0
Czech Rep.	7.5	6.8	4.1	75.3	3.5	6.5
Denmark	9.0	7.5	5.3	77.2	2.9	3.4
Finland	7.4	5.7	3.8	78.5	2.6	2.3
France	10.1	7.7	4.4	79.4	3.4	3.8
Germany	11.1	8.7	4.4	78.4	3.4	6.6
Greece	9.9	5.1	5.9	78.1	4.4	-
Hungary	7.8	5.5	9.2	72.4	3.2	5.9
Iceland	10.5	8.8	3.0	80.7	3.6	-
Ireland	7.3	5.5	6.2	77.8	2.6	3.0
Italy	8.4	6.3	4.5	79.9	4.1	3.9
Luxembourg	6.1	5.2	5.1	78.2	2.7	5.7
Netherlands	9.8	6.1	5.1	78.6	3.1	3.2
Norway	10.3	8.6	3.8	79.5	3.1	3.1
Poland	6.0	4.3	8.1	74.7	2.5	5.1
Portugal	9.6	6.7	5.5	77.3	3.3	3.1
Slovak Rep.	5.9	5.2	8.6	73.9	3.1	5.9
Spain	7.7	5.5	3.9	80.5	3.2	3.1
Sweden	9.2	7.9	3.4	80.2	3.3	2.4
Switzerland	11.5	6.7	4.9	80.4	3.6	3.9
Turkey	6.6	4.2	43.0	68.7	1.4	2.3
UK	7.7	6.4	5.6	78.5	2.2	3.7

Source: TESEV, *Doğu ve Güneydoğu Anadolu'da Sosyal ve Ekonomik Öncelikler* (İstanbul: TESEV Yayınları, 2006), p.118

Table 39.

Health indicators by geographical regions, 2002.

Region	Infant mortality	Population per health post	Population per doctor	Population per midwife	Population per nurse	Inpatient bed per 10,000	Per capita average clinical examination	Percentage of health posts without doctor (%)
Mediterranean	37.13	11,051	3,595	2,341	5,440	19.20	0.91	9
Aegean	40.13	9,348	3,565	2,333	4,597	23.50	1.12	13
Central Anatolia	41.77	11,077	3,985	4,339	5,409	26.60	0.80	14
Black Sea	42.33	8,214	3,747	2,952	4,770	26.40	0.95	13
Marmara	39.36	20,091	7,651	5,569	9,382	27.50	0.66	11
Eastern Anatolia	53.36	11,029	5,223	4,511	5,923	18.00	0.58	20
Southeastern Anatolia	48.33	16,305	7,304	6,960	10,477	10.90	0.53	20
Turkey	43.00	12,057	4,708	3,672	6,196	23.30	0.79	13

Source: TESEV, *Doğu ve Güneydoğu Anadolu'da Sosyal ve Ekonomik Öncelikler* (İstanbul: TESEV Yayınları, 2006), p.119.

Table 40.

The distribution of hospitals, hospital beds among regions and number of hospital beds for 10,000 in different regions, 2004.

	Total		Ministry of Health		SII		University		Private		Other		Bed per 10,000
	Institution	Bed	Institution	Bed	Institution	Bed	Institution	Bed	Institution	Bed	Institution	Bed	
Mediterranean	117	18,121	71	11,540	11	3,358	7	1,995	26	1,128	2	100	19.4
Aegean	163	23,162	92	12,740	26	4,714	7	3,590	33	1,480	5	638	24.6
Central Anatolia	212	33,740	134	18,042	23	5,195	16	8,210	26	1,128	13	1,165	27.6
Black Sea	178	23,578	138	15,776	28	5,132	6	2,351	6	298	0	21	28
Marmara	334	51,811	119	22,322	37	10,850	9	7,768	149	7,190	20	3,681	27.4
Eastern Anatolia	104	12,077	81	8,160	14	1,698	4	2,085	5	122	0	12	18.7
Southeastern Anatolia	67	9,399	48	6,130	7	1,491	3	1,300	8	428	1	50	13.1
Turkey	1,175	171,888	683	94,710	146	32,438	52	27,299	253	11,774	41	5,667	23.9

Source: TESEV, *Doğu ve Güneydoğu Anadolu'da Sosyal ve Ekonomik Öncelikler* (İstanbul: TESEV Yayınları, 2006), p.122.

Table 41.

The number of inpatient institutions, hospital bed per 10,000, and population in regions determined by the SPO in accordance with the level of development of the provinces, 2006.

Regions according to their levels of development	Total		Ministry of Health		University		Private		Other		Population	Bed per 10,000
	Institution	Bed	Institution	Bed	Institution	Bed	Institution	Bed	Institution	Bed		
1st region	410	79,239	173	50,394	26	15,261	184	9,604	27	3,980	28,756,000	27.6
2nd region	265	36,954	175	28,234	13	6,056	71	2,452	6	212	15,731,000	23.5
3rd region	169	26,105	144	22,721	8	2,818	17	566	0	0	9,017,000	29.0
4th region	114	11,284	105	10,888	1	101	8	295	0	0	4,981,000	22.7
5th region	113	18,948	89	13,466	7	4,962	17	520	0	0	7,900,000	24.0
6th region	92	8,237	83	7,465	1	502	8	270	0	0	6,588,000	12.5
General total	1,163	180,767	769	133,168	56	29,700	305	13,707	33	4,192	72,974,000	24.8

1st region: Adana, Ankara, Bursa, Gaziantep, Mersin, İstanbul, İzmir, Kocaeli.
2nd region: Aydın, Balıkesir, Çanakkale, Denizli, Edirne, Kayseri, Tekirdağ, Konya, Manisa, Muğla, Sakarya, Antalya, Hatay, Zonguldak, Eskişehir, Yalova.
3rd region: Afyonkarahisar, Bilecik, Bolu, Burdur, Düzce, Giresun, Isparta, Kütahya, Ordu, Osmaniye, Rize, Samsun, Kırklareli, Trabzon, Uşak, Bartın, Karabük, Kırıkkale.
4th region: Amasya, Çankırı, Çorum, Kastamonu, Kırşehir, Nevşehir, Niğde, Sinop, Tokat, Yozgat, Aksaray, Karaman, Kilis.
5th region: Artvin, Elazığ, Erzincan, Erzurum, Kahramanmaraş, Malatya, Sivas, Şanlıurfa, Diyarbakır.
6th region: Adıyaman, Ağrı, Bingöl, Bitlis, Hakkari, Kars, Mardin, Muş, Siirt, Tunceli, Ardahan, Iğdır, Batman, Şırnak, Gümüşhane, Bayburt, Van.

Note: 42 institutions and 15,900 beds of the Ministry of Defense are not included. If we include these numbers, total number of institutions would be 1205, beds would be 196,667 and the number of beds per 10,000 would be 27.

Source: Ministry of Health official web site, Yataklı Tedavi Kurumları İstatistik Yıllığı, 2006, http://www.saglik.gov.tr/TR/BelgeGoster.aspx?F6E10F8892433CFFAC8287D72AD903BEFFB31DDACD1CE3B0 (December 2007)

Table 42.

The institutional distribution of the number of inpatient and outpatient cases in hospitals, 2002-2006.

Institutions		Outpatient		Inpatient		The ratio of inpatient cases (**)
	Years	Numbers	% Growth	Numbers	% Growth	
Ministry of Health	2002	66,231,841		2,806,588		4.2
	2003	68,957,525	4.1	2,896,540	3.2	4.2
	2004	91,257,412	32.3	3,522,173	21.6	3.9
	2005	164,758,149	80.5	5,081,539	44.3	3.1
	2006	189,422,137	15.0	5,379,198	5.9	2.8
University	2002	8,823,361		781,990		8.9
	2003	9,637,840	9.2	838,486	7.2	8.7
	2004	10,685,275	10.9	921,735	9.9	8.6
	2005	11,493,879	7.6	1,025,614	11.3	8.9
	2006	12,588,872	9.5	1,165,277	13.6	9.3
Private (*)	2002	4,407,122		529,511		12.0
	2003	5,033,572	14.2	586,961	10.8	11.7
	2004	6,187,371	22.9	637,731	8.6	10.3
	2005	10,804,981	74.6	871,329	36.6	8.1
	2006	15,277,331	41.4	1,215,520	39.5	8.0
SII	2002	43,561,287		1,363,191		3.1
	2003	44,977,045	3.3	1,382,636	1.4	3.1
	2004	43,911,817	-2.4	1,338,260	-3.2	3.0
	2005					
	2006					
Other public	2002	1,293,748		26,983		2.1
	2003	1,127,136	-12.9	31,894	18.2	2.8
	2004	809,366	-28.2	20,901	-34.5	2.6
	2005	243,265	-69.9	33,032	58.0	13.6
	2006	252,085	3.6	4,656	-85.9	1.8
Total	2002	124,317,359		5,508,263		4.4
	2003	129,733,118	4.4	5,736,517	4.1	4.4
	2004	152,851,241	17.8	6,440,800	12.3	4.2
	2005	187,300,274	22.5	7,011,514	8.9	3.7
	2006	217,540,425	16.1	7,764,651	10.7	3.6

Notes: * Private section covers the activities of hospitals owned by associations, endowments, foreigners, minorities and individual persons.
** The ratio of inpatient cases is calculated based on the number of outpatient cases.

Source: Ministry of Health official web site, Yataklı Tedavi Kurumları İstatiatik Yıllığı, 2006, http://www.saglik.gov.tr/TR/BelgeGoster.aspx?F6E10F8892433CFFAC8287D72AD903BEFFB31DDACD1CE3B0 (December 2007)

Table 43.

The health expenditures of the Retirement Fund, 1980-2006.

Years	Expenditures		Number of cases	Health expenditure per case ($)	Number of RF members	Per capita health exp. ($)
	(million TL.)	Dollars				
1980	788	10,368,421	401,411	26	788,773	13
1981	1,646	14,963,636	439,997	34	864,594	17
1982	2,927	18,293,750	454,228	40	892,558	20
1983	4,346	19,401,786	468,647	41	920,891	21
1984	7,155	19,656,593	784,889	25	1,542,307	13
1985	13,435	25,936,293	498,006	52	978,582	27
1986	24,351	36,399,103	511,870	71	1,005,825	36
1987	44,323	51,839,766	529,336	98	1,040,145	50
1988	85,353	60,065,447	536,027	112	1,053,293	57
1989	200,980	94,801,887	556,886	170	1,094,281	87
1990	312,783	120,024,175	571,573	210	1,123,141	107
1991	634,637	152,264,155	610,380	249	1,199,397	127
1992	1,510,610	220,077,214	670,576	328	1,317,682	167
1993	3,195,642	291,392,522	712,723	409	1,400,501	208
1994	7,521,613	253,493,310	781,719	324	1,536,078	165
1995	17,858,065	367,830,597	828,553	444	1,545,788	238
1996	34,625,900	436,296,489	920,572	474	1,865,977	234
1997	84,040,546	551,562,557	952,360	579	1,965,032	281
1998	187,040,519	598,108,592	1,036,501	577	1,998,865	299
1999	360,267,000	667,040,056	1,121,643	595	2,088,080	319
2000	623,072,600	927,515,724	1,186,139	782	2,203,003	421
2001	1,089,395,190	756,751,989	1,266,626	597	2,322,302	326
2002	1,840,221,231	1,123,330,375	1,359,875	826	2,406,354	467
2003	2,498,189,724	1,789,745,725	1,446,420	1,237	2,508,741	713
2004	2,795,695,601	1,969,633,346	1,464,480	1,345	2,552,141	772
2005	2,917,045,576	2,176,899,683	1,481,243	1,470	2,557,141	851
2006	2,744,374,342	1,960,267,387	1,530,026	1,281	2,722,120	720
30.6.2007	1,525,087,225	1,159,762,148	1,528,205	759	2,711,336	428

Note: After 1.1.2005, YTL is used in calculations.
Source: Social Security Institution official web site, http://www.emekli.gov.tr/ISTATISTIK/saglik.html#s1 (December 2007)

Table 44.
Health insurance premium collection / health expenditure of Bağ-Kur, 1986-2005.

	Premium Collection	Health Expenditures
Years	Thousand YTL	Thousand YTL
1986	5.7	0.5
1987	17.0	6.0
1988	81.3	31.6
1989	180.6	159.6
1990	307.3	277.5
1991	480.2	421.6
1992	1,463.6	524.2
1993	1,782.1	1,060.8
1994	3,778.1	2,987.2
1995	7,396.0	8,044.7
1996	15,162.9	18,411.9
1997	43,269.6	54,499.5
1998	75,973.1	201,254.1
1999	142,706.5	413,417.2
2000	285,075.0	730,295.6
2001	518,815.7	1,228,848.9
2002	964,303.0	2,195,308.2
2003	1,410,561.1	3,183,146.3
2004	1,965,189.0	3,719,356.0
2005	1,707,701.0	3,625,615.0

Source: Social Security Institution official web site,
http://www.bagkur.gov.tr/finansman/zaman.html (December 2007)

Table 45.

Total health and medicine expenditures of SII, 2000-2006.

Years	Total health expenditures	Rate of change of total health expenditures	Medicine expenditures	Rate of change of medicine expenditures	Ratio of medicine expenditures in total health expenditures
2000	1,280,189	71.0	572,409	88.3	44.7
2001	2,257,958	76.4	992,616	73.4	44.0
2002	3,594,350	59.2	1,878,558	89.3	52.3
2003	4,981,194	38.6	2,101,496	11.9	42.2
2004	6,635,691	33.2	2,687,750	27.9	40.5
2005	7,677,105	15.7	3,552,940	32.2	46.3
2006	11,699,804	52.4	5,265,514	48.2	45.0

Source: Social Security Institution official web site, SSK, 2004 Yılı Çalışma Raporu, http://www.sgk.gov.tr/doc/istatistik/sgk_bulten2006_04.pdf (December 2007)

Table 46.

The budget transfers to the social security institutions, 1994-2005.

Years	Social security institutions (Billion TL)				% of GNP			
	SII	Bağ-Kur	RF	Total	SII	Bağ-Kur	RF	Total
1994	14,480	4,530	20,000	39,010	0.37	0.12	0.51	1.00
1995	59,200	8,000	41,000	108,200	0.75	0.10	0.52	1.38
1996	146,000	70,100	119,200	335,300	0.97	0.47	0.80	2.24
1997	337,000	123,000	280,000	740,000	1.15	0.47	0.95	2.52
1998	451,000	435,000	610,000	1,496,000	0.84	0.81	1.14	2.80
1999	1,105,000	796,145	1,035,000	2,936,145	1.41	1.02	1.32	3.75
2000	400,000	1,051,460	1,775,000	3,226,460	0.32	0.84	1.41	2.57
2001	1,108,000	1,740,000	2,675,000	5,523,000	0.63	0.99	1.52	3.15
2002	2,386,000	2,622,000	4,676,000	9,684,000	0.87	0.95	1.70	3.52
2003	4,809,000	4,930,000	6,145,000	15,884,000	1.35	1.38	1.72	4.45
2004	5,757,000	5,273,000	7,800,000	18,830,000	1.34	1.23	1.82	4.39
2005	7,507,000	6,926,000	8,889,000	23,322,000	1.54	1.42	1.83	4.79
2006	8,527,000	4,330,000	10,035,000	22,892,000	1.58	0.79	1.86	4.23

Source: Social Security Institution official web site, http://www.sgk.gov.tr/doc/istatistik/sgk_bulten2006_28.pdf (December 2007)

Table 47.

Health posts and health stations unattended by doctors and midwives by geographical region, 2002.

Region	Health posts without doctors		Health stations without midwives		% of births unattended by health staff
	Number	%	Number	%	
Marmara	97	11	891	62	1.5
Aegean	129	13	814	55	5.6
Mediterranean	78	9	808	70	3.2
Central Anatolia	151	14	1,353	80	3.7
Black Sea	130	13	2,326	77	3.9
Eastern Anatolia	116	20	1,660	90	18.6
Southeastern Anatolia	84	20	984	90	20.3
Turkey	785	13	8,836	75	5.8

Source: TÜSİAD, *Charting the Way Forward: Health Care Reform in Turkey* (İstanbul: TÜSİAD - Türk Sanayici ve İşadamları Derneği – Turkish Industrialists' and Businessmen's Association, 2005), p.62.

Table 48.

Regional differences in health outcomes.

	1993	1998	2003
Births with skilled delivery assistance			
National average (%)	75.90	80.6	84.0
Eastern region (%)	50.30	52.3	59.7
Eastern/national ratio	0.66	0.65	0.71
Infant mortality rate			
National average	53	43	29
Eastern region	60	61	41
Eastern/national ratio	1.14	1.42	1.41
Child immunization, % fully vaccinated			
National average (%)	64.70	45.7	54.2
Eastern region (%)	40.60	22.9	34.8
Eastern/national ratio	0.63	0.50	0.64
Contraceptive use, all methods			
National average (%)	62.60	63.9	71.0
Eastern region (%)	42.30	42.0	57.9
Eastern/national ratio	0.68	0.66	0.82

Source: World Bank, *The World Bank in Turkey: 1993-2004 – An IEG Country Assistance Evaluation* (World Bank, 2006), p.43.

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Interviews

Public Health Specialists and Physicians

* Aslı Davas, Ege University Public Health (tape recording, İzmir, Turkey, March 2006)
* Ata Soyer, 9 Eylül University Public Health (tape recording, İzmir, Turkey, March 2006)
* Ayşen Bulut, İstanbul University Institute of Child Health (tape recording, İstanbul, Turkey, January 2007)
* Cemal Güvercin, Ankara Chamber of Medicine (tape recording, Ankara, Turkey, March 2006)
* Doğan Benli, retired health bureaucrat, worked with Nusret Fişek (tape recording, Ankara, Turkey, August 2006)
* Erdal Atabek, Head of Turkish Medical Association between 1966-84 (İstanbul, Turkey, September 2006)
* Erdem Aydın, Chair of Hacettepe U. Medical History and Deontology (tape recording, Ankara, Turkey, August 2006)
* Esin Tuncay, Yedikule Breast Health Hospital, Head of 8th Clinic (tape recording, İstanbul, Turkey, May 2006)
* Feride Saçaklıoğlu, Chair of Ege University Public Health (tape recording, İzmir, Turkey, March 2006)
* Gazanfer Aksakoğlu, Chair of Dokuz Eylül University Public Health (tape recording, İzmir, Turkey, March 2006)
* Gençay Gürsoy, Head of Turkish Medical Association (İstanbul, Turkey, July 2006)
* Güngör Çamsarı, Yedikule Breast Health Hospital, Head of 2nd Clinic (tape recording, İstanbul, Turkey, May 2006)
* Gürhan Fişek, Ankara University Faculty of Political Science (tape recording, Ankara, Turkey, March 2006)

* Hamdi Aytekin, Chair of Uludağ University Public Health (tape recording, Bursa, Turkey, July 2006)
* Kayıhan Pala, Uludağ University Public Health (tape recording, Bursa, Turkey, July 2006)
* Levent Dalar, Yedikule Breast Health Hospital (İstanbul, Turkey, October 2005)
* Levent Karasulu, Yedikule Breast Health Hospital (İstanbul, Turkey, October 2005)
* Mustafa Sütlaş, Sağlık Hakkı Hareketi Derneği (İstanbul, Turkey, August 2006)
* Neşet Berçin, retired bureaucrat from MHSA (tape recording, Ankara, Turkey, February 2007)
* Rahmi Dirican, retired public health specialist, worked with Nusret Fişek (tape recording, Bursa, Erdek, Ortaklar village, July 2006)
* Rezzan Tuncay, Istanbul University - Çapa Neurology (İstanbul, Turkey, September 2006)
* Turhan Temuçin, Former Head Doctor of Ankara Numune Hospital (tape recording, Ankara, Turkey, March 2006)
* Zafer Öztek, Chair of Hacettepe University Public Health (tape recording, Ankara, Turkey, March 2006 and February 2007)

Planners

* Muharrem Varlık, planning expert, General Directorate of the Social Sectors and Coordination of the State Planning Organization (tape recording, Ankara, Turkey, February 2007)
* Necat Erder, the head of the Social Planning Office of the State Planning Organization between 13 June 1961 – 24 September 1962 (tape recording, Ankara, Turkey, February 2007)

Social Workers

* Kezban Çelik, Ankara Sami Ulus Child Hospital (tape recording, Ankara, Turkey, March 2006)
* Maide Erdoğan, Ministry of Health Dışkapı Hospital, Social Service (tape recording, Ankara, Turkey, March 2006)