HEALTH SECTOR RESTRUCTURING IN TURKEY: THE IMPACT OF NEOLIBERAL POLICIES AND EUROPEAN UNION MEMBERSHIP CANDIDACY; REASONS, RESULTS AND REPERCUSSIONS

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ABSTRACT

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This thesis aims to analyze the inner dynamics as well as the outcomes of the health sector restructuring process in Turkey, by focusing on Neo-Liberal transformation, New Public Management practices and European Integration process. The thesis argues that health reform process along with other public sector reforms have been initiated by Neo-Liberalism as the new face of institutional and structural arrangements during 1980s. Within that process, it is underlined that New Public Management approach with its commitment to private sector methodology and techniques reflected the underlying philosophy and basic premises of Neo-Liberalism which dominated the health sector restructuring process in Turkey, as well as in Eastern Europe since 1990s. Often characterized with the notion of "efficiency", the New Public Management techniques and methodologies claimed to bring a more efficiently working health system. In order to refute this claim, the health sector reforms that have been exercised in the past two decades in Turkey as well as in Eastern Europe are analyzed within a historical context. It is also argued that while the Neo-Liberal policies and policy initiatives proposed by International Monetary Fund and World Bank had a direct effect on health sector restructuring process, the role of the European Union has been indirect with regard to organization and service provision. Therefore, the main objective of this thesis is to analyze the outcomes of the health reforms carried out in Turkey in a multidisciplinary manner in order to reveal its political, economic,

social and administrative implications in terms of service providers and service takers.

Key words: Neo-Liberalism, New Public Management, European Health Policy, Health Reform, Health Policy, Health Sector Restructuring, Efficiency, Privatization.

ÖZ

TÜRKİYE'DE SAĞLIK SEKTÖRÜNÜN YENİDEN YAPILANDIRILMASI: NEOLİBERAL POLİTİKALARIN VE AVRUPA BİRLİĞİ ADAY ÜYELİĞİNİN ETKİLERİ; SEBEPLER, SONUÇLAR VE YANSIMALAR

Uluskaradağ, Özge

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Bu Tez, Türkiye'deki sağlık sektörünün yeniden yapılandırılma sürecinin iç dinamiklerini ve sonuçlarını, Neo-Liberal dönüşüm, Yeni Kamu İşletmeciliği, ve Avrupa entegrasyon sürecine odaklanarak incelemeyi amaçlamaktadır. Bu tez, diğer kamu sektörü reformlarıyla birlikte sağlık reform sürecinin; kurumsal ve yapısal düzenlemelerin yeni yüzü olan Neo-Liberalizm tarafından 1980'lerde başlatıldığını savunmaktadır. Bu süreç içinde, Yeni Kamu İşletmeciliği'nin özel sektör yöntem ve tekniklerine olan bağlılığıyla 1990'lardan beri Türkiye'de ve Doğu Avrupa'daki sağlık sektörü yeniden yapılandırma sürecine egemen olan Neo-Liberalizmin altında yatan felsefeyi ve temel öncüllerini yansıttığının altı çizilmektedir. Sık sık verimlilik kavramıyla karakterize edilen Yeni Kamu İşletmeciliği teknik ve yöntemleri, daha verimli çalışan bir sağlık sistemi getirdiğini iddia etmektedir. Bu iddiayı reddetmek amacıyla, son yirmi yılda Türkiye'de ve Doğu Avrupa'da uygulanmakta olan sağlık reformları tarihsel bir bağlamda incelenmiştir. Bunun yanında, Neo-Liberal politikalar , Uluslararası Para Fonu ve Dünya Bankası tarafından önerilen politika girişimlerinin sağlık sektörünün yeniden yapılandırılma sürecinde doğrudan bir etkisi olduğu tartışılırken, Avrupa Birliği'nin organizasyon ve hizmet sunumuna ilişkin etkisinin dolaylı olduğu belirtilmiştir. Sonuç olarak, bu tezin temel amacı Türkiye'de yürütülen sağlık reformlarının sonuçlarını çok disiplinli bir bakış açısıyla inceleyip,

hizmet sunan ve hizmetten yararlananlar açısından siyasi, sosyal, ekonomik ve idari sonuçlarını ortaya çıkarmaktır.

Anahtar Kelimeler: Neo-Liberalizm, Yeni Kamu İşletmeciliği, Avrupa Sağlık Politikası, Sağlık Reformu, Sağlık Politikası, Sağlık Sektörünün Yeniden Yapılandırılması, Verimlilik, Özelleştirme.

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LIST OF ABBREVIATIONS

CEECs	Central and Eastern European Countries
CEE	Central and Eastern
EC	European Community
ECJ	European Court of Justice
EU	European Union
GDP	Gross Domestic Product
IMF	International Monetary Fund
JDP	Justice and Development Party
MOH	Ministry of Health
MP	Motherland Party
NGO	Non-Governmental Organization
NPM	New Public Management
OMC	Open Method of Coordination
PM	Public Management
SDPP	Social Democratic Populist Party
SPO	State Planning Organization
TUSIAD	Turkish Industrial and Business Association
TMA	Turkish Medical Association
TPP	True Path Party
WB	World Bank

CHAPTER 1

INTRODUCTION

The beginning of the 1980s not only marked the emergence of a new era in economic and political spheres but made itself visible in every social aspects of life as a whole. The changes in the world economy reflected itself in political as well as in administrative structures of the state which ended the so –called post war compromise[1] while marking the beginning of a new world order , namely the Neo-Liberal order.[2]

The capitalist system known as the "Golden Age of Capitalism" due to its success in providing full employment and maintaining prosperity for almost three decades, started to create the path to its own end in the second half of the 1960s and early 70s. The crisis of the Keynesian Welfare state regime of course could be tied to variety of events that took place in the world at large at that time. Among which, the two oil shocks of 1970s, the collapse of the Bretton Woods institutional arrangements, the adoption of the flexible exchange rate mechanism, increasing budgetary problems of the state due to social spending, dissolution of corporatist agreements in labor market, decline of competition in the developed industrial countries were the most prominent ones. The need to re-organize the state/capital/labor relations at the national as well as

[1] The period is referred to by variety of terms such as Keynesian Welfare National State (Jessop, 2002), Embedded Liberalism Period (Ruggie, 1982) and Social Democratic Consensus (Barry, 1987).

[2] 'It is impossible to define neoliberalism purely theoretically, for several reasons. First, methodologically, although neoliberal experiences share important commonalities, neoliberalism is not a mode of production. Consequently, these experiences do not necessarily include a clearly defined set of invariant features, as may be expected in studies of 'feudalism' or 'capitalism', for example. Neoliberalism straddles a wide range of social, political and economic phenomena at different levels of complexity. Some of these are highly abstract, for example the growing power of finance or the debasement of democracy, while others are relatively concrete, such as privatization or the relationship between foreign states and local non-governmental organizations (NGOs). (Saad Filho&Johnston, 2005, pp.1-5) Here, in order to emphasize the stance of this thesis, it is important to note that the term neoliberalism is used to refer to the concrete implementations like privatization, deregulation, liberalization and implementation of the market reforms by the state.

at the international levels[3] of operation was explicitly evident in order to get rid of what is called the "heavy bureaucracies" of the states to enhance profitability and competition. The "New Order" in that sense, in contrast to the Keynesian Era, represented a different approach in order to maintain the well functioning of the market economy by taking up a different approach other than the one exercised during the Keynesian period. In the light of such developments, witnessing a crisis in the late 1970s, the big industrial capitalist countries felt the need to restructure their economies and public sector as a whole at the international level as well as at the national levels of operation.

The new approach represented by a market oriented system-the so called Neo-liberal order- aimed at altering the ways through which the institutional arrangements in the public sector are organized and performed. Within that context, Neo-liberalism not only brought about institutional reforms that would enable the transformation of the public sector itself, but also brought about a system in which the term "public" itself redefined that it no longer represented the old bureaucratic ways of organizing the public sector and service provision by the state but a privatized, liberalized, and deregulated public sector in accordance with the private sector methods. Under the new system, the "hierarchical bureaucracy" put under severe criticism and blamed to be inefficient and unresponsive by its nature to the current changes in the world at large. Under Neo-liberalism, the ideas and practices advocated the primacy and superiority of the private sector-namely market reforms- and inefficiency and inability of the public sector and the state to maintain the effectiveness, efficiency and the competitiveness. The rules and regulations brought by Neo-liberal understanding emphasized that the state is no longer able to pursue objectives like full employment and equality together with controlling effective demand. Keynesian remedies like spending way out of recession, running an extensive welfare state which was

[3] Due to the pressures of globalization and financialization at the international level, states were challenged to adapt to their economies, political structures and social orders to a new set of rules and regulations associated with the changes.

sufficient in a closed national economy had lost their basis (Esping-Andersen, 1996, p.6). As the role and the way through which the states function was criticized and pinpointed as the only reasons for the system's failure, it was advocated that the state had to be minimized and the role assigned to the states in providing certain functions had to be exercised by the private sector.

Neo-Liberal policies, in order to deregulate the ways through which the states organize themselves and perform public services, redefined the nature of the practices exercised in the field of public administration. Privatization and contracting out of the services, what is called as the "public goods and services", in that sense served as the common exercises experienced since the beginning of the 1980s. Those two terms, in addition to defining the common ground in which the reforms took place in the field of public administration, also defined the very nature of the New Public Management[4] approach that have been associated with the Neo-liberal transformation. The New Public Management approach by putting emphasis on privatization, deregulation and liberalization of the public goods and services, for a fact, provided a solid ground for the reformers to accomplish a market oriented government idea by leveraging the change through the market. This new understanding has served as the new conceptual framework for the public administration systems of the welfare states nearly for three decades now.

Focusing on managerialism and the new institutional economics[5], the New Public Management approach has introduced management methods like performance evaluation, managing by results, contracting out and *quasi-market* ways of service delivery within public sector. Thus, it redefined the focus in public administration towards a new management paradigm by introducing a result-oriented public

[4] To be more specific, the New Public Management approach can be understood as running government like a business. (Hood, 1990 & Osborne and Gaebler 1992). In that sense, the New Public Management understanding is nothing but a mere transformation of the state towards a market oriented structure.

[5] For a more detailed expalanation for the term see: C. Hood (1991) 'A public management for all seasons?', *Public Administration* pp 3-19.

management system. In this new structure, the first target was the public services, they way through which they are organized and performed. The new institutional arrangements, in that sense, made a room for market reforms to take place smoothly and private sector to have a bigger role in service delivery than the public sector does. This development was the mere reflection of the states' restructuring process. The size of governments attempted to be reduced by privatizations and quasi-market reforms. In that sense, the New Public Management approach, by focusing on the implementation process, redefined the extent and form of public intervention and introduced the application of private sector methods in order to deliver public services. By putting emphasis on the efficiency notion within service delivery, it provided with a basic ground for the reforms of the current economic understanding to take place that focused more on "steering" and less "rowing".

Within this restructuring and transformation process that have been exercised since the beginning of the early 1980s, the impact of the international bodies like European Union, World Bank and International Monetary Fund is undeniable. The privatization policies have been transferred through structural adjustment policies and World Bank loans to the developing countries. Especially after mid 1990s, as the relations with European Union started to be accelerated, its impact on the Turkish public administration structure became more evident in most areas. In that sense along with European Union, other international organizations like World Bank, World Trade Organization and International Monetary Fund have played primary leading roles in enabling the adaptation of privatization and deregulation policies in Turkish public sector after 1980s. Being acknowledged with Maastricht Treaty and strengthened with Amsterdam Treaties respectively, the main aim of the European Union has been to create a common free market economy within which competition and profit making are secured through adopted policies. However, as the most European states hold different welfare state structures, adapting a single way of service provision became difficult to carry out. While on the one hand, one group in which France played a leading role held an approach that focused more on expansion of public

services, on the other hand, a group of countries headed by England were prone to hold a more Thatcheright approach by focusing more on the free market model in which profit-making through competition had been the primary concern. Therefore, although; while on the one hand we could argue that European Union does not hold a single approach when it comes down to public service provision process-that is each and every country has their own models- on the other hand we could say that, in practice, especially with regard to newly engaged developing countries including Turkey, it imposes obligations, new standards and procedures to be followed and abided by in order for those countries to organize their public administration systems in accordance with the dominating Neo-Liberal policies.

In that sense, the imported values and common practices from industrialized capitalist countries played a stimulating role in terms of defining a common basis for the structural administrative reforms that Turkey, along with Eastern European countries, has been undergoing. Those reforms in that sense were carried out without considering the social, political and economic structures of the societies, thus had destructive results. Especially with the introduction of 2004 Public Administration Reform in Turkey, public sectors are strongly affected, one of which was the health sector. Especially with the introduction of Public Health Reform, there have been a number of chances within service provision in health sector. The new approach by focusing on New Public Management logic, advocated that the service provision process should involve private sector and be regulated according to cost-benefit analysis. The managerial principles along with the values associated started to be implemented within health sector. It again based on the assumption that public sector lacks the essential resources to invest and works inefficiently. However, this kind of vision reflected a false premise because; there is no empirical reality which proves that private sector is working more efficiently and effectively than the public sector. Moreover, the proponents of privatization overlooked to the right to health which is presumed as a human right and everyone has the right to access to health services as equally as possible.

Within the process of transformation, the way that public services are provided and the way the distribution relations are regulated have been subjected to alteration. Some newly adopted policies within health sector have proven to be working to the disadvantage of the health personnel and public in general. New policy formulations that are being introduced within health sector focused on the re-organization of structures of the Ministry of Health and public hospitals. In these policy formulations, the managerial principles of NPM are initiated. Especially in Turkey, with the introduction of the Health Reform, a number of policies like General Health Insurance System, Family Medicine System and contributive payment system by citizens started to be implemented. Within that process, those policies can be characterized by their managerial principles vested in their structures. Disregarding the social character of the public administration system, the way public services including health services are provided and the way public hospitals are organized started to be shaped around an efficiency understanding that is disjoint from the society itself. The structures of the private sector organizations pinpointed as the efficiently working role models that will set as the successful examples for the public sector re-organization.

In the light of the brief theoretical framework drawn, in this thesis, my main aim is to reveal the political and administrative implications of the health reform in Turkey by examining different dimensions of it. In that sense, I will argue that the New Public Management that take their roots from Neo-Liberal understanding form the basis of the health reforms that have been realized in the past three decades. In order to examine the subject, this thesis will focus on critical evaluation of Neo-liberalism and NPM understanding, the history of the administrative reform attempts in Turkey as well as in the world at large and the reorganization of public administration in the aftermath of 1980, the history of the health reforms in Turkey and the impact of yet continuing health reforms which aimed at changing the administrative structure of the health sector in Turkey. The argument will be presented in a consecutive way throughout three bodies, an introduction and conclusion chapters.

After an introductory first chapter, in the second chapter, the historical context within which Neo-liberalism incarnated itself will be touched upon as the theoretical basis of the transformation process in the 1980s. Then I will move to the evaluation of the post 80 public management theories in order to make sense of the administrative turn over. Examining the issue by taking into account of the political, economic and social dimensions will provide us with a vision about why and how this phenomenon is related to the current health care reforms that the world as well as Turkey has been undergoing for quite some time. In the light of such developments, I will try to examine the health sector restructuring in Turkey aiming at detecting the implications of health reforms in terms of the parties involved that has been in effect since the early 1980 onwards. While doing that, first of all, I will focus on the changing understanding with regard to public administration system and public services that is brought by the rise of Neo-Liberal reforms in order to make sense of the reforms that have been undergoing for quite a while. I will argue that the public administration reforms are closely related with the Neo-Liberal logic that focuses on reducing the scope and functions of the public sector in providing services including health. I will underline the fact that the new logic has been practiced by New Public Management approach within public sector and particularly in health sector. In that sense, I will start by analyzing the underlying philosophies of Neo-Liberalism and as a reflection of it within public sectors, the NPM respectively. I will put the inner structures of the NPM approach and will focus on how it perceives the public sector and public sector organizations and show how it proposed to reform them. I will argue that Neo-Liberalism forms the backbone of NPM approach which reveals itself in the proposed policies within health sector. After examining the approach in a detailed manner, I am going to focus on the relations between health policies, NPM. I will try to tie them to one another and establish close links between them in terms of health sector restructuring.

In the third chapter, my main will focus will be on the European exercise. After a brief examination of the European health policy and the methods that are used to coordinate the health policies of the member and candidate countries including

Turkey with respect to the treaties implemented after 1990, I will move into the Central and Eastern European case and try to reveal its problematic reform process hoping to show how above-imposed reforms created different outcomes. In this chapter, I will argue that although Europe does not have a clear-cut, common health policy that will clearly re-define the health structures of the member and candidate countries; it in fact guides states towards adaptation of policies that are commonly associated with the NPM exercise which, according to its logic, will ensure the well functioning of a free market economy as a whole.

In the fourth chapter, in the light of framework drawn the characteristics of Turkish health system will be evaluated starting from 1980 onwards. After explaining the distinctive changes in the health sector, the provision of the health service will be exemplified. The imposed reforms and new policy formulations known as Neo-Liberal policies within health sector will be assessed. The interrelation between the international trends, the role and impact of the international organizations, the effects of the domestic economic contexts and the changing laws related to health services will be examined. I will also try to address to the fact that some changes in Turkish health sector took place due to the credit agreements that were made with IMF and WB which promised a certain release of the loans in exchange for implementing some fundamental changes within health sector.

Particularly, the attention will be given to the 2003 Health Care Reform package in order to make sense of the reforms undertaken. In this chapter, I will argue whether or not the NPM exercise within health sector provided a well functioning, namely efficient and effective health system in terms of all the parties involved. By examining the policies within health sector, I will try to reveal their implications in terms of service providers, the health personnel involved and service takers namely citizens. While doing that, the problems associated with the implementation of the reform will be addressed to. Finally, the thesis will end with a conclusion chapter including the summary of the arguments made in the previous chapters.

Among a number of theses written on the health sector in Turkey, this thesis aims to distinguish itself with its emphasis on the political, economical, as well as ideological dimensions of the administrative change. In this way, the thesis is going to support the very claim that politics and administration should be analyzed together, not distinct from one another. It also will refute the argument that the NPM practices are used within health sector in order to increase the "efficiency" both in service delivery and organization. Rather, the thesis is going to reveal how inefficient and dysfunctional results these policies created within health sector. Besides, it also aims to disprove the common understanding that perceives the public administration as simply a technical field of operation by revealing its "social" character.

CHAPTER 2

THE NEO-LIBERAL RESTRUCTURING PROCESS: TRANSFORMATION OF PUBLIC SECTOR

In this chapter, in order to make sense of the public sector reform and health reforms respectively and to understand the role of the NPM approach within health sector, the underlying logic of the policy proposals that were introduced three decades ago within public domain will be examined within an historical context. Neo-Liberalism, from its emergence, will be analyzed as the theoretical backbone of NPM approach. Then the focus will shift towards NPM and approach. After revealing the inner structures and their relation to health sector, the changing nature of the public service provision will be analyzed as a whole.

2.1. Neo-Liberalism as the New Logic of Policy Formulation of the Post 1980s

"For the last 25 years, economic policy and public's thinking have been dominated by a conservative economic philosophy known as Neo-liberalism"[6] (Palley, 2004:20). After the Second World War until the early 1970s, Keynesianism constituted the dominant paradigm for understanding the determination of economic activity as well as politics. This was the era within which the tools of monetary policy-control of interest rates-and fiscal policy-control of government spending and taxes-were developed. However, Keynesianism was destroyed by the crisis that followed the first oil shock of 1973-74. The persistent combination of high unemployment and high inflation proved impervious to the "scientific" economic interventions of the major capitalist states (Aksoy, 2003:545-547).

[6] 'Neo-liberalism is in the first instance a theory of political economic practices which proposes that human well-being can best be advanced by the maximization of enterpreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. See: Harvey, 2006: 145-158.

Increases in public expenditures led to persistent government deficits and seemed to worsen the global budget crisis. The price system associated with profitability at the time, collapsed with the breakdown of the Bretton Woods arrangements. "The institutions that sustained the post-war boom faced intolerable pressure, none more so than the Bretton Woods Agreement, which was put in abeyance in 1971 and finally collapsed in 1973" (Lapavistas, 2004:34). Starting from the mid 1970s, the Keynesian force was no longer able to meet the increasing economic and social crisis and started to be replaced by a revived Neo-Liberalism. Neo-liberalism marked an important era of defeat for the post war mode, re-creating the rules of economic regulation and its class compromise between state, capital and labor. In that sense, it enormously triggered further development and consolidation of Neo-liberalism (Jessop, 2003:4).

The emergence of Neo-liberalism, thus, can be tied to the bad economic conditions of the second half of the 1970s. The economic crises followed by societal crises spread out to many industrialized nations in a short while. These conditions triggered conflicted debates over the role of the state with regard to the economic activity. Conservative social movements began to attack the state-market relations that had been shaped during the immediate postwar period, within which governments were assigned substantial control over how the domestic economic activity would be organized and maintained a variety of barriers to insulate national economies from foreign trade and capital flight (Cohen& Centeno, 2006:34). The welfare state structure, the expanded public services, so-called heavy bureaucracies and the Fordist mode of production, which is based on mass production, were perceived as the reasons responsible for the for the crisis. In fact, the role of state in socio-economic activities has been put under severe criticism by the proponents' of Neo-liberalism. The rising public expenditures and state intervention to the market has been considered as the main reasons for destruction of profitability, productivity and free choices of individuals. Although, the world was far from returning to the early form of liberalism which was the typical 19th century capitalism, the market re-emerged as the central actor governing the economic activity and the underlying philosophy of

Neo-Liberalism progressively injected itself into state structure and public institutions throughout the world. Favoring the abolishment of the instruments of state intervention in the economy, Neo-liberalism established its hegemony by dominating the economics, national governments and supranational organizations such as International Monetary Fund and the World Bank (Cohen& Centeno, 2006:34).

In terms of economic policy understanding, the main attack of Neo-Liberalism was towards state interventionism in creating jobs and serving public utilities. Under the new logic, as opposed to the Keynesian era, unemployment and inflation were the essential prices to be paid in the re-stabilization of capitalist welfare economies. The expected results of this new logic became evident with the attacks on labor unions under Thatcher government in Britain at the time. Enhancing flexibility in labor market, creating mass unemployment and promoting the expansion of casual labor become the signatures of the healthy capitalist economies (Lapavistas, 2004: 34). Welfare provision also came under increasing criticism and the state began to retreat from ownership of production, by privatizing public utilities. The policies that were introduced in the Neo-Liberal era considered as the only medicine to what is called-the ill conditions of the late 60s and early 70s. These policies have claimed the superiority of the private sector and the market methods vis-à-vis the public sector aiming at narrowing the public sector by reducing public expenditures and direct public services provision by the state.

As a result of these policies, liberalization of finance and trade, deregulation, privatization and marketization of public services and minimal state has become the new phenomena that challenged the roles and functions of former capitalist welfare state. In this process, the provision of welfare for citizens started to be formulated in accordance with the rules of the free market. Private sector methods and values started to be implemented into the public organizations. This was due to the general assumption that private sector is indeed “superior” to the public sector in terms of maintaining efficiency, effectiveness and productivity. Among the policies that were

implemented during the Neo-Liberal era, the opening up state owned enterprises to the private sector initiatives, reducing constraints upon private sector, reducing public expenditures, reducing trade barriers, increasing private sector participation in the provision of public services, loosening controls on capital, tax reductions and decreasing the number of civil servants were the most prominent ones. Moreover, in order to provide "efficient and effective" public service delivery, new institutional reforms that were compatible with the market mechanisms were introduced. Together with the "Structural Adjustment Programs" of the IMF and the World Bank, various market-oriented policies have been imposed including privatization, deregulation…etc.(Güler,2005: 141-171). This shift in "policy paradigms" implied a substantial reorganization of domestic political economies as well as the international order. "Market-oriented reforms involved trade-offs in which some of the some of the societal ideals that were pursued and to some degree achieved, during the postwar era (like social security, consumer and worker protections, improving wealth and income equality) may ultimately be lost" (Cohen & Centeno, 2006: 33).

While opposing the crisis period that capitalist welfare states faced within the late 1960s and 1970s and pinpointing the states as the sole reasons for failure, Neo-Liberalism was also constructing its theoretical and ideological basis by nurturing from the revised conservatism that is to say New-Right ideology in the early 1980s. Like the advocates of Neo-Liberalism, new right ideologues also accepted the free market as a more efficient and productive method for the allocation of resources in society, for the protection and promotion of greater freedom and allowing choice when compared to state (Johnson, 1997: 29-34). Moreover, with its focus on conservatism and conservatist values, individualism, liberalism, middle class and social solidarity[7], new right served as the buffer zone between the old ways of

[7] Here, it is important to emphasize that it was in no sense of the term used refer to a socialist welfare state pracitce within which the social and collectivist understanding of society could be at reach but it refers to a situation that when the deficiencies of the system comes to the surface, a conservatist solidarity understanding is seen as the only way that could prevent the middle class, that is presumed

capitalist welfare state structure and Neo-Liberal transformation. By constructing its societal basis, new right ideology has tried to secure and maintain the Neo-Liberal system as it is on moral grounds. Although the terms are most of the time used interchangeably, we cannot simply assert that the changes are simply the result of new right ideology, in fact some of the left governments at the time like Australia and New Zealand also adapted market-oriented policy changes inspired by Neo-Liberalism (Walsh, 1995).[8] Therefore, we can say that the roots of the multidimensional changes that capitalist system has undergone in the last three decades are to be found in the New Right ideology and Neo-liberal policies. In that sense, in order to fulfill the preferred accumulation regime, states tried to construct appropriate ideological and political grounds.[9] Having considered the developments that have occurred since 1980s, we can conclude that the state was successful in doing so. A number of total transformations have been felt in every aspects of life as a whole.

Within this transformation process, the public administration systems of the countries are used as an agent to change the social structure of the societies. Especially with regard to the periphery capitalist countries including Turkey, a top-down and pre-determined rules and regulations were imported from western societies as if they are ideal scientific facts valid through time and space and started to be injected as the ideal methodological premises into the public reform process (Akbulut, 2006: 167-171).[10]

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to have the potential to initiate the change within society and to be the most affected segment of society by the failures of the new system brought-namely Neo-liberalism, from rebelling against it.i

[8] However it is important to note that 'State after state, from the new states that emerged from the collapse of the Soviet Union to old-style social democraces and welfare states such az New Zealend and Sweden, have embraced, sometimes voluntarily and in other instances in response to coercive pressures, some version of neo-liberal theory and adjusted at least some of their policies and practices accordingly.

[9] It clearly reflects the fact that states were the active players that would ensure the smooth running of the transformation process itself.

[10] The degree to apply these methods in the public sector is described by Akbulut with the term "ideametric".See: Akbulut, Ö. (2006), "Türkiye'de Kamu Yönetimi İncelemesini Tanımlayıcı Bir Kavram Önerisi: Ölçücülük-Ideametric", *Amme İdaresi Dergisi*, Vol.39, No.4, December 2006, pp.159-193.

2.2. Policy Paradigms in the Neo-Liberal Era

It was no surprise to us that the initial target of Neo-Liberalism was the transformation of public sector which was perceived as rigid, outdated, excessively centralized, hierarchical and indeed inefficient by its nature[11] in order to open up new areas for capital accumulation at the state levels of operation. The first attempt to re-shape the way public sector is organized and public services are performed was through the introduction of new mechanisms and methods that would improve the efficiency within public sector. Public Management followed by the New Public Management approach, had been utilized in order to reach the desired outcomes. In that sense, understanding the underlying philosophies of these two approaches will be beneficial in order to grasp the inner logic of structural and institutional changes that public sector, specifically health sector has been exposed to in the past three decades.

2.2.1. The Public Management Approach

The Public Management Approach was the primary theoretical reflection of change of attitude towards public sector introduced in the early 1980s. The Public Management approach appeared as a "new rivalry alternative theory"[12] to the then mainstream public administration that is now considered as the old public administration. It represented a clear break from the old ways of public administration systems of the capitalist welfare states within which the distance between politics and administration seemed to be reduced. The Public Management approach was first introduced by James Perry and Kenneth Kraemer in the book called 'Public Management: Public and Private Perspectives' appeared as the "third way". In this

[11] However, in order to define the stance of the argument it is important to underline that while critically evaluating the neo-liberal policy paradigms (public management, new public management, governance) one shoul not overlook tha fact that the old public administration system had its fair share of problems and deficiencies which based on Weberian 'dehumanized' bureaucracy.

[12] It was not 'new' to the extent that it focused on the politics and administration distinction like the old public administration systems. See: Woodrow Wilson (1887), 'The Study of Administration', *Political Science Quarterly,* Vol.II, No 1.

book, it was argued that the primary aim of the public management was to find and develop the ways through which public organizations assign tasks and implement, to concentrate on the executive branch as the basic instrument of analysis, to find and develop new methods and techniques in order to make public officials work more efficiently and to focus on comparative analysis between organizations in terms of methodology. By focusing on those principles, in fact, the theory aimed at replacing what is called the rigid, hierarchical, highly bureaucratized and centralized traditional public administration and public organizations with flexible, market friendly, cost-conscious, customer-oriented, de-bureaucratized system. Therefore, the above mentioned principles let us conclude that the management techniques were tried to be introduced within public organizations. In addition to that, the underlying philosophy of the change should be analyzed within a bigger picture that the change indeed brought was not a simple change within the public administration systems; therefore, should be analyzed with reference to Neo-Liberal transformation. As contrary to the views that tend to separate administration from politics, this parallel transformation, I think, should have proven the close relation and connection between them. Despite the various ideas about whether the public management approach provided a new paradigm or not, it is clear that it brought significant changes into the realm of public sector as a whole.

The public management approach due to its reductionist approach started to be criticized in the late 1980s. The first line of criticism lied in the fact that the public management approach focused only on the public organizations. Because public sector cannot simply be reduced to public organizations alone, this was considered a deficiency within the theory. Another line of criticism was that linked to its focus on the executive branch. It was stated that, the public sector cannot be limited with the executive branch only. Therefore, it was not possible to draw clear lines between law, political science and public administration and to isolate the public administrators from the society and administrative position (Üstüner, 2000: 17). Thus, Public

Management approach this approach was not successful in providing a promising solution to the actual problems of public administration.[13]

To sum up, the public management approach that emerged with the claim of representing a new paradigm in order to overcome deficiencies of traditional public administration was not able to provide necessary solutions to the problems of public administration, the so-called traditional public administration. This is because its focus was on the instruments rather than the main problem. Therefore, the reductionist and limited approach created its own legitimacy problem, thus there emerged the need to redefine the approach; this process resulted in the introduction of the New Public Management Approach.

2.2.2. New Wine in the Old Bottle: The New Public Management Approach

Following in the footsteps of previously introduced Public Management Approach, the New Public Management Approach[14] emerged in the early 1990s in order to go beyond the reductionist and limited nature of the public management approach. The first use of the term could be seen in OECD reports at the time and in the workings of Christopher Hood (Hood, 1991). Hood was the first scholar that has used the term "New public management". He announced the birth of "New Public Management" and underlined the importance of a revolutionary process that marked the transition

[13] 'Linked with this ideological analysis in a theoretical onslaught on traditional public administration, led principally by economists and management scientists, aided and abetted by practitioners of personnel management (now termed human resource management) and by those who argue more generally that the arts of private sector management should be transposed to the public sector in the name of increasing efficiency (Gray&Jenkins, 1995: 41). If none of this new, it is now an integrated and sustained attack on what is perceived as the 'failure' of traditional government and public administration (Rhodes, 1995:21). Moreover, this intellectual baggage (or selected elements of it) has been harnessed by many political actors as a means to promulgate and fashion their ideological vision of the state (Pollitt, 1993: 32).

[14] Although, like public management, the new public management approach represented as a new paradigm, it is argued that new public management's underliying hilosophy is in line with Max Weber. As Weber clearly stated 'Bureaucracy functions more perfectly, the more it is ''dehumanized'', the more it succeeds in eliminating from official business love, hatred and all purely personal, irrational and emotional elements which escape calculation' (Weber,2004: 249).

from traditional public administration to a new managerial paradigm (Hood, 1991:3). According to Hood, new public management offers a key to better provision of public services. The traditional models of service delivery, and the organizational, administrative and personnel systems of traditional bureaucracy were criticized as being inefficient, ineffective and non-responsive to the new global economic and technological changes. There have been attempts to create decentralized management environments within which the nature of the highly centralized hierarchical organizations could be challenged and could be converted into something more flexible and efficient.

Moreover, the New Public Management approach criticized the active role played by the state in managing the economy and in the direct provision of services and proposed managerial reforms and values as a solution to the economic and fiscal crises of states.[15] Thus, the trust to traditional bureaucracy and politicians had diminished. The legal rational understanding has been replaced by managerial-economic understanding. Within this process, the administrative law that had been the focus in the field has lost its former appeal when compared to the commercial law which based on contractual relations rather than status relations (Güler, 2005: 32). There had been attempts to reduce the public spending and to privatize public enterprises that are owned by the state itself. Furthermore, the notion of flexibility, in this period, was widely applied. The flexible provision of public services was emphasized instead of previous highly bureaucratic, centralized and rule based methods. New methods based on privatization and contracting-out systems were introduced. Especially, with the impact of Post-Fordist mode of production, the classical structures of public organizations have changed. In addition to that, the performance-related systems were introduced within the public sector itself. Public managers started to be evaluated on the basis of prescribed performance-

[15] However, the active roles played by the states in the maintenance of the system was crucially important. See: Gray, J. (1989), 'Limited Government', David McKevitt,& Alan Lawton (1994) (Ed.), *Public Sector Management: Theory, Critique and Practice,* Sage Publications, London, pp.25-36.

measurement. The success, accountability and transparency of public agencies and personnel systems started to be evaluated according to performance evaluation system. The employment process also changed. The employment procedure of the public personnel is based on a contract. Such a control mechanism of public management systems is accepted as the measure of accountability to citizens. Furthermore, competition, which is presumed to be the fundamental element of a better functioning of market and public sector, the creation of competitive environments within the public sector and among the public sector organizations has been supported. In that competitive environment in which it was believed that efficiency and effectiveness could be maintained, the citizens are no longer seen as merely citizens but as customers, thus should have been governed according to the customer oriented methods. In that sense the notion of "citizen" was replaced by 'customer' with demands and expectations from the market. Therefore the manifestation of de-bureaucratized, deregulated, privatized, contracted-out public services became essential components of this new understanding.

In addition to policy changes, the public managers are also encouraged to be given more autonomy and freedom within the decision making process. The rationale behind the idea was to ensure the ability to hire and fire public personnel as it is in the case of private sector. According to this line of thinking, if managers do have freedom in choosing proper policies for better provision of services, and evaluate the performance of public personnel according to a pre-defined set of performance measurements and then they will be free to hire or fire public employees like the managers within private sector. Due to the emphasis on the principles of the new public management; efficiency, effectiveness and economy became the main goals of public administration rather than being simply the tools of the administrative process (Aksoy, 2003: 558). According to this "3Es" principle, the private sector has been considered as the most efficient, effective and economical instrument for the public service provision. As a result of application of such techniques and rules of the private sector to the public, the so-called problems of inefficiency and unproductive

nature of the public sector tried to be eliminated by the introduction of new values and methods. Hence, public organizations started to act like private sector organizations by simply focusing on results or outputs rather than inputs. Performance evaluation has gained crucial role in order to evaluate the successful performance of the public organizations and public personnel. Within this process, public organizations are concentrated on achievement of their goals instead of rules and regulations, in turn; rules and regulations have become flexible enough to meet the demands of the customers'. As Rhodes rightly argued;

> *".....NPM focuses on results. In an organizational network, no one actor is responsible for an outcome; there may be no agreement on either the desired outcome or how to measure it; and the centre has no means of enforcing its preferences. There is the problem of 'many hands' where so many people contribute that no one contribution can be identified; and if no one person can be held accountable after the event, then no one needs to behave responsibly beforehand".*[16]

2.2.3. The Nature of the New Public Management

Described as the "one size fitting all", the New Public Management has become shorthand term for a set of broadly similar administrative doctrines that dominated the public administration reform agenda of the most developing countries from the late 1970s (Hood, 1991). NPM is seen as a body of managerial thought (Ferlie et al., 1996: 9), or as an ideological system based on ideas generated in the private sector and imported into public sector (Hood, 1991; Pollitt, 1993). Althoug not a homogenous whole, the New Public Management, is influenced by various theories such as Public Choice, Managerialism and Reinventing Government theories

[16] Rhodes, R. A. W. (1995), 'The New Governance: Governing without Gowernment', Political Studies, 1996, XLIV, p.663. Also for further discussion See: M.A.P. Bovens, (1990),'The social steering of complex organizations' British Journal of Political Science, 20 , p.115

(Üstüner, 2000: 20-21). Although these theories may be differentiated from one another to a certain extent, they share common grounds in constituting the theoretical grounds of the New Public Management approach. As it is in the case of public choice theory, individualism in the NPM understanding is persistent. The theory like public choice makes no distinction between the actors in the public sector and in the private sector. For instance, Tullock[17] prefers to analyze government as an apparatus, just like the market, in which actors try to achieve their private ends. This line of thinking is not in contrary to the New Public Management understanding because as it encouraged the private sector actors to have a bigger role in the public sector service provision or policy-making processes, derived from its liberal roots, those actors in the public sector may act to reach to their own ends. Just like the NPM approach, the public choice theory favors a competitive environment of a free market economy and rejects any state intervention which is also accepted as a general integrated part of Neo-Liberal economics. Besides, the customer-oriented logic of public choice theory was inherent in the NPM approach. In addition to that, another line of parallel criticisms lied in the fact that both theories attacked on heavy public sector and both focused on budget cuts, privatization, separation of bodies that produce and provide public services, introducing contracting out mechanism in the public service delivery, introduction of user charges to public services, competition, decentralization, legal spending constraints and excessive regulation.

New Public Management theory besides public choice theory also affected by the principles of managerialism[18] and reinventing government[19] approaches. Therefore, we can assert that NPM derives some of basic principles from them. With their focus on private sector experience and management techniques and values, they reflected a consistent line of thinking with one another. In accordance with managerial

[17] One of the founders of Public Choice Theory. See: Tullock, 1976, The Vote Motive, London: Institute of Economic Affairs Pres.
[18] See: Murray, M. (1983). 'Comparing Public and Private Management: Public and Private Perspectives, pp.60-71.
[19] See: Osborne, D.& Gaebler, T. (1992) 'Reinventing Government: How the Enterpreneurial Spirit is Transforming the Public Sector. Massachussettes: Addision-Wesley.

principles, NPM proposed the performance evaluation of public personnel according to the pre-determined performance based criteria. Building up its organizational dimension with those two theories, NPM constructed its organizational dimensions. Finally we can state that, all three theories criticized the old type of public administration that based on highly-centralized and bureaucratized and tried to replace it with more flexible type of organizations. Moreover, they preferred to view individuals as customers rather than merely citizens so government are expected to adopt itself to the changing conditions of market and consumer demands by acquiring those managerial techniques along with the values associated. In that respect, "reinventing government approach is not reinvention of anything".[20]

Reinvention[21], in that sense, meant "to reduce government to its "inescapable core" (Painter, 1997: 52). Therefore, it can be concluded that the reinventing government

[20] Üstüner, Y. (2000), 'Kamu Yönetimi Kuramı ve Kamu İşletmeciliği Okulu', Amme İdaresi Dergisi, Vol 33/3, p.24

[21] In that sense, the government should not be abolished by all means but must be market-oriented, managed by the sprit of entrepreneurship[21], in other words, should be re-invented on the basis of ten principles. These ten principles may be summarized as follows[21]:

1. **Catalytic Management:** Governments, to the extent possible should transfer their powers to the private sector. It is no surprise to us that this principle is in accordance with a basic principle of the public management theories that is 'steering rather than rowing'.
2. **Community-Owned Management:** Instead of directly providing services to the citizens, the community should be authorized to produce their own services as acting like public entrepreneurs themselves. With regard to this principle, the related terminology within the Public Management School is the 'enabling government'.
3. **Competitive Management:** In this principle, the competition should be both within the process of service provision and within the public sector within itself. This basic assumption is compatible with the liberal understanding: competition both provides the social dynamism and increases quality.
4. **Purpose-Oriented Management:** The government should leave aside the pre-defined rules and regulations and should focus on their goals so that the productivity, flexibility and innovation could be improved.
5. **Ends-Oriented Management:** In this principle, the focus is on and end-oriented or output-oriented management that could be maintained through the advancement of performance evaluation and measurement systems which stand for one of the key principles of New Public Management Approach.
6. **Customer-Oriented Management:** Due to the association of public organizations with that of private sector organizations, there is a general tendency to view the citizens who benefit from public services as the customers of those organizations. In that sense, it gains importance to view the citizens as customers and to improve the services on the basis of customer demands.
7. **Entrepreneurial Management:** Rather than simply spending money for services, the aim should focus on profit making. Just like a manager of a private sector company, the public sector organizations should aim at making profit within the process of service provision not only aim at balancing the budget.

approach is closely linked to the new public management approach with their look-alike characteristics. Not considering the social ills that NPM creates stemming from the overlook to the social, political and economic structures of the societies itself, "the one size fitting all" reform agenda has indeed strengthened by the inclusive principles of reinventing government approach.

2.2.4. The Impact of New Public Management on the Way Health Services are Performed in Turkey

In the light of such developments, the transformation process that was put into practice at the time of the Motherland Party in the late 1980s, started to become evident within health sector both at the organizational levels of hospitals and the service provision system. In terms of these newly proposed objectives, the health sector represented no exception. As mentioned in detail above, the general trend within health sector favored an autonomous structure from the state apparatus that would provide health services. In other words, the aim was to grant greater autonomy to the public organizations, in this case hospitals, in the service delivery. The general trend was to separate the financier and provider of the health services. With regard to the financing of the system, the introduction of contractual employment status and

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8. **Far-Sighted Management:** Within the government organizations, rather than simply curing mechanisms, there should be preventive measures. According to this principle, a management system that is dynamic, open to new changes and far-sighted should be maintained.
9. **Decentralized Management:** Instead of hierarchical structure, the participatory group work-oriented methods should be promoted within which the decision making processes would move away from hierarchic center so that the authority could be delegated.
10. **Market-Oriented Management:** According to this principle, public organizations and public sector mechanisms should operate according to the market-oriented principles. The old models of hierarchical bureaucracies should be replaced by flexible type of organizations. In this model the relations should be determined by the market mechanisms.
11. **Catalytic Management:** Governments, to the extent possible should transfer their powers to the private sector. It is no surprise to us that this principle is in accordance with a basic principle of the public management theories that is 'steering rather than rowing'.
12. **Community-Owned Management:** Instead of directly providing services to the citizens, the community should be authorized to produce their own services as acting like public entrepreneurs themselves. With regard to this principle, the related terminology within the Public Management School is the 'enabling government'.

increasing user chargers namely premium payments, dominated the agenda. Together with 2002 Urgent Action Plan of JDP and 2003 Social Security and Health Reforms respectively, a number of new policy proposals were introduced within health sector in Turkey. Moreover, the adaptation of performance system together with full time law reflected the increasing competitive nature of the health service provision. The flexible working hours and wage system further stimulated the competition among health personnel. Just as proposed with the NPM approach, the legislative alterations were implemented in terms of establishing a competitive and flexible structure. In addition to that, it was also suggested that the public hospitals should be unified under the public hospital unions within which the status of the employment would be contractual and the structure would be autonomous from the state authority. Besides, with respect to budgets, the hospitals would be completely independent of the Ministry of Health. This development clearly can be considered as the pure reflection of the promoted ideas of the past three decades that focused on the decreasing the scope and authority of state within public sector. By freeing those organizations from state domain, not only they would maintain an autonomous structure that would carry out the self organization process but the so-called burden on the state would also be reduced. Moreover, with the introduction of the General Health Insurance system, the user charges for health services increased, thus the contribution of the state budget through taxes to the financing of the system was also reduced. With respect to sub-sectors in the health sector, there has already been contracting out practices which led to subcontracting tendencies with within health. It is then can be stated that the provision and financing of the health services clearly reflected the NPM logic that entranced itself into the health reform agenda in Turkey.

It can be argued that most of the NPM practices shaping health sector today, as discussed previously are coming from private sector managerial practices, such as emphasis on service quality, focusing on results, contractual employment status and performance measurement as the best mechanism for control (Cejudo, 2008: 114). The adaptation of new mechanisms within health sector not only represented the

change of attitude towards health service provision but also indicated a new practice that took its roots from what is believed to be "superior" and "more efficient" private sector. Together with the introduction of the new reforms in health sector, the increasing role of the private sector as a partner to the public sector is emphasized. Characterized with a process within which privatization, contracting-out and alike tendencies have been practiced, health sector restructuring especially at the organizational levels introduced the self-governing hospitals. Moreover, it has been emphasized in the health reform that, the ministry of health will be assigned a new role that will focus more on regulating the health sector rather than the provision of health services. Ministry of Health in that sense will be a regulatory body that would coordinate how the reform process would take place and be implemented. It will ensure the proper implementation of the new reforms within health sector by means of steering mechanisms. Besides, the discharged place by the Ministry of Health is expected to be filled with more private sector activity. In fact, the opening up new private hospitals is encouraged. It is believed that the process would help the self-financing of the health system and take some of the responsibility from the ministry in the health care financing.

However, the introduction of the private sector methods within health sector has its fair share of repercussions. Due to the distinctive and sensitive characteristics of the health system such as commitment to enhancing public interests, protecting disadvantaged, promoting justice and equality in service delivery, improving and maintaining human life…etc, the application of private sector methods within health may raise certain concerns since it is very likely that private sector logic could overlook these characteristics as it focused more on results and profitability rather than the process. As a human and social right, health is a sensitive area where the human life is at stake, therefore the policies has to be carefully considered and measured before any concrete step taken towards restructuring.

Up to this point, I have tried to discuss the inner structures of the reform processes. I pinpointed Neo-Liberalism as the backbone of the restructuring process within the

public sector as a whole including health. In that sense I analyzed PM and NPM approaches as the reflections of the new logic represented within public domain. I analyzed the inner structures and proposed policy changes by focusing on the PM and NPM structures. Then I shifted my focus on health sector reforms and attempted to draw a bridge between NPM approach and health sector reforms by proposing that the changes in the health sector reflects the very core structure of the NPM approach. In the fourth chapter, I will focus more on health sector by discussing health care as public health and public policy area and try to show how the economy is affecting the health care policies and vice versa.

2.3. Conclusion

In this chapter my main aim was to show the close connection between the Neo-Liberal policies and PM and NPM. I argued that the Neo-Liberal reforms that have been undertaken since the beginning of the 1980s in order to reform the public sectors of the states, has constituted the basis of the PM and NPM approaches. By arguing that two approaches have been utilized as the policy tools of the past three decades, I tried to emphasize the fact that they affected the way health policies have been shaped. I underlined that these two approaches with their focus on the elimination of the close relationship between the provision and financing of public services, supported the very claim that public sector works inefficiently in the provision of public services. These two approaches advocated a system within which the de-politicized notions of control mechanisms are prevalent.

The management of public sector is seen as a technical process. By assigning managerial principles and techniques the public sector has been reshaped. However, as stated earlier, this process neither characterized an apolitical nor indicated a technical process that could be thought independent of the public. The way public services are provided has so many implications in terms of the beneficiaries. For instance, the introduction of user contribution payments with regard to the health

financing, not only put a constraint on people's budgets but also did not stand for them as an "efficient way" to have access to health system which has been the catchword of the reform agenda of the post 80s and 90s in Turkey and throughout the world.

In the next chapter, I will focus more on the European context and evaluate Turkish health restructuring in terms of the accession process as a candidate country. By uncovering the structures of the health schemes within Europe and some of the methods that are used to coordinate the health sectors in the member as well as in the newly engaged countries, I aim to show EU's impact on the way health sector is re-organized in Turkey.

CHAPTER 3

EUROPEAN HEALTH POLICY, NEW PUBLIC MANAGEMENT AND THEIR REFLECTIONS ON THE MEMBER AND CANDIDATE COUNTRIES' HEALT SECTORS

Health policy, since the early industrialization period has been in a close encounter with nation states. Especially when nation states discovered the close relations between their populations' health and the productivity and the effectiveness of their economies and when it has been recognized as a human right of each and every individual, health policy became a specific state-building project in many countries (Rosen, 1969: 17-61). It has been and still is an indispensable part of domestic politics regarding public security and international social stability. The development of health care in the modern sense of the term and public health respectively, constituted the core elements of the welfare states, which developed as an essential part of the nation state (Therborn, 1995). Therefore, we can conclude that health policy has been a central concern of national politics since the emergence of the national welfare states. Similarly in European states, health policy along with other social policies has become an important area of concern for the last decade since the creation of a "Social Europe"[22] would require a sectoral integration of domestically integrated areas like health sector. In order to achieve this aim, a number of differentiated, although not uniformed or detailed, set of reforms were introduced in

[22] In order to make Europe a more legitimized political authority, in the Nice Treaty (2000), EU governments adopted a social affairs agenda laying out their future prospects. These included job creation, employee protection, gender equality, and combating poverty and discrimination, dealing with social exclusion and ageing societies and modernization of social security systems. However, it is argued that the new European Social Model which is pushed by the EU administration is not so much about a 'Social Europe', but about subsuming the social to the economic model of 'Global Europe (EC, 2006) which is fostered by the EC attempting (among others) to create (even artificial) markets in every area of social life. See: Mahnkopf, B., (2009), The Impact of Privatization and Liberalization of Public Services on the European Social Model.

the European context regarding the newly member and candidate countries' health sector restructuring.

Known as the Health Sector Reform, these set of policies referred to two levels of change regarding the health sectors of the newly member and candidate countries. One is concerned with the Europeanization and creation of a single market aspect that mainly focused on the free movement of health professionals, patients, health services, medical supplies (blood products and human tissues) and medical technology. The other aspect referred to the organization and financing of the health sector and health services. For instance, the changes regarding this aspect have been introduced with regard to the financing of the health services as governments seek to find alternatives to reduce the level of public spending shifting away from tax-based systems to individual-based financing systems including the introduction of user-charges, private insurance and compulsory health insurance (Collins&Green&Hunter, 1999: 69-70). Moreover, the separation between the provider of the health services and purchaser of the services, the development of contractual relations, the assignment of a more active role by private sector in health service provision, decentralization and the introduction of user charges in exchange for health services can be considered as the reflections of this aspect and they all fall under the heading of "New Public Management" (Hood, 1991: 3).

For the stance of this thesis, it is important to underline that this chapter will mainly focus on the changing nature of the health service provision and organizational structures upon which it is structured. Therefore, this chapter will mainly deal with discussing the general tendency towards a common health care policy at the European level with regard to the newly member and candidate countries including Turkey. In order to do this, first of all the common health care tendencies at the European level will be touched upon. The main aim is to identify the main characteristics of the health care reform that is expected of the newly member and candidate countries by taking into account of the main health schemes and tendencies in Europe. To examine

European health policy is important for two reasons. First of all, it will help determine the main patterns of the health sector restructuring in newly member and candidate countries' health sectors and second, it will determine the level of Europe's influence on shaping a policy area that is considered within the domestic jurisdiction of the states themselves. Turkey, being a candidate country, has been in a close economic and political transmission with the European Union and is no exception to such changes. It is expected to follow the proposed procedures within its health sector since the European Union laid out the reform agenda before both candidate and newly member countries.

In this chapter, the aim is to discuss the European health experience in terms of Turkey's accession process in order to show how the patterns of European approach to health affects the way Turkey handles its health policy. In order to do that, the development of European health systems will be briefly touched upon first. Then the legislative framework and the experiences of the new member states will be elaborated on in order to understand the changes at the implementation levels. Finally a general conclusion will be drawn.

3.1. Main Health Systems in Europe: Bismarck and Beveridge

The expansion of main patterns of health systems throughout Europe has much to do with socio-economic and political developments that European countries experienced in the past. In order to eliminate the disturbing effects- mainly poverty and epidemics-of industrialization process on public health, Britain in that sense was the first country in Europe to develop a National Health System that was free of charge and was considered for the whole population. After the economic turmoil in 1930s and two world wars respectively, countries felt the need to prevent the harsh effects of those events from threatening their populations' health; they started initiating their own health systems. Following Britain, the Scandinavian countries in 1950s developed their own national models and during the 1970s and 1980s Eastern

European countries followed this pattern of development. Although there are different health and social security systems in Europe, the main priorities were given to two models: Bismarck and Beveridge. Especially after the World War II, the Beveridge model came as a part of the welfare state development throughout Europe and was institutionalized.

Although the development of model dates back to an earlier period, it can be stated that the system in the modern sense of the term was first introduced in 1880s by Prussian Chancellor Otto von Bismarck in Germany. The aim of Bismarck was to prevent the unification of the working class under a raising socialist vision at the time and to unify a powerful German state. In that sense, he initiated the model as a means to integrate the labor unions to the system by introducing occupation-based sickness funds and put their activities under state control. The model was based on a specific health insurance model called "sickness funds" that was financed through joint contributions from the employers and employees through payroll deduction with a minimum subsidy from the state. In order to benefit from this sickness fund, also known as premium-based fund, one has to pay contribution payment.[23]

While the Bismarckian system is characterized with the premium based contributions by the working class, the Beveridge system focused on the whole population. The system was first introduced in the post war period by William Henry Beveridge in 1942. He presented an inclusive social policy agenda to the British parliament with a focus on the creation of a comprehensive social insurance system and a general health service system. Since the main target of the governments in the post world war II period was to initiate changes that would maintain full-employment so as to create a consuming working class in the aftermath of the economic recession, the Beveridge system was designed accordingly and provided family assistance and protection measures against mass employment. It included the entire population and targeted

[23] Bismarck versus Beveridge: A Comparison of Social Insurance Systems in Europe, CESifo DICE Report, 4/2008

universalism by being primarily financed from state budget via general taxes and called for uniform lump-sum contributions (Cremer&Pestieau, 2003: 181-196). The main aim was to guarantee at least minimum subsistence level to each and every citizen (Bonoli, 2000: 59).

Although the European countries do not entirely follow the same patterns of those two forms, it can be stated that some countries with some deviations from the pure form, followed either Beveridge or Bismarckian form. Among the countries that tend to follow Bismarckian model are Germany, France, Italy, Belgium, Netherlands and Spain and Beveridge model are UK Denmark Sweden and Norway (Bonoli, 2000: 10-12). In the case of Central and Eastern European countries, it can be argued that they tend to follow the Bismarckian lines that focus less on the state budget for financing. Since these countries try to move away from state-centered economies to a market-based economy based on the European Union expectance, a tax based health insurance model was not preferable. In other words, it was hard for them to make the health expenditures from the general budget while trying to cut down on social expenditures thus; they ended up adopting the Bismarckian system.

Table 3. 1. Sources of Funding for Social Protection, 1995-2005 (percentage of total receipts)[24]

	General Government Contributions			Social Contributions									Other Receipts**		
				Total			Employers			Protected Individuals*					
	1995	2000	2005	1995	2000	2005	1995	2000	2005	1995	2000	2005	1995	2000	2005
Austria	34.4	32.5	33.1	64.6	66.2	65.3	38.5	39.1	37.9	26.1	27.1	27.4	0.9	1.3	1.6
Belgium	26.1	25.3	24.7	71.1	72.2	73.4	49.0	49.9	51.4	22.1	22.3	22.0	2.9	2.5	1.9
Bulgaria	n.a	n.a	36.1	n.a	n.a	60.7	n.a	n.a	42.4	n.a	n.a	18.3	n.a	n.a	3.1
Cyprus	n.a	45.0	53.7	n.a	37.3	34.7	n.a	20.5	19.7	n.a	16.8	15.0	n.a	17.7	11.6
Czech R.	20.8	25.0	18.1	78.1	73.8	80.7	53.4	49.8	54.3	24.7	24.0	26.4	1.2	1.2	1.2
Estonia	n.a	20.6	20.4	n.a	79.0	79.4	n.a	79.2	79.0	n.a	n.a	0.4	n.a	0.2	0.1
Denmark	69.7	63.9	63.2	24.0	29.4	28.8	10.2	9.1	10.3	13.8	20.3	18.5	6.3	6.7	8.0
Finland	45.8	42.9	43.7	47.4	50.0	50.2	33.7	38.0	38.8	13.7	12.0	11.4	6.9	7.0	6.1
France	21.5	30.3	30.6	74.9	65.9	65.6	47.4	46.0	44.7	27.5	19.9	20.9	3.5	3.8	3.8
Germany	28.3	31.8	35.6	69.2	66.1	62.7	40.5	38.5	35.0	28.7	27.6	27.7	2.5	2.1	1.6
Greece	29.0	29.2	30.7	60.9	60.8	58.4	37.4	38.2	35.5	23.5	22.6	22.9	10.0	10.0	11.0
Hungary	n.a	31.6	34.8	n.a	59.8	57.9	n.a	47.0	42.0	n.a	12.8	15.9	n.a	8.7	7.3
Ireland	62.8	58.3	53.9	36.3	40.2	40.0	22.3	25.1	24.7	14.0	15.1	15.3	0.8	1.5	6.1
Italy	30.0	40.6	41.4	67.6	57.7	57.0	50.3	42.8	41.7	17.3	14.9	15.3	2.3	1.6	1.6
Latvia	n.a	33.5	35.3	n.a	66.5	64.0	n.a	50.2	47.1	n.a	16.3	16.9	n.a	0.0	0.7
Lithuania	n.a	38.5	39.6	n.a	59.6	59.8	n.a	53.7	53.8	n.a	5.9	6.0	n.a	1.5	0.5
Luxemburg	47.0	46.9	45.3	47.8	48.5	51.3	25.9	24.7	26.9	21.9	23.8	24.4	5.2.	4.6	3.4
Malta	32.3	30.5	34.5	64.2	66.8	62.7	45.5	45.3	43.5	18.7	21.5	19.2	3.4	2.6	2.8
Netherlands	17.1	14.4	19.9	63.8	67.5	67.8	21.0	29.4	33.4	42.8	38.1	34.4	19.2	18.1	12.3
Poland	n.a	32.5	39.2	n.a	55.3	50.3	n.a	30.5	28.0	n.a	24.8	22.3	n.a	12.2	10.4
Portugal	31.9	39.1	42.2***	53.6	53.0	47.4***	35.9	35.6	31.7***	17.7	17.4	15.7***	14.5	7.9	10.4***

[24] Source: Eurostat, Database of Living Conditions and Welfare, Social Protection Receipts, Receipts by Type, 2008.

Romania	n.a	n.a	11.7	n.a	n.a	73.2	n.a	n.a	49.7	n.a	n.a	23.5	n.a	n.a	15.0
Slovak Rep.	35.5	31.0	14.0	62.6	66.8	80.5	46.4	48.3	62.0	16.2	18.5	22.4	1.9	2.2.	1.5
Slovenia	n.a	31.5	31.7	n.a	66.3	67.4	n.a	27.0	27.4	n.a	39.3	40.0	n.a	2.2.	0.8
Spain	30.3	29.4	33.3	67.1	68.0	64.5	50.0	51.8	48.9	17.1	16.2	15.6	2.7	2.6	2.1
Sweden	49.8	45.8	48.0	42.3	49.9	49.8	37.0	40.5	41.0	5.3	9.4	8.8	7.9	4.3	2.3
UK	50.5	46.4	50.5	47.9	52.4	47.9	25.4	29.9	32.4	23.3	22.5	15.5	0.9	1.2	1.6
EU-27	n.a	n.a	37.6****	n.a	n.a	59.1****	n.a	n.a	38.3****	n.a	n.a	20.8****	n.a	n.a	3.4****
EU-25	n.a	35.4	37.7	n.a	60.9	59.0	n.a	38.7	38.2	n.a	22.2	20.8	n.a	3.6	3.3
EU-15	32.1	35.6	37.9	63.9	60.9	58.9	39.2	38.7	38.2	24.7	22.2	20.7	4.0	3.5	3.2
Norway	62.2	60.5	55.8	37.0	38.4	44.1	22.6	24.4	29.5	14.4	14.0	14.6	0.9	1.1	0.1
Switzerland	19.2	21.0	22.0	62.0	60.4	59.7	31.8	29.3	27.6	30.2	31.1	32.1	18.8	18.6	18.0

* Employers, self-employed, pensioners and others
** Resources of various kinds such as interests and dividends
*** 2004
**** Estimated Value

It can be asserted from the table that in the twenty seven EU countries in 2005, the most crucial source for social protection expenditures was social insurance contributions paid by workers, employers, pensioners and others almost amounted to 59.1 % while the government allocations from tax revenues amounted to 37.6 % and interests and dividends amounted to 3.4 % of the total receipts. In the mid-European countries like Czech and Slovak Republics, Australia, Belgium, Estonia, France and Slovenia where the Bismarckian system is expected to be followed, the proportion of the social insurance contributive payments exceeds 65 % of the total receipts. In contrasts, in countries where the Beveridge system has been at use like Cyprus, Denmark, Ireland, United Kingdom and Norway, the total share of the taxes exceeds 50 % of the total receipts.[25]

[25] Source: Eurostat, Database of Living Conditions and Welfare, Social Protection Receipts, Receipts by Type, 2008.

While the numbers indicate a clear division between the respective countries, together with the changing economic, social and demographical climate in Europe, the clear-cut differences that stem from the application of both systems have become weaker. Moreover, increases in life expectancy and decline in fertility rates also resulted in the expansion of the non-working and dependency periods creating a further challenge for European states to finance their social security systems especially for those who follow Bismarckian system. The governments are now forced to support an increasing number of people who do not contribute to the functioning of the system as a whole. The financial challenge created by the demographic pressures was not only for those countries that follow Bismarckian system but was also apparent for those who applied Beveridge system. In terms of health care, the demographic changes have become a burden on tax revenues both quantitatively since there are more older and illness-prone individuals and qualitatively since the medical services and technology are more expensive. In fact, the problem arises from the fact that health care system must be at competition with other policy areas in order to increase its shares from the tax revenues which means Beveridge-like social insurance systems are also becoming difficult to finance. "A pure systematic change in itself is no solution. It is still unclear how far the trend of convergence will go. But one thing is certain: as long as there is difference in living standards among the European countries, a full convergence cannot be realistically expected" (Pestieau, 2006: 35-36).

Due to the changing socio-economic and demographic environment, ageing populations, the pressures of globalization, technological advancements and the social security budget crises which can be labeled as the reasons behind the health reform that became a much debated issue in the past decade across Europe, in the aftermath of 1990s, Neo-liberal restructuring that focused on profit maximization through competition and privatization became widely applied policy tools within health sector. The European approach to re-shaping health sector through reform although not defined a specific path to be followed by the newly member and candidate

countries, namely a specific health policy, it however, created a legislative framework that draw some boundaries within which the countries are expected to adapt their previous systems to a more flexible and competition-enabling model that is believed to be more efficient than the previous system. It was believed that this new model characterized with Neo-liberal restructuring, would "hopefully" reduce the government spending on health by increasing contributive payments from beneficiaries of the system reducing government responsibility in providing health care and solve their budget-focused problems.

3.2. European Union's Overall Approach to the Health Reform: Legislative Framework and Open Method of Coordination

As stated earlier, there is not a specific health policy agenda to be followed by the new member and candidate countries; still Europe expects the policies that governments apply will not be in a contradictory position with the competitive environment that is evident across Europe. This has much to do with the creation of a single market economy within which the countries are expected to apply policies that are in line with the common market ideology. Since there is not a specific health model to be followed by the candidate and new member countries, the European Union has granted a certain degree of "autonomy" to these countries to determine their domestic health patterns within the boundaries it has already defined with specific treaties and agreements. However, the autonomy does not indicate a process whereby the member states are free in determining their national policy agendas, rather; it indicates a process where this autonomy is bounded by European rules, regulations and treaties.

While determining the European Union's impact on the creation and shaping of national health policies with respect to member and candidate countries, the direct and indirect effects of European integration process through legislation and coordination should be examined. In order to do that, the legislative framework

through which EU affects national health policies and the open method of coordination known as a "soft method"[26] will be elaborated on.

3.2.1. The Legislative Framework Related to European Health Policy

Health care as an important part of the domestic policy arena, has gained a considerable importance in the aftermath of 1990s. Especially with the introduction of Amsterdam Treaty in 1997, the creation of a political union was aimed. Within that process, domestically defined policies like health care policy has inevitable been moved to the EU level. Since health sector is considered as an important part of the economic policy, with its huge volume of labor supply and resource allocation, it is an indispensable policy area for the states and EU.

The development of the EU legislation related to health care indicated that health care politics has gained a considerable move upwards in the EU policy agenda in the second half of 1990s and early 2000s. The process has been fostered with the idea of a creating "European Social Model" especially within the integration process of Central and Eastern European countries. The founding treaties as the serious legal acts of the EU as well as the decisions of the different European bodies are fundamental sources of the health policy-making referral within the EU. When we look at the past treaties that founded the European Union, the early treaties including the Rome, Maastricht and Amsterdam, we see that the treaties are mainly concerned with the promotion of the inner market practices and free movement of health professionals. Treaty of Rome in its articles 36 and 59 focused on the impact of free movement of services' and the imported exported goods' on protecting and promoting human life.[27] The Single European Act also used health within the single market economy context and referred to it as such:

[26] The soft method refers to the process whereby EU through soft governance methods indirectly influences the policy making processes within member and candidate countries.
[27] http://www.eurocare.org/resources/policy_issues/eu_health_strategy/public_health_at_eu_level_historical_background

"When the Community takes harmonizing measures to create a single market, the Commission will take a high level of health protection as a base for its proposals in the field of health, safety, environmental protection and consumer protection"[28]

It was not until the Maastricht Treaty(1992) that European Commission has been given the authority to act in order to protect and maintain public health[29]. Article 129 of Maastricht Treaty specified the Community's role in coordinating national health policies limited with the topics of general interest such as prevention of diseases, health information and education. Moreover, it suggested that health shall be considered as a fundamental part of Community's other policies and called for community action in health protection. It also called for cooperation among member states as well as among "the third world countries" and the "competent international organizations" with regard to public health. It obliged the EU to check its other policies, measures and instruments to see whether or not there is any provision that is in a contradictory position with health policy. Lastly, it is explicitly stated in the treaty that "the Community shall fully respect the responsibilities of the member states for the organization and delivery of health services and medical care." [30]

In the Amsterdam Treaty (1997), the role of the EU in health protection is described in article 152.Among a number of propositions offered in this article the improvement and protection of public health were the main focus of attention. Besides, the promotion of co-operation and co-ordination among member states were also promoted for the maintenance of the well functioning of the system. The Community can now adopt measures aimed at ensuring (rather than merely contributing to) a high level of human health protection. This new article amended the article 129 of Maastricht Treaty and had a broader scope. The new article

[28] Ibid
[29]Public Health mainly concerned with preventing diseases and promotion health through organized act of individuals and institutions. (Winslow, 1920).
[30] Maastricht Treaty See: http://eur-lex.europa.eu/en/treaties/dat/11992M/htm/11992M.html

expanded the scope of coordination areas with respect to health among the member states. It included not only list of diseases and important health repercussions, but also laid out the causes of danger for human health and general objectives in order to improve health.[31]

In the Charter of Fundamental Rights (2000), it was evidently stated in the articles 34 and 35 that everyone has the right to have an access to social security and preventive health care and has the right to be able to benefit from medical treatment as it is determined by the national laws and practices.[32] The measures in the field of public health continued in the coming years as the community published a health framework in 1993 underlining the importance of health promotion, education and training. The Community also gave priority to publishing annual reports concerning health. In the 2000, the first European Health Strategy proposal was published. In this report it was argued that the commission should take action within the fields concerning health, where member states are unable to handle on their own. It proposed joint health-related work at the community level with other policy areas in order to achieve health objectives.[33] Following the health strategy proposal, in 2002, the 5 year Community Action Program for health was published. The program mainly focused on health information exchange and coordination among member states and called for joint action of the networks as well as states and non-governmental organization in order to find necessary measures to protect and improve health.[34] In 2007, European Union developed a Health Strategy and in this strategy besides the objectives that focused on cross-border health issues, taking appropriate measures for ageing populations as well as supporting new health systems and technologies underlined. In 2007 another Community Action Plan for public health was issued. In this second 5-year plan, the Community objectives related to preventive health care was stimulated and the

[31]Amsterdam Treaty See: http://europa.eu/legislation_summaries/institutional_affairs/treaties/amsterdam_treaty/a16000_en.htm
[32]Charter of Fundamental Rights: http://www.europarl.europa.eu/charter/pdf/text_en.pdf
[33]http://www.eurocare.org/resources/policy_issues/eu_health_strategy/public_health_at_eu_level_historical_background
[34] Ibid.

reduction of health inequalities between member states, the improvement of citizens' health security, the generation and dissemination of health knowledge among member states in order to determine best practices, was fostered.[35]

The Lisbon Treaty, adapted in 2008, acknowledged the fact that the decisions taken with regard to the public health shall be adopted by a co-decision procedure which gave the power and the authority to the European Parliament to issue initiatives together with European Union.[36] But the scope of these initiatives is not defined in the treaty. It was also asserted by the article 168 that the union shall fully respect the responsibilities of the member states in defining, designing, managing, resource-allocating and organizing their own health services and medical care by promoting the principle of subsidiarity[37] whereby states are expected to take decisions as closely to the beneficiaries of the services-namely citizens.

While the focus is clearly on the preventive health care reforms, what does Lisbon say about the health services as a part of the public service? It is stated by the critiques that the Treaty threatens public services, including healthcare, in various ways. First of all it was argued that EU would like to limit the public spending of the member states. This is considered as a process through which the public services will be open to the private contractors across the EU and later to world markets at the WTO. "This process would worsen the problems of access accountability and quality in our services and put the profit motive centre stage" (Higgins, 2008: 1). Second, it was suggested that Lisbon gave more power to Brussels to have a more control over how the public expenditure is allocated. The Treaty would include "price stability" in

[35] Ibid.

[36] The co-decision procedure (Article 251 of the EC Treaty) was introduced by the Treaty of Maastricht and comprises one, two or three readings.

[37] The principle of subsidiarity is defined in Article 5 of the Treaty establishing the European Community. It is intended to ensure that decisions are taken as closely as possible to the citizen and that constant checks are made as to whether action at Community level is justified in the light of the possibilities available at national, regional or local level. Specifically, it is the principle whereby the Union does not take action (except in the areas which fall within its exclusive competence) unless it is more effective than action taken at national, regional or local level.

the EU's "objectives", and add new powers "to set out economic policy guidelines" for Euro-zone members (Art.115). Procedures to deal with "excessive deficits" have been strengthened (Art.104). "This means pressure to curb public spending, hive off parts of the public sector and expand the use of Public Private Partnerships – which have proven costly and unreliable" (Higgins, 2008: 1).

Third, it was claimed that Lisbon does not protect the public services from the intervention of market rules. Under the existing rules, it was argued that any EU business will have the room to ask for the right to provide a service in any member state. European Commission policy on social and other services, based on rulings from the European Court of Justice (ECJ), is that "... in practice… the vast majority of services can be considered as 'economic activities' within the meaning of EC Treaty rules on the internal market" (COMM 725, 2007: 8). Therefore, the Commission's policy here is to ensure competition through private contractors within public sector for services and to have state as the regulator in order to make sure the competitive nature of the process endures.

Although it is argued that the European Union's role is limited with the activities in the field of public health only, other policy areas within the scope of EU that have health implications has a considerable influence on the way health care services are organized and performed within member states. "Provision and Organization of health care systems of member states are directly influenced by activities related to research training of professionals pharmaceuticals medical technology and social security (Cucic: 2000: 22). The ECJ in some of its rulings also indicated that hospital treatment can be considered "a service" in itself under the terms of the Treaty.[38]

[38] See: Kohl&Decker and Smits-Peerbooms rulings. Case C-120/95, *Decker* v. *Caisse de Maladie des Employes Prives* [1998] ECR 1831; Case C-158/96, *Kohll* v. *Union des Caisses de Maladie* [1998] ECR I-1931.

3.2.2. The Open Method of Coordination and European Health Policy

European Union, as a method of cooperation within the integration process between the member states and EU and as a means to stimulate the integration process, fostered the development of Open Method of Coordination. In 2005, health and long-term care were included in the agenda of OMC. Rather than directly imposing rules to be followed, it was believed that this method would not only prevent possible opposition from the member states and question the EU's legitimacy during the integration process but also improve the level of communication between the member states and EU. It was also believed that through OMC, the creation of a Social Europe would be possible. It can be defined as such:

> *"The Open Method of Coordination (OMC) is an attempt to reach common European goals, without uniform, legally binding rules or targets, through cross-national benchmarking and exchange of experiences, especially in the field of social and employment policies" (Heidenreich, 2009: 10).*

The process within which the OMC is applied is described as a cyclical process of developing shared goals in reaching certain objectives; in this case, health objectives. It includes national reform programs, national action plans and annual progress reports of the EU member states giving details about the national performance. In these reports, these countries are expected to explain how they will achieve the desired or pre-determined goals. The process also includes peer reviews and in some cases, certain recommendations from the Community (Heidenreich, 2009: 10). The application of the OMC in the member states, therefore, can be described as a process where the Community influences the national policy changes in an indirect way without giving direct orders from Brussels. It has been done through three interrelated forms of policy changes: changes in national policy thinking (cognitive shifts); changes in national policy agendas (political shifts); and changes in specific national

policies (pragmatic shifts) (Zeitlin, 2009: 217). The most common method used is the cognitive shifting or political shifting. The Community becomes influential in placing new issues on the national political agendas of the member states by incorporating EU concepts and categories into the national debates; exposing domestic actors to new policy approaches, often inspired by foreign examples and questioning established domestic policy assumptions and programs (Zeitlin , 2005b: 450-457). The OMC started to be widely applied in the case of Central and Eastern European Countries; however, there is also a continuing debate whether or not this new political dialogue is effective in maintaining desired policy adaptations. It has been argued that the method, rather than allowing room for domestic maneuver in determined policy areas, refers to a highly professionalized and bureaucratic process with a limited number of NGO or social partner involvement within which the common goals for domestic social policy areas like health and employment are formulated (Heidenreich, 2009: 10). Besides, it is also supposed that in the long term, the process may result in more binding European regulations.[39] So how does OMC integrate the national heath policies into the European level? In order to give an answer to this question we shall look at the common goals and objectives of the EU with regard to its social and economic policy agendas. A wide range of Community legislation both have direct and indirect effects on the member states' health systems, simply because health policy has been developed within a general context aiming at completing an internal single market to make sure that free movement of persons, goods, services and capital is maintained within the Community (Lamping & Steffen, 2005: 193-196). Even though, European Commission has had no authority for uniting national health systems, Commission has tried to draw up general framework on how the health regimes should be since the mid 1990s and early 2000s.

Health policy, in that sense is understood as a necessary "component and part of the common market project subordinated to economic objectives". As having a

[39] Ibid

"traditionally strong social embeddedness"[40] within the society, health policy, is simply reshaped within the process of European integration. Within this process, the EU defines new entry and exit rules by simply focusing on the European health care market according to which the member states have to adjust their national institutions. Moreover, during the adaptation process, European internal market described with a competition regime, imposes its rules on national health policy makers in the form of "cartel law, liberalization of legal privileges, European union wide possibilities for health service providers to work and to invest, development and extension of transnational contracting, possibilities to exploit price differentials within Europe etc."[41] However, the adjustment within the national health care systems with regard to organization and management is an open process. Ii is a common knowledge that the institutional structures of the member states have to be organized in such a way that would allow room for single market and competitive environment of the EU. With regard to health sector, it is expected that the adjustment of the new accession and candidate countries to European integration process and the adopting the existing EU health policy regulations will inevitably lead to a second transition in these countries. It will confront them with new and far-reaching requirements that will affect their service delivery systems even though it remains under national competence (Lamping & Steffen, 2005: 198). Although public services and public utilities defined as non-market sectors for normative reasons, the ECJ and the Community, with rulings and legislations, enforce competition on public services[42], thus they end up pushing for further change.

[40] Ibid
[41] Ibid
[42] See: *The Internal Market and Health Services*, (2001) ,Report of the High Level Committee on Health, Brussels.

3.3. Understanding the Change: The Case of Central and Eastern European Countries

When it comes to providing health care and how it is provided and organized, it would not be wrong to say that the case of Central and Eastern European Countries it is the most concrete place that we can observe the extent of Europe's influence within health sector restructuring process. Previously described with their strong traditional state-centered economies and public sectors, the newly engaged countries at the Central and Eastern Europe have been undergoing a considerable turnover in their public sectors including health. Described by a number of adaptations and pre-determined alterations, the transformation process expects these countries to adapt their economies to the rules and regulations of the single market economy driven by the forces of competition.

With the exception of Yugoslavia, the remaining rest-Central and Easter Europe-were following the Semashko system up until the engagement with the European Union. In this system, health policy was centrally planned and administered and all the health personnel were state employees. It was a labor-intensive system within which the allocation of funds was driven by norms derived from historical levels of infrastructure and staffing (Rechel & McKee, 2006: 43). Besides, health services were free of charge for the whole population in order to provide equality in provision. The system is also characterized with publicly owned health sector within which the application of private initiatives was not allowed. With regard to the financing of the health services provided, the system was centrally financed through taxes. There was also no separation between provider and financier of the health system (Borowitz et al, 1999: 7).

The collapse of the Soviet Block in 1989, the ongoing military conflicts at the region at the time and poor macro-economic performance due to the impact of the economic shocks in the early 1990s, the process that is characterized with liberalization and

deregulation had already started in the CEECs before EU membership came to the agenda. For instance, in Hungary and Czech Republic, the institutions of the Bismarckian systems had already started to be established with the separation of Social Insurance Fund from the general government budget. In Hungary, the privatization attempts within health sector were experienced. Similarly, in Czech Republic, with the adaptation of the General Health Insurance Act (No. 550/1991 Coll.) and the Act on the General Health Insurance Fund (No. 551/1991 Coll.) in 1991, the private sector initiatives were allowed to invest within health sector by generating new contractual insurance models (Rokosovà & Hàva, 2005:13). In that sense, the liberalization program opened the way for further reforms within health sector in the following years especially after the European Union encounter.

Followed by a process within which the strengthened Neo-Liberal logic dominated the reform agenda of the Central and Eastern European Countries especially when combined with Neo-Conservative governments' power periods, the liberalization, privatization and marketization attempts within health sector were accelerated (André & Hermann, 2009: 131). The driving force behind the health sector reforms in the CEECs countries was mostly due to the bad economic conditions of the post 80 periods and rising budgetary costs. There is no point in denying that the delivery of public services in the post war-period until the liberalization and deregulation policies started was without problems but privatization and excessive deregulation made the scenario worse (Hermann, 2009: 233). Given this legacy of bad economic conditions, it was not a surprise that liberalization and privatization policies were not completely rejected by the service users in the CEECs, rather the people had hoped for the improvements that are proposed by the advocates of privatization (Hermann, 2009: 233). The IMF-endorsed policies being implemented in CEE countries, while on the one hand it improved the economic performance up until the 2008 economic crisis, on the other hand abolished what citizens grew up to accept as their social rights (Mahnkopf, 2009:225). The governments whether be conservative or socialist, showed a serious commitment to dismantling welfare provisions, deregulating

employment and putting more emphasis on partnership between state funding of public services and private enterprises-after privatizing industries, network facilities, hospitals and various educational institutions after 1990 (Mahnkopf, 2009:225). The citizens in the CEE countries did not reject the new set of economic changes within their public sectors but they were not happy that they were not able to benefit more from the changing structure. There was little resistance against the health care privatization and the only segment of the society that showed concern over the newly applied policies was trade unions and pensioners. They feared that, the pension funds that were set up under the socialist rule could be used for commercial purposes after privatization (Mahnkopf, 2009:225).

After the integration process started to take place in the CEECs, the reform process which had already started under IMF and WB guidance accelerated. EU in that sense provided these countries with a more systematized, specified and time-tabled reform agenda in implementing already determined policy changes in public sector. The liberalization of the health services had already been initiated in CEECs but the reforms were not successful enough in securing an "efficiently working health sector" and were controversial thus, countries suffered from the repercussions stemming from that rapid liberalization and privatization process (Rokosovà & Hàva, 2005:13). European Union, in order to de-stabilize the reform process, took the initiative and gave guidance on how to follow and adapt the new policies. EU encouraged member states cooperation through OMC and coordinated the process. However, the member states to some extent were not willing to move the health policy at the European agenda by arguing that health care is not an economic activity since the majority of the providers do not intend to make a profit (Martinsen, 2005: 1041). As a result of these efforts, health care was excluded from the scope of the Internal Market Service Directive adopted in December 2006. Notwithstanding the previous oppositional tendencies of the member states, in 2007 the Commission circulated a draft for a Directive on Cross-Border health care the aim of which was to "ensure that there is a clear framework for cross-border healthcare within the EU" (European Commission,

2008). However, the freedom of member states to design and administer their national health services in fact, conflicts with one of the fundamental freedoms of the EU which is the free movement of goods, services, persons and capital. In that sense, it becomes unlikely for EU to stay away from the administration and provision structures of health services as a whole.

Although health care reform is a gradual process with regard to CEECs, it can be stated that the integration process accelerated the procedures within health sector. Beginning in the late 1980s with the separation of the social security system in Hungary, the reform process continued with the devolution of the ownership of primary care surgeries, polyclinics and hospitals to local government along with the responsibility to ensure the supply of health care services to the local population (Lorant, 2009: 36-37). This process followed by the introduction of the family doctor system. Family doctors were financed by the Health Insurance Fund according to their clients within a capitation payment system. The reform agenda also anticipated that family doctors be privatized and contracted with the local government. (Lorant, 2009: 37). The real privatization of the health care began with the dental services followed by the privatization of hospitals and insurances in May 2003. However, while on the one hand the privatization of the dental services did not meet a public resistance, on the other hand, the privatization of public hospitals and health insurance received just the opposite reaction from the public and health personnel. For instance, when the Hungarian parliament adopted a specific act allowing the privatization of health care institutions, a considerable reaction came from the two largest interest representation groups within the sector: the Hungarian Chamber of Physicians and Democratic Union of Health and Social Care Employees (Lorant, 2009: 37). Similarly, in a referendum held on December 5, 2004 many public demonstrations held but the government did not change its attitude towards privatization of health services. Similarly, in Poland, after the liberal government pushed for a reform package that opened the door for privatization in the health care in November 2008, trade unions and even right wing political parties opposed the

process. The argued that; “human health (that is a sick person) is not to be viewed as merchandise and cannot be turned into such” (Lorant, 2009: 37). Moreover, in the Czech Republic, as I previously discussed similar reforms were carried out as it was in Hungary and met strong opposition tendencies from trade unions. In Slovenia, as the privatization of health care infrastructure and management has been limited so far, the tension within the society is moderate (Lorant, 2009: 37). Most of the European governments now tend to leave the provision of public services including health to the “free play” of the market forces and within this process the role of the state is reduced to making sure that the private competing service providers have access to the markets (Hermann& Verhorest, 2008). Unlike the previous privatization tendencies that gradually developed within health sector in CEECs which was rather an autonomous procedure, in the CEE countries after the European integration, it became an important part of the transition. Within that process, not only the service provider has changed but also, the economic and political systems have changed by raising a strong opposition from the public itself (Lorant, 2009: 37). In that sense, the role of the EU is important in terms of institutionalizing and accelerating an ongoing process within Central and Eastern Europe.

As discussed in the previous chapter, the most concrete reflection of the Neo-Liberal logic in the public sector restructuring process described with the NPM practices and the best way to secure a privatized and deregulated health sector at the European level is to apply NPM exercise. EU, in that sense, by fostering the implementation of the NPM principles in the CEECs, made no exception. “The European agenda for liberalization has been accompanied with a strong trend towards privatization at the national level” (Hermann& Verhoest, 2008). In order to describe this process, EU even introduced new terminologies such as the “services of general interest” or “services of general economic interest” in order to replace the old notion of “public service”[43]. “Hence it is about serving to the public, this line of policy is of course what is defined as one of the key elements of the New Public Management, namely

[43] http://www.pique.at/reports/pubs/PIQUE_PP5.pdf

the promotion of consumer sovereignty and choice in the provision of public services" (Van Gyes& Vael &Vandekerckhove, 2009: 2). By promoting the efficiency notion of the private sector in providing public services, the accountability for results, the decentralized control and offering alternative public service delivery mechanisms in the CEECs, the EU indirectly pinpoints the NPM[44] exercise as the most appropriate form of restructuring. Although the EU is not in the first instance responsible for the social regress in Europe, the EU Commission has been the driving force of the Neo-Liberal discourse that accompanied privatization, liberalization of public utilities and deregulation tendencies that are associated with the NPM exercises (Bieling &Deckwirth, 2008). The CEECs are, therefore, increasingly operating to create entrepreneurial and competitive institutions which in turn result in the creation of certain premises for the structural transformations embraced by the world market (Mahnkopf, 2009:226). With regard to social services including health, the negative impact of such policies put a hinder in the creation of what is called "a Social Europe". These new policies and processes by lowering the social protection standards (i.e. less people being covered by the public funds, the increased premium payment dates, the reduction of public spending particularly on health and education…etc), rather than promoting competition and efficiency within Europe will inevitably have serious repercussions in terms of the beneficiaries and will lead to a process where people start questioning EU's legitimacy. The EU by referring to NPM exercises in that sense, proposed a single model in the health sectors of the CEECs which will open the way for better functioning of the single European market economy.

In relation to the newly engaged countries and candidates, Europe's attitude towards health reform shows similar tendencies which I will touch upon in the following part by examining the EU's influence on Turkish health sector restructuring process.

[44] In recent years, due to the deficiencies both at the theoretical and practice levels, the application of NPM especially in develoing countries started to be questioned. Instead, it has been argued that the NPM practices has left its place to a new form of state and public administration system that looks like the old public administration system referred to as Neo-Weberian state.

3.4. The Impact of European Union on Turkish Health Sector Restructuring

The role and the impact of the European Union in Turkish health sector restructuring can be observed in the progress reports presented. Along with the Neo-Liberal restructuring process, the changes within health sector, therefore can be tied to the either direct (through certain agreements and legislative adaptations) or indirect (proposals, annual and progress reports) of the European Union. It can be stated that the purpose of the alterations and adaptations made in the Turkish health sector with regard to the European case, is not to contradict with the internal market rules and regulations stated in the treaties and the ECJ decisions. The Ministry of Health in its various publications stated very clearly that the aim of some alterations made within health is to make sure that the health sector is more compatible with the EU norms and standards.[45] Turkey since the start of the negotiation process with EU in 2005, has been in constant flux of policy changes and inevitably influenced by the norms and values of the EU (Yıldırım&Yıldırım, 2008: 1-2). Both within the organization structure of the Ministry of Health and within the policy process, there have been some changes. Within the organizational structure of MoH, the European Union Coordination Unit was established in order to carry out the adaptation process and carry out specific health projects and allocate resources that are granted from the EU (MoH, 2010: 3).[46]

The scope of the EU's influence on Turkish health sector restructuring is a debated issue. It is stated in the Commission reports that the member and candidate states are left to their own will to determine the organization and service provision techniques according to the subsidiarity principle. However, as we discussed in the previous section, the newly engaged countries with no exception widely adopt a Neo-Liberal reform agenda to restructure their health sectors.

[45] See: http://www.pydb.saglik.gov.tr/node/140

[46] Sağlık Bakanlığı Avrupa Birliği Koordinasyon Başkanlığı (2010), Avrupa Birliği ve Sağlık Bakanlığı Uyum Çalışmaları, Elif B. Ekmekçi (Ed.), ISBN: 978, 975, 580, 312-2, No: 780, Sağlık Bakanlığı: Ankara.

When we look at the progress report (2008), the EU's focus within health sector in Turkish case has been on the free movement of the goods services and individuals, maintaining a proper social policy and employment strategy, preventing contagious diseases and providing better primary health care services. In that respect the family doctor system has been established and this is considered as a positive development (Yıldırım&Yıldırım, 2008: 4). With regard to other health policy changes it can be argued that the application of NPM principles which suggest changes such as flexible organizational structures, financial liberalization and market-oriented and competitive service provision techniques…etc., does not contradict with the common EU values that made up the single market economy within which the principles of competition is evident. Therefore, it can be argued that although the reform with regard to the organizational and provision of the health services is not specified by the EU within the integration process with respect to candidate countries, it is for sure that EU would be sympathetic towards such changes characterized by NPM principles that could easily be added to the structure of a single market economy ensuring its functioning. In that sense, it can be stated that EU draws the broader boundaries within which the certain health structures proposed in the common reports of the IMF and WB mostly, could best survive and function.

3.5. Conclusion

In this chapter, I tried to discuss the health reform agenda of the European Union. I tired to examine the existing European Health policies and tried to show whether or not Europe envisages a common health policy proposal with regard to its new member and candidate countries. In order to do that, the existing health schemes are examined. Besides, the health sector restructuring processes of the newly engaged countries in relation to organizational and service provisional structures are elaborated on. It was concluded that the reform agenda started with the Neo-Liberal turnover in the late 1980s before the European integration process started. However, it is also argued that the EU with its commitment to single competitive market

economy within which the establishment of flexible structures are favored, draw a common broader boundary without specifically pinpointing how the inner structures will be designed. In that sense, the newly engaged and candidate countries including Turkey, continued the already started health reforms during the integration process to EU's benefit. Therefore, it would not be wrong to say that The European influence in the application of NPM principles has been indirect.

In the next chapter my focus will be on Turkish Health policy restructuring process and health as a part of a public policy understanding. I will try to explain the health reforms within a historical context and discuss the relative importance of health in terms of economy and public policy.

CHAPTER 4

HEALTH CARE POLITICS, HEALTH POLICIES AND HEALTH SECTOR RESTRUCTURING IN TURKEY

4.1. Health Care Politics

Over the past few decades health has become a major area of concern in all developed and developing countries. Increasing ageing populations, the introduction of new medical technologies, increasing public expectations and demands concerning better health conditions, increasing levels of service costs and the need to have more equal access to health services among various other factors, have put the place of health at the top of countries' political agenda. At this point, in order to have a better understanding how health care emerged and how it came to affect the government political agendas as a part of public policy having economic and social implications, we shall first have a look how it emerged as public health in the first place.

4.1.1. The Emergence and Shaping of the Term: Public Health

The term health as a part of public itself has a long journey back to the end of 1800s. To be able to talk about public health in the modern sense of the term one needs to go back to the "Industrial Revolution". At the end of 1800s, within the process that had its initial start in England, the term public health emerged as a reaction of the public to the social disruptions caused by the rapid industrialization process itself. The public felt the need to respond to those social problems and solve them. Public Health in that sense emerged as a result of public action as the idealized and desired outcome that would enable the public to find solutions to the existing problems that were threatening the health and well being of themselves. Therefore, it is important to underline the three main causes that let to emergence of the notion "public health".

First of all as I briefly mentioned above, the social and health problems caused by the rapid industrialization was labeled as the first and foremost reason for the emergence. Second, the panic atmosphere created by epidemics especially the outburst of cholera in the late 1830s marked another crucial reason.[47] The third factor that contributed to the process is the unhealthy urbanization. It was concluded that the epidemics became widespread as the number population increased. Therefore, it had to be controlled (Fee and Porter, 1992:1-4).

Besides the role of the three factors that commonly argued to had been the main ones contributing to the development of the term public health as a part of a societal expectation, the effects of the 1848 revolutions are undeniable in the formation of consciousness with regard to health. Those developments turned every problem area including health into a politicized struggle area requiring the follow-up solutions by the respective authorities. In other words, the need to live in healthy conditions began to take part in the political demands of the public. The demands related with public health became a part of political actuality. For instance, during French Revolution, the concept of rights became legitimized and entered in the constitution, including the very right to have access to health. This improvement put the health in the focus center of socio-political movements. Thus, we can conclude that public health did not rise as a health movement altogether but as a societal movement which attached itself to the socio-economic and political changes and developments taking place at the time. That's why its preventive nature was at the forefront (Ringen, 1979:9).

The very first step taken regarding the public health was the Chadwick Report dating back to 1842. In this report, for the first time public health defined as a problem belonged to the public realm and it was said to be threatened by the miasma caused

[47] The epidemics in the 1830s created a panic atmosphere however; it initially did not alter the ways things handled in the public health area until 1840s. Two reasons can be pinpointed; one is that the poor found better ways to express their lively concerns to the government at the time. Second is the impact of the truth that epidemic besides affecting the poor or the ordinary public also affected those of the aristocracy and the upper rich classes. Thus, threatened the social well-being of the society as a whole.

by the waste. Thus, it was concluded that by collecting the waste, the wider spreading of epidemics could be prevented. Another conclusion that the report came to achieve had been the fact that the ill conditions and epidemics were stemming from poverty.[48] In this report, a number of precautions were sorted out such as personal and environmental cleaning, the controlling of industrial waste, the introduction of new standards in environmental cleaning and the provision of clean water sources for the public. In the report, besides stating the to-do list, the central state authorities and the assigned territorial authorities were labeled as the responsible parties to carry out those implementations (Porter, 1994:12).

The report led to another development in 1848. Named as the "Public Health Law", this new law was considered as the first law in history in the modern sense of the term. Having inspired by the Chadwick report[49], the new law contributed to the existing structure with two new developments. With the introduction of this new law on health, two new frames were introduced. First of all, as a part of a central state unit, "the general board of health" was established. This board clearly defined the role and responsibility of the state in the provision of health services. Second, a new local authority was introduced in order to check and control the municipal arrangements concerning the environmental layouts. This law had a historical importance in the sense that it was the first to stress the state responsibility concerning public health.

The 1848 law on health, while being the first to raise awareness on public health, could not have a lasting effect due to the limited investments on health. Because of the failures of the board of health, John Simon replaced Edwin Chadwick in the

[48] It was important in the sense that the report directed the attention towards societal and macro causes of epidemics and illnesses. Considering the political conditions within which the liberal ideology was at its peek point, it was important to be able to underline the fact other than tying the reasons simply to short-term causes.

[49] Although Chadwick report initiated some of the changes in the public health understanding, Edwin Chadwick nevertheless was considered as a reformer outside of the health as he focused more on the engineering measures that was related to environmental settings with regard to health, rather than stepping aside to initiate changes that would help reduce poverty prevailing in the society at the time. For further information see: Hamlin, C. (1994), *State Medicine in Great Britain, the History of Public Health and Modern State* (Edited by Porter, D.), Amsterdam.

board. Simon criticized the previous work of Chadwick in the sense that the public health was neither the duty of management nor engineering but the doctors'. Simon, with his focus on medicine as a means of profession, helped to open up a new understanding of the public health. Public health became more of an affair that the state owned with more responsibility. Thus, state and doctors were the two parties that were becoming more and more active in the matters concerning public health. From that time on, public health turned into a practical activity corresponding to medicine (Fee& Porter, 1992:17). Moreover, by pointing out that the state should handle all fields of public health systematically and comprehensively, Simon was in a sense tried to define the new orientation. In that sense, a new ministerial arrangement as a part of a central state authority was proposed in order to carry out activities concerning public health. This new proposal that a separate ministry should be assigned to undertake responsibility within public health, followed by a new law more focusing on research and feedback concerning public health. Having been called "the Blue Book" at the time, it included the annual reports on the incidence of the illnesses and the causes of them enabling the government to hold more of a scientific statistical data about health (Porter, 1997: 35).

The law that passed in 1858, amended in 1866 and a new law concerning the health was enacted. In addition to that, local authorities started to have more responsibility in the matters concerning health and they were assigned duties in order to provide clean water both to the households and the city, to help the poor take necessary precautions in their homes in order to prevent diseases spreading and to deal with epidemics and if needed to punish the responsible parties (Porter, 1997:41).

John Simon, in his term of office tried to focus more on raising the state's awareness to be responsible for public health and on creating a public-oriented health approach. Public health in those times began to gain a seat as a part of a state structure. However, due to the insufficient and limited nature of the "Poverty Law", he resigned from his position. After Simon, a third important contribution to the field of public

health can be found in the works of Rudolf Virchow. Virchow was a famous pathologist of his time, worked in the Prussia as a government official. Unlike Chadwick, Simon and the other contemporaries, he put his emphasis on the social roots of diseases and health. According to him; "the poor and the oppressed people should not wait for the heaven" and "healthy existence is a right to live for everyone" (Rosen, 1974: 19). These two quotations clearly demonstrated and underlined the fact that health is a social right of an individual that can be attained while living. Besides they also served as a means of proof of the appropriation of the right to health in the 1840s.

An incident during an outbreak of a disease in the 1848, can clearly elaborate on the perception of Virchaw concerning public health. Upon a typhus outbreak in 1848 in the Upper Silesia in Prussia, Virchaw was appointed to examine the outbreak. After a three-week examination at the field, he prepared a report stating the socio-economic and cultural reasons for the epidemic. He proposed a number of radical precautions in order to prevent epidemics such as full-employment and education campaigns. However, these suggestions were not approved by the government itself and resulted in his dismissal from the post (Taylor&Rieger, 1985: 15). After a while, in 1861 he decided to engage in politics. In his political activities, he tried to spread the "right to health" principle and focused his whole attention on the social roots of diseases. Virchaw, in terms of being the first one to make a sociologic explanation of the epidemiological patterns of disease, typhus, was also considered a radical at his time. In his approach, he was influenced by the writings of Engels. Though being an anti-communist, Virchow, was impressed mostly by a work of Engels named as "The Condition of the Working Class in England in 1844". In his understanding of public health and in his workings, a similar point of view was dominant[50] (Baegelhole & Bonita, 1999: 17). For example, he stressed the importance of the role of the governments and labeled public health care as one of the primary aims of the

[50] For further information see: Engels,F. ,(1974) , *'The Condition of the Working Class in England in 1844'*, Harmondsworth, Middlesex, England ; New York, N.Y., USA : Penguin Books, c1987,2005.

government itself, advocated a constitutional assurance of the public health care rights, promoted a system within which medicine should be a part of a political process as a field in order to provide welfare to all and encouraged doctors to be the advocates of the poor. While stating the theoretical foundations of the desired changes, Virchow also succeeded in the implementation process. He designed a sewerage system for Berlin and helped to implement the draft. Besides, although he was a supporter of localization and local politics, he highlighted the role and importance of the state as the public health care provider and battled against the idea of abandoning public health to the private initiatives or private sector as a whole. However, his ideas could not bring down the dominant micro-level solutions presented with regard to health in the history of public health[51] (Rosen, 1974: 27).

4.1.2. The Factors that Affected the Shaping of the Health Care Politics

A number of different socio-economic factors can be classified as the reasons for the shaping of the health care politics and policies. First and foremost, the role of the states had much to do with the shaping of health care politics and policies since 1840s. As I mentioned previously, in the 18th century, the role of the states was limited with garbage collection from the environment. Local authorities and voluntary community organization were more active in the cleaning process of the environment or building hospitals for the poor. However, with the 19th century, there had been a number of developments that would put a strain on central governments as a whole. The outbreak of epidemics in Europe at the time, for instance, created an atmosphere of fear within society forcing states to take action and essential measures eventually. However, the main force of action was the embracement of health as a human right by the mass population. The expansion of rights including health as a part of a socio-

[51] The dominance of individual-oriented and short term temporary solutions to the public health matters, namely the health care policies had much to do with the dominant ideology at the time which was liberalism. The individualistic nature of liberalism clearly showed itself in the way states acted. That's why states preferred to find specific solutions to specific health problems rather than proposing macro level solutions in order to wipe out the social problems. In that sense, we can conclude that politics and political choices have had a great deal of saying in the shaping of health care policies.

political development, in a way forced the "impartial liberal state"[52] to take action concerning health matters. Public Health Law (1848) in that sense marked a turning point in terms of defining the role of the states. This development forced states to take responsibility even if they were reluctant to do so (Carmichael, 1993: 52). By following the footsteps of England, other states initiated a number of regulations as well. For instance, in France, local health advisory councils were founded in 1848 as a part of a central authority. While Europe was experiencing similar kind of changes, on the other side of the Atlantic, the United States due to its fragmented state system did not for a long time took action as a central authority figure in the field of public health until the beginning of 20th century. For instance, in 1912, Child Bureau was founded and American Naval Health Service was turned into American Public Health Service. However, the general tendency towards public health was limited to the services for certain groups related with specific cases and diseases. Second, the economic crises, collective action movements, class struggles and the quest for individual rights and liberties affected the way health policies had been shaped. Public Health in the 19th century could be defined as a process within which individuals sought for collective action in order to protect their physical well-being because, public health was the primary concern of those groups and individuals who wanted better living conditions for themselves and for those around them. Additionally and most importantly, the economic crises and the social disruptions caused by rapid industrialization have had an enormous effect on the way health have been perceived. For instance in 1929, the Great Depression, marked the beginning of a new period within which states as a whole had to give up the tendency to be ignorant in the social matters. States in order to overcome the harsh effects of the great depression, started to apply protectionist policies. In this time around, as opposed to the emphasized individual responsibility understanding of liberalism, a collective responsibility understanding and collective action started to emerge as a

[52] In the Classical Liberal sense of the term, it refers to the minimal responsibility taken by the states and governments that is limited with protecting individuals from coercion and the realization of justice. Other than those activities, the states should not take any responsibility with regards to public.

part of a societal expectation. Especially due to the outbreak of social diseases caused by the capitalist rapid industrialization in the 1920s, the collective action was triggered (Fox, 1994:109). Therefore, we can conclude that the governments had to take a step forward with regard to health in the times of strong and persistent pressures, social disruptions, and in the times of collective movement by the masses. Such developments implicitly reveal an accountability problem that states face in every single crisis situation or during an economic conflict followed by an immediate follow up short term solutions. Health in that sense became a part of an economic policy understanding of the governments rather than being a part of a societal demand as a whole. Another factor that is shaping the health politic and policies has been the fact that health has become internationalized. The thing that internationalized health is the fact that it became a part of governments' economic policy that needs to be regulated accordingly. The increasing roles of the international bodies like European Union, International Monetary Fund and World Health Organization in the past three decades is undeniable. The policy proposals and credit agreements were designed in such a way that they would guide states in order to take up and initiate similar policies concerning health[53] as a part of an economic policy.

In this part, I have tired to make an introduction to the public health and give brief historical information about how the term the evolved in time. I tired to show the increasing roles and responsibilities taken by the states in time concerning health matters based on different reasons.

[53] I will be going into a more detailed analysis of the policy proposals by IMF and WB with regards to Turkish health system in the following parts.

4.1.3. Health Care as Public Policy

Despite differences at the implementation levels, more and more countries are now applying similar health care practices and service provision systems as a part of their health policies due to various reasons. When one talks about health policy, we can simply point out some of the characteristics of our health system and may include them in our health policy understanding. But what does the term actually refer to? In order to understand the term health policy, I think it is important to grasp the meaning of the term "policy" first.

So what does the term policy refer to? In fact, the term "policy" refers to a wide range of differentiated meanings. The simple process "Politicians and parties present their intended actions as policies to be pursued and they defend past actions as policies to be extended" (Blank & Burau, 2007:1). Political annotators often talk about different type of policies like government's housing policy, crime policy or drug policy in general terms while others mention a specific government action. 'Policy then can be used to refer to general statements of intention past or present actions in particular areas or a set of standing rules to guide actions taken by the governments themselves' (Blank & Burau, 2007:2). Public policy is defined here as a decision taken by the government or on behalf of it. Therefore, public policy can be understood as an action taken up by the governments with regard to public matters like education, health, energy, social welfare etc. In the light of this definition, therefore, we can conclude that all health policies include a basic government decision whether to take action or not.[54] Because, only the governments have the legitimate authority and the essential means to make binding decisions on behalf of people that they represent. This statement while on the one hand reveals the political character of the decisions taken by governments in relation to health sector, also underlines the fact that as they are accountable to their citizens, they have to formalize the health policies in accordance

[54] See: Howlett, M& M. Ramesh (2003) ,*'Studying Public Policy: Policy Cycles and Policy Subsystems'*. Oxford: Oxford University Press.

with the needs and demands of people they claim to represent not in accordance with some pre-determined economic agenda shaped by some economic concerns that they may have.

When we talk about health policy[55], we refer to a set of rules and regulations that are designed to encompass a wide range of actions having health implication including provision, financing of health services and governance of health sector as a whole. This also includes the courses of action by governments that affect the health of their populations as a whole as well as including how they take health services and what services they take. Of all areas of public policy, health policy is the most sensitive one because, there are high emotional values attached as it involves life and death situations and high economic stakes are involved, therefore, should be carefully designed. While determining the nature of health services taken and the ways through which those services are going to be provided to the citizens, it is important to keep in mind the overlapped and interrelated character with various other social and economic policy areas including economic, welfare, social and unemployment policies. Health policy, as a part of public policy, should be understood in relation to other social and economic policies, because there are health dimensions in all policy areas. Therefore, health cannot be separately read from social, welfare, unemployment and poverty policies (Blank & Burau, 2007:184-189).

While realizing health objectives, as pointed out by many scholars as well, despite variations from nation to nation, in general, governments due to falling national

[55] Here it is important to point out that some scholars prefer to distinguish between health policy and health care policy and health care politics, referring to health policy as a much broader term overlapping with economic, social welfare and employment policies and including all matters having a health implication, referring to health care policies as a narrow term covering all types of action of governments to deal with financing, provision and management of health services and referring to health care politics as a comprising the interactions of political actors and institutions in the health care field in each country. For the purpose of this thesis, I will refer to health policy as a set of rules and regulations and the institutional framework designed by the government to deal with health sector with regard to financing and service provision. For further info on the distinguished policy areas within health see: Blank, R.H. & Burau, V. (2007), *'Comparative Health Policy'*, Palgrave Macmillan, pp.1-30.

incomes especially during economic crises, limited resources and growing health care expenditures may encounter some problems like difficulty in financing and delivery of health services. These budget constraints usually pointed out as the single reason in health sector failures by governments. However, it is important to note that any limitation on health spending will be corresponded by strong resistance from those of the population who are negatively affected (Altman et al, 2003: 21). Similarly, any attempt to limit having access to the sophisticated health technology will have similar repercussions both in terms of service takers and practitioners that are using the medical technology[56]. So what governments should do? Although there is no single answer to this question, we can state that while shaping a country's health policy, it is important to bear in mind that a public policy in order to have a positive feedback from the mass population as it puts the place of public at the center, have to be designed in such a way that it encompasses a great deal of consensus both from public and from health care providers. In fact, in order to reach this end, while designing health policies, governments should be effectively working with those hospitals, doctors associations and medical personnel involved in order to have a better understanding of the deficiencies of the health sector and the problems that health sector are facing at the level of implementation. "Because of the centrality of health professionals to the delivery of health care, a policy can only be successful if it has at least the tacit support of the medical community"(Blank & Burau, 2007: 4). Besides, it would be better for governments to carry out broad surveys among mass population in order to understand the problems with regards to financing and service provision that they are facing while getting health services. This will help to single out the most complained aspects of the health systems both in terms of citizens-the service takers- and hospitals-service providers. Moreover, to increase the level of interaction between the government officials and the health sector professionals and the population, would help the policy-makers while planning and prevent them from

[56] Despite the costs, physicians would want to utilize the most contemporary technology in medicine due to the expected benefits from that new medical technology in the patient treatment. Likewise, patients would want to have access to the newest technologies if they think that they are beneficial for their physical-well being.

having an isolated place from the actual practice. Thus, it would in turn help to allocate resources in a more efficient way than it used to.

While designing health policy, it is of crucial importance to keep in mind that producing health services are not simply a goods production process but a service provision process having social and economic implications for the society as a whole. Therefore, as an important component of planning and policy making processes, analyzing the economic aspects of health policy would be beneficial for out discussion.

4.1.4. The Relation Between Health and Economy: The Impact of Economy on Health Sector and The Impact of Health Sector on Economy

The Impact of Economy on the Health Sector

While taking into account of the health as a part of public policy, I think it is important to talk about the impact of economy on health sector. There is a two fold relationship between health sector and the economy. While on the one hand, health sectors are affecting the economy, on the other hand the economy and economic relations are affecting health sectors as a whole (World Bank, 1975: 25). Two main level of relationship can be drawn as the impacts of economy on health sector. First of all, the relation between those two is related to the level of gross national income per capita. Different statistical data collected from various countries usually shows that the determining factor in the allocation of resources for health sector from the general budget has been the GDP/per capita. What is that mean? It means that as the level of wealth and general health status within a society increases, the allocated budget levels to health tends to increase. This is usually the case in developed

industrialized countries. In fact, the level of increase in the health budgets tends to be higher than the level of increase in the general budgets [57](Belek, 2009:44).

The second factor that determines the level of impact between the economy and health sector is the labor-intense characteristics of health sector. Contrary to the other sectors of economy, health sector, due to its labor-intense structure cannot be easily regulated. In the times of economic recession, for instance, the government usually don't meet the increasing wage costs with a corresponding increase in productivity within health sector because, health services are simply services produced at the individual levels. If the level of income within health sector rises, it, as it supposed to, does not counteract with a corresponding increase in the production levels as it is the case in most other sectors in the economy (Belek, 2009: 43). Thus, it inevitably increases the costs within health sector when compared to other sector in the economy. As I mentioned before, this effect tied to the labor intense structure. In addition to that, "contrary to other sectors, the introduction of a new technology in the health sector does not reduce the levels of employment but just does the opposite" (Belek, 2009: 44). That is way governments usually try to make profit out of health sector by simply contracting out of the services or introducing special insurance systems and new individual payment methods within health sector.

The Impact of Health Sector on the Economy

As a production area, health can be considered a component of the general political economy understanding of a country. Thus, it inevitably has some effects on the way economy is shaped within society. With regards to health and economy relationships we can pinpoint three main effects of the health sector and health of individuals on the economy. First of all, if the mental and physical well-being of the population is

[57] Although there had been a considerable drop in the overall health spending due to the austerity policies of the 1980s in the late 1980s and in the beginning of 1990s, starting from the late 1990s, there has been an increase in the overall spending in the health sectors of countries.

somehow disrupted, led it be by an epidemic or mass-effecting incident, economy will be among those that would inevitably be effected. For instance, during the times outbreak of a disease, besides the person's well-being, the economy will lose its human power to produce. In addition to that, secondly, the increasing levels of health spending, has put the given health sector a new status in the economic sense of the term. To illustrate, with regard to most industrialized countries, health sector with its cover of more than 10% of the Gross National Income, may create a squeezing effect towards other sectors due to its big shares within the economy (Belek, 2009: 45).

As a third and the most important impact of health sector on the economy, we can single out the labor intense structure of the health sector. This characteristic reflects itself in the employment levels within the economy. In fact, health sector contributes to the economy with its huge volume of employment capacity and varied employment capability. This affects both the level of employment within society and affects the regulation in personnel policies of the government. For example, when we examine the inner structure of health sector we come across two different sides of employment. While on the one hand, there lays the highly educated qualified work force, the doctors, nurses, and other health personnel, on the other hand, we see the low educated work force working in the same place, workers working in the sub sectors related to health within a hospital for instance like cleaning and food. This structure shows us the reason why the health policies disregarding the employment structure of health sector are destined to be ineffective. Besides, the ineffective provision of health services and public-isolated health policies not only has serious repercussions in terms of posing a threat to general health but also can lead to some problems with regard to economy.

4.2. Turkish Health System and Health Policies between the Periods 1980-2010

The changes within health sector in Turkey as well as in other parts of the world that have been experienced for the past three decades constituted an important pillar of the Neo-Liberal policies that have been implemented since 1980s. Health sector, in that sense, served as an important area that the alterations with regard to health services as a part of a public service understanding can be observed. In the aftermath of 1980, as discussed in the second chapter in detail, the Neo-Liberal thesis for the fallout of the capitalist welfare state structure laid in the assumption that welfare state failed due to its over-capacity. Many countries, in order to get rid of this so-called "over capacity" problem, started to implement a new set of policies with regard to their public sectors under the new rhetoric put by Neo-Liberal understanding including health. "Heavy welfare states"[58], in order to reduce the contribution of capital to social spending and to increase the profitability of capital, started to transform and reduce their public sectors introducing new methods and set of policy proposals under the name of New Public Management approach starting from the early 1980s. This new understanding would not only help accumulate the resources in the hands of the capital by reducing the amount of capital that was allocated to the public sector, but also aimed at opening up new investment areas by underlining the privatization process as a part of a big transformation process. Privatization some of the public goods and services in that sense, would not only solve the immediate debt problems of the states by introducing a system where mandatory financial contributions of the beneficiaries of services were primary that they were facing at the time, however, it also would enable the private sector to fill the remaining gap left by the decreasing function and activity of the public sector in the service provision process (Soyer, 2003: 301). Related to one another, these two trends that are Neo-Liberalism and New Public Management as the center of policy proposals since 1980s, revived the privatization within public

[58] According to this understanding, it was stated that welfare states in order to getr rid of the burden of public spending, had to give up its role as the provider for public services and transfer some of its respeonsiility to the private sector in the provision of public services like health.

sector including health. In this way, a more "efficient"[59] and "effective" way of service delivery has been claimed. However, to determine "the level of efficiency" within health sector is a complex task that goes beyond the simple understanding of NPM. The relative importance of health puts it in a different place than other "pure markets". Health is not a pure market that functions smoothly according to the pure, private market principles. There are some important factors that differentiate health sector from others. First of all, the quality of the goods and services produced within health sector is more important than the quantity of it. Because, the more quality the health services have, the more satisfaction and benefit people will get. In that sense, a moral standpoint must be taken into account since everybody must receive a high-quality treatment regardless of who they are and what their income levels are. Second, health is a major factor in the labor productivity of a country that too high health inequalities could put the social cohesion within a country into question. Third, it does not fulfill the characteristics of a pure and perfect market since there is information asymmetry.[60] Given these characteristics, it becomes crucial for states to ensure the equal access to health services as well as guaranteeing the quality of services given (André & Hermann, 2009: 129). In that sense, the responsibility of the states in planning and managing the health care sector becomes crucial. It cannot be simply left to the rules of the NPM and expected to produce "efficiency".

The new approach laid out by Neo-Liberal understanding in the aftermath of 1980, therefore, could be found in the institutional arrangements implemented since then. Pointing out state's intervention as the single reason for the failures within health system, this new line of thinking introduced a number of NPM reforms within health sector. However, as contrary to the intended "neutral position" of the state between the public and private sectors, an active role was undertaken by the states in favor of the private sector in the past few decades. Those changes with regard to health sector

[59] By 'efficiency', the NPM understanding simply referred to the service provision at the least possible costs.
[60] Pure markets differentiated from others since every actor is assumed to have the perfect information regarding every transaction before they act, invest or produce.

in fact, reflected the political choices of the respective governments that held office since 1980s. The new approach, besides, having been supported by the governments in power, also promoted by international organizations such as World Bank and International Monetary Fund. It is possible to find a concise expression of the respective policy proposals in the WB reports of the time. According to a World Bank Report, the problems that have been faced within health sector stem form the inadequacy of the states' financial resources in meeting the demand for health services. Besides, it was also claimed that funding through general budget has also deepened the inequalities within health sector. As the solution to the projected problems, the lessening of the "burden" upon states in the provision of public services and the increasing active role and contribution of the private sector were proposed. In addition to that, the introduction of user contributions for those who are benefiting form the heath services where the public sector remains as the service provider, was encouraged. By "private sector contribution" what WB meant in that report was both the privatization of some of the state-owned health care organizations and provision of incentives and exemptions as well as technical and financial support to the private sector (World Bank, 1986; World Bank: 1990). In the light of such developments in the aftermath of the 1980s, a closer look to the constitutional changes, implemented laws and policies would be beneficial in understanding the nature of the changes within health sector in the past three decades in Turkey.

4.2.1. 1980-1989 Period

As a part of the financial liberalization program of 1980s and restructuring attempts, health sector had been subjected to significant changes over the years. In this period, health policies became a part of the state's restructuring process. In the aftermath of the military coup in 1980, a number of Neo-Liberal policies started to be implemented. Those policies were characterized with the rhetoric that public spending should be reduced to a minimum level. At the center of those policies there laid the idea that tax burden on capital should be reduced. This development had two

implications. First of all, it created a pressure on the public sector to reduce the amount of budget that was allocated for social spending. Second, it also put the pressure on the public sector for the privatization of public services. In terms of personnel expenses, when compared to pre-80 period the level of spending fell considerably from 46.4% to 37.5 % in 1988. Between the periods 1989-1993, it again rose to a level of 46.7% but felt sharply to 36.2% with the 1994 economic crises (Boratav, 2006:173). The most important results of those developments in terms of health sector was the reduction of the allocated resources to health and the deterioration of the reel income of the public personnel working in the health sector[61]. In addition to that, shares of health care investment declined by a ratio of 2/3. In fact, as a part of public investments, the shares of the social services like education and health declined considerably (Oyan, 1989: 39).

In this period especially the low-wage policies of the time affected the health and living conditions of a considerable amount of the population and became the leading factor that disrupted the public health. The declined reel incomes of the mass population not only put a constraint on the people's purchasing power in the economy but also served as an obstacle in terms of having access to health services. Moreover, as the second important characteristics of the period, the lowering levels of tax revenues can be stated. As the tax burden on capital started to be reduced in the post 1980 period as a part of the newly adopted economic policy that is to say market economy, the tax revenues fell letting to significant declines in the allocated budget for social spending. Between the periods 1980 to 1983, under the National Security Council administration after the military coup, some significant alterations were made within health sector with regard to the provision and financing of the heath services. First of all, there had been a change in the pursuit of health as a state responsibility. In the 1961 constitution, it was stated that the right to health is a social and human right

[61] This development not only deteriorated the purchasing power of the public personnel working in the health sector, but reduced the real incomes of those individuals working in the public sector as a whole. For details see: Boratav, K. (2006) 'Türkiye İktisat Tarihi' (1908-2005).

and it is the duty of the state to provide the necessary conditions for the maintenance of each and every individual's physical and mental health (Turkish Constitution, 1961: c49). However, with the 1980 constitution it was clearly underlined that state's role in providing health care to its citizens should be a regulatory role. It was also underlined that state executes this role by supervising the health institutions when necessary (Turkish Constitution, 1982: c56).

Under National Security Council administration, another new approach was characterized with a famous catchword that "there is no service without a charge". With this statement, the new desired structure with respect to heath sector restructuring had been emphasized. With regard to the financing of health services, the usage of extra budgetary and working capital applications within public hospitals encouraged. As the first step towards maintaining the depicted system was the introduction of pricing system within health sector. Besides, the preparatory groundwork for the General Health Insurance system which based on the premium payments by the beneficiaries had been initiated in that time period however was never culminated. In addition to that, the organizations related to health like Turkish Doctors Association and Revolutionary Health Association were shut down due to their left-oriented structures (Soyer, 2003: 188).

Although some alterations had been exercised with regard to health sector, the most prominent implementations of the time, however, was not put into practice until Motherland Party (ANAP) government came into power in 1983. The re-organization attempts of the health sector started with Turgut Özal government under Motherland Party. In this period, the party program and the fifth five-year development plan constituted the two crucial components of the Motherland Party's approach to health and were important in terms of reflecting the health policy of the government. First of all, within the party program it was stated that it was MP's aim to provide with each and every citizen a social insurance system and build a system where people can go to whatever hospital they choose. Similarly, in the fifth development plan in order to

maintain the "rational and efficient" public health institutions, bringing a management understanding to the public health institutions was advocated as the primary principle of the change. Besides, it was also emphasized that private sector and the opening up new private hospitals should be encouraged. With regard to the pricing system within private hospitals, it was underlined that the prices ought to be unleashed. In addition to that, it was pointed out that whenever needed, the private health staff should be utilized within public hospitals.[62]

While some basic alterations made with regard to health sector, the core of the change within MP's power period represented by a law that was legislated in May 7, 1987 named as the Health Services Fundamental Act (No: 3359). This law was important in terms of clearly underlying the responsibility of the state as a regulatory body with regard to the health matters including service provision and was the first to acknowledge the pricing of the health services and self-financing of public hospitals. In this act, the state was defined as a regulator of the health services different form the previous era that depicted state as the sole guarantor of the equal access to health services. This law stated a clear boundary between public and private sectors and described the position of state as a body standing in the middle of those two with an equal distance from both. In other words, it was advocated that state should not under any circumstances take any favoring position to support either of the sectors.[63] With regard to the health personnel, this act proposed a new system under which the status of the health personnel would also be subjected to change. It was proposed that the health sector personnel should be contractual workers and both in public and private sector hospitals they should be having a compulsory service.[64] Besides, the Ministry of Health was granted the authority to temporarily or permanently dismiss the health personnel from service whenever it sees necessary. However, due to its disfavoring

[62] See: www.belgenet.com/parti/program/anap-1.html, www.belgenet.com/parti/program/anap-2.html. , http://ekutup.dpt.gov.tr/plan/plan5.pdf
[63] However, as I mentioned before in the previous paragraphs, the government party in fact, was more in favor of supporting the private sector to take more active role in the provision of health services.
[64] Health Services Fundamental Act No: 3359 (1987).

nature of the health personnel, the act was not supported by the Doctors Associations, Health Professional Organizations, and some of the opposition parties including Social Democratic Populist Party (SHP) therefore remained as a top-down act independent of the health sector professionals. Thus, some of its articles were annulled by the constitutional court.[65]

The general attitude of the Motherland Party towards health care and health sector was so much in line with the common Neo-liberal rhetoric. It was advocated by the Neo-Liberal ideologues of the time that health sector suffers from over-centralization, bureaucracy, bad administration, lack of competitiveness and clumsiness which according to them reflected itself as inefficiency within service provision. In addition to that, "under-pricing" of the heath services was labeled as the cause of the financing problems of the health sector that it was facing at the time. It was also underlined that the public hospitals were lacking the good managers that would implement the managerial principles within public hospitals that would increase efficiency and effectiveness with regard to service provision. It was proposed that the public services just like market services should be priced. Moreover, for the first time, the idea of "family doctor" came into the agenda which reflected the changing penetration concerning the primary care health services.[66] To sum up, the main approach during the time of Motherland Party towards health lied in the claim that the problems within health sector are stemming from its public provision. In other words, as the public sector was the service provider, it causes inefficient and ineffective service provision and therefore, in order to overcome this problem, privatization should be considered as one of the solutions to the common problems tied to health services and some private sector methods should be introduced within health sector in order to make it more efficient and the service provision more effective (Soyer, 2003:309).

[65] It was rather surprising to see that while SHP was critical of this act in 1987, it was among the coalition parties in 1995 that granted the autonomy to the Highly Specialized Hospitals (Yüksek İhtisas Hastaneleri).

[66] It can surely be stated that the core of the changes within health sector since AKP government, can be found in Motherland Party's approach to health. The policy proposals within health sector can be considered as a continuation of the proposed policies in the time of the Motherland Party.

4.2.2. 1989 and Aftermath

As a reaction to the health sector restructuring, "the spring strikes" of the trade unions and "the white strikes" of the doctors put a constraint on the government's accountability and resulted in the change of government. After MP, the TPP and SDPP (DYP-SHP) coalition government came into power and followed the footsteps of the MP with regard to health. Between the periods 1989 and 1994, a relative increase in the public investments and expenditures were noticeable (Boratav, 2006: 173). However, after 1994 economic crisis the short lived prosperity era came to an end. The deterioration in the income distribution clearly affected people's access to health services which became one of the factors that threatened the public health at the time. Depending on the crisis in the public finances, the social expenditures were regressed. As a continuation of the MP's approach, "the user pays" understanding was tired to be dominated with new policy proposals. In January 1992 Economic package it was stated that, the government had not enough money to allocate for the health sector and the budget and investment gap within public sector is going to be compensated with the incentives that would be given to the private sector. Moreover, it was also underlined that with the green card system the social insurance system will be expanded and the health sector will be open to the direct investment of the foreign capital (Soyer, 2003: 311). However, as the basis of the changes at the time of the coalition government, "the health reform" occupies the broader position. Among the primary debated subjects with the health reform, the replacement of the health care centers[67]with family doctors system, the privatization of some of the public hospitals, the transition to the general health insurance system with respect to financing of the health services, decentralization in the service provision in health and the making health personnel contractual workers were prominent (Belek, 1994: 87).

The concrete step towards implementing the new policy proposals was the foundation of the Health Reform Project General Coordination Unit during the time of the coalition government. With this coordination unit, the aim was to reduce the scope of

[67] Sağlık Ocağı

authority of the Ministry of Health concerning health matters and to implement new health projects that are in line with the World Bank policies. In fact, in this direction the first step was taken in the time of the Motherland Party government. For the first time in 1990, health project credit agreement was signed with the World Bank. The underlying philosophy of this agreement lied in the fact that the WB would release some loan in exchange for adapting the demanded policies within health sector in Turkey which was much in line with the above mentioned new policy formulations.

Between the years 1990 and 1997 there had been three health projects that were constituted and published in the official gazette dating back to the; October 7, 1990 (20658), December 22, 1994 (22149) and December 17, 1997 (23203). In those issued laws the aim was the same with that of 1993 Health Reform Draft. According to those three agreements, the transformation in the health sector was about to take place within three stages. The first level of transformation was about the organizational structure of the hospitals and in that sense, more management autonomy was granted to the hospitals and localization was aimed. The second level of transformation involved the pricing process. With respect to the provision of services, it was proposed that those (with some exceptions)[68], who benefit from the health services should pay a certain amount of the "price of the services provided"[69] and this kind of an understanding, in fact, became prevalent. The third line of the change tied to the direct privatization attempts. In that sense, it was underlined that the role and the functions of the Ministry of Health Project Coordination Unit be increased in order to regulate the privatization process of the health services in Turkey. Moreover, with the adaptation of April 5, 1994 decisions the state contribution within the health sector reduced to a level of government payrolls to the health personnel.[70] The role of the state is limited with the provision of preventive health care and health services to those in need. Public hospitals due to insufficient

[68] Green Card users
[69] DPT, (1994) , VII Five-Year Development Plan. Available at www.ekupt.dpt.gov.tr
[70] It was this time around that the High Specialized Hospitals were granted autonomy with a regulation dating back to 1.11.1995.

financial assistance were dragged into serious debt problems. In the aftermath of 1995, the privatization attempts continued within health sector. In this period, total quality management measures that are compatible with the ISO 9000 standards started to be implemented as if the public hospitals were private sector companies (Kutbay, 2002: 11-12). Those issued laws and proposed reforms in a way set the grounds for the future reforms and at the same time reflected the ideological as well as legal bases of the post 80 understanding concerning the transformation of public sector.

Throughout 1990s, the general attitude towards health sector restructuring was more or less shaped by the loan and credit agreements signed with WB. It can be argued that health reform has been put as a condition by IMF and World Bank to Turkey for the release of a considerable part of the loan credits. Similarly, by the European Union, this reform has been presented as an inevitable condition to be a member of the Union. Although the importance and severity of the agreements within health sector restructuring is undeniable and the international character of the changes within health sector restructuring has been at the forefront, the role and the attitudes of the governments in power in fact had much to do with this process. It can be stated that the reform agenda reflected the political choices of the governments that came to power since the early 1980s.

In the 1999, the ISO 9000 application started to be used in Social Insurance Institution Hospitals. It determined how many personnel (doctors, nurses and health personnel) would work within a service and calculated the estimated amount of profit that each hospital would make. The aim according to the Ministry of Health was to create an efficient management system and to increase the quality in public hospitals. However, this development was criticized on the grounds that it led to direct privatization in the name of quality management by introducing different applications like changing the administrative structures within hospitals and dividing the hospitals and thus service provision into different units (KESK, 2003).

Starting with 2000s, the health reforms, especially with JDP government, started to take place extensively. Right after the elections on 3rd November 2002, the basic objectives were sequenced with the introduction of the Urgent Action Plan in 2002[71]. This new set of reform described the new role and the functions of the health sector and Ministry of Health with respect to the organizational structures and service provision as well as the personnel of health sector. This reform package envisaged that the changes would introduce a new system that would focus on creating efficient and effective health sector and service provision. It stated the fundamental changes that are expected within health sector. As a part of this plan, the key objectives were stated as follows[72]:

- Administrative and functional restructuring of the Ministry of Health,
- Covering all the citizens by the universal health insurance,
- Gathering the health institutions under one umbrella,
- Providing the hospitals with an autonomous structure administratively and financially,
- Introduction of the implementation of family medicine,
- Giving special importance to mother and child healthcare,
- Generalizing the preventive medicine,
- Promoting the private sector to make investment in the field of health,
- Devolution of the authorities to the lower echelons in all public institutions,
- Eliminating gap resulted from the lack of health personnel in the areas which have priority in development,
- Implementing the e-transformation in the field of health.

[71] www.belgenet.com/eko/acileylem_161102.html
[72] Health Transformation Program in Turkey and Primary Health Care Services November 2002-2008, Ministry of Health.

Right after the Urgent Action Plan, the Health Transformation Program was prepared and announced to the public by Ministry of Health. The Health Program aimed at transformation in the framework of eight themes:

- Ministry of Health as the planner and supervisor,
- Universal health insurance system aimed at unifying everyone under a single umbrella
- Widespread, easily accessible and friendly health care system,
    a. Strengthened primary health care services and family medicine,
    b. Efficient and gradual referral chain,
    c. Health facilities having administrative and financial autonomy,
- Health manpower equipped with knowledge and skills and working with high motivation,
- Education and science institutions to support the system,
- Quality and accreditation for qualified and efficient health services,
- Institutional structuring in the rational management of medicine and supplies,
- Access to effective information at decision making process: health information system (MoH, 2008).

The basic changes can be drawn from above mentioned principles. First of all, the differences between public, insurance and institution hospitals were expected to be eliminated by unifying them under the public hospital unions. Second, it was stated that the administrative and financial autonomy would be granted to the hospitals. Third, the general social insurance system would be established. Fourth, transition to the family doctor system and the introduction of dispatch system were proposed. Fifth, it was pinpointed that the preventive health care would be universalized. Sixth, the private sector investment in health said to be promoted.[73] In the same year that the reform came into the agenda, with the support of the WB, a grant agreement was signed with the Japan Development Bank. With this grant agreement, the preparatory

[73] www.belgenet.com/eko/acileylem_161102.html.

work for the implementation of the Transformation program in Health had been accomplished. In 2004, another loan agreement was signed with the WB amounting to 49 million Euros in order to maintain the foreseen changes within health. The leading bodies within this transformation project were indicated as the Ministry of Health and the Ministry of Social Security. The famous catchwords of the transformation project in general, focused on the effective, efficient service provision based on equity understanding.[74] In order to accomplish this aim, the Project Management Support Unit was founded. This unit was in charge of carrying out the essential changes within service provision, the organizational as well as structural changes within the ministry and the social security institution. It also defined the phrases of the transformation within health. The first phrase of transformation included the service provision restructuring that focused on the introduction of the general health insurance system and financing of the system. The second phase of transformation more tied to the way that the Ministry of Health and the Social Security Institution have handled the transformation process.

Those changes not only transferred the way public services are perceived and performed, but also introduced a new understanding in terms of organizational structures within health sector. In that sense to examine the new policies that have been put into effect would be beneficial in out understanding of the transformation.

4.2.3. The Family Medicine System

The system has long been in the agenda of the health sector since the times of the Motherland Party's government. However, it has not been put into practice until 2004. It aimed at replacing the old ways of service delivery with regard to the primary and preventive health care services. With the adaptation of the law 5258[75], the pilot application of the system came into effect in November 24, 2004 in 11 provinces and later in 2007, 11 more provinces were added to the list. According to

[74] http://www.pydb.saglik.gov.tr/node/69
[75] www.saglik.gov.tr/.../5258-sayili-aile-hekimligi-pilot-uygulamasi-hakkinda-ka-.html

the Ministry of Health, the aim with the introduction of the family medicine/doctor system was to improve the service quality in the primary and preventive health care system and to enhance the proportion of people that access to the health care services (MoH, 2008: 143). According to the law no 5258, the family doctor would be responsible for at least 1000 individuals and at most 4000 individuals respectively. The responsibility of the doctor involves having a closer encounter with the registered patients and families, registering and following the health histories of the patients and forming a more personalized contact with the patient so as to create a trusting environment. The government is responsible to be paying for one physician, one nurse and one midwife. It is also allowed for the family doctor if sees necessary, to hire additional health personnel with the permission of the Ministry of Health under contractual status. Every person who are residing in the areas where the family medicine system is established, if apply to the other health institutions without the referral of the family doctor (with some exceptions)[76] is tied to a contribution payment. But to apply to a family physician is free of charge for the insured people.

In order to understand and grasp the inner characteristics of the family medicine system, a private interview held with the head of the department of family medicine in the Ministry of Health, Savaş Akbıyık.[77] Dr. Akbıyık (2010) stated the need for transformation within health sector especially in the field of primary health care services. With the family medicine system what the ministry aimed had much to do with the old system failures that have been experienced since the mid 1970s. According to him, the health clinic system that was established in the 1960s was successful in terms of meeting the demands of the public at the time. However, together with the increasing population and the increasing demand for health services,

[76] Under extraoudinary circumstances or in case of emergency.

[77] A voice recorder was used during the interviews with the consent of the participants to capture their narratives. The dialogues lasted no shorter than an hour and no longer than two-and-a-half. A list of questions was brought to the interview scene. However, some additional questions were formulated during the interview depending on the flow of the conversation. The questions demanded to know their personal experiences and observations regarding working in the health sector, so that links with our theoretical considerations could be established.

the system had some difficulties in meeting the demand as a result of which the family medicine system was proposed. People, due to common practices, the disregarded nature of the previous primary health care system and their distrust to the primary health care, preferred to go to the hospitals. With the establishment of the family medicine system, the aim is to create a system that is characterized with efficiency, effectiveness and equity in service provision. According to him, the family physicians would not only prevent false referrals, but also the disorders and unnecessary health expenditures that might cause individuals and service providers to lose time. In that sense, family physicians prevent the waste in health care expenditures; hinder the unnecessary long waiting lists and patient's suffering in secondary health care services.

The referral system that is associated with the family medicine system however was not put into effect. In that sense the application of the family medicine system in the Turkish case, represents a unique character that has not been experienced in the world at large up to now. The reason for this orientation was tied to the general dissatisfaction with the previous system. Akbıyık (2010) stated that, although the referral system stated in the law, they delayed the implementation of it for now in order to prevent the public reaction that could stem form the fact that referral system put some constraints on the individual's ability to directly go to any health institution as they wish. In that sense, he stated that they delayed the implementation because; they did not want the public to react to the limitation that is brought by the referral system. With regard to the specialization of the family physician, according to Akbıyık (2010), the ministry gives one year training to each doctor who wished to be employed under the family medicine contract system. He also stated that they plan to create an area of specialization specifically for the family physicians. However, the system will probably be put into practice after 2017 as the implementation is in its transition period. Through this way, the quality of the family physician will improve, he stated. With respect to the provision of the health services, Akbıyık (2010) also reflected the perception of the Ministry of Health by stating that "we are not in an era

within which we expect the free provision of public services, on the contrary, in order to get health services one should pay a certain amount of money because the state is not producing money to cover for the health expenses". He also underlined that the adaptation of the family medicine system was also promoted by the World Bank and European Union as a part of the accession process.

This new model, however, was put under severe criticism by the Turkish Medical Association in terms of its clear departure form the old values and means that the health system was structured around. First of all, according to TMA, this new system by introducing contractual employment creates job insecurity. The status of the working personnel except for the ones stated in the law is not secured and not clearly defined in the respective laws. This application with its emphasis on the flexible employment therefore, results in the loss of right in terms of health personnel. Moreover, by creating a system within which the job security is dismantled, an unorganized mass will also be created inevitably (TTB, 2006). The second line of criticism was tied to the nature of the family physician system. The system with its focus on performance payment and competition would in a way force the doctors to focus more on those patients whose illnesses are valued with more points within the system in terms of performance payments. The third line of criticism was tied to the right to choose the family doctors. It was stated that every individual has the right to choose their own doctor. However, in the case of family doctors, one single family will be registered with one doctor so different individuals in one family will not be able to choose their doctors independent of one another. This will not only falsify the primary claim but also will lead to some disordering. The fourth line of criticism was that the preventive health care facilities will be overlooked because as the family doctor is expected to focus on the individual families, would not focus on the preventive health care independent of the individual that he/she is seeing. Besides, the coordination between the family doctors in terms of providing preventive health care will also lead to some conflicts in terms of realizing the common characteristics that need to be taken into consideration while providing preventive health care (TTB,

2006: 45). Besides, the system, given the fragmented geographical structure of our country, may lead to regional inequalities in carrying health services to each and every part of the country. Since some regions become unreachable especially in the winter times due to heavy snow it becomes almost impossible for a family physician to be able to perform at those times.

With regard to the family medicine system, we can conclude that it did not take the support of the medical community therefore remained as an above-imposed reform package supported by the international organizations whose effects yet to be seen in the near future.

4.2.4. The General Health Insurance System

The general health insurance and social security system was put into practice with the law 5510 named as the "Social Insurance and General Health Insurance Law" May 31, 2006. The effective date of the law was planned as of 1 January 2007. The law, no. 5510 has claimed that crisis in social security system could be overcome with regulations, like increasing the revenue and decreasing the expenditure. With this law, it was proposed that the public hospitals should be unified under one umbrella, the financing and the provision of the services should be separated, the user contribution payments should be introduced in terms of financing, the administration units should be decentralized and the autonomy should be granted to the public hospitals (TTB, 2003: 25). It was claimed that with the implementation of this system, the standardization within public hospitals will be maintained. The main change that is brought by the introduction of the general health insurance system has been the implementation of the individual contribution payment with regard to the financing of the health care services. In other words, the radical change brought with regard to the financing of the system. In that sense, the individual contribution payments within health service provision started to play a forefront role in the financing. This development not only separated the service provider and major

financier, but also represented a clear break from the old system within which the major responsibility belonged to the Ministry of Health. In addition to that, the system more focused on the contributions by the beneficiaries of the system and relied less on the government budget. This aim was characterized by the separation of the financing and the provision of the health services.

The constitutional base for the reform was the 60th provision that underlined the fact that everyone has the right to social security. The main focus of the reform was, according to the ministry of health, to secure all the population and include them under the health security umbrella in terms of financing. According to the ministry, this would equalize the chances of people in terms of accessing to the health services (MoH, 2007: 61). [78]

In terms of pension systems, the main goal of the law has been identified as the transformation of five different pension regimes, including civil servants, workers, self-employers, agricultural workers and self-employers in agriculture, into single retirement insurance regime. In order to eliminate the differences between the social security institutions concerning the retirement age, premium rate, income replacement rate, and limit subjected to premium payment and period of premium payment, some crucial changes have been offered. Raising the limit subjected to premium payments, gradual increases in the age of eligibility for pension, reducing income replacement rate, increasing the period of premium payment and rate of premium were among those offered in order to achieve long-term sustainability within the system. According to the "Social Insurance and General Health Insurance The Law (5510)", the minimum conditions for an old-age pension will be age 60 for men and age 58 for women with 25 years of work and period of premium payment will be at least 9000 days. Beginning in 2036, the retirement age will rise gradually up to 65 years by 2048 for both men and women. Whereas in the present system average retirement age is 50, it will increase to 65 with this law. Also, period of premium payment will

[78] www.tusak.saglik.gov.tr/pdf/kitaplar/200801221602180.GSS.pdf

gradually increase from 7000 days to 9000 days (25 years) for pensioners of SSK in order to equalize it with ES and Bağ-Kur. In addition to this, through increase in period of premium payment and the basis of earnings related to premium, pensions are decreased.[79]

Together with the general insurance and health reform, SSK hospitals were delivered to the ministry of Health (5283), and it was allowed for each and every individual to apply to and benefit from each and every hospital for which they seek to apply. The Social Security Institution named as the single payer besides individuals and the Ministry of Health as the service provider. It also introduced the user contribution payments within public hospitals. According to this law, those who wish to apply to the university hospitals which provide the third step health services as well as providing the first and second step health services should pay the highest contribution and those who wish to apply to the public hospitals pay the minimum amount of contribution rate. And for those who apply to the family doctors, the service is free of charge. (TTB, 2003: 35). With respect to those people who are unable to pay their premiums, the green card system is offered.

4.2.5. The Green Card System

With the introduction of the General Health Insurance System, there have been some changes with regard to the acquisition of green card by those who are considered as the poor that are unable to pay their premiums in order to benefit from the health care system. It was stated in the law no 5510 that the ability to benefit from the health services depends on the number of days of premium payment of a person in the past one year before being fired or leaving work. According to the law, the person who do not have a social insurance can apply to the governorship, if resides in a province; if resides in a district, can apply to the district governorship for green card.[80] The

[79] Social Insurance and General Health Insurance Law, No.5510, Article 28.
[80] http://www.isvesosyalguvenlik.com/anasayfa/haber36.htm

applications are evaluated by the administration committees and those who are qualified for unemployment benefits for 6-8-10 months respectively are covered by the General Health Insurance System according to the 60th clause of the law no.5510. However, there are certain conditions attached to the eligibility criteria. First of all, it is inquired whether or not this person is deprived of social security. Secondly, after determining that the person does not any kind of social security, it is investigated that whether or not the level of domestic income per person is below the one third of the minimum wage (222 YTL /144 $ as of today). As a result of these inquiries if it is concluded that this person provides the necessary requirements then, s/he is granted green card. In the discretion of General Health Insurance Law, however, there was no regulation concerning the green card system. Instead, it was stated that those whose income levels are below a certain amount will be examined by the Social Security Institution and be regarded as insured and will be free of premium payment.[81] A two-year transition period had been envisaged for this system to come into force effectively. Besides, it was also underlined that the responsibility in determining the eligible people from October 1, 2010 would pass to the Social Security Institution from governorships and district governorships.

The green card and general health insurance system as a whole with its current applicability, however, implicates certain loopholes in terms of those who are in real need. First of all, the duration of assistance of those who are unpaid is short as a result of which the number of those who are not receiving the unemployment insurance is high. First of all, if the person before becoming unemployed pays the premium for 90 days within the one year while working, becomes eligible for receiving health care services for 100 days after becoming unemployed. Secondly, if there is no premium payment within the last one year of work, this person can receive health care services free of charge for 10 days after becoming unemployed.[82] When the assistance is cut, there are two alternatives for these people. They can either apply

[81] Social Insurance and General Health Insurance Law, No.5510, Article 60.
[82] Ibid.

for green card or they may, if have the adequate means, pay their premiums and benefit from health services. The problem in fact arises for those who cannot fall into the category of "poor" to be able to apply for a green card, that is to say if the person's monthly income does exceeds the one third of the minimum wage (222 YTL), then this person has to pay the necessary premium in order to benefit from the health care. If the monthly income falls between 222 and 666 YTL, these people has to pay 26.64 YTL each month to benefit from health services. Similarly, if the income falls between the amounts 666 and 1332 YTL, then they have to pay 79.92 YTL on a monthly basis to benefit. If the income exceeds 1332 YTL, the must-pay amount rises to 159.84 YTL. In addition to that, if a person does not primarily apply for a green card within the boundaries of their residence and goes directly to the Social Security Institution in order to ask for a health assistance, the monthly income, without being subject to the income test by the SSI, is regarded as 1332 YTL and therefore the person is forced to pay the maximum amount in order to benefit from the system. Besides that, another regulation concerning the young population who are continuing their education is that those who are under 18 years of age are automatically considered as insured, the ones who are continuing the secondary education until the age of 20 are considered as insured and the ones that are receiving higher education until the age of 25 are considered insured thus can benefit from the health services.

The General Insurance System, while on the one hand put some implementations into effect in favor of the citizens, on the other hand, created a system within which the premium payment became prevalent. This created some negative implications in terms of citizens who benefit from the system. First of all, although the poverty limit is defined in the green card system, the factors according to which the limit is going to be defined are not clear (TTB, 2003:32). For those people, who are working in the informal sector and uninsured and those who are not defined in the poor category but who don't have the means to pay for premiums, there has been no regulation. They are simply expected to pay their premiums in order to benefit from health care

services. Second, as the system focused on the premium payments by the citizens, it was clearly stated in the 13th article of the law that those who cannot afford to pay their premiums will not be able to benefit from the system until the interest and the actual amounts of the debts will be paid.[83] In fact, then it becomes impossible for us to talk about the generality of the system, as it becomes clear that those who cannot pay will inevitably be left out of the system itself. Moreover, the retired people will also be expected to pay premiums. This would put a constraint on the purchasing power of those individuals whose salaries are already low. In addition to that, considering the general employment structure of Turkey, the huge amount of the incomes of the people are not registered therefore, based on the individual statement thus, it becomes harder to determine the monthly income and deduce the premium amounts especially as it is stated wrong. In the light of such considerations, it becomes harder to base the system on the premium contributions by the people themselves. Therefore, in order for this system to work efficiently as proposed, the balanced distribution of income should be maintained and the unemployment should be reduced.

4.2.6. The Full Time Law and Performance Systems

The Full-Time Law no.5947 regulates the working hours of the health personnel and the teaching staff of the university hospitals. It involves the regulations concerning the extra payments to the health personnel including performance payments and floating fund revenues within public hospitals. It was designed to be effective on January 30, 2010 which brings about a system within which the health personnel will be subjected to performance evaluation and expected to work from 8:00 to 17:00. According to the Ministry of Health, one of the basic aims of this law is to prevent the teaching staff of the university hospitals that are believed to have a tendency from leaving the work earlier than they supposed to and to prevent the patient shift from

[83] Social Insurance and General Health Insurance Law, No.5510, Article 13. It was also stated with this article that the ones having a life threatening situation will be protected against the risk of illness.

hospitals to the private clinics of the teaching staff. This law prevents the teaching staff working at the university hospitals from opening up private clinics. According to this law, in order to open a clinic one has to resign form his post at the university hospital. The other areas of focus within the law, revolved around the determination of the maximum and minimum limits of the performance payments to the health personnel and teaching staff. With this law, a performance led system is established within which the extra payments will be determined with respect to doctors (as well as other health personnel) by simply looking at the number of patients that they see everyday. However, upon the request of the main opposition party, the Republican People's Party, the constitutional court abolished the adaptation of eight articles including the one that regulates the opening up private clinics of the university hospital's teaching staff.[84]

With regard to the latest development concerning the law, the working hours are determined as 8:00 – 17:00, the opening up private clinics were allowed and tied to some regulations and conditions. With the full time law and performance system the objective was to create an environment in which the competition among doctors and health personnel would be fostered. In order to disclose the inner logic with respect to performance system, I made a private interview with one of the specialists within the Ministry of Health at the department of Strategy and Development, Harun Kırılmaz (2010). According to Kırılmaz, the application of performance system that has been effective since 2004 is designed in order to create a system within which the citizens will have an access to "better" quality of services. While determining the health policy he stated, the two determining factors are the political power and public bureaucracy. In order to meet the increasing demands and expectations of the citizens, how to use the limited resources becomes a concern for the political power and public bureaucracy. In addition to that, he underlined that the economic, social and political structures of the country also plays a crucial role in the determination of health policy. In that sense, according to him, the ministry with its focus on effective

[84] www.resmi-gazete.org/gundem/.../tam-gun-yasa-tasarisi.html

service delivery tries to meet the demands and expectations of the citizens. He stressed that by "effective service provision" what is meant is that to the extent that ministry allocates the resources to the most appropriate uses, it is considered as the most efficient usage. Therefore, the effective service delivery will also be maintained. Moreover, with the full time law, as he pointed out, the patients will have more time in terms of seeing the doctors therefore the examination time of each patient will have inevitably increased. Besides that, another aim was to increase the urge and motivation levels of the doctors and health personnel by subjecting their salaries to performance criteria, in this way he states, not only the performances of the health personnel would increase but also the health services will be measurable and assessable. In addition to such objectives, he also underlined the fact that the right to health is a constitutional human right. In that sense, the state is under the responsibility to provide health care to its citizens and to help them protect their health. However, according to him, there are some economic constraints that have a squeezing effect on the governments' budgets that changes the way health policies are formalized. In that sense, it is impossible in practice to provide health care to the whole population according to him. On the other hand, he added, although the priority is put on the demands and expectations on the citizens concerning health care while determining the health policies, they are relatively changing and subjective thus, cannot be considered as the true measurement criteria for the effective and efficient health service delivery. Because, although the service quality is highly efficient and effective, the person may not be satisfied with the health services as s/he may have different expectations from the doctors and hospitals. For this reason specifically, the feedback of the population may not be an accurate measurement technique for the service quality.

While the perceptions of the ministry of health in terms of performance system focused on the idea of efficiency with regard to the service delivery, it had different implications in terms of doctors and patients. Therefore, at this point, to examine the differentiated reactions of the doctors and patients will be beneficial in terms of

generating our understanding of the reflections of the aimed objectives at the implementation level.

4.3. The Reactions of the Doctors and Doctors' Unions to the New Policy Proposals

The policy proposals that are introduced within health system in Turkey, resulted in different reactions with regard to doctors working in different public and private hospitals. These policy proposals not only altered the ways through which health services are organized and performed, but also implicated some crucial changes in terms of doctors.

The reform when first introduced in the early 2000s, met a reactionary response by the doctors unions. Public demonstrations called "the white movements" hit the public tabloids, taking place with huge participation. In these demonstrations as well as in the publications by the medical unions, the attention was directed towards anticipated changes with regard to job security. The first line of argument by the doctors unions lied in the fact that, the new reform program within health opened up the ways to a system within which the contractual work status will replace the cadre status of the doctors. The reform was criticized in terms of leading to the creation of an insecure job environment for medical personnel.[85] By suggesting that the public hospitals should be autonomous in terms of both financing and determining their personnel status, the reform package clearly indicted a change in the status of the workforce within health sector. As envisaged in the report by World Bank, this change would take place in two steps. The first step towards the creation of an autonomous structure with regard to public hospitals included the idea of unionization of the public hospitals under one umbrella. The main aim was to reduce the responsibility of the Ministry of Health with regards to managing public hospitals and financing. The second step included the self financing and organization of the

[85] http://www.ttb.org.tr/TD/TD100/1.php

public hospitals (WB, 2003:69-73). In that sense, the second line of criticism was about privatization attempts, family doctor system and financing of the system. It was stated in the general congress of Turkish Medical Association in 2003 that, the general health insurance system due to its financing structure that mainly relies on the contributions by the beneficiaries of the system is not applicable for three reasons. First of all, as the rural population is high, the number of people who are self-employed and whose incomes are based on the individual declaration is high, therefore it changes and it is hard to cut a certain amount on a monthly base from those individual's incomes. Second, due to the high unemployment rates, a mass proportion of the population do not have the means to contribute to the self-financing of the insurance system and thirdly, the existence of the informal sectors due to same reason, raises the questions about the applicability of the system. Moreover, the implementation of the family medicine system was also criticized. The main line of the argument had been that the system would, with its new organizational structure inevitably turn into private health care centers as it allowed doctors to hire temporary contractual workers including the health personnel and staff.[86] While the medical associations held a rather criticizing approach, the perceptions of the doctors working in various public and private hospitals differed. In order to understand the inner characteristics of the change at the implementation levels, I made private interviews with ten doctors working in public and private hospitals.

Having explicated the fundamental theoretical considerations to be held, we should now seek to briefly touch upon the methods used to reflect them on the main analysis. So as to study the changes at the implementation levels, I have held eleven one-to one interviews with doctors who have worked/been working at a public or a private hospital for over 25 years. Two of them have only been working for six and seven years respectively, one of which have just transferred from public to a private hospital due to personal reasons. Therefore, the generalizations made regarding wages, specialization levels etc. should not apply to them. The other nine have spent at least

[86] http://www.ttb.org.tr/c_rapor/2002-2006/2002-2006_b.pdf

25 years in the field having positions with differing titles in accordance with the polyclinics within which they work. They all speak at least one foreign language and are metropolitan dwellers (Istanbul and Ankara) between the ages 30 and 55. Eight of them are male and the two of them are female. A voice recorder was used during the interviews with the consent of the participants in order to capture their narratives. The dialogues lasted no shorter than an hour and no longer than two and a half hours. A list of questions was brought as the only written materials to the interview scene. However, as the conversation and the topics evolved, as a part of the semi-structured interview, different questions were asked other than the written ones. The questions had been organized in such a way that demanded to know their personal experiences and observations regarding the implementation level of the newly introduced policy proposals within health system in Turkey. Although some of them gave me the consent to use their names within my thesis, some were reluctant to do so for security reasons. Therefore, I preferred to refer to their names by assigning some letters out of respect for their wishes. I met the interviewees during the interview. None of whom I know beforehand. The interviews were held at Ankara Numune Eğitim ve Araştırma Hastanesi, Ankara Üniversitesi İbn-i Sina Hastanesi, Ankara Yüksek İhtisas Hastanesi and Dünya Göz Hastanesi in Ankara.

Doctor A, who is an associate professor and clinic chief and who has worked for 32 years in the public hospitals started the conversation by evaluating the transformation within health sector. First of all, he underlined that the performance system had some repercussions in terms of doctors. According to him, the evaluation criterion for the performance system is based on a very subjective perspective. According to him, health is a very sensitive area and trying to measure the importance and quality of the services given by simply assigning some numbers to it is very wrong. As the doctors are dealing with life and death situations, he stated, you cannot measure the value of it with any amount of money. Another problem with regard to the nature of the performance system that he pinpointed is related to the attitudes of the doctors. As the performance system put the payment at the very center, some doctors would

inevitably, in order to gain more, focus on examining more patients which in turn, reduce the quality of the service given and the amount of the time that each doctor allocates for the patients. As opposed to the common belief that the full time law will be beneficial for the patients in terms of increasing the time that each patient has with the doctors, it will have just the opposite effect when thought together with the performance system. In fact, due to the above mentioned reasons, the 10 minute examination time will even be reduced further and the wage inequality and gap will also increase, he underlined. In order to prevent the abuse of the system, the best solution according to him, is to remove the future concerns of the doctors by providing them with a considerable amount of income that is enough to provide a certain quality of living so that they will not be having economic concerns in terms of their futures. Besides, they will be able to focus more on their duties as doctors that is healing the patients. In terms of the implementation of the family doctor system, he criticized the system in terms of the short training time and its structure. He mentioned that as the family doctor is allowed to hire contractual health personnel and workers, this will increase the job insecurity and may lead to privatization. Moreover, he pointed out that, the family doctor system should be a separate area of specialization if the system wants to differ from the old one. However, even if the specialization is introduced with regard to the family doctors, in time due to over specialization, some problems may occur as to which family doctor to go. He also thinks that the trust of the people with regard to the primary health care is low and that is why most people prefer to go to the university hospitals and education and research hospitals as they receive a more detailed examination including the essential tests. Concerning the General Health Insurance system, just like other doctors that I interviewed, he considers some of the developments as positive ones in terms of patients. For example, with the new system the patients can go to whichever hospital they choose. Although this development can be regarded as a positive one in terms of the mass population, the general health insurance system, as it anticipates that every person has the ability to pay premiums, will put a burden on the people's budgets a probable dismay will likely to occur in the near future. At this point, he stressed the

importance of health as a human right and pointed out that it is a secured right by the constitution itself and everyone has a right to health therefore, it is under the state responsibility to provide health care for the population.

In terms of the Ankara Numune Education and Research hospital, he talked about some of the problems that they encounter as doctors while working. First of all, he specified that they are lacking medical supplies and their needs are not met. They even make up new materials by cutting and sewing some of the existing ones in order to use them during the surgeries. Second, he indicated that the numbers of nurses are not enough within the hospital to meet the demand and there is a constraint in terms of increasing the personnel. Besides, the hospital is characterized with its huge capacity to attract most of the population especially those with the lowest level of incomes prefer to go to the Ankara Numune. In addition to that, the hospital provides health services for the three levels of health services thus more or less serve its foundation purpose. In general, while the new system introduced some positive changes in terms of patients, it totally disregarded the hospitals and health personnel working.

Doctor B, who is also an associate professor and clinic chief and who has worked for 28 years in the public hospitals directed the attention to the technologic developments within health. He regarded such developments as positive ones that contributed to the better functioning of the system. With the new technological developments in his area of research that is radiology, the faster diagnosis became possible saving a lot of time and energy. However, he pointed out that to say the same thing with regard to some of the policy changes is difficult. He signified that for patients to be able to benefit form every hospital is a good thing but it nevertheless reduced the amount of people coming to the hospitals every day. In fact, the already existing high numbers are increased nearly three fold. This would not only put a further burden on the doctor's shoulders in terms of meeting the increasing demand, but also, with the introduction of performance payments, a competition atmosphere is created expanding the wage

gap between the health personnel. Under this system, even a nurse can be paid more than a doctor with regard to her performance. In terms of family doctor system, he indicated that, it is difficult for the new system to reduce the burden of the hospitals in terms of the primary health care services because as the family doctor does not have the adequate specialization, it becomes harder for the people to trust and prefer the system.

Doctor C, who is also an associate professor and clinic chief and who has worked for 33 years in the public hospitals underlined that in order to reduce the intensity within the second and third level of health care services within public hospitals, the infrastructure of the primary health care should be strengthened. According to him, it is hard for the system with its current existence, to form the necessary trust among people because as the training program in order to become a family doctor is very short, it does not differ from a practitioner with regard to the education levels. Therefore, in the eye of the public mostly, the family doctor is mainly associated with a practitioner. In order for the system to attract some of the population that prefers to go to the hospitals for the primary care health services, it has to invest more to the primary health care and preventive health care, he stressed. If the preventive health care applications are increased, the number of people that apply to the family doctors or hospitals will be reduced. With regard to the performance system, he pointed out that some policlinics will be more crowded leading to the higher performance points than other policlinics as a result of which the doctors who are working in the relatively less intense departments will not be pleased because their performance points will be relatively lower when compared to other departments. This would both contribute to the unequal income distribution and the dissatisfaction of the some departments in terms of payments. In terms of the other constraints that the hospital encounters, he pointed out the nurse deficit and lack of medical supply as the two commonly faced problem.

Doctor D, E and F and who are working 4, 10 and 12 years respectively within public hospital and highly specialized hospital, focused more on the functioning of the performance system during the interview. Doctor D talked about the subjectivity of the system. Although he supported the implementation of the performance system, he was not pleased with the way it is structured. For instance, he gave me the example of a recent examination that involved the fluid drawing from the spinal cord of a patient. According to him, this is a high risk situation where a slight slip may cause the patient to have serious health complications as the spinal court is a very sensitive area. Even though the severity of the situation is known by the authorities he pointed out, the performance point is the same with a simple injection as in both situations the injection syringe is the main tool operator. He wanted the performance points to be higher with respect to other departments because due to the severity of the job that they perform everyday. While doctor D wanted the system to be structured on more fair grounds in terms of its evaluation criteria, doctor E directed the attention towards another crucial aspect of the performance system that is the moral grounds upon which the system is structured. He stated that he works in the internal medicine polyclinic within which the performance points are the lowest. This not only creates the income inequality and widens the gap, but also leads to the creation of a system that focuses on unfair competition. Besides, it also is morally wrong in terms of doctors because he stated that had he known that the general surgery departments would have the highest performance points then he would have chosen one of them to specialize in considering the low levels of the registered incomes of the doctors. Doctor F took a one step further and suggested that the system does not encourage the motivation among doctors as it clearly expressed in the press most of the time, on the contrary, it, together with the application of the full time law curbs the potential that the doctors have in terms of examining huge amounts of patients every day. He indicated that the system increased the amount of people that a doctor sees every day and reduced the examination time of each patient because the doctors are forced to act in a competitive way in order to gain more at the end of the month. With regard to the family doctor system, all three doctors agreed on the idea that the effects of the

system will yet to be seen in the next years to come. They complained about the crowdedness of the hospitals and the only way to decrease the amount of people that come to the hospitals is to build a strong structure in the primary health care system, according to their point of views. If the system is able to place a strong primary and preventive health care system, then the amount of the people will inevitably be reduced.

In order to have a closer look to the situation within the university hospitals with respective to the changing environment within health, I made interviews with two doctors one of which is the vice chancellor and the coordinator of the financial analysis unit at the Ankara University Ibn-i Sina Hospital, Assoc. Prof. Dr. İsmail Ağırbaş. He, first of all, started by evaluating the newly introduced policies within health system. According to him, the implementation of the family doctor system at the implementation level does not seem to be promising for two reasons. First of all, the system is not designed by taking into account of the demographic and geographical structure of Turkey. For instance, to reach a family doctor in the rural areas and eastern part of Turkey is difficult especially for those who are living in the mountainous areas where the infrastructure does not allow especially in the winter time. The family medicine systems, as built in the places close to the centers will not be reachable in terms of these people. Secondly, he underlined that there is no regulation as to how the members of a family will choose their family doctors. He asked whether or not will it be allowed for different members of a family to choose different doctors? If not, what consequences will it generate in terms of the idea of freedom to choose the doctor? , he remarked. In relation to the general health insurance system, he expressed that as the system based on the premium contribution by the citizens, considering the high unemployment rates within the country; the system will inevitably drag those people who cannot pay the premiums out of the system. Although there are some regulations concerning those who cannot pay, it is not enough to cover those who are in real need. In order to provide a more equal system, he proposed the financing of health services via taxes which would maintain

a system within which a more fair distribution would be in effect. In relation to the performance system, he noted that, although there has been a relative increase in incomes, in terms of some departments that are considered as low risk groups whose performance points are relatively lower than the rest, the system creates unfairness. In terms of the functioning of the university hospitals, he stressed some of the problems that they are facing. First of all, he complained about the crowdedness of the hospital and underlined the fact that the hospital does not serve to its founding purpose that is to provide tertiary (third level) health services. He talked about the huge number of people that come to the hospital each day and denoted that the university hospitals should go back to their foundation purposes. The only way to maintain such a system would be to strengthen the infrastructure of the preventive, primary and secondary health care services so that there will be less people to apply to the university hospitals for simple illnesses. Besides that, he also pointed out the budget constraints that the hospital has. As the institutions that generate their own budget themselves, the university hospitals at least, according to him, should be given some additional budget other than the personnel payment to spend on education. These institutions are medical training institutions that provide the medical employment capacity for the state to use thus the Ministry of Health should granted some extra money to the university hospitals to allocate and use for education purposes. In fact, as a university hospital, he underlined that they are running some budget deficits which forced them to ask for extra money from those who wish to be examined by the associates. Besides that for some tests specifically, he pointed out that they also ask for money which put a constraint on the people's budgets that prefer to use the university hospitals. Moreover, it was also mentioned that the premium payment is also the highest when one chooses to use the university hospitals. In addition to such problems, just like the other public hospitals, they are lacking in number in terms of health personnel especially nurses.

While the public hospitals are encountering more or less similar problems, the situation within private hospitals varied. Over the years, within the reports the

Ministry of Health as well as the State Planning Organization's annual and development reports (1996), (1998), (2000), (2001), (2007) and the "Health Transformation Program" of JDP, it has been underlined that private sector should take up a more active role in its pursuit of providing health care services besides the public sector in Turkey. It has always been stressed that private sector should be encouraged and given the essential incentives to play actively within the process of service delivery. Since the early 2000s, especially together with the JDP's coming into power, the desired active role of the private sector in the public service delivery especially with regard to health services has been put under the spot light. The private sector hospitals within the framework of general health insurance system, it has been allowed for public officials and insured citizens to benefit from the public sector hospitals in exchange for paying a certain amount for the health services and tests that they are having.

The Ministry of Health, spoke with high volumes that the private sector investments should be extensive enough to attract more people. In that sense, the private hospital regulation was shaped. In the new regulation that became effective as of September 2010[87], the private hospitals are expected to have at least 100 bed capacities with some exceptions.[88] With this new regulation, it became clear that the private sector hospitals are expected to work with a greater capacity than before. In that sense, the existing hospitals are expected to re-shape their structuring by adjusting their investment capacities accordingly. Besides this new regulation, with the introduction of General Health Insurance system, it was allowed for public workers and insured people including the retired employees to benefit from the private hospitals in exchange for paying a certain amount of the service since 2007.[89] At that point, in

[87] 'Regulation of Private Hospitals', (2010), Article 5.
[88] There also have been some changes with regard to the foundation of private hospitals. With the permission of the Ministry of Health, upon the consultation of Planning and Employment Commission, an authorization in opening up private hospitals whose bed capacity are under 100 could be granted. One condition attached to this regulation is that the bed capacity should be at least 50.
[89] The amount is determined according to the class of the private hospital. For instance, while the A class private hospitals can ask from patients up to 70% of the amount that the Social Security

order to understand the current situation within private hospitals I made interview with three doctors who evaluated the current situation regarding the patient intensity at the private hospitals. Doctor G, H and F agreed on the idea that health is a human right and state should take the main responsibility to provide health care to its citizens. With regard to the increasing role and functions of the private hospitals Doctor G and H stated that everyone has the right to choose the hospitals that they wish to go and the financial constraints should not be a problem in this matter. In that sense, opening up private hospitals to the usage of insured people and public workers besides the ones who benefit from the service by simply paying the price is a positive development in terms of those who cannot afford to pay the whole amount. Moreover, doctor G also added that he wished the state could provide health services free of charge for the whole population but as it is not possible, to provide more alternatives to the public is a positive development in terms of the ones who benefit from health services. When asked what they understood from public service and public health, doctor G indicated that to the extent that the health services are provided effectively, then the public interest would be protected. One way to accomplish this aim, according to him is not to force people to go to a single type public hospital. At this point, private hospitals stand for an appropriate alternative given the high number of patients. Besides, doctor G and H agreed that private hospitals work in a more efficient way than the public hospitals do and the existence of a competitive system increases the quality of the services given. With the introduction of the new system within which the insured people would benefit from the private hospitals without paying the whole cost of the service, they denoted that the number of the people that apply to the private hospital who have general health insurance have risen considerably, besides the ones with private health insurance. With regard to the functioning of the hospital doctor H pointed out that in the hospital, people without waiting in the long queues can have health services and there is no such crowdedness as it is the case in public and university hospitals. In addition

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Institution pays to them as the examination cost covering all the tests, as the class lowers, the amount is also lowered.

to that with regard to the functioning of the hospital, both doctors suggested that they are giving clinic services including primary and secondary health services, however, as the infrastructure is not enough, there may occur some problems regarding the service provision. In order to overcome this obstacle, doctor G suggested more investment on the infrastructure and equipment and doctor H suggested the idea that more qualified and health related management staff should take part in the hospital management other than the ones existing who are not related to health in any way.

While doctor G and H supported the idea that private hospitals should be more active role in the service delivery, doctor F held a rather criticizing approach even though she works in a private hospital. She underlined that since the beginning of the new implementations that allowed more people to come to the private hospitals without paying the whole cost of the services given, thee has not been a considerable change in the number of people that come to the hospital on a daily base. As the private hospitals address to a particular segment of society whose income levels are above a certain level that provide them with the opportunity to benefit from the high-cost services, the number of people did not considerably rise, she states. She, as a doctor who worked at the public hospital for several years, even stated that at times she gets bored due to the lack of intensity. According to her, even if the introduction of General Health Insurance system brought about a certain level increase in the number of patients, the people in fact still are hesitant to come because they still have to pay. With regard to the new comers, the system as it still not grounded, includes certain regulations that may not be in favor of the patients. When I asked what she meant by that statement she talked about the dissatisfaction of the patients that complain about the extra payments that they have to make for tests and other additional medical procedures. The hospital charges for some additional tests, she exclaimed. Other than that, from her point of view the patients prefer private hospital for two reasons: first they do not have to wait in the long queues and second, the examination time is relatively long when compared to the public and university hospitals.

In this part, I tried to reveal the inner structural changes that focused on the new policy changes in the health sector. In order to accomplish this aim, I tried to analyze both the policy-making and implementation sides of the health reform by making private interviews with doctors and policy-makers. In the following part, I will refer to the interviews made with various employees and workers from different sectors to have a general idea about the patients' point of view about the newly adopted health reform and to uncover their specific experiences.

4.4. The Reactions of TUSIAD (Turkish Industrial and Business Association) to the New Policy Proposals within Health Sector

The reaction of TUSIAD (Turkish Industry and Business Association) to the newly proposed policies within health sector that have been in effect since beginning of the early 2000s, have been supportive unlike the Turkish Doctors' Associations. It advocated the Justice and Development Party's claim in a report dating back to 2004[90] that Turkish health sector was in fact in need of reformation. In this report, some expressions that were mentioned in the 59th government program had been underlined as the-must-be- ingredients of the new reform in health sector. In the report, the emphasis was put on the financing and the organization of the system as a whole. In relation to the financing of the system, it was stated that;

> *"Turkey's current very fragmented structure of health finance should be replaced by an integrated public health financing system which is funded and supported by premiums collected that is based on wage and income levels and general taxes. In terms of social security, the current roles of the health insurance programs (ES, SSK and BAĞ-KUR), the green card application and the public health finance functions of the Ministry of Health should be collected under a single payment agency (General Health Insurance)." (TUSIAD: 2:2004)*[91]

[90] Tusiad's Health Report (2004) available at: http://www.tusiad.org/FileArchive/duyuruno539.pdf
[91] http://www.tusiad.org/FileArchive/duyuruno539.pdf (Articles: 1.1., 1.3., 1.4., 6.2.)

As clearly stated above, the role of the ministry with regard to the financing of the system is redefined. In fact, the financing of the system is designed to be composed of the individual contribution payments by the users themselves which will be supported by the inspection fees. The report also addressed to the establishment of contractual relations between the health providers and patients. For instance, it introduced the "Third Party Administrators" system where the patients with serious illnesses that requires expensive and complex treatments, will be expected to enter into contractual relations with private sector in order to get the essential treatment (Article 5.4.). However, there was no concrete reference made to the ones who cannot pay their premiums. It was only stated that a separate structure should be established for them (Article 1.2). The model that is designed within the report, suggested the implementation of a competitive market-based approach within which the public and private visions will co-exist and co-operate creating a multi-discipliner working environment (TUSIAD: 2004:2). In that sense, a governance model was emphasized within health sector where the policies will be determined by co-operation of public and private sectors and civil society. It was proposed that public sector should not be in a position to provide public services but to pay for the services (Article 6.1.). With regard to the organizational structure of the health system, the proposed changes were again so much in line with the JDP government's reform proposals. The recruitment of contractual health personnel(Article 7.4.), the establishment of a regulatory body that would deal with insurance structures, monetary control of hospitals as well as the hospital administrations (Article 1.3), the granted autonomy to the public hospitals(Article 8.3), were among those that corresponded to the desired changes in the government program. These policies not only reflected the core of the government reform process but also stood for the public reforms that have been introduced by the NPM approach since the early 1980s. The reflection of these reforms within health sector can be seen as the introduction of contractual employment, individual financing systems and the autonomous and regulatory bodies that would unify the public hospitals under one roof.

In the light of above-mentioned developments in terms of the participation of the representative of the big capital as a part of civil society we can argue that the new health reform is designed in accordance with the mentioned principles in the health report published by TUSIAD. Therefore, we can conclude that health reformation process is supported by the big capital in Turkey. In fact, it will not be wrong to state that it was clearly affected by the proposal of TUSIAD. While on the one hand we see the application of the NPM reforms within health both at the organizational and structural levels, on the other hand we realize the "common dialogue" that have been tired to be realized in relation to good governance. As emphasized under the title "good governance"[92], an increase in social dialogue is aimed to be enhanced in the designing process of social policies including health. In this process, the state alters the traditional decision making processes by involving other actors. The objective of government in this regard is to eliminate the legitimacy problem that may arise from the fragmentation, decreasing scope of the state authority and marketization which are regarded as the problematic characteristics of the NPM approach (Ateş&Kırılmaz, 2007: 536). Thus, within health restructuring process in order to overcome such obstacles, the involvement of various actors within policy-making process as different partners to the social dialogue within which the objectives of the health policy will be realized, is advocated. However, it is clear to us that the essential partners in the determination of health policy are invisible within this process, namely the doctors associations and the representatives of the public as civil society. It directs us towards a common criticism made about the notion of good governance that it works in favor of capital. In fact, it is stated by some of the scholars that governance describes a model that separates important elements from democratic inquiry and favors the involvement of capital (Bayramoğlu, 2005: 20). According to some other, the Neo-Liberal reform agenda is not characterized by the elimination of politics form the public administration systems; on the contrary, it aims at introducing new politics

[92] The promlems associated with governance according to the notion of 'good governance' stems form developing countries' inability to adapt the reforms within their public sectors.

that focused on market relationships that promotes the interests associated with such relationships (Rodan, 2006: 215).

In that sense, TUSIAD can be labeled as an active partner to this social dialogue which would give health policy its final shape according to the good governance understanding. The state will fulfill the main objective by making sure the involvement of the civil societal actors as well as public and private sectors in this process. To the extent that it accomplishes this aim, it is believed that the deficiencies of the system will be eliminated. However, when we have a closer look, the absence of the doctors associations and the public as citizens raises certain concerns about the applicability of such a system.

4.5. The Reactions of the Public as "Patients" to the New Policy Proposals

In this part of the chapter, I will try to touch upon the personal experiences of the ordinary public including public officials, waged workers, unemployed people and retired people. I made interviews with 40 people. The focus of the interviews was about the daily encounters of them with the changes while they are taking health services. The questions aimed at revealing the consequences of some of the recently implemented policies in terms of patients.

The interviewees varied between the ages 27 and 55. They composed of 40 individuals residing in Izmir, Ankara and Istanbul respectively. 70% of them are public sector workers, 15% of them are retired individuals, 10% of them are private sector workers and 5% of them are unemployed. The generalizations regarding wages therefore do not apply each one of them. 80% of the interviewees are male and 20% of them are female. During the interview besides a voice recorder, a list of questions handed to them in order for them to feel comfortable while answering the questions. Some of them preferred to give written answers and gave to me the filled papers later. Some of them allowed me to use the voice recorder. The dialogues lasted no longer

than an hour and no shorter than a half an hours. The questions had been organized in such a way that demanded to reveal their personal experiences as patients while taking health services. The questions were designed to uncover their experiences as patients. Although the results of this field work cannot be generalized for the whole population, the results can be considered as a glimpse of what is in fact happening in the actual practice. In that sense, it is beneficial in terms of generating our understanding of the health policies that were implemented.

First of all, it can be stated that the interviewees when asked about what comes to their minds when one ask about what is the right to health? As a whole, they consider the right to health as a human right and acknowledged the state responsibility in providing health care for the citizens. A mass proportion further argued that the health expenses have to be covered by state and should be free of charge. When asked about how they evaluate the current General Health Insurance System, 50% of them stated that they are not happy with the health insurance system for two reasons. 70% of this fifty percent are not happy with their social insurance because it cannot cover all the health and medicine expenses[93]. They say when they go to the hospital they have to pay a contribution for each and every test and examination. They also stated that state also does not pay for most of the drugs given by doctors and they usually have to pay the whole amount from their pockets. The other remaining 30% more focused on the service quality and they think that the health insurance should provide them with a better quality service. They are simply not satisfied with the service quality given at hospitals of any kind; let it be public or private. When asked about what kind of hospital they prefer to go almost 70% of them named the university and research and education hospitals because they said that they are more trustworthy in terms of examining patients. Besides, they added that there are more tests and inquiries done in order to make a diagnosis and the doctors are considered more qualified. 20% of them named the private hospitals and 50% of this 20 percent people

[93] While the working people are paying 20% of the medicine expenses, the retired pay 10%.

underlined that they go to private hospitals for simple illnesses, if they think that they have a more serious illness then they said that they go to university hospital. Those who prefer private hospitals stated two reasons. First of all, when they go to the private hospitals they say that they do not wait for long hours to be examined. Second, they underlined that they have more examination time and a better attention. 50% of the 70 percent that prefer to go to the public and university hospitals think that the private hospitals are money traps that want to drag more money out of people's budgets as they are making extra unnecessary tests and asking for money for each and every single test and medical examination. The remaining 20% does not prefer to go to the private hospitals simply as they do not trust the quality of the services given at private hospitals. 30% of them underlined the fact that the choice for hospital usage in fact is determined with some economic concerns. In fact, they choose the type of the hospital by taking into account of the contribution payments that they will pay when they go to that hospital. For instance, if somebody wants to have services within a university hospital, then this person has to pay the maximum contribution payment. As the service quality is regarded as the highest within university hospitals, the amount of contribution payment is the highest. With regard to the General Health Insurance system, when they are asked about the positive developments that is brought by the new system, 60% of them consider the opening up public hospitals to the general use, a positive development in terms of the service takers. 25% of them consider the absence of propulsion system a beneficial development as the system allows them to go to whatever hospital they wish. However, they compare the system to the past where they do not have to pay a premium in order to benefit from the health services. Now, they criticized the system as each hospital asks for contribution payment from the patients. When asked about whether or not they found the new system secure and efficient enough to allows room for easier access to health services, they underlined the fact that due to the existence of the contribution payments, 20% of them are not feeling secured as they see the state as a body that is under the obligation to provide health care to its citizens free of charge. 65% of them summarized the new system with this sentence: "if you do not

have money then you do not get treatment". When asked about the family medicine system, 55% of them stated that they have not used the system therefore, have neither an idea as to how it neither functions nor can evaluate the effectiveness. 30% of the remaining 45 percent expressed that they prefer the family medicine centers to have basic health care services as they cannot have access to health care as they wish due to the crowdedness within public hospitals. 5% of the remaining 15 percent are actually satisfied with their family doctors that they think they can trust. 10% of them prefer the family medicine centers as they are located close to their homes. They underlined that, they do not have to wait when they go to the family doctors and they do not pay contribution in order to benefit unlike the public, university and private hospitals. 25% of the 45 percent also noted that the family doctors should be given more education and differ with its quality from the previous practitioners. With regard to the accessibility of the health services, the views varied. 60% of them underlined that they cannot have an easy access to health services in the public and university hospitals due to the crowdedness. They state that with the new system, there has been no change regarding the long waiting hours and short examination periods. 15% of them mentioned that they do not prefer to go to the hospitals as they do not want to lose the whole day waiting. 50% of this 60 percent underlined the fact that if the number of patients is high then it becomes harder for each person to have an easy access to the health services. In order to have a queue number, they noted that they have to be present at 5 am in the hospital in order to be examined in the morning. In addition to having an easy access to the health services given, a small proportion of them directed the attention towards having a better quality services within hospitals and marked this as important as the easy access. 20% of them remarked that they are having an easy access to health services as they have a health insurance, but for those who do not have a health insurance, they do not think the access is easy. As regard to the unsatisfied and unwanted situations within both public and private hospitals, 70% of them first stated the contribution payments and 40% of those underlined that with the introduction of the general health insurance system and the implementation of the contribution payments within health sector,

opened up the ways to privatize the system. Almost 90% of them when asked about the undesired situations that they have to encounter when they go to the hospitals, complained about the crowdedness, waiting long hours in the queues and short examination times in public and university hospitals. 20% of them are unhappy about the way doctors and health personnel treat them. 20% of them criticized private hospitals as they are asked to pay extra for each and every test and medical procedure. 10% of them dissatisfied with the appointment system about certain tests and procedures. With regard to the MR and tomography they note that the hospitals giving dates months ahead, especially within university hospitals. Thus, they usually end up paying extra in order to speed up the process and get an earlier date. Besides that, they are not happy with the extra pricing of the health services that they come across when they wish to be examined by associates. Finally, when asked about how they perceive the terms like public interest, public service and public health, most of the interviewees stated that the phrases do not evoke them anything because, according to them the terms are emptied out inside. When I asked them to further elaborate on exactly what they meant, they ended up answering that the state refrained from some of its powers such as protecting public interest by providing the citizens with the necessary means to have an easy and low-cost access to the health services to protect the public health as a whole. Others specifically referred to public interest as the initiatives in favor of the public that are carried out by some of the state organs, to public health as the health of the population as a whole and to public service as the services provided by state to the people that make up of the public itself. In those definitions, there was a consensus about the active role of the state in the provision of public services.

4.6. Conclusion

In this chapter, I tried to give a historical account of the emergence of the notion of public health, elaborated how it evolved through time and how states have come to realize their role and responsibility in providing health care to its citizens and evaluated health as a part of public policy by revealing its inner structures and

examining the close relations that it has with economy. In that sense, I not only pinpointed the differentiated structure of health, but also I was able to show why it has a huge contribution to economy as a whole. Then I moved into analyzing health services as a part of the public service understanding. In a sequential way, I tried to reveal the inner structures of the health reforms in Turkey by discussing about the health developments that are implemented with respect to different government power periods. I concluded that the roots of the health reforms of the 2000s can be found in the proposed policies in the time of Motherland party. Then I moved into analyzing some of the basic policy changes within health sector and tried to reflect the underlying philosophies as well as strengths and weaknesses of the proposed reforms. While doing that, I make use of the results of my field work that aimed at reflecting the current situation at the implementation level in terms of doctors, big capital and patients. This reform process that the JDP government has undergone for a while has proven itself to be inefficient both in terms of service providers and service takers. The reform process of the JDP government creates considerably negative outcomes both in terms of health personnel and patients. In terms of health personnel, it creates a competitive system within which the doctors and other health personnel that is subjected to the performance charging system with some economic concerns be driven into competition with one another. This not only creates and unfavorable conditions in terms of patients whose examination periods are relatively shortened, but also creates a huge income inequality which results in the dissatisfaction of the health personnel economically. This indeed proves the idea wrong that focused on the claim that private sector methods will increase efficiency and effectiveness in the public service provision that is promoted by the NPM approach because performance system will motivate doctors to do their jobs. In fact, it has just had the opposite effect. The health personnel who are working in the polyclinics whose performance points are relatively low are not happy with the way the system is structured. Even the ones who are working in the polyclinics with the highest performance evaluation points are complaining about the inconsistency of the system. With respect to the family medicine and general health insurance systems, the

situation more or less seems similar. The family medicine system as the education level of the doctor does not differ much from the simple practitioner of the previous system and introduces the contractual work status of the health personnel additionally hired by the family doctors does not seem to be promising in the long run. Besides, a considerable amount of the patients that I interviewed, for this reason, does not trust the primary health care services. Thus, the number of patients that prefer to go to the public and university hospitals in order to get primary health care services will not likely to diminish anytime soon. As for the general health insurance system, the picture is more complicated than it seems. The unification of the different social insurance systems under one roof, besides allowing patients to choose the hospitals that they wish to go freely, introduced an individual financing system that puts a burden on the budgets of the citizens especially to those whose income levels are already low. The system also lacks the essential regulations in terms of finding a solution mechanism for those who do not have social incurrence and those who cannot pay their premiums. Moreover, the system with its current use, applies to those whose incomes are not based on the individual statement. In other words, the financing of the general health insurance system as it based on the premium contributions by the users, can only draw money instantly from the incomes of those who are already registered (i.e. public officials). The system therefore will inevitably exclude a certain segment of the population resulting in accountability problems in terms of the parties involved in the formation of the health policies.

CHAPTER 5

CONCLUSION

In this study, I tried to explain the reasons, results and repercussions of the current health sector reforms in Turkey by taking into account Neo-Liberal restructuring as a universal practice, the New Public Management applications and European Integration process. The ending of the post war period and the introduction of Neo-Liberalism in the early 1980s was taken as the starting points of the change of attitude towards public sector. It is argued that Neo-Liberalism marked the ending of the interventionist state period within which public services are organized under a state-centered structure. The introduction of the new reforms within public sector is tied to the changing economic as well as political and social structures marked with Neo-Liberal transformation. The NPM applications are presented as the organizational structural reflection of the Neo-Liberal restructuring process. By referring to the European and Turkish cases respectively, I tried to analyze the motive behind the common health care reforms and tried to find answers whether the NPM applications provides and efficient and effectively working health system in Turkey or not.

In the first chapter, I made a general introduction stating how the topic is outlined and going to be analyzed. After a brief introductory section drawing the general picture within which I utilized the common knowledge on how and why health sector is restructured, I arranged the topic in three main chapters. I analyzed two main causes of the health sector restructuring in Turkey; the impact of Neo-Liberal policies designed with NPM principles and the role of the European Union.

In the second chapter, in order to discuss the theoretical basis of the health reforms as well as the principles NPM as the policy formulation of Neo-Liberal logic, I disclosed the inner structure of the NPM. In that sense, my main aim was to show how Neo-Liberal logic has designed the NPM principles in such a way that focused on altering

the ways through which public sector is organized and performed its functions. I discussed how Neo-Liberal agenda has been promoted since the early 1980s and as a reflection of it in the public sector, I analyzed Public Management and New Public Management approaches. I discussed the role and function of the NPM as a newly proposed policy tool in the late 1980s and early 1990s. I stated that Neo-Liberalism constituted the very logic of the NPM reforms that transformed the public sector. I also talked about managerialism, public choice and reinventing government approaches as the common bases that formed the NPM. I argued the aim of the NPM applications within public sector was to generate and secure a public administration system within which a free market economy will survive and function well. In order to maintain such a system, NPM introduced market reforms and private sector methods within public sector along with flexible organizational structures, performance related systems, contractual employment regimes, and contribution payments with regard to public services and claimed that this new structure indeed would maintain a more efficiently and effectively working public sector. This claim stemmed from a false premise that private sector is working more efficiently than public sector. While on the one hand, the claim presupposed the public sector's relative inferiority to the private sector, on the other hand it has promoted the idea that politics and administration should be analyzed separately. In order to argue to the contrary, I tried to show how the political and economical developments affected the nature of the administration itself by focusing on the political and economical developments that came to be effective since the early 1980s. Starting from 1980s onwards, I argued that there has been a worldwide trend towards aiming at reducing the role of state in socio-economic activities, particularly under the influence of Neo-Liberal policies that represent a redefinition in the role and structure of state through deregulation, privatization and liberalization. This not only indicated a departure from the traditional role of state as the provider of public service, but also shifted individual risks that are associated with sectoral failures from state level to individual levels. After giving the theoretical background of the reforms ongoing reforms in the public sector, I tried to analyze whether or not the NPM applications associated with

Neo-Liberal policies, maintain an efficiently working health sector. In that sense, I gave current health reform examples and concluded on the contrary.

In the second chapter, I briefly looked at the European experience and European health policy understanding and gave examples of the recently member countries' health sector experiences. In this chapter, I pinpointed the Open Method Coordination as a tool that has been utilized within Europe with respect to member states. I discussed whether or not Europe does have a common health policy agenda that could guide the member and respective candidate countries towards a certain application. In order to deepen the subject, I analyzed the existing health schemes in Europe and elaborated on the newly member states' health sector restructuring processes and experiences. I argued although health policy is still considered in the national competence of member states and although EU does not have a structured health policy, as it is it is shaped around a free market understanding within which the flexible methods of private sector altered the ways through which the countries' health policies are formed, any application towards enabling the process would be welcome. In that sense I underlined that EU draws the common boundaries within which such a system would be secure and well functioning. In order to elaborate on the current policy changes, I gave country-specific examples and talked about the repercussions of the above-imposed health reforms within those countries. I concluded that health reforms both in Central and Eastern Europe and in Turkey started with Neo-Liberal restructuring process long before the European engagement and strengthened with the EU agenda.

I argued that the public sector reforms that have been undertaken in Turkey to a great extent have been shaped in line with the WB and IMF policies. These reforms have been set as conditionality by such institutions in exchange for a release of a certain amount of loans. However, I also added that the reforms are not totally by the external powers; instead it reflected the political choices of the respective government that came into power since the early 1980s.

In the light of theoretical discussions I made in the previous three, in the fourth chapter I analyzed Turkish health sector restructuring process within a historical context. First of all, I started with analyzing the emergence and the shaping of the term "public health" and its relative importance. I underlined how states came to understand their responsibility to provide health care to its citizens in order to maintain the social cohesion. Then I moved into explaining Turkish health sector restructuring process since the early 1980s. I examined government-specific policy changes since the past three decades and concluded that the health reforms that have been undertaken since the times of MP, reflects although not a continuous, but a common understanding. This understanding fostered the adaptation of private sector methods and practices within health. Moreover, I underlined the fact that to determine the level of efficiency especially within health sector is a complex task due to the special characteristics of health. I argued that health is not a typical market, thus, the general private sector measures that are expect to increase the level of productivity in a perfectly competitive market would not apply to health. I argued that everyone must receive the equal treatment regardless of their income and social status and I claimed that the so-called efficiency understanding of the NPM would inevitably neglect this aspect.

In order to elaborate on the changes that Turkish health sector has been exposed to and show that the NPM principles vested in Neo-Liberal policy proposals does not create an efficiently working health sector. In that sense, I tried to analyze the specific policies that are introduced within health sector in the past decade. In order to see the actual practice, I made one-to one interviews over 50 individuals including policy-makers, doctors, health personnel and patients. As a result of this field work, I came to conclude that the reform, although introduced some relatively positive changes in terms of patients like opening up hospitals to the usage of insured people, totally disregarded the employment structure of the health sector. First of all, the reform did not take the support of the medical community in Turkey which reflected itself in the Turkish Medical Association's publishing's and public demonstrations of the doctors.

As I discussed in the beginning of the fourth chapter, health sector with its unique structure contributes to the economy to a great deal and to ignore the employment structure will not be a wise move while determining health policies. For instance, with the introduction of the performance system I argued the creation of an uneven system within which the doctors are expected to compete with one another in order to gain more. This development not only had repercussions for the health personnel who are working in the relatively low-ranked policlinics in terms of performance points but also decreased the examination period of the each patient gets. Another aspect of the performance system is that in time it may lead to the intensification of medical students in certain departments whose performance points are relatively higher than the others. This would not only widen the already existing income gap, but also force people in a way that they eventually have to choose the departments due to the economic concerns and not according to their interests in the subject. With regard to the family medicine system, it was usually underlined that the system if it wants to be differing from the old practitioner system and build a trust among people to the primary health care, has to focus on education. In other words, it is concluded that the system with its more qualified health personnel would attract more people and hopefully this would in turn reduce the amount of people that apply to the university and public hospitals for primary health care services. However, as the training time for family doctors are very short, the system with its current application does not seem to be promising. Most people with whom I interviewed stated that, as they do not trust to the primary care, they do not prefer family medicine centers to take primary health care services. Besides that, I also argued that the applications of preventive health care services are also relatively low. As the system more focused on finding solution to specific health care problems in the short run, it is reluctant to take up measures that would prevent the emergence of certain diseases beforehand as it seems more costly. With regard to the general health insurance system, it can be stated that the system with its introduction of individual contribution payment system, is not approved by the mass population whose purchasing power in the high inflationary economy is low. People are mostly concerned about how they are going

to meet the increasing health expenditures. They stated that most of the medicine is not paid by the social security institution thus they had to pay for most of them directly from their pockets. Besides, they are also not happy with the way that hospitals ask for extra money for each and every test and medical procedure. They consider this development as the creation of a system within which they were afraid that they are not going to have health services unless they have enough money to cover the expenses. In that sense, they are now pleased with the state's refraining responsibility in providing health care to its citizens. In addition to that, the system includes a loophole for the unemployed people, for the ones who are working in the informal sectors and for the ones who cannot considered as poor to apply for a green card but at the same time who do not have the means to pay monthly premiums in order to benefit from the health services. This not only creates a feeling of distrust between the government and its citizen, also questions the governments' accountability that have been stressed with good governance approach as they promise to be there for their citizens in times of need . Therefore, it can clearly be stated that any attempt to place limits on access to the health spending will be met by strong resistance from groups negatively affected (Altman: 2003). With regard to the functioning of the private hospitals, most of the people that I had interview with stated the different charges for different health services revealing the inner inconsistencies of the system as a whole. Thus, we can conclude that although the private sector participation in the provision of health services is advocated, there has been no strong concrete control mechanism to prevent the misuse of the system by the rant-seeking private hospitals.

Having explicitly argued the different characteristics of the health reform, we can conclude that as the reform neither did take the support of the medical community nor determined in accordance with the demands and expectations of the public, standing as an above-mentioned and one-sided reform. With its current application it has some serious structural problems that need to be eliminated. The reform in that sense, not only introduced a system within which health sector are structured in accordance with

the current dominant policy paradigms that took their roots from Neo-Liberal understanding that saw the state responsibility in the provision of social services as something that needs to be get rid of due to some economic concerns but also shifted the social risks from state discretion to individual responsibility by promoting active stance taken by the individuals in providing and maintaining their health care.

To conclude, in order for individuals to have better functioning health systems and a more equal access to health care and an efficient service provision system governments should seek to find ways to design health policies without neglecting its "social" character and they have to look for macro economic solutions like decreasing the unemployment rates and poverty levels within society.

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