TRANSFORMATION IN THE ORGANIZATIONAL AND FINANCIAL SET-UP OF THE HEALTH CARE SYSTEM IN TURKEY - ITS REPERCUSSIONS AND SIMILARITIES WITH THE ENGLISH MODEL

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL OF SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

BENGİ DEMİRCİ

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY
IN
THE DEPARTMENT OF POLITICAL SCIENCE AND PUBLIC ADMINISTRATION

JUNE 2012

Approval of the Graduate School of Social Sciences

_____

Prof. Dr. Meliha Altunışık
Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Doctor of Philosophy.

_____

Prof. Dr. A. Raşit Kaya
Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Doctor of Philosophy.

_____

Prof. Dr. Şinasi Aksoy
Supervisor

Examining Committee Members

Prof. Dr. Raşit Kaya (METU, ADM) _____

Prof. Dr. Şinasi Aksoy (METU, ADM) _____

Prof. Dr. Melih Ersoy (METU, CRP) _____

Assoc. Prof. Dr. Örsan Akbulut (TODAİE) _____

Assist. Prof. Dr. İpek Eren Vural (METU, ADM) _____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last name: Bengi Demirci

Signature :

ABSTRACT

TRANSFORMATION IN THE ORGANIZATIONAL AND FINANCIAL SET-UP OF THE HEALTH CARE SYSTEM IN TURKEY - ITS REPERCUSSIONS AND SIMILARITIES WITH THE ENGLISH MODEL

Demirci, Bengi

Ph.D., Department of Political Science and Public Administration

Supervisor: Prof. Dr. Şinasi Aksoy

June 2012, 331 pages

This thesis analyses the transformation in health care system in Turkey with particular emphasis on Health Transformation Program (HTP) which has been in progress since 2003. This analysis is done from political science and public administration perspective where neoliberal restructuring process and related approaches such as New Public Management and epistemic communities are utilized. This dissertation argues and verifies that health care reforms in general and HTP in particular mainly target organizational and financial set-ups of the health care systems and these reforms are not only highly interrelated among themselves but are also the ones which bring about the most serious outcomes. In this regard an attempt is made to clarify the long-lasting confusion about what decentralization means in health care systems and to understand the trend in health care reforms towards producing hybrid models for organizational and financial set-ups. The thesis argues and explores that health care reforms targeting organizational and financial set-ups have been producing serious impacts regarding economic, political, managerial, clinical, equity and conceptual aspects of the health care system. This argument is supported by primary data derived from the research conducted in a public hospital in the post-HTP period. In its efforts towards understanding the repercussions of the

HTP, this thesis points to the value of referring to the English NHS - particularly its way of reforming itself- where it not only extracts out the common points between the two cases but also attempts at making inferences from the latter for the incipient former.

Keywords: Health Transformation Program (HTP), decentralization, finance, English NHS Model.

ÖZ

TÜRK SAĞLIK SİSTEMİNDE YERELLEŞME VE FİNANSMANA YÖNELİK DÖNÜŞÜM ÇABALARI, BUNLARIN ETKİLERİ VE İNGİLTERE MODELİ İLE BENZERLİKLER

Demirci, Bengi
Doktora, Siyaset Bilimi ve Kamu Yönetimi Bölümü
Tez Yöneticisi: Prof. Dr. Şinasi Aksoy

Haziran 2012, 331 sayfa

Bu tez Türkiye'deki sağlık sisteminin dönüşümünü analiz etmektedir. Çalışma ağırlıklı olarak 2003 yılından itibaren yürütülmekte olan Sağlıkta Dönüşüm Programı (SDP) üzerinde yoğunlaşmıştır. Sağlık sistemindeki dönüşümün analizi siyaset bilimi ve kamu yönetimi perspektifinden yapılmaktadır. Bu bağlamda neoliberal yeniden yapılanma ve Yeni Kamu İşletmeciliği gibi ilgili yaklaşımlar kullanılmaktadır. Tez, sağlık reformlarının ve SDP'nin esas olarak sağlık sisteminin organizasyonunu ve finansman yapısını hedef aldığını; söz konusu reformların birbirleriyle yakından ilişkili olduklarını ve aynı zamanda da dönüşümün en ciddi sonuçlarının buralardaki değişikliklerden çıktığını iddia etmekte ve ortaya koymaktadır. Bu bağlamda sağlık hizmetlerinin yerelleşmesi konusuna özel bir önem verilmiş ve bu konuda süregelen kavramsal karışıklığı gidermeye yönelik derinlemesine bir analiz yapılmıştır. Buna ek olarak, dönüşümün, sağlık sistemlerinin organizasyonu ve finansmanıyla ilgili olarak ortaya koyduğu hibrid (karma) yapılanma dönüşümü anlamada başvurulan önemli bir yaklaşım olmuştur. Tez, dönüşümün, sağlık sisteminin organizasyonu ve finansman yapısını hedef alan reformlarının, sağlık hizmetlerinin ekonomik, siyasi, yönetimsel, klinik, eşitlik ve kavramsal yönleri üzerinde ciddi etkileri olduğunu iddia etmekte ve ortaya koymaktadır. Bu iddia ve ilgili analizler, SDP sonrası dönemde meydana gelen değişiklikleri anlamak üzere bir kamu hastanesinde yapılan

araştırmadan elde edilen birincil verilerle de desteklenmiştir. Çalışma, SDP'nin etkilerini anlamaya çalışırken, İngiliz Ulusal Sağlık Sistemi (NHS)'nin - bilhassa bu sistemin reforme edilme biçiminin- analiz edilmesinin önemine işaret etmekte ve bu bağlamda iki model arasındaki ortak noktaları tespit ederek İngiliz modelinden Türkiye'deki dönüşüm hakkında çıkarımlar yapılabileceğini ortaya koymaktadır.

Anahtar Kelimeler: Sağlıkta Dönüşüm Programı (SDP), yerelleşme, finansman, İngiliz (NHS) Modeli.

TO

***MY MOTHER* NECLÂ DEMİRCİ**
&
***MY FATHER* MEHMET ALİ DEMİRCİ**

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Health has been an important and a popular issue in the history of societies for ages. Undoubtedly this is primarily related to its vitality for the survival and thus in a manner for the raison d'étre of these societies. However, with the emergence and consolidation of the modern state, health has gained political and economic connotations that it has become an important domain of legitimacy and power for the modern state.

Within the course of capitalist development, health has become one of the most substantial and also most targeted parts of the public sector. Besides various other factors, this was highly related to and was also shaped by the phases of the capitalist development processes such as the emergence of the welfare state and other crisis so far.

The recent popularity that the issue of health has gained should be considered within this context - which can be most broadly put as the neoliberal restructuring of the state taking place since 1980s. It is mainly this process which has brought about serious attempts to transform health care systems all over the world together with the restructuring taking place in the public sector as a whole. Again it is within this same context that ordinary citizens started to have more and more "health care issues" on their agendas during their daily lives, which basically stems from increasing commodification that have been taking place in health care services as a result of the neoliberal restructuring process. As it will be explained in the following relevant section, while acknowledging its various peculiarities, the case of Turkish health care reform can be (and should be) analyzed within the general neoliberal restructuring framework.

When the reforms undertaken so far to transform health care systems in this regard are analyzed, it is seen that they have been having serious repercussions for the

socio-economic, political, managerial, clinical and cultural aspects of health care systems which make them an important focus of study for not only medical sciences but also for social sciences where a comprehensive political science and public administration perspective is also highly required. In fact this has been one of the most triggering motives behind the launch of this study. Being the latest and the most radical chain in the course of neoliberal transformation of the health care system in Turkey which has been in action since 1980s, Health Transformation Program (HTP) (Sağlıkta Dönüşüm Programı)[1] which has been launched in early 2000s has been having (and will continue to have) serious repercussions on the above-mentioned aspects of the health care system in this country. Hence, the desire to understand the then incipient (and by now quite advanced) HTP reforms initiated to transform the health care system in Turkey and its aforementioned impacts highly motivated the author for the conduct of this research.

In order to be more explicit in expressing the aim and the scope of this study, it would be better to lay down the main arguments raised and the related findings put forward by this study:

1. The very first argument of this study can be stated as follows: Health care reforms in general and the Turkish HTP in particular should be conceptualized within the context of the neoliberal restructuring process.

As it is well-known neoliberal restructuring is a process which has had its causes and results. Cyclical crisis of the capitalist system that was experienced by the early 1970s can be taken as the most important cause behind this process which in turn has led to a serious restructuring process within the capitalist system worldwide where neoliberal restructuring of the state and the public sector has been one of the most crucial end products.

Within the context of neoliberal restructuring of the public sector, health care systems have been one of the most important targets where the launch of the New Public Management (NPM) reforms can be seen as the reflection of this restructuring

[1] Sağlık Bakanlığı (2003)

on the whole public sector realm. Health care reforms which have come to the fore within this neoliberal restructuring context have been having serious economic, political, managerial, equity and conceptual repercussions for the health care system they have been targeting.

In fact when they are analyzed carefully, it can be said that health care reforms are not only the end products of the neoliberal restructuring but are also the tools which have been devised to provide/facilitate this transformation. Therefore in analyzing health care reforms, as a first step, neoliberal restructuring process should be taken as one of the main reference points. More information on neoliberal restructuring process and New Public Management will be given later in the section titled "Theories to Conceptualize Health Care Reforms" where these arguments would be made more clear and explicit.

When it comes to the Turkish case, besides its various peculiarities - such as lagging behind other counterparts in terms of timing of reforms - health care reforms in this country can be and should be read within the context of neoliberal restructuring process. As it will be seen in the following sections, since the formulation of the national health policy and the foundation of the national health care system in the Early Republican Era, there have been various attempts for reform. From 1980s onwards the above-mentioned neoliberal restructuring process has been affecting the Turkish health care system. During 1990s various attempts were made to realize the neoliberal transformation in health sector, however, great majority of them could not be finalized. It was in early 2000s that the most serious transformation in health care system could be initialized by the Health Transformation Program (HTP). By now quite a lot has been accomplished in terms of transforming the health care system within the context of the HTP which can be considered as the last - and to a certain extent a bit late - chain in the neoliberal restructuring of the Turkish health care system which has started in 1980s. Once the details and the quite serious repercussions of the HTP on the economic, political, managerial, equality and philosophical aspects of the health care system are deeply analyzed in the coming sections, its peculiarity within the context of neoliberal restructuring process will be understood more clearly.

Thus it can be repeated once more that as the first step in understanding health care reforms worldwide and for those undertaken in Turkey in particular, neoliberal restructuring process should be taken as one of the main conceptual frameworks and must be studied carefully.

2. Second argument voiced in this dissertation is that in order to explain health care systems that have been undergoing reforms, it seems necessary to refer to "hybrid models".

First of all this provides an explanatory framework as it is not possible to explain the health care systems that have been undergoing reforms with the mainstream health care system typologies. In addition to this, it can be argued that having recourse to hybrid models is quite compatible with the requirements of the neoliberal restructuring process and its accompanying New Public Management Reforms which find it easier to have recourse to (and create) hybrid models that would respond to the ups and downs and the requirements of the neoliberal transformation targeted and thus to attain rather smoother and less problematic restructuring.

As it will be explained later, there are various typologies to explain health care systems. Among these the most frequently cited one is the classical classification which groups health care systems as the Beveridge, Bismarckian, Liberal and the vanishing Semashko models.

Since each of these models have been undergoing transformations themselves and since it is not possible to explain the health care systems that are produced by health care transformations with just one of these classical models and in line with the above-mentioned tendency of the neoliberal restructuring process to have recourse to hybrid models, hybrid model approach will be another framework utilized by this study to understand the health care reforms.

In the same line of thought it can be argued that Health Transformation Program (HTP) which was launched in Turkey in 2003 has been ending up in a hybrid model

together with its similar catalyzing and smoothing role within the context of the neoliberal transformation process.

Characteristics of the hybrid model will be analyzed in detail in the forthcoming sections. Before that to make a brief definition, hybrid model in this study refers to a health care system which is created by adopting various characteristics of the Bismarckian and relatively more than that various characteristics of the Liberal model on top of the Beveridge model characteristics.

When the reform attempts in England (which is taken as the stereotype of the Beveridge Model of health care systems) and other related countries that have been undergoing health care reforms (including Turkey) are analyzed, it can be seen that with each reform attempt, impact of the liberal model characteristics have been intensified on the health care system in question while making it even more hybrid. In this regard it can be said that hybrid models that have been emerging as a result of health care reforms have been contributing to the neoliberal restructuring processes in the countries in question as they can also be seen as the end-products of these processes as well.

To be more explicit on the argument on how the emerging hybrid model in Turkey has been helping the neoliberal transformation in health care system; it can be said that with the HTP reforms now Turkey has a health care system which is more open and vulnerable to the dynamics of market mechanisms where it is easier to have private actors in the provision of health care services, there has been an increase in out-of-pocket payments, there has been more corporatization in public hospitals which are now more efficiency and performance-oriented, there has been contraction in the content of health care services provided by the public sector packages and everyone has to pay certain amounts of premiums to benefit from these health care packages. These are only some of the characteristics of the hybrid model that has been emerging in Turkey which is not only the end-product of the neoliberal restructuring process but also the one which facilitates and perpetuates this process together with providing the means required for the legitimization of this transformation.

3. Third argument raised is that organization (decentralization) and finance are the two most critical aspects targeted by health care reforms that have been taking place within the context of neoliberal restructuring process.

While trying to understand health care reforms and their legacies, it is seen that they have organization (which is usually expressed with the term decentralization) and finance at their center as the main targets to transform - which therefore should be the main focus of the studies which attempt at understanding these reforms.

It should be noted that reforms targeting organizational and financial set-up not only constitute the most critical parts of the transformation, they are also interrelated among themselves that change in one of them affects the other and vice versa.

In fact this study argues that health care reforms are mainly oriented towards transforming the financial set-up of the health care systems in question. However achieving this transformation requires transformation in the organizational set-up where decentralization (and depending upon the context re-centralization[2]) emerges as a critical issue. Thus there is a mutual and close relationship between transformations in financial set-up and transformations in organizational set-up of the health care system that is undergoing reforms. In fact this trend is also compatible with the New Public Management (NPM) reform approach which highly stresses decentralization and cost-efficient financial models in the provision of public services where health services are of no exception.

Regarding the above-mentioned close relationship between the reforms targeting the organizational set-up (decentralization/re-centralization) and those targeting the financial set-up of the health care system, it can be said that within the context of the HTP, the former highly supports the achievement of the latter which altogether make it easier to have more marketization in the provision of health care services. For

[2] As it will be explained in the following relevant section, although health care reforms usually stress the importance of achieving more decentralized health care systems, in many cases it is seen that decentralization attempts go together with (re)centralization which are made either in simultaneous or continuous manner. This trend is also compatible with the hybrid model approach adopted by these reforms.

example the emphasis on having administratively and financially autonomous hospitals and on the establishment of family doctor system at the primary care level has been having serious financial implications. Within the context of autonomy given to them, these health entities are asked to meet their ends which makes them adopt cost-efficient techniques and purchase more services from the market in a way to contribute to their competitiveness - all of which in the final analysis have serious repercussions for the overall financial set-up of the health care system. More examples of this kind can be - and will be- given to support this argument.

As has been the case for the majority of the health care reforms worldwide, HTP has also been attempting the organizational (decentralization) and financial aspects of the health care system - both of which should be studied as the two most critical focuses for the transformation in question. In this line of thought, in its attempt at understanding the transformation brought about by the HTP, this study has also mainly concentrated on organizational (decentralization) and financial aspects of the reforms.

To have a bird's eye view of the situation, it can be said that decentralization is more utilized for attaining transformation in the organization of the health care system, particularly in the provision and purchase of health care services where the Ministry of Health which is left with less responsibility in the direct provision of health care services and where autonomous hospitals and family doctors are presented as prominent components of the new system which are asked to meet their needs themselves and in this regard provide and purchase services on a decentralized basis.

Regarding finance it can be said that actual trend is towards (re)-centralization although discourse might be directed towards decentralization through emphasis on financially autonomous hospitals and family doctors. Nevertheless with the recently-founded Social Security Institute (SSI), health care finance has become quite centralized as now it is the SSI which is the most powerful actor and has the final say on the majority of the financial issues.

While this is the general trend, it should be noted that decentralization is a process which has often been going together with (re)centralization where regionalization has

also emerged as a meso-level solution in certain circumstances. For example as it will be mentioned below, HTP complains about centralization in the Turkish health care system and emphasizes the need to decentralize it. In this regard it foresees a system where the role of the Ministry of Health in the direct provision of services is minimized, hospitals are given administrative and financial autonomy and a family doctor system is established at the primary care level. However within the context of the Health Transformation Program, Social Security Institute has been established to carry on the financial issues of the new system from the center. Finally, with the very recent Statutory Decree[3], now the Ministry of Health has a new organizational set-up where the central bureaucracy has been highly enlarged and Public Hospital Unions and Regional Hospital Unions have been established. Thus it would not be wrong to say that there is a mutual and interactive relation between decentralization and (re)centralization attempts within the context of health care reforms which are formulated according to requirements of the transformation process that they may either go together or in a consecutive manner. This is apparently compatible with the hybrid model approach discussed above.

4. Fourth argument is that the English National Health Service (NHS)[4], particularly its way of reforming itself, exhibits a model for the incipient health care reforms in Turkey. In many respects the model put forward by the HTP resembles the English model. In this regard, while acknowledging the differences between the two countries, it seems quite possible to draw lessons from the English case for the incipient Turkish case.

England has been one of the leading countries where the neoliberal transformation of the 1980s has emerged and flourished. The country has been singled out for its public sector reforms which have been carried out around the New Public Management

[3] Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions (Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname), (Resmi Gazete 2011).

[4] NHS is the official name for the health care system funded by the public sector in England. However, it is also commonly used to denote the publicly-financed health care services in Wales, Scotland and Northern Ireland as well. In this study main area of interest will be the NHS in England. However while talking about the health care system or the NHS in England expressions such as "British" or "UK" Health Care System/NHS will be used interchangeably with the "English" Health Care System/NHS.

(NPM) tradition and England became a country whose reform style has become a model for many other countries undergoing similar transformations. Besides various public sector reforms, this has been the case for the health care system that the NHS's way of reforming itself has been adapted by the countries transforming their health sector.

It has already been argued that HTP could be understood much better if it would be conceptualized within the context of neoliberal transformation and the accompanying NPM reforms framework. Drawing upon this argument and the leading role of England in terms of devising and adopting NPM reforms (while also referring to the convergence/divergence dichotomy and policy transfer discussions that will be touched upon in the following sections), it could be argued that England's way of reforming its health care system has become a model for the succeeding reforming countries including the incipient Turkish case.

This argument is compatible with the above-mentioned hybrid model approach proposed for the explanation of health care reforms. As it can be recalled, hybrid model has been briefly explained as a health care system where the Beveridge Model is added with elements from the Bismarckian Model and particularly with those from the Liberal Model. That is to say, the hybrid model approach can be used to conceptualize NHS's way of reforming itself - where each consecutive reform attempt has been bringing about more elements from the liberal model- as well as for many other countries transforming their health care systems in the similar neoliberal tradition. Characteristics of the hybrid model will be examined in detail in the following relevant section.

NHS and its reforms, common points of the HTP with the NHS reforms and lessons that could be derived from the English case for the Turkish case will be discussed in a separate chapter. However in order to make the above-mentioned argument more clear it would be better to give examples on some of these common points and lessons that can be derived.

Regarding common points between the NHS reforms and the HTP, it can be said that both attempt at the creation/consolidation of the following: universal coverage and universal health insurance; internal market within the health care system together

with its complementing elements of provider/purchaser split and competition; family practice system within a staged model of health care services; managerialism and managerial principles within the health care system; autonomous hospitals; public-private-partnership (health campuses) model and more private provision of health care services and private health insurance.

When it comes to the lessons that could be derived from the British case for the Turkish case, it could be argued that with further implementation of HTP reforms, Turkish health care system would become more market-oriented and more competitive with more commodification of health care services. There would be more regulatory activities and more regulatory bodies would be introduced to the system. Hospitals could be expected to work more on managerial principles rather than the principle of public good which would not only create problems in terms of equality in access to health care services but also would make hospitals cope with competitive challenges which might even lead them face bankruptcies. It could also be inferred that health sector would become a more politicized policy realm.

Thus, this study argues that it would be quite enlightening to examine the English National Health Service (NHS) - particularly its way of reforming itself- while trying to understand the transformation of the health care system in Turkey. That's why the British case of NHS is studied in this dissertation as a part of its conceptual framework.

5. Fifth argument is that, as pointed out earlier, transformation in health sector has had and will have serious impacts on economic, political, managerial, clinical, equity and conceptual (cultural/philosophical) dimensions of the health care system in Turkey which should not be considered as mutually exclusive but on the contrary as highly interrelated outcomes in most of the circumstances.

As for the economic impacts, there has been an increase in the following since the adoption of the HTP: total expenditure on health (as % of GDP), total expenditure on health per capita, out-of-pocket payments per capita, transfers made to social security system from the general budget and payments made to health care providers by the Social Security Institution.

When it comes to the political impacts of the HTP, one of the most striking examples can be the adoption of the public-private-partnership (PPP) model in the form of "health campuses" which points to emergence of new types of relations and regulatory activities in the organization and finance of health care services where private law, private investments and contractual relations are held prior to public investments and 'public' characteristic of these services. In addition to that emergence and strengthening of new actors in the health sector vis a vis some old ones (such as the Social Security Institution and private hospitals have become more powerful vis a vis the Ministry of Health and Doctors' Association), increase in the number of foreign direct investments since 2005, quite striking increase in the number of private hospitals since 2002 and the increase in the amount of public funds channeled to private sector can be taken as some of the other political repercussions of the HTP which certainly have strong economic connotations as well.

Managerial impacts of the HTP can be briefly exemplified as the adoption and internalization of managerial principles in the health care system as a whole and in public hospitals in particular. In this regard creation of internal market and provider/purchaser split together with autonomous hospitals which are expected to compete with each other and thus adopt managerial principles attract attention as these have serious implications not only for the management of hospitals but also for all the stakeholders within the system including the health workforce and the patients. For instance performance-based payment system has highly affected the working conditions of the health workforces and also has created various ethical and solidarity problems which in the end have also affected the quality of the services provided for the patients. In addition to that public hospitals working more on efficiency and profit-based orientations not only cause patients to make more out-of-pocket payments but also do challenge the public character of the services they utilize.

HTP's impact on clinical aspects of the health care system are more visible as it is possible to draw upon exemplifying parameters to measure this impact which can be backed by statistical data as well. For instance number of total hospital visits has

increased since 2002 for all the sectors however with more striking increase in consultations held in private hospitals. (i.e. number of total hospital visits to Ministry of Health hospitals has increased from 109,793,198 in year 2002 to 235,172,924 in year 2010 where this increase was from 5,697,170 to 47,712,540 for the private hospitals[5]). It is possible to detect some other changes since 2003, such as the increase in number of per capita hospital visits and number of surgical operations or improvements in various health indicators such as life expectancy at birth or infant mortality rates. However insufficiency in the number of doctors per 100,000 populations (which is still far below the European average) or the loss in clinical autonomy of health workforce (particularly in that of doctors) should also be discussed among the impacts of the HTP on clinical aspects of the health care system.

HTP has serious implications for equity matters. Although now it is easier for the patients to reach health care services, the content and quality of these services are said to have deteriorated due to various HTP practices which in the end point to equity issues. One of the major components of the HTP is the Universal Health Insurance (UHI) and it is based on compulsory premium payment. That is to say only those citizens who paid their premiums would be covered. In addition to that, UHI would provide health services in the form of standard health care packages which would make many people get complementary private health insurance and make more out-of-pocket payments to get better services. In this system where 'service follows money', equity of the overall health care system would be highly challenged.

In addition to that, as has been argued by some authors, HTP reforms have brought about new state-citizen relations and new citizenship practices which have challenged the so called pre-HTP hierarchy among the people insured by the then social security institutions (Üstündağ and Yoltar 2007: 91-92). As Üstündağ and Yoltar claim, although now every citizen is said to be subjected to equal norms and procedures, inequalities do still emerge on various bases other than premium payment, such as having information on the facilities provided by the new system,

[5] Ministry of Health of Turkey (2011: 97, Table 8.1)

which altogether in the end create more inequalities which are mostly experienced by the unemployed, poor and women (Üstündağ and Yoltar 2007: 91-92).

Last but not the least, conceptual change brought about by the HTP is of serious importance. In fact most of the above-mentioned impacts have contributed to this change where change in the definition of health services and the one on the attributes of the medical professions together with the change in the roles and responsibilities of the state in the provision of health care services deserve serious attention. With the HTP, health service has started to lose its "public service" characteristic while becoming more a commodity purchased and sold in the market. This was added with the recent statutory decree which has abolished the previous mandate which read "doctors practice their profession to serve public interest"[6]. Another example that can be given to show the change in the conceptualization of health care services is the change that will be made in the names of "public/state hospitals" which will be titled as "city hospitals"[7]. How this change in the conceptualization of health care services is internalized/reacted to by the actors affected by it and how it is fostered by the reformers are of critical importance for the future course of the HTP.

This was just to give a brief idea on some of the impacts of the HTP on economic, political, managerial, clinical, equity and conceptual aspects of the health care system in Turkey. Repercussions of the HTP on these issues will be discussed in detail in the relevant succeeding sections.

In order to see how things have been changing in practice and thus to conceptualize the above-mentioned impacts of the HTP better, a research was conducted in a public hospital in Turkey. Idea was to lay down a flowchart which would show the processes that patients go through from their referral to discharge from the hospital in the post-HTP era. Data obtained in drawing such a flowchart would not only provide the information on what have been changing in the hospital system but also would

[6] Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions (Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname), [Article 58(14ğ)] (Resmi Gazete 2011).
[7] Medihaber (2011)

provide information which would help in understanding the repercussions of the HTP reforms in various aspects.

To this end this research employed various methods. Observation was one of them as the processes that were passed through by patients and medical and administrative staffs in the hospital were observed. In addition to that interviews were made with random groups among them. Moreover various interviews were also made with people who were thought to provide reliable inside information both from the hospital and from other relevant institutions such as the Doctors' Association. Finally, document analysis was another method employed when it was possible to reach necessary official documents.

Details of this research can be found in Chapter 8. As it will be seen there, primary data obtained from this research was such that it was supporting the arguments put forward at the beginning of this study and complying with the discussions made on the impacts of the HTP and with the theoretical and conceptual framework drawn initially. To give a few examples, HTP's impact on making hospitals work more as corporations functioning around managerial principles or strict control of the Social Security Institution over "autonomous" hospitals were only some of the critical issues observed during this research regarding the impacts of the HTP.

HTP is an on-going process which has not yet been put into practice fully. As it has been mentioned, those already realized components have brought about serious changes to the health care system. Nevertheless there are other critical components which have not yet been put into practice, such as the Universal Health Insurance which will make every citizen pay compulsory premiums to benefit from health care services or the establishment of Public Hospital Unions with which public hospitals will become more corporatized and work around managerial principles. In fact it is with its full implementation that HTP will have its entire and exact effects.

One of the most difficult issues to cope with during this study was this on-going and to a certain extent rather incremental characteristics of the HTP that the author had to up-to-date with the constantly-coming new legislations and practices – which sometimes contradict with the previous ones - and reflect these changes on this study. One such reform attempt was made the very last minute when this dissertation

was almost finalized. A Statutory Decree which brought about serious changes was issued[8]. In fact this Decree has realized the aforementioned missing components of the HTP which were said to bring about those critical impacts that were discussed throughout this dissertation, thus verifying the arguments put forward so far. These last changes will be elaborated on in the conclusion section. Nevertheless it should be noted that they should be analyzed quite carefully together with their legacies, which might be the subject matter of future studies.

Thus, in the light of what have been put forward and discussed so far, it can be argued once more that HTP is a process which implies serious repercussions for various aspects of the health care system in Turkey where particularly economic, political, managerial, clinical, equity and conceptual changes deserve careful attention. Therefore, it should be studied attentively where adopting a critical outlook and deriving possible lessons for the future are of crucial importance which was something that this study tried hard for.

1.1 Methodology

This is a *qualitative research* where the main Independent Variable is the Health Transformation Program (HTP) - particularly the transformations it foresees regarding decentralization (organization) and finance - and the main Dependent Variable is the impact of these reforms on the Turkish Health Care System – particularly its impacts on the socio-economic, political, managerial, clinical, equity and conceptual aspects of this system.

To a certain extent this is an *explanatory research* - particularly when analyzing the English case and the case of Turkey in the pre-reform era. However, this is also an *exploratory research* - particularly in trying to extract out inferences for the incipient Turkish case from the British case.

[8]Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions (Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname) (Resmi Gazete 2011).

In operationalizing the main issues mentioned above, research is made mainly through *document analysis*. In this regard data collection is made in a way that any relevant pieces of writing such as articles, books, reports, legislative texts, reform proposals, draft laws, court decisions, journal news and web pages may all be analyzed within the context of this study. Available statistical data is also utilized, particularly in analyzing the legacies of the HTP on economic, political, managerial, clinical, equity and conceptual aspects of the health care system, which allows better conceptualization of the changes that have been brought about by the transformation process.

This dissertation utilizes both *primary and secondary resources*. When available (published or may be unpublished) documents are not satisfactory or revealing enough information, some *field work* – such as *interviews* with relevant actors or *observations* in settings such as hospitals – are made. In that vein, a field work has been conducted in a public hospital which intended to understand the practical changes that have been brought about by the HTP so far.

In this research primary aim is to understand the processes that patients go through starting from their referral to their discharge from the hospital. It mainly attempts at figuring out a flowchart showing those stages, however, such an effort is expected to help in the conceptualization of the changes that have occurred within the internal functioning of the hospitals - particularly those changes pertaining to administrative and financial capacities of the hospital system and to provide the chance to see how things go on in practice.

Methods employed in this research are *observation* of the processes passed through by the patients and by the relevant medical and administrative staff in the hospital and *interviews* that are made with a random group chosen among them. When necessary, this research is supported by interviews with people working in other relevant institutions such as Doctors' Association to attain required information. In addition to these, analysis of the documents obtained on the processes that are thought to be of close interest is also employed as another supplementing method.

Besides document analysis, *Interpretative Textual Method* is also employed in certain parts; e.g. in analyzing how decentralization is conceptualized and practiced in the organization and provision of health care services.

Descriptive Historical Analysis is another method that is utilized in this study; particularly in understanding the development of the health care system and health care reforms in Turkey from the foundation of the Republic till today, where the main aim is to provide a descriptive picture on the development of health reforms and of the health care system in Turkey together with the dynamics and related factors that paved the way for them.

It should be noted that this study does not aim at providing a critical historical analysis of the health care system and its reforms in Turkey but to make a descriptive historical analysis. However, this will not prevent this dissertation from adopting a *critical outlook* on both the above mentioned issues and in other sections of this study. When the on-going character of the HTP is considered it is evident that there are many critical legacies to come along which thus make the adoption of critical outlook rather essential. Therefore it can be said that this study heavily depends on the method of *overall critical reflection*, as critical outlook is preserved throughout the research.

It is obvious that this research adopts *case study method* as it attempts to make a systematic analysis of the British case and the Turkish case of health care systems together with the reforms they have been undergoing regarding decentralization (organization) and finance.

Nevertheless it is acknowledged that it is not possible to make a fully comparative analysis which is mainly due to the on-going characteristics of the reforms in Turkey which are not yet fully accomplished. Therefore it is only possible to make certain inferences from the British case for the incipient Turkish case - which is still quite valuable in understanding and analyzing the HTP reforms. Here it should be noted that in figuring out similarities between the two cases, extra care and attention is paid to the differences between them in certain other aspects such as the institutional set-

ups, regulatory patterns, policy-making traditions, socio-economic and cultural concerns.

Health care services and health care systems are multi-dimensional and complex issues. Therefore research in this area has to be comprehensive, encompassing and multi-disciplinary. The recently-developed concept *Health Services Research (HSR)* highly acknowledges this quality of research in the area of health care. It is stated that

> HSR is about trying to make sure that health care technology and services are effective, acceptable, efficient, equitable and that such services are implemented - i.e. interventions and services are appropriate and of high quality… Since these domains overlap they need integrating through multidisciplinary research (Dieppe 2005: 9-11).[9]

Thus being multi-disciplinary in research - i.e. the involvement of people from different disciplines or approaches is said to be an essential part of a good HSR.

In this regard this research could also find itself a place within the context of HSR, which highly encourages and welcomes research on health care systems from different disciplines including social and political sciences.

[9]Health Services Research (HSR) has been devised as "a set of techniques used in applied health research with the aim of improving health, health care and its delivery …[whose main purpose has been determined as an] attempt to integrate the four main requirements of a good health service- namely effectiveness, efficiency, equity and acceptability- and to research methods of implementing such services" (Dieppe 2005: 7). In this regard it is argued that anything done to improve health and health care should be effective, efficient, improve equity, be acceptable by the public and have impementability by the people concerned.

1.2 Organization of the Chapters

This dissertation is organized in two major parts: Part I sets the theoretical and conceptual framework and includes the following five chapters:

Chapter 2 gives basic information on the organization of the research and it contains the sections on literature survey, theories that will be utilized in conceptualizing health care reforms and the HTP and the section which explains how this research is operationalized.

Chapter 3 deals with the definition of health and health care system where the development of modern health care systems and the question of how health care has become a social right and gained public service character are elaborated on. This chapter ends with analysis of different types of health care systems in the world and with various classifications made for analyzing health care systems. Such a descriptive chapter on health and health care systems is believed to provide a useful framework to be used in the analyses that would be made in the succeeding chapters.

Chapter 4 lays down an in depth discussion on the issue of decentralization in health care systems. In this regard an attempt is made to override long-lasting confusions in the conceptualization of decentralization and other related concepts such as deconcentration, delegation, devolution and privatization in health care services. In so doing, besides elaborating on the pros and cons of having a decentralized health care system, a discussion is made on the question of to what extent the assumptions made on the impact of decentralization in health care services match with real life practices.

Another important question asked and searched for in this chapter is why decentralization is so much emphasized in health care reforms? As it has been argued at the very beginning of this dissertation decentralization (organization) is one of the most targeted aspects in health care reforms. This chapter tries to understand why this is so and what is behind the increasing interest in decentralizing health care systems.

The question of whether it is possible to talk about the emergence of a common global trend for the health care systems aiming at decentralization is also attempted where the emergence of various trends such as the co-existence of decentralization and re-centralization and that of regionalization is also discussed. This discussion also contributes to analysis made regarding the emergence and consolidation of hybrid models within the context of health care reforms.

Chapter 5 introduces main methods of health care finance and their relations with different types of health care systems. Besides explaining general tax revenues, social health insurance, private health insurance, out-of-pocket payments, medical savings accounts, community financing, loans, grants, donations, transfers and foreign aids as different methods for funding health care services, the chapter touches upon the advantages and disadvantages of these methods for countries having different characteristics in terms of socio-economic development, fiscal capacity, implementation capacities, political accountability and the like. Moreover this chapter deals with the questions of why financial set-up is so much targeted in health care reforms, what could be repercussions of different choices of finance methods on resource allocation and equity, and whether there emerges any common trends in health care reforms targeting health care finance.

Chapter 6 attempts at understanding the health care system in England where the main focus is to give a brief explanation on the main characteristics of the National Health Service (NHS) – particularly on those characteristics related to its organizational (decentralization/recentralization) and financial set-up. This is followed by analysis of the reforms that the NHS has gone through regarding these two main aspects so far. In this regard most crucial reform subjects such as the creation of internal market (provider/purchaser split) within the health care system, managerial reforms, public-private partnerships, purchasing services from private sector and the like are all covered. This chapter is expected to provide quite supportive data on the above-mentioned claim that there are many things common between the HTP and NHS's way of reforming itself and that inferences can be made from the NHS reforms for the incipient Turkish case – which are going to be elaborated on at the end of the succeeding chapter.

Part II is devoted to the transformation of the health care system in Turkey. To this end Chapter 7 gives a detailed analysis of the health care system in Turkey including its development and reformation processes so far. In so doing organizational and financial structure of the health care system are the main focuses.

Special emphasis is made on the Health Transformation Program (HTP) which is examined and discussed in detail. In this context besides studying its goals, basic principles, main components, general context (national and international dynamics) within which it has emerged and complementary regulations issued to perpetuate it, HTP is analyzed with respect to the characteristics of the transformation it has brought about. In this regard what kind of decentralization (organization) and financial model is foreseen by this transformation for the Turkish health care system are two questions attempted at. This is followed by a discussion on the effects of the HTP on economic, political, managerial, clinical, equity and conceptual aspects of the health care system in Turkey. This chapter ends with elaborations on the common points of the HTP reforms with the NHS and its reforms and on the inferences that could be derived from the British case for the incipient Turkish case.

After such a detailed analysis on the Health Transformation Program (HTP), Chapter 8 attempts at a taking a cross-sectional photo of the HTP through findings from the research conducted in a public hospital with a view to understanding the practical changes that have been brought about by the HTP. The research is based on observations, interviews and document analysis which are also supported by relevant data obtained from other resources such as Doctors' Association, etc.

In conducting this research primary aim was to understand the change in the processes the patients go through from their referral to discharge from the hospital in the post-HTP era. In figuring out such a flowchart quite valuable information was obtained to help capture the changes that have occurred within the internal functioning of hospital system - particularly those occurred in their administrative and financial capacities which made it possible to elaborate on the effects of the HTP on hospitals (their functioning), patients, health work force and the conceptualization

of health care services while also pointing to the fact that primary data derived from this research supports the arguments and the general theoretical framework put forward at the very beginning of this dissertation.

The very last chapter of the dissertation – namely the conclusion – recapitulates the main findings and underlines the authentic contributions that can be said to have been made to the literature and to the research area by this dissertation. In addition to these, it draws attention to the potential of further research that could be and needs to be done on this topic while emphasizing the on-going characteristics of the health care reforms.

PART I THEORETICAL AND CONCEPTUAL FRAMEWORK

CHAPTER 2

ORGANIZATION OF THE RESEARCH

2.1 Literature Survey

While making a literature review on the Health Transformation Program (HTP) in Turkey no studies were found which analyze these reforms by prioritizing their organizational (decentralization/re-centralization) and financial aspects - which are argued to constitute the core elements of these reforms by this dissertation. Neither, any of the work written on the HTP studied the British NHS - particularly its way of reforming itself - with a view to extracting out correspondences between this system and the incipient health care reforms in Turkey. These two points were highly influential in making this research start off.

Although in Turkey the subject has only recently gained popularity in academic circles other than medical schools, organization and finance of health care systems and health care reforms have long been studied in the world- not only in medical schools but also in related social sciences disciplines. Health care reforms - particularly reforms in organizational and financial set-ups of health care systems - not only have their roots in the general socio-economic and political context but they also have serious socio-economic, political, managerial, clinical, equity and cultural repercussions. Therefore they should be analyzed by social sciences - which is an issue quite lacking in Turkey so far.

Literature on health care systems, health care finance and decentralization of health care services are quite dense particularly in western writing and the writings coming from these countries on health care systems of underdeveloped countries. Within the context of this study literature on NHS and its reformation process will be examined in the relevant section.

When it comes to the socio-economic, political, managerial, clinical, equality and conceptual repercussions of health care reforms, there have been various studies on these issues in the world, however not much should be expected from these studies most of which end with words such that "there is little or inconclusive evidence to state the impact of this aspect of health care reform on that phenomenon". As Peckham et al. put it, lack of any literature analyzing decentralization in terms of key criteria such as equity, access, responsiveness and the like and lack of qualified empirical evidence verifying assumptions made on the advantages of decentralization in health care services is one of the most problematic issues in this subject (Peckham et al. 2005: 77, 131). Nevertheless it is still quite useful and enlightening to analyze these studies while trying to understand the socio-economic, political, managerial, clinical, equality and conceptual impacts of the Health Transformation Program in Turkey.

In analyzing effects of decentralization/recentralization on economic dimensions of health care systems, inspired by Oates, Magnussen et al. state that there is generally not much evidence on the relationship between fiscal decentralization and economic performance (Magnussen et al. 2007: 107). Nevertheless, they say that it is still possible to draw conclusions regarding economic effects of health care reforms - particularly those that target decentralization. In this regard they highly emphasize taking the following issues into account as the determining factors of the impacts on economic dimensions (Magnussen et al. 2007: 107-108):

- number and type of agents to whom power is transferred: either power is transferred to local authorities such as municipalities or provincial local authorities or it is transferred to administratively/financially autonomous health authorities such as the primary care trusts or regional health authorities.

- degree of financial discretion given to the local authorities and/or to autonomous health enterprises: do they have the authority to determine their budgets or not.

- relationship between local authorities and/or autonomous health authorities: are they directed towards strict competition among themselves as in the case of Tiebout effect or towards limited competition as in the case of strict partitioning where geographical boundaries or rules of the market are strictly set.

- types of decisions that are decentralized: are they allowed only to purchase the services that are already decided by the center or are they allowed to decide which services to provide.

- organization and selection of health care providers: Are local authorities and/or autonomous health authorities both providers and purchasers? Are they free to contract with any health care supplier?

- the flexibility and type of contracts used between providers and purchasers: do they use global budgets or refined prospective payments?

Among these issues those that are relevant to the case of Turkish health care reform can be employed in analyzing the effects of decentralization reforms on economic dimensions of health care.

In their study where they looked at the Norwegian case Magnussen et al. (2007: 110) detected that the decentralized model did not work satisfactorily either from cost containment or from efficiency perspective.

They argue that in the Norwegian model of decentralization the central government served as the principal and the counties which were devoted powers regarding health care services as the agents with the responsibility to finance county services. However with centrally- determined tax rates counties had little financial discretion. Moreover they detect that counties and hospitals also had another principal-agent relationship among themselves where the former acted as principal and the latter as agents.

The authors argue that in the end this model of decentralization has brought about soft budgeting where the hospitals' budgetary burdens were passed on to the central government via counties which in the end has led to inefficiency and unsatisfactory cost containment. Therefore they claim that the main assumption of fiscal federalism did not hold true as the counties which seem to enter into competition for services created duplication of services and reduced technical efficiency.

In 2002 Norway experienced a move towards reducing local autonomy, reinforcing central planning and reducing incentives for soft budgeting by transferring ownership to central government. Results are to be seen.

In their analysis on the adoption of the internal market in the UK, Magnussen et al. (2007: 114) state that there is lack of evaluation (which according to them is also due to the poor quality of data in the NHS) on whether there has been any increase in efficiency in the NHS with the creation of internal market and provider-purchaser split.

It is known that under the New Labour while the main features of the internal market remain there occurred a movement towards more central control.

In their analysis on the adoption of the internal market in Sweden, Magnussen et al. (2007: 115) state that there has been an increase in technical efficiency in the Swedish counties that adopted provider-purchaser split however they also point out that there has been a lack of *cost control* in this process. They add that Sweden has also experienced more direct political control on the internal market and thus a certain degree of re-centralization.

Magnussen et al. also analyzed the case of provider-purchaser split in Italy where they quoted the studies conducted in Italy to measure the efficiency of hospitals by using Data Employment Analysis (Magnussen et al. 2007: 115). These studies suggest that autonomous hospitals have had higher efficiency rates than those that are part of the central system. However they add that these results are not that trustworthy due to several deficiencies inherent in the measurement methods and due

to some other incentives used in those autonomous hospitals that might have highly affected the results (Magnussen et al., 2007: 116).

In analyzing effects of decentralization/recentralization on political dimensions of health care systems Maino et al. start by asking several questions (Maino et al. 2007: 120-123):

- What is the of impact decentralization/re-centralization in health care system on the relationship between different levels of government?

- What is the impact of decentralization on the organization and delivery of health care services?

- What is the impact of decentralization on community involvement in health care decision-making?

- How decisions are made in order to determine who gets what, when and how and who pays in health care?

- Which types of decisions (formal and informal politics of planning, prioritization, delivery, financing, coordinating health services) are taken at what levels and what are their implications for different actors?

- How is the coordination and power- sharing between and across levels and units? (What are the formal and informal coordination mechanisms? In this regard what types of mechanisms can be employed in order to coordinate political decision-making vertically (between levels) and horizontally (between sectors and parallel decentralized units)?

- To what extent does change in the formal political/organizational structure affect the “real politics” of health care which is argued to take place outside of the formal political arena as it may well occur in corporate arrangements and in day-to-day

decisions of health professionals in their service delivery which may again well be influenced by pharmaceuticals companies, media and local advocacy groups?

- Are decisions concerning clinical practice and technology taken at the same political levels as decisions regarding funding and organizing health care services?

- To what extent are local decision-makers constrained by national agreements on salary and working conditions for professionals?

- Is there any relationship between more collective vs. market-based decision-making and the closeness to patients' needs?

- To what extent the municipal/regional role is growing?

- To what extent the management of provider institutions has been decentralized?

Although all these questions make any researcher examining the political impacts of health care reform quite enthusiastic, finding out their answers is not that viable - at least for all of them at a time- for various reasons. In this regard Maino et al. (2007: 122) suggest concentrating on the "changes in the institutional structure underlying health politics" as a more feasible practice.

In their study where they examine several country examples, Maino et al. (2007: 137) figure out that attempts to decentralize health care services have usually gone hand in hand with attempts to introduce reforms towards creating internal (quasi) markets with their complementary provider-purchaser split and managed competition, which in the end have led to the strengthening of local levels vis a vis the central government. They also detect that attempts to create internal/quasi markets have led to the emergence and strengthening of meso levels (e.g. regions, counties, autonomous communities) as the levels to undertake the implementation and administration of these internal markets (Maino et al. 2007: 137).

Besides this the authors point out that in all four countries that they studied they detected an increase in differences among health care services at different units of the meso level and thus draw attention to the risk of regional disparities and equity concerns in health care services which might increase as a result of implementing decentralization and internal market reforms in health care systems (Maino et al. 2007: 137). In this regard they also mention the recent trend towards re-centralization where they observe that national governments are trying to get (back) more responsibility in terms of coordinating and monitoring health care services (Maino et al. 2007: 137).

The authors also highly stress that political decentralization can produce inequality in service provision therefore the state had to undertake a stewardship role for those regions that are lagging behind. They also argue that the trend towards regionalization in health care also requires the national level to take on these kinds of stewardship responsibilities in order to eliminate inequalities and to provide quality assurance through various ways including the traditional public health measures and the like (Maino et al. 2007: 122).

It seems quite worthy to at least try to adapt some of these questions and concerns to the case of Turkey as there are nearly no studies on this issue in this country.

When it comes to analyzing effects of decentralization/recentralization on managerial dimensions of health care systems, first of all decentralization in managerial terms is basically defined as the "shift in the scaling of administrative decision-making" (Axelsson et al., 2007: 141)

Axelsson et al. suggest that effects of decentralization on managerial aspects of health care systems can be analyzed by looking at its effects on the following:

- administrative costs
- managerial competence
- efficiency
- coordination and integration of different health and health-related services.

In their analyses of country cases, Axelsson et al. have detected the following impacts of decentralization (and (re)centralization) reforms on managerial aspects of health care systems (Axelsson et al. 2007: 162-163):

Decentralization of health care services could lead to increasing bureaucratization at the institutional level where health care services are concentrated into large district health authorities (e.g. Sweden).

Decentralization could lead to increasing transaction costs_especially when accompanied with internal market regulations and particularly with its complementary contractual relationships between the providers and purchasers.

There are also administrative costs tied to this process. (This kind of increases in transaction costs and administrative costs are particularly seen when health care systems are decentralized to regional county councils- as has been the case in Sweden and Spain).

Nevertheless as Axelsson et al. point out, the question here is whether increases in transaction costs are compensated by any increase in efficiency in the management and delivery of health care services. However as the authors state there is very little evidence to answer this question (Axelsson et al., 2007: 163).

Decentralization of health care services has also been reported to have led to intensive training and development of managers as this is required by the decentralization of authority and responsibilities for the administration, financing and provision of health care services. However as Axelsson et al. underline effects of this on managerial competence and efficiency remain to be seen. (Axelsson et al. 2007: 163).

It has been reported that in certain countries, with the decentralization of health care systems, there have been some indicators of improved coordination and integration between the health systems and other sectors of the society (Axelsson et al. 2007: 163). In Spain, France and Nordic countries examples of horizontal integration such

as networks and partnerships have been attributed to the devolution of health care services to autonomous communities (Spain) and to regionalization attempts (France).

Although it is not possible to fully detect which changes are the pure results of decentralization/centralization and to fully isolate them from the effects of other changes in different health care systems (Axelsson et al. 2007: 163) adapting the aforementioned aspects to the extent that they are viable and feasible to the case of Turkey could be somewhat enlightening in efforts towards understanding what would be the managerial impacts of the on-going health care reforms in this country.

Regarding the effects of decentralization/re-centralization on clinical dimensions of health care systems, the study by Kinnunen et al. which tried to analyze the effect of decentralization/centralization on health status point out that since health status is influenced by many factors it is not that easy to evaluate how decentralization reforms affect health status (Kinnunen et al. 2007: 167-188). Therefore they say it is important to look at which dimensions of health care are decentralized - its finance, delivery, planning or regulation (Kinnunen et al. 2007: 168).

The authors argue that in analyzing the impact of decentralization/centralization on clinical aspects of health care systems the following issues should be examined carefully (Kinnunen et al. 2007: 168):

- Its impact in terms of population health (its effect on participation of communities, whether it contributes to improved implementation of health programs, whether it leads to more effective allocation of resources)

- Its impact in terms of individual health care services (which can be measured by the quality of services which in turn can be measured in terms of process, safety and outcome of care and prevention)

As the authors emphasize clinical outcomes and health status of a population are highly affected by a variety of factors and measures such as “demography, geography, socio-economic status of the population, education, income, employment, genetic endowment, nutrition, environment, accident prevention, housing, lifestyle, health awareness, historical experiences, public health and health financing infrastructure, resources (e.g. hospital beds/1000 population or percentage of GDP per capita spent on health), process of care measures (e.g. utilization rates or PYLL-Potential Years of Life Lost), outcome measures of morbidity, mortality, indicators such as DALYs (Disability-Adjusted Life Years), QALYs (Quality-Adjusted Life Years), anemia rates, peer review, knowledge, attitudes and practices (of consumers, providers and the population), and cost-benefit analysis”. (Kinnunen et al. 2007: 168-169).

Nevertheless they report that few studies have been done to measure the impact of decentralization on these factors. Basing their arguments on the limited available evidence they claim that decentralization/recentralization could play only a small role in influencing clinical outcomes compared to these more fundamental factors (Kinnunen et al. 2007: 169).

Although it seems even more complicated to examine the effect of health care reforms on these aspects of health status for the case of Turkey, it would still be valuable to touch upon those aspects which are viable and feasible, at least as a starting step for their future discussions.

When it comes to effects of decentralization/re-centralization on equity dimensions of health care systems, first of all, in terms of health care systems, equity is usually defined as “receiving treatment according to need and the financing of health care according to ability to pay” (Koivusalo et al. 2007: 189).

Koivusalo et al. point out that equity dimension of any health care systems is highly related to its financing and organization structure. In this regard they draw attention to the following issues for attaining equity in health care services (Koivusalo et al. 2007: 190):

- Ensuring that access to health care is based on need rather than geographical area or capacity to pay and that quality of services does not differ between population groups, health conditions or geographical areas.

- Progressivity of overall health care financing has a lot to do with the equity dimension of that particular health care system.

- Inequalities in health outcomes are also important indicators of equity in health care services - however it is not always possible to draw conclusions about the equity of any health care system simply by looking at inequalities in health outcomes.

Basing their arguments on their analysis of different country examples, Koivusalo et al. (2007: 192, 201-202) put forward the following statements regarding the impact of decentralization/re-centralization of health care services on equity dimensions (Koivusalo et al. 2007: 192, 201-202):

- Without mechanisms for cross-subsidization decentralization of financing will always be problematic for equity.

- Decentralization could be problematic if local decision-making is left without guidance on citizen rights and responsibilities of the local level as local decision-makers may use resources in a way that could increase or decrease inequity in access to health care.
  Moreover inequalities between areas may arise from different capacities to use resources efficiently.

- It is possible that there may be cases where local priorities might contradict with national policy priorities (e.g. Finland, Sweden)

- Inequities may arise if local governments are given more responsibilities than resources for the provision and financing of health care services -

which usually leads to local resource gathering through regressive financing and to user cost-sharing.

It is noted that even applied with cross-subsidization, the freedom of local governments to impose fees and allowing faster access to care via cost-sharing or subsidies for the use of private care increase inequities.

In this context it should be noted that the level of decentralization matters as the existence of risk pools regarding health care costs may not be a problem in regional units but may well be a problem in smaller local units which may not be able to afford hospital costs without cross-subsidizing mechanisms.

- Emphasis of health care reforms on choice are said to cause problems in decentralized administration and financing because population-based estimates become more difficult to make. Moreover it is known that "choice" option usually benefits those highly educated people who are usually healthier and have access to health care everywhere. Also it is reported that due to specialists' tendency to remain in urban centers and different capacities to choose and utilize services, inequities get more intense between different disease groups

The authors argue that equity is a matter of political choice and the impact of decentralization and health care reforms on equity highly depends upon the political context and the overall political choices. In this regard they touch upon the NPM reforms which according to them reflect some ideological preferences besides merely technical preferences where cost-cutting and privatization have been the most clear-cut aims of the overall reforms and where efficiency aims usually dominated the aims for equity. (Koivusalo et al. 2007: 194, 201-202).

They also draw attention to another important issue that in a highly globalized world where regulatory framework for trade and commerce have been becoming increasingly international (*i.e. centralized*) equity concerns become more complicated. This global context is highly influential on the regulatory means that

are applied at national, regional and local levels which aim at equity especially where health care services are provided by a mix of public and private actors (Koivusalo et al. 2007: 202).

All in all the authors conclude that although decentralization is expected to increase equity there is little evidence of this. However in contrast it is more likely that decentralization of health services causes more variation mainly due to the increase in local/regional autonomy. Therefore decentralization usually needs to be complemented by re-centralization and coordination activities such as re-centralization of regulation, standard setting, performance criteria and cross-subsidization across areas and population groups (Koivusalo et al. 2007: 101).

The issues raised by Koivusalo et al. regarding the impact of decentralization/re-centralization on equity dimensions of health care services can be adapted to the case of Turkey to the extent that it is possible in order to better analyze this very important aspect of health care reforms.

2.2 Theories to Conceptualize Health Care Reforms and the HTP

2.2.1 Neoliberal Restructuring of the State

Together with other public sector reforms that have been initiated from early 1980s onwards, health care reforms should be analyzed within the general framework of the neoliberal restructuring process.

As it is well-known the global crisis of the 1970s did challenge the capitalist state, particularly its the then prevalent form, namely the welfare state, which paved the way for the rise of new right and neoliberalism and thus have had direct repercussions for the re-definition of the state, the public sector and state-society relations (Aksoy 2003; Bedirhanoğlu and Yalman 2010; Ataay 2006; Maino et al. 2007).

In general it is argued that although neoliberalism is historically shaped, it is practiced and managed contingently at different levels through alternative strategies of structural adjustments (Bedirhanoğlu and Yalman 2010: 107). In addition to that, taking these alternative strategies as "hegemonic projects" which the new right ideology have had recourse to in order to facilitate the transformation required by the then state of affairs of the capitalist system is another commonly used perspective to understand the post 1980 transformation in state-society relations (Bedirhanoğlu and Yalman 2010; Tünay 2002). From this perspective it is further argued that consolidation of the neoliberal hegemony project in a society in general is highly related with its consolidation in the sub-fields such as education, law or media (Şengül 2007: 87). In this regard health sector can definitely be seen as one of the main sub-fields at which the neoliberal hegemony project has been targeting. A final remark in this context could be that the way/strategy followed by this project in penetrating any sub-field is highly dependent on its authentic characteristics and its level of relative autonomy (Şengül 2007: 88).

The necessity of analyzing health care reforms and also the HTP within the general context of neoliberal transformation of the state is highly emphasized by this study. Thus, it seems quite useful to adopt the aforementioned theoretical framework where the following remarks are worth making:

First of all, although the new right's attempt at hegemony and the transformation it launched in the post-1980 Turkey did have its authentic characteristics, this process had many resemblances to the Reaganizm and Thatcherism of the same era (Tünay 2002: 177). The two periods of neoliberal consensus were by and large experienced in Turkey in a similar way with the world. Washington Consensus, which is said to continue until mid-1990s, was followed in Turkey where free market ideology pointing to a "strong state to eliminate the barriers in front of the free play of the market forces", deregulation and liberalization in trade and finance led to first generation structural adjustment reforms within the context of neoliberal restructuring, which was a process accompanied by the attempt of the civilian government of the post-coup d'état of 1980 at "developing an expansive hegemonic project" (Bedirhanoğlu and Yalman 2010: 110). In the same way post-Washington

Consensus which was favoring social market ideology with its implications for "the state to get on crucial roles in the construction of the institutions through which the market forces would play properly" has also been adopted in Turkey, particularly during the last two governments (Bedirhanoğlu and Yalman 2010: 110- 11). It is in this period that the Turkish government has attempted at "an acceleration in neoliberal institutionalization under the guidance of IMF and the EU" where the "need for an institutional turn in the neoliberal reform process" started to be felt since 1990s with the Customs Union, the Helsinki Summit and the stand-by agreement with the IMF (Bedirhanoğlu and Yalman 2010: 111, 120). It is argued that neoliberal restructuring in Turkey exhibits a continuity since its launch in the early 1980s, together with the continuation of the authoritarian form the state has taken right after the coup d'état of 1980 and has been preserving throughout the neoliberal transformation era, while also retaining the "dissident but hegemonic discourse" (Bedirhanoğlu and Yalman 2010: 119, 122; Yalman 2002b; Yıldırım 2010: 2).

As it has been mentioned above, neoliberal transformation process proceeds through consolidating itself in the main sub-fields where health sector has been one of the most attractive ones. This has been the case in Turkey, however, compared to other countries transformation in health care sector in this country has been realized quite late, which besides other factors that would be elaborated on in the relevant section of this study, could be explained with the aforementioned explanation which points to the authentic characteristics of the field and its level of relative autonomy within the general transformation project.

At the end of this section it could also be noted that David Harvey's model on "the circuits of capital" by which he tries to explain the capital accumulation problem and the capitalist system's strategy to overcome this crisis by investing in built environment can also be enlightening in understanding the health care reforms of the post-1980 period where as the state draws back from investing in health care sector, private sector is highly encouraged to invest in this area and allocates the accumulated capital in this sector. (Harvey 2003: 108-115; Şengül 2001: 12). It is also the case that while a built environment is created around the health sector through models such as health campuses as a form of public-private partnerships, it

is obvious that via health sector reforms as such serious amounts of public resources are channeled to the private sector. In addition to this, while talking about corporatization and privatization of public assets within the context of neoliberal restructuring, Harvey touches upon the issue of "loss of rights" regarding "right to national health care" and right to a state pension to the private domain which he denotes as "one of the most egregious of all policies of dispossession pursued in the name of neoliberal orthodoxy" (Harvey 2003: 148; Loeppky 2011: 75-76).

2.2.2 New Public Management

Although neoliberalism has had an anti-state rhetoric and an anti-state hegemonic discourse, it does not reject the state at all; on the contrary it has had recourse to the famous "minimal but effective state" which in fact has been highly required in order to facilitate the required neoliberal transformation (Bedirhanoğlu and Yalman 2010: 109; Aksoy 2003: 546). Therefore reforms targeting transforming the public administration systems and various public sectors should be understood in this context as both the main reflections of and also the main means for the neoliberal restructuring of the state.

When the issue is public administration and public sector reforms within the context of neoliberal transformation, New Public Management (NPM) should definitely be touched upon as one of the most important theoretical frameworks that have backed these reforms in the post-1980 era. It is argued that together with its variations such as New Public Management and Re-inventing the Government, Public Management Approach have had exhibited serious compatibility with the New Right and neoliberalism both in theory and practice (Üstüner 2000: 25). It is argued that NPM and the managerial principles and practices it brought about for the public sector has been quite attractive within the context of the economic downturn of the 1970s which made the governments cut down on public expenditures (Cole and Jones 2005: 567). Therefore as Clarke and Newman put it, while talking about managerial state, managerialism is located "as a cultural formation and a distinctive set of ideologies and practices which form one of the underpinnings of an emergent political

settlement" (Clarke and Newman 1997: p. ix quoted in Pollitt and Bouckaert 2004: 9).

NPM approach basically emerged with the claim of providing kind of a third way for the dichotomy between the public and private sectors through adopting private sector principles and practices to public sector which was expected to bring about efficiency and improvement to the latter (Cole and Jones 2005: 567; Üstüner 2000: 16). Since the reflections of NPM on health care reforms will be analyzed in the relevant sections of this study – particularly in the section where HTP is examined – detailed explanation of this approach is not attempted here. However it could be quite useful to remember the basic tenets of the public management approach.

According to Hood seven doctrines of the NPM agenda could be summarized as follows:

- professional management with public managers having managerial autonomy and being held accountable for their actions
- definition of targets and evaluation of the service's performance in meeting those targets
- greater emphasis on output controls with resources allocated on the basis of results achieved
- shift to a disaggregation of units by breaking up centralized units into smaller manageable ones
- introduction of greater competition to public sector in order to encourage higher standards at lower costs
- emphasis on private sector styles of managerial practices
- emphasis on greater discipline and parsimony in resource use to encourage public sector bodies to maximize their use of public resources

(Hood 1991, quoted in Cole and Jones 2005: 568)

A similar summary of the basic tenets of the NMP approach could be found in Üstüner, where the author draws upon the ten principles put forward by Osborne and

Gaebler in their study on re-inventing the government approach. In this study NPM approach is said to have the following characteristics:

- a catalyzing government which steers rather than rows
- an enabling government which enables its citizens to produce the services rather than doing this itself
- a competitive management
- a target-oriented management
- a result-oriented management
- a customer-oriented management
- an entrepreneurial management
- a far-sighted management
- a decentralized management
- a market-oriented management

NPM approach has highly influenced the public sector reforms of the post-1980 era, particularly those that have been taking place in the OECD countries (Cole and Jones 2005: 567)[10]. In this regard health sector reforms in general and as it will be seen in the relevant section of this study the HTP in particular carry serious traces of this approach. It should also be noted that having an Anglo-Saxon origin, NPM have been quite influential in the UK where the NHS has also been one of its targets.

At the end of this section to recapitulate briefly the influence of the NPM approach on health care reforms, the following concepts could be underlined once more with a view to their penetration into the health care systems that have been undergoing reforms:

decentralization, creating administratively and financially autonomous health units (hospitals), entrepreneurial government where the Ministry of Health has taken its steps back from direct provision of health care services, injecting managerial principles and market mechanisms into the health sector, creating internal market and

[10] For a detailed report by the OECD itself on NPM reforms in OECD countries, refer to OECD (1995) *Governance in Transition – Public Management Reforms in OECD Countries.*

the provider/purchaser split within the health sector, competition,[11] privatization, creating public-private partnerships for the provision of public services, contracting-out public services to private providers, result-orientedness, performance-based payment systems, recruiting public personnel on contractual terms rather than on permanent cadre-base, evidence-based policy-making, cost-benefit/efficiency analysis, encouraging user charges, patient choice and customer-oriented practices, less stress on the public character of health care services.

2.2.3 Hybrid Models

This is actually an incipient theory- like approach which this study considers quite helpful in understanding the health care reforms within the framework of the new public management reforms. The basic idea is that NPM reforms highly rely on devising 'hybrid' models in their efforts to transform the public sector that they target. Having recourse to such hybrid models is quite pragmatic for these reformers as these models provide them with the chance to adapt to the requirements of the transformation at hand.

When the reforms that have been attempted in the health sector both in Turkey and in the world are analyzed, it is clearly seen that they have produced hybrid models for both their organizational and financial set-up.

Utilization of "hybrid models" by new public management reforms is not explicitly written down as a theory or an approach yet – at least we haven't encountered such a theory/approach so far. However it is possible to detect the implicit utilization of hybrid models in explaining the health care systems that have come out of the reform processes in certain countries. For instance the National Health Insurance (NHI)

[11] It is highly believed that the idea of creating internal (also called "quasi") markets within the public sector and its complementary provider-purchaser split did emerge from the New Public Management understanding and that the creation of internal markets can also be attributed to the consolidation of the idea of decentralization in public sector reforms whereby autonomous agencies are created particularly on the providers' side (Magnussen et al. 2007: 113). This was barely seen in the NHS reforms of the 1990s where in line with the idea of NPM, it was believed that by creating an internal market within the health sector and by splitting providers and purchasers there would be competition among providers and this would lower costs, increase efficiency and improve quality (Magnussen et al. 2007: 113).

Model, which Lee et al. elaborated on in explaining the health care systems that have come to the fore in South Korea and Taiwan by the reforms of the 1990s, can be considered as a hybrid model (Lee et al. 2007). Although the authors introduce the NHI as a new typology of health care systems it seems more appropriate to take it as a hybrid model which provides a combination of the mainstream health care types. As it will be seen in the following sections, NHI is a model which basically aims at universal coverage through a single system for the entire population, where however private sector (i.e. the liberal model) has more say in health care finance. In addition to that Kutzin et al. also mention the emergence of another hybrid model in the health care system of Kyrgyzstan, which they define as "Bismarckian system meets the Beveridge"; pointing to the emergence of a hybrid model in health finance which carry characteristics from both systems at the same time (Kutzin et al. 2009).

In the same regard it has been argued that in countries like Turkey which has not experienced any settled form of welfare state, health care reforms have produced a model which on the one hand aims at universal coverage dictating compulsory participation of all citizens and on the other hand aims at market-oriented reforms targeting efficiency in the provision of health care services and increasing the share of private sector within the whole system (Keyder et al. 2007: 8). As it will be analyzed in detail in the following sections of this study, health care system that has been brought about by the HTP does point to a hybrid model which carries characteristics from mainstream health care system typologies.

Therefore it can be said that neoliberal restructuring process has been using hybrid models in order to make the transformation easier and in order to have a rather easier adaptation to the conditions that are at hand. Thus hybrid model approach could provide a useful tool in understanding the health care reforms within this context.

2.2.4 Convergence-Divergence Dichotomy

This dichotomy basically refers to the question whether it is convergence or divergence which characterizes health care reforms taking place all over the world for the last three decades.

According to a group of authors it is convergence which dominates these reforms[12]. They argue that with the particular motivation and impositions coming from certain international institutions such as the World Bank, OECD, WHO, WTO, there has been a trend towards convergence in health care reforms. This implies that countries undergoing health care reforms are adopting similar strategies (Lister 2008: 22, 24; Palier 2004: 78). In a similar way, while discussing the converging effects of the European integration process on national health care systems of European countries, Bieling talks about certain tendencies of "convergent hybridization"[13] (Bieling 2011: 41).

It should be noted that discussions on convergence is closely related with the idea and practice of *policy transfer* which has become a common practice in the public sector reforms of the post-1980 era. NPM-guided reforms of this period first emerged in Anglo-American countries such as the UK, USA, Australia and New Zealand and later they were transferred by both developed and developing countries (Pollitt and Bouckaert 2004: 31). As for the health care reforms, it is argued that particularly with the motivation coming from international actors such as the OECD and the WB, a global reform model has come out, which in the end has made countries of different development levels adopting similar reform packages (Palier 2004: 78; Ağartan 2007: 38).

Another group of authors on the other hand argue that it is divergence rather than convergence which dominates health care reforms[14]. This implies that in line with their specific economic, political, social and cultural characteristics, countries adopt reforms diverging from one another's.

[12] Pfaller et al. 1991 and Rhodes 1995 quoted in Giaimo and Manow 1999; Mechanic and Rochefort 1996, Chernichovsky 1995 and Wessen 1999 quoted in Blank and Burau 2006.

[13] Bieling defines "convergent hybridization" as "the emergence of mixed types of formerly distinct health care systems brought about by specific reform measures such as more competition between different kinds of health insurance, clinical practices, hospitals etc; privatization of hospitals; restriction of the catalogue of services; outsourcing of medical services from compulsory offering; introduction of supplementary insurances and medical treatment charges; standardized medical care guidelines and so on" (Bieling 2011: 41).

[14] Giaimo and Manow 1999; Garrett and Lange 1996 quoted in Giaimo and Manow 1999; Nemec and Kolisnichenko 2006; Hassenteufel 2001; Arrowsmith and Mosse 2000; Blank&Burau 2006.

When health care reforms adopted so far in different parts of the world are analysed, it should be admitted that there is very strong degree of convergence among these reforms. However this should not be taken too far to obscure the reality that countries have also put forward their own way of reformation in various respects which again points to the emergence of hybrid models by health care reforms.

2.2.5 Epistemic Communities

Epistemic communities have been quite influential both on NPM reforms in general and on social policy and health care reforms in particular (Stone 2001 and Lister 2008: 76). In line with the arguments on convergence in NPM and health care reforms, role of epistemic communities in these processes has become more of a focus of interest. Therefore understanding the epistemic community approach can be quite enlightening in analysis of health care reforms.

Haas defines epistemic communities as "networks of knowledge-based experts…with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (Haas 1992: 2-3). He states that drawing upon their power which stems from their control on knowledge and information, epistemic communities take their role in articulating complex problems the states face, help them identify their interests and propose specific policies. As a result of these we have more convergent state behavior and international policy coordination (Haas 1992: 2, 4).

Role of epistemic communities for the design and execution of the HTP in the Turkish case is an important issue to examine. As it will be mentioned in detail in the succeeding sections, since 1990s Ministry of Health have been undertaking various projects in collaboration with the World Bank to realize the transformation in health sector and it is known that epistemic communities under the leadership of the WB have been quite influential on these works[15] [16]. Finally, HTP has also been highly

[15] In 1990 the Project Management Support Unit was established within the Ministry of Health in order to carry out the health projects in collaboration with the World Bank.

supported by such WB projects. In addition to this it is also possible to detect a proliferation in the number of policy/research centers and think tanks dealing with social policy and health policy issues, which can be taken as new chains that have been added to the epistemic communities' network. Therefore it can be argued that epistemic communities have already been taken their place in the health transformation process in Turkey which in turn points to more policy transfers and more convergent policies and international policy coordination.

2.3 Operationalizing the Research

1. As decentralization (organization) and finance are taken as the core aspects of the transformation in health care systems, the concept of decentralization and its meaning within the health care system and the subject of health care finance will be studied. In so doing the concept of health, health care system and typologies of health care systems will also be touched upon.

2. In order to understand the change in the health care system that has been brought about by the HTP, characteristics of both the pre-HTP and post-HTP systems will be analyzed with a view to understand the changes that have been taken place regarding the organizational (decentralization/re-centralization) and financial set-up. It is this analysis which would help in understanding the characteristics of the hybrid model that has been produced by the HTP.

3. Impacts of the HTP on economic, political, managerial, clinical, equity and conceptual/ philosophical aspects of the health care system in Turkey will be analyzed by looking at various parameters - particularly to those for which statistical data are available for the period between the launch of the HTP and present time.

In this regard effects of the HTP on economic dimensions of the health care system will be examined by looking at the following parameters: total expenditure on health

[16] World Bank is known to be one of the most powerful actors in the formation of epistemic communities in countries undertaking health care reforms - thanks to its financial strength and capacity to finance such transformation projects (Lister 2008: 76; Stone 2001: 352).

(% of GDP), total expenditure on health per capita, public expenditure on health (% of total expenditure on health), public expenditure on health per capita, out of pocket payments as % of total expenditure on health, out of pocket payments per capita, share of public and private health expenditure in GDP, health insurance coverage for a core set of services, share of private health insurance coverage, share of the budget of the Ministry of Health in GDP, allocations made for the family practice system, transfers made to Social Security Institution from the general budget, payments made to health care providers by the Social Security Institution, expenditures made on pharmaceuticals and medical technologies and share of public expenditures in this.

Effects of the HTP on political dimensions of the health care system will be analyzed by looking at what kinds of new relations have emerged in the organizational and financial set-up of the health care system by the HTP: whether there occurred any change in the balance of public/private investments in the health sector, whether there occurred any change in the amount of foreign direct investments in health care services, whether there occurred any change in the number of private hospitals, whether any incentives have been given to private capital to invest in health sector and whether any change has occurred in the number of applications made to private hospitals (any incentives have been given to patients to go to private health care providers), whether there occurred any monopolization in health care sector, whether any change has occurred in the number of private insurance holders, whether HTP has played any role in the channeling of accumulated private capital to the health sector and also became a means for channeling public funds to the private sector, whether there emerged new actors within the health care system and whether there occurred any change in the balance of powers of among the previous actors, whether there occurred any change in the "public" character of the health care services and what kinds of changes have occurred in the policy preferences of the state regarding the number of hospital beds (and their allocation between primary, secondary and tertiary level) and the number of medical schools and the number of students that would be accepted to these schools.

Effects of the HTP on managerial dimensions of the health care system will be analyzed by looking at whether HTP has adopted new managerial models and

principles for the provision of health care services which have perpetuated the consolidation of managerialism in health care system and what have been its effects on hospitals, patients, health workforce and on the quality of services.

Effects of the HTP on clinical dimensions of the health care system will be examined by looking at what kind of a change has occurred in the clinical autonomy of the health workforce and by looking at what kinds of change have occurred in the health status of the country with the adoption of the HTP. In this regard the following basic health indicators will be analyzed for the time period between the launch of the HTP and the present time: total hospital beds per 1,000 population, average length of stay for inpatients, number of doctor consultations per capita, per capita visits to Ministry of Health Care Centers, number of per capita visits to primary, secondary or tertiary level health care centers, number of total visits to Family Medicine Centers, number of total hospital visits in the public and private sector, number of per capita hospital visits in the public and private sector, change in the number of surgical operations both in the public and private hospitals, number of doctors/specialists and nurses per 100,000 population, change in life expectancy at birth, change in infant mortality, change in the incidence of certain infectious diseases, change in risk factors such as obesity rates or tobacco consumption rates, change in immunization coverage, average number of follow-ups per pregnant, ratio of births realized in hospitals and the use of MRs, CTs, mammography devices, etc.

Effects of the HTP on equity dimensions of the health care system will be analyzed by looking at what kind of a change has occurred in the reach of the population to health care services after the adoption of the HTP. In this regard it is important to see what kind of a change has occurred in the coverage of the population in terms of reach to health care services- whether are there still people who are de facto not able to reach health care services. To this end it is important to understand whether there occurred any change in the amount and share of out of pocket payments or contribution payments in health care finance. Also it is necessary to see whether there are any mechanisms in the new system to provide incentives for those who are not well-off to reach to health care services and if so how these mechanisms do function. In this regard the Green Card System deserves attention. In addition to this

it is also vital to understand whether HTP has caused any change in the previous system in terms of the reach of different groups of citizens to health care services. Moreover it is also necessary to see whether HTP has led to any change in state-citizen relationships and citizen practices defined around consumption of health care services.

Effects of the HTP on conceptual/philosophical/cultural dimensions of the health care system will be analyzed by looking at whether there occurred any change in the conceptualization of the health care services- particularly by the patients. In this regard it is important to understand whether there occurred any (further) change in the "public" character of health care services and what kind of a change has been experienced in the balance of responsibility between the citizens and the state in reaching health care services. Moreover it is also important to see whether there occurred any change in the satisfaction rates of citizens from health care services after the adoption of the HTP.

In addition to these a research will be conducted in a public hospital to take a cross-sectional photo of what has been taking place in practice. Since hospital is the core venue where the change in question can be observed in its practical context, such a cross-sectional photo is expected to give a brief idea on the change that occurred in economic, political, managerial, clinical, equity and conceptual aspects of the health care system by the adoption of the HTP.

In investigating whether the British NHS has emerged as a model for the recent health sector reforms in Turkey, en effort will be made to figure out the common points between the NHS and its reformation strategies and the reforms proposed for transforming the Turkish health care system by the HTP, after which an attempt will be made to make inferences for the incipient Turkish case from the British NHS.

CHAPTER 3

ON HEALTH AND HEALTH CARE SYSTEMS

3.1 What is "Health"?

It seems quite appropriate to start this study with a section on the definition of health and health care system.

It is possible to define health in many different ways which implies that there is not one single definition on which everyone would agree.

In its narrowest sense of meaning health is defined as "the absence of disease/illness" (Dieppe 2005: 3; Alban and Christiansen 1995)[17]. According to Dieppe prevalence of this rather narrow outlook in defining health has many things to do with the consolidation of modern health services which have rather "concentrated on the prevention or treatment of disease rather than on health" (Dieppe 2005: 3). He states that it is the biomedical revolution which has won the struggle against lay and folk remedies particularly in the western world. Although it suffers from uncertainty on behalf of the society about their health and inability in coping with chronic illnesses which has been rising severely in the last decades, it is still dominant vis a vis complementary and alternative medicine (Dieppe 2005: 4-5). Therefore Dieppe argues that this leads to the prevalence of the above-mentioned definition of health particularly in practical terms.

In addition to this Dieppe refers to "super specialization and increasing fragmentation of health care …around systems or diseases" in western health care

[17] Here it might be useful to briefly touch upon the nuances between the concepts "disease", "illness" and "sickness" in the English language although it may not be that obeyed by the authors studying health policy in this language. *Disease* is defined as "an abnormality of the structure or function of the body". *Illness* is "a symptom experience which can include features such as pain or distress, restriction of normal activities or reduced ability to participate in life in the ways in which an individual would like". "Disease and illness can lead to *sickness* which is the role played by people with illness in the society" (Dieppe 2005: 3). It should be noted that so far we have not come across with wide use of such nuances in the Turkish language.

systems which is highly helped by the rapid development in health technologies (Dieppe 2005: 6). It is this fragmented outlook which leads to lack of comprehensive and integrated health care for individuals and thus adds a lot to the deficiencies of these systems.

According to World Health Organization (WHO) health is “not merely the absence of disease and infirmity” but is “a state of complete physical, mental and social well-being” (WHO 2009b). This reflects a rather comprehensive outlook which implies reference to multi-dimensional characteristics of health and health care. This is also the definition that is most commonly referred to in academic literature on health care.

Here it seems quite possible to argue that there has been a change in the conceptualization of health with the advent of neoliberal policies. In this regard the most fundamental change has been that health has become a commodity as the state has been rolling back from the direct provision of health care services where there has been rapid increase in private provision of health care services together with the increase in the number of people getting private health insurance.

In addition to this as the market for health care grows there has been increasing emphasis on “healthy living”. This has also been supported by the advance in health technologies, pharmaceuticals, cosmetics industry and in many other related areas ranging from organic foods to healthy clothing and natural care. The fragmented outlook for health care which foresees separate care for different parts of the body also added to the growth of this market. In fact the two – i.e. the growth of the market for health care and prevalence of the notion of healthy living have perpetuated each other. This in the end has led to a change in the definition of being healthy which has now been extended to include many things which are being provided in the rapidly-growing health market.

3.2 What is a "Health Care System"?

Different definitions have been made for explaining what a health care system is.

In its broadest and most pragmatic sense health system is viewed as a system "made up of users, payers, providers and regulators…[and] the relations between them…[where] relations referring to four key functions of health systems are regulation, financing, resource allocation and provision of services" (McPake et al. 2002 & Mills and Ranson 2001 quoted in Nolte et al 2005: 12).

Adopting a rather narrower perspective, Anderson defines health care system as "…a system with entry and exit points, hierarchies of personnel and types of patients…[which consists of] the officially and professionally recognized helping services regarding disease, disability and death" (Anderson 1972 quoted in Nolte et al. 205:13).

Field defines health system as "the aggregate of commitments and resources (human, cultural, political and material) any society devotes to or sets aside to or invests into the 'health' concern as distinguished from other concerns such as general education, defence, industrial production, communications, capital construction and so on" (Field 1973 quoted in Nolte et al. 2005: 13). Field also puts forward another more specific definition in which he defines health system as a "societal mechanism which transforms generalised resources or inputs (mandate, knowledge, personnel and resources) into specialized outputs in the form of health services aimed at the health problems of the society […] - namely the five Ds: death, disease, disability, discomfort and dissatisfaction" (Field quoted in Nolte et al. 2005: 13).

Roemer, who is an author highly referred to by many of the studies analysing health care systems makes the following definition for health care system: "the combination of resources, organization, financing and management that culminate in the delivery of health services to the population" (Roemer 1991 quoted in Nolte et al. 2005: 13-14).

As it can be seen definitions put forward by both Field and Roemer reflects a structural-functional perspective with emphasis on the structures used to deliver health care (Nolte et al. 2005: 13-14).

Drawing upon the definition of health made by the WHO, Weinerman defines health system as "any set of arrangements in a society…which assigns social roles and resources to achieve the goals of protecting or restoring health to the eligible population" (Weinerman 1971 quoted in Nolte et al. 2005: 14). In the same line, Long states that "any service designed to improve the physical, mental or social-well-being of one individual or groups of individuals must be considered a health service" (Long 1994 quoted in Nolte et al. 2005: 14). [18]

Thus, according to Weinerman and Long a health system includes any activity of a society aiming at restoring health where education, nutrition, housing, environment and the like come into the picture (Nolte at al 2005: 14).

Finally WHO (2007: 12) put forward the following explanation for health care system:

> A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly-owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example encouraging the ministry of education to promote female education, a well- known determinant of better health.

[18] Long differentiates medical care from health care where he takes the former as one of the several types of services identified as health care services. He defines medical care system as the "organization, financing and delivery of medical care services that comprise… preventive care, acute care and long-term care" (Long 1994 quoted in Nolte et al. 2005: 14). Nevertheless although it seems to be a rather encompassing definition than the ones mentioned above, Long's definition for health care system also reflects a narrow perspective by focusing on the provision side of health services (Nolte et al. 2005: 14).

As it can be seen WHO adopts a very broad definition for health system where “the crucial determinant of whether something is within or outside a health system is the intent to improve health” (Nolte et al. 2005: 14). In this regard it reflects an understanding which makes it rather easy to embrace any private activity directed towards the maintenance or improvement of health (care services) within the health care system.

It is possible to define health care systems by national borders. There are many activities which may be considered within the health system in one country but not in another country- such as social care for elderly people, training of health care professionals or production or regulation of pharmaceuticals and medical technology.

However with the advance of globalization, national borders have become less determining than they were before in defining health care systems at the national level. For instance, with the General Agreement on Trade in Services (GATS), international corporations can take part in service delivery within any national health care system with their own way of provision. Moreover what is common in nearly every country is that each has a complex mixture of different health care systems making it difficult to define health care systems with reference to national borders (Nolte et al. 2005: 12-13). Nevertheless it should be kept in mind that any health care system reflects the historical paths that have been passed through by the country in question in terms of political, economic, social and cultural developments.

At the end of this section it should be noted that health care system is related to a wide range of issues such as public health, food, water and air safety. So this is quite a broad topic. However this study will mainly deal with its organizational and financial aspects- particularly the transformation having been undertaken regarding these aspects and their impact on the provision of health care services and the overall socio-economic, political and cultural legacies of all these.

3.3 Development of Modern Health Care Systems - Health Care as a Right and Public Service

This section will mainly elaborate on how modern health care systems came into being and evolved in time. In this regard issues such as how health care became a (constitutional) right and subject of public service in many countries some decades ago will also be touched upon. Understanding these processes will make it easier to understand the transformations health care services have been undergoing since late 1970s all over the world.

Development of health care systems is highly related with the general context within which national governments started to take on responsibility for the provision of health care services. Boundaries and characteristics of these responsibilities in turn determined the basic features of the health care systems being experienced in the world today.

In this regard it is possible to pinpoint several developments which can be regarded as the cornerstones in the emergence and development of modern health care systems as they played serious roles in determining the basic characteristics of these systems. In this context nation state formation process, the two world wars and rise and fall of the welfare state and social state understanding can be taken as the major breaking points in the development and evolution of modern health care systems. These can be added with the recent reformation/transformation processes which have been the predominant characteristics of any type of health care systems since 1980s.

Modern health care systems, which were highly organized compared to the long-lasting traditional health care and which were intended to benefit the majority of the population, emerged almost a century ago (WHO 2000: 11). Although hospitals have a much older history, modern health care systems of Europe started to emerge towards the 19th century when the previously established hospitals which were mostly designed for the very poor and usually managed by the churches or charities started to be taken over by local public bodies (Palier 2005: 9) [19].

[19] In England starting from the 16th century, with the laws enacted for the poor, local public authorities started to take on the responsibilities for the health care of the poor, which had been

It is evident that development of health care systems followed some different paths due to their particular socio-economic, political and cultural contexts, where the industrial revolution and the successive nation state formation practices and political developments played key roles.

Emergence of Western European Social Insurance Systems has many things to do with the great change brought about by the industrial revolution in the lives of people and the following strong sets of relationships between employers and employee associations in Germany and France following the Industrial Revolution (Nolte et al. 2005: 14). With the industrial revolution, health of workforce started to be taken seriously by the company owners, particularly in order to secure productivity aims. After a while health of workers became a political issue in some European countries such as Germany where in 1883 Bismarck - the then Chancellor of Germany- passed a law demanding employers of low-wage workers in certain occupations to pay contributions for the health coverage of their employees. This was done in an environment where the German government wanted to secure support from the rising workers' movements. Later this was made to apply to other groups of workers and subsequently leading to the establishment of the first example of "state-mandated social insurance system" (WHO 2000: 12) which is today widely known as the Bismarckian Social Insurance Model.

Another example could be Russia where the Bolshevik Revolution dictated that the entire population would be provided with free medical care within its huge network of provincial medical stations. This was the first example of "completely-centralized and state-controlled model" of health care system (WHO 2000: 12) which is widely-known as the Semashko System.

Finally it is argued that individualism which characterizes much of American way of living has been highly influential on the formation of the US health care system (Nolte et al. 2005: 14) which is today known for limited state involvement for only certain population groups and leaving the scene mostly to private health insurance

---

previously undertaken by the churches or charities. The same thing was done in France right after the French Revolution (Palier 2005: 9).

companies (WHO 2000: 13). This is usually known as the Liberal Model of Health Care System.[20]

The two World Wars highly influenced the development and evolution of health care systems. It was after the First World War that Bismarckian Social Insurance Model started to spread outside Europe. In 1922 Japan adopted this system where its tradition of managerial paternalism also played an important role in its provision of the Japanese workforce with health benefits (WHO 2000: 12). Chile and Denmark also adopted work-related social health insurance systems in 1924 and 1935 (WHO 2000: 12).

Second World War did have two-dimensional effect on the development of health care systems. On the one hand during the war, previously-established health care systems were highly damaged. On the other hand, war-time experience paved the way for the emergence of new types of health care systems. For example it was during the occupation of the country in the Second World War that Social Health Insurance System was introduced in Netherlands (WHO 2000: 12). Also it was the war-time experience which did highly influence the emergence of the British National Health Service (NHS) (Nolte et al. 2005: 14) where the country's national emergency service to deal with casualties during the war was helpful in the construction of this system in 1948 (WHO 2000: 12). This is the most commonly-cited example of the Universal Health Insurance Model which is also known as the Beveridge Type Health System which mandates the provision of comprehensive and free health care for everybody irrespective of occupation, age, sex or means (WHO 2000: 12).

After the Second World War, particularly in the immediate post-war period, the process of founding modern national health care systems were almost completed around the four major models briefly touched upon above- namely the Bismarckian Social Insurance Model, the Beveridge Model of Universal Health Insurance, the Semashko Model and the Liberal Model. This holds true for the developed world, the

[20] Health Care Systems and their different classifications will be analysed in detail in the following section.

then Second World countries and more or less for the developing world. It was in this period that health care systems did experience rapid developments thanks to the economic growth and the following socio-political developments of the era (Palier 2005: 8).

The rise of welfare state and social state understanding in the later post-war period highly influenced the evolution of health care systems. Starting from this period health care services have been regarded more as social services rather than private business in the majority of western European states, which was reflected in the public expenditures on health care (Axelsson et al. 2007: 142).

It is widely argued that apart from being a response to the market failures that have been experienced in health care services, this has also a lot to do with the rise of values that regard "access to necessary health care as a human right" (Esping-Andersen 1990; Axelsson et al. 2007: 142). It was in 1948 that the right to health care was included in the Universal Declaration of Human Rights, Article 25 of which reads as follows (United Nations 2010):

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
>
> (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

As Esping-Andersen mentions, welfare state conceptualized health as a right and as basic constituent of citizenship (Esping-Andersen 1990). In the same line of thought Axelsson et al. emphasize that health care had strong citizenship entitlement (Axelsson et al. 2007: 142). Since it regarded health as a right, the notion of social state foresaw some definite responsibilities for the state to undertake in terms of health care provision for its citizens.

Here it should be underlined once more that this emphasis on health as a right for every citizen was made possible with the post-war economic growth and with the consolidation of the Keynesian welfare state understanding particularly in Western Europe. According to Keynesian approach, objectives of political economy and that of social policy were highly compatible and public expenditures made on health care would contribute to economic growth besides their contributions on the health and living conditions of the population (Palier 2005: 26). This approach of Keynes was shared and adopted to a serious extent by the figures which were in charge of health policies in Europe in during 1950s and 1960s such as William Beveridge who is known as the founder of the Beveridge System in England and also by Pierre Laroque, the founding father of the French Social Security System (Palier 2005: 24).

However with the collapse of the welfare state and the succeeding neoliberal restructuring of the public sector, citizenship entitlement of health care started to loosen and the conceptualization of health as a right started to be replaced with the understanding which sees health as a commodity. In fact with the neoliberal restructuring process, health care systems and health care services have become one of the most central and critical focus of transformation. In this regard state started to take its steps back from the provision of health care services and limited its responsibilities to planning, standard setting and to some other strategic issues[21]. This has been added by the increase in the number of regulations coming from international organizations such as the WHO, WTO, WB, EU which have direct or indirect impacts on health care services. This transformation process will be analysed in detail in the following sections.

To recapitulate, it is possible to identify four major types of health care systems being established in the post-war period and to detect that they got consolidated with the Keynesian policies. It is these models - namely the Beveridge Model (National Health Systems), the Bismarckian Social Insurance Model, the Liberal Model and the Semashko Model (although it is quite difficult to find pure examples for this last

[21] As has been the case in many other countries, it is possible to observe this kind of a transformation in the conceptualization of health care in Turkey. While 1961 Constitution clearly defined the right to health, 1981 Constitution foresees a more regulatory and a less servant role for the state in health care services which has also been perpetuated with the recent public sector reforms. This transformation will be explained in detail in the section on the development of the health care system in Turkey.

model) which are still taken as the framework of reference when studying health care systems. However it should be underlined once more that besides the serious degree of convergence observed in health care reforms, what still also holds true is that since different health care systems developed in different countries in accordance with their particular social, economic and political developments within their particular historical contexts, these differences in turn have been highly influential on their way of reforming (Axelsson et al. 2007: 162).

The following section will elaborate on classification of health care systems.

3.4 Types of Health Care Systems in the World

The issue of classifying health care systems has been dealt with by various authors for so long.

In the majority of texts written on health care systems, the most widely-used classification taken as framework of reference is the one which classifies health systems as the Beveridge Model, the Bismarckian Model, the Liberal Model and the Semashko Model - to which some authors also add Developing Countries as another separate category.

Before explaining this classification in detail, it seems quite useful to have a brief outlook on some of the other attempts made at classifying health care systems. Such an effort is expected to shed light on the issues left outside or untouched by this rather classical classification which is found simplistic by some authors (e.g. Nolte et al. 2005: 15).

3.4.1 Classification Made by Field (1978)

Table 1 Classification by Field

	General Definition	*Position of Physician*	*Role of Professional Associations*	*Ownership of Facilities*	*Economic Transfers*	*Prototypes*
Type 1 Private	Health care as item of personal consumption	Solo entrepreneur	Powerful	Private	Direct	USA, Western Europe
Type 2 Pluralistic	Health care as consumer good or service	Member of variety of groups / organizations	Very strong	Private and public	Direct and indirect	USA in 20th century
Type 3 National Health Insurance	Health care as an insured / guaranteed consumer good or service	Member of medical organizations	Strong	Private and public	Mostly indirect	Sweden, France, Canada
Type 4 National Health Service	Health care as state-supported consumer good or service	Member of medical organizations	Fairly strong	Mostly public	Indirect	Great Britain
Type 5 Socialized Health Service	Health care as a state-provided public service	State employee and member of medical organizations	Weak or non-existent	Entirely public	Entirely indirect	Soviet Union

Source: Nolte et al. (2005: 16) (Types of national health systems, as classified by Field)

In this classification Field takes the role played by the state and/or market as the factor which determines the general character of the health care systems. In addition to this the author takes the position of the physician, role of professional associations, ownership characteristics and economic transfers as the other factors that help define a health care system.

3.4.2 Classification made by Roemer (1977)

Another classification was made by Roemer who tried to group national health systems along lines of economic level (GNP/capita) and the level of market intervention in health policy.

Table 2 Classification by Roemer

		Market Intervention			
		Entrepreneurial & permissive	*Welfare-oriented*	*Universal & comprehensive*	*Socialist & centrally planned*
Economic Level (GNP/capita)	*Affluent& industrialized*	USA	W.Germany Canada Japan	G. Britain N. Zealand Norway	Soviet Union Czechoslovakia
	Developing&transitional	Thailand Philippines S. Africa	Brazil Egypt Malaysia	Israel Nicaragua	Cuba N. Korea
	Very poor	Ghana Bangladesh Nepal	India Burma	Sri Lanka Tanzania	China Vietnam
	Resource-rich		Libya Gabon	Kuwait S. Arabia	

Source: Nolte et al. (2005: 16) (Types of national health systems, as classified by Roemer)

3.4.3 Classification made by Elling (1994)

Adopting a Marxist perspective, Elling classified national health systems by concentrating on the strength of labour movements. In this regard the author identified five groups of countries with their associated health care systems: (Nolte et al. 2005: 17)

a. Core Capitalist Countries: These countries are characterized by low strength of workers' movements, market-oriented health systems which may have elements of a

national insurance system and great inequities in access to health services due to class, ethnicity, gender and the like. E.g. USA, Switzerland, Germany.

b. Core Capitalist-Social Welfare Countries: These countries have stronger labour movements and they do have health insurance systems on national or regional basis. E.g. Canada, UK, Scandinavian Countries.

c. Industrialized- Socialist Oriented Countries: These were the countries existing before the collapse of the Soviet Union where labour movements were integrated within the Communist Party and where there were regionalized national health services with fewer disparities than they had in core capitalist countries.

d. Countries having Capitalist Dependencies: Labour movements were suppressed in these countries and they have very little or no collective provision of health services with inequity in access to health care. E.g. Brazil, India, Philippines.

e. Socialist - Oriented Quasi Independent Countries: These countries have strong labour movements and they are characterized by regionalized health services where there is more equity in access to these services. E.g. China, Cuba, Tanzania.

As it can be seen even from these very brief summaries, the above-mentioned classifications reflect the political conjuncture of the era in which they were developed. In some of them one can see a forced effort to extract out a typology or to place a country in one of those typologies created. Nevertheless it is still useful to have a look at them to get insights for the analysis that will be made in the following sections.

3.4.4 Classification made by Frenk and Donabedian (1987)

Table 3 Classification by Frenk and Donabedian

		Basis for population eligibility			
		Purchasing power	*Poverty*	*Socially perceived priority*	*Citizenship*
Mechanisms for state intervention	*Regulation*	Private enterprise	Private charity	Company-based services	Social insurance (German model)
	Financing	-	Medicaid (USA)	Incipient health insurance	National health insurance
	Delivery	-	Public assistance	Social security (Latin American model)	Socialized (national health service)

Source: (Nolte et al. 2005: 18)

This classification of health care systems takes the mechanisms of state intervention in health care and the population's eligibility to receive health care services as the two main dimensions in classifying health care systems. As Nolte et al. point out, this approach helps one to see different modalities of state intervention existing together in a health care system of a particularly country. For example in the American health care system financing and delivery of health services are provided by both private employers (for their workers) and by the state (for the poor- state financed Medicaid and services provided by the state for veterans) (Nolte et al. 2005: 18).

3.4.5 Classification by the OECD

Being one of the most important supporters for health care reforms, OECD has been working hard in figuring out frameworks for comparing health care systems.

In this regard besides publishing reports on the performances of different health care systems from different parts of the world, OECD does also publish OECD Health Data on a regular basis for comparing health statistics across OECD countries. In this regard they also publish Health at a Glance on annual basis where they provide comparable data on different aspects of the performances of health care systems in OECD countries.

In addition to these OECD devised the SHA - System of Health Accounts - as a framework for standard reporting for expenditures on health and its financing and as a framework for international data collection. This framework would complement National Health Accounts and provide comparability across different countries with different health care systems (OECD 2000: 11).

In 1992 OECD put forward the following framework where they differentiated between seven models of health care systems which were classified according to their sub-systems of finance and methods of paying providers (Nolte et al. 2005: 18).

Table 4 Classification by the OECD

Model	*Example*
Voluntary, out-of-pocket payment	Supporting role only, e.g. purchase of over-the-counter medicines, cost-sharing for prescribed medicines
Voluntary (insurance with) reimbursement of patients	Private sector in UK and Netherlands
Public (compulsory insurance with) reimbursement of patients	Elements retained in the social health insurance systems in France and Belgium
Voluntary (insurer/provider) contract	Individual Practice Association and prepaid group practices in Spain (private sector)
Public (insurer/provider) contract	Primary care in Germany, Netherlands, Ireland, UK; hospitals in Belgium, Germany, Netherlands, UK
Voluntary insurance with integration between insurers and providers	USA: Health Maintenance Organizations
Compulsory insurance with integration between insurance and providers	Spain; public hospitals in France and Ireland (previously public hospitals in UK)

Source: Nolte et al. (2005: 19)

3.4.6 Framework derived by Checkland based on Systems Theory (1981)

Checkland adapted systems theory to health care systems. According to this approach, as any other systems (living organisms) a health care system is composed of sub-systems and that it has a purpose, it contains decision-making processes which are themselves systems as well, it interacts with its environment and it has some degree of continuity thanks to its ability to adapt to environmental changes.

This classification implies that in the face of this kind of complexity, it is necessary for health care studies to be multi-disciplinary. It is also argued that one should move away from the understanding of evaluating health care systems as a whole to an understanding which evaluates its separate functions - namely its sub-systems - that contribute to the overall health care system (Nolte et al. 2005: 20).

As it will be seen in the following section this approach was adopted by the framework developed by the WHO.

3.4.7 Framework by the World Health Organisation (WHO)

In World Health Report 2000, WHO examined and compared various aspects health care systems around the world. The report brought together the available data in order to assess the performance of the health care systems of WHO member countries. In so doing, to a certain extent in line with the systems approach, “the functions” (and sub-functions) of health care systems were depicted where comprehensive explanations on health care systems and their objectives in general were made. In this context the functions and sub-functions of health care systems were stated as follows: stewardship (Oversight), financing (collecting, pooling, purchasing), creating resources (investment and training), provision (delivering services) (WHO 2000: 25).

In line with this approach Nolte et al. state that it could be possible to proceed with the CATWOE model developed by Checkland (1981) where CATWOE symbolizes the acronym for the elements making up the health care system which reads as

follows: Customers (beneficiaries of the system), Actors (who carry out or cause to be carried out by the transformation), Transformation process (the means by which defined inputs are transformed into defined outputs), Weltanschauung (vision of the world assumed for the system to function), Ownership of the system (someone with prime concern for it and the power to cause it to cease to exist), Environmental constraints in the environment (geography, national wealth) or in related systems (legal, educational, financial) (Nolte et al. 2005: 23).

3.4.8 The "Classical" Framework for Classifying Health Care Systems

It was not possible to find out who was the inventor of this classification. However it is certain that it is still this classification which is referred to in the majority of studies dealing with health care systems.

3.4.8.1 Beveridge Model

This is also called National Health Care System. It is named after Lord William Beveridge whose 1942 Report[22] identified health care as one of the three basic prerequisites for a viable social security system (WHO 2000: 12) and who proposed a National Health Service for the UK in 1940s, before the war was over.

This Report was followed by a White Paper from the government in 1944 which stated the policy that "Everybody irrespective of means, age, sex or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available" and that "those services should be comprehensive and free of charge and should promote good health as well as treating sickness and disease." (WHO 2000: 12*)*

In line with the developments in the field of social welfare and with the help of war-time experiences (particularly those regarding emergency services) the year 1948

[22] Its full name is "Social Insurance Allied Services - Report by Sir William Beveridge" however it is often known as the "the Beveridge Report" (Socialist Health Association, 2010).

pointed to the date for the establishment of today's famous National Health Service (NHS) in England.

Since then the NHS turned out to be "the most commonly-cited example of the Universal Health Insurance Model" and almost "the most widely influential model of health system" (WHO 2000: 12).

The most characteristic feature of the Beveridge Model is that it provides "universal coverage" and in this regard "it mandates the provision of comprehensive and free health care for everybody irrespective of occupation, age, sex or means" (Nolte et al. 2005: 12; WHO 2000: 12; Palier 2005: 28).

The system is principally publicly financed - i.e. from (general) taxation revenues (Nolte et al. 2005: 12; Palier 2005: 28). Resources are traditionally distributed by budgets, sometimes on the basis of fixed ratios between populations and health workers or facilities (WHO 2000: 13).

Although it relies primarily on public provision which is principally organised by the state (WHO 2000: 13; Palier 2005: 28) "substantial volume of health care is provided in the private sector, both to those that have private health insurance and increasingly for those who choose to pay directly" (Nolte et al. 2005: 12).

Although it is the UK which is taken as the prototype for the Beveridge type of Health Care Systems, it was New Zealand which was the first country to introduce a National Health Service in 1938 (WHO 2000: 12). It was followed by Costa Rica in 1941, South Africa in 1944, Soviet Union, Japan, Norway, Sweden, Hungary and Chile in the post-war period which attempted to establish National Health Systems similar to the British model (WHO 2000: 12-13).

As a result of the evolution of health care systems in these particular countries, today not all of them are included within the Beveridge Model. After England[23], the most

[23] "There have been growing differences in the way in which health care is organized in the four constituent parts of the UK- in particular Scotland moving increasingly away from the model evolving

amplifying examples of the Beveridge Model are the Nordic Countries such as Sweden and Norway, Canada - however with more private providers-, Denmark, Finland, Ireland, Italy, Spain, Portugal, Greece, Australia and New Zealand.

Since it is principally planned, organised and financed by the state, Beveridge Type of Health Systems are known to be rather centralised systems. However there have been many attempts to decentralise these systems, particularly in the Nordic countries and also in England where decentralization attempts go together with re-centralization at various times.

According to Palier, Beveridge Type of National Health Systems generally guarantee greater equality in access to health care and relatively low level of health care expenses. However the quality of health care services they provide is disputed and they are usually characterised by very long waiting lists of patients who are to see specialists (Palier 2005: 29). Moreover he argues that it is the national health systems of the Nordic countries whose budgets are not that much restricted and which have the best results in terms of health outcomes and financial and social success (Palier 2005: 27).

3.4.8.2 Bismarckian Model

This is also known as the Social Insurance Model. It is named after the German Chancellor who introduced Social Insurance in this country towards the end of the 18th century (Nolte et al. 2005: 15). As it has been explained above, emergence of this first state-mandated social insurance system did have many things to do with the socio-economic and political developments taking place in Germany and in most of the European countries in that period.

It is an insurance-based health care system which is mainly financed by the Sickness Funds which are the central institutions of the system. Drawing upon the system

---

in England" (Nolte et al. 2005: 12). As it has been mentioned at the very beginning of this study, main area of interest in this study is the NHS in England.

established by Bismarck in 1883, it is mandatory for the employers, the employees and the government to contribute to these funds according to the premium rates designed for them separately. The aim is to cover all or most of the citizens through compulsory employer and employee payments to Sickness Funds (WHO 2000: 13). Nevertheless in practice it covers only those people who are entitled with a specified scheme.

There is structural split between finance and provision of health care services (Axelsson et al., 2007: 162). However, health care is provided through both public and private providers (WHO 2000:13). Provision of health care is partly privatised (e.g. ambulatory care, certain hospitals or clinics) and partly provided by public organisations (notably the hospital services) (Palier 2005: 28). Whereas costs and the expenses incurred as a result of the health care services provided are in the charge of different health insurance funds and are financed by the social contributions (social premiums) collected in these funds (Palier 2005: 28-29).

In general patients' choice of doctors is guaranteed as well as the doctors' right to private practice (Palier 2005: 28).

The earliest such social insurance systems usually evolved from small, initially voluntary associations and the later versions were usually created ex-nihilio by public action (WHO 2000: 13). Although the first attempts taken during the Bismarckian era were to cover some low-wage workers, in the later periods social insurance scheme was extended to cover other groups of workers as well. It was in the post-war period that social health insurance systems became more consolidated thanks to the Keynesian climate that the world was experiencing then.

As has been mentioned above, Bismarckian Social Insurance Model started to spread outside of Europe after the First World War and it was adopted in countries such as Japan and Chile. Today other than Germany, France, Belgium, Luxembourg, Japan, Holland before the Dekker reform and certain countries in central and eastern Europe are referred to as the countries having some kind of a social insurance-based health care systems.

Organisation of the system might exhibit certain differences among different countries. For instance the system in France is rather centralised while the one in Germany is organised according to the Regions (Landers) (Palier 2005: 29).

According to Palier, Bismarckian Type of Social Insurance Systems guarantee patient choice and comfortable and often quality health care. However he concludes that this is quite often achieved at the expense of high levels of expenditures made on health care services and sometimes at the expense of inequality in access to health care as it only covers those who are entitled with a scheme (Palier 2005: 29).

3.4.8.3 Liberal (Privately-Funded) Model

It is mainly based on private insurance where the government has very little role to play.

In general it is used to define the American health care system. However the reforms that have been undertaken in central and eastern European countries and Latin American countries are also examined within this context by some authors (Palier 2005: 29). In fact as it will be seen in the upcoming sections, health care reforms of the post-1980 era can be said to have serious traces from the liberal model.

The American health care system is usually regarded as a rather heterogeneous system which combines three possible types of health protection with their different payment plans: 1. Free health care provided for the very poor - the Medicaid and SCHIP. This scheme shows many variations from one state to another. 2. Health insurance for the very old - the Medicare. 3. Private insurance for the middle classes and the well-off (which is financed by the employers or by the individuals themselves) (Nolte et al. 2005: 12; Palier 2005: 29).

In addition to this there is a range of other federally-funded programmes such as those for the armed forces, for veterans and for the native Americans (Nolte et al. 2005: 12).

As it can be seen the most characteristic feature of this system is that it foresees limited state involvement which is only for certain population groups. Public protection for illnesses is residual. Only people with great urgency of health care, those very poor, of very old age and the disabled benefit from public support for their health care needs (WHO 2000: 13; Palier 2005: 29). The rest of the population is left with the search for private insurance implying private finance, provision and ownership of health care facilities (WHO 2000: 13). That is why it is called the liberal (privately-funded) model. In such a system it is not difficult to consider how powerful the private insurance companies are.

As it has been mentioned above the limited state involvement in health care services and it's leaving the scene mostly to private insurance companies and private provision and private finance of health care services is said to be related to individualism which has come to define American way of living for so long (Nolte et al. 2005: 14).

In this system provision of health care services is almost entirely private (Palier 2005: 29). An important part of the population rest without health insurance. However, the American health care system is known for having highest levels of health care expenses. These are the two most important aspects for which this system is highly criticised.

As Palier argues the American Model of Liberal Health Care System exhibits technologically high-performance and it permits more comfortable access to better health care. However he says it is characterised by very strong inequalities (particularly in access to health care and in the health status of the population) and high level of health care expenses (Palier 2005: 29).

3.4.8.4 Semashko Model

It is the name given to the health care system which was introduced in the Soviet Russia and was implemented in the former USSR and the former Eastern Block

Countries where the state was the main owner, provider and financer of the health care system.
It was named after Nikolaj Semashko - the minister for health of the Russian Republic during 1918-1930 (Mossialos and Dixon 2007: 27).

The basic characteristics of this model were that it was a centrally-planned and state-funded health care system.

In the case of the Soviet Union the health care system was known "to contain a large number of parallel systems for those employed in the armed forces, the railways, Aeroflot (the Soviet airline), as well as the Nomenklatura (the Communist Party elite)" (Nolte et al. 2005: 12).

As Atun argues these countries are known to have been adapting health sector reforms since 1990s whereby the UK reform model has been highly followed (Atun 2007: 250).

3.4.8.5 Health Care Systems in Developing Countries

The above four are the main models that have long been cited in studies on health care systems. However in the recent years it has become a common trend to add the category of "Health Care Systems in Developing Countries" as the fifth model to the classification of health care systems.

Due to the influence of the reforms they have been undergoing - especially with the imposition from international organisations such as the World Bank and OECD, this model is being called the "World Bank Model" by some authors (Lister 2008: 180).

It is mainly this category which is said to be at the center of the convergence/divergence debate where most of the systems in this group are said to have converged to one of or to a mixture of the first three models cited above (thus also questioning the existence of this category).

Nevertheless it is not only the health care systems in developing countries which undergo changes. Health care systems in other countries have also been undergoing changes. In Spain the health care system has changed from an insurance-based Bismarckian System to a tax-financed Beveridge system. The French health care system has been following a similar path no matter the structural split between the finance and provision of health care services remains intact as one of the fundamental signs of the Bsmarkian system of social insurance. The Nordic Countries on the other hand had originally Beveridge type of health care systems however they have been undergoing many changes. In Canada health care system is based on public financing as in the case of a Beveridge system however with private providers of health care services (Axelsson et al., 2007: 162).

One other way of classifying health care systems, which also complements the above mentioned classical classification is by looking at *how the supply of health care is regulated* (Palier 2005: 74-78):

Regulation by the State: This usually occurs in countries which have national health care systems and where the regulation of the health care supply is done by the state, which is the main financer of the system (e.g. UK).

Regulation by Negotiation: In this model health care supply is negotiated with the participation of relevant national actors such as the Sickness Funds, Doctors' Organizations, etc. (e.g. Germany).

Regulation through the Market: Here the majority of the health care supply is provided by the private sector (e.g. USA).

As it can be seen this classification corresponds to a reasonable extent to the so called classical one. However this one concentrates more on the regulation of the supply of the health care services. In this regard Regulation by the State could correspond to the Beveridge Model; Regulation by Negotiation could correspond to the Bismarckian Model and Regulation through the Market could correspond to the Liberal Model.

While analysing the so-called classical models of health care systems, it is also possible to relate them to the famous *classification made by Esping-Andersen* for explaining different welfare state regimes which goes as follows (Esping-Andersen 1990: 26-27):

Liberal (Anglo-Saxon Type) Welfare States - They are characterised by

modest benefits, low taxation, state encouraging the market, growing middle classes directed mainly towards private market schemes, means-testing, modest universal transfers plus social insurance plans.

(e.g. USA, Canada, Australia, UK).

This type can be corresponding partly to the Liberal Model in a Welfare State Regime.

Corporatist (Conservative) Welfare States - These are characterised by

corporatist actors which are active in decision-making on welfare issues, universal social insurance especially by payroll contributions, social insurance based on occupational segregation, limited role for the market, growing middle classes absorbed through social insurance, limited de-commodification.

(E.g. Germany, Austria, France, Italy).

This type can be corresponding to Bismarckian Model in a Welfare State Regime.

Social Democratic (Nordic Type) Welfare States - Their main characteristics are

high benefits, high taxation, universalism and decommodification of social rights which are extended to middle classes where market is crowded out.
(E.g. Scandinavian countries).

This type can be corresponding to Beveridge Model in a Welfare State Regime.

It should be noted that today systems having a hybrid character and embodying features from the different models cited here are quite prevalent. Therefore it is not that easy to find pure examples for any of these models.

However like the majority of the authors who write in this field, this study also appreciates these kinds of classifications which make the quite complicated issue of studying health care systems simpler, particularly when intending to make inferences from one case for another. These kinds of classifications are also necessary to be able to make critics and to see the trend in what ways these models are converging/diverging and to see whether any of them emerge as the dominant model for the others. For instance one of the claims of this dissertation is that the English National Health Service (NHS) - particularly its way of reforming itself seems to emerge as a model for transforming the health care systems in the world in general and in Turkey in particular.

The issue of "benchmarking" is usually referred to in studies on health care systems and particularly on health care reforms. In health sector benchmarking refers to "looking at countries similar to one's own in income and spending levels, whose health system performance is particularly effective" (Roberts et al. 2008: 25). Benchmarking is often utilized by health reformers in

> comparing national performance with various standards…which can be in the form of ethical benchmarking (comparing performance to widely-accepted norms), internal benchmarking (comparing performance across groups or regions in the country), historical benchmarking (comparing performance to a nation's own prior performance) or external benchmarking (comparing performance with that of other similarly situated countries) (Roberts et al. 2008: 123).

As Nolte et al. (2006: 9) emphasize benchmarking health care systems is a challenging activity in the face of the reality that health systems are complex and have multiple functions. They also criticize the current approaches to performance

assessment and benchmarking health care systems because of the fact that they are "related to underlying definitions and availability of data, selection of indicators, methodological issues, interpretation of data, variation in information needs of different users and possible time lags between interventions and outcomes" (Nolte et al. 2006: 9).

The issue of benchmarking will get into the way of this study in the relevant sections, as the WHO, the OECD and various other international or national organisations working on health reforms elaborate and highly depend on these kinds of efforts where the World Health Report 2000 by the WHO and the OECD Health Care Quality Indicator Project can be given as examples in this regard.

CHAPTER 4

DECENTRALIZATION IN HEALTH CARE SYSTEMS

Main tenets of public sector reforms having been adopted since 1980s can be clearly seen in health care reforms. In this regard it is possible to refer to almost all main principles of (New) Public Management when analysing reforms/transformations having been undertaken in health care systems- although in varying degrees and effects.

This study will mainly concentrate on the two major aspects of health care reforms- decentralisation and finance as it argues that it is those reforms made under the banner of decentralization and finance which have brought about the most critical transformations in health care systems not only in Turkey but also in other countries.

It should be noted that these two aspects of health care reforms are interrelated among themselves and affect each other reciprocally. Attempts towards decentralizing health care services usually go hand in hand with attempts towards creating an internal market and a provider/purchaser split in the health care system, which has clear implications for health care finance (Maino et al. 2007: 137). "Decentralization of health finance" and in that regard "financial decentralization" (also called "fiscal federalism") are highly referred to within the context of health care reforms (Bankauskaite and Saltman 2007: 14; Magnussen et al. 2007: 106).

Therefore in analysing health care reforms in this study, main areas of concern are limited to decentralization (organization) and finance. Thus other aspects of health care reforms will only be touched upon whenever they are relevant to the discussions and analysis being made on these two main axes.

Nevertheless as Roberts et al. also point out, it should be kept in mind that reforms usually affect more than one aspect and change in one of these aspects affects change in others (Roberts et al. 2008: 28-29). Cultural/structural factors, changes in other

sectors, changes in macro-economic policies all affect health sector reforms. Therefore a comprehensive approach is needed not only for effective reforming but also for understanding these reforms. In this regard, the issue of payment might be touched upon while studying health care finance. Or in the same way this study might have to elaborate on the issue of regulation in various sections as an umbrella term affecting reforms directed towards both decentralization and finance in health care.

4.1 The Concept of Decentralization

This section will mainly attempt at conceptualizing what decentralization means in health sector and what does it refer to in health care reforms.

In this regard basic definitions put forward for the concept of decentralization in genera and those made within the context of health care systems will be covered.

To start with it should be stated that decentralization is a concept which has been used in many different contexts ranging from politics to organizations or from economics to decision-making. What is more is that in nearly none of these contexts there exist any sound consensus on its meaning, as the scholars and practitioners working in any of these fields have come up with different definitions.

As Conyers point out “everyone knows roughly what ‘decentralization’ means, but defining it precisely presents problems because it can be used in a number of different ways and in significantly different contexts” (Conyers 1984: 187 quoted in Hutchcroft 2001: 24). The literature on decentralization is found in a large range of disciplines and theories, often with few links between them (Peckham et al. 2005: 22).

It would not be wrong to say that the great density of literature on decentralization in fact reflects the extent of disagreement on its definition among scholars and practitioners. Serious disagreement holds also for the definition of the related

concepts such as deconcentration, devolution and delegation as well as for the advantages/disadvantages and limits of decentralization.

Decentralization has been an issue quite attractive in both literature and practice since a long time. Particularly discussions on authority and power, formation and nature of state, democracy and the like all made considerable references to the issue of decentralization (Hutchcroft 2001: 24, 28). Therefore it can be said that starting from the 19th century the discipline of political science have been the most important scene for the development and discussion of the concept.

In this regard Peckham et al. quote Chadwick and Toulmin Smith as the forerunners of the discussions on two poles of centralization/decentralization in local government within the context of political science (Peckham et al. 2005: 23). They also refer to Mill, Hobbes, De Tocqueville, Burke, Cole and Webbs as the contributors to this debate. They make references to fields such as local democracy, democratic theory, central control and central domination thesis and central-local and intergovernmental relations. They also refer to discussions on new localism, federalism, politics of government grants and political devolution as other areas contributing to decentralization debate from the UK perspective (Peckham et al. 2005: 23).

Moreover as Hutchcroft summarizes, while classical theorists draw considerable attention to territorial dimensions of authority and power modern political inquiry focus more on power relations within particular institutions and among major social classes as they extend across territories. According to Hutchcroft although scholars of state formation provide insights into historical processes of centralization they do not formulate the conceptual vocabulary for describing centralization and decentralization. However he says these scholars emphasize the inextricable link between the process of administrative centralization and the very creation of modern states (Hutchcroft 2001: 24, 28).

In addition to Political Science, elaborations on decentralization came from the disciplines of Economics, Public Administration, Organizational Theory,

Management, Development Studies, geography, history, journalism and the like (Peckham et al. 2005: 23).

In the field of economics, public choice theory and fiscal federalism made strong references to decentralization. While Public Choice Theory argues that efficiency is associated with competition, information on organizational performance and small organization size; Fiscal Federalism is based on determining the optimum size for units carrying out the basic functions of public finance. Fiscal Federalism put forward a measurement for decentralization - social expenditure at the local level as a percentage of national social expenditure (Peckham et al. 2005: 23).

There has been a great deal of work on decentralization within the context of Development Studies (Peckham et al. 2005: 23). The conceptual framework developed by Rondinelli has become the dominant classification in these studies. This framework of Rondinelli was later adapted to health sector in developing countries by Mills (1990) and then by other authors to health care systems in general (e.g. Vrangbaek 2007; Roberts et al. p.231).

There are many sub-areas within the field of management such as quantitative approaches, accounting approaches and organization theory where decision-making approaches make serious elaborations on decentralization (Peckham et al. 2005: 23).

Moreover as has been analysed in detail in the relevant section of this study, New Public Management Approach, which has been highly influential in public sector reforms since 1980s, puts great emphasis on decentralization. As Pollitt et al. put it “[decentralization] is a miracle cure for a host of bureaucratic and political ills (Pollitt et al. 1998: 1).

As it has been mentioned, in this study attention will be limited to the meaning of decentralization in the context of health sector. Therefore only those definitions of decentralization made within this context will be dealt with.

In their study where they try to understand decentralization attempts in European health care systems, Saltman et al. point to the "complexity of the definitional question" regarding decentralization. As the editors of the book which seeks to understand the trend towards decentralization in European health care systems they state that

> [they] choose not to impose one exclusive definition of decentralization on contributing authors …but enable them to define and use decentralization in their chapters as they feel best fit the aspects they address and the particular country experience they describe [since] Europe contains a number of political, economic, organizational and legal variants of decentralization each supported by its logic (Saltman et al. 2007: 1-3).

As has been the case in the other fields it has been used, "far from being a unitary, clearly-defined concept, decentralization breaks apart into a kaleidoscope of different, sometimes contradictory definitions, each hollowed in its own theoretical and practical context" in the field of health systems studies (Saltman et al. 2007: 1).

Nevertheless in this study it is quite necessary to have a look at this "complexity of the definitional question". At least it will be useful to recapitulate the basic terminology in the existing literature- even if it may not be possible to get at "unitary definitions on which wide consensus would be attained". Or may be an attempt could be made to figure out the commonalities in the already-made definitions or as Saltman et al. underlined it could be an attempt to "define and use the concept(s) in the way we feel best fit the aspect we are addressing or best fit the particular country experience we are trying to understand" (Saltman et al. 2007: 1-3).

4.2 Decentralization in Health Care Systems

4.2.1 Decentralization

It seems quite enlightening to start with the definition and classification made by Rondinelli et al. (1983), which has become the most frequently cited definitional framework in studies analysing decentralization in health care systems.

Rondinelli et al. define decentralization as

> the transfer of responsibility for planning, management and resource raising and allocation from the central government and its agencies to: (a) field units of central government ministries or agencies (b) subordinate units or levels of government (c) semi-autonomous public authorities or corporations (d) area-wide, regional or functional authorities or (e) non-governmental private or voluntary organizations (Rondinelli et al. 1983: 13).

In line with this definition they classify four major types of decentralization:

deconcentration within the central bureaucracy,
delegation to semi-autonomous or quasi-public corporations,
devolution to local governments and
privatization as the transfer of functions to non-governmental organizations.

The classification made by Rondinelli et al. (1983) has been adopted by many authors (e.g. Mills 1990; Vrangbaek 2007) and institutions focusing on health care reforms [e.g. the OECD and the European Observatory on Health Systems and Policies (EOHSP)]. In this section attempts made at defining decentralization within the context of health care sector will be reviewed altogether as they look at the issue from the same point of view – which is in fact the path opened up by Rondinelli et al. (1983) - namely by the Rondinelli framework. However although in principle they

follow the same line of thinking, as it will be seen, these definitions do also reflect serious nuances among themselves.

Decentralization has been defined by the OECD as "the transfer of responsibility to democratically independent lower levels of government, thereby giving them more managerial discretion, but not necessarily more financial independence" (OECD 1997: 17).

European Observatory on Health Systems and Policies (EOHSP)[24] defines decentralization as

> changing relations within and between a variety of organizational structures/ bodies, resulting in the transfer of the authority to plan, make decisions or manage public functions from the national level to any organization or agency at the sub-national level […] or more generally from higher to lower levels of government. [25]

Mills who has made an extensive study on the conceptualization of decentralization in health care systems has adopted the definition made by Rondinelli et al. (1983) in nearly the same words as they were used by the authors. Thus she defines decentralization as "the transfer of authority, or dispersal of power, in public planning, management and decision-making from the national level to sub-national levels, or more generally from higher to lower levels of government" (Mills 1990: 11).

Finally Vrangbaek who elaborates on "a typology for decentralization in health care" defines decentralization as

[24] The Observatory is a partnership between the World Health Organization Regional Office for Europe, the Governments of Belgium, Finland, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the World Bank, the London School of Economics and Political Science (LSE), and the London School of Hygiene & Tropical Medicine (LSHTM) (WHO 2009a).
[25] WHO (2009a)

> the transfer of formal responsibility and power to make decisions regarding the management, production, distribution, and/or financing of health services, usually from a smaller to a larger number of geographically or organizationally separate actors (Vrangbaek 2007: 44-46).

When the common points made in these definitions to explain the concept of decentralization within the context of health care systems are examined, it can be seen that they all take the "transfer of responsibility/authority" as the core definitive phrase for decentralization. However although for all of these definitions this "responsibility/authority transfer" comprises those responsibilities/authority regarding planning, decision-making and managerial functions for some it does/does not - may/may not cover "financial responsibilities/authority" such as the authority to raise and allocate resources.

The second most crucial point in these definitions is that they all mention about a transfer of responsibility/authority "from" somewhere "to" somewhere, however these "locations" vary among different definitions. As it will be seen below in this section, different forms of decentralization are classified mainly according to these differences in terms of the locations where responsibility/authority is transferred.

All in all to extract out a definition from the above-mentioned attempts, decentralization in health care systems could be defined as the "transfer of responsibility/authority for decision-making in planning, management and/or financing of (i.e. raising and allocating resources for) health care services from higher/central/governmental units to lower/sub-central/non-governmental units".

As we have already mentioned, following Rondinelli et al. (1983) all these studies that we have quoted here for their definitions for decentralization classify the main forms of decentralization as deconcentration, delegation, devolution and privatization.

4.2.2 Deconcentration

According to Rondinelli et al. deconcentration refers to "handing over of some amount of administrative authority or responsibility to lower levels within central government ministries and agencies" which entails a "shifting of the workload from centrally located officials to staff or offices outside of the national capital" (Rondinelli et al. 1983: 14).

The authors state that in deconcentration some discretion is given to field agents for planning and implementing programs and projects or may be to adjust central directives to local conditions however within the boundaries of the guidelines set by the central ministry or agency headquarters (Rondinelli et al. 1983: 14).

OECD on the other hand defines deconcentration as "the transfer of responsibility from central ministries to field offices or more autonomous agencies, thereby becoming closer to citizens while remaining part of central government" (OECD 1997: 17).

According to the definition made by the European Observatory on Health Systems and Policies (EOHSP), deconcentration denotes

> passing some administrative authority from central government offices to the local offices of central government ministries [where] only administrative, and not political, authority is transferred to one or more lower levels [as] in reality, all decisions continued to be made in the capital[26]

EOHSP states that this term has also been called the "ministerial" model.

To make things more concrete EOHSP gives an example saying that deconcentration in a Ministry of Health would mean that sub-national (district/regional/local) level administrative units of the Ministry take over administrative duties which were previously undertaken by the Ministry. However in so doing the sub-national

[26] WHO (2009a)

administrative units of the Ministry would remain subordinate to the national government (e.g. health authorities at provincial or district level, health management boards).

According to Mills deconcentration refers to "the handing over of some administrative authority to locally-based offices of central government ministries" and it entails "the transfer of administrative rather than political authority" and thus is "the least extensive form of decentralization" (Mills 1990: 16).

Mills distinguishes between two different patterns of deconcentration- the vertical pattern and the integrated pattern:

Under Vertical Pattern of Local Administration, the local staff of each ministry is responsible to his/her own ministry although some form of coordinating structure (e.g. district development committee) may be set up.

Under Integrated Pattern of Local Administration (also called Prefectoral Pattern) a local representative of central government (e.g. a prefect, governor or district officer) who is accountable to a central government agency (such as the Ministry of Interior or the Ministry of Local Government) is made responsible for the performance of all government functions in his/ her area.

The author states that

> for the Ministry of Health [deconcentration] implies establishing local (e.g. district level) management with clearly defined administrative duties and with a degree of discretion that would enable the local officials to manage without constant reference to ministry headquarters (Mills 1990: 16).

According to her deconcentration may be accompanied by amalgamation of central and local government health services within new district organizations in order to facilitate planning and management of health services on an integrated basis across

the whole district[27]. Or it can be in the form that certain services within the district, such as referral and specialized hospitals, may remain directly under central control while other services are set as local responsibility. E.g. in England in the pre-1974 period, primary and secondary health care services were managed locally but teaching hospitals remained directly responsible to the centre (Mills 1990: 18).

Finally Vrangbaek defines deconcentration as the

> transfer of responsibility and power from a smaller number to a larger number of administrative actors within a formal administrative structure (vertical deconcentration) or from central management to other non-managerial groups such as health professionals (horizontal deconcentration) (Vrangbaek 2007: 48).

For a typical example of vertical deconcentration in health care systems Vrangbaek quotes the transfer of power from central authorities to Strategic Health Authorities (which are seen as the local representatives of the central level) in the UK.

To extract out a definition for deconcentration by drawing upon the aforementioned attempts made in this regard, deconcentration could be defined as the "transfer of some amount of administrative responsibility/authority from the central government agency to its field units where some discretion is given for planning and implementing the programs whose essence has been determined by the center which also dictates the boundaries of the provided discretion through detailed guidelines."

4.2.3 Delegation

Rondinelli et al. define delegation as the "transfer of managerial responsibility for specifically defined functions to organizations that are outside the regular

[27] E.g. In the UK under the 1974 re-organization of the National Health Service local authority responsibility for Community Health Services was transferred to the National Health Service and at the same time new District and Area Health Authorities were set up to take on district and area-wide responsibilities for health care to replace the previously fragmented system for hospital and community health services management. Moreover in 1982 Area level of management was removed and the District and and Sub-district level management structures were strengthened. Nevertheless the UK Depratment of Health and Social Security has remained as the ultimate responsible for the actions of the National Health Service: i.e. administrative authority has been decentralized but not the political authority (Mills 1990: 18).

bureaucratic structure and that are only indirectly controlled by the central government" (Rondinelli et al. 1983:19).

According to this definition the agent/organization to which specified functions are transferred has broad discretion to carry out these functions however the ultimate responsibility remains with the sovereign authority to which those functions belonged to beforehand.

The authors quote the creation of regional development agencies, special function authorities and semi-autonomous project implementation units- which are common particularly in developing countries- as examples of delegation.

According to the authors delegation has been used by the governments for various purposes:

as a way of removing important functions from inefficient government bureaucracies (it is assumed that autonomy or semi-autonomy will free the organizations from all sorts of inefficiencies), as a means of maintaining public control over highly profitable or valuable resources and as a way of providing goods and services for which user or unit charges can be determined. In this regard they argue that delegation could be used as a way of offering public goods and services through a more "business-like" organizational structure that makes use of managerial and accounting techniques normally associated with private enterprise (Rondinelli et al. 1983: 19-20).

OECD's definition for delegation is more regulation-oriented and it is used to define "the formal relationship in which competence for an aspect of the regulatory process is given by one level of government to a second level of government" (OECD 1997: 17).

European Observatory on Health Systems and Policies (EOHSP) defines delegation as passing responsibilities for planning and implementing decisions relating to particular activities to local offices or organizations outside the structure of the central government such as quasi-public (non-governmental) organizations without

direct supervision by a higher authority (central government) which however retains indirect control[28].

Mills makes a similar definition for delegation and states that it involves the transfer of managerial responsibility for defined functions to organizations (often termed "parastatal organizations") that are outside the central government structure and only indirectly controlled by the central government where the ultimate responsibility rests although the agent has broad discretion to carry out its specified functions and duties (Mills 1990: 21-22).

Mills quotes two examples of delegation from the health care sector: 1. Management of teaching hospitals which are organized as parastatal institutions with their own board of management and which are loosely responsible to the Ministry of Health 2. Provision of medical care financed by social insurance where "decentralized organizations" which are structured as institutes or councils with their own governing boards, sources of funding, property and legal status provide services.

As did Rondinelli et al. (1983), Mills also mentions that governments may see delegation as a means for avoiding the inefficiency of direct government management, for increasing cost control and for setting up an organization that is responsive and flexible. Moreover for her delegation is not incompatible with deconcentration as both have been suggested for the British NHS where it was thought that delegation on the lines of a public corporation model might remove the NHS from the political arena and make it more efficient. Besides these however she points out that delegation might cause problems of coordination and duplication of services (Mills 1990: 22)

[28]WHO (2009a)

Vrangbaek takes delegation together with autonomization and says that these two terms refer to “the transfer of selected functions to more or less autonomous public organizational management” (Vrangbaek 2007: 49).

According to him delegation should be seen as “further deconcentration of responsibilities but for limited functions, usually for specific periods of time and to organizational or network levels that are less directly controlled by the public hierarchical structure” (Vrangbaek 2007: 49).

He states that delegation and autonomization are often implemented through contracting in health care services. In this regard as more specific examples of delegation/autonomization in health care he quotes the creation of semi-autonomous entities (public enterprises) to arrange and deliver hospital care in Norway, the role of sickness funds in negotiating budgets with hospitals in social insurance systems and the creation of implementation networks including public and privately practising doctors and patient organizations in several health care systems.

Drawing upon these definitions delegation can be defined as the transfer of managerial (planning/implementing) responsibility/authority for specifically defined functions to agents/organizations which are outside the regular bureaucratic structure of the central government (e.g. quasi-public/non-governmental/parastatal organizations) whereby the central government carries the ultimate responsibility and exerts only indirect supervision over the agent/organization which enjoys broad discretion to carry out the specified responsibilities/functions transferred to themselves.

4.2.4 Devolution[29]

Rondinelli et al. defines devolution as "the creation or strengthening-financially or legally-of sub-national units of government, the activities of which are substantially outside the direct control of the central government" (Rondinelli et al. 1983: 24).

After making this brief definition the authors elaborate on the legal autonomy enjoyed by local governments vis a vis the central government where the latter exercises only indirect supervisory control over the former as specified in legal terms. They also refer to the recognized geographical boundaries and the exclusive authorities enjoyed by local governments to perform granted or reserved functions where they may also raise revenues and make expenditures (Rondinelli et al. 1983: 25).

OECD puts forward a very broad definition for devolution which simply states that it is "used as an umbrella term covering all forms of transfer of responsibility" (OECD 1997: 17).

According to the European Observatory on Health Systems and Policies (EOHSP), devolution involves passing responsibility with respect to a defined set of functions to sub-national levels of government (regional or local government) that are substantially independent of the national level, however with or without financial responsibility (i.e. the ability to raise and spend revenues)[30].

Political decentralization is another name used for devolution by the EOHSP.

EOHSP states that the most critical difference between devolution and deconcentration is that in devolution the sub-national levels in question are

[29] Political devolution and administrative devolution are the two major types of devolution. Here it is administrative devolution which this study attempts at understanding while trying to analyse decentralization in health care systems as it is possible to have administrative devolution in unitary states.

[30] WHO (2009a)

substantially independent of the national government with respect to their functions and responsibilities.

Mills defines devolution as the "creation or strengthening of sub-national levels of government (often termed as local government or local authorities) which are substantially independent of the national level with respect to a defined set of functions, which have clear legal status, recognized geographical boundaries, a number of functions to perform and statutory authority to raise revenue and make expenditures" (Mills 1990: 19).

She states that since local authorities are largely independent of the national government in their areas of responsibility compared to the subordinate administrative units, devolution implies a much more radical restructuring of health service organization than deconcentration.

Mills also draws attention to the fact that devolution in health care services creates heavy demands on recurrent expenditure and that in the face of local governments which usually have a very limited tax base and which are reliant on revenue sources such as land or property taxes which cannot be easily increased, things usually get complicated. In the end local governments become heavily dependent on central government which implies a reduction in their autonomy. Therefore she says in developed countries the trend has been to shift health services ownership and/or financing out of local governments as health services have become too expensive for them to carry out[31].

Vrangbaek also refers to devolution as political decentralization and defines it as "decentralization to lower level political authorities such as regions or municipalities" (Vrangbaek 2007:48).

[31] As it will be explained in detail in the relevant sections of this study, within the context of the re-organization of the administrative system in Turkey, Basic Law on Public Administration (Kamu Yönetimi Temel Kanunu) foresaw a system where responsibilities for health care services were devolved to provincial local governments- type of local government in this country. However later this was not practiced and local governments were not given any responsibility regarding health services.

He gives examples of devolution of power to Scotland, Wales and Northern Ireland in the UK and devolution of powers to regional and municipal authorities in Scandinavia.

He argues that political devolution may apply to all functional areas of health care such as financing, arranging, delivery, and the like.

He also points out that under devolution the central level keeps various regulatory and supervisory duties and that what happens in practice is mixed responsibility among levels which may provide some flexibility to adjust to changing conditions or may lead to duplications and ambiguities in responsibilities (Vrangbaek 2007: 48).

Vrangbaek states that although in theory it is possible to talk about devolution to organizational level elected boards (e.g. used by some schools in Scandinavia) this is uncommon for health care and would be restricted to very specific functions.

Finally he states that devolution has a more comprehensive character than the other forms of decentralization mostly because it entails considerations for democracy, participation and legitimacy (Vrangbaek 2007: 50).

Drawing upon the aforementioned definitions it is possible to define devolution as the transfer of responsibility/authority with respect to a defined set of functions to lower level political authorities- namely to sub-national levels of government such as local/regional governments- which have clear legal status, recognized geographical boundaries and substantial independence from the central government which has only legally defined indirect supervisory control over them and which retains various regulatory duties. In devolution the local authority in question may/may not have statutory financial authority to raise revenues and make expenditures.

4.2.5 Privatization

According to Rondinelli et al. privatization as a form of decentralization occurs when

> governments divest themselves of responsibility for functions [e.g. for producing goods or supplying services] [that were previously offered by parastatal or public corporations] either by transferring them to voluntary organizations or by allowing them to be performed by private enterprises (Rondinelli et al. 1983: 28).

Rondinelli et al. quote the cases where the government transfers responsibility to "parallel organizations" such as national industrial and trade associations, professional groups, religious organizations, political parties or cooperatives as forms of privatization. In such cases these parallel organizations are given the responsibility to license, regulate or supervise their members in performing functions that were previously performed or regulated by the government (Rondinelli et al. 1983: 28)

European Observatory on Health Systems and Policies (EOHSP) defines privatization in health sector as “the transfer of ownership and government functions from public to private bodies, which may consist of voluntary organizations and for-profit and not-for-profit private organizations [where] the degree of government regulation is variable”[32].

Mills makes a similar definition whereby she states that “privatization involves the transfer of government functions to voluntary organizations or to private profit-making or non-profit-making enterprises, with a variable degree of government regulation” (Mills 1990: 22).

According to Vrangbaek “privatization exists when responsibility for particular functions is transferred from public to private actors either permanently (e.g. through purchase) or for particular time periods (e.g. through contracting)” (Vrangbaek 2007: 49).

[32]WHO (2009a)

For him it is possible to have privatization of health functions at all levels however he says it is more common to have this through regional or local level contracts (e.g. in social health insurance systems contracts are made with private deliverers) and he adds that in such privatizations there may occur some transfer of power to geographically or organizationally separate units (Vrangbaek 2007: 49-50).

Vrangbaek sees public-private partnerships as a combination of delegation and privatization and the issue of patient choice as "radical privatization of the demand function in health care" where in the latter case the funding and delivery remain public although the decisions that would have great impact on the finance of services are privatized. Moreover he says that in certain countries patient choice covers private health care services besides the public ones (Vrangbaek 2007: 49-50).

The author also mentions the adoption of user payments and voluntary private insurance as "different and far-reaching examples" of privatizing health care finance which "reduces political and/or administrative responsibility for the financing of health services to particular groups" (Vrangbaek 2007: 50).

Drawing upon these definitions, privatization as a form of decentralization can be defined as the transfer of responsibility/ownership for particular functions either permanently (e.g. through purchase) or for a specific time period (e.g. through contracting) from public bodies to voluntary organizations, not-for-profit or for-profit private organizations and to parallel organizations (such as national industrial or trade associations, professional groups, cooperatives, etc.) where the degree of regulation retained by the central government varies.

In this section so far the framework which was first devised by Rondinelli et al. (1983) and then became dominant in the studies analyzing decentralization in health care systems has been briefly reviewed. As it is seen although they look at the issue from the same point of view, definitions made from within this framework also differ in various respects. In this regard this section tried to shed light on this definitional confusion by trying to extract out common definitions drawing upon the definitions made within this framework.

In addition to this framework which can be called the Rondinelli Framework, there are other classifications and elaborations on decentralization which are worth mentioning here:

Burns et al. 1994 (quoted in Peckham et al. 2005: 30) and Hambleton et al. 1996 (quoted in Peckham et al. 2005: 30) have made a categorization by underlining various aspects of decentralization that are fundamental to them. In this regard Burns et al. identified the following five-dimensional categorization for decentralization (Burns et al. 1994 quoted in Peckham et al. 2005: 30):

Localization: physical re-location to local offices away from a central point
Flexibility: multi-disciplinary teams and multi-skilling
Devolution: decision-making powers are delegated
Organisational: re-orientation of organizational values and culture
Democratisation: widening opportunities for public involvement

In a similar way Hambleton et al. put forward the following framework (Hambleton et al. 1996 quoted in Peckham et al. 2005: 30):

Geography-based: physical dispersal
Power-based: decision-making authority delegated
Managerial: improving the quality of services
Political: enhancing local democracy

As Peckham et al. put it, there is a potential overlap between categories in these classifications- e.g. between power and political categories (Peckham et al. 2005: 30). Moreover it is evident that they do not provide an encompassing framework for explaining decentralization. However as they point to different aspects of the issue they are worth quoting here.

In addition to these it is also a common trend to classify decentralization as functional decentralization vs. geographical (area-based) decentralization. In functional decentralization authority for performing particular functions- e.g. health

care- is transferred to a specialized local office whereas in geographical decentralization broad responsibilities for public functions are transferred to local organizations that have well-defined geographical boundaries (Mills 1990: 15-16).

Mills states that organization of health services may be decentralized in either way. However she says the Ministry of Health may well have more power to influence the degree of functional decentralization than that of geographical decentralization (Mills 1990: 15-16). According to the definition made by Hutchcroft in an area-based system prefects are responsible for implementing all aspects of national policy within their sub-national units whereas in a function-based system each national department maintains its own field staff of specialists responsible for implementing the particular programs of that functionally- defined department throughout the country (Hutchcroft 2001: 30).

Drawing upon these definitions it can be very briefly said that territorial decentralization is used to refer to the transfer of responsibility/authority (administrative or financial) to local authorities for health-related issues and functional decentralization is used to refer to the transfer of responsibility/authority to health care organizations (e.g. hospitals or other health care providers), to the field units of the Ministry of Health or to the agencies established to perform specified tasks at some specified levels (e.g. establishing health authorities at regional level).

When health care reforms aiming at a decentralized system are analysed it is seen that although these two ways of decentralization could be adopted together it is functional decentralization which is more common and which has started to dominate these reforms. In the case of Turkey at the beginning territorial decentralization was foreseen for the health care services- as the Basic Law on Public Administration declared that majority of the health care services would be carried out by the Provincial Local Governments. However later with the adoption of Health Transformation Programme it is functional decentralization which has started to dominate reforms in health care system.

Another very common way of classifying decentralization is administrative - political and financial decentralization. However this classification is also highly disputed as different authors made different definitions for these categories- particularly for administrative and political decentralization. Drawing upon those different definitions it would be more appropriate to define administrative decentralization as "decentralization of powers and functions vertically within the same corporate entity" and political decentralization as "decentralization of powers and functions to a different corporate entity within the public sector such as the local government" (Atun 2007: 247).

It is rather more common to refer to deconcentration and delegation as forms of administrative decentralization and devolution as a form of political decentralization (Atun 2007: 247; Vrangbaek 2007: 48; European Observatory on Health Systems and Policies-EOHSP). However there are authors like Hutchcroft who consider devolution as a form of administrative decentralization (Hutcroft 2001: 25) according to whom the impact of administrative decentralization would be more in an area-based system than in a function-based one (Hutchcroft 2001: 44).

Here it seems quite useful to quote the review made by Bossert regarding the four major analytical frameworks that have been used in studies on decentralization in health care sector (Bossert 1998 quoted in Peckham et al. 2005: 23):

Public Administration Framework: For Bossert this is the one that has been put forward by Rondinelli as deconcentration, delegation, devolution and privatization.

Local Fiscal Choice Framework which for him is largely the contribution of economists writing about fiscal federalism.

Social Capital Framework is the one linked to the work of Putnam which suggests that localities with long and deep histories of strongly- established civic organization will have better performing decentralized governments than localities which lack these networks of associations. This framework is said to be built on the work of de Tocqueville and is linked to works on local democracy and democratic theory.

Principal/Agent Theory Framework is the one which largely draws on the works of economists who examine the relations between the principal who has specified objectives (e.g. central government) and the agent who achieves these objectives (e.g. local authorities or hospitals). Its focuses on the different ways (e.g. using hierarchical, market or network strategies)- under conditions of information asymmetry- in which that objectives can be achieved. This framework is the one favoured by Bossert on which he develops his concept of 'decision space'.

At the end of discussions on the frameworks proposed to conceptualize decentralization so far, quoting the evaluation made by Peckham et al. on these frameworks would be quite contributing to this study. According to Peckham et al. (2005: 33-34):

-These frameworks generally tend to focus on organizational and geographical aspects and are concerned more with describing the institutional framework of government or administrative systems. Therefore they argue that there is need to identify the extent of autonomy and what area of activity or responsibility that autonomy relates to.

-There is limited applicability of any single framework that can be applied in all circumstances.

-With respect to health care it is also important that any framework can capture not just organizational contexts but also the place of the individual within the health care system as clinician, health care practitioner or patient. Moreover they say that it is also important to capture the role of central governments as funder, regulator and steward of health and the increasing role of international dynamics of health care services and the role of central professional and regulatory bodies.

According to Peckham et al. the frameworks put forward so far tells very little about the most crucial aspects of decentralization, which they call the "what" and "where" of decentralization. They argue that any framework in this regard should ask and answer the following two main questions: (Peckham et al. 2005: 37-43)

What is decentralized? (Which tasks, inputs, processes and/or outputs are decentralized?)

From where to where they are decentralized? (Global, Europe, Nation State, Region, Organisation, Sub-unit, individual?)

Elaborating on these two axes Peckham et al. devised the Arrows Framework which they say contain all these aspects together and with which they say it is possible to show that centralization and decentralization could go together.

It should be underlined that the Arrows Framework does make it possible to match these two crucial questions. However these are already the questions which were also asked implicitly in the definitions made by the Rondinelli Framework and some others. Nevertheless it is good to have these together in a single Framework.

Finally it would be quite suitable to end this section with the suggestion made by Peckham et al. that it is necessary to develop a conceptual model and a framework for health services decentralization as much of the evidence used has been generated in other contexts, sectors, countries and that further research is needed to understand what is transferable or generalizable (Peckham et al. 2005: 130). This seems a very valid suggestion that should be paid attention. This study tried to review the present frameworks and tried to get at certain conclusions from their definitions about what does decentralization mean in health care sector. An attempt at developing a framework for health care decentralization in Turkey or in UK could be the next study that would follow this current one.

Objectives of decentralization and the issue of pros (and very rarely cons) of decentralization in health care systems are highly elaborated in literature (OECD 1997; Bankauskaite and Saltman 2007: 15-16; Kinnunen et al. 2007: 171-172; Koivusalo et al. 2007: 193; Atun 2007: 247; Peckham et al. 2005: 26)

Here the list put forward by Rondinelli et al. (1983) can be quoted as reflecting the dominant outlook in literature on the objectives of decentralization in health care

systems. It is usually the case that any reform attempt towards decentralizing a health care system justifies itself with these objectives.

Rondinelli et al. summarize the objectives of decentralization as follows: (Rondinelli et al. 1983: 9-11):

to reduce overload and congestion in the channels of administration and communication and reduce delays,

improve government's responsiveness to the public and overcome administrators' indifference to satisfying the needs of their clientele,

increase the quantity and quality of the services the government provides,

serve as a way of managing national economic development more effectively or efficiently,

serve as a means of creating larger numbers of skilled administrators and managers as such skills are said to become strengthened when administrators have meaningful managerial responsibilities,

serve as a way of mobilizing support for national development policies by making them better known at the local level,

allow projects to be completed sooner by giving local managers greater discretion in decision-making so as to enable them to cut through the "red tape" and the ponderous procedures often associated with over-centralized administrations,

increase the efficiency of central ministries by relieving top management of routine, repetitive tasks and allowing them more time to plan and monitor programs that absolutely require central direction or control,

increase the ability of central government officials to obtain better and less suspect information about local or regional conditions and thus to plan local programs more responsively and to react more quickly to unanticipated problems that may inevitably arise during implementation,

provide greater participation in development planning and management by allowing groups in different regions to participate in decision-making and thus increase their stake in maintaining political stability and promoting national unity,

motivate community leaders to take an active role, create better communications between local residents and leaders and between local and national officials, and increase community solidarity and interest in reform projects,

provide greater equity in the allocation of government resources as representatives of a wide variety of political, religious, ethnic, and social groups participate in development decision-making,

provide easy monitor of deterioration or breakdowns,

and finally it is argued that sub-national administrations are more effective levels at which to coordinate actions requiring the participation of many agencies.

In literature “there is a predominant view that decentralization is in itself a good thing both in terms of process and outcome” (Peckham et al. 2005: 26) and it is assumed that having a more decentralized system in health care sector would make the health care system in question get more closer to these objectives.

Peckham et al. provides a good summary of the key assumptions made on the impact of decentralization in health care systems in literature- which would be quite useful to quote here (Peckham et al. 2005: 27-28):

Assumptions about outcomes: Decentralization increases professional autonomy and this enables autonomous professionals to make the best decisions and thus in the end

help increase clinical efficiency. (However it is noted that this contradicts with the idea of evidence-based medicine which assumes that evidence is clear-cut in clinical decision-making.)

Assumptions about process measures: Decentralization decreases decision load by sharing it with more people; increases organizational flexibility; increases quicker responses and provides easier coordination among individuals (no matter it makes overall coordination harder).

Assumptions about humanity: Decentralization makes public agencies become more conscious of their relations with local communities, more open, accountable and responsive towards them which in the end make them more effective in meeting their needs and thus attain more effective outcomes.

Assumptions about staff morale/satisfaction: Decentralization increases managerial autonomy, job satisfaction, job loyalty, self-control and generates higher morale. (However it is declared that it becomes more difficult to recruit skilled officials at local level).

Assumptions about Equity (Horizontal but not Vertical): Decentralization allows services to better meet the needs of particular groups (this is usually attained through targeted funding) and thus improve horizontal equity. (However the more common assumption is that decentralization widens local variation and inequality).

Assumptions about allocative efficiency: Decentralization allows sensitive service delivery by targeting resources to particular areas and groups which in the end improves the quality of services.

In the same vein by increasing patient responsiveness and accountability decentralization provides better matching of public services to local needs which in the end improves allocative efficiency.

Assumptions about technical efficiency: Decentralization leads to fewer levels of bureaucracy, better knowledge of local costs, more attentive and responsive managers, more experimentation and innovation, learning from diversity, having smaller and thus better performing organizations, cheaper services as they are provided locally, easy control of costs, more organizational flexibility and quick responses which altogether help increase technical/productive efficiency.

Assumptions about centrally-set targets: Decentralization strengthens the hierarchical chain of command between the center and locality and thus ensures that central targets are adhered through contractual relations.

Assumptions about responsiveness and accountability: Decentralization
enhances civic participation (it neutralizes entrenched local elites).
increases political stability
strengthens local democracy
improves community development
encourages political awareness
better reflects local preferences
increases accountability to and responsive and conscious relationship with local population

However as it has been already mentioned in the above sections while operationalizing this research, the outcomes of real life practices have revealed that decentralized health care systems do not always help attain these objectives and they do not always verify these assumptions. On the contrary it has been experienced that decentralization may lead to problems such as increases in inequity, inefficiencies of scale, soft budgeting and the like and it has been argued that centralization can also produce many of the positive outcomes attributed to decentralization such as innovation (Koivusalo et al. 2007: 194-195; Walker 2002 quoted in Peckham et al. 2005: 26)[33]. Therefore not only for the case of health care services but for any case in general regarding decentralization, scale should not be attributed any positive

[33]May be that is why in an increasing number of cases decentralization attempts have been accompanied by re-centralization movements.

connotations on itself which would otherwise lead one to ‘spatial fetishism” (Şengül 2001: 144, 162).

Moreover it is known that despite the prevalence of assumptions about the benefits of decentralization in health care systems there is quite a limited number of (usually of low quality and context-specific) evidence to provide support for this (Peckham et al. 2005: 77, 123, 127). This is in fact one of the most problematic issues about the studies on decentralization in health care. Therefore as Kinnunen et al. state “it is important to clarify which dimensions of a health care system are being decentralized and how it is financed, delivered, planned and regulated” (Kinnunen et al. 2007: 168). In the same way as one of the reports from the World Bank points out although decentralization holds a lot of promises, whether it provides any improvement depends on its design and the institutional arrangements governing its implementation (World Bank 2001: 4).

According to Rondinelli et al. who made long elaborations on the objectives of decentralization, the results of the process in general have been mixed. In some countries they say it resulted in greater participation, more effective and efficient administration and expanded administrative capacity. However they state that in nearly all countries there occurred serious problems of implementation, insufficient central political and bureaucratic support, inappropriately designed decentralization policies and programs and failure to transfer sufficient financial resources to those organizations to which responsibilities were shifted (Rondinelli et al. 1983: 4).

It is evident that there has been an increase in reforms towards decentralization in both Beveridge and Bismarckian countries in the world. However it is also quite prevalent that there is a rising trend towards a dialectic interaction of decentralisation and re-centralisation in health care systems. For example in England health sector reforms are usually said to have been characterised by (even sometimes accused of having) this kind of decentralization/re-centralization attempts going hand in hand or in a successive manner (Baggott 2007).

Many health systems and health reforms contain decentralization (e.g. management and service delivery are decentralized) and re-centralization (e.g. standard-setting, setting general economic targets and monitoring/evaluation are centralized) together. (Maino et al. 2007: 122 and Atun 2007: 265).

What is more is it is argued that "regionalization" has emerged as a common trend – kind of meeting point between these two trends of decentralization and re-centralization (Axelsson et al. 2007: 144) As it is known regionalization reforms have become quite common in OECD countries for the last several decades. Creation of autonomous regions, Regional Development Agencies and Regional Health Authorities are some of the most common practices in this regard.

Here it should also be noted that health care decentralization is highly related with the political context of the country in question and its constitutional set-up. Where decentralization is popular and on the agenda of a country in general (in political and administrative terms for example) and where there have been movements towards the delegation of public services to lower constitutional levels, it is usually the case that health care decentralization is on the agenda of that particular country (e.g. Spain, France, Turkey) (Axelsson et al. 2007: 144).

"Why is decentralization so much emphasized in health care reforms?" emerges as another question to be answered.

As it has been mentioned above, in literature decentralization has been attributed various objectives such as providing competition, efficiency, participation, consumer choice, closeness and sensitivity to the needs of the locality and the like. However besides these mainstream writings there are also those authors who claim that decentralization in health care systems has another purpose –which however may not always be that explicit- namely privatization of health care services (e.g. Lister 2008; Atun 2007). According to them that's why the OECD, WB, WTO and the health care reforms encouraged by these global economic actors do over-emphasize decentralization of health care services. In fact this kind of a statement does not seem

wrong when one recognizes that these reforms together with their other components exhibit strong orientations towards privatisation- be it explicit or implicit.

In analysing health care systems decentralisation is usually considered as a way of changing the organizational structure. From this point of view it is merely seen as a way of re-allocation of responsibilities/authorities regarding health care services between different levels and organizations. Although this constitutes a very important aspect of decentralization it is not the end of the story.

As it has been mentioned above, decentralization has also many things to do with the efforts to change the system of health care finance. Here it should be remembered once more that health care decentralization is usually accompanied by the efforts to create an internal market within the health care system with a separation of providers and purchasers of health care services. In addition to this being one of the forms of decentralization that has been referred to within the context of health care systems privatisation is another very important aspect of decentralization in health sector.

According to Mills in the face of great increase in demand and expenditures for health care, governments have started to search for alternative ways and sources for health care finance. In this regard their reliance on the private sector has increased to a great extent (Mills 1990: 23). As it has been explained in the above section severe increase in demand for and expenditures on health care services did hit the first row among the reasons for the attempts at reforming health care systems in almost every country.

In this regard when taken together it would not be wrong to say that among various others, decentralization and accompanying privatisation attempts have been used as the two very important tools for attaining the restructuring process in the public sector which has been on the scene in the last decades. And that is why they have been highly advocated by the New Public Management (NPM) Reforms and encouraged by its major actors such as the OECD and the WB.

As Koivusalo et al. points out NPM reforms are not merely technical practices but they reflect "political preferences for certain types of values over others" and that emphasis on decentralization within the context of such reforms usually implies cost-cutting and privatization as the more clear-cut aims (Koivusalo et al. 2007: 194). In the same line of thought Mills argues that privatization is an ideological issue whereby the ideal of a free market is considered 'the ultimate' in decentralization policies by the proponents of a market system of health care (Mills 1990: 23). As Rondinelli et al. (1983:9) put it "the principal mechanism of economic decentralization [is] the market". However Mills points out that issues such as the ability of the consumers to pay, motivation of providers, patterns of government regulation and equity in access to health care all come into question in these circumstances (Mills 1990: 23).

Mills states that privatization might seem to be a pragmatic solution as voluntary agencies and private organizations might provide certain services more efficiently than the government does and that they may dare to work in the areas that might have been avoided by the government due to several reasons (e.g. because they are controversial like family planning, because they are too expensive like geriatric care or because they are more suited to voluntary provision like home care). However she says problems might also arise when the provision of services is privatized but the cost of services is paid from the public funds because in this case it is difficult to provide cost control and cost escalation is not easy to prevent. Finally she also draws attention to the fact that privatization does not free the government of its responsibilities regarding health care management. On the contrary she says privatization in health care requires strong regulatory authority to monitor the supply and quality of services across the country (Mills 1990: 23).

Relationship between decentralization and privatization in health care services is analyzed by authors who adopt a rather critical outlook in analyzing health care reforms (Atun 2007; Lister 2008; Soyer 2007). Atun elaborates on how privatisation is used as a decentralization strategy in health sector in Europe and how the two have been linked to each other (Atun 2007: 246-267).

In this rather critical line of thought the main argument is usually that decentralization in health sector (in certain contexts together with the accompanying re-centralization or regionalization processes) makes privatization of health services easier through various ways:

First of all decentralization makes it easier for the central government get rid of its responsibility for the provision of health care services and provide easy privatisation in this regard (Lister 2008: 124; Roberts et al. 2008: 162).

Secondly together with other components of health care reforms it provides easy channelling of public funds to the private sector (Soyer 2007: 105). Severe and unnecessary increase in the expenditures made by the private hospitals within the context of the reimbursement system of the Social Security Institution (SSI), which has also been detected by the Social Security Institution itself, will be touched upon in the following sections while discussing the impacts of the HTP on economic and political dimensions of the health care system. It is also argued that the merger of the former Social Security Hospitals (SSK Hospitals) with Public Hospitals (Devlet Hastanesi) - which can be considered as an example of re-centralization- has been done in order to make it easier to privatize various sections of health care services and to override the bargaining power which the former SSK Hospitals used to enjoy in purchasing their pharmaceutical needs. Moreover giving hospitals autonomy and thus making them less tied to the public system is said to make it possible and easier to privatise health care services in the successive phases of reform.

Thirdly emphasis on a participatory governance model for health care administration makes it easier for the powerful interest groups at local level to manipulate these services in various ways according to their interests (Lister 2008: 123).

As it has been already mentioned, decentralization of health care services cannot be analyzed without referring to the neoliberal restructuring of the public sector where the global actors/supporters of this process such as the OECD, WB, and WTO have been the very supporters of health care reforms favoring a decentralized system. Therefore emphasis on decentralization in health care reforms could also be analyzed

within the globalization/decentralization framework where the two are two faces of the same phenomenon rather than being two contradictory processes (Keating and Hooghe 2001: 242). Decentralizing health services makes it easier for the global capital to invest in health sector of that country. WTO is known to be pressing hard to apply the GATS to health care services. As it is well-known health care has become quite an attractive sector to invest especially for the big companies working on a global scale which try to manipulate any opportunity for their interest. In this regard global capital sees health and anything related to "healthy living" as good areas of investment and decentralized systems make it easier for them to penetrate easier into these systems.

Finally the following questions could be asked: Is it possible to talk about the emergence of a global model for health care reforms regarding decentralization? Is there a World Bank Model that dominates as Lister (2008) argues? Is it possible to get at any conclusions in this regard by looking at the practices of decentralization in health care systems in different countries?

When decentralization-oriented reforms that have been on the agenda of health care systems are analysed, it is seen that in general they do not exhibit a total detachment from centralized tendencies at all- on the contrary they sometimes utilize the co-existence or successive manipulation of the two. Regionalization has also played a key role in this regard. However among the forms of decentralization that have been elaborated on in the above sections regarding health care systems, it is delegation and privatization which dominate health care reforms in general. That is to say in these reforms it is a more common attitude to transfer responsibility/authority for health care services to autonomous health institutions (delegation) or to for-profit or not-for profit private institutions (privatisation) rather than delegating them to local authorities (devolution)- which implies that functional decentralization is more common than territorial decentralization.

Although it is not within the scope of this study to make comprehensive examinations of the countries that have been reforming their health care systems along decentralization trends some of them can be quoted to make things somewhat

more concrete. In this regard Sweden, Norway, UK, Poland and even the incipient case of Turkey can be quoted as some of the examples among many others for re-centralization in health care services. In most of these cases responsibilities/authorities which had been devolved to regional or municipal level (e.g. responsibility for the operation of local hospitals) were transferred back to the national level (Axelsson et al. 2007: 162; Baggott 2007: 135; Roberts et al. 2008: 162). Regionalization has been another common trend in most of the OECD countries where France, UK and again Turkey can be quoted as some of the many examples where there have been attempts to create regional (and usually autonomous) health authorities. In the same vein delegation of responsibility/authority to individual hospitals which are expected to undertake self-management is also another common trend seen in these countries. Finally making health care services be provided by private institutions (either by those for-profit or those not-for-profit) and encouraging private provision of health services including private health insurance have become another common trend in most of the countries that have been undergoing health reforms besides the US which has been the heading country in this regard.

Therefore it is possible to say that there is a serious degree of convergence among health care reforms having been taking place all over the world where privatization, delegation and regionalization emerges as the most common patterns in reforms aiming at decentralization in health care and which are also accompanied by certain re-centralization attempts where it is seen necessary to make the reformation process continue. As it has been discussed above, this convergence has many things to do with the NPM reform tradition which have started to take place since early 1980s as a response to the need to restructure the state vis a vis the requirements of the capitalist system then and the successive ones which came to fore since then with a similar logic behind which the strong position of the global actors such as the OECD, WB, WTO and the like working in collaboration with the state in question undertaking these reforms can be seen.

CHAPTER 5

HEALTH CARE FINANCE

5.1 Health Care Finance

At the beginning of this chapter a brief clarification of several concepts that are used in the study of health care finance seems to be of use.

The word “financing” refers to “all mechanisms for raising the money that pays for activities in the health sector [which] include taxes, insurance premiums and direct payments by patients” (Roberts et al. 2008: 26). As Roberts et al. state “the design of the institutions that collect the money and allocation of the resources to different priorities are also parts of financing”. (Roberts et al. 2008: 26). In short financing is generally defined as “the mechanisms by which money is mobilized to fund health sector activities and how it is used/allocated” (Roberts et al. 2008: 153).

“Funding” on the other hand is rather broader in its meaning, referring to provision/supply of money for health care purposes (Longman, 1995).

In this study within the context of health care sector there would be instances where the concepts of financing and funding might be used interchangeably.

Finally “payment” which refers to “the methods for transferring money to health care providers in the form of fees, capitation, out of pocket payments, etc.” is another concept which is highly used in health care finance (Roberts et al. 2008: 27).

5.2 Different Methods for Funding Health Care Systems

In this section different types of health care finance will be briefly explained and their relationship with different types of health care systems will be emphasized- e.g. which type of financing dominates which system?

In fact in theory there are two extreme methods for financing health care services: 1. having everything financed out of public funds. 2. having everything financed by individuals demanding health care services. However, in practice countries usually have hybrid models designed somewhere in between these two extreme cases. (Sağlık Bakanlığı 2003: 16).

Main methods used for financing health care systems can be listed as follows[34]:

5.2.1 General (Tax) Revenue

In this method health care system is financed mainly out of the general budget where many kinds of taxes - such as direct taxes (e.g. personal income tax, corporate profit tax, property tax), indirect taxes (e.g. sales tax, value-added tax, import duties, export taxes), national or local taxes, general or hypothecated taxes (i.e. taxes earmarked for health care which can be either direct or indirect) - are used (Mossialos et al. 2007: 14-16).

It is commonly observed that where health care systems are mainly financed out of general tax revenues they usually have to compete with all the other publicly-financed services such as education, defense and the like in order to get more government funds.

Both rich and poor countries use general tax revenue as a major source for financing their health systems. The richer the county the larger the share it allocates from general revenues for its health care expenditures- this is mainly due to its larger tax base and increased ability to collect taxes. (Roberts et al. 2008: 164). Low income countries on the other hand tend to rely more on easy-to collect taxes such as import and export fees in financing their health care systems (Roberts et al. 2008: 161).

[34]Being the two most recent and quite comprehensive and easy-to understand texts written on health care finance, works by Roberts et al. (2008: 160-179) and Mossialos et al. (2007: 14-25) will be frequently referred to and quoted in this section.

It is known that different types of taxation have different equity and efficiency connotations as they place different burdens on different population groups (Mossialos et al. 2007: 14 and Roberts et al. 2008: 165). Nevertheless it is general revenue financing of health care services which is accepted to allow some degree of tailoring in meeting horizontal and vertical equity concerns and to have the capacity to pool health risks across a wide population (Roberts et al. 2008: 165).

It is also argued that general revenue financing provides high level political accountability with the justification that in democratic systems key decisions regarding taxation and their allocations are made through legislative processes. Nevertheless it is not possible to attain full transparency in processes such as tax concessions when for example a tax-payer is exempted or made to pay lower amounts of taxes since he/she made investments in health care (Roberts et al. 2008: 161). Moreover since it is rather easily controlled by the political authority, general revenue financing might be risky in weak political systems and in those systems that are open to corruption/favoritism. Furthermore there might occur problems in those countries where public acceptability and collectability of taxes are low (Roberts et al. 2008:165). In addition to these it should also be kept in mind that extensive data systems are required for certain types of tax revenues (Roberts et al. 2008: 161)

As it has been mentioned general tax revenue is a major source for financing health care systems in the majority of the countries all over the world. Regardless of the dominant method of financing health services in any particular country, it is usually the case that certain types of health care services are provided with some tax support- e.g. public health services, preventive health services or health care services for the poor. This is mainly because of the fact that "taxes can be re-distributive and can be raised from a broad base" (Roberts et al. 2008: 165).

Mossialos et al. (2007: 14) quote the following countries for having health care systems financed through general tax revenues:

UK, which is taken as the stereotype for the Beveridge Model, funds its National Health Service mainly from direct taxation as it is predominantly a tax-based system funded by public finance.

In France and Italy hypothecated or earmarked income taxes are used to finance health care services. In Belgium and UK a certain part of the tax revenues collected from the sales of cigarettes are earmarked for health care expenditures.

Denmark, Finland, Norway, Sweden, Bulgaria and since 2000 Italy are the countries where regional or local taxes have been the main source of revenue for health care services.

Spain, Portugal, Greece, Poland and Albania are also quoted as the countries where national taxes are the main source of revenue for health care.

5.2.2 Social Health Insurance

Social insurance is compulsory- i.e. “everyone in the eligible group must enroll and pay the specified premium…[which]… is often [a] specified percent of the wage [and thus] that person is entitled to the specified benefits” (Roberts et al. 2008: 165).

Social insurance schemes cover only those workers who are eligible- i.e. who are entitled from among the formal sector. Therefore if a country attempts at universal coverage for all of its citizens/residents then the government has to have recourse to general tax revenue in order to subsidize those who are outside the eligible group- namely the pensioners, the unemployed, the poor, workers in the informal sector, and even some small businessmen and farmers (Roberts et al. 2008: 165).

In countries which have Social Insurance Systems, premiums can be collected by a single national health insurance fund (e.g. Croatia, Estonia, Hungary and Slovakia), by a single social insurance fund (e.g. Belgium), by independent funds (e.g. France), by local branches of a national fund (e.g. Romania), by individual health insurance funds either occupationally or geographically defined (e.g. Austria, Czech Republic,

Germany, Lithuania, Switzerland) or by an association of insurance funds (e.g. Luxembourg) (Mossialos and Dixon 2007: 17).

Social Health Insurance Systems are mainly employed in Europe where the core Bismarckian systems (such as Germany and France) and the newly established systems in the CEE countries after the collapse of the Semashko systems are quoted as the main examples and also in some Latin American and far eastern countries. While the Western European countries (Bismarckian Systems) have highly established social insurance systems, those in CEE countries are rather newly-established where the attraction of these systems are mainly due to their independence from the central government and where health sector reforms have been highly influenced by decentralization and privatization attempts (Mossialos and Dixon 2007: 17).

As it has been mentioned in the previous section, it is the Bismarckian Systems which are highly referred while studying Social Insurance Systems. These systems operate through Sickness Funds which are non-profit organizations divided along industrial, geographic or occupational lines. It is Sickness Funds which plan and manage social insurance schemes and programs. Only to a limited extent can Sickness Funds compete for enrollees and they can only allow for limited variations regarding benefit packages and consumer choices (Roberts et al. 2008: 166).

Roberts et al. summarize the major differences between general revenue-financed health care systems (i.e. Beveridge Systems- e.g. England, Sweden) and Social Insurance Systems (i.e. Bismarckian Systems- e.g. Germany, Japan, Taiwan) as follows: First of all in social insurance systems contributions/premiums paid are earmarked only for the specified social insurance programs. Secondly social insurance funds are required to maintain their solvency and they are expected to exhibit more transparency and accountability. Finally social insurance is not a right of all citizens but only covers those who are eligible and who paid the minimum contributions as the benefits they receive are often related to their contributions- thus the benefits are not welfare from the government (Roberts et al. 2008: 166).

Different social insurance schemes have different equity connotations. Presence of many social insurance plans imply less horizontal equity as this may lead to situations where a more favorable mix of members are offered lower premium rates or better care for the same price (Roberts et al. 2008: 166). This is also highly related with the widely accepted idea that plans with upper-income workers not only have more revenue but also they are likely to have smaller sick populations given the correlation of economic and health status (Roberts et al. 2008: 166). It is reported that in Germany until inter-sickness fund transfers were imposed in the 1990s, white collar workers were paying lesser amounts of premiums compared to those of blue collars (Roberts et al. 2008: 166).

Social Insurance contributions are paid together by the employer and the employees. In general it is the workers who pay for the largest share of the social insurance premiums- which is a fact underlined by both theory and empirical observations. This happens either directly in terms of real premium payment or indirectly by getting lower wages. Ratio of premiums paid by the employers to the contributions made by the employees is closely related with the conditions in the labor market, particularly to the power of the related unions (Roberts et al. 2008: 167).

Regarding risk pooling, social insurance only pools the health risks of those workers who are in the eligible formal sector and thus covered by a particular social insurance scheme. (Roberts et al. 2008: 167)

Roberts et al. argue that social insurance systems may have two-sided effects on the citizens: On the one hand its rather autonomous position vis a vis the central state agencies and its having a separate and dedicated fund may encourage citizens to pay their premiums more comfortably and regularly. However on the other hand the authors argue that especially in the countries such as Hungary where tax evasion was widespread citizens might associate the social insurance system with the government and all those negative attributions made to that state apparatus (Roberts et al. 2008: 167).

Mossialos and Dixon depict quite an encompassing picture for the advantages and disadvantages of social insurance systems which is worth mentioning here. As for the advantages they quote the following characteristics: It is more transparent, more acceptable to the public and better protected from political interference as most of the processes are conducted by autonomous agencies (nevertheless the authors also point to the fact that these independent agencies can also be captured by certain interest groups), it is highly portable for insurees while moving jobs or moving in or out of the labor force (unless it is defined along occupational lines), it creates a larger risk pool than private insurance (where the pool is at the level of the whole sector or workforce rather than being at the level of a single firm) (Mossialos and Dixon 2007: 17).

Regarding disadvantages it is argued that high social insurance premiums increases labor costs and reduces international competitiveness which also make employers avoid recruiting new workers and thus cause unemployment problems (Roberts et al. 2008: 167). Secondly since eligibility is defined in terms of occupation it excludes non-employed population including old people and the unemployed. Thirdly in countries where formal sector employment is low it may not generate sufficient revenue for health care finance. Fourthly the risk of adverse selection and cream skimming can also be experienced in social insurance systems particularly where consumer choice is allowed and where competition is allowed between different social insurance programs. Finally although single fund social insurance systems reduce administration costs, make regulation of the system easier and provide rather universal risk pooling it leaves insurees with no choice, sometimes inefficient implementation processes and lack of consumer responsiveness (Mossialos and Dixon 2007: 17-18).

5.2.3 Private Health Insurance

In this method of health care finance, “buyers voluntarily purchase insurance from independent competitive sellers (either for-profit or non-profit) who charge premiums that reflect the buyer’s risk rather than his/her ability to pay” (Roberts et al. 2008: 168).

Private insurance schemes can be classified in three different ways (Mossialos and Dixon 2007: 19):

They can be substitutive, supplementary or complementary.

Substitutive insurance is alternative to compulsory insurance and purchased by the people who can get exemption from compulsory public coverage. For instance it is quite common among high income people to purchase substitutive insurance in Germany and Netherlands no matter this causes the Bismarckian systems become rather regressive in these countries.

Supplementary insurance is generally used either to have quicker access to health care services or to have more qualified services or hotel facilities. It is evident that this causes inequality problems among those who can have and who cannot have private insurance.

Complementary insurance is purchased to get the services that are not provided by the compulsory/public health coverage. This type of private insurance is also usually available to those in the higher income groups.

They can be risk, group or community rated.

This classification is done according to how premiums are calculated.

In risk-rated private insurance schemes, premiums are calculated actuarially by looking at the probability of the risks of the individual who demands insurance.

In group-rated insurance, premiums are calculated by looking at the average risk of the employees in the particular firm whose employer demands insurance for his/her employees.

In community-rated insurance, premiums are calculated by looking at the average risk of the population who live in a particular geographical area.

They can be provided by for-profit or not-for-profit institutions.

Agents collecting private health insurance premiums can be private for-profit insurance companies or they can be independent not-for-profit agents as in France, Germany, Netherlands, and the UK.

It is the USA which is quoted as the most prominent example for having competitive private insurance in financing its health care system, where the system heavily relies on private group-rated insurance purchased by the employers since the last 50 years (Roberts et al. 2008: 170).

Nevertheless private insurance has become one of the most prominent and common mechanism for financing health care services all over the world. According to Roberts et al. there are two main reasons for this interest in private insurance: First of all private insurance is expected to mobilize additional resources where the problems of tax evasion will be minimized as people provided with a choice of a plan are expected to pay with more willingness for their health care. Secondly a competitive market is believed to respond to different attitudes and values of people by offering differentiated plans which is not that much possible nor intended under the publicly controlled social insurance system (Roberts et al. 2008: 168).

It is common for both the employers and the employees to get private insurance as an economy grows where particularly the well-off employees in middle-income countries prefer to opt-out from social insurance schemes in order to buy private insurance (Roberts et al. 2008: 168).

Risk selection is one of the most critical aspects of private insurance as competing and profit-seeking companies want to sell policies only to healthy people or if they do sell to sick they charge high rates enough to make profit. It is clear that this kind of a practice creates strong incentives for the sick to lie about their health to insurance companies. (Roberts et al. 2008: 168-169). This must be the reason why private insurance is cited as one of the most prominent examples for the principle-

agent theory where the problems of information asymmetry, moral hazard and adverse selection have to be coped with.

Another problem with private health insurance is to attain equity. As premiums do not vary with income levels, health care systems financed mainly through private health insurance are highly regressive. In addition to that risk-rated premiums make the low-income groups and the poor pay more. It is usually the case that these people have worse health status and thus classified in the high risk group which make them pay higher premiums although they cannot afford (Roberts et al. 2008: 169).

When all these are taken together, as it has been the case in the USA, it is usually the case that those who are in most need for insurance are left uncovered in health care systems which are mainly financed by private health insurance.

Private health insurance is known for high transaction costs as it incurs various administrative costs for risk assessment, determining premiums, preparing different packages with different coverage, contracting, billing, reviewing, marketing and the like (Mossialos and Dixon 2007: 20). In addition to that having competitive private insurance markets requires complex regulatory and management capabilities on behalf of the government as "high levels of analytic competence and political integrity are required to undertake these duties" (Roberts et al. 2008: 171).

Private health insurance might be subsidized by the state- most frequently via taxation strategies. In some cases tax revenues are used to make poor or uninsured people purchase health insurance either by means of providing them with vouchers or by direct purchase of private insurance for them by the state. It is also common to provide tax relief where "premiums are deducted from gross income before tax is charged" or to provide tax credits which are "deducted from the tax liability of an individual" (Mossialos and Dixon 2007: 20-21).

Tax credits and tax relief are used by Austria, Ireland and Portugal. Germany and Netherlands use limited tax relief which is capped for the entire social security system and thus it does not encourage private insurance purchasing. France, Spain,

Sweden, Belgium, Denmark, Finland and the UK on the other hand do not provide tax relief for private insurance purchasing (Mossialos and Dixon 2007: 20). It should be noted that in countries where private insurance purchasing is encouraged, health care finance moves in a rather regressive direction (Mossialos and Dixon 2007: 21). Another comment regarding subsidizing is that the more the private insurance is subsidized the more the health care finance system moves away from private insurance financing towards tax-based financing (Roberts et al. 2008: 171).

Risk pooling in private insurance applies to rather smaller groups compared to social health insurance systems (Roberts et al. 2008: 169). If the level of risk pooling across different health care financing systems is ranked, it is the general revenue financing which provides the highest level of risk pooling. It is followed by the social health insurance system and then comes private insurance system (i.e. group insurance). In out of pocket payments there is no risk pooling.

Although competitive private insurance markets have been thought to be decreasing health care costs, the US experience of increased competition among insurance plans during 1990s did not reveal any decrease but on the contrary increase in health care costs since then (Roberts et al. 2008: 170). As Roberts et al. explain, the main reason for this increase was that when the consumers were not satisfied with the limited care they got as a result of the competitive markets, the insurers had to loosen their control on health care providers, which in the end led to increases in health care costs in the USA (Roberts et al. 2008: 170).

5.2.4 Out-of- Pocket Payments

These include any cost paid by the individual patient to health care providers directly out of his/her pocket (Mossialos and Dixon 2007: 22; Roberts et al. 2008: 171).

Out of pocket payments are of three main types:

a. Direct payments: They refer to the payments made by the patient for the health care services purchased from the private sector as these services are either not

covered by the public health system or are not easily accessible in that context. Payments made in the private sector to private dentists, private physicians, private hospitals or to the pharmacists for over-the-counter or de-listed drugs are the most common types of direct payments. In some countries it is possible to make deductions for direct payments which in the end provides strong incentives for patients to go for health care services in the private sector (Mossialos and Dixon 2007: 22).

b. User Charges (Formal Cost-Sharing): This category is used for the out-of-pocket payments made for the health care services provided in the public sector (Roberts et al. 2008: 172).

User charges may be levied in the form of *Co-payments* where fixed payments are made by the patient for each service he/she gets; *Co-insurance* where the patient is responsible for a certain percentage of the total cost of the service and in the form of *Deductibles* where the patient is liable for the costs up to a ceiling and the rest is covered by the insurer (Roberts et al. 2008: 204-205).

There is kind of a dilemma with which the advocates of user charges have to cope with. On the one hand user charges are seen as a means for raising revenue, particularly in low income countries where there is not a properly functioning health care system or where funds allocated to health care is insufficient. On the other hand it is also seen as a means for discouraging patients from using unnecessary health care services. Nevertheless these two aims attributed to user charges do not logically go in the same direction as the achievement of the one distracts that of the other (Mossialos and Dixon 2007: 22; Roberts et al. 2008: 172).

Although it is argued that revenue raised from user charges could be used to maintain equity among the rich and the poor, in practice it is observed that user charges shift the burden of health care finance away from population-based, risk sharing models such as tax-based or social-insurance based financing towards payments by individuals or households. This in the end increases the relative share of financing

burden on poor and unhealthy people as richer and healthier people do not subsidize the poor and the unhealthy (Mossialos and Dixon 2007: 23).

c. Informal Payments: They refer to the out-of-pocket payments made overtly for the health care services provided in the public sector despite it is not allowed officially and is illegal. They may be in various forms such as ex-ante payments, ex-post gifts, large envelope payments, etc. (Mossialos and Dixon 2007: 23).

Since they are illegal there is limited official information about their prevalence, however it is widely-known that informal payments are practiced in CEE, FSU and Southern European countries mostly due to lack of financial resources in the public sector, lack of private services, cultural traditions (Mossialos and Dixon 2007: 24; Roberts et al. 2008: 173).

It is argued that informal payments can only be evaded by capable governments which can regulate providers properly through setting priorities or limiting the services on offer (Mossialos and Dixon 2007: 24).

Out-of-pocket payment is considered the worst method of health care finance in terms risk pooling and equity where those people who are both poor and sick do face with serious difficulties.

User charges are usually collected at the point of service provision such as the hospital, the physician or the pharmacist. However in certain cases it may be collected in a later phase as has been the case in Turkey where recently the pharmacists have started to collect the charges for physicians' examinations.

5.2.5 Medical Savings Accounts (Individual Savings)

Medical Savings Accounts is listed as one of the methods for financing health care in the related literature. However its practice is not that widespread, particularly when compared to the attention it has been receiving in the international health reform

literature. It is mainly implemented in Singapore and to a limited extent in the United States and China (Mossialos and Dixon 2007: 21; Roberts et al. 2008: 174).

The idea behind Medical Savings Accounts is to make the individual contribute a proportion of his income to his individual account on a regular and compulsory basis and to use the money accumulated in this account when that particular individual is in need for a health service in the coming years. In short, individuals are made to save today when they are young to spend later when they get older on occasions of need for any health care services, particularly for those services with great costs. Individuals having Medical Savings Accounts are encouraged not to use the money in their accounts until they reach a certain age.

Medical Savings Accounts have been use in the States to a limited extent where it must be combined with a high-deductible health plan which insures against catastrophic health care costs (Mossialos and Dixon 2007: 21). In introducing Medical Savings Accounts in the States it was thought to eliminate the problems of moral hazard and adverse selection with which the private insurance sector have to cope with. Moreover it was expected that self-employed people or those workers employed by a small employer who experience difficulty in purchasing private insurance would get a chance for some coverage (Mossialos and Dixon 2007: 21-22).

As has been the case both in Singapore and the States, Medical Savings Accounts are usually considered as part of a mix of funding mechanisms as they have to be complemented by mandatory catastrophic insurance schemes (Mossialos and Dixon 2007: 21).

Medical Savings Accounts are criticized for not providing any risk pooling. In addition to that it is also argued that despite the interest it attracts especially in the international literature, medical savings accounts are said to have strong cultural connotations for its proper functioning. In this regard Singapore's unique savings culture, family responsibility, high GDP per capita and sophisticated government system are all said to contribute to the proper functioning of this system in this

country. This also raises the question of whether this model could be transferred to other cultural contexts. (Roberts et al. 2008: 75; Mossialos and Dixon 2007: 21).

5.2.6 Community Financing

The idea behind this method of health care financing is to make local communities raise and spend the funds to be used for primary care locally through compulsory membership (compulsory prepayment schemes). Communities control the provision primary health care services and secondary care is usually contracted by some of these schemes (Roberts et al. 2008: 176).

Community financing is used in low-income countries such as Sri Lanka, Southern India, particularly for financing rural health care services through mini health-maintenance organizations with salaried doctors. The idea is that local control will provide accountability, transparency and contribute to efficiency as well as increase people's willingness to contribute and compulsory membership will eliminate free-rider and adverse selection problems (Roberts et al. 2008: 176-177).

Although theoretically community financing works on the basis of compulsory membership (prepayment), it is also quite common to have community financing on voluntary basis. Moreover it is usually the case that services provided within the context of community financing coverage are quite limited and that (additional) financing quite often come from national tax revenues (Roberts et al. 2008: 177).

Pros and cons of community financing are explained by Roberts et al. in the following way:
Community financing can provide some degree of risk pooling where it requires compulsory membership and thus compulsory prepayment. However it is usually the case that even when it is compulsory, community financing cannot generate that much resource as the majority of the people engaged are of low-income population. In this regard it is important to ask the question of whether it is fair to force people who do not have sufficient income to pay for their health care services. In addition to these problems it is also observed that community financing requires at least certain

degree of administrative and organizational capacity and serious community leadership, which are not that common in those low-income regions. Therefore central governments have to pay extra attention to the capabilities of the communities when deciding on the implementation of community financing schemes otherwise it would produce a case where the not well-off government transfers its responsibilities regarding health care finance to even less well-off local communities (Roberts et al. 2008: 177-178).

5.2.7 Loans/Grants/Donations/Transfers/Foreign Aids

Donations and grants from non-governmental organizations, transfers from donor agencies and loans from international banks make up to a serious amount of health care financing in low and middle income countries (Mossialos and Dixon 2007: 25).

Regarding grants and donations problems arise when the central government is by-passed by the donating agency which yields incoordination problems and undermines the capacity of the national government (Mossialos and Dixon 2007: 25). What is more and more crucial is that these donations and foreign aids mostly come with "the donors' commitments to specific objectives …including donor concern, donor values and donor politics" (Roberts et al. 2007: 178-179). As Roberts et al. point out in the recent years donating institutions have been concentrating on their own "specific programmatic objectives with measurable outcomes- [such as] vaccination, disease elimination and safe childbirth" rather than focusing directly on the health care reform that particular country requires or inclined to (Roberts et al. 2008: 179).

Regarding loans, it is certain that they have to be repaid in a certain time period and that their extensive usage is usually considered as a burden on the shoulders of future generations (Mossialos and Dixon 2007: 25).

Till now basic methods for financing health care, which make up the main literature on this subject, have been briefly examined. As has been mentioned, each method has its advantages and disadvantages in different respects such ad equity, risk pooling and the like. Therefore while choosing the suitable financing method for its

health care system a country should consider several aspects among which Roberts et al. particularly underline the following four (Roberts et al. 2008: 154-159):

Socio-economic development: The authors group countries with respect to their income levels and observe which health care finance method match with them accordingly.

In this regard for low-income countries they say that 40% to 60% of health expenditures are financed by tax revenues, 10% to 15% by social insurance and 40% to 50% by out-of-pocket payments. Private insurance is seen as negligible.
For middle-income countries the authors state that the role played by social insurance grows in these countries parallel to the growth of the formal sector. However they say it is still the general revenue or direct payments which make up the main resources for financing the overall health care expenditures. Private insurance is also said to have its role though to a limited extent.

As for the high income countries –except the US- they argue that it is predominantly the universal insurance/coverage which characterizes the financing of health care systems in these countries.

Fiscal Capacity: The authors argue that in choosing the proper financing method for its health care services a country has to consider its fiscal capacity which also has to do with its administrative capacity or its willingness to give up some other expenditures in favor of health care expenditures.

In this regard authors state that a country which is to use general revenue in financing its health care services has to consider the size of its different tax bases. Those which are to use social insurance have to check their fiscal capacity which is highly related with their ability to collect contributions both from the employers and the employees. In deciding the use of private insurance for financing its health care a country has to be careful that high income people would prefer to get private insurance than to pay taxes from which poor people could also benefit and that it would be quite difficult for the latter group to get private insurance and to access health care. As for the

countries thinking about community financing for their health care finance the authors warn that this method has a limited capacity to make up funds for health care but they say they could make important contributions for the finance of primary level health care services. Finally they state that out-of-pocket payments are common in low and middle-income countries and that there is greater capacity in high income countries to go for this type of financing. This has to do both with the higher incomes and with the reality that standard service packages do not cover certain services that people have to go for direct purchasing of services from private providers.

Implementability: In deciding which health care finance method to employ a country should also consider its implementability where factors such as administrative costs, the complexity of the system, country's administrative capacity and social acceptability of the chosen system have their roles to play.

In this regard the authors warn that private insurance system incurs high administrative/transaction costs and that they also necessitate the establishment of a complicated system in order to undertake all those regulations, analyses and monitoring activities. Therefore they that say countries lacking these characteristics usually go for taxes that are easy to collect for financing their health care systems. As for the social acceptability of the financing method used, the authors argue that social insurance model might exhibit more acceptability due to its social contract characteristics and due to the belief people have in the presence of funds collected and processed separately from the general revenues of the state. Thus they say raising revenue with this method would be rather easy.

Political Accountability: It is argued that the state of political accountability and its conceptualization does also play its role in health care financing method. Where political accountability is low there is a trend towards having health financing decisions be made in autonomous organizations which are thought to be separated from the drawbacks of the political processes and that this would increase the amount of resources channeled directly to the health care system.

As it has been mentioned health care reforms targeting financial set-up have been on the agenda of nearly every country in the world. When this is the case the question of whether there is any trend in these reforms towards any of the models mentioned above or whether these reforms aim at any common points in general?

As an instant answer to these questions, it can be said that most of the countries that have been trying to reform their health care systems have the basic objective of attaining universal coverage for all of their citizens/residents. In fact until recently health care reformers felt the necessity to make a choice between Beveridge Model or Social Insurance Model to realize this aim. However in the recent years there occurred a trend towards forming out hybrid models which carries characteristics from both systems.[35] These hybrid models which aim at establishing a health care system which provides health care coverage to everyone living in that particular country are usually called National Health Insurance (NHI) Models.

As it has been mentioned each model has its own advantages and disadvantages for different contexts. Therefore countries have started to go for these kinds of hybrid models in order to better satisfy their country-specific needs, where mostly the basic characteristics of the Beveridge Model are added by certain characteristics of the Social Health Insurance Model and the Liberal Model such as making certain categories of citizens pay premiums in order to become eligible for benefiting from the universal coverage provided by the National Health Insurance System. Basic Characteristics of National Health Insurance Model will be analyzed later in this study in the section where the health care reform in Turkey will be examined, as this model is thought to be exemplifying quite well the system that is being adopted in this country.

It is a bare fact that health care finance has been one of the most important and most targeted aspects of health care reforms. Among the reasons for this attention, the

[35] In this regard besides the cases of Korea, Taiwan, Krgyzstan and many other other countries reforming their health care systems towards a National Insurance Model, it is also interesting to look at the cases such as Japan and France. It is difficult to classify the former as a classical Social Insurance model but rather as a Hybrid model of National Health Insurance (Lee and Chun: 2006: 15-16) and for the latter the question of "Why is the French Health Insurance System becoming so British?" has taken its place on the agenda of researchers for a while (Hassenteufel 2001).

continuous increase in health care expenditures and the desire of governments to curb public expenditure on health care service hit the first row. There are also various other reasons such as fiscal limitations on national governments imposed by globalization and competition - that is to attract more investments in certain other sectors governments need to decrease public investments in health care.

All these take us to an important aspect that should be touched upon while discussing health care finance- namely allocation and rationing issues. Once resources are raised it is also crucial to analyze how they are allocated and rationed- i.e. how and for whom they will be used. Answers to these questions will in the end determine which population groups have access to health care and of what type, quality and quantity are these services (Roberts et al. 2008: 179).

In the context of health care systems resource allocation refers to the decisions on "how resources are proportioned to a population group or for selected types of services such as primary care or hospital services" (Roberts et al. 2008: 180-181). Rationing on the other hand refers to "the distribution of scarce health care to individuals" (Roberts et al. 2008: 181).

Different criteria have been used in making decisions on resource allocation. In countries such as the UK and Canada funds could be allocated to communities on the basis of income and health status. Or as has been the case within the context of World Bank they could be allocated on outcome basis such as cost-effectiveness (Roberts et al. 2008: 181).

Regarding the rationing of the health care services methods such as pricing, longer waiting time or discouraging demand by making certain services less attractive could be used in various countries for the rationing of scarce health care services to individuals (Roberts et al. 2008: 181).

These different criteria for resource allocation and the methods for rationing all have their advantages and disadvantages for different segments of the society in a particular country. It is a well-known fact that any decision on any component of

health care finance is a process that is highly political. It is argued that "politics plays the critical role in deciding who pays the costs and who receives the benefits of health care" (Marmor and Bar 1992 & Reich 1994- quoted in Roberts et al. 2008: 182-183). Roberts et al. support this argument by stating that "economic and political elite of any country usually support certain world-class tertiary hospitals… [and that these institutions] usually have substantial political connections…that allow them to defend their interests effectively" (Roberts et al. 2008: 183).

At this point the recent trend towards privatization in health care sector should be touched upon once more. It is known that in many countries there has been serious increase in the investments made in health care services by the private sector which goes parallel to the increase in the funds allocated from the public sector to the private sector. Governments do not tend to make investments in health care or they do not tend to provide health services directly but rather prefer to purchase health care services from the private sector which is quite enthusiastic about getting their share from these demand inelastic and highly profitable services. Trend towards contracting-out health care services, making it easier for the people to consult private hospitals within the context of universal coverage or encouraging the purchase of private insurance by limiting the contents of standard coverage all make the allocation of public funds to private sector easier.

This chapter concentrated on methods of health care finance and tried to cover important aspects of this subject. Therefore by the end of the chapter this study has already covered the two main aspects of health care reforms- namely decentralization and finance. As it has been mentioned above decentralization and finance are interrelated among themselves and co-play their roles in health care reforms. For example the family practitioner model which has become one of the most central components of health reforms in many countries bears strong traces of the both. Family practitioner system not only has serious implications for health care finance but it also brings about a decentralized autonomy for the family practitioners who have autonomy in various aspects such as organizing their affairs and using their budgets. In the same vein Unions of Regional Hospitals also enjoy certain level of organizational and financial autonomy in undertaking their affairs combining

decentralization and financing issues. The relationship between decentralization and finance will be more profoundly examined while analyzing the related components of the health care reform in Turkey.

CHAPTER 6

HEALTH CARE SYSTEM IN ENGLAND

6.1 Health Care System in England

Being the most outstanding stereotype of the Beveridge Model of health care systems, the British National Health Service (NHS) was established in 1948 and since then it has become almost "the most widely influential model of health system" (WHO 2000: 12). It was argued that countries which formerly had Semashko type of health care systems (e.g. the former Eastern Bloc Countries) have been adopting health care reforms since 1990s whereby the British reform model has been highly followed (Atun 2007: 250).

Actually, as it has been discussed above what occurs in both developed and developing countries which attempt at transforming their health care systems is that they end up with hybrid models and convergent hybridization. This also holds true for the British model that it has also been adopting various changes- mostly towards the liberal model though. It was argued that NHS reforms have already taken their place at the most radical edge among the health care reforms in Europe that NHS has been the health care system which has been exposed to market-oriented reforms at the greatest intensity which has also made it undergo constant (re)(dis)organization in the last four decades (Lister 2008: 185-186)

Nevertheless since main area of interest in this study is to understand the Turkish case of transformation in health care services, drawing upon the resemblances detected between the two cases, it is quite enlightening to analyze the British case as the model from which insights for the incipient reforms in Turkey can be drawn. As it has been mentioned health care model that is about to settle down by the Health Transformation Program (HTP) bears a hybrid character where however the impact

of the reformed NHS (Beveridge model) is quite overwhelming vis a vis the other main stream health care typologies.
Thus in this part the National Health Service (NHS) of England will be briefly introduced with particular emphasis on its organizational (mainly to figure out its decentralization/centralization dynamics) and financial set-up and the reforms that has been undertaken on these aspects.

Beveridge type of health care system was explained in detail the above section. However, if to recall some of its main characteristics the following are worth mentioning: it is mainly funded through general taxation, it attempts at universal coverage through public planning and finance, health care services are usually provided by public authorities which is commonly known as the public integrated model which implies that both the finance and production of the services are undertaken by the same public authority (Nalçacı et al. 2006: 37).

However these established characteristics of the Beveridge system have also been changing. For instance although it is said that the main source for financing the health care system comes from the general budget, countries having Beveridge type of health care systems do also employ other means for finance. In England for instance, of all funds allocated to health care 76% comes from general revenues, 12% from social insurance, 10% from private insurance and 2% from out of pocket payments (Roberts et al. 2008: 154). In the same way the public integrated model has also been challenged seriously with the introduction of the provider-purchaser split to the NHS. In addition to that although it is stated that health care services are mainly provided by public agencies in the Beveridge system, with the adoption of the public-private- partnership model, private sector does also have a serious role in the provision of health care services. Finally, although the basic aim in the foundation of the Beveridge system was to provide every citizen with the required health care services free of charge, with the reforms that have been put into practice since 1980s, now the NHS demands additional user charges from the patients for the provision of various health care services. It was declared that after the employment of these kinds of user charges there occurred an increase in the number of private hospitals and private health insurance companies (Ateş 2011: 86).

When it comes to the British health care system, first of all it was this country which named the system "Beveridge" through the famous Beveridge Report which was published in 1942. Therefore by definition the general framework drawn above for the Beveridge model holds true for the British health care system which is commonly called as the NHS.

As it has been mentioned since its establishment NHS has gone through various stages of development and reforms, which even challenged some basic premises of the Beveridge model. In the following section reforms that have been undertaken within the NHS will be examined, with particular emphasis on those that have been adopted in the post-1980 period targeting Organizational (Decentralization) and financial set-up of the NHS.

6.2 Reforms Targeting Organizational and Financial Set-up of the NHS[36]

As it has been mentioned at the very beginning of this study (and as it will be seen in the course of writing), decentralization and finance are highly inter-related areas in health care and reforms undertaken in these areas are in a sense complementary to each other within the broad picture of transformation.

6.2.1 Decentralization of the NHS

Centralized structure of the NHS has usually been condemned for being one of the important causes for the *politicization of the NHS*. It was argued that party in power was highly influencing NHS policies to get re-elected- e.g. they manipulate waiting times- or undertake day-to-day micro management to avoid media and public criticism (Baggott, 2007: 143).

In this regard in order to eliminate politicization of the NHS, one of the arguments raised was that the NHS should be given greater independence from the central

[36]In this rather chronological and descriptive section, three sources - namely the work by Rob Baggott (2007), John Lister (2008) and the one by the Socialist Health Association of England found at http://www.sochealth.co.uk/news/NHSreform.htm (last accessed on 10.06.2011) – will be relied on.

government- that it should be given a formal status or be set up as an independent non-departmental public corporation (Baggott, 2007: 143).

In order to avoid possible criticisms on accountability and democratic participation it was argued that local authorities could be given greater powers of oversight and scrutiny and they may be given a commissioning role in relation to NHS services so that more effective mechanism for patient/public involvement at the local level could be introduced. Another idea was to regionalize the NHS with some oversight powers from regional assemblies. (Baggott, 2007: 144). However, direct provision of services by local governments was not an issue that was discussed in this regard.

Nevertheless it has been frequently argued that politicization is something inevitable for the NHS because it is mainly funded out of national taxation (publicly funded), it is a large employer, its services affect many people, there is a huge amount of money involved and everything that is related to health is quite sensitive (Baggott, 2007: 144).

All these discussions and attempts to "*take the NHS out of politics"*, which were highly matched with discussions on "decentralizing the NHS", can be seen as one of the reflections of the politics/administration (management) dichotomy of the NPM reforms of the era.

Looking at the reforms that have been adopted so far it can be said that decentralization has usually been conceptualized as *giving more autonomy to health care units* (such as hospitals, NHS trusts, PCTs and GPs) rather than delegation of authority to local governments for the provision of health care services. This issue has also been taken up within the context of creating an internal market and provider/purchaser split in the NHS- which will be dealt with in the following sections.

When it was established in 1948, NHS was a tripartite system with hospitals owned and funded by the state, state-funded family health services provided by independent contractors such as GPs and dentists and community and public health services run

by local councils. In this picture the Minister (Now the Secretary of State for Health) was responsible for the NHS in general and was accountable to the Parliament for policy, funding and service delivery.

Funding of health services and appointment of regional and local boards were done centrally. However, some prestigious NHS Hospitals had autonomous boards and GPs and other independent contractor professions were administered by separate Executive Councils and were insulated from central control in which the central government did neither have the capacity nor the inclination to intervene. In fact up until late 1970s and early 1980s the Ministry of Health was relatively weak- just providing guidance and advice to local health bodies where there was a strong medical professional organization at local levels signifying local autonomy.

From 1960s onwards central government tried to exert much stronger influence over the NHS in order to have financial control and attain efficiency, effectiveness, quality, and regional equality in the provision of health care services. However, attempts to make NHS units more accountable to the center were accompanied by those aiming at giving NHS organizations greater responsibility which points to “the paradox that decentralization can be accompanied by centralization in the British NHS” (Baggott 2007: 132; Pollitt et al. 1998 and Peckham et al. 2005).

Year 1974 pointed to the end of the original tripartite structure that a new structure was established where community health services were run by local authorities, three tiers of health service management were created at regional, area and district level (i.e. Regional Health Authorities, Area Health Authorities and District Level Health Authorities) and independent contractors such as GPs and Family Practitioner Committees (FPCs). Creation of District level health authorities was an attempt of the Thatcher government to soften the criticism that the systems was top-down and bureaucratic. It was in 1982 that Area Health Authorities were abolished and District Health Authorities were reorganized.

Since 1970s there have been many attempts to decentralize - and re-centralize- the NHS. It can be said that decentralization of the NHS is still an on-going process in the UK that there has been “constant re-organization (decentralization/re-

centralization)" within the NHS, which was criticized for causing constant "re-disorganization"[37]. According to Baggott some of the main reasons for this constant re-organization are that it is found useful by the politicians as a symbolic tool showing that they take action on something, it shifts the attention to the administration and thus can avoid criticisms away from central government policies and it is usually done with over-optimism. (Baggott, 2007: 135)

6.2.2 Planning and Regulation

The issue of decentralization has always been discussed with the planning and regulation practices in the NHS which has long been condemned for causing a further top-down system. In the early 1960s "planning", which was previously given little consideration, started to become an important policy tool within the UK health policy. The Hospital Plan issued in 1962 signified a turning point in this regard by providing rules on manpower and resources and mainly aiming at capital expenditure. This plan was followed by other plans such as the NHS Reorganization White Paper (1972) and NHS Reorganization Act (1973) (Baggott, 2007: 136).

In year 1976 a new planning system was introduced where each health authority would produce plans which would then be passed up to the central department (the DHSS), which in turn would produce a priorities document setting out a framework. However, this planning process remained persuasive rather than directive and the government's priorities encountered considerable resistance at local levels. (Baggott, 2007: 136).

When it comes to 1980s, Thatcher government attempted to simplify the planning strategy which was started in 1960s. However, although at the beginning local health authorities were given a general statement of priorities rather than detailed guidance, in a while central guidance became more prescriptive. In this regard an Annual Priorities Document was produced which set various goals and targets for specific services. Moreover plans were subject to much closer scrutiny by upper level authorities.

[37]Baggott (2007: 135); Socialist Health Association (2011)

Thatcher government devised new policy initiatives in the 1990s such as the Patient's Charter which set a range of standards and rights (such as maximum waiting times) whose targets were expected by the government to be achieved by the health authorities. Another planning strategy was the Health of the Nation Strategy which set targets for improving public health. (Baggott, 2007: 137). Cost-effectiveness of clinical procedures, evidence-based practice, use of national clinical guidelines and medical audit (to monitor the quality of care) were the main items stressed by this strategy (Baggott, 2007: 145).

Since the introduction of the internal market led to further regulation, market rules were enhanced and a Clinical Standards Advisory Group was established in this period in order to assess the impact of the market on access, standards and quality of the NHS services. (Baggott, 2007: 145).

Planning strategy of the Labour government had some similarities with that of the Conservatives. For instance an attempt was made to integrate health care and social care by combining planning and guidance for the NHS and local authorities. Moreover, NHS organizations and local governments were imposed a duty of cooperation. In addition to that Local Health Plans were changed into Health Improvement Programs which focused on health care and health authorities were expected to include local stakeholders such as local governments and voluntary sectors in their formulation (Baggott 2007: 137).

Although a promised reduction was made by the labour government in planning requirements, there occurred a proliferation of plans at the national level (Baggott 2007: 137). First of all, Three-Year Plans replaced Annual Plans. The NHS Plan, which was based on a broad review of the services, set a range of policy objectives and targets which included new waiting time targets (e.g. maximum waiting times of 48 hours to see a GP, 3 months for an outpatient appointment and 6 months for an inpatient appointment). This plan was followed by the NHS Improvement Plan which set further goals like 18-week maximum waiting time from GP referral to receiving treatment. In addition to these, White Papers outlining policies on issues such as choice, public health, health care outside hospitals set out a range of new

policy aims and objectives. Besides these the government also formulated Specific Service Plans and Frameworks such as the Cancer Plan or plans on mental health, diabetes, older people, children's services and the like. These plans were expected to be implemented at the local level.

Labour government created various commissions and agencies: *The Commission for Health Improvement (CHI)* was a statutory body established to monitor NHS performance against service standards which were set by national bodies such as the NICE and NSFs. It was also responsible for inspecting NHS bodies and recommending closure or suspension of services and producing information on performance including "a *system of star ratings*" in which NHS organizations were given 3, 2, 1 or no stars depending on their performance and those with high ratings were promised more autonomy and those with lower ratings would face more scrutiny and intervention. The star rating system was replaced by "*annual health check*" which employs a scoring system reflecting the organization's effectiveness in using financial resources and the quality of care they provide where health care organizations were measured against standards set on patient safety, clinical effectiveness, public health and government targets.

CHI was later reconstituted as the Commission for Healthcare Audit and Inspection (CHAI) and is now known as the Healthcare Commission and it has overall responsibility for assessing the performance of the NHS organizations, reporting on the state of health care, regulating the private health sector and promoting improvements in health care provision. It is a statutory non-departmental public body accountable to the Parliament and to the health minister. Its board is appointed by the NHS Appointments Commission. However, it must follow government policy and some aspects of its work are subject to direction from ministers. It is expected that the Healthcare Commission will be merged with the Commission for Social Care Inspection (CSCI) (Baggott 2007: 145).

National Patient Safety Agency (NPSA) was created to ensure the introduction of a new system of incident reporting and to ensure that appropriate guidance is given to health care organizations to avoid such incidents. National Clinical Assessment Authority (NCAA) was another body created for assessing the needs of doctors and

dentists who fell short of the required standards and for advising their employers on how to deal with poor clinical performance. NCAA has been taken over by NPSA (Baggott 2007: 146).

Since mid-1990s UK has a system of accreditation in health care where the United Kingdom Accreditation Service (UKAS) is the sole national accreditation body recognized by government to assess, against internationally agreed standards, organizations that provide certification, testing, inspection and calibration services[38].

In addition to UKAS there are also private accreditation institutions such as the HQS- Health Quality Service which has been the oldest health accreditation service in the UK and in the rest of Europe. It works with the British and international healthcare organizations to improve the quality of patient care through consultancy services and the development of health care standards and assessment processes[39].

NICE (National Institute for Clinical Excellence) which was established in 1999 as a special health authority to provide evidence on the cost-effectiveness of new and existing health care interventions and to develop clinical guidelines for various conditions and to assist the NHS with clinical audit, has become one of the most important agencies within the NHS.

It is one of the most prominent institutions practicing Health Technology Assessment, which is an important element of recent health care reforms. It has responsibility for checking the safety and efficacy of new clinical procedures and evidence- based public health.

Since 2002, NICE guidance to the NHS has been mandatory. In the absence of guidance, PCTs and trusts may decide not to fund a particular treatment which causes problems for the patients who want to benefit from new treatments. (Baggott 2007: 147)

[38] UKAS (2011)
[39] UKAF – United Kingdom Accreditation Forum

In the face of criticisms on NICE's too much reliance on cost-effectiveness, in 2005, the Secretary of the State for Health stated that PCTs must not refuse to fund the treatment purely on grounds of cost which for a while caused the by-pass of NICE judgments. NICE has also been accused of being under the influence of the government, the pharmaceuticals industry and patients' organizations. It is criticized for lacking transparency, basing judgments on a limited range of evidence, taking too much time to evaluate new treatments and limiting clinical freedom by preventing certain treatments which in certain circumstances might be justified and useful (Baggott 2007: 147)[40].

MONITOR was established as a national regulator together with the creation of Foundation Trusts in 2003. It is accountable to the Parliament and to the health minister. It was constituted as a non-departmental public body responsible for authorizing the framework for each foundation trust (like the conditions on the range of services it provides, the level of private practice, restrictions on borrowing and asset sales). It authorizes initial financial plans and governance structures. It may intervene where a foundation trust has breached its authorization. It may replace senior managers and members of the governing board. However, it should be noted that the quality of the services provided by foundation trusts remains subject to regulation by Healthcare Commission.

As it can be expected there has been a serious increase in the amount of new regulation in the NHS mostly coming from these new regulatory bodies which has also led to the argument that regulatory reforms has caused further centralization of the NHS with the regulatory regime's strong emphasis on national standards, frameworks and processes. (Baggott 2007: 147).
In the same regard it was argued that drawing upon the justification that "due to the dysfunctional nature of the health market, central government should subsequently regulate behavior that could lead to higher costs, increased surplus and reductions in access and quality of services, the Blair government followed a policy of "command

[40] For further information on NICE and its resemblances with the Pharmaceuticals and Medical Devices Institute which is on its way in Turkey, see Demirci (2008).

and control in health policy" which thus led to the criticisms that "the NHS management had become over-centralized" (Baggott 2007: 141).

In this context Blair government introduced national inspectorates, standard setting bodies and the government took on new powers to intervene in health authorities where great intervention was seen in the appointment of NHS managers and in franchising out the management of NHS bodies to other management teams including the private sector. Also the ministers continued to intervene in health authority and trust appointments to ensure that their initiatives are respected at the local level. However in the face of criticisms about the politicization of appointments, ministers handed over this process to a special health authority called the NHS appointments. (Baggott, 2007: 142).

It should be noted that the new regulatory regime has been criticized for not having guaranteed independence as most of the regulatory bodies are constituted as special health authorities which are potentially subject to a degree of ministerial intervention[41]. Another criticism for health care regulation is that it is very fragmented.

However there are also those who argue that the creation of Healthcare Commission represents a significant step away from a centrally directed bureaucratic structure (Baggott 2007: 148).

[41] Although MONITOR has greater constitutional independence as a non-departmental public body reporting directly to Parliament it also has to report to the Secretary of State for Health who appoints its members. Also it is required to act in a way consistent with ministers' general duties in relation to the NHS.
The Healthcare Commission has some independence- as it it has been constituted as a non-departmental public body accountable to the Parliament and to the minister. It is appointed by the NHS Appointments Commission rather than the minister directly. However it is subject to ministerial involvement in some aspects of its work (in setting standards, criteria for performance ratings, initiation of reviews and investigation) (Baggott 2007: 148). The Secretary of State for Health may issue ultimate directions if he/she believes the Healthcare Commission is not fulfilling its functions properly and has powers to remove its chair and individual members on grounds of incapacity or failing to discharge their duties.

The new regulatory regime for health care is also criticized for imposing substantial costs on the NHS where most of the costs is said to be hidden costs such as the cost of compliance with regulation.

There are also concerns about the capacity of regulators to engage with practitioners at the front line and their ability to actually improve service standards.

It should be noted that creation of these institutions also coincides with a period where a series of scandals occurred within the NHS, which increased media and public attention to health affairs and which strengthened ministers' commitment to stronger regulation.

In the face of criticisms on over-centralization of the NHS management, the government announced its new approach from 2000 onwards- *New Localism*- which was the major theme of the NHS Plan promising "a lighter touch for those who complied with central objectives and to this end greater autonomy, additional resources and less inspection of NHS bodies that performed well." This was also called "*Earned Autonomy*" which tried to bring about a new system of performance assessment such as the star rating system (Baggott 2007: 142) The localist approach was also seen in the creation of Foundation Hospitals and the expansion of the private sector's role as a supplier of services on behalf of the NHS.

Attempts at regulating the NHS continued with the establishment of the NHS Modernization Agency in 2003 and Commission for Healthcare Audit and Inspection in 2004. In 2005 Modernization Agency was replaced by the NHS Institute for Improvement and Innovation and in 2009 Health Care Commission was replaced by Care Quality Commission.

According to Baggott central government will continue to intervene in areas where political stakes are high and that that proper devolution could only be achieved by giving bigger roles to independent inspectorates and by creating autonomous regional health authorities (Baggott 2007: 142).

Enthoven on the other hand argues that what has been done by the New Labour government does not suggest any re-centralization as he claims that the three features of the internal market still remained: the provider-purchaser split, the Hospital Trusts and the commissioning of specialist health services from the GP level (Enthoven 2000 quoted in Magnussen et al. 2007: 114).

To sum up the basic features of NHS reforms regarding re-organization the following highlight can be made:

There has been "an oscillation between centralization and decentralization". The center has taken on more active role in setting plans and targets for the NHS in recent decades. There has been "a large increase in regulation and inspection in the NHS" through creation of new regulatory bodies and efforts made to strengthen self-regulation by the professional bodies. This centralization has been accompanied by a process of decentralizing responsibility to the local levels of the NHS. This is usually interpreted as "shifting the blame away from the central government to the local NHS" (Baggott, 2007: 153-154).

The Arrows Framework underlines the fact that centralization and decentralization may occur at the same time that "decentralization often involves a strong dose of central intervention" where in fact "decentralization is often seen as a symbolic policy masking for tighter control of local organizations" (Baggott 2007: 132). It is argued that if fully implemented those reforms could lead to a more decentralized system, but past experience showed that these may turn out to be tightly-managed systems (Baggott 2007: 153).

There has been an increasing pace of change where constant re-disorganization and relentless reform are the main characteristics and these have negative effects on the NHS and its staff, lead to further gaps between policy and practice, can be counterproductive and costly.

It has been argued that constant reorganizations are useless reform tools because it takes at least two to three years for a reform project to perform at least as good as the

previous one. Nevertheless NHS has been re-organizing itself every two years which means that it is usually left with all the costs of reorganization and with only several advantages (Walshe et al 2004 quoted in Lister 2008: 189).

NHS is said to be a highly politicized area due to its funding and organization and the prominence of issue of health on the political agenda. Therefore it can be said that the calls made to take the NHS out of politics is not that viable given this context.

Finally it can be said that there is kind of a rivalry between those who favor the "big bang approach" to reforming the NHS organization and those who favor a rather incremental approach (Baggott 2007: 135).

6.2.3 Managerial Reform

Although managerial reform is usually discussed within the context of decentralization it is also argued that increase in central planning is said to have reflected the desire to strengthen line management in the NHS. (Baggott 2007: 136).

1974 re-organization introduced "consensus management" to the NHS which implied the formation of management teams from different backgrounds such as doctors, nurses, administrators, etc., which at least in theory foresaw equal representation and veto powers for each of these professions where emphasis was on consensual decision-making (Baggott 2007: 139).

Thatcher government stressed the necessity of a more influential *managerial reform within the NHS*. To this end the Griffiths Inquiry was conducted with the resulting Griffiths Report.

The Report recommended separation of policy-making from implementation (management) and argued that with the establishment of a coherent management there wouldn't be any need for the central initiatives (Baggott, 2007: 140). However this was not realized. Another attempt to separate policy-making from

implementation was the establishment of NHS Management Executive which replaced the Management Board. It was later named the NHS Executive (NHSE) and survived until 2000. These bodies all remained as parts of the DoH and did not have separate accountability for the NHS.

The Griffiths Report suggested that general management should replace consensus management where a general manager would be held accountable for the management performance of each service providing health authority. Strong *line management* was highly advocated for the NHS. Although this was strongly opposed by professional groups, it became an entrenched part of NHS management (Baggott 2007: 140). In this regard, in 1984 General Managers were appointed throughout the NHS. General Managers were selected from other areas of experience and it was argued that this re-organization was aiming at empowering the managerial line vis a vis the medical professionals and thus to make the upcoming market-oriented reforms rather easier (Lister 2008: 191).

Throughout 1980s and 1990s the performance of the NHS was subjected to closer scrutiny by the DHSS/DoH. To this end *performance indicators* were developed, league tables were introduced, targets were set to provide a basis for reviews at each level of the NHS.

The Griffiths Report also recommended a stronger leadership role for health authority chairs, greater involvement of clinicians in management at the local level, better quality information about effectiveness and efficiency of the NHS. (Baggott, 2007: 140)

In 1985 the system of QALYs was adopted which can be taken as an important step in adopting the Health Technology Assessment to the NHS, which will be furthered by the later foundation of NICE. It was in this same year that 90 Family Practitioners Committees became autonomous authorities.

In 1986 NHS Management Board was established and in 1988 Department of Health was separated from Department of Social Security

As it can be seen the Griffiths Report, which was issued upon the demand of the Thatcher government for a managerial reform within the NHS, introduced a "business- oriented approach" to the administration of the NHS which emphasized "corporate responsibility" (of staff to their host organizations), upward accountability (of NHS organizations to higher level authorities and ultimately to the DoH) and reshaping of health authorities as "corporate bodies" (including senior managers on their boards, abolishing the requirement to have local authority nominees and strengthening the role of chairs).

It was argued that adoption of the General Management System has brought about a separation between the administration of providing units and that of health authorities (Lister 2008: 191). Therefore after this report central government gained closer interest in the appointment of health authorities, which however led to criticisms that these bodies were dominated by Conservative Party supporters and people from business background. (Baggott, 2007: 140, 141).

Despite efforts to control and regulate the NHS, considerable power remains at local level in the hands of the medical profession (Baggott 2007: 149). Doctors are still able to resist initiatives coming from the center, they are notoriously difficult to manage, they have high degree of autonomy especially in technical matters, they generally oppose to being line-managed and do not like taking on management responsibilities.

Since the Griffiths reforms, several attempts have been made "to bring doctors both into and under control of management". Some of the doctors have undertaken managerial duties. However within the profession these jobs are not prestigious as they involve heavy workloads, promise limited opportunities for career development, treated with suspicion by colleagues and regarded as having little influence over medical practice (Baggott 2007: 149).

Professional self-regulation was also reformed. Since 1980s, governments tried to promote audits of medical and clinical work but this could not challenge professional autonomy. Blair government introduced the Council for Healthcare Regulatory

Excellence (CHRE) to oversee health professionals' self-regulatory bodies, to promote cooperation between them and to have them create new rules in exceptional cases. In certain circumstances CHRE has powers to over-rule the decisions of these bodies. Further changes in the system of medical regulation are expected such as a new system of revalidation for doctors under which they would have to prove their fitness to practice (Baggott 2007: 146). These kinds of regulations were also considered within the framework of the NPM reforms which were argued to serve to weaken professional dominance in health care sector (Kinnunen et al. 2007: 173).

Blair government introduced "clinical governance" as a means of encouraging audit and service improvement. This involved establishing clearer lines of responsibility for care, a comprehensive program of quality improvement, procedures for identifying and remedying poor performance, clear policies for identifying and minimizing risk and appropriate institutional arrangements within each Trust. Clinical governance is considered as a system of internal quality assurance reflecting responsibility for the quality of care newly imposed on NHS chief executives.

It is argued that after the introduction of clinical governance there have been signs for improvement in clinical quality issues and improvement in collaborative and transparent ways of working in medical professional bodies. However it is also argued that there is evidence of poor implementation of policies and variations between Trusts, failure in communication and learning across organizations and limited impact of clinical governance so far mainly due to the government's failure to make clinical governance work and to engage with clinicians at the local level (Baggott 2007: 150).

Blair government responded these criticisms by New Localism and by highlighting the need to shift the balance of power to the "front line", i.e. to the managers who have been empowered so far vis a vis doctors. Although not much has been achieved in practice so far certain steps have been taken in to this end.

Introduction of "Beacons" was an attempt "to spread good practice in the NHS" where examples of innovative practice were identified by a competitive selection

process and they were then disseminated around the NHS as others were encouraged to learn from their experience. Another initiative was “collaborative network” which sought to challenge existing ways of delivering services.

Both of these initiatives are said to have the potential to “change the culture of the NHS” and improve services bottom-up, however it is argued that they have been introduced within a framework of central control and targets. It is argued that to be successful they should not be seen as a top-down exercise but must genuinely empower local managers and clinicians to pursue improvements in services.

In this regard it is argued that command and control models of decision-making have been highly discredited and that new systems of policy-making and governance which empower professionals, service users and other stakeholders and which encourage innovation, learning and experimentation are credited (Baggott 2007: 150-151).

All in all it can be said that managerialism and management reform has been an important feature of the NHS reforms where managers are regarded as key players in implementing government policies. It is argued that since 1990s there have been many efforts to control specialists and GPs which in fact has the implicit aim of controlling the cost and quality of the services they provide. Making (sometimes forcing) them to work with pre-determined constant budgets was said to another way of maintaining control and discipline over medical professionals (Lister 2008: 198). However, despite the efforts of the government so far, medical profession still remains powerful within the NHS.

6.2.4 Creation of Quasi (Internal) - Market and Provider/Purchaser Split within the NHS

The 1989 White Paper titled “Working for Patients”, reflected a different outlook for reforming the NHS. Its aim was to create a quasi-market (internal market) within the health care system. This was realized in 1991 with the establishment of the provider/purchaser split.

Creation of the internal market and its complementary provider-purchaser split in 1991 was one of the most prominent steps of the NHS reforms introduced by the Thatcher government.

Actually this reform attempt is said to have pointed to a “deeper shift in philosophy from the conventional welfare state approach to a neoliberal perspective” (Baggott 2007: 132).

With this reform NHS bodies became providers or purchasers of health care. “Providers” would be the self-governing NHS trusts, removed from health authority control and promised greater freedom to manage their affairs. Providers would earn their income through service contracts negotiated with the purchasers. “Purchasers” included relatively smaller health authorities such as District Health Authorities (DHAs) and fund-holding GPs- whose budgets would be allocated according to their population profile.

It was argued that with the creation of autonomous providers there would be competition among them in the internal market as they would compete for making contracts with the purchasers either from the public or from the private sector and this would in the end lower costs, increase efficiency and improve quality (Magnussen et al., 2007: 113). In this regard it should be underlined that competition has become one of the most critical issues in NHS both in terms of competition among the public providers and as it will be seen below among the public providers and private providers.

As it has been mentioned, within the context of NHS, decentralization has been mainly conceptualized as giving more autonomy to the hospitals. Therefore besides its very serious implications for the financial aspect of the NHS, provider/purchaser split is considered as one of the most serious attempts towards decentralizing the NHS. In this regard 57 NHS Trusts, which have their own boards of executives appointed by the government and non-executive directors were established. NHS Trusts were designed to act as self-governing public corporations which were expected to derive their revenues from the contracts they made with the purchasing

health authorities for which they would compete. They are encouraged to do their best to create revenues through various ways such as manipulating personnel wages, selling their assets, competing with other public providers to make contracts with the purchasing authorities, etc. (Lister 2008: 191). Since the establishment of first wave of NHS Trusts in 1991, hospitals were encouraged and thus started to feel the need to turn into NHS Trusts. Thus in the succeeding years the number of NHS Trusts has reached to 270. It should be noted that these so-called autonomous NHS Trusts were made responsible to the Department of Health through Regional Health Authorities (Lister 2008: 189).

As a complementing element to the internal market model, starting from early 2000s hospitals were started to be rated and listed in the so called kind of league tables where performances of hospitals are measured and hospitals are ranked according to their performances in league tables. Hospitals get or loose autonomy, financial grants and even number of patients preferring them, according to their ranking in these league tables.

In 2004 the NHS Trusts who were granted 3 stars according to the Star Rating System were encouraged to turn into Foundation Trusts which would be non-profit-seeking public corporations audited by local councils and accountable not to the Department of Health but to the newly-established autonomous Commission for Health Care Audit and Inspection.

Foundation Trusts were promised certain freedoms in managing their affairs such as retaining surpluses, borrowing from financial markets, selling their assets, entering into private partnerships, widening their scope for services through opening private beds and rewarding staff. However in practice constraints have been imposed on these activities. Foundation Trusts are subject to an independent national regulator (called MONITOR) that can intervene in certain circumstances. Foundation Trusts are also accountable to the local community through governing boards that contain a majority of representatives elected by local people and patients (Lister 2008: 191). Foundation Trusts were established in a limited number before the 2005 elections however with the declaration of the Blair government that all NHS Trusts would be

encouraged to become Foundation Trusts. First crisis about Foundation Trusts was experienced in 2004 in Bradford Foundation Trust when it faced a serious deficit (Lister 2008: 192).

During 1990s there have been many (re)(dis)organizations within the NHS. From 1997 onwards the Labour government attempted at further organizational changes where however the division between purchasers (by now known as Commissioners) and providers of health care was retained. Some of the most prominent reorganizations undertaken in this era can be summarized as follows:

In 1991 GP Fund-holding system was established that some of the GPs (306), who have normally been autonomous contractors, were turned into fund-holding GPs. This meant that fund-holding GPs would be allocated an annual delimited budget according to the demographic profile of the population in their area. They would use this budget to purchase services (except from emergency services) for their patients (either outpatient or hospitalized patients) from the competing providers. They were encouraged to use their bargaining power to purchase higher quality services at lower costs and they would be allowed to keep the residual from their annual budget at the end of the year (Lister 2008: 190). They would be free to direct their patients to any NHS Trusts. GPs who did not choose to become fund-holders would be limited by only those NHS Trusts with which the health authorities they were tied to had made contracts beforehand. It has been reported that GPs were highly encouraged to become fund-holders in order to make the system become consolidated. GP fund-holding was abolished in 1998.

In 1999 Primary Care Groups (PCGs) were established in local areas to commission services. PCGs would be open to all the area and would work as a sub-branch of Regional Health Authorities. It was envisaged that PCGs would eventually become Primary Care Trusts (PCTs) as the free-standing bodies that could take on service provision as well as commissioning roles. The move from PCG to PCTs was expected to be voluntary and dependent on the local context. However, in early 2000s all PCGs were converted into PCTs as part of the program called “shifting the balance of power” in the NHS to the local level and their number eventually reached

to 300. It is also argued that they did not enjoy all the autonomy promised to them initially. (Lister 2008: 180). In 2009 PCTs separated themselves into "commissioning" and "providing" arms. Finally year 2011 has welcomed some reorganization in PCTs already. Under the "Shifting the Balance of Power" initiative, PCTs acquired responsibility for over ¾ of the NHS budget. However they did not have the autonomy which the government proclaimed for them- i.e. PCTs discretion was limited by the requirement to attain governments' targets, they had limited management capacity and scarce resources. Politically it was extremely difficult for PCTs to dramatically alter funding flows to acute and specialist providers. This could be considered as an effort to keep the issue of allocation of funds under the control of the center.

In addition to these, reconfiguration of District Health Authorities as Health Authorities, abolishment of Health Authorities and establishment of 28 Strategic Health Authorities and Reorganization of Regional Health Authorities (numbers reduced from 14 to 8) could be mentioned as some of the other important reorganization attempts of the era.

It is argued that although it was expected to create powerful incentives for change, internal market created limited competition and it could not provide incentives for dramatic change (Baggott 2007: 152). It is also argued that whether the provider/purchaser split has led to any increase in efficiency and made any effects on lowering unit costs is still a highly disputed issue (Magnussen et al. 2007: 114). The impact of the creation of the internal market on the overall quality of care on the other hand was said to be difficult to ascertain. However creation of internal market in health care did have some viable impacts which could be summarized as follows (Baggott 2007: 152):

1. It created some kind of entrepreneurialism among fund-holding GPs (the early entrants to the scheme seemed to be more entrepreneurial in their outlook than the average GP).
2. NHS Trusts became more efficient and productivity increased (measured by changes in activity relative to resource).

3. There was evidence that inequities were arising from these reforms especially in terms of differential access to hospital services among the patients of fund-holding GPs and non-fund-holding GPs (Baggott 2007: 152).

6.2.5 Patient (Customer)-Oriented Practices

In 1990s new policy initiatives such as the Patient's Charter set a range of standards and rights for the patients (such as maximum waiting times) which were expected to be realized by the health authorities in question.

The Labour government set a range of policy objectives and targets which included new waiting time targets (e.g. maximum waiting times of 48 hours to see a GP, 3 months for an outpatient appointment and 6 months for an inpatient appointment). This plan was followed by the NHS Improvement Plan which set further goals like 18-week maximum waiting time from GP referral to receiving treatment. In addition to that various White Papers outlining policies on issues such as patient choice, public health and health care outside hospitals were issued.

In 2003 "patient choice" which allowed NHS patients to choose from a menu of potential service providers including the private sector was adopted. According to patient choice patients who have been waiting for 6 months or more for getting treatment could refer to other service providers- including the private providers. It is argued that patient choice has become one of the leading factors in creating a new wave of competition in the sector and a new channel for allocating more of public resources to the private sector (Lister 2008: 198).

Launch of Patient Forums in 2004, replacement of patient forums with Local Involvement Networks in 2008 and the reformation of the NHS Complaints System are some of the developments undertaken in the name of patient-oriented reforms.

6.2.6 Reforms Having Direct Implications on Financial Aspects of the NHS

Introduction of “prescription charges” in 1949, right after the foundation of the NHS, can be taken as the first attempt to manipulate the financial set up of the NHS. Charging patients for being prescribed for their treatment was abolished in 1965 however re-introduced in 1968.

It was in 1970s that the British government launched its attempts towards curbing public expenditures on health care. In this regard in 1976 in line with the IMF directives “Cash Limits” was introduced into the NHS which meant that spending authorities could not exceed the sums of money allocated to them. In 1988 charges were imposed on certain health care services such as eye tests and dental check-ups. Actually it would not be wrong to state that all the reform attempts that have been covered so far did mainly emanate from the need and desire to curb public expenditure on health and to channel these funds to the places appropriate for the restructuring of the market.

During 1990s health care expenditures as a share of the GNP in England remained far behind the OECD and EU averages (Lister 2008: 187). It was with the Labour Government in early 2000s that there occurred a serious increase in the budget of the NHS.

Rationalization was an important tool used in curbing public expenditures on NHS which referred to approximately 0 % increase in NHS expenditures or to bed/hospital closures during 1980s. Curbing on hospital beds highly influenced certain group of patients particularly those in need of expensive treatments such as those having cancer or mental illnesses and elderly people. It has also led to longer waiting times which have long been one of the most critical problems of the NHS.

As it has been mentioned above there have been attempts to regulate the pharmaceuticals sector (e.g. NICE). This however has had a serious impetus behind to curb expenditures on pharmaceuticals. It has been reported that there have been

many cases where the GPs have been forced to prescribe cheap generic medicines instead of expensive ones (Lister 2008: 188).

Blair government turned back to a system inherited from the Conservatives and it began to introduce "supply-side reforms" such as the introduction of independent treatment centers, franchising of NHS management and foundation trusts. In this vein, a new system called "payment by results" was launched in 2006 to reimburse providers for individual treatments supplied, based on the standard cost of a group of producers (known as" tariff") (Baggott 2007: 152). Moreover "practice-based commissioning" was also supported by determining weighted *capitation* shares at practice level. Under a capitation system, healthcare service providers are paid a predetermined amount for each enrolled person assigned to the physician or group of physicians in question, whether or not that person seeks care, per period of time. *Earmarked funding*, which basically refers to the efforts to allocate resources based on measures of need, also continued throughout 1980s and 1990s. Moreover it was declared that Trusts could no longer rely on large scale block agreements to generate income but would have to sell their services to PCTs, GPs and their patients. However, the government maintained that failure by providers to generate sufficient income would ultimately lead to the closure of services.

On the demand- side, Blair government sought to re-introduce elements of GP fund-holding by devolving budgets to the practice level. Even it went further than the Conservatives by allowing NHS patients to choose from a menu of potential service providers including the private sector.

Here it should be noted that despite all these reform attempts as a general principle health care expenses are made from the general budget. Besides that there has been serious increase in public expenditures on health and in the rates of taxation which have been added by increasing rates of channeling public funds to the private sector.

6.2.7 Purchasing Services from the Private Sector & Privatization

In 1983 *Competitive Tendering for ancillary services* was introduced and it was from this date onwards that there has been "systematic privatization of the NHS" (Atun 2007: 255).

Since 2000 *outsourcing*, which basically refers to contracting out a service to an external provider, has been used in the NHS as one of the methods for privatizing health care services (Atun, 2007: 256).

With the Patient Choice adopted in 2003, Labour government allowed NHS patients to choose from a menu of potential service providers including the private sector. As it has been mentioned above patient choice is seen as a new way to foster competition in the health sector and to channel more public funds to the private sector (Lister 2008: 198). It was argued that the serious increase made to the NHS budget in early 2000s was channeled to the private sector through the contacts made with private providers while there were many NHS hospitals suffering from great deficits and thus facing with problems of closing beds (Lister 2008: 187).

It is argued that for a long period of time governments are dedicated to purchase more and more health care services from private providers. In this regard in 2005 the government made annual contracts with private providers to purchase various services amounting to a serious prices which meant a doubling in the number of services purchased from the private sector so far and thus a serious increase in the amount of money that would be channeled to private sector (Lister 2008: 195).

Besides channeling public funds to private sector, this kind of a practice is said to cause NHS hospitals to fall behind in competing with the private hospitals in terms of the quality of service provision, waiting lists and finding qualified personnel who would choose to work in the private hospitals which in the end would make cause a decrease in demand for the services they provide and thus make them face the danger of going bankruptcy (Lister 2008: 196).

6.2.8 Private Finance Initiative (PFI) and Public-Private-Partnership (PPP)

These were devised as methods originated in the UK to finance high cost hospitals and related projects. Since 2000s many hospitals have been constructed with this model and it has been declared that nine of ten new hospital projects are funded with PFI model and that only one is funded with the money coming from the treasury (Lister 2008: 199).

PFI hospitals are criticized for their increasing costs, unsatisfactory performance and failure in their design and construction (Lister 2008: 199). It was argued that insistence of the Labour government to agree on the construction of £ 7 billion PFI hospitals which it would lease meant the same thing as privatizing 1/3 of the total NHS assets (Lister 2008: 199). Moreover it is known that PFI hospitals and other NHS assets are bought and sold in the financial markets as risk-free profit flows (Lister 2008: 199).

This chapter tried to have a brief outlook on the NHS with particular emphasis on its organizational and financial set-up and related reforms so far. What have been covered here regarding the NHS's way of reforming itself will provide the necessary background for the later analysis which will elaborate on the common points between the NHS (and its reforms) and the system that has been pursued in Turkey by the HTP.

PART II TRANSFORMATION OF THE HEALTH CARE SYSTEM IN TURKEY

CHAPTER 7

HEALTH CARE SYSTEM IN TURKEY

In this section Turkish Health Care System will be briefly explained with particular emphasis on its way of organization and finance.

An attempt will be made to explain the Turkish Health Care System within the framework presented above for classifying health care models to see which model best explains the Turkish system? Or do we need to extract out a hybrid model to explain this system?

Before doing that, development and evolution of the present system will be briefly analyzed in order to provide the background which will help in understanding the reforms being undertaken today. In so doing this study will try to relate the developments/changes in health care services to the political and socio-economic context of the era and attempt at a periodization in this regard.

Although it is the recent Health Transformation Program (HTP) (Sağlıkta Dönüşüm Programı) which foresees the most radical transformation so far, health care reform has always been on the agenda of the previous governments. Therefore reforms that have been realized/proposed before the HTP will be analyzed within the context of the aforementioned periodization. In this regard the general political and socio-economic conjuncture of the era and the relevant documents issued will be covered.

This chapter will end with a profound analysis of the Health Transformation Program which has been on its way since 2003.

7.1 Development and Reform of the Health Care System and Health Policies in Turkey

Health Transformation Program (HTP) puts forward a periodization for the development of the health care system and health policies in Turkey (HTP: 8-10)[42]. Here this periodization will be adopted; however, the periods will be named according to their most significant characteristics.

1920- 1938 Period: Foundation of the Republic and the Turkish Health Care System

This is the Early Republican Era in which health policy and the national health care system started to be formulated and founded where many institutions including the Ministry of Health were established and many legislations- many of which still exist today- were enacted.

Besides aiming at solving the health care problems of the new-born Republic such as combating communicable disease, this period is mainly characterized by the efforts to organize the health care system starting from the center towards the villages and to spread and consolidate preventive health services.

Institutions such as Central Hygiene Institute and School, Dispensaries (Dispanser), Health Centers (Sağlık Merkezi) and Health Houses (Sağlık Ocağı) and legislations such as Law on Legal Medicine, Law on Pharmaceuticals, Law on General Hygiene, Law on Officers and Establishment of the Ministry of Health and Social Aid and Law on Practice of Medicine and its Branches were all the end products of this period which are still the basic components of the health care system in Turkey.

[42] Due to very frequent use of the Health Transformation (HTP) document, in this chapter reference to the HTP will be made as (HTP: page no) instead of (Sağlık Bakanlığı 2003: page no).

1938- 1960 Period: Strengthening Central Institutions and Development of Socialized Policies

Main developments of this period can be summarized as follows:

Vertically-structured organizations focused on specific communicable diseases which had become widespread right after the Second World War were established.

In 1945 Labor Insurance Institution (İşçi Sigortaları Kurumu) - the ancestor of the Social Security Institution (Sosyal Sigortalar Kurumu) - was established and this ended the monopoly of the Ministry of Health in health care services and employment in health sector.

Steps were taken towards the establishment of the Pension Fund (Emekli Sandığı) and towards expanding the coverage of social security.

Hospital services that had been performed by Local Governments such as Provincial Local Governments were transferred to the Ministry of Health, pointing to a sort of centralization in health care services.

Institutions that would be performing on regional basis were established- e.g. Regional Model Hospitals (Bölge Numune Hastaneleri), Regional Maternal, Children, Tuberculosis and Mental Health Care Hospitals.

Starting from the village level, the number of Health Houses (Sağlık Ocağı) was increased.

Many legislations were enacted which are still in action today- e.g. Law on Turkish Medical Association, Law on Turkish Pharmacists' Association, Law on Pharmacists and Pharmacies and Law on Nursery.

1961- 1980 Period: *Socialization of Health Care Services*

One of the most prominent developments of this period was the Law on the Socialization of Health Care Services (Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun - Law Number 224) which was enacted in 1961 and started to be implemented by 1963. Health policies had been shaped within this context until 1980.

Before analyzing important aspects of this Law, it should be noted that steps taken towards the socialization of health care services in this period was directly related to the new Constitution adopted in 1961. This new Constitution did have strong clauses on social and economic life. It declared health as a right and it made the state directly responsible for providing the citizens with physical and mental health and with the necessary health care they require (Article 49)[43].

In addition to this, social security was also declared as a right for the citizens of the Republic. In this regard the state was held responsible for the foundation of social insurance and social aid institutions (Article 48)[44].

As it is clear from its title, Law no 224 aimed at socialization of health care services in Turkey. Socialization of health services basically refers to a system in which the service user is not asked to pay anything at the point of service provision as there is already a fund designed for those expenditures[45].

When one looks at the Law on the Socialization of Health Care Services, it is seen that it mainly aims at the financial and organizational aspects of the health care system. As it has been mentioned in various parts of this dissertation, these are also the two core axes that the present HTP concentrates on.

Regarding financial clauses, the Law foresees a mixed model in which premiums paid by the citizens, budget allocations to relevant institutions and out-of-pocket

[43] TBMM (2010a)
[44] ibid.
[45] Türk Tabipleri Birliği (2010)

payments all have their share. In addition to that, once they pay the required fee, patients are allowed to choose the practitioner/health care institution they want to apply within the socialization area. Citizens who apply to the Health Houses that they are registered get health care services for free. Finally it is declared that Practitioners who are not engaged with the socialization program are free to work in the sector[46].

When it comes to the organizational aspect, the Law dictates the adoption of the following[47]:

Full Time (Whole – Day) Practice for health care personnel (Tam Gün Uygulaması), Chain of Referral (Kademeli Sevk Zinciri Uygulaması), Integrated Health Care Services (Entegre Sağlık Hizmetleri), Health Services Proportionate to Population (Nüfusa Orantılı Hizmet), Continuous Education for health personnel, Building the necessary infrastructure, Foundation of higher Boards for Planning and Evaluation (Planlama ve Değerlendirme Üst Kurulları), Participation, Employment of personnel on Contract- Basis (Sözleşmeli Personel İstihdamı)., Inter-sectoral Cooperation.

As it will be seen later, most of the aspects aimed at by this Law have also been elaborated on in the recent Health Transformation Program (HTP), although they might have different objectives.

At this point it should be noted that Dr. Nusret Fişek, designer of the Law and the then Undersecretary of Health was highly impressed by the English and Swedish Health Systems, which are grouped under the Beveridge Model[48]. It is also worth noting that the Law is accepted to be compatible with the criteria set by international documents on health care[49]- namely the Alma Ata Declaration of 1978- which formulates the international criteria for basic health care services and the WHO's Health for All Initiative which aims at achieving equity, community participation,

[46] ibid.
[47] ibid.
[48] ibid
[49] ibid

inter-sectoral collaboration and sustainable development[50] in health care systems by the year 2000.

It was only in 1983 that the whole country could be covered under the socialization project. Nevertheless attempts made by the Law No. 224 towards socialization of health care services did not prove to be successful- which is also a point emphasized in the HTP (HTP 2003: 10). This failure in full implementation of the Socialization Law has various causes behind, among which the lack of political will, lack of necessary personnel qualified in socialization issues, lack of necessary infrastructure and objections coming from practitioners could be mentioned[51].

Besides the legislation of the Law 224, discussions on Universal Coverage and adoption of Universal Health Insurance (Genel Sağlık Sigortası) also emerged in this period. It was in 1967 that the first draft law on Universal Health Insurance was prepared. However it could not make its way to the Council of Ministers. The issue found itself a place in the Second 5-Year Plan and two law proposals were submitted to the General National Assembly in 1971 and 1974. However neither of them could turn into legislation (HTP 2003: 10).

It is also in this period that Turkey started its planned era with the launch of the Five -Year Development Plans. Starting from the 1st Five-Year Development Plan (1963-1967 period) health sector and social security have always been among the topics that have been highly elaborated on in these plans. When one looks at these Plans it is seen that both the problems and the relevant reform suggestions regarding these two areas have more or less been repeated in the same way in the consecutive plans up until the last plan and the recent HTP which is the final document aiming at realizing those issues mentioned so far. Universal coverage, health care system organized in stages, chain of referral system, balanced and equal distribution of health care services throughout the country, and many other aspects have been elaborated on in these plans so far[52].

[50] Health for All Network (2010)
[51] Türk Tabipleri Birliği (2010)
[52] DPT (2010)

1980-2000 Period: Neoliberal Restructuring of the State and Attempts to Transform the Health Care System to this End

It is in this period that Turkey has started to experience neoliberal restructuring in many parts of its public sector where health was not an exception but on the contrary the one which has become one of the most central sectors in this regard.

The first attempt towards this neoliberal restructuring can be observed in the conceptualization put forward by the 1982 Constitution. While 1961 Constitution clearly defined health as a right within the direct responsibility of the state, 1982 Constitution foresees a more regulatory and a less servant role for the state in health care services.

Without mentioning health care as a fundamental right, Article 56 of the 1982 Constitution mentions that the state would plan and regulate the provision of health care services throughout the country. The article reads that the state would undertake this duty by making use of the health care institutions functioning both in the public and private sector. Finally it is also stated that in order to make health care services widespread Universal Health Insurance can be adopted by enacting the necessary legislation[53].

In addition to this, Article 60 of the same Constitution declares that everyone has the right to social security and that it is the state which would take the necessary precautions and establish the necessary institutions to this end[54]. Moreover 1982 Constitution (Article 61) also mentions those groups who would be under special protection in terms of social security needs such as the veterans and their families, the disabled, elderly people and the children in need of care[55].

Developments in health sector in late 1980s and 1990s can be listed as follows (HTP 2003: 10):

[53] TBMM (2010b)
[54] ibid.
[55] ibid.

In 1987 Universal Health Insurance re-appeared on the political agenda but could not be realized.

In the same year Basic Law on Health Services (Sağlık Hizmetleri Temel Kanunu) was issued however necessary arrangements for its implementation could not be achieved so far. Although it did not find the chance to be implemented, this Law could be considered as the first concrete attempt towards transforming the health care system in Turkey after the adoption of the 1982 Constitution. The Law foresees a Ministry of Health which is left with planning and coordination duties, provides patients with the choice of practitioners, turns public health care institutions into enterprises working on the basis of managerial principles and having legal personality, charges fees for curative health care services provided in these enterprises and allows employment of health personnel on contractual basis[56].

The 5th Five-Year Development Plan in fact implied the neoliberal restructuring of health care services starting from the 1980s on. In this plan it was declared that health care institutions would be approached from a managerialist perspective in order to increase their efficiency, establishment of private hospitals would be encouraged, doctors working on their own would be contacted more for the provision of health care services and that public sector and social security institutions would make less effort for establishing their own institutions for the provision of health care services (Yenimahalleli-Yaşar 2008: 160).

Yenimahalleli-Yaşar (2008: 159-160) quotes the following developments in the 1980-1990 period as the main steps taken towards neoliberal restructuring in health care system: investments to be made in health care were taken within the context of incentives which in the end provided the channeling of public resources to the private sector; Law on Whole- Day Practice of Health Personnel (Tam Gün Yasası) was amended whereby its clauses on salaries and financial liabilities were annulled while keeping clauses on longer working hours and 4-year compulsory service intact; competences attributed to Medical Association and other related chambers were narrowed down; social services were separated from the Ministry of Health; doctors

[56] Sağlık Bakanlığı (2010)

were given the authority to serve in their private places besides their employment in public hospitals; people covered by social security were also made to pay certain amounts of money for their pharmaceutical expenses.

It was in 1987 that the Basic Law on Health Services (Sağlık Hizmetleri Temel Kanunu) was enacted. The Law emphasized that health care institutions serving in the public sector could be turned into health care enterprises working on the basis of managerial principles and that doctors employed by the state could work in private enterprises at the same time. Moreover it allowed the health care institutions to employ their personnel on contractual basis. (Yenimahalleli-Yaşar 2008: 160). According to the author this Law reflects quite explicitly the neoliberal perspective which started to characterize health care services in this period. However it should be noted that upon the annulment of many of its clauses by the Constitutional Court this Law could not find the chance to be implemented.

When it comes to 1990s neoliberal restructuring in health care system became more intensified. It was in 1990 that General Coordination Unit for Health Projects (Sağlık Projesi Genel Koordinatörlüğü) was established within the Ministry of Health in order to carry out World Bank Projects regarding the Turkish Health Care System (Yenimahalleli-Yaşar 2008: 161). It is known that the policy reform approach of the WB had strong orientations towards privatization in issuing its credits for these projects. In addition to that decentralization which implies more autonomization of health care institutions and utilization of various financial resources were also adopted by the WB projects (Yenimahalleli-Yaşar 2008: 161).

In addition to these in 1990 State Planning Organization (DPT) prepared a Masters Plan on Health Sector. In line with this plan the First National Health Congress was held in 1992 which launched a new restructuring process in this sector. The following year Second National Health Congress was held where National Health Policies were adopted (HTP 2003: 10)[57].

[57] It was not possible for us to reach any documents/reports on these two congresses or on the Master Plan or National Health Policy mentioned. However HTP mentions that although several arrangements were attempted in line with the decisions made in the Second National Health Congress,

In 1993 in order to make them able to reach health care services, poor people without any social security coverage were granted Green Cards- a system which survived through 1990s and 2000s and is also included within the recent HTP.

All in all while analyzing the developments of 1980s, HTP declares that those were the years where the socialization policies launched in 1960s were attempted to be made widespread (HTP 2003: 10). However it is also a commonly-held view that with the adoption of neoliberal policies, these years were characterized by policies and arrangements directed towards privatization rather than socialization not only in health care services but also in all social sectors[58].

It is also interesting to observe the change in the suggestions made for the reform of the health care system in the Five-Year Development Plans in this period- which could also be analyzed within the context of the neoliberal restructuring of the public sector in Turkey. In this regard it is seen that privatization, managerialism, administratively and financially autonomous health care institutions competing with each other, separating financial and provisional aspects of health care services (provider/purchaser split), cost-based pricing, limiting the role of the central administration, user-payments (out-of pocket payments) for secondary care emerged as the core aspects of the suggestions made for reforming the health care system starting from the 5th Five-Year Development Plan (1985-1989 Period)[59]. As it will be seen in the following section these are also the central components of the HTP.

2003- Today: Launch of the Most Radical Transformation Attempt in Health Care System: Health Transformation Program (HTP) (Sağlıkta Dönüşüm Programı)

Health Transformation Programme will be analyzed in its detail in this chapter. However before passing to that it would be useful to have a look at the pre-HTP situation in the Turkish health care system- particularly to its organizational and financial set-up.

---

they could not have been successful. In this regard it underlines the failures in the attempts made towards making hospitals autonomous entities and towards their privatisation (HTP 2003: 10).

[58] Türk Tabipleri Birliği (2010)

[59] DPT (2010)

7.2 Organization of Health Care System in Turkey: A Brief Overview of the Pre-HTP Situation

Before putting forward its main tenets, Health Transformation Program (HTP) makes the following observations about the organizational set-up of the health care services in Turkey in the pre-HTP period (HTP 2003: 14-18):

-Health sector is complicated embodying institutions of different types where strategic administration is a serious deficiency.

-Hospitals run by different institutions, such as the Ministry of Health, the Social Security Institution (as one of the first steps of the HTP, these hospitals are now run by the Ministry of Health), universities, various public institutions and private hospitals serve in the health sector. Nevertheless these hospitals lack effective coordination among themselves and this causes ineffective use of national resources.

-The Pension Fund (Emekli Sandığı), the Social Security Organization for the Self-Employed (Bağ-Kur) and Social Security Institution (SSK) serve only for their members and this also causes inefficiency in the overall system. (As another step taken within the context of the HTP, now it is the Social Security Institution (SGK) which embodies these three social security institutions and at least theoretically now every citizen has the right to apply to any of the hospitals functioning within the context of the newly-established Social Security Institution, however various differences in terms of practical procedures).

-Primary care is not as effective as it should be that health houses (sağlık ocakları) do not function properly in rural areas and they are not widespread enough in urban areas- particularly in metropolitan areas. In addition to that other primary care level institutions such as Family Planning and Mother&Child Health Care Centers do not function properly.

-It is necessary to have an effective chain of referral system in order to decrease the cost of the services provided and to increase their quality.

-Health care system is organized on a highly-centralized basis where planning, organizational set-up and control mechanisms are all directed from the center and where the primary and secondary level health care services are organized vertically. Although this centralized organizational set-up has proved to be successful in the provision of the health care services nation-wide, it has various drawbacks such as causing inefficiency and making the system vulnerable to manipulations that might come from the center.

As it can be seen HTP is highly critical of the centralized structure within the health care system in general and in the individual hospitals in particular and implies having administratively and financially autonomous hospitals competing with each other.

-Lack of the notion of managerialism in the administration of the hospitals causes various problems such as inefficiency and political manipulations in health care provision.

Again it is clear that HTP highly emphasizes the necessity to inject the idea of managerialism into the health care system. It elaborates on the need to separate health care administration from health care management and to embody elements of managerialism within the health care system such as having health care personnel on contractual basis.

-Having responsibilities regarding planning, service provision and financing at the same time makes the Ministry of Health get into contradictory positions. On the one hand the Ministry provides health care services, on the other hand it plans these services and sets the standards to which they should conform. In addition to these with the schemes such as the Green Card the Ministry also undertakes the responsibility for financing these services which in the end causes contradictory positions for this institution. Its involvement in direct service provision makes the Ministry become rather ineffective in undertaking its duties regarding policy development, standard-setting and directing the health sector as a whole.

Here it is possible to see that HTP implies the necessity to create an internal market within the health care system with its provider/purchaser split which has been the case in the UK since 1990s. In fact this has started to be practiced in Turkey with the establishment of the Social Security Institution as the financer of the health care services vis-à-vis the Ministry of Health as the provider of the services- along which also private institutions take their place as other providers. In the same vein it is also possible to see that HTP implies having a Ministry which concentrates on policy-making, planning, standard-setting and control rather than direct provision of services- which steers rather than rows in accordance with what the public management doctrine mandates. When this would be the case it is not difficult to predict that in the long-run there would be an increase in the provision of health care services by the private sector which would be purchased by the financing agency.

-Information systems used in health sector (e.g. health records of individuals) are not as efficient as they should be where the ones used by the Ministry of Health do not serve the whole system but only for its own institutions.

-Many problems have been experienced regarding human resources in health care sector- in terms of quantity, qualifications and their dispersal across the country.

7.3 Finance of Health Care System in Turkey: A Brief Overview of the Pre-HTP Situation

Health Transformation Program (HTP) makes the following observations on the state of health care finance in the pre-HTP period (HTP 2003: 14-16):

-In the absence of Universal Coverage (General Health Insurance) applying to every individual in the country, different insurance institutions serve along different regimes. (Now these different social security institutions have been merged under the Social Security Institution).

-Health care services are financed through three main resources: general budget, social security institutions and payments by individuals. In Turkey it is the public finance which plays the major role in health care finance.

-It is declared that health care financing and the provision of health care services have been undertaken largely by the state. In line with its general attitude towards the separation of service provision and finance which has been touched upon in the above section, here HTP re-implies that these two functions should be separated because in the face of increased demand the state transfers far more resources to this sector and the use of these resources cannot be controlled due to the complex structures and procedures of the public finance mechanisms, which in the end increases the burden over the general budget and causes deficits.

-However HTP also mentions that the share allocated from the GNP to health care expenditures is not at the ratio that it should be and that there has been a decrease in the proportion of the budget of the Ministry of Health to the general budget from 1960 to 2002 (HTP 2003: 17).

-As it has been declared by the HTP itself, since there is not yet a regular System of National Health Accounts in Turkey, it is not possible to get at correct information and figures on the shares of different resources within the overall health care finance[60].

In the same vein it is not possible to determine the exact number of insured people and thus it is not possible to calculate the cost of health care expenditure per person. In the end all these deficiencies make it quite difficult to have proper projections and plans for the future.

[60] Data for health statistics are obtained from the administrative records kept by the Ministry of Health, from the researches conducted by the same Ministry and the Research on Population and Health in Turkey (Türkiye Nüfus ve Sağlık Araştırması) conducted every 5 year. Statistics Institution of Turkey has declared that it is necessary to set up a System of National Health Accounts for Turkey in line with the OECD Health Accounts System. Until then it would be the Statistics Institution which would carry out the duty of calculating health care expenditures for the year 2010 (TÜİK 2010).

-Although it is not possible to calculate the exact amount of out-of-pocket payments, it is estimated that the rate is above the one that has been hit by all of the OECD countries-approximately reaching 50%.

-Resources allocated to health care services in Turkey are below the OECD countries when compared proportionally. Due to lack of coordination these resources are used inefficiently.

At this point it would be quite useful to have a look at the figures available regarding certain aspects of health care finance in Turkey:

According to OECD statistics total expenditure on health has increased in the last decade in Turkey. While in the year 2000 total health spending accounted for 4.9 % of GDP, it was 5.4 % in year 2004. When it comes to the year 2007 it was measured as 6 %, which was however still below the 2008 OECD average of 9 %.[61]

When it comes to total health expenditure per capita (including public and private spending) there occurred an increase since the year 2000. In the year 2000 total health expenditure per capita was 433 $. It increased to 520 $ in the year 2004 and to 767 $ in the year 2007. Nevertheless Turkey has the lowest health spending per capita among the OECD countries where the average was 3060 $ in the year 2008. Here it should also be noted that Turkey has the lowest GDP per capita among the OECD countries.[62]

As is the case in all OECD countries (except the USA and Mexico), public sector continues to be the main source of health funding in Turkey. Although there occurred an increase in the share of public expenditures within the total expenditure on health care from 2000 to 2003 (62.9 % in the year 2000 and 71.9 % in the year 2003) it started to decrease in the rest of the decade. In the year 2007 it was measured 67.8 %, which was again below the 2008 OECD average of 72.8 %.[63] (This might be taken as

[61] OECD (2011a); OECD (2010)
[62] ibid.
[63] OECD (2010)

an implicit indicator pointing to the rise of the share of private funding in health care services.)

Regarding public health expenditure per capita it is seen that there occurred a serious increase in the last 10 years. While public health expenditure per capita was 272 $ in the year 2000, exhibiting a continuous rise in the following years- particularly after the year 2004- it reached 520 $ in the year 2007.[64]

Another point worth noting is that out-of-pocket payments per capita have increased from the year 2004 onwards. While it was 82 $ in the year 2004, with a continuous rise it has reached 167 $ in the year 2007.[65]

All in all it can be clearly said that there has been an increase in health care expenditures in Turkey. As has been mentioned above, this has been the case for the majority of the countries all over the world, which in fact has been the main motive behind the recent attempts towards reforming health care systems.

When it comes to the share the Ministry of Health gets from the general budget in Turkey, HTP declares that there has been a decrease from 1990 until 2002. While the share of the budget of the Ministry of Health was about 4 % of the general budget in 1990 it was recorded as 2.25 % in 2002 (HTP, 2003: 17). However, it can be said that since 2004 there has been some increase in this ratio. Finally it has been declared that the ratio will be 4.40 % in the 2011 budget[66].

Although there has been an increase in the share that the Ministry of Health gets from the general budget in the recent years it is widely accepted that this is not sufficient and that this ratio ranks Turkey far below the European countries[67].

Therefore it would not be wrong to get at the following conclusion: in the face of highly-increasing health care expenditures the share allocated from the general

[64] ibid.
[65] ibid.
[66] Document obtained from the Ministry of Health Department of Strategy Development.
[67] Türkiye Gazetesi (2004)

budget to the Ministry of Health is not sufficient, which points to the fact that public investments in health care is quite below the required level[68]. However it is observed that there has been serious increase in the private investments in health care where the most striking data would be the dramatic increase in the number of private hospitals in Turkey. General Secretary of the Turkish Medical Association reported that there has been a 26 % increase in the number of private hospitals within two years[69].

In the same vein another important point that has been noted above can be recalled: that there has been a serious increase in the amount of the resources allocated from the public resources to the private actors operating in the health sector[70]. It would not be wrong to forecast that this trend of the public sector towards buying health care services from the private sector would increase more with the establishment and consolidation of the provider/purchaser split. The initial steps of this system have been made by the establishment of the Social Security Institution (SSI) which now operates as the purchasing body where the Ministry of Health has taken its mere place among its private counterparts as one of the providers of health care services.

A final remark could be that the state's taking its hands off the health sector has also been backed by the increase in the out-of-pocket payments and by the adoption of the Universal Health Insurance with which it has been made compulsory for the citizens to pay certain amounts of premiums and thus be active participants in the finance of the health care system in Turkey.

At the end of this section, right before going deep into a detailed analysis of the HTP, to put forward a brief definition for the Turkish health care system in the pre-HTP period in the light of the information derived about types of health care systems so far, the following statements can be made: In the pre-HTP period, health care system in Turkey could be defined as a hybrid (mixed) system in which the Beveridge model had its weight besides the elements of Bismarckian (social security) model and at the

[68] "Türk Sağlık-Sen Raporu" quoted in Evrensel (2008).
[69] Tıp Dünyası (15.02.2009)
[70] President of İstanbul Chamber of Medicine reports that while the amount of resources allocated from the public funds to the private health care institutions was 503 million TL in the year 2002 it increased to 3 billion YTL in the year 2007 (Evrensel 2008).

least degree the liberal model. This was so as it was the public (sector) finance which bore the biggest share in health care finance which was followed by the social security system and to the least extent by the private sector.

Now it's time to analyze what HTP brings about for the organizational and financial set-up within the Turkish health care system. This is what will be attempted in the following section.

7.4 Health Transformation Program (HTP)[71]

After putting down the present situation and the problems experienced by the health care system in the pre-HTP period, HTP states that solution is possible through adopting a comprehensive approach in which every component will be related to each other in a systematic manner (HTP 2003: 32).

It also dictates that it is necessary to adopt "project logic" in determining the sequence to be followed while solving these problems and to relate them to each other. It is stated that the government is dedicated to take the health sector as a whole and to solve the existing problems one by one by HTP (HTP 2003: 32).

As it can be guessed it's the HTP itself which is put forward as the overall solution to all these problems together with the tools it provides to attain the solutions.

In this section besides making a detailed analysis of what the HTP brings about to the health care system two related topics- namely the general characteristics of the transformation/reform and the general socio-economic and political context (i.e. international and national dynamics) for the emergence of the HTP will also be covered.

[71] (Sağlıkta Dönüşüm Programı)

7.4.1 "Transformation" or "Reform"?

In HTP it is stated that the government does not call it a "reform" but a "transformation" due to the following reasons (HTP 2003: 24):

1. Because they are aware of the fact that they do not put forward a completely different idea than the previous ones.
2. Because those attempts made so far with the banner of "reform" have had a negative impact on the public in general due to their failure in realizing what they foresaw.
3. Because it is not realistic to totally end the present system and shift to a completely new one.

HTP points out that the word "transformation" has a sense of meaning which is more modest than the one the word "reform" implies and that it is the word "transformation" which better reflects what is aimed by this last project launched.

However when one looks these two words up in the dictionary it is seen that the situation is totally the reverse. That is to say the word "transformation" has a rather ambitious meaning than the word reform[72]. Nevertheless it can be argued that this reflects the real situation – i.e., what the HTP has been doing so far is quite ambitious than the attempts made to this date to change (or to say "reform") the system and (though contrary to their argument) the word transformation better reflects this rather serious change than the word "reform".

Here it should also be noted that use of this terminology (i.e. the use of the word "transformation" to denote these recent changes within the health sector in Turkey)

[72] Reform: 1. the improvement or amendment of what is wrong, corrupt, unsatisfactory, etc. 2. to change to a better state, form, etc.; improve by alteration, substitution, abolition, etc.3. correction, reformation, betterment, amelioration. 4**.** better, rectify, correct, amend, emend, ameliorate, repair, restore (Dictionary.com, 2009a).
Transform: 1. to change in form, appearance, or structure; metamorphose.2. to change in condition, nature, or character; convert 3. to change into another substance; transmute. 4. to undergo a change in form, appearance, or character; become transformed. 5. to change one thing into another. 6. TRANSFORM suggests changing from one form, appearance, structure, or type to another (Dictionary.com, 2009b).

also contradicts with the incremental approach that the HTP says to adhere (HTP 2003:8).

7.4.2 General (National and International) Socio-Economic and Political Context for the emergence of HTP

It is known that until the HTP was launched in 2003 not much could have been achieved by the reform attempts made in the health care system within the context of the neoliberal restructuring of the public sector. Therefore the question of why it could have become possible to launch this transformation in 2003 comes to one's mind. In order to answer this question it would be useful to have a look at the international and national dynamics which paved the way for the emergence of and the practice of the HTP in this period.

7.4.2.1 International Dynamics

HTP declares that it will take into consideration the WHO policy "Health for All by the Year 2000", basic documents issued within the context of the EU Accession process and other relevant international practices (HTP 2003: 26). In this regard HTP stressed the importance of creating mechanisms in order to benefit from the experiences of organizations such as the World Health Organization or from the experiences of scientists and experts dealing with health issues worldwide in order to catch up with the developments taking place in the international arena which implicitly refers benefiting from epistemic communities available in the course of the HTP (HTP 2003: 38).

7.4.2.1.1 Effects of the EU Accession Process on HTP

HTP highly refers to the EU Accession process in formulating its agenda for reform. In this regard Council Decision on the Accession Partnership with the Republic of Turkey[73] (Katılım Ortaklığı Belgesi) and Turkey's National Program are mentioned

[73] Full name of the document is: Council Decision of 18 February 2008 on the Principles, Priorities and Conditions Contained in the Accession Partnership with the Republic of Turkey (ABGS 2011).

(HTP 2003: 26). In addition to these, adaptation of the Turkish health legislation to the European health legislation, defining duties, authorities and responsibilities of professionals working in the health sector in line with the requirements of the accession process and effective use of the funds supplied by the European Commission are highlighted (HTP 2003: 26, 33, 38).

Before going deep into these documents it would be useful to understand how health issues are taken within the EU context:

First of all the Community does not have common health policy that "each EU country is free to decide on health policies"[74] of their own[75]. However, although harmonization of health policies has not been realized so far, the EU has already issued various directives on issues such as having common standards on food safety and nutrition labeling, on safety of medical equipment, blood products and organs, quality of air and water. In addition to these the Union allocates funds for improving health security, reducing inequalities, providing information on health, safe consumption of alcohol, combating consumption of tobacco and drugs, preventing major diseases and pandemic threats and health research. In addition to these with the free movement principle it is stated that in certain conditions EU citizens would be able to get treatment in any EU country that they chose even when they are not on holiday[76].

Health policy is not counted as a policy area of the EU. That is to say EU does not have direct effect on health care systems of the member countries. Rather the EU has been taking indirect action on health issues - which are usually taken within the contexts of "Public Health", "Consumer Protection", "Food Safety", "Environment (air and water quality)" and "Working Conditions and Safety at Work".

Nevertheless it should be noted there are those authors who claim that the EU has been pressing for "collaboration among member states" at the EU level regarding

[74] EUROPA (2011)
[75] Article 152 of the Treaty on European Union and the Treaty Establishing the European Community (EUR-Lex 2006)
[76] EUROPA (2011)

health care services and tries to extend Open Method of Coordination (OMC) to health care and long- term care and to support patient mobility within the EU (Maino et al. 2007: 137). According to Maino et al., by adopting several Communications[77] in this direction, the Commission has put forward the signs of "an overall strategy to develop a shared vision for European Health Care Systems" (Maino et al., 2007: 137). In addition to this Koivusalo et al. also argues that "the European legal sphere is expected to matter more in light of Services Directive and work in the context of services of general interest"[78] (Koivusalo et al. 2007: 197). In line with Maino et al., Koivusalo et al. also argue that "EU has brought in decentralization as a means to improve the effectiveness of health care systems in the context of future cooperation and for the use of open method of coordination (OMC) in the field of health services" (Koivusalo et al. 2007: 194).

All in all it can be said that being an issue of re-regulatory policy area of positive integration rather than the more popular and easier de-regulatory policy area of negative integration, health has been started to be discussed within the context of the recent OMC tool[79]. However as has been the case with the other positive integration issues which entails more distributional aspects (such as social policy) EU has been

[77] European Commission (2004c) *Communication from the Commission: follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union*, COM (2004) 301 final. Brussels, European Commission.

European Commission (2004b) *Communication from the Commission: modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination"*, COM (2004) 304 final. Brussels, European Commission.

[78] European Commission (2001) *The Internal Market and Health Services: Report of the High Level Committee on Health.* 17 December. Brussels, European Commission.

Eurpean Commission (2003) *Green Paper on on Services of General Interest.* 21 May 2003. COM. Final. Brussels, European Commission.

European Commission (2004a) *Proposal for a Directive of the European Parliament and of the Council on Services in the Internal Market.* COM 2004.2. Final. 13 January 2004. Brussels, European Commission.

European Commission (2004b) Communication from the Commission - *Modernising Social Protection for the Development of High-Quality, Accessible and Sustainable Health Care and long-term Care: Support for the National Strategies Using the "Open Method of Coordination"*. COM 2003.304. Final. Brussels, European Commission.

[79] For more information on de-regulatory and re-regulatory policy areas and OMC in the EU refer to Hix (2005).

rather reluctant to have effective harmonization and has left member states free to adopt their own policies.

In the Accession Partnership document[80] health was taken under the title of "Consumer and Health Protection" where mere reference was made to further alignment of the acquis in the areas of blood, tissues, cells and tobacco and ensuring enforcement capacity, improvement of general level of health and development of community-based services in the area of mental health were underlined.

When it comes to the National Programs, the National Program of 2001 refers to the issues of Health Protection and Consumer Protection, Public Health, Work Safety, Environment (air quality, water quality, waste disposal) and medical and para-medical activities related to free movement of individuals. However regarding alignment of the Turkish legislation and practices with that of the EU, in general the document says that there is need for further work to collect data and analyze these topics[81].

A more or less similar approach was adopted in the National Program of 2003 where health issues were merely touched upon in their relation to Environment and Consumer Health Protection[82]. The same outlook was adopted in the document issued by the Ministry of Health in the year 2003 which was titled "the National Health Program of Turkey in its Alignment with the EU Acquis"[83].

National Program of 2008 did also follow the same route where health was taken within the context of Food Safety, Environment and Consumer and Health protection[84]. However in this case under the title of Consumer and Health Protection rather detailed information was given on issues such as the regulation of tobacco and alcohol markets, organs, cells and tissues and on the activities of related institutions on these topics. Besides that the National Program of 2008 did also reflect upon the

[80] Council Decision of 18 February 2008 on the principles, priorities and conditions contained in the Accession Partnership with the Republic of Turkey and repealing Decision 2006/35/EC (ABGS 2011).
[81]Dışişleri Bakanlığı (2011)
[82]Avrupa Birliği Bakanlığı (2011a)
[83]National Health Program of Turkey in its Alignment with the EU Acquis-(Avrupa Birliği Müktesebatının Üstlenilmesine İlişkin Türkiye Ulusal Sağlık Programı) (Sağlık Bakanlığı, 2009).
[84] Avrupa Birliği Bakanlığı (2011b)

issue of the functionality of Public Administration under the title of political criteria where reforms that had been made (e.g. Ethical Board for Public Servants) and those that would be made (e.g. Institution for Public Auditing, re-organization of center-local relations through Municipal Law, Metropolitan Municipality Law, Law on Provincial Local Governments) in the realm of public administration were mentioned.

Finally it would not be wrong to say that although the EU accession has been a serious leitmotiv for many reform attempts in Turkey, compared to other international actors such as the OECD and the WB, the EU has not been that influential in shaping the HTP- no matter the accession process has been highly referred to in the HTP document itself. As it has been already underlined, the EU has not achieved any harmonization regarding health care systems and basic health policy matters. Its only impact might have been on the standards and criteria regarding public health issues[85] in the course of health care reforms in question.

7.4.2.1.2 WHO - Health for All by the Year 2000

Working within the United Nations System, World Health Organization (WHO) is "responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends."[86] In this regard documents issued by WHO has long been taken as a guiding many reform attempts not only in Turkey but also in many other countries.

"Health for All by the Year 2000" which was mentioned in the HTP was in fact the goal voiced in the Declaration of Alma-Ata which was issued at the end of the International Conference on Primary Health Care, held in Kazakhstan in 1978 with the participation of many countries and international organizations.

[85] In this regard reports such as "General Overview of the Public Health Sector in Turkey in 2006" issued by the European Parliament's Committee on the Environment, Public Health and Food Safety can be referred to (European Parliament, 2010).
[86] WHO (2011g)

Besides its assertion on taking health as a fundamental human right, holding governments responsible for the health of their people and reduction of the gap between the health status of developing and developed countries, the Declaration puts great emphasis on primary health care[87]. As it can be understood from the name of the conference itself, the ambitious goal of providing "health for all" would be attained through consolidation of primary level health care. In this regard HTP's stress on the realization of the Family Medicine System and strengthened primary health care can be recalled –as also one of the fundamental aims of health care reforms so far.

WHO is known to be an independent organization. However it has been argued that WHO has been playing its role in the consolidation of neoliberal health reforms where more market-oriented health care practices such as money following the patient, public-private partnerships, private finance and provision of health care services are praised by the WHO. In this regard particularly World Health Report 2000[88] which outlined a ranking of the performances of the health care systems of 191 countries is taken as a reference point for the arguments that WHO has been following market-oriented health reforms in line with the World Bank's approach (Lister 2008: 89-95).

Regarding health care reform in Turkey the following works by the WHO are worth mentioning here:

Country Cooperation Strategy which gives a brief picture of what has been going on in the health care system in Turkey so far and which puts forward a Strategic Agenda for 2004-2010 which supports basic components of the HTP such as enhancing the stewardship role of the Ministry of Health, strengthening primary care, emphasis on health financing, inter-sectoral advocacy and the like[89]. This document also refers to the importance of the World Bank-funded project to back HTP.

[87] WHO (2011f)
[88] The World Health Report 2000 – Health Systems: Improving Performance (WHO 2000).
[89]WHO (2011a)

National Health Accounts on Turkey[90], *Country Health Profile*[91], *Selected Basic Statistics*[92], and *Highlights on Health in Turkey*[93] are the documents issued by the WHO which basically contain statistics on selected health indicators and health status in Turkey.

In addition to these within the context of the series of work on Health Care Systems in Transition (HiTs) – as a collaborative work by European Observatory on Health Care Systems and Policies- *Health Care Systems in Transition (HiT) Turkey (2002)* was issued. This document provided an in depth analysis of the health care system in Turkey together with reform attempts made and those in progress.

Finally WHO has concluded *the Biennial Collaborative Agreement 2010 -2011*[94] which sets the priorities and objectives for collaboration for the period 2008-2013. The Agreement holds both the WHO/Europe and the Turkish government responsible for the achievement of the goals stated and for financial support where the latter would also be encouraged for fundraising to this end. The objectives to be achieved as set forth in the Agreement were quite compatible with those of the HTP where enhancing the stewardship role of the Ministry of Health, strengthening family medicine system and evidence-based policy making are worth mentioning here.

7.4.2.1.3 World Bank as an Actor in Health Care Reforms and Its impact on HTP

WB Projects in collaboration with the Ministry of Health in Turkey

Being one of the most influential actors of the post-war restructuring process, World Bank has been playing an important role in public sector reforms of the developing since 1980s. World Bank projects to attain restructuring of the public sector have been accompanied by the IMF's structural adjustment program directed towards developing countries.

[90]WHO (2011b)
[91]WHO (2011c)
[92]WHO (20111d)
[93]WHO (2006)
[94]WHO (2011e)

In 1990s World Bank did already become the institution allocating the greatest amount of funds to health sector activities and outscoring the WHO in this regard (Lister 2008: 56).

In 1987 WB issued the report titled *Financing Health Services in Developing Countries: An Agenda for Reform* in which minimal state intervention, market-oriented practices, privatization and user payment system were advocated (Lister 2008: 56). This report was followed by many other documents issued by the WB which were in line with the neoliberal restructuring of the health sector and thus seeking market-friendly solutions (Lister 2008: 56).

World Development Report 1993 – Investing in Health has been quite influential in developing countries in adjusting their health sectors[95]. Main highlights from this Report could be summarized as follows: (World Bank 1993: iii)

Governments in developing countries should *promote competition* in the delivery and financing of health care services. They should finance public health and essential clinical services and leave the rest to *private finance* which would be mediated through insurance or *social insurance* where government regulation should *encourage private insurance markets*. Even for publicly financed clinical services governments can *encourage competition* and *private sector involvement* in service supply and can help private sector improve its efficiency by providing key information.

In addition to these the Report elaborates on the adoption of *Essential (Minimum) Clinical Package* where governments would ensure access to a package of essential clinical services which would be determined through principle of cost-effectiveness, resources available and the size and distribution of health problems of the population rather than political considerations. In the Report it is argued that these measures would improve health outcomes, contain costs and enhance consumer satisfaction (World Bank 1993: 112). It is also argued that this Essential Clinical Package could

[95] World Bank (1993) World Development Report – Investing in Health.

only be affordable when accompanied by *user charges* together with the above mentioned measures directed towards private finance (World Bank 1993: 108).

It is clearly seen that what were proposed by the WB in its 1993 Report have been directing health sector reforms in developing countries and that these proposals have already taken their place in the HTP.

World Development Report 2004[96], in which health is taken as one of the services directly linked to human development and poverty, states that there is no single solution fitting all services in all countries. Besides that the report highlights the importance of "public responsibility" where the need for more public spending and reform of institutions are stressed for the improvement of services. In this regard both market failures and government failures are emphasized in terms of health systems that have been in use so far.

However although the Report underlines the importance of public responsibility it is still the private spending that matters. Governments are deemed to be the active purchasers of health outcomes through strategic contracting. To this end benchmarking for performances, fostering autonomous providers for clinical services and establishing strong monitoring functions are put forward by the report for improved health care systems.

Finally the necessity to link sectoral reforms to the on-going or nascent public sector reforms in areas such as budget management, decentralization and public administration is emphasized.

Compared to the Report of 1993, this Report might seem to refer more to public responsibility. However it is still the private spending that matters and the government's purchasing these services from private providers is foreseen. Direct provision of health services by the public sector is limited to those areas in which the private sector does not have interest. This and various other fundamental approaches of the Report shows that the WB's policy towards health care systems and their

[96] World Bank (2004)

reforms in developing countries has not changed its direction but what happens might be that the WB tries to adapt the failed aspects of its previous reform packages to the requirements of the structural adjustments and restructuring today. In this regard it is also interesting that at the end of the section on health, the Report gives a brief analysis of the Cuban health system with praise to its reform and performance (Lister 2008: 68-71).

Among the international actors, HTP makes more reference to the EU accession. However in practice it is the World Bank and its counterpart in public sector reforms-the OECD which play more important roles in the realization of the transformation. These two agencies support the transformation process both financially and theoretically. This fact is also stated by the WHO which declares that "the World Bank is the main international agency contributing to health system reform" in Turkey[97].

Since 1990 Turkey and the World Bank started to undertake projects which aimed at improving the health care system in this country. In 1990 General Coordination Unit for Health Project (Sağlık Projesi Genel Koordinatörlüğü) was established within the Ministry of Health in order to carry out these projects where experts from WB became more influential compared to the bureaucrats of the Ministry in the preparation and undertaking of these projects (Yenimahalleli-Yaşar 2008: 161).

With the adoption of the HTP, in 2004, WB and the Government of the Republic of Turkey concluded the agreement for the issue of 49 million Euros credit for the "Health Transformation Project to Support Health Transformation Program"[98]. In order carry out this project, the Project Administration Support Unit (Proje Yönetim Destek Birimi) was established, which also replaced the previous General Coordination Unit for Health Project. This project is carried out by the Ministry of Health and the Social Security Institute and is designed to be carried out in two phases.

[97] WHO (2011a)
[98] Sağlıkta Dönüşüm Programına Destek Sağlıkta Dönüşüm Projesi- Sağlık Bakanlığı (2011a)

Phase I has 5 components:

C1. Re-organization of the Ministry of Health for better guidance
C2. Developing institutional capacity for Universal Health Insurance
C3. Re-organization the provision of health care services
C4. Enhancing public health services
C5. Project administration and Institutionalization of Health Education Centers.

With the issue of the credit in 2004 work project teams were established for each component and by 30 June 2009 Phase I has been concluded with the realization of the following:

C1.

1. Strategy Planning and Policy Development capacity of the Ministry of Health has been strengthened.
2. Draft Law was prepared for the establishment of the National Pharmaceuticals and Medical Devices Institute (Ulusal İlaç ve Tıbbi Cihaz Kurumu).
3. Framework for Performance Administration for Autonomous Health Agencies (Özerk Sağlık Tesislerinin Performans Yönetimi Çerçevesi) has been prepared.
4. Capacity Developed for the Practice, Monitoring and Evaluation of Health Reform (Sağlık Reformu Uygulaması ve İzleme ve Değerlendirme Kapasitesinin Kurulması).
5. Health Information System (Sağlık Bilgi Sistemi) has been established.

C2.

1. Capacity of the Social Security Institute has been enhanced
2. Social Security Information System (Sosyal Güvenlik Bilgi Sistemi) has been established.

C3.

1. Family Medicine System has been established.

2. Introduction to Autonomy in Public Hospitals (Devlet hastanelerinde Özerkliğe Giriş)
3. Raising Public Awareness and Communication
4. Public Health Programs have been enhanced.

C4.

1. Refik Saydam Institute has been strengthened.
2. School of Public Health has been strengthened.

C5.
Health Education Center has been established

Phase II of the Health Transformation Project, which would be carried out in the period 2009-2013, is said to be on its way to be concluded (now it is January 2011). The Loan Agreement for this phase has become effective as of September 2009 with a total of $ 75.1 millions[99].

Phase II is planned to have the following three components:

C1. Enhancing the Guidance, Service Provision and Public Health functions of the Ministry of Finance

C2. Designing Pilot projects for the realization of output-based financing in primary health care services

C3. Enhancing the capacity of the Social Security Institute

As it can be clearly seen, World Bank has been playing quite an active and an influential role in the transformation of the health care system in Turkey. Health Transformation Project which was initiated by the WB and the Republic of Turkey in

[99]World Bank (2011)

2004 with a prospect for the year 2013 clearly shows that HTP has been going parallel to the mandates of the project.

7.4.2.1.4 OECD, IMF and WTO as Actors in Health Care Reforms and their Impact on HTP

OECD defines its mission and working principles as follows:[100] Their basic mission is to promote policies that will improve the economic and social well-being of people around the world and to this end they share experiences, seek solutions to common problems, analyze and compare data to predict future trends, set international standards on all sorts of things and in the end recommend policies in that particular area of interest. In so doing they declare their shared commitment to market economies which imply that their policy recommendations would be directed by this commitment.

Health is listed among the major topics of interest to the OECD. In this regard the OECD not only issues detailed analysis and data on health status and health care systems of the member countries but it also makes international comparisons to attain convergence and compatibility among the health policies and health care systems of the member countries and issue recommendations on their reform of health care systems and support projects in this respect (Lister 2008: 79-80).

Among these documents the most famous ones are OECD Health Data issued annually, Health at a Glance (issued for different regions such as Europe or Asia/Pacific), OECD System of Health Accounts (by which the OECD tries to attain common denominators for data collection in OECD countries to make better comparisons)[101], Working Papers on Health, Environment, Safety and Technical issues. In addition to these OECD issues annual OECD Health Data for specific countries (e.g. OECD Health Data 2011 - How does Turkey Compare?) and detailed

[100] OECD (2011d)

[101] In this regard report on the implementation of A system of Health Accounts: Implementation-Turkey (OECD 2000: 5) was published upon the need for reliable and comparable statistics on health expenditure and finance among OECD countries (Kartal et al. 2004: 5).

analysis of health care systems of member countries (e.g. OECD Reviews of Health Systems- Turkey).

With all these activities, OECD plays an important role in health care reforms of its member countries and thus for the realization of the HTP in Turkey. To this end they participate in and support WB projects and various other activities of different epistemic communities.

Lister, who calls OECD as the "organizator of health care reformers" argues that works of OECD are far from being neutral that they advocate market-oriented reforms of the British type, curbing public expenditures on health care, supporting more role for the private sector and thus being somewhat biased in their ranking of the performances of health care systems (Lister 2008: 79-80).

IMF: IMF has been quite an influential actor in shaping neoliberal public reforms in developing countries within the context of structural adjustment programs. In this regard IMF has been highly interested in the health sectors and social security systems of these countries.

Turkey became a member of the IMF in 1947 and first stand-by agreement was signed in 1958. Since that date till late 2000s Turkey's economy and its political and social dynamics have been highly affected by the IMF directives.

IMF's insist on curbing public expenditures in Turkey has been reflected on health and social security expenditures. In this regard particularly starting from 2005, Letter of Intents submitted by the Turkish governments have made serious references to health care and social security reforms within the context of their requests for financial support from the IMF.

In order to understand the impact of the IMF on the recent HTP, it would be quite enlightening to have a brief look at these letters of intent[102]:

[102] TCMB (2011)

Letter of Intent of July 2002 stated that high expenses on pharmaceuticals would be diminished and that the Ministry of Health would realize its program for cheap purchase of drugs by the end of 2002.

Letter of Intent of April 2003 declares that the authority to make excess-payments for transfers to social security institutions and to make excess-expenditures within the context of Green Card procedures would be banned.

It is by the year 2005 that health care and social security reforms have started to take an important place within the Letter of Intents.

Letter of Intent of April 2005 declared that HTP and the Social Security Reforms are oriented towards long-term savings in the public finance. Moreover it stated that Universal Health Insurance would be accomplished by the year 2006. The Letter also underlined that steps towards decreasing expenses on drugs would continue to be taken and that a financial framework would be developed to keep health care expenditures under control. Moreover it is declared that a thorough review would be made over public sector employment and payment strategies.

Letter of Intent of November 2005 announced the adoption of the previously-mentioned framework for the control of health care expenditures. Moreover it declared that in order to have better control on health care expenditures Global Budget system would be adopted by public hospitals by which each public hospital would be expected to finance expenditures of their own patients through the global budgets which would be allocated to them at the beginning of each year. Also this global budget would also constitute the upper limit that social security institutions would be able to pay to public hospitals. Another point that the Latter of Intent of November 2005 mentioned was that social security institutions would be more empowered to have control and auditing mechanisms and that public hospitals would have more administrative authority. Finally the Letter declared that a re-organization was aimed in the collection of the social security premiums and that in case any excess expenditures on health care occurred in the period targeted additional precautions would be taken.

Letter of Intent of July 2006 stated that the following additional precautions would be taken in order to take health care expenditures under control: expenditures on pharmaceuticals would be made under more control, public hospitals would adopt the system of payment per case (vaka başına ödeme) and that necessary protocols would be signed to adopt the global budget system. It was declared that these precautions would provide serious savings. In addition to these the Letter declared that Family Medicine System and Chain of Referral System would be accomplished and that those services which were excluded from user charges would be limited to those people who are in real need. Finally again the intent to re-organize premium collection system was underlined.

Letter of Intent of November 2006 declared that in order to control health care expenditures, the Social Security Institution would be given the authority to change/regulate the amount of user charges in drugs and treatments it provided, performance-based payment system practiced in public hospitals would be improved and that the system of reimbursement in drugs would be re-organized.

Letter of Intent of 2007 put forward the following in order to take health expenditures under control: each public hospital would determine 3-month budget objectives, hospital receipts would be subject to more thorough control, hospitals would be introduced to new purchasing methods in their purchases of services and equipment, getting differentiated user charges would be made possible in primary, secondary and tertiary level for outpatient treatment (ayakta tedavi) and that Family Medicine System would be accomplished in more provinces by the end of the year 2007. Finally it was declared that if health care expenditures would excess the predetermined amounts, cuts would be made in other sections of the budget.

The Letter of Intent of 2008 mentioned the increase in health care expenditures-particularly those incurred in private hospitals. The Letter repeats the following precautions in order to control expenditures made on health care as such: public hospitals would have 3-month global budgets which would be rather tougher, differentiated user charges would be practiced soon and that Family Medicine System and the Chain of Referral System would accomplished.

As it can be seen it is quite possible to figure out the basic components of the HTP by following the Letters of Intent submitted to the IMF by the Turkish governments-particularly the post-2005 ones. This shows that IMF has been one of the most influential actors with which the Turkish governments have cooperated for the realization of the HTP.

***WTO*:** Although for the time being WTO does not have too much direct effect on health care reforms of countries in general it is worth mentioning here that liberalization in health care services and thus enabling foreign investors and traders to provide health care services have long been discussed within the WTO circles. Although due to its specific characteristics liberalization of health care services has been left to the voluntary intentions of the member countries the WTO often makes recommendations to these countries on how they could adopt the GATS regulations to health care services in their countries (Lister 2008: 80-81). As Lister argues when the great potential to benefit from the huge health services market for foreign traders is considered it is quite evident that liberalization in health care services would keep its place on the agenda of the WTO and particularly on that of affluent countries of multi-national corporations which would like to make the most of the this potential and of the huge funds allocated to health sector in many developing countries (Lister 2008: 81-82).

Regarding Turkey there has not been that radical attempt to apply GATS to health care services so far. Doctors, pharmacists, nurses, dentists, responsible directors of private hospitals and veterinarians are still the professions assigned only to Turkish citizens[103]. However foreigners are allowed to establish private hospitals with the permission of the Ministry of Health[104]. Following the argument by Lister developments in this regard are to be seen particularly when the size of the health care market and the amount of public funds allocated to this sector are taken into consideration.

[103] WTO (2011a)
[104] WTO (2011b)

It is seen that in fact all the international actors having a say in health care reforms are to a certain extent collaborating with each other and thus looking from the same perspective which is compatible with and thus still serving the requirements of the neoliberal restructuring process**.** To give a few concrete examples in this regard which have already been referred to above, in World Development Report of the WB it was stated that "WHO has been a full partner with the WB in preparing this report" (WB 1993: iii). In the same way in the Health Transformation Project conducted by the WB and the Ministry of Health of Turkey it is stated that HTP is a reform initiative designed to bring Turkey's health indicators in line with those of OECD countries[105]. Finally it is known that since 1960 the European Commission has been taking part in the works of the OECD where the representatives from the European Commission work with the OECD experts in the preparation of texts and participate in discussions on the OECD's work program and strategies, and are involved in the work of the entire Organization and its different bodies[106].

In their analysis of economic restructuring in the post- 2001 crisis era in Turkey, Öniş and Bakır argued that powerful international actors such as the IMF and the EU has been quite influential in pushing for institutional reforms in this country. In this regard they emphasized how effective they had been on helping domestic policy-makers in overriding the strong resistance on part of domestic interest groups, increasing credibility of these reforms through conditional agreements, providing public support for the reform processes and providing long-term improvements in the institutional capacities of the state (Öniş and Bakır 2007: 3-4). These analysis made by Öniş and Bakır for explaining the importance of the international actors in the adoption of the institutional reforms in stabilizing the economy can also be used to understand the role of international actors in the realization of the HTP.

As it can be clearly seen international dynamics have played important roles in the emergence, formulation and realization of the HTP. In fact besides its various national peculiarities this process has had many things in common with the health

[105] World Bank (2011)
[106] OECD (2011c)

care reform vawe which have been experienced by the majority of the countries all over the world in the last three decades. Here once more the convergence/divergence debate could be referred as both arguments are viable to a certain extent in health care reforms.

7.4.2.2 National Dynamics

The role of international actors and their impact on affecting domestic actors (policy-makers and other interest groups) in the realization of public sector reforms have been touched upon in the proceeding section. Nevertheless as Öniş and Bakır who highlighted the importance of the international actors did also underline the fact that it is not possible to fully rely on external actors in explaining the push for reforms (Öniş and Bakır 2007: 4).

First of all neoliberal restructuring of the state and the public sector since early 80s should be referred to as the general framework in understanding the transformation in health care system- which is in fact quite embedded with the international processes that have been analyzed in the previous section.

Within this general framework the following developments could be counted as the factors having paved the way to health care reform in Turkey:

Health care expenditures have risen dramatically in the recent years and taking them under control has been one of the main concerns of the governments not only in Turkey but also in all over the world. In fact this has been the most important factor behind the attempts to reform health care systems. In this regard developments in health technologies and pharmaceuticals industry and the parallel increase in the demand for more and advanced health care services and products could also be counted among the reasons which caused increase in health care expenditures. In short curbing increasing health care expenditures and having more efficiency in the provision of health care services have been the most crucial objective behind health care reforms (Keyder et al. 2007: 7; Palier 2005: 58; Figueras et al. 1999: 4; Mossialos et al. 2007: 7).

Health care system in Turkey has been having many problems such as regional disparities in the provision of health care services, deficiencies in primary and preventive health care and structural problems which have been making the whole health care system unbearable for both health care professionals and patients (e.g. heavy workload, long waiting lists, differentiated access to health care due to differentiated social insurance systems, unfair out-of-pocket payments etc.). These problems have also been noticed by the opponents of the HTP as the system has been struggling with them for so long. Therefore reform has long become a necessity for the health care system and has long been demanded by many different segments of the society.

Moreover, in line with the aforementioned international dynamics and the related neoliberal restructuring process within the public sector, private sector has started to have great interest in health sector which it started to see as a very profitable area for investment. This in the end necessitated a re-formulation of the role of the state in health care services and a re-formulation of the relationships between public and private sectors and national-local-global levels. Needless to say all these have made it more than imperative to make comprehensive reforms not only in health care system in particular but also in the public sector in general.

In analyzing the national dynamics that have paved the way for the realization of the HTP, it is quite important to have a special look at the post-2002 period which coincides with the Justice and Development Party (JDP)'s coming to power. As it is well-known after 2002 till today there have been serious attempts at reforming and transforming many aspects of the political, social and the individual realms where a dedicated attitude towards a comprehensive transformation is observed ranging from constitutional amendments to public sector reforms.

It is within this context that the realization of the HTP could have become possible. As it has been mentioned before, there had been several attempts to reform the health care system since the launch of the neoliberal restructuring process in the early 1980s. However it is with the HTP that Turkey has been experiencing the most radical transformation in its health care system which has many things to do with the

dedicated adherence the present government has been having to the this rather macro level transformation project in the state apparatus and socio-economic realms. Within this comprehensive reform project it has become relatively more effortless to attain the objectives of the HTP. In this regard it has become rather easier to supplement the HTP with legislations in areas such as the social security system or it has become rather less problematic to finalize the legislative processes. In addition to these, the present government which has been in power for the last three terms has been ruling the country as a one-party government before which the country had long been ruled by coalition governments. This also makes the present government more powerful to attain its reform projects[107].

In this regard two arguments are worth mentioning: the first one is the "dissident but hegemonic discourse" and the "populist discourse" which have been attributed to the party in power as one of the keys to its success in undertaking all these reforms and to the support it gets from the public for these reforms (Yıldırım 2010: 2)[108]. In the same vein Öniş and Bakır argue that in order to be able to realize these reforms it is necessary to have high degree of domestic societal mobilization and to take care of developmental and redistributional challenges (Öniş and Bakır 2007: 17).

The second argument is on the change that the present one-party government has attained in the bureaucratic cadres so far that now there is rather very limited resistance to change from bureaucracy compared to previous periods, which makes the transformation in the public sector rather easier. In this regard Öniş and Bakır draw attention to the political centralization in bureaucracy and to the increased autonomy in particular relevant sections of bureaucracy which according to them contributed to the strengthening of the state capacity and thus to the realization of public sector reforms (Öniş and Bakır 2007: 4).

[107] It is argued that "the neoliberal authoritarian form the state had acquired as early as the 1980s has persisted since then through the powerful articulation of economic, political and cultural processes into each other" and that JDP represents a continuity in the neoliberal restructuring project than a radical change in state-society relations whilst claiming to initiate radical changes in this regard (Bedirhanoğlu and Yalman 2010: 3-4).

[108] For more information on "dissident but hegemonic discourse" refer to Yalman (2002a) and Yalman (2002b).

Last but not the least, as it has been mentioned above, it is in this period that the government could get into international projects with different international organizations and could get serious financial support from them in order to realize the transformation in its health care system.

In the final analysis HTP should be considered as part of a bigger/macro transformation project where both global and national factors have their roles. In fact this transformation project could be traced back to the process of restructuring the state and the public sector which has started in early 1980s.

Therefore anyone who analyses HTP should also have a look at the complementary reforms being adopted together with the HTP. In this regard Reform in Public Administration or Reform in Social Security System should be considered as parts of the same project having great intersection areas with the HTP. Although legally it has not been put into practice yet, the former foresees many changes for the (re)organization and decentralization of the Health Care System while the latter brings about great changes to the system of health care finance. When analyzed carefully it is seen that both attempts impose a serious transformation in the conceptualization of heath care services and have serious socio-economic, political and cultural implications as a whole.

7.4.3 What does HTP foresee and bring about? HTP Tells Itself

7.4.3.1 Goals and Objectives of the HTP

HTP states its objectives as the “effective, efficient and equitable organization, finance and provision of health care services” (HTP 2003: 24).

As it can be seen from the wording of the HTP, organization- where decentralization argument plays a key role - and finance constitute the two core parts of this transformation. In fact transformations in these areas go together with the transformation in the philosophy/conceptualization of health care services which is another important aspect that this dissertation heavily emphasizes.

According to HTP “effective” refers to health policies having the aim of improving the quality of the health of the population. “Efficient” refers to decreasing costs through proper use of resources and producing more services with the same amount of resources where rational use of pharmaceuticals, managerialism in health care (sağlık işletmeciliği) and holistic approach to resources in the health sector all have their say. Finally “equity” refers to public’s reach to health care services proportionate to their needs and refers to their contribution to the finance of these services proportionate to their wealth. Reducing disparities between different social groups, between rural-urban population and east-west are also considered within this context (HTP 2003: 24).

7.4.3.2 Basic Principles of the HTP

Basic principles of the HTP are stated as being human-centered (i.e. taking family health care as the key concept), sustainable, participatory, negotiating, voluntary and embodying continuous quality improvement, separation of powers, decentralization and competition (HTP 2003: 25).

When one looks at these aforementioned goals and objectives put forward in the HTP, it would not be wrong to say that they carry serious reflections of the Public Management approach and aim to restructure health sector in this direction. Some of the critical and in fact the disputed ones could be quoted as follows:

Decentralization: In HTP it is argued that health care institutions should be rescued from their cumbersome structures caused by centralized administration. To this end decentralization is put forward to refer to establishments which are administratively and financially autonomous and thus having faster decision-making mechanisms and using their resources more efficiently.

As has been mentioned many times in this study, re-organization of the health care system is quite central to the HTP. In this regard decentralization has become one of the core aspects of the transformation where many attempts have been made so far to decentralize the system. These attempts and characteristics of the decentralization

have already been and will be more elaborated on throughout this study where necessary.

Separation of powers: HTP implies that finance, planning, inspection/audit and production of health care services should be separated from each other. It is argued that in this way there would not be clash of interests and that service provision would be more efficient and of more quality.

Again this principle is a reflection of the impact of managerialism on the re-organization of health care services which mainly stems from the idea of politics/administration/management dichotomy in public management reforms in general.

This principle is not only complementary to the aforementioned principle of decentralization but also to the principle of *competition* which is highly by the HTP. In this regard as it has been mentioned above, creation of internal market within health sector by separating provision and purchasing of health care services (provider-purchaser split) has been one of the most common and popular aspects of health care reforms in the world.

Regarding competition HTP stated that health care provision would no more be a monopoly but this would be a sector within which different providers ascribing to a set of standards would compete- as a result of which there would be incentives for quality improvements and cost-reductions. This clearly implies the injection of the internal market model into the health care system in Turkey where providers and purchasers of health care services would be separated.

When it comes to *negotiation* and *participation* HTP states that all related parties would be asked for their opinion about the foreseen transformation in the health sector. However it has been highly disputed to what extent they had the chance to have their say in the preparation and realization of the HTP. Doctors' Associations, Pharmacists' Associations, related trade unions and various patients' groups have

been asserting that they have not been involved in the transformation process as they should be.

Voluntariness: HTP states that parties which produce and get services within the health care system should take their place on the basis of being volunteers via provided incentives rather than compulsory regulations. However, it is known that General Practitioners were "highly encouraged" to become Family Doctors at the beginning of the Family Medicine Project.

7.4.3.3 Main Components of the HTP

HTP is composed of eight main components which are said to be interrelated among themselves (HTP 2003: 3, 26-37):

7.4.3.3.1. Ministry of Health Left with Planning and Auditing Responsibilities

The Ministry of Health foreseen by the HTP is the one which develops policies, sets standards, conducts audits- i.e. which undertakes the main role of directing in order to attain effective, efficient and equitable use of resources by both the public and the private sector (HTP 2003: 26).

It is stated that the Ministry of Health will be organized in accordance with the "principle of decentralization" and that it will be left with the basic responsibility of "planning" the whole health care sector- which would also be in accordance with the duties attributed to it in the Constitution[109]. Thus in the end the Ministry would be turned into a strategic organization. (HTP 2003: 26-27).

As it can be clearly seen from the vision put forward by the HTP, the Ministry of Health is tried to be taken out of domain of direct provision of health care services as much as possible. This is highly compatible with the notion of "rolling the state

[109] Article 56 of the Constitution of the Turkish Republic declares that the state would undertake the planning among health care institutions in order to provide everyone with healthy life and in order to attain efficiency, cooperation and economies in human and material resources. Moreover the Article states that the State would realize this planning duty via drawing upon and also through auditing health care institutions both in the public and private sector (TBMM, 2010c).

back" from the direct provision of public services and the notion of "state which steers rather than rows" within the context of the New Public Management reforms in the public sector.

Moreover some clues can also be found in the HTP about how the Ministry is expected to make its re-organization according to the principle of decentralization. It is stated that vertical organizational structure of the Ministry will be given up and instead "integrated health care services"[110] will be encouraged. In addition to this the Ministry will be made to delegate its administrative and financial control duties to its field units which are deemed to be given more responsibilities in the administration and "management" of the "health service networks" (HTP 2003: 26).

It is also stated that the Ministry of Health will prioritize preventive and primary health care in line with the social state understanding while realizing its organizational restructuring and that it will focus on issues such as quality control, educating customers, accrediting relevant institutions, regulating the insurance sector, public health and epidemic diseases (HTP 2003: 26).

Thus HTP mentions how the re-organization of the Ministry of Health will be achieved by this transformation. However it is still not that clear in the document what kind of a division of labor is foreseen between the center, its field units and local authorities. To get this information it is necessary to look at the succeeding and preceding complementary documents (e.g. with the Basic Law on Public Administration and the Law on Provincial Local Governments, many of the duties of the Ministry of Health -in fact the duties of its field units- were said to be delegated

[110] Integrated Health Care Service is defined as the integrated provision of many primary health care services including preventive health services, emergency services, examination, treatment, rehabilitation services, services regarding pregnancy-child delivery-maternity and child welfare services, outpatient (ambulatory) and hospitalization services including medical and surgeical operations, dentistry, forensic mediccne and environmental health services in centers determined by the Ministry (Sağlık Bakanlığı, 2011d).
Integrated Health Care Services were favoured and encouraged by the Declaration of Alma- Ata 1978 (Article VII/6) for the provision of Primary Health Care Services (WHO 2011f).
Integrated Health Care Services are said to be compatible with the socialization of health care services in the post-war era where the idea is to provide as much health care services as possible in a small area or small health care center which focuses on the family and the society rather than the individual and thus provides not only more balanced distribution of health care services throughout the country but also economies of human and material resources and saves time (Aktan and Işık 2006: 5).

to the provincial local governments). However, although at the beginning of the reform process the trend was towards giving more authority to local governments regarding health care services (as it was foreseen in the Basic Law on Public Administration which has not been yet put into practice), in the recent years the trend has turned towards making hospitals more autonomous in terms of their administrative and financial procedures. These issues are covered in the relevant sections of this study.

7.4.3.3.2. Universal (General) Health Insurance (UHI) Covering Everyone

HTP declares that a new insurance system will be adopted where the contributions of citizens will be proportionate to their ability to pay and where they will benefit from health care services proportionate to their needs (HTP 2003: 27).

Although it accepts that the previous insurance system did manage to cover an important majority of the population, HTP puts forward the drawbacks caused by the previous tripartite system as follows[111] (HTP 2003: 27):

1. They did not separate health insurance from retirement pensions.
2. Their deficits were remedied from the general budget.
3. They had irrational regulations which were not compatible with professional insurance understanding.
4. They were serving at different levels and in different ways and that they could not put forward any standardization.
5. Despite their achievement in covering an important majority of the population there were still a great number of uninsured people whose problems could not be solved but on the contrary got complicated with programs such as the Green Card.

After stating the drawbacks of the previous system, HTP puts forward what are aimed by the new system as follows:

[111] Before the foundation of the Social Security Institution on 20.05.2006 (Law on Social Security Institution-Law No. 5502- Sosyal Güvenlik Kurumu Kanunu) there was a tripartite social security system in Turkey where Emekli Sandığı, Sosyal Sigortalar Kurumu and BAĞ-KUR were the three separate institutions responsible for the conduct of social security services for different segments of the society.

1. improving quality of service,
2. providing each patient with basic health care services on equal footing,
3. eliminating any monetary relationship between the patient and the doctor.

It is argued that such an insurance system where price control and finance of health care services will be undertaken from one center (namely the Social Security Institution) will lead to an effort towards decreasing health care costs and expenditures, encouraging preventive health care and decrease excess use of pharmaceuticals and medical devices (HTP 2003: 28).

In order to achieve its above mentioned goals HTP declares that the following steps will be taken: (HTP 2003: 28-29)

1. Every Turkish citizen will be covered by health insurance.
2. A poverty line will be determined in order to detect those who do not have the ability to pay their contributions.
3. Funds will be raised to pay the contributions of those who are unable to pay their premiums.
4. A Basic Health Care Package (Sağlık Hizmetlerinde Temel Teminat Paketi) will be figured out.
5. A system which will detect demographic and epidemiologic requirements at provincial and sub-provincial levels will be established.
6. Mechanisms to conclude contracts with primary care institutions and hospitals for purchasing health care services will be established.
(This is in fact a very explicit step taken for the adoption of provider/purchaser split which means the injection of internal market mechanisms into the health care system).
7. Health Insurance and health care premiums will be separated from other social security premiums such as Retirement Pensions and from any other insurance types and the former will be conducted by the same single body (which points to the Social Security Institution).
8. In case of failures to pay premiums or in case of being uninsured the case will be handled by the insuring institution not by the health care providers.

9. Payment to health care providers will be made from a single body, be made in time and regularly (which again points to the Social Security Institution as the body to make the payments).

In addition to these HTP announces the creation of National Health Accounts System (Ulusal Sağlık Hesabı Sistemi) in order to eliminate the lack of information regarding health care finance and thus to make it possible to follow what amount of resources are spent on what within the health sector on annual basis.

Another important point that HTP touches upon is that besides the adoption of Universal (General) Health Insurance (UHI), development of Private Health Insurance Sector will be encouraged as the latter is expected to play its complementary role within the system. It is stated that those who want to get health care services in addition to the Basic Health Care Package provided by the UHI will be encouraged to purchase private health insurance (HTP 2003: 28-29).

As it has been mentioned adopting Universal Health Insurance System covering every citizen has long been on the agenda of development plans and governments. However it is with the recent health transformation program that it could have been realized. Again as already mentioned, Article 56 of the Constitution declares that in order to attain the widespread provision of health care services Universal Health Insurance can be adopted by enacting related laws[112].

In order to realize Universal Health Insurance, Law on Social Security Institution and Law on Social Insurance and General (Universal) Health Insurance were enacted in 2006[113]. Passing through various legal procedures such as the review of the President of the Republic and the judicial review of the Constitutional Court, now these two Laws are fully effective. The former elaborates on the foundation, organization, duties and responsibilities of the Social Security Institution. It states the aim of the

[112] TBMM (2010c)

[113] Law on Social Security Institution- (Sosyal Güvenlik Kurumu Kanunu) Law No. 5502; Date: 20.05.2006 (Türk Tabipleri Birliği, 2008).
Law on Social Insurance and General (Universal) Health Insurance- (Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu) (Türk Tabipleri Birliği, 2009).

Social Security Institution as running a social security system which is effective, fair, accessible, actuarially and financially sustainable and which is based on contemporary principles/standards of social security (Article 3). Implementing social security policies and helping their development are also counted among the responsibilities of the Institution (Article 3/a).

The latter on the other hand puts forward how the UHI will work, who will be covered with what conditionalities and how the system will be financed in general. In this regard the Law makes definitions and puts forward the conditions for

Social Insurance,
Universal (General) Health Insurance (as the insurance which primarily aims at protecting the health of the insurees and which finances their health care expenses in cases where they face health risks- Article 2),
Insurees (as people whose premiums have to be paid either personally by themselves or by the related parties on behalf of them and thus who would be deemed as covered by the UHI- Article 2. The Law lists who would be counted as "insured" and those "not insured" – Article 4 and 6),
Health Care Service (as medical services or devices which would be financed by the Social Security Institute- Article 2),
Health Care Provider (as public and private bodies who/which provide/produce health care services- Article 2),
Co-Payments (The Law gives a list of the health care services for which co-payments will not be demanded – Article 69),
Getting Voluntary Insurance,
*Staged Health Care Services and Chain of Referral System (*It is declared that the Ministry of Health will classify health care providers as the primary, secondary and tertiary and the Chain of Referral System will be established by the Social Security Institution. It is also stated that the insurees have to obey the chain of referral system in order to have their health care expenses be financed by the Social Security Institute- Article 70),
Determination of the Amount that will be paid by the Social Security Institution (It is declared that the amount that will be paid by the Social Security Institution for the

health care expenses of the insuree will be determined by the Health Care Services Pricing Commission [Sağlık Hizmetleri Fiyatlandırma Komisyonu]. Moreover it is stated that the Commission could classify health care providers on the basis of this pricing and that it is authorized to determine the amount that will be paid by the Social Security Institution on the basis of the level that the health care service in question is provided and by taking cost-effectiveness criteria into consideration- Article 72).

Methods for the Provision of Health Care Services and their Finance (The Law states that health care services will be provided through contracting between the Social Security Institution and the national/international service providers or through pure out-of pocket payments by the patients/insurees who purchase health care services from the providers who/which have not made any contracts with the Social Security Institute- Article 73. Moreover it is also declared that it is the Institute which is obliged to announce the national/international service providers who/which have made contracts with the Social Security Institute and that the insurees are free to choose among these providers- Article 77).

Compulsory Basis for being covered by the UHI and Premium Payment (The Law declares that it is compulsory for those listed in the Law to get UHI and thus to pay the defined amounts of premiums on time- Article 92).

In addition to these laws, Social Security Institution Notification on Health Care Implementation (Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği) was issued in 2010[114].

The aim of the Notification is set as follows: to declare the principles and the procedures on which the insurees covered by the UHI would benefit from the finance provided by the Social Security Institution for their health care expenses and to determine the amount that would be paid by the Social Security Institution in this regard (Article 1).This Notification puts forward detailed information on how the people whose health care services would be financed by the Social Security Institution would act within the system- i.e. how and to which health care institutions

[114] Social Security Institution Notification on Health Care Implementation (Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği) (Resmi Gazete, 2010).

they could apply, how they would be reimbursed, on what criteria they would pay user charges (co-payments), which pharmaceuticals and medical devices could be prescribed and reimbursed and the like.

Finally it should be noted that various amendments have been made to the By-Law on Green Card (Yeşil Kart Uygulaması Hakkında Yönetmelik)[115] which has been preserved by the HTP and its UHI System for a while. However as of 1 January 2012, with the full implementation of the UHI the Green Card System has been abolished. In the new system everyone is supposed to pay premiums determined according to their income levels in order to get health care services under UHI coverage. Premiums of those people who are detected to have incomes under a certain level after the income test will be paid by the state.

When the statements of the HTP regarding Universal Health Insurance are analyzed carefully the following points are worth re-mentioning:

First of all it is interesting to see that HTP- a document which constantly complaints about the centralized structure of the health care system in Turkey foresees a Universal Health Insurance System which is quite centralized in terms of the price control and finance of health care services. This again points to the de-centralization/re-centralization duality which has been manipulated by the reform process, which has been explained in the above sections.

Secondly it is quite clear that the above-mentioned clauses of the HTP on Universal Health Insurance aim at securing the smooth transfer of resources from the public sector to the private sector within the context of internal market with provider/purchaser split. These clauses try to free health care providers as much as possible from direct contact with the patients and put the Social Security Institution in a mediating position in this regard.

[115] By-Law on Green Card (Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Devlet Tarafından Karşılanması ve Yeşil Kart Uygulaması Hakkında Yönetmelik) (Sağlık Aktüel, 2010).

Thirdly these clauses also encourage the development and purchase of private health insurance as complementary to the Basic Health Care Package that would be provided by the Universal Health Insurance.

Finally it is evident that the Universal Health Insurance System is compatible with the internal market model which brings about the provider/purchaser split for the health care sector where the Social Security Institution would provide a central role in dealing with the service providers from both the public and private sectors.

It is clear that changes adopted so far like the foundation of the Social Security Institution and the adoption of the Universal Health Insurance and other complementing regulations have brought about and imply serious changes for the finance of health care services. As it will be discussed in detail in the succeeding sections of this dissertation, the new system brought about by the adoption of Universal Health Insurance points to a hybrid model which some authors call the National Health Insurance (NHI) Model (Lee and Chun 2006; Kutzin et al. 2009). In this model health care system is mainly financed by the compulsory premiums collected from the citizens within the context of the UHI and by the general revenue. In addition to these two main resources, private health insurance is also highly encouraged for the finance of health care services in this hybrid model.

7.4.3.3.3 Widespread, Accessible and Friendly Health Care System

In HTP it is stated that due to its socio-economic and geographical characteristics, Turkey needs a “heterogeneous (differentiated) model for improving its health care system”. In the face of problems such as irregular increase in population, continuous immigration from rural to urban and deep disparities in income, HTP argues that the socialization project of the 1961 should be adapted to today’s requirements. It praises the systems of village clinics (sağlık ocağı) and health houses (sağlık evi) founded by Law no. 224 (Sağlık Hizmetlerinin Sosyalleştirilmesine Dair Kanun) as one of the most developed and modern models for that era and argues that this system should be strengthened today (HTP 2003: 29-30).

However, besides this, HTP also calls for the development of "competition" and the co-existence of "private entrepreneurs" within this system with the justification that this will provide efficient use of the country's resources, accessible health care services for everyone and decrease in inequalities.

Although HTP refers to disparities in access to health care and calls for a differentiated health care system and an adapted form of the socialization project of the 1960s it also foresees a system in which competition and the role of private actors are strengthened. Once again heavy reflections of the NPM on HTP which refers to competition and private actors to achieve the widespread, accessible and friendly health care system are seen.

7.4.3.3.3.1 Strengthened Primary Health Care Services and Family Medicine[116]

In order to strengthen Primary Health Care Services HTP states that besides supporting preventive health care services through village clinics (sağlık ocağı) in the rural areas, in the urban areas where they have been rather lacking these services will be undertaken by Public Health Centers (Kamu Sağlığı Merkezleri) (HTP 2003: 30).

In addition to this HTP refers to the concept of "patient's choice"- one of the most popular items in HTP- that preventive services targeting individuals (bireye yönelik koruyucu hizmetler) and primary level health care services will be undertaken by doctors chosen by the individual himself/herself and that this would help better control and follow up of the patients' records (HTP 2003: 30).

HTP points to the problem of deficiency in family doctors in Turkey. In the first instance it aims to solve this problem by educating GPs to make them capable of practicing as family doctors. Where this could not prove to be sufficient, recourse would be made to free medical professionals (serbest hekim) and private health care centers/clinics (HTP 2003: 31).

[116] (Güçlendirilmiş Temel Sağlık Hizmetleri ve Aile Hekimliği)

With this last remark HTP makes a strong implication for the opening of a path which could end up with the privatization of health care services at the primary level. In 2004 Law on the Pilot Implementation of Family Medicine[117] was enacted and after gradual inclusion of the then convenient provinces, by the end of year 2010 Family Medicine System is now in effect all over the country where every citizen has been appointed a family doctor.

Family Medicine System constitutes one of the most central elements of the HTP which is related with both the organizational and the financial aspects of the transformation. In fact reform at the primary care level has been realized under the banner of Family Medicine System where the internal market model with its provider/purchaser split has been injected into the Turkish health care system through this family medicine system. Nevertheless being complementary parts of a bigger transformation project family medicine system should be analyzed together with the Universal Health Insurance, Chain of Referral System, autonomization of public hospitals and the other components.

7.4.3.3.3.2. Effective and Staged Chain of Referral[118]

Chain of Referral is an important and complementary aspect of family practice system.

In HTP it is stated that the prerequisite for an effective chain of referral is to let the patient get primary health care services from the practitioner he/she chooses. This is the essence of the famous “patient’s choice” system.

In providing patients with the choice of doctors and establishing an effective chain of referral system, HTP aims at treating majority of the patients at the primary care level and thus leading to a decrease in the overpopulated hospitals at the secondary or tertiary level. Moreover it is stated that this would also lead to improvement in the quality of the health care services, decrease waste of resources, provide continuous

[117] Sağlık Bakanlığı (2011c)
[118] (Etkili ve Kademeli Sevk Zinciri)

follow up of the patients through their records and finally make it possible to provide health services in shorter times and with lesser costs (HTP 2003: 31).
Finally HTP declares that those who do not want to go through the chain of referral will not be forced to do so. However they will be asked to face additional costs which is said to be something not against the social state understanding and patients' rights.

Chain of Referral System was started to be practiced right after its inclusion in the HTP. However its practice was postponed to January 2009. Still (by December 2011) it is not yet in practice, which means we have a family medicine system without one of its essential parts. However, in essence within a family medicine system patient should first go to his/her family doctor and then with the doctor's referral goes to higher level health care institutions. If the patient does not follow this chain he/she has to pay from his/her pocket. Nevertheless in Turkey, with the current practice a patient covered by the Universal Health Insurance can either refer to family doctor or directly to any hospital - including the private ones- which have made contracts with the Social Security Institution.

7.4.3.3.3.3 Health Care Enterprises Having Administrative and Financial Autonomy[119]

This is another subtitle of the HTP which brings about serious changes for the health care system in Turkey.

First of all it is stated that every hospital in Turkey - including the private ones- will be eligible to serve any citizen of the Turkish Republic through making contracts with the Insuring Institution- i.e. the Social Security Institution. In so doing hospitals will be under control in terms of securing the quality of the services they provide and the prices they charge.

[119](İdari ve Mali Özerkliğe Sahip Sağlık İşletmeleri)

It is stated that in financing health care, it will be the individuals rather than the providing institutions which will be subsidized and the latter will get their shares proportionate to services they provide (HTP 2003: 31).

In the same vein it is stated that in order to get adapted to this new system, to be able to turn into more efficient enterprises and to become capable of competing with other actors in the sector, public hospitals should get rid of their present state of over-dependence on the center. To this end all public hospitals will be given administrative and financial autonomy and also the autonomy for deriving the inputs required for the production and administration of health care services.

It is declared that all public health care institutions will be autonomous bodies under the supervision of the Ministry of Health. To this end, first of all kind of a "unity of service provision" (Hizmet Sunumu Birliği) will be achieved among these hospitals and at the second phase each institution will be delegated its autonomy separately (HTP 2003: 31).

At this point HTP states that health care institutions do not necessarily have to be directly linked to the State (i.e. the Ministry of Health), but municipalities, private companies, foundations, provincial administrations and universities can set up health care institutions.

HTP states that as a result of this autonomization, each hospital will be responsible for its administrative decisions, service quality and efficiency. However it also says that those hospitals which are not economically efficient will be subsidized for preserving the continuation and quality of services (HTP 2003: 32).

It is also added that although public health institutions will be asked to finance themselves, they will not be turned into expensive institutions which give up service quality for more profit. (HTP 2003: 32).

HTP declares that it is also inevitable to adopt “performance management system” with its performance indicators and performance-based payment systems in order to attain the ultimate system that HTP aims at (HTP 2003: 32)

It is stated that in the new system local dynamics (though not specified who they are) will be able to have their say in decision-making mechanisms and that there will be a shift to customer-oriented organizational structure (HTP 2003: 32).

It is clearly seen that HTP foresees a system where hospitals are made to work along managerial principles where efficiency, competition, performance-based payment, consumer-orientedness, change in the conceptualization of health (from right to commodity) and patient (to consumer) have all their weight. In addition to these, practices such as publishing league tables ranking hospitals according to their performances, granting (more) administrative and financial autonomy and resources to hospitals according to their performance and ranking in these tables, being more customer-oriented in the provision of health services, having fiscally and administratively autonomous hospitals/health providers which are responsible for their decisions would also be added to the picture in the later phases. It would be seen that many of these practices are highly compatible with the New Public Management way of reforming health care systems where the British NHS deserves special attention.

Draft Law on the Pilot Implementation of Union of Public Hospitals (Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı) was submitted to the Grand National Assembly in March 2007. The process was interrupted by the 2007 general elections. Another draft law was prepared in October 2007. Finally in March 2010 the draft law passed from the Planning and Budgeting Commission. However it has not yet been turned into a law (by March 2011).

The draft law foresees serious changes for the hospital system in Turkey. First of all it groups secondary and tertiary level public hospitals under unions of public hospitals where no public hospital can be excluded. These unions will be managed

by managerial boards and the hospitals by hospital managers all along managerial principles (Articles 1-4).

Hospitals will be classified as A, B, C, D, E class hospitals according to patient/employee satisfaction, service infrastructure, organization, quality and efficiency where this evaluation and could be done by public or private evaluation bodies. Hospitals classified as such will be grouped and those with an average grade of C and above will be turned into unions. If the union fails to retrograde to class E or downgrades compared to previous evaluation its managerial board is abolished by the Ministry of Health (Article 5).

The Managerial Boards of the Unions have serious authorities including the authority to sell or rent any property belonging to the union or buying necessary services including health care services where necessary (Article 6).

Organizing hospitals in the form of hospital unions have serious implications both for the organization and finance of the health care system in Turkey together with a change in the conceptualization of public health care services. HTP and the draft law foresee a system where the hospital system is organized on regional/ union basis whose dependence on the center will be minimized. Public hospitals will be administratively and financially autonomous where only the hospitals in need will be subsidized by the center. They will be competing not only with the private ones but also among themselves. In this system major role of the Ministry of Health will be dealing with measuring the performances of the competing hospitals rather than dealing directly with the provision of health care services.

Establishing managerial principles in the functioning of public hospitals is one of the most important attempts of the HTP and the draft law as with the foundation of the public hospital unions all hospitals will be asked to perform along managerial principles which means that they will be guided by more with the principles of efficiency, profit-making, customer-oriented service provision, performance-based payments rather than the ideal of providing public services. This clearly points to a serious change in the conceptualization of health care services in the public context.

In addition to these, foundation of public hospital unions also encourages further privatization in the provision of health care services where not only the present private hospitals are taken into the system but also foundation new of private hospitals are encouraged.

As it has been mentioned above, organization of health care services at the regional level is a trend that has emerged within the context of health care reforms of the recent years. Regarding Turkey, initially decentralization of health care services was conceptualized as the transfer of these services from the center to the local authorities. Basic Law on Public Administration (Kamu Yönetimi Temel Kanunu) and several other previous documents had this perspective. However later with the adoption of the HTP, decentralization of health care services were started to be taken as the transfer of authority to the hospitals and health care institutions. It is in fact this second perspective which has also been adopted by European countries including the UK in decentralizing their health care services.

In addition to the Public Hospital Unions, the Ministry of Health has been carrying out the project of *Health Campuses* where Public-Private-Partnership model has been adopted. In this model health campuses which are composed of different hospitals specialized in different areas of health care services together with all other complementary service units will be built by the private sector. When the campuses are finalized the Ministry of Health will use these buildings by paying rents to the consortium that built them. Those consortiums could be formed out by national and/or foreign capital where they could also be carrying out certain services such as the laboratory or radiology services in these campuses.

As it is widely known Public-Private-Partnership Model has been highly used in England in the post 1980 era where health sector is no exception. Politicians and bureaucrats in charge of health care reform in Turkey have also been referring to the Public-Private-Partnerships in England as a model for the Health Campuses that they have been planning to build[120].

[120] Medikalproje.com (2011); Sağlık Bakanlığı (2011b)

Health Campuses would be built in 29 cities which would be turned into centers of attraction for health care services and which would help "health tourism" flourish further in Turkey. Moreover it is argued that with this model the dynamism and financial capability of the private sector would be injected into the health care services provided by the public sector[121].

7.4.3.3.4 Qualified and Motivated Human Resources in Health Care

HTP states that duties, authorities and responsibilities of professionals working in the health sector will be defined by taking into account Turkey's accession process to the European Union. (HTP 2003: 33)

In addition to that it is declared that success of the HTP would depend on the creation of an effective system of health managers. It is strongly argued that "health system management" should be developed as an independent discipline instead of wasting resources by employing physicians in managerial jobs -which not only ends up with inexperienced managers but also with wasting the resources devoted to medical professions (HTP 2003: 33).

This is another explicit trend that is seen in HTP towards managerialism where separation between physicians and the so called health system managers is urged-which also brings about some clashes between them.

Besides these HTP also elaborates on the abolition of Compulsory Service (Zorunlu Hizmet) and adoption of Permanent Contracted Personnel (Çakılı Sözleşmeli Personel) which is said to encourage more voluntary and efficient work in the public sector. Development of family nursing (aile sağlığı hemşireliği) at primary care level complementary to the target of strengthening family health, development of better cooperation with Medical and Dentistry Schools in order to attain the quality and quantity desired in medical professionals are also foreseen in the HTP.

[121] Sağlık Bakanlığı (2011b); Medikalproje.com (2011)

Here what attracts attention is the emphasis on contractual relations for those that would be employed in public health sector and the abolition of compulsory service which might add to the disparities among different regions of the country in terms of their health status. It should also be noted that these are parallel changes to the ones adopted in the personnel regime in general.

Active participation of local authorities, NGOs and professionals' associations and decentralized human resources planning in which health managers could participate are highly praised by the HTP (HTP 2003: 33). Here, HTP does not elaborate on what kinds of mechanisms are foreseen to realize this participation or which of the aforementioned actors would participate in the process in practice. As is the case with many other components of the HTP, this will be seen through future practices.

In this section final remark should be made on the regulations dictating Full-Day Employment of Health Personnel which has been center of hot debates among the doctors, the Ministry of Health and the judiciary for so long. Various regulations have been put forward to realize full-day employment of health personnel so far, which would also complement the performance-based payment system in the health care system. However, they have been annulled or ruled not to be implemented many times by the judiciary and re-issued by the government again. Although recently the Council of State ruled that doctors working in the public hospitals can open their private surgery but are not allowed to work in private hospitals[122], the final Statutory Decree[123] again ruled that they are not allowed to do that. It seems that this will continue to be an issue of tension among the doctors and the reformers for a while.

7.4.3.3.5 Scientific and Educational Institutions Supporting the New System

HTP underlines the need for human resources mastered in health policy, health management, health economics, health planning and public health. In this regard it calls for the establishment of an institution which will educate human resources for

[122]TRT Haber (2011)
[123] Resmi Gazete (2011a) (Statutory Decree No. 650, Date. 26.08.2011).

making sector analysis, planning researches and advising governments. (HTP 2003: 33).

It also calls for new regulations for the education provided in medical schools to make them compatible with the mandates of the HTP and mentions about the establishment of a Health Academy or a Health Specialization Institute (Sağlık Uzmanlık Kurumu) to coordinate these duties (HTP 2003: 34).

7.4.3.3.6 Quality and Accreditation for Qualified and Effective Health Care Services

HTP calls for the establishment of National Quality and Accreditation Institute which will deal with authorization, certification and accreditation in health sector. (HTP 2003: 34).

It is stated that this will be an autonomous institution and that all related parties in the sector will have their say in its administration.

One of the main duties attributed to this institution is to develop systems with which health outcomes will be measured. According to the results of these measurements, performance indicators will be defined for health care providers. In the end a database consisting of the performances of health care providers will be created which will lead to the definition of "good practice" and applicable performance indicators.

In addition to these HTP underlines the importance of ethical values and calls for the establishment of Ethical Board which will be composed of representatives from the sector and which will have strong discretionary powers (HTP 2003: 34).

Here another explicit reflection of public management- namely the emphasis on measurability and adoption of performance management- is seen evidently on HTP. It should also be noted that this is a system complementary to the idea of creating competitive internal market and provider/purchaser split.

7.4.3.3.7 Institutional Set-up for Rational Management in Pharmaceuticals and Medical Equipment [124]

HTP states that there is need for institutional set-ups which will deal with standardization, authorization and rational management of pharmaceuticals, medical equipments and medical devices in accordance with international norms and standards.

It underlines the importance of having these institutions as autonomous organizations working beyond political considerations.

7.4.3.3.7.1 National Pharmaceuticals Institute

HTP puts forward the need for the establishment of National Pharmaceuticals Institute as follows (HTP 2003: 20):

1. Expenditure made on pharmaceuticals and pharmaceutical products is very high in Turkey.

2. Due to the present policies of social security institutions (this was written before the merger of social security institutions under the name of Social Security Institution) majority of the population are insensitive to the prices of pharmaceuticals. (Here HTP basically refers to the famous moral hazard issue of the principal-agent theory which has been commonly raised in these discussions.)

3. Rise in prices of pharmaceuticals is not based on scientific reasons.

4. Turkey does not have a national policy for pharmaceuticals. This has been causing many problems in the authorization, production, pricing, export, R&D and intellectual property rights. Commissions for the authorization and control of pharmaceuticals work on the basis of voluntariness which causes serious delays.

[124] (Akılcı İlaç ve Malzeme Yönetiminde Kurumsal Yapılanma)

Moreover, there are serious disparities between social security institutions in the consumption of pharmaceuticals.

It is declared that the share of pharmaceuticals consumption in the overall health care expenditures in Turkey is approximately two times higher than developed countries – e.g. Turkey 40%, UK 15%, USA 10% (HTP 2003: 21- Table 8)[125].
In order to remedy this situation HTP calls for the establishment of National Pharmaceuticals Institute which would have regulatory role in determining basic policies on pharmaceuticals and in authorization, production, advertisement, research and development of pharmaceuticals. (HTP 2003: 35). This institution is said to be an autonomous one which would be working in line with national policies.

HTP also elaborates on making the authorization process of pharmaceuticals more transparent, effective and faster; devising a new method for the pricing of pharmaceuticals on which all relevant parties would agree; protecting intellectual property rights in pharmaceuticals production; making national pharmaceuticals industry competitive in international markets; adopting more scientific methods in public purchases of pharmaceuticals (in line with pharmacoepidemiology and pharmacoeconomics) and directing and regulating pharmaceuticals consumption according to scientific criteria (HTP 2003: 35).

7.4.3.3.7.2 Medical Devices Institute

HTP declares the establishment of Medical Devices Institute which will focus on clinical engineering services at hospitals and which will have regulatory, auditing and educational authorities at the national level.

It also foresees that this institution would create information databases, issue plans and comparative reports on medical devices, purchase these devices and help in the making of relevant legislations and implementations (HTP 2003: 35).

[125] Detailed information on the incresease in expenditures on pharmaceuticals and recent declarations by the government and the Social Security Institution on this issue will be touched upon in the following sections while analysing the impacts of theHTP on economic dimensions of the health care system.

It will also deal with development of national standards besides the international ones which will make things easier for national producers and it will deal with standardization of devices used in health care services.

As a result of all these, HTP expects an increase in efficiency and quality of services and a decrease in waste of materials and time.

Several steps have been taken in the name of rational management in pharmaceuticals and medical devices where the merger of social security ınstitutions, grouping pharmaceuticals in equivalent groups and adopting the use of equivalent drugs system and allowing insurees get their drugs and medical devices in strict periods deserve attention.

Draft Law on the Establishment and Responsibilities of the Pharmaceuticals and Medical Devices Institute was issued in 2006, with which hot debates have started within the pharmaceuticals sector- particularly among pharmacists- who call this Draft Law as the final and the most important step taken to transform the pharmaceuticals sector, which should be seen as one of the most important parts of the macro level health transformation project (Kaplan 2007: 1). It is argued that with this Law liberalization of pharmaceuticals market would be realized, the responsibility of the state (the Ministry of Health) in pharmaceuticals sector would be ended and the Pharmaceuticals and Medical Devices Institute that would be established could not be held responsible for many issues although it would have the authority, pharmaceutical products and drugs could be sold at places other than pharmacies and advertisements would be possible for pharmaceuticals (Kaplan 2007: 1-4).

Finally in November 2011 with the Statutory Decree No. 663[126] Pharmaceuticals and Medical Devices Institute of Turkey (Türkiye İlaç ve Tıbbi Cihaz Kurumu) has been established.

[126] Resmi Gazete (2011b) Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions), No: KHK/663, 02.11.2011.

It would be quite contributory to analyze NICE (National Institute for Health and Clinical Excellence) of England while trying to understand the Pharmaceuticals and Medical Devices Institute in Turkey as these two institutions seem to have many things in common. NICE, which was established in early 90s has been highly debated both within the NHS administrative circles and in the British society[127].
With the establishment of Pharmaceuticals and Medical Devices Institute relevant sectors and their actors in Turkey will be introduced to concepts such as health technology assessment, evidence-based decision-making, rational use of resources and cost-effectiveness in pharmaceuticals and medical devices. As it has been mentioned many times throughout this dissertation, these again should be considered within the context of New Public Management Reforms together with all their implications for regulatory and institutionalist connotations.

7.4.3.3.8 Health Information System

HTP calls for an "Integrated Health Information System" (Entegre Sağlık Bilgi Sistemi) in order to attain secure and continuous preservation of health records, to increase efficiency of services, follow how and where resources are used, determine problems and priorities in the sector, develop better policies, plan investments and researches and evaluate quality of the services provided (HTP 2003: 36). In line with the developments in technology, it stresses a system where there is less dependence on consumer-service provider relationship.

Here HTP also refers to the Chain of Referral System and the MERNIS Project with which now every Turkish citizen has a Citizenship Number (HTP 2003: 37).

After putting down the main components of the transformation in the health care system as such, HTP makes the following general remarks:

It states that the document itself is a preliminary draft and that each and every component of it will be discussed with national and international specialists in order

[127]For further information on NICE and its resemblance with the Turkish case, refer to Demirci (2008).

to outline basic conceptualizations, objectives and principles. In this regard the next step is said to be the legislative process where the mandates of HTP will be transformed into legislation. In this context limited and controlled pilot implementations of certain components are said to be realized before making them mandatory in the whole country (HTP 2003: 37-38). (As it would be recalled, Family Medicine System was launched as pilot projects in several provinces until its full adoption in the whole country by the end of year 2010.)

HTP declares its dedication to transparent administration of all its processes. Construction of a special web page on which every step made and any ideas from anyone will be published is promised (HTP 2003: 38). However this has not been realized so far. A strong commitment is made to provide the participation of all relevant parties including scientists, professionals' associations, trade unions, industrial organizations, businessmen, private sector, entrepreneurs in health sector, NGOs, political parties, deputies and the public in general (HTP 2003: 38).

Here it should be asked to what extent the actors mentioned were asked to participate in the formulation of the HTP and in the legislative process started afterwards to realize its mandates. It is known that many of these mentioned groups complain that their voice was not heard in these processes- particularly deputies from opposition parties, doctors' association, pharmacists' association, certain NGOs, scientists and various segments of the public.

In addition to these HTP also stresses the importance of creating the mechanisms to benefit from the experiences of organizations such as the World Health Organization or from the experiences of scientists and experts dealing with health issues worldwide in order to catch up with the developments taking place on the international arena where contributions from Epistemic Communities are highly praised.

Finally HTP also stresses the effective use of the funds supplied by the European Commission to Turkey (HTP 2003: 38).

As it can be seen, with all its aforementioned components like family medicine system, compulsory universal health insurance, autonomous public hospital unions and the like HTP foresees a very serious transformation in health care system where decentralization and finance play a central role. A critical overview of this transformation will be made in the following sections of this study.

7.4.4 Other Regulatory Attempts Complementing to HTP

It has been mentioned that HTP should be taken as part of a rather macro restructuring process where some other regulatory attempts having a complementary characteristics to the HTP- at least those that have been attempted since 2003- are also worth mentioning. In this regard Basic Law on Public Administration, Law on Provincial Local Governments, Municipal Law and Law on Metropolitan Municipalities can be mentioned as the legislations which make references for the reformation of the health care system- particularly in terms of its organization and decentralization. These laws- particularly the Basic Law on Public Administration- foresee a system which favors a more decentralized administrative structure in Turkey in general[128].

Here it should be noted that the incremental and trial and error characteristics of the reforms in general have also been felt in these legislations which makes them closer or different from the successive HTP legislations. This could clearly be seen in the shift in the decentralization understanding where previously the above mentioned laws foresee a decentralization in which the idea was to transfer health care services from the central government to local governments- particularly to provincial local governments- whereas the HTP and its complementary legislations foresee a decentralization where the idea is to transfer administrative and financial autonomy to hospitals and related health care institutions- which is in fact the trend followed in most of the countries which have been undergoing health care reforms.

[128] Basic Law on Public Administration was passed from the GNA however it has not come into effect since then.

In addition to these, Law on Foundation, Coordination and Duties of Development Agencies can also be mentioned as a complementary legislation to HTP. Although it does not make any direct reference to health care issues, since the law charges development agencies with planning regional development and undertaking required duties to this regard, it seems that these agencies would have a say in health care investments and in public-private partnerships in this area.

Finally, it should be added that the legislations that have been mentioned so far are the ones which have been well to the fore within the context that has been analyzed. Many other legislations have already been enacted in order to realize the mandates of the HTP- such as the Circular on the Provision of Ambulatory Services (Acil Sağlık Hizmetlerinin Sunumu ile İlgili Başbakanlık Genelgesi) or Guideline on the Grading of Private Hospitals (Özel Hastaneler ile Vakıf Üniversite Hastanelerinin Puanlandırılması ve İlave Ücret Alınması Hakkında Yönerge) and the like – which have not been covered in this study.

7.5 What kind of a Transformation is foreseen by the HTP?

7.5.1 What kind of a Decentralization Model is foreseen by the HTP?

When the HTP and its complementing documents are analyzed it is seen that on the one hand the reform process praises and foresees quite a decentralized organization for the health care system, however, on the other hand there have also been various attempts towards re-centralization. This points to a *hybrid model* for the organization - decentralization pattern of the HTP. It has been mentioned earlier that this kind of mutual or consecutive decentralization/re-centralization attempts have been highly experienced in the countries that have been undergoing public sector reforms.

In fact this mutual or consecutive combination of decentralization/re-centralization attempts are quite compatible with the small but strong state/public sector understanding of the New Right and the Neoliberal restructuring process and with its accompanying New Public Management Approach in order to be able to realize required transformations (Aksoy 2003: 557). As Aksoy points out, although they

appear to favor a pro-decentralization approach, they try to preserve a strong and hierarchical central structure (Aksoy 2003: 557). Here it would not be wrong to argue that devising this kind of hybrid models has emerged as a strategy which is quite handy and thus been used by the restructuring processes of the capitalist state so far.

As it has been quoted in the above sections, successful decentralization is said to require careful planning and implementation where programs of decentralization should be small in scope, given adequate time to prove themselves, centered around specific financial or managerial functions, and include a training component (Rondinelli et al. 1983: 4).

Moreover developing countries are advised to have an incremental attitude in their decentralization attempts in order to build the capacity of non-governmental and local organizations to make them accept and effectively carry out their new functions and responsibilities. In addition to that it is recommended that the process should be carefully "nurtured from the center" with a shift in the orientation of central bureaucracy from control to facilitation and support **(**Rondinelli et al. 1983: 4**)**.

This attitude in fact highly reflects the path that has been followed in Turkey so far regarding the transformation in health care services where even the most radical steps are taken in an incremental manner such as "two steps forward and one step back". This kind of an incremental attitude can be observed not only in nearly every aspect of the health care transformation but also in many other public sector reforms. A muddling through way of reforming has been another outstanding characteristic of the capitalist state in its restructuring process which is also compatible with its inclination for putting forward hybrid models.

Here it should be repeated once more that there has been a shift in the conceptualization of decentralization that would be adopted for the health care system in Turkey. Previously, with the Basic Law on Public Administration, the attitude was towards delegating authority and responsibility for the provision of health care services to local government bodies. However later HTP and legislations

complementing HTP have brought about an understanding which favors delegating this authority and responsibility to the hospitals and related health care institutions- particularly to Public Hospital Unions which are deemed to have administrative and financial autonomy. In fact it is this second approach which is actually adopted by the countries that have been undergoing health care reforms.

As it has been analyzed in the above sections, HTP and its complementary legislations such as the Law on Family Medicine and Law on Public Hospital Unions have brought about serious arrangements for the organization (decentralization/re-centralization) of the Turkish health care system. As it has been mentioned right at the beginning of this dissertation, arrangements targeting organization (decentralizing/re-centralizing) of health care services also have implications for the financial aspects of this system (and also vice versa) which will be dealt with in the succeeding section.

Finally it should be noted that reforms attempting decentralizing/re-centralizing Turkish health care system have many things in common with the ones experienced within the British NHS, which will be discussed in the following sections. At this point practices such as making hospitals have administrative and financial autonomy, creating an internal market within the health care system with a provider/purchaser split and its dynamics towards more competition and finally the mutual/consecutive embodiment of decentralization and re-centralization can be quoted.

7.5.2 What kind of a Financial Model is foreseen by the HTP?

As is the case with its organization (decentralization), HTP foresees a hybrid model for the finance of the health care system. The hybrid financial system put forward by the HTP is based on three main axes: compulsory premiums paid by every citizen, general revenue (general taxation) and complementary private insurance. This points to a model which carries elements from the three main health care financing models – namely the social health insurance model, the Beveridge model and the liberal model.

In several recent studies, health care systems financed by similar hybrid models are called National Health Insurance (NHI) Model (Lee and Chun 2006). This hybrid model basically aims at universal coverage through a single system for the entire population. This model is also defined as an output of the "Bismarckian System's meeting the Beveridge" where the co-existence of these two models in a unified and functional manner is said to be central to their success (Kutzin et al. 2009).
In this hybrid model, universal coverage is funded from the following: general revenues where citizenship/residence is taken as the criteria, compulsory social health insurance benefits paid by the citizens and private insurance whose purchase is highly encouraged as complementary to the explicit benefit package. In addition to these all the other related local budgetary funds, co-payments and the like are all pooled in a single national fund designed for the Social Security Institution, to be used for the purchase of the health care services.

Social Security Institution purchases health care services for the whole population entitled for the Universal Coverage from the providers. The purchases are done on the basis of outputs (such as case-based payments) and needs (such as capitation) (Kutzin et al. 2009: 550). In this system more autonomy is given to hospitals as the health care providers regarding their administrative and financial affairs.

An explicit benefit package is determined and it is purchased by the Social Security Institution from the providers for the (whole) population covered by universal health insurance.

It is stated that in this model general budget revenues- which often used to be the main source for health care finance- are transformed from directly subsidizing the supply of health care services to subsidizing their purchase (Kutzin et al. 2009: 549).

Regarding this kind of hybrid models, Kutzin et al. argue that they demonstrate it is possible to use different sources of funds in a complementary manner to enable the creation of a unified, universal system (Kutzin et al. 2009: 549).

It is not easy to denote the health care systems which have gone through health care reforms with the mainstream health care system typologies. It is usually the case that the reformed systems carry a hybrid character which bears traces from those mainstream models.

In this regard it seems quite explanatory to refer to the new typology devised by Lee and Chun (2009) - namely the National Health Insurance Model (NHI) - in analyzing health care systems that have gone through transformations. It should be noted that Lee and Chun devised this model in order to better explain the health care systems of Korea and Taiwan which they think could not be fully explained by the mainstream health care models (Lee and Chun 2009: 3). However, when one analyses this new typology he/she could see that it quite clearly denotes the basic characteristics of the hybrid model that this study has been trying to figure out for Turkey after the HTP.

According to the classification made by Lee and Chun (2009: 12) main characteristics of NHI model could be summarized as follows:

First of all the basic principle which the NHI model is centered around is "universalism", which implies attaining universal coverage within the whole country.

In this regard the second principle is the "citizenship" entitlement which means that universal coverage would be attained on the basis of citizenship regardless of any other criteria such as sex, age, income, health status, etc.

Thirdly, the NHI model sets the boundary of social solidarity as "national" which implies that the range of risk pooling would be the entire nation.

Fourthly, NHI model is taken to allow extensive use of private health care resources which points to the fact that the model relies greatly on private financing of the health care services. In this regard, source of health care financing for the NHI model is listed as citizens' contributions + tax revenues. Although Lee and Chun do not mention explicitly the share of private health care resource in this column, as has just

been mentioned they dedicated a separate column to this item as “extensive existence of private health care resource” within the NHI.

Fifthly, it is seen that proportion of public financing in total health care expenditure is also high in the NHI model, no matter it is not as high as in the Beveridge model.

Sixthly, NHI foresees a health care system in which a single specialized institution carries on the responsibility of health care financing on a centralized basis.

Finally, in the NHI model, the role of the state is more of kind of a regulator and a conductor rather than the direct provider. In this regard the strength of state regulation on private health care resource is defined as “extensive, strong and detailed”.

Here the table prepared by Lee and Chun, in which they put down the basic characteristics of the NHI model and compare them with that of mainstream health care models, will be quoted as it is quite explanatory and enlightening for the purposes of this study.

Table 5 Comparison of NHS, SHI, NHI and Liberal Type of Health Care System

	NHS model	**SHI model**	**NHI model**	**Liberal model**
1. Social value for constitution of health care system				
1.1 Basic principle	universalism	Corporatism	Universalism	Liberalism
1.2 Principle of population coverage	citizen	the insured	Citizen	the vulnerable
1.3 Boundary of social solidarity	national	among individual groups of the insured	National	between the vulnerable & the others
2. Main body of health care services provision				
2.1 Existence of private health care resource (*Percentage means the proportion of public beds)	limited GB: 96.0%(1998)	Germany: limited Japan: extensive Germany: 53.1%(2003) Japan: 35.8%(1998)	Extensive Korea: 17.5%(2004) Taiwan: 33.0%	Extensive US: 33.7%(1995)
2.2 Strength of state regulation on private health care resource	extensive, strong, detail	Germany: limited, medium, general, Japan: extensive, strong, detail	extensive, strong, detail	limited,
3. State intervention into health care system				
3.1 Proportion of public financing in total health care expenditure	UK: 83.0%(2001)	Germany: 78.6%(2001) Japan: 81.7%(2001)	Korea: 54.4%(2001) Taiwan: 64.4%(2001)	US: 44.9%(2001)
3.2 Source of health care financing	Tax	Germany: social insurance contribution Japan: social insurance contribution & tax	social insurance contribution & tax	tax, premium
3.3 State administration of health care financing	Single	Multiple	Single	Multiple
3.4 Characteristics of state intervention	Provider	Germany: regulator Japan: conductor	Conductor	regulator at low level

Source: (Lee and Chun 2009: 12 - [Table 5] Comparison of NHS, SHI, NHI and Liberal Type of Health Care System)

When this table is carefully analyzed, it would not be wrong to argue that the NHI model – which is a hybrid model carrying characteristics from three of the mainstream health care systems – bears more common characteristics with the Beveridge Model compared to the other two models. As it has been mentioned (and as it can be seen from the table as well) NHI is a model where "Bismarck meets Beveridge" (Kutzin et al. 2009) - and according to us it also meets the liberal model to a serious extent as well. That is to say NHI exhibits a model in which elements from Bismarckian model (e.g. compulsory premium payment) and elements from liberal model (e.g. increase in private health care resources) have been added to the main Beveridge Model together with a shift in the role of the state from being direct provider to conductor of health care services. Thus this strengthens the argument of this study that health care systems that have been undergoing reforms have been evolving towards a hybrid model in which the Beveridge model constitutes the base however with increasing elements from the liberal and Bismarckian models.

As it has been mentioned above before the HTP Turkish health care system did also exhibit a hybrid model in which Beveridge characteristics had a serious weight vis a vis the other two models (as the system was mainly financed by the general revenues) where with the liberal model having the least weight compared to the Bismarckian model (as there were three different social security institutions collecting premiums and that the share of private resources in health care finance were quite less).

Now after the HTP, Turkish health care system still exhibits a hybrid model where the base model is still the Beveridge model however this time with more emphasis on the liberal model relative to the Bismarckian one. At this point it seems that the post-HTP system has many things in common with the NHI model.

In reforming health care finance, the most fundamental step taken has been the adoption of Universal Health Insurance.

In addition to that Private Health Insurance has been encouraged as complementary to the Universal Health Insurance.

It should be noted that transformation in health care system have strong implications for privatization oriented practices -which are sometimes held simultaneously under the banner of decentralization. These practices can be exampled as follows:

a. Assignment of hospitals belonging to the former Social Security Institution (SSK) to the Ministry of Health (as an example of re-centralization). After this assignment now all public hospitals are subject to same rules and regulations in making contracts within the internal market created in the health care sector. It is speculated that this merger would provide the easy privatization of public hospitals in the long run. It is also added that transfer of the hospitals of Social Security Institution to the Ministry of Health also deprived those hospitals from their competence to wholesale and thus cheaper purchase of pharmaceuticals from the market.

b. Citizens covered by the new Universal Health Insurance are made free to apply to private hospitals. As a response to that there has been a serious increase in the number of private hospitals since the adoption of the HTP. Increase in the reimbursements made by the Social Security Institution to the private hospitals will be touched upon in the following section while discussing the impacts of the HTP on economic and political aspects of the health care system. In addition to these it is also argued that allowing citizens covered by Universal Health Insurance Scheme to go to private hospitals is a way of channeling public funds to the private sector via Universal Health Insurance and the Social Security Institution where not making the chain of referral system work is also said to be contributing to this process.

c. It is known that besides auxiliary services such as cleaning or alimentation more and more clinical services such as MR or laboratory services are contracted out by the public hospitals. Even in some cases these private contractors can serve not only in a competitive manner but also physically side by side with the providers of the hospital in question[129].

[129] This last remark is based on a personal experience of the author where she witnessed in a public hospital that MR services were provided by both the hospital itself and the private contracter and that their personel were serving side by side in the same phsical environment where that of the private contractor were behaving in a quite competitive manner. (Venue: Ankara Dışkapı Hastanesi; Date: January 2010).

d. With the launch of the discussions on the full-time employment of the doctors working in the public sector, a great number of doctors have resigned from their posts in the public hospitals and universities and started to get employed in the private hospitals whose numbers have increased in a dramatic manner since the adoption of the HTP[130]. It is argued that this is another way of urging privatization in the health care system which would also have serious drawbacks for the working life of the doctors[131].

As it has been mentioned several times till now, attempts towards decentralization (re-centralization) and towards reforming the financial system of the health care services usually go hand in hand.

In Universal Health Insurance, price control and finance of health care services are undertaken from one center. (In the Turkish case this is done through the Social Security Institution.) It is argued that this would lead to an effort towards decreasing health care costs and expenditures, encourage preventive health care and decrease excess use of pharmaceuticals and medical devices. (HTP 2003: 28).

Here again it is possible observe that HTP which constantly complaints about the centralized structure of the health care system in Turkey wants to centralize the price control and finance of health care services. This attitude is the result of the same logic that has been discussed above- i.e. in order to have a rather smooth transformation and restructuring process it is necessary to have a strong center - no matter how big its size is.

To be more precise in terms of transformation of health care services, it is possible to say that such a strong central organization is necessary for the rational use of resources, for their easy manipulation and allocation to the targeted realms - e.g. to the greedy private sector which have been highly investing in the health care sector.

[130] Bayer (2011)

[131] A final step to note on this issue is that the Higher Education Board has declared that they have been working on a proposal with which they would make it possible for the instructors of medical schools who prefer to open their own surgeries or work in the private hospitals to become contracted personnel for the university (hurriyetEgitim.com, 2011).

Moreover such a strong central organization would make it easier for the state to attain the curbing it plans to make on health care expenditures.

As it has been analyzed above, practices regarding Family Medicine and Public Hospital Unions have also brought about serious changes for the finance of the health care system. With these regulations GPs and hospitals would be granted financial autonomy which basically makes them responsible for the management of the money allocated to them. Moreover with this financial autonomy, in certain occasions they would also be asked to create their own resources within the context of the competitive internal market which would be created in the health care sector.

With their given or self-created budget, GPs and public hospital unions would purchase required services from the providers within the internal market. In this way they would be made to survive in this competitive environment. In this context their allocations would be subject to their performance computed according to various criteria including the frequency of their being preferred by the patients. If they would fail to satisfy the necessary criteria and fall below the determined score their allocations would be diminished or they might be abolished at all.

This competitive internal market context highly affects doctors who now face situations which they are not educated for. They are made to behave according to market rules and managerial principles which not only diminish solidarity among them but also challenge their clinical autonomy. This also makes their working conditions more open to abuses, make them more defenseless vis a vis rather harsh demands of the market and cause various ethical problems.

Finally, it can be said that, at least in the eyes of the public, this model has caused a shift regarding the responsibility for the provision of health care services from the state to the hospitals and doctors which are now deemed to have more autonomy.

As it can be clearly seen all these development have brought about serious changes for the health care finance in particular and for the overall health care system in general.

At the end of this section, in the light of all these findings, it is possible to detect two outstanding characteristics of the transformation which are worth re-mentioning here:

The first one is regarding its *incremental* attitude and the second one is the about the *hybrid* character of the models proposed by the transformation.

7.5.3 Incremental Change vs. Bigger Change

HTP exhibits a serious transformation which has been rather incremental. In the HTP document it is clearly stated that incremental and continuous change is preferred to bigger and ambitious changes in reforming Turkish health care system.

According to the document the most important difference between developing and developed countries in terms of reforming their health care systems is this incremental vs. bigger changes where the latter creates distrust and antipathy in reforms in developing countries. In this regard the document declares its adherence to small and effective changes within the system in order to attain continuous change and development (HTP 2003: 8). As it would be recalled from the above quotation, this attitude is right compatible with the suggestion made for the developing countries (Rondinelli et al. 1983: 4).

It is also declared that it may not be the case that every component of the HTP is perfect. However what is important is said to have a look at the whole program as it says in the recent years, over-consideration on attaining the perfect in separate pieces caused failures in the overall reformation processes. (HTP 2003: 26).

However it should be noted that although HTP calls for incremental change, when one analyses the changes/reforms made to the health care system in Turkey so far, he/she can see that it is the HTP which brings about the most ambitious and most radical changes so far. Here it is possible to refer once more to the above discussion made on the use of the terms “reform” vs. “transformation” in denoting HTP.

In fact incremental approach is compatible with the neoliberal restructuring process that has been taking place in the public sector since 1980s, where the process makes a muddling through and accords itself to the upcoming developments where usually hybrids models have been the end products.

As HTP itself declares, the route it follows is not diverting from the one launched in 1980s. As it has been mentioned above HTP has many common points with the socialization process of 1960s and with the other mostly non-accomplished reform attempts made in the post-1980 period. However, it is evident that it's the HTP which has a rather ambitious character in terms of achieving the most serious transformation attempted so far.

Therefore it would not be wrong to say that HTP aims at achieving the most radical transformation ever in health care system- however with an incremental attitude which in the final analysis is quite compatible with the requirements of the restructuring process of the capitalist state.

7.5.4 Hybrid Models

Regarding the two aspects of the HTP which this study mainly concentrates on- namely its organization (decentralization) and finance- it is possible to see that we are introduced to some hybrid models:
In terms of organizational aspects, although on the one hand HTP complains about over-centralized structures in the health care system and favors more decentralization on the other hand it shows strong commitments to practices towards re-centralization as well. That is to say HTP foresees a health care system which accommodates both decentralization and re-centralization together in a hybrid model. As it has been discussed above, this is in fact what this kind of a transformation process requires in order to accomplish its mandates- i.e. to be flexible enough to find its way through the current tides of the transformation and restructuring processes.

When it comes to finance again it is seen that HTP foresees a Hybrid model which has been recently called the National Health Insurance (NHI) Model in certain

contexts- where a rather centralized organization is tried to be established with the Universal Health Insurance and Social Security Institution no matter discourses are put forward on the drawbacks of centralization and advantages of decentralized structures. As it has been mentioned, this model highly deserves to be called "hybrid" as it puts forth a system which bears characteristics from the three mainstream health care typologies- namely the Beveridge, the Bismarckian and the Liberal model. Finally, at the expense of repetition, it can be emphasized once more that creating hybrid kind of models is an attitude which is highly compatible and easy-going with the state restructuring processes that have been experienced so far.

7.6 What Have Been/Would Be the Impacts of the HTP Reforms?

Health is an issue which should not be analyzed without an examination of the socio-economic and political context- among which there is an interactive relationship. Therefore, as it has been repeated several times, HTP should also be examined within its socio-economic and political context.

In this section socio-economic, political and cultural (philosophical) impacts of the HTP reforms will be discussed. This discussion will be made around the criteria that have been adopted at the beginning of this study while operationalizing this research. In analyzing the impacts of the HTP reforms so far, this study will try to refer to factual (statistical) information as much as (and to the extent that it is) possible/available. Finally it should be noted that the classification made for the impacts of the HTP as economic, political, managerial, clinical, conceptual, etc. are mainly done with the aim of making things easier to explain. Other than that it is certain that there is high degree of transitivity among these categories – e.g. any legacy that is analyzed under the banner of economic impacts may quite certainly have political repercussions.

7.6.1 What Have Been/Would Be Its Effects on Economic Dimensions of the Health Care System?

In Turkey total expenditure on health (% of GDP) has increased since year 2002. It was 5.4 in 2002 and 6.1 in 2008 (latest year available) (OECD 2011b). However, this was still below the OECD average which was 9.5 in 2009 (OECD 2011a: 1).

When it comes to total expenditure on health per capita, there has been a serious increase- from 442 $ in year 2002 to 818 $ in year 2008 (OECD 2011b). However, being the country having the lowest GDP per capita among the OECD countries, Turkey does have the lowest health spending per capita (which was 902$ in 2008) where the OECD average was 3223$ in 2009 (OECD 2011a: 1).

As it has been mentioned above public sector continues to be the main source of health care funding in all OECD countries, except Chile, Mexico and the USA (OECD 2011a: 2). Public expenditure on health (% of total expenditure on health) was 70.7 in year 2002 and it has risen to 73.0 in 2008 where the OECD average was 71.7 in 2009 (OECD 2011a and 2011b). However, the increase was rather more striking between 2000 and 2001 (62.9 and 68.1 respectively) which points to the period before the HTP.

There has been a serious increase in public expenditure on health (per capita) which was 312.6$ in 2002 and has risen to 658.6 in 2008 (OECD 2011b).

Out of pocket payments as % of total expenditure on health was measured 19.8 in year 2002 and it has risen to 21.8 in year 2007 (OECD 2011b). There has been a serious increase in out of pocket payments per capita (US $), which was 87.7 in 2002 and has risen to 167.4 in 2007 (OECD 2011b).

Share of public and private health expenditure in GDP (%) was measured as 3.79 public health expenditure and 1.57 private health expenditure in year 2002 (total 5.36) and 4.44 public health expenditure and 1.64 private health expenditure (total 6.08) in year 2008 which shows that there has been an increase in both public and

private health expenditure since the adoption of the HTP (Ministry of Health of Turkey 2011: 125, Figure 9.1).

Public health expenditure per capita (US $) was measured 133 in year 2002 and it has risen to 456 in year 2008; whereas private health expenditure per capita was measured 55 in year 2002 and 168 in year 2008 (Ministry of Health of Turkey 2011: 126, Figure 9.3). This shows that there has been an increase in both public and private health expenditure per capita since the launch of the HTP.

Health insurance coverage for a core set of services was measured as 67.2 for Turkey for the year 2003 (latest year available), which was around 100 for the majority of the OECD countries in year 2007 (OECD 2009). Private health insurance coverage was 1.8 in Turkey in year 2006 (latest year available) which was of type primary health insurance (OECD 2009). Nevertheless data for the share of private health insurance in total health expenditure for Turkey was not available.

It has been reported that there has been an increase in private health insurance holders where especially having complementary health insurance has been encouraged (SES 2011: 19). This is mainly due to ambiguity in difference payments, increase in the use of contributory payments and out of pocket payments and limitations and ambiguity regarding health care packages provided within the context of universal coverage, which in the end all shifts the burden of health care finance from the state to the individuals. It is claimed that with the establishment of public hospital unions there will be more increase in the no/share of private health insurance companies (SES 2011: 20). There has also been an increase in the number of Individual Retirement Insurance holders which is a system introduced in 2003 (SES 2011: 20). Finally it has been reported that within the finance sector it is the insurance sector which comes the second after the banking sector in terms of growth (SES 2011: 20).

Share of the budget of the Ministry of Health in GDP was measured 0.87 in year 2002 and it has risen to 1.53 in year 2009 (Ministry of Health of Turkey 2011: 129, Figure 9.9). In addition to that it has been reported that allocations made for the

Ministry of Health has risen by 23.7% in the 2011 budget compared to the budget of the previous year (SES 2011: 9). It has also been reported that allocations made for the family practice system has increased by 146.6 % in year 2011 compared to the one made in the previous year- which points to a really serious increase (SES 2011: 9). Transfers made to the Social Security Institution from general budget have risen from 9,684,000 (in year 2002) to 52,599,691 (in year 2009) (SES 2011: 9). Revenues collected by Social Security Institution through premiums (excluding contributions from the state) was measured as 21,178,426 thousand TL in year 2003 and it has risen to 54,579,182 thousand TL in year 2009 (SES 2011: 10). Payments made to health care providers by the Social Security Institution was measured as 10,661,718 TL in year 2003 and it has risen to 28,810,684 in year 2009 (SES 2011: 10).

When it comes to expenditures made on pharmaceuticals and medical technologies there is no statistics available for Turkey after the year 2003- which makes it impossible for us to make an evaluation about the effect of the HTP in this area. However it has been reported that public expenditures made on pharmaceuticals was 12,720 TL in year 2002 and it has risen to 15,400 TL in year 2010 (SES 2011: 10). It has been reported that there has been a 20.8 % increase (6.3. billion TL) in public expenditures on pharmaceuticals in the first half of the year 2009 compared to the very same period the previous year (Gazetevatan.com, 2009a).

Faced with this increase, the government has been thinking of adopting measures such as global budgeting or providing that expenditures would not exceed pre-determined amounts. The Ministry of Health has been reported to be firm on decreasing health care expenditures- particularly those made on pharmaceuticals. It is reported that to this end government has been negotiating with pharmaceutical companies in order to decrease the difference it has been paying for the reimbursement of the equivalent drugs. (Government pays the difference only up to the amount 15% of the cheapest drug available in the market, i.e. it reimburses those drugs which cost 115 TL where the cheapest available equivalent costs 100 TL in the market) (Gazetevatan.com, 2009b). In the same regard it has been stated that besides curbing public expenditures on pharmaceuticals, bills paid to private hospitals will be decreased by increasing the additional money demanded in these hospitals,

promoting primary care health care services and adopting Family Practice System in every province by the end of year 2010. By so doing it is expected that there will be a total saving of 3 billion in expenditures on social security expenditures (1.5 billion of which will be made in expenditures on pharmaceuticals) which in the end will ameliorate budget deficits (Alp 2009a).

7.6.2 What Have Been/Would Be Its Effects on Political Dimensions of the Health Care System?

Public-Private-Partnership (PPP) model has been adopted within the context of the HTP. In this regard Public-Private-Partnership Chamber has been established within the Ministry of Health- which is in fact the first example in the history of public administration in Turkey. As it has been mentioned above PPP model has originated in the UK and it is the UK practice of PPP which has been followed in the project of "health campuses" in Turkey.

This model has brought about new relations in the organization and finance of health care services which are mainly based on private law and contractual relations which highly challenges the "public" character of the health care services (SES 2011: 18).

Health campuses (PPP) model also shows the link between decentralization and finance discourses/practices of health care reforms. First of all with this model public investments in health care services have been decreasing while making it more possible and profitable for the private sector to invest in this area, which in the end has been leading to an increase in the number of private investments in health sector. It is not only the national capital but also the international capital which have been investing in this sector in an increasing number, which points to the strong link between decentralization (organization) of health care services and their finance. The amount of foreign direct investment which was 74 million $ in the year 2005 risen to 106 million $ in the year 2009 and has been measured as 54 million $ in the first 8 months of the year 2010 (SES 2011: 19).

In addition to this the increase in the number of private hospitals has also been striking. In 2002 the number of private hospitals was 271 and this has risen to 489 in year 2010 (Ministry of Health of Turkey 2011: 55, Figure 6.1). This increase in the number of private hospitals has been highly related with the HTP's making it possible for everyone (including the civil servants) to go to private hospitals within the context of the Universal Insurance System and the non-practice of the chain of referral system so far - both of which exhibit real incentives for the patients to go to private hospitals and in turn for the private capital to open up new private hospitals.

It was reported that there has been continuous increase in the reimbursements made to private hospitals by the SSI since 2004. Although this amount was 743 million TL in 2004, it was 1 billion; 1.7 billion; 2.4 and 4.4 billion TL in the succeeding years. It has been reported that the amount has been 2.3 billion TL for the first half of the year 2009 (Alp 2009b). In addition to that it has been detected by SSI experts that with the regulation which allows the patients to benefit from private hospitals, there has been great increase in the number of private hospitals which has been "creating their own patients" in order to survive economically, which in the end leads to lots of unnecessary tests and operations.

The experts point out that this has nothing to do with the accessibility of services or their improvement but has many things to do with the consolidation of the risk for creating an unhealthy society (Alp 2009b)[132].

As it has been mentioned above, with the adoption of the HTP which encourages having private insurance there has also been serious growth in the private insurance sector. As a result of all these developments hospital chains, mergers and monopolization have been the rising trends in the health sector in Turkey (SES 2011: 19). Thus it would not be wrong to say that HTP reforms have been playing a great role in channeling public funds to private sector.

[132] A very striking example given by one of these experts is that in a sub-province before the adoption of the HTP and before the opening up of private hospitals there was just one public hospital and at that time the number of by-pass operations made in one year was 20. However after the adoption of the HTP two private hospitals were opened in this sub-province and the number of by-pass operations made in one year has suddenly reached to 150- where it has been reported that these hospitals made lots of unnecessary operations to make profits (Alp, 2009b).

In this regard inspired by Harvey it can also be argued that health sector has been quite an important area for the capitalist system to overcome its cyclical problems on capital accumulation. With the adoption of the HTP while the state has been taking its steps back from investing in health sector it also opens and eases the way for the private sector to make investments in this area. Moreover with the aforementioned practices the state also channels public funds to the private sector through the health care system. Health campuses can be considered as a serious project in this regard which not only creates built environments but also provides wide opportunities for the private sector to invest and channel accumulated capital to the health sector which is an area where less and less public investments are seen.

With the adoption of the HTP new and powerful-actors have been introduced to the health sector where the Social Security Institution (SSI) and the private actors (mostly seen in the form of owners of private hospitals and private insurance companies) have been the most outstanding ones.

After the HTP, Social Security Institution (SSI) has come out as the actor which occupies the most critical position within the health care system. In the new system it is the relationship between the citizen and the SSI and the one between the health care providers and the SSI that are central to the health sector processes. As it can be guessed it is the SSI which is the determining actor in these relationships since it is this institution which collects the premiums from the citizens and makes the payments to health care providers. With the declarations/notifications it issues, SSI has been having a great say in the post-HTP health care system.

As it has been mentioned above, position of the SSI within the health care system points to co-habitation of decentralization and (re)-centralization discourses/practices within the HTP where although decentralization has been praised in many respects such as having administratively and financially autonomous hospitals SSI has been placed at the center of all critical processes with a determining position.

Private capital- which is mainly seen in the form of private hospitals and private insurance firms – have also emerged as another powerful actor in the post-HTP

period. In the light of what have been discussed above, such as the serious increase in the number of private hospitals, in the amount of foreign investments and the trends towards mergers and monopolization in the health care sector it seems quite predictable that in the near future private capital will strengthen its position within the health care system in Turkey.

In this regard one of the powerful actors of the pre-HTP period – namely the associations of health workforce (particularly Doctors' Association) – continue to voice their comments and critics on HTP, however, their prospective position vis-à-vis the aforementioned two actors which have been strengthening their position within the health care system will be seen in the course of the development of the upcoming HTP reforms which have also been directed towards re-ordering working conditions of the health workforce in many respects so far.

At the end of this section depending upon the available statistical data, it would be useful to make the following remarks on the HTP-related policy preferences of the recent period:

First of all it can be said that there has been an increase in the number of primary level health centers (owned by the Ministry of Health). The number of Family Health Centers (Aile Sağlığı Merkezleri) has risen from 943 to 6,367 from the year 2007 to 2010. The number of Population Health Centers (Toplum Sağlığı Merkezleri) has also risen from 182 to 961 in the same period. Finally the number of 112 Emergency Care Stations has risen from 480 to 1,375 from the year 2002 to year 2010 (Ministry of Health of Turkey 2011: 68, Table 6.12).

However there has been a decrease in the number of hospital beds provided by the Ministry of Health. Number of Ministry of Health hospital beds per 10,000 population was 17.0 in the year 2007 and this number has decreased to 16.3 in the year 2010 (Ministry of Health of Turkey 2011: 59, Figure 6.4). This can be taken as another indicator of shrinking public investments in health care services. In the same regard another indicator can be the relative increase in the number of hemodialysis centers owned by the Ministry of Health compared to the one that has been observed

in the private sector which was really high. The number of hemodialysis centers owned by the Ministry of Health has increased from 235 in year 2002 to 319 in year 2010 whereas the increase in the number of hemodialysis centers owned by the private sector was from 170 to 390 (Ministry of Health of Turkey 2011: 62, Figure 6.9). All these can be taken as explicit indicators of the attitude of the HTP which rather prefers to concentrate on/invest in primary level health care services and let the secondary level or tertiary health care services be provided by other sectors- where the private sector hits the list. This argument is also supported by the latest financial crisis emerged in the university hospitals some of which have already been devolved to the Ministry of Health.

One final remark can be made regarding the increase in the number of medical schools and the number of students enrolled to these schools- which can be taken as the complementary policy of the HTP- that this increase in the number of doctors was required in order to respond to the growth in the demand fostered towards health care services in Turkey. In the year 2002 there were 40 medical schools in Turkey which has risen to 69 in the year 2010. The number of students enrolled to medical schools were 31,786 in the year 2002 and this number has increased to 41,664 in the year 2010 (Ministry of Health of Turkey 2011: 88, Table 7.15).

7.6.3 What Have Been/Would Be Its Effects on Managerial Dimensions of the Health Care System?

One of the most fundamental changes brought about by the HTP was the adoption of managerial principles by the health care system as a whole and particularly by the hospitals which have been encouraged to enjoy administrative and financial autonomy. In this regard corporatization of public hospitals which are classified according to their performances and which are made to compete with each other and other health service providers in the internal market created within the health care sector has become an important outcome of the HTP. As it has already been mentioned, a research was conducted in a public hospital in order to understand the effects of the HTP at the hospital level. That research did provide a cross-sectional photo of how this corporatization/managerialisation has been occurring at the

hospital level in practice. Details of this research can be found in the following section.

Increasing influence of managerialism and consolidation of managerial principles within the health care system as a whole can be clearly observed in various practices which have been introduced/consolidated by the HTP. In this regard creation of internal market and the provider/purchaser split within the health care system together with its autonomous service providers and the competitive environment, adoption of health technology assessment and establishment of pharmaceuticals and medical devices institute, increase in out-of-pocket payments, performance-based payment system and customer-oriented health care services are worth mentioning. All these examples and the others that have been elaborated on in the above sections do point to the fact that HTP has made serious attempts towards internalizing managerialist principles and practices in the health care system.

Internalization of managerialist principles have had serious impacts on the hospitals, patients, health workforce and on the quality of health care services provided.

It can be said that with the administrative and financial autonomy granted to them hospitals have been left to their own. They are expected to meet their ends themselves and also are under the strict control of the Social Security Institution (SSI), which is in fact the main determining actor within the health care system. Nevertheless, with such autonomy granted it is as if the state has shifted the responsibility for the proper provision of health care services to the hospitals. During the research mentioned above which was conducted in a public hospital it was reported that there have been cases where the SSI asks the hospital to discharge an uninsured patient without charging any money for the treatment it has provided however where the SSI also asks the same hospital to set the account for this patient properly at the reporting period. During the research it was also declared that with the establishment of the Public Hospital Unions this process of managerialisation would get even more intensified as the new institutional set up would require further adoption of managerial principles.

Adoption of managerial principles has highly affected the health workforces who are now expected to work according to the new competitive environment created within the health sector. For instance family doctors have been classified according to their performances and those who fall behind a certain score are faced with the sanction that they may face a 20% cut from their monthly allocations (SES 2011: 11, 16). With the performance-based payment system people employed in the public health sector do earn more compared to the previous era however there emerged serious problems regarding ethical and solidarity issues among them. Moreover it has been reported that working conditions of health workforce has deteriorated and that there occurred an increase in the number of contracted employees who do not enjoy job security which was something common to them in the previous period (SES 2011: 15).

Regarding its impacts on the patients, as it has been mentioned above, with the HTP patients have also been faced with an environment where they do have to take care of the market conditions created within the health care system. Now everyone has to pay premiums and patients do pay more contributory payments and make more out-of- pocket payments. Although now it is easier for the patients to reach health care services compared to the pre-HTP period, the quality of the services they receive has deteriorated due to drawbacks of various managerial practices. There have occurred cases where the doctor applied unnecessary treatments/operations (even sometimes at the expense of worsening the health status of the patient in question) or that the hospital did favor principles of cost-efficiency or profitability against quality of the service provided.

7.6.4 What Have Been/Would Be Its Effects on Clinical Dimensions of the Health Care System?

As it has been mentioned above, adoption of managerialist principles have had serious implications for the autonomy of and solidarity among the health workforce together with rising ethical considerations. In this regard clinical autonomy has been challenged that due to the increasing weight of market conditions and managerialism there occurred a decrease in the clinical autonomy of the health workforce,

particularly in that of doctors. While being obliged to act according to managerialist principles such as evidence-based decision-making, performance indicators or cost-efficiency, doctors have lost their clinical autonomy which in the end does affect the quality of the services they provide.

HTP complained that Turkey was lagging far behind among middle income countries in terms of health status (HTP 2003: 13-14). In order to see whether there occurred any improvement in health status of the country with the adoption of the HTP, the following basic health indicators worth analyzing- of course within the limits of the data available:

Total hospital beds per 1,000 population was 2.1 in year 2003 and with a slight increase this number has risen to 2.5 in year 2009, which is still the lowest number among the OECD countries (OECD 2011b).

Average length of hospital stay (days) for inpatients has decreased in all segments since year 2002. The numbers were 5.7 for the Ministry of Health Hospitals, 8.6 for university hospitals and 3.1 for private hospitals with a total of 5.8 in the year 2002. These numbers have decreased to 4.4, 6.2, 2.0 and 4.1 respectively in the year 2010 (Ministry of Health of Turkey 2011: 106, Figure 8.7). This decrease is compatible with the reform trend towards high turnover in hospital beds which is expected to be more cost-efficient.

Number of doctor consultations per capita has increased since the adoption of the HTP. It was reported as 2.8 in year 2003 and 7.3 in year 2009 (OECD 2011b). When the figures for the same data is analyzed for different OECD countries it is seen that this increase is highly related with the demand fostered within the health care system besides the procedures which now make it rather easier to reach health care services. In this regard it is really important to see how this increase in the number of doctor consultation per capita is dispersed among different regions of the country for which no data is available for the time being.

Per capita visits to Ministry of Health Care Centers have increased since the adoption of the HTP. Number of per capita visits to primary care health centers was 0.9 in

year 2002 and this number has risen to 2.7 in year 2010. Number of per capita visits to secondary or tertiary level health care centers was 1.9 in year 2002 and this number has risen to 4.1 in year 2010 (Ministry of Health of Turkey 2011: 114, Figure 8.17).

According to Ministry of Health Statistics number of total visits to Family Medicine Centers has increased from 22,902,118 to 108,976,049 from year 2007 to year 2010. Again number of total visits to Mother and Child Health and Family Planning Centers has increased from 1,869,385 to 11,309,093 in the same period (Ministry of Health of Turkey 2011: 112, Table 8.16).

Number of total hospital visits has increased for all sectors from 2002 to 2010- however the increase in the private sector has been really striking- which accounts to an increase of more than 9 times. Number of total hospital visits to Ministry of Health Hospitals was 109,793,198 in year 2002 and this has increased to 235,172,924 in year 2010. The increase was from 8,823,361 to 20,098,754 for university hospitals and from 5,697,170 to 47,712,540 for the private hospitals (Ministry of Health of Turkey 2011: 97, Table 8.1.).

Number of per capita hospital visits has increased for all sectors from year 2002 to year 2010- again with a striking increase in per capita visits to private hospitals compared to per capita visits to Ministry of Health Hospitals and university hospitals. Per capita hospital visits to Ministry of Health Hospitals was 1.66 in year 2002 and increased to 3.19 in year 2020 and per capita visits to university hospitals was 0.13 in year 2002 and increased to 0.27 in year 2010 –both of which point to an increase of approximately 2 times. When it comes to per capita hospital visits to private hospitals, we have an increase of more than 7 times in the same time period – 0.09 in year 2002 and 0.65 in year 2010(Ministry of Health of Turkey 2011: 97, Table 8.2).

Number of surgical operations has increased for all sectors from 2002 to 2010- again with a more striking increase in the number of surgical operations held in private hospitals. Number of surgical operations held in Ministry of Health Hospitals has increased 4 times (from 1,390,357 to 5,658,819), number of surgical operations held in university hospitals has increased approximately 3 times (from 389,099 to 1,126,066) and number of surgical operations held in private hospitals has increased

more than 6.6 times (from 274,195 to 1,829,904) from the year 2002 to year 2010 (Ministry of Health of Turkey 2011: 101, Table 8.6).

Number of doctors per 100,000 populations is quite low in Turkey compared to Europe. According to figures derived in year 2009, number of doctors per 100,000 population was 153 for Turkey which is quite low compared to the European average which was measured as 322 in the same year (SES 2011: 15-16). The figures were 80 and 226 respectively for the specialist and 141 and 727 for nurses in the same year (SES 2011: 15-16).

Life expectancy at birth has increased from 71.8 to 74.3 in total from year 2002 to year 2010. The increase for women was from 73.9 to 76.8, and for men it was from 69.8 to 71.8 for the same period (Ministry of Health of Turkey 2011: 11, Figure 2.1).

Infant mortality rate per 1000 live births was 28.5 in year 2003 and this number has decreased to 10.1 in year 2010 (Ministry of Health of Turkey 2011: 12, Figure 2.2).

Crude death rate at hospitals was at total 17.0 in year 2002 and this number has decreased to 13.5 in year 2010 (Ministry of Health of Turkey 2011: 109, Figure 8.13).

As an indicator of morbidity incidence of certain infectious diseases (per 100,000 population) such as measles, hepatitis B and malaria has decreased from 2002 to 2010; however with an increase in HIV infections (Ministry of Health of Turkey 2011: 22, Table 3.2)

When it comes to risk factors, there occurred a decrease in tobacco consumption since year 2003. In 2003 tobacco consumption (% of adult population who are daily smokers) was 34.5 and this number has decreased to 27.4 in year 2008 (OECD 2011b).

Regarding obesity- another risk factor- there occurred an increase since year 2003. Obesity rate (as percentage of total adult population) was reported 12 in year 2003 and this number rose to 15.2 in year 2008 (latest year available) (OECD 2011b).

Immunization coverage by years has improved in various types most of which have reached to more than 95% (Ministry of Health of Turkey 2011: 41, Table 5.1).

Average number of follow-ups per pregnant was 1.7 in the year 2002 and this has risen to 4.2 in year 2010. Average number of follow-ups per infant was 3.4 in year 2002 and this has risen to 7.1 in year 2010 (Ministry of Health of Turkey 2011: 48, Table 5.3).

Ratio of births realized in hospitals (in 100) was 78 in year2003 and this has risen to 92 in year 2010. Share of cesarean sections in all births (in 100) was 21 in year 2003 and there occurred a serious rise in this number in year 2010 that it was reported 46. Use of any contraceptive method in women aged 15-49 (in 100) was 71 in year 2003 and with a very slight increase this was reported 73 in year 2010 (Ministry of Health of Turkey 2011: 45, Table 5.2).

Regarding use of use of MRs, CTs, mammography, etc., no data was available for Turkey either in OECD statistics or in that of Ministry of Health.

7.6.5 What Have Been/Would Be Its Effects on Equity Dimensions of the Health Care System?

As it has been mentioned in the above sections, after the HTP it is easier for all the patients to reach health services compared to the pre-HTP period. However as it has been declared during the research at the hospital and as it can be inferred from the information derived so far the quality of the services they get has deteriorated.

When it comes to coverage it has been declared that with the Universal Health Insurance System (General Health Insurance) every citizen will be covered under the scheme provided by the Social Security Institution. However this coverage is

premium-based- i.e. health insurance will be provided to those who have paid their premiums.

Even in this context of compulsory health insurance coverage (thus compulsory premium payment) by the year 2010 number of people not covered by any social insurance was reported as 17% of the total population (SES 2011: 10).
In the new system, so far, the Green Card System has been preserved even with an increase in the number of Green Card holders and an increase in the content of this system. Although the logic behind the Green Card System was to make those who were not well-off to reach health care services, Green Card holders are also asked to make contributory payments. However they can now go to university hospitals with referral (SES 2011: 1, 14-15). It has been reported there is still a serious disparity in the allocation of Green Cards across regions (SES 2011: 14). Green Card System does not have a good reputation for so long that there have been many corruptions in the system so far. Nevertheless the Green Card System has been retained in the new system so far (i.e. up until September 2011) - most probably with the aim of providing kind of a subsidizing mechanism for the poor people to make them kept within the system. However the Green Card system is going to be abolished by the end of the year 2011. In this context Green Card holders will be subjected to kind of a "revenue test" and only those who are detected to have revenue under a certain level will keep their privileges to reach health care services under the state guarantee. The revenue tests are said to be repeated regularly to detect whether there occurred any change in the revenue levels of those who enjoy these privileges[133].

Thus by the beginning of the year 2012 compulsory Universal Health Insurance System will be put into practice for all the citizens in the country which will make everyone pay compulsory premiums. Only those who are officially entitled to be under a certain level of revenue will be exempted from paying premiums as their premiums will be paid by the state.

Besides the Green Card holders it is the former SSK insurees who have ameliorated their conditions as now they can refer to public hospitals and university hospitals and

[133] Gülten (2011)

can purchase their medicines from the pharmacies in the market rather than spending long waiting times at the queues in front of the hospital pharmacies. (However, as it has been mentioned, with the adoption of this new procedure now these people cannot enjoy cheap purchases of medicines which were the result of the monopoly enjoyed by the pharmacies of these hospitals through group buying). Whereas patients previously covered by the Retirement Fund have experienced a narrowing in terms of their reach to health care services and pharmaceutical products.

It can be said that with the new system there occurred an increase in out-of-pocket payments, particularly with the adoption and increase in the frequency of contribution payments and difference payments. In addition to that provision of health care services in forms of standard health care packages implies serious narrowing in the composition and content of health care services utilized by the citizens covered by the compulsory Universal Health Insurance. Even if you are an insuree who have paid all your premiums Social Security Institution (SSI) has the initiation to determine which treatments/tests would be covered (at what ratio) by the health package offered to you. Those expenditures which exceed the limits set by the SSI have to be paid by the insuree, which nevertheless makes these people feel the need to get complementary private health insurance.

All these imply that it is more and more the case that health care services are provided in a manner that “service follows money” compared to the pre-HTP period which in the end has negative effects on reach to qualified/satisficing health care services and thus highly challenges equity in health care. Increase in the number of applications to emergency services after the adoption of the HTP - as services provided in emergency services are free of charge- is a good indicator of this situation.

In this context it can be said that with the adoption of the HTP it is mostly the requirements and interests of the market which has been created within the health sector that have been cared so far. Although for the time being it seems that there have been various improvements in reach of patients to health care services compared to the pre-HTP period, with full implementation of the HTP together with

its all components it would be requirements of the internal market and the private investors in health care which would benefit from this transformation process in the long run. In this process it is the SSI which mediates between the public hospitals, the private sector and the individual insurees and dictates them the requirements of the internal market procedures.

It has been argued that with the adoption of the HTP new state-citizen relations and new citizenship practices have emerged (Üstündağ and Yoltar 2007: 91-92). According to Üstündağ and Yoltar (2007: 91-92) in the pre-HTP period there was a serious hierarchy among the people insured by the former Retirement Fund (Emekli Sandığı), Social Security Institution (SSK), Bağ-Kur, Green Card System and those who are not insured at all. In this hierarchy people insured by the Retirement Fund were the most privileged group followed by the SSK and Bağ-Kur insurees who faced certain difficulties in terms of reach to and quality of services. Green Card holders and uninsured people were at the lowest rank of the hierarchy where the former had a relatively better position compared to the latter. Üstündağ and Yoltar argue that with the HTP reforms this former hierarchy has been damaged that these groups have been made to become subject to equal norms and procedures where however we have new differences and inequalities. The most significant one is that with the Universal Health Insurance Model now the most important inequality is between the ones who have paid their premiums and the ones who have not. However, according to the authors inequalities also do exist among the ones who have paid their premiums. These inequalities arise on the bases of having information on the illnesses/treatments included in the basic health care packages, having information on difference payments and on facilities for benefiting from the services provided by private hospitals and at the same time covered by the Social Security Institution, and the like. These all point to a new model where the citizen has to be aware of the facilities provided by the health care system and particularly by the market created within this system in order to make the most of it. When this is the case it is not difficult to guess that unemployed people, women, poor and those people living in rural areas would highly lag behind in terms of reach to services and in terms of the quality of the services they utilize. All in all according to Üstündağ and Yoltar these point to the establishment of a new type of state-citizen relationship which is quite different from the one we used to have in the pre-HTP period.

7.6.6 What Have Been/Would Be Its Effects on Conceptual/Cultural/Philosophical Dimensions of the Health Care System?

What have been discussed so far about the impacts of the HTP imply an overall change in the conceptualization and philosophy of health care services in Turkey. With the HTP, health care has started to loose its characteristic of being a right related to citizenship and has become more a commodity that is sold and bought in the internal market that has been created where the state has smaller part to play. In this regard the burden of responsibility is less on the state and more on the individual himself/herself.

This change in philosophy and conceptualization of health care services constitutes one of the most critical aspects of the transformation. In fact this change in philosophy is not limited to individual patients who have been made to accept it and behave accordingly but also applies to any actor within the health care system who for instance have been made to work according to managerial principles in line with the mandates of the transformation at the expense of losing their clinical autonomy. This has to be so as this change that has been brought about by the HTP to the conceptualization of health care services reflects the consolidation of the neoliberal transformation which has been in action since 1980s.

Architects of the HTP stressed the importance of making this change in the conceptualization and philosophy of health care services become consolidated and internalized by the society. To this end HTP emphasized bureaucrats' backing the transformation in health care services, the importance of explaining this transformation to the social groups that would be affected by its results and get their support and the importance of social marketing for this project supported with advertorial activities through the media (HTP 2003: 7).

It can be said that efforts made towards making the transformation accepted and supported by the society so far has been successful to a serious extent. This can be seen in the figures reflecting the rates of satisfaction with the health care services since year 2003. In year 2003 General Satisfaction with health care services was

reported as satisfied: 39.5 %, moderately satisfied: 39.3%, unsatisfied: 21.2 %. These rates were reported as satisfied: 73.1 %, moderately satisfied: 13.8 %, unsatisfied: 13.1 % (Ministry of Health of Turkey 2011: 120, Figure 8.27).

It should be noted that all the legacies of the HTP have not come to the fore yet as some of its most critical components have not been put into practice yet. Therefore it can be said that the most critical and full effects of the HTP will be observed with the full implementation of its all components such as the Universal Health Insurance, abolition of the Green Card System and the obligation that every citizen would pay compulsory premiums to get health care services, consolidation of health package systems, establishment of public hospital unions, establishment of Pharmaceuticals and Medical Devices Institute and the adoption of health technology assessment. Thus it is evident that satisfaction rate measurements will be highly affected by the full implementation of every component of the HTP.

To give two spotting examples which provide explicit reflections for the change in the conceptualization of health services and professional attributes of doctors, the two very recent developments can be cited here: One is the statutory decree which changes the "public service" characteristic of the profession performed by doctors[134] and the second one is the change made in the titles of the former "public/state hospitals" which are deemed to be named as "city hospitals" from now on[135]. It is clear that both of these recent developments have made serious contributions to the change in the conceptual/philosophical/cultural aspects of the health care system in Turkey.

[134]Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions (Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname) [Article 58(14ğ)] (Resmi Gazete, 2011).
[135] Medihaber (2011)

7.7 What Future Impacts Could Be Inferred from the NHS Reforms for the HTP and the Turkish Health Care System?

7.7.1 Common Points of the HTP Reforms with the British NHS and Its Reforms

As it has been mentioned above UK has been the country which has had a leading role in the rise of neoliberal reforms and NPM reforms. It has been declared that the attempt of the new right at consolidating its hegemonic project in Turkey has many things in common with that of Reaganism and Thatcherism (Tünay 2002: 177). In fact influence of UK on health care reforms worldwide has been highly acknowledged where as a result of the mentioned reasons Turkey is among the ones which shares many commonalities with the NHS in terms of its reformation process. In fact as has been mentioned above NHS has been a model for the Turkish health care system even in the 1960s. However this influence gained strength in the post 1980 period, particularly with the 2003 HTP process which has brought about the most serious convergence with the British model of health care system. When one makes a review in the media it is possible to see declarations coming from the government which explicitly points out the influence of the British model on the HTP[136].

So far both the Turkish and British cases of health care systems and reforms have been covered. Now it is time to put down the common points between these two cases in a more compact way. However it should be noted that the point here is not to find out one to one correspondences between the two cases in every aspect of their health care systems. The point is to figure out the extent to which the way of reforming the Turkish health care system resembles the way of reforming that has been in use in the NHS.

[136] To give an example, during his visit to England in 2007 in order to examine the English Health Care System and to exchange experiences and practices, Minister of Health of the Republic of Turkey declared that Turkey would cooperate with England and benefit from the experiences of this country for the adoption of family practice system, universal health insurance, public-private partnership in hospitals and performance-based payment system which have long been in practice in this country. (Köker, 2009); İhlas Haber Ajansı (2009).

-Both are national health care systems emphasizing consolidation of this characteristic.

-Both attempt at Universal Health Insurance and universal coverage. In England it works on the main principle of being a resident in the country. In Turkey in principle it is free to those citizens who are below the age of 18 and for those above the age of 18 it is based on premium payments. However it should be noted that under both schemes of universal coverage there are many limitations which resemble each other such as standard/basic health packages and the like.

-Both have Standard/Basic Health Care Packages prescribing the services to be reimbursed within the context of universal coverage provided by Universal (General) Health Insurance (UHI).

-As a complementing element to Health Care Packages, Capitation is used in both systems which basically implies allocation of shares for each person insured under the UHI for a specific service unit.

-Both have been centralized health care systems where there have been constant discussions and attempts towards decentralization and re-centralization. Thus both systems experience the co-existence of centralization and decentralization practices at the same time.

-In both countries there has been increase in regulations (attempting/implying centralization) which goes together with arguments on decentralization where it is argued that decentralization is used as a symbolic policy masking tighter control (Baggott 2007: 132).

-Both are funded mainly by general taxation. However both systems have been experiencing move towards a hybrid model of finance in which there has been an increase in the utilization of private financial means together with compulsory premium payments by individuals in Turkey.

-Both countries stress the utilization of integrated health care services.

-Both systems highly stress primary care and they both have Family Medicine (Doctor) System. In England chain of referral system is used as a central element of the staged health care model whereas in Turkey this has not been put into practice yet.

-Family Doctors in Turkey resemble the Fund-holding GPs in England as they are asked to purchase required health services for their patients from the secondary or tertiary level hospitals with the budget allocated to them beforehand. In England GPs were highly encouraged to become fund-holders and in a similar way in Turkey GPs were highly encouraged to become family doctors.

-Both have attempted at creating an internal market and provider/purchaser split within the national health care system.

-Both stress the injection of competition into the health care sector among public providers and between public and private providers.

-Both attempt at creating administratively and financially autonomous hospitals. Public Hospital Unions in Turkey highly resembles the NHS Trusts in England in terms of the autonomy they are deemed to enjoy.

-In both countries hospitals are becoming autonomous corporate entities with their managerial boards and various other managerial principles and practices at work.

-Managerialism and managerial reform are highly praised and commonly practiced in both cases of reform.
-In both countries there have been attempts to bring medical professionals under managerial control and/or to make them somehow engage in managerial activities.

-Both have adopted Health Technology Assessment - NICE in UK and Pharmaceuticals and Medical Devices Institute in Turkey.

-Both systems are encouraging private sector – not only private provision of health services but also private insurance are encouraged.

-Both adopt PPP/PFI models in financing high-cost hospital projects - e.g. Health Campuses that have been constructed on the PPP model were adopted from the UK.

-Both are adopting patient choice - both in terms of being able to choose their GPs and being able to choose a private provider to consult.

-In both countries there has been an increase in the amount of services purchased from the private sector and thus an increase in the amount of public resources channeled to the private sector.

-Both have health care budgets set centrally. Resources are allocated to purchasers on per-capita basis (capitation); however, there is not much opportunity for local purchasers to raise revenue locally, although they might be asked to do so in certain circumstances.

-In both countries there has been an increase in the use and amount out-of-pocket payments.

-Ministry (Department) of Health is separate from Ministry (Department) of Social Security in both countries

-In both countries there has been an increase in the resources allocated to health care in general.

-Both systems adopt prescription charges.

-Both use National Health Accounts System

-Accreditation systems are used in the UK (e.g. UKAS) and are on its way in Turkey. HTP calls for the establishment of National Quality and Accreditation Institute (HTP

2003: 176). In addition to UKAS there are also private accreditation institutions in the UK which might also be encouraging for the Turkish case in the coming years.

-Both adopt performance-based ranking for service providers. The model foreseen in Turkey resembles the one already in use in the UK where performances of hospitals (service providers) are measured and hospitals are ranked according to their performances in league tables (e.g. the Star Rating System). Hospitals get or loose autonomy, financial grants and even number of patients preferring them, according to their ranking in these league tables. In Turkey we started to have private hospitals and the family doctors ranked in Classification Tables and the one for the public hospitals is on its way to come.

-Both countries experience an on-going reform process in their health care systems- although the case is a bit more complicated in Turkey.

-Both systems have been undergoing constant re-organization/disorganization which is something highly criticized in the UK and starting to be so in Turkey as well mainly for its drawbacks such as policy gaps and increase in costs.

-In both countries reforms are highly market-oriented and leading to increasing privatization.

-In both countries reform attempts are discussed within the boundaries of big-bang approach vs. incremental approach where either the former or the latter dominates from time to time.

-Health system and its reform are highly politicized policy areas in both countries where pork-barrel politics and various pre-election strategies are often utilized.

-Finally it should be noted that due to the on-going character of the reforms (particularly those in Turkey), this list might be added or subtracted with the adoption or withdrawal of new regulations/practices.

7.7.2 Inferences from the British Case for the Incipient Turkish Case

Drawing upon the resemblances between the two cases which have been mentioned in the previous section and by looking at the developments taken place so far, the following inferences could be made from the British case for the incipient Turkish case on what would occur in the Turkish health care system with further implementation and consolidation of HTP reforms.

-creation and consolidation of internal market within the health care system with more competition among service providers - both public and private.
-consolidation of managerialism and corporatization in public hospitals.
-public hospitals would be given more autonomy however would face difficulties in competing with each other and with private providers where going into bankruptcy would be a serious threat.
-more commodification of health care services with a loss in their “public” character where health care services would be more a matter of the market and the individual than the state and the public sector.
-increase in the amount of services purchased from the private sector and privatization -both at the national and international level - and allocation of more public funds to private sector.
-more politicization of health care services.
-continuing re/dis/organization in the health care system together with the costs this incurs.
-co-existence of decentralization and re/centralization practices in the health care system where decentralization would be accompanied with a central command and control system in order to respond to the requirements of transformation. (This has already been achieved to a serious extent with the establishment of the Social Security Institution).
-more responsibility would be passed down to the lower units shifting the blame away from the central government.
-increasing dissatisfaction with health care services with further consolidation of the HTP practices.
-increase in supply side reforms.

-deterioration in the quality of services.

-deterioration of equality regarding access to health care services.

-increase in the number of regulatory attempts and regulatory bodies.

-increase in the amount and frequency of user charges and out-of-pocket payments.

CHAPTER 8

A BRIEF OUTLOOK ON PRACTICE: TAKING A CROSS-SECTIONAL PHOTO OF HTP

In this section an attempt is made to understand the changes that have occurred within the health care system in Turkey after the adoption of the HTP by looking at what is going on in practice. In so doing attention is limited to those issues that are directly related to the research questions and the scope of this study.

In this regard a research was made in a public hospital in order to understand the processes that patients go through starting from their referral to their discharge from the hospital. Such an attempt to figure out a flowchart showing those stages enabled us to conceptualize the changes that have occurred within the internal functioning of the hospitals- particularly those changes pertaining to administrative and financial capacities of this system. This provided the chance to see how things go on in practice on issues such as the hospitals' purchase of services from outside, collection of hospitals' resources and the way they are disposed and the relationship between the hospitals and the Social Security System (SSI) and the Ministry of Health. Since change in public hospital system was the center of attention private hospitals and/or private insurance holders did come into the picture to the extent the context or the issue in question necessitated.

Methods employed in this research were observation of the processes passed through by the patients and by the relevant medical and administrative staff in the hospital together with interviews made with a random group among them. When it was necessary recourse was made to information from people working in other relevant institutions such as Doctors' Association. In addition to these analysis of documents obtained on the processes analyzed was also employed as another supplementing method.

8.1 Flowchart for Patients Consulting Hospitals after the HTP

In figuring out such a flowchart the first step should be to make a classification between those who are insured and who are uninsured.

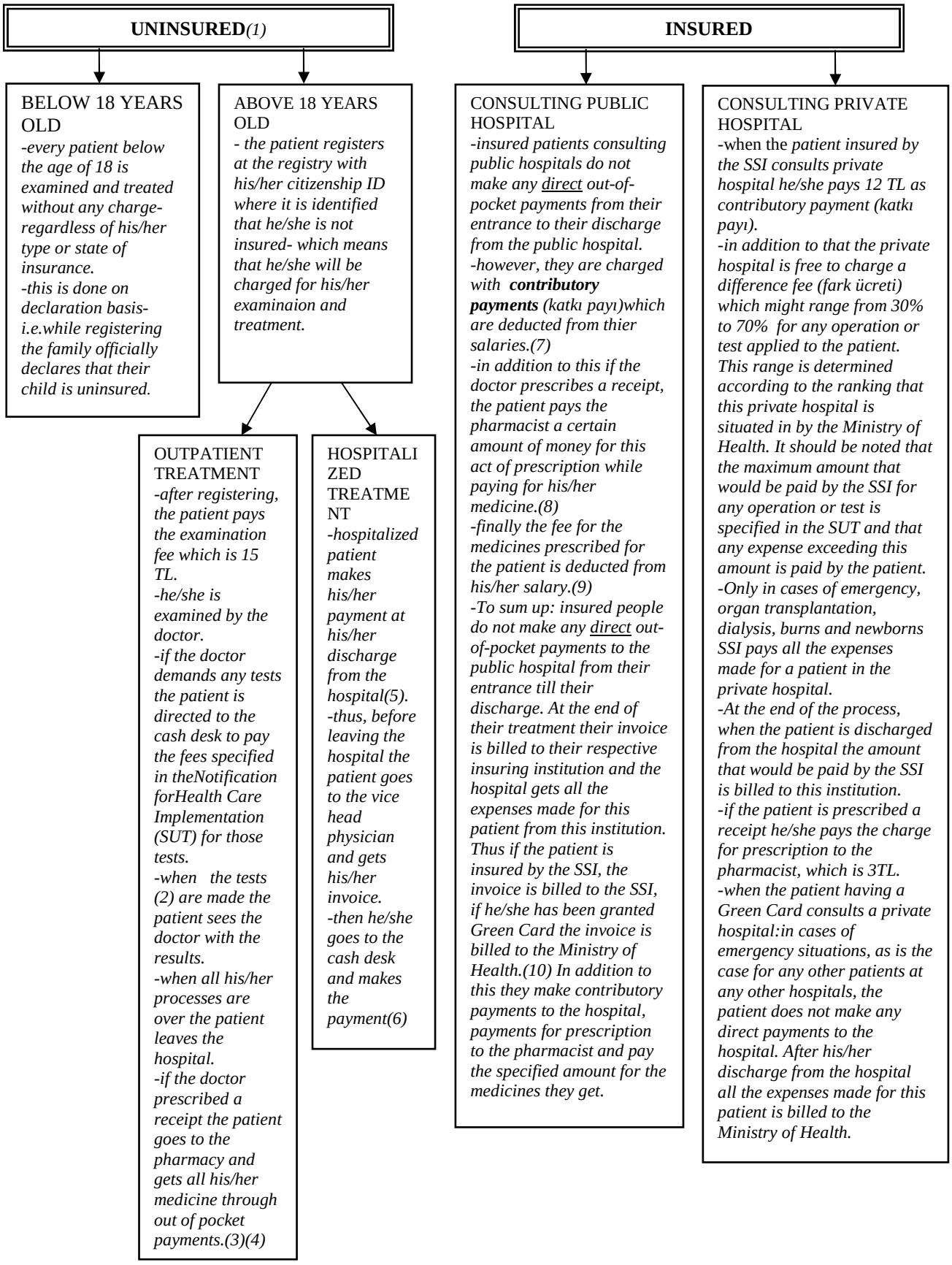
After the adoption of the HTP, **insured** people are the following:

those who are covered by the compulsory Universal Health Insurance (UHI) and in this context those who have paid their premiums to the Social Security Institution (SSI). (It should be reminded that people who were formerly covered by the SSK, Emekli Sandığı and Bağ-Kur are now considered within this framework as these three have been merged under the name of SSI). Health care expenses of these people are expected to be dealt with by the SSI.
those who are granted Green Card. Health care expenses of these people are expected to be dealt with by the Ministry of Health.
every citizen under the age of 18. Health care expenses of these people are expected to be covered by the SSI.
those who have private health insurance.

With the adoption of the HTP **uninsured** people are the following:

those who are over the age of 18 and who owe to the SSI (i.e. who have not paid their premiums to the SSI).
those who do not have a Green Card.
those who do not have private insurance.

Table 6 Flowchart for Patients Consulting Hospitals after the HTP



(1)Any citizen – insured or uninsured- consulting *emergency services* (either in private or public hospital) is examined and treated without any payment.
(2) These tests are made either by the facilities of the hospital itself or by the private providers with which the hospital has made contracts on purchasing the services in question. In this second case the patient is directed to the private provider which is situated either within or outside the hospital.
(3) If the patient consults the same unit within 10 days after his/her discharge, this is considered to be within the control period, and in this case the patient does not pay any fee for examination in his/her next consultation.
(4) In certain cases when an uninsured patient consults University Hospitals, it is possible to bill the invoice to Social Solidarity Foundations which are linked to Prime Ministry.
(5) This is mainly because it is not possible to fully detect all the expenses that might incur until the patient is discharged from the hospital. (i.e. various additional tests, operations or medicaments might be demanded throughout the hospitalization period.).
(6) It is possible for the patient to get an installment plan. In this case an Address Fact-Finding Report (Adres Tespit Tutanağı) is drawn up by the hospital and the patient is expected to come to the hospital at the specified dates to pay his/her debt. Although it is not legal to draw up any kind of deposit slips by the hospitals, what is experienced in practice is drawing up Address Fact-Finding Reports which are in fact not legally-binding on the patients; but in most of the cases make them come and pay their debts.
(7) Amounts of contributory payments to be charged are specified in the SUT. The insured patient pays 3TL when he/she consults a public hospital; 5TL when consulting an Education and Research Hospital and 2 TL when consulting Family Doctor.
(8) The insured patient pays 3 TL to the pharmacist for "the act of prescription" after consulting public hospital or education and research hospital. He/she does not pay this charge if he/she consulted family doctor. All the charges made for the patient for prescription are collected at his/her account in the information system and the patient is asked to pay the total amount once he/she goes to the pharmacist.
(9) The rate deducted is 20% of the total amount for the employed and 10% for the retired.
(10) If the patient consulting public hospital has private insurance he/she pays all the expenses incurred directly to the hospital as out-of-pocket payments and later submits the invoice he/she gets from the hospital to the company he/she works for or to the insurance company and gets the money he/she paid to the hospital.

As it has been mentioned above, while following the stages taken by the patient throughout his/her journey in getting health care services in the post-HTP period, this research provided the chance to analyze the changes that have taken place within the internal functioning of the hospitals. In line with the scope drawn and the research questions outlined for this study at the very beginning, the following issues that have been encountered during this research are worth mentioning, as they also provide

supplementary primary data for the discussions made in the above sections about the characteristics and impacts of the HTP.

8.2 A Brief Outlook on Practice: Changes brought about by the HTP to the Internal Functioning of Public Hospitals

8.2.1 Public Hospitals' Purchase of Services from Outside

During this research it was detected that there has been an increase in the number of services purchased by public hospitals from outside after the adoption of the HTP and that this has become a rather easier activity compared to the previous period.

It is possible for the public hospital to purchase *any* service from outside – which is up to the decision of the hospital itself.

In purchasing services from outside a public hospital can refer to other public hospitals or to the private providers:

It is possible for the public hospitals to make protocols with other public hospitals (including university hospitals) for getting the services which they cannot provide themselves. In this case the patient is directed to the providing public hospital to get the service. Regarding payment, providing public hospital sends the invoice to the purchasing public hospital which in turn gets the money from the SSI and then pays to the providing hospital.

It is possible for the public hospitals to purchase any service from the private providers through contracting out[137]. In this study it was found out that there has been an increase in the number and variety of services purchased from the private sector.

[137] In fact there are two ways of purchasing for a public hospital: One is Direct Purchase which can be done any time whenever the hospital is in need of something. In this case the hospital gets three proposals and in line with the terms and conditions of contract set beforehand makes the contract with the provider which gives the lowest price. The second type is Tendering which is done annually where the hospital purchases the services from the private provider which proposes the lowest price while securing the terms and conditions of contract specified beforehand by the authorized institutions.

In this case payment is made to the private provider by the purchasing public hospital. The amount of money that would be paid by the SSI for any test or operation that would be purchased by the public hospital from private providers is specified beforehand by the SSI. After the service is purchased the purchasing public hospital sends the invoice to the SSI and once it gets the money it pays the bill to the private provider. If the purchasing public hospital makes its contract with a lower price than the one specified by the SSI, the residual amount can be retained by the hospital. The terms and conditions of the contract that would be made by the hospital are specified by the SSI in the SUT. In line with these terms and conditions, the hospital makes the contract with the private provider which proposes the lowest price. In this process before calling for a tender for purchasing a specific service the hospital has to get the results of the market research conducted by the Chamber of Commerce.

Once the contract is made it is possible for the private provider to provide the service in question either within the hospital building or in its own place.

It is possible for a public hospital to call for tendering on behalf of other public hospitals while doing its own tendering.

Increases in the number and frequency of purchases of public hospitals from other providers clearly points to the enhancement of provider-purchaser split which also points to efforts for the creation of internal market within the health care system together with the injection of motives for a more competitive system and consolidation of managerial principles.

8.2.2 Hospitals' Relations with the Ministry of Health and the SSI

With the adoption of HTP and particularly with the establishment of SSI the influence of Ministry of Health has started to decrease over the hospitals where the SSI has become the leading institution over the hospitals. As it has been declared in the HTP, Ministry of Health was planned to be turned into a body which would be dealing with planning and controlling issues and that its activity regarding service provision was planned to be decreased.

What is seen in practice is that this aim of the HTP has started to be realized to a serious extent so far. The Ministry of Health has been dealing with planning and control activities and with the salary payments and has been withdrawing from direct service provision in a gradual manner. With the establishment of SSI, the Ministry of Health has lost its authority regarding health care finance to a great extent to this institution. Being the institution directing financial issues of the health care system now it is the SSI which is more influential over the hospitals compared to the Ministry of Health which is left with planning, control and salary payment duties. In this research it was found out that the SSI is in a more powerful position in its relations with the public hospitals as it is the SSI which determines the financial context that is binding for the activities of the hospitals. Thus after the adoption of the HTP the Ministry of Health has shifted to a rather secondary position in terms of its influence over the hospitals compared to the SSI as the former is left with only planning and control activities and the salary payments.

As it has been mentioned, administrative and financial autonomy of hospitals is an issue which has been highly elaborated by the HTP which has been going hand in hand with the elaborations on having a more decentralized system. Again as has been mentioned in the above sections, decentralization is a process which goes together with (re)centralization attempts in public sector reforms. This has been the case regarding HTP reforms which on the one hand talks about granting more administrative and financial autonomy to hospitals and on the other hand puts forward serious centralization attempts by devolving all SSK hospitals to the Ministry of Health and more than that by establishing a centralized institution like the SSI to deal with the financial issues of the whole health care system from one center.

By this token it could be noted that there has not yet been any serious change regarding the actual set-up of hospital management. That is to say they still have the head physician system (başhekimlik sistemi) in which the names nominated by the Ministry of Health are appointed as the head physicians and vice head physicians in line with the cadres available. Although they have been elaborated on in the HTP, neither professional hospital managers nor board of trustees (mütevelli heyeti) or

managerial board or participatory management have been adopted in the management of hospitals yet.

8.2.3 Provision of Health Care Services in the form of "Packages"

One of the major changes that have been brought about by the HTP and particularly with the adoption of the Universal Health Insurance and the SSI is the provision of health care services in the form of packages which limits the quantity and quality of services provided to the insured people.

For the patients insured by SSI (particularly for the outpatient treatments), the SSI has specified a Basic Health Service Package (Temel Sağlık Hizmeti Paketi) in which the maximum amount of money that would be paid per operation/test/treatment is specified. E.g. maximum amount of money that would be paid for a patient consulting internal diseases department has been specified by the SSI. If this patient is applied any test/operation/treatment which exceeds this amount, the difference is paid by the hospital if the patient is covered by the SSI and by the patient himself/herself if he/she is uninsured. Apart from the amount specified by the Basic Health Service Package, SSI pays only the expenses for the tests/operations/treatments that are listed in the SUT[138] Appendix 10 C. Those that are not covered in this Appendix are again paid by the hospital for the patients insured by the SSI and by the patient himself/herself if he/she is uninsured. It should be noted that cost for each operation/test/treatment has been announced by the SSI according to which all these payments are made.

For the hospitalized patients covered by the SSI the SSI pays the expenses for the tests/operations/treatments listed in the SUT Appendix 9 which is also called the Health Service Package for the hospitalized patients and the ones listed in the SUT Appendix 8. Expenses made for the tests/operations/treatments which are not listed in these two appendices are paid by the hospital for the patients covered by the SSI and by the patients themselves who are not insured.

[138] Social Security Institution Notification on Health Care Implementation (Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği) (Resmi Gazete, 2010).

For the Green Card holders Health Service Package is applied only for the hospitalized patients. All the expenses made for the outpatient patients are paid by the Ministry of Health.
As it has been mentioned earlier, no health package is specified for any of the patients consulting emergency services- neither for those covered by the SSI or those having Green Card. Expenses made for these patients at the emergency services are paid by the SSI and by the Ministry of Health respectively.

This was just to give a very brief explanation on how Basic Health Package is applied in practice. It is quite a complicated issue where lots of small measurements have to be made. What is important for this study is to recognize the importance of the Basic Health Package practice as one of the key developments within the HTP which implies the consolidation of managerialism within the health care system together with its emphasis on quantification, measurement and limited payment for specified services.

8.2.4 Resources of the Hospitals

To have a brief outlook on the resources of a mainstream public hospital the following list could be made as a handy reference:

Money from the Treatment Services of the Ministry of Health: These are the payments made to the hospitals by the Ministry of Health for the health care expenses of the Green Card holders. Drawing upon information gathered from this study it can be expected that in a short while this issue will also be transferred to the SSI leaving the Ministry of Health more outside financial issues.

Money from the Ministry of Health on various occasions: It is possible for the Ministry of Health to allocate some amount of money to a hospital with the condition of taking it back in a later period. It is also possible for the Ministry of Health to allocate resources from a public hospital whose resources have been detected to be over a certain amount to those public hospitals whose resources have been below a certain level. During this study it was declared that resources have been allocated

from Mouth and Tooth Health Centers (Ağız ve Diş Sağlığı Merkezleri) to Family Doctors within this context.

Funds coming from the World Bank: These funds are coming to the Ministry of Health and then allocated to hospitals.

These three do constitute the general budget of a public hospital.

Money from the SSI: This is the money paid by the SSI for the expenses made by the hospital for the insured patients.

Money received by the hospital from the uninsured patients.

These two constitute the resources for the Revolving Fund of a public hospital, which is the main budget out of which basic expenses of the hospital (such as material and service purchases, expenses on electricity, water etc. and performance payments) are made.

As it has been mentioned above salary payments are made directly by the Ministry of Health to the employees of the public hospital where the hospital has no intervention.

During this research it was detected that there has been a shrinking in hospitals' budgets after the adoption of the HTP[139]. With the decrease in the influence of the Ministry of Health on financial issues and the rather strict market logic that dominates the SSI which has become the leading actor in this area, hospitals have been left to face their destiny for managing themselves financially. Some of the interviewees declared that this might even lead hospitals to go into bankruptcies which would end up with their privatization[140]. What is more is while on the one

[139] This statement is based on the information obtained from a managerial staff employed in the public hospital that this research was conducted. Nevertheless it was declared that it was not possible to obtain any official budgetary documents from the hospital.

[140] In November 2010 debts of university hospitals were erased by a decision of the Council of Ministers and revolving funds of 22 university hospitals were granted support by the state. This was furthered by the transfer of some university hospitals to the Ministry of Health (SES 2011: 12). These transfers not only demolish the autonomy of university hospitals and thus imply serious challenges for their educational and research activities but also once more show the manipulation of

hand hospitals are left to their own in managing their financial activity on the other hand they are under strict control by the declarations and other legal documents issued by the SSI. All these once more show the strong link between the discourses (and also practices) regarding decentralization- (re)centralization and finance in health care reforms.

8.2.5 Performance Payments

As it has been mentioned above, performance payments are made out of the Revolving Fund revenues. To have a very brief outlook on how performance payments are made the following main steps can be cited: 1. First of all every activity that is performed by each and every health care personnel in the hospital has a corresponding point according to which monthly total points of a particular personnel is computed by adding up the his/her total number of activities. Addition of total points of every personnel gives the total points of that particular hospital. 2. By subtracting total expenditures of the hospital from the total of its input resources the total revenue for performance payments is found. 3. This total revenue is divided by the total points of the hospital to find out the unit point of the hospital. 4. Finally, by multiplying this unit point with various coefficients (such as specialization, risk factors, etc.) performance points of each personnel are computed according to which his/her performance payment is made.

Ministry of Health has declared that in making performance payments, the hospital in question has to satisfy the following two criteria: the amount of its debts should be below a certain level and that it should have scored a certain level of points in the quality control inspection made by the Ministry. During this research it was detected that being one of the criteria affecting the realization of performance payments, quality control inspections made by the Ministry of Health have started to become quite influential on the hospitals. In order not to miss performance payments, hospitals have started to take these quality control inspections more seriously which in the end have positive impacts on the quality of the services provided. These inspections are made once every six months and they can be done without any pre-

---

decentralization/(re)centralization dynamics and their deep interaction with the financial realm and the manipulation of both by the requirements of the transformation process.

notice to the hospital in question. Results of the quality control inspections are reported to the head physician.

Performance Payments have been one of the most important and disputed changes that has been adopted within the context of HTP. With its full name Performance-Based Additional Payment System (Performansa Dayalı Ek Ödeme Sistemi) has been put into practice in public hospitals with the aim of increasing motivation among health care personnel and increasing the efficiency of the whole system. However it has been criticized in many respects among which increase in unnecessary prescription of services and thus waste of resources and worsening in the quality of the health care services consumed by the patients and demolition of solidarity among health care personnel have been highly discussed in various platforms and were also detected during this research. .

8.2.6 Competition

As it has been touched upon in various parts of this study so far, competition has been one of the most important aspects that have been injected into the health care system by the HTP. With the adoption of provider/purchaser split (making Ministry of Health less involved with financial issues and taking steps towards creating an internal market within the health sector) and with the steps taken towards more autonomous hospitals (administrative and financial autonomy) hospitals have been pushed into a competitive environment and made to survive in such a context with which they have not been that familiar until then.

In this competitive environment, being the "providing" institutions, hospitals have become the bodies which compete with each other to "sell" their services to the SSI, which is the "purchasing" institution. In this regard hospitals have become more "customer-oriented" in order to attract more patients (customers) and prescribe more services in order to "sell" more services to the SSI, which would also mean more resources for the hospital to meet its ends and thus to survive. Another interesting issue that this study revealed was that public hospitals have started to provide patient transfer services in order to make reach of patients to hospitals easier and thus making these hospitals more attractive to these patients. In addition to this, the highly elaborated "patients' choice of doctors" has also been considered within this context

of patient (customer)-oriented health service provision. Last but not the least, the issue of creating hospital league tables in which hospitals are ranked according to their qualifications which in the end determines the price of the services they provide have been adopted for the private hospitals. It is expected that with the establishment of Regional Hospital Unions this system will also be adopted for the public hospitals which in the end will enhance the competitive environment for the functioning of public hospitals.

After drawing this brief picture of what have been found out during this research in this public hospital now it is time to make some final analysis that would shed light on the practical impacts of the HTP reforms and to elaborate on how they relate to the arguments put forward at the beginning of this study on HTP reforms.

As it has been argued several times throughout this study, HTP has brought about serious changes for the health care system where organizational and financial aspects have been subjected to the most critical transformations. It is these two aspects which are not only the core parts of the transformation but also they are the ones which are highly interrelated among themselves perpetuating each other. What is more is that transformations that have been taken place in organizational and financial set-ups have brought about serious implications for the economic, political, managerial, clinical, equality and conceptual aspects of the health care system some of which have been clearly observed during this research.

In this regard to recapitulate what have been covered so far during this research in a more systematized way in terms of the practical implications of the HTP, following analysis would be quite helpful and enlightening.

8.3 A Brief Outlook on Practice: Impacts of the HTP on Hospitals, Patients, Health Workforce and Conceptualization of Health Care Services

8.3.1 Effects of HTP on the "Hospital"

First of all it should be underlined that many aspects of managerialism and public management approach can be observed in the practical changes that have been

brought about by the HTP, among which the most outstanding ones can be listed as follows:

One of the most critical aspects of the transformation has been the steps taken towards the creation of an internal market within the health care system with the provider/purchaser split and injection of competition into the system. With the creation of provider/purchaser split now public hospitals compete with each other and with other service providers to sell health services to the SSI and other purchasers. During this research it was found out that there were public hospitals which provide transportation services to their patients in order to get a more advantageous position vis a vis other public hospitals providing the same health care services.

Another effect of the provider/purchaser split and competition is that in cases where it is more profitable, public hospitals prefer to purchase health care services from other providers rather than providing these services themselves. In this regard there has been an increase in the number of services purchased by the public hospitals from the private providers.

Public hospitals have started to internalize managerial principles and started to function with the logic of private hospitals where they started to prioritize principles like efficiency, effectiveness and profitability. Besides the necessity to become more competitive, this has many things to do with the pressure exerted on public hospitals that they have to meet their ends themselves both financially and administratively within the context of financial and administrative autonomy they have been granted with. In addition to these more quantification-oriented practices such as adopting health care packages, performance-based payments, ranking private hospitals in league tables and arranging payments to be made accordingly (which is a practice expected to be adopted for the public hospitals with the finalization of the establishment of public hospital unions), and SSI's use of a new coding system called DRC (Diagnosis Related Coding) (Teşhise Dayalı Tedavi Sistemi)[141] have

[141] With this system the SSI codes patients on the basis of diagnosis made for them by which SSI now has the capacity to control whether the treatment and medicine prescribed for a particular patient is in line with the diagnosis made.

been realized within the context of the HTP. Furthermore public hospitals now have more customer-oriented practices where the emphasis on patients' choice of doctors has been the most popular one. In fact the critical issue here is the change in the attitude towards patients who are now seen more as "customers".

Finally it can be said that with all these changes, public hospitals have taken serious steps towards "corporatization" (firmalaşma) where they are asked to adapt to this new competitive internal market environment, to adopt managerial principles and to behave as a "corporate firm" on themselves.

It should be noted that with the establishment of public hospital unions and health campuses, corporatization and its legacies will be more deeply felt, which altogether will make hospitals work more on managerial principles. As it has been mentioned above, these new hospitals will be managed by professional managers and managerial boards with members from different economic and political realms. Moreover hospitals will be free to purchase any services- including clinical ones- from outside on the basis of profitability as they will also be asked to meet their expenditures with their revenues. In addition to that these hospitals will be classified (as has been the case with private hospitals) and those which get bad scores will be faced with certain sanctions. It will also be possible for the hospitals to be rented or sold out. To this end, a serious number of public hospitals have already been merged in certain provinces, which is an attempt expected to continue in the coming years (SES 2011: 12). In addition to that calls have been made for tenders for the construction of health campuses in various pilot provinces which will be carried on the basis of public-private-partnership (PPP) model. In so doing those firms which were declared eligible to make the contract were also informed that they could become subcontractors (taşeron) for the auxiliary health services in the health campuses they construct (SES 2011: 12).

8.3.2 Effects of HTP on the Patients

As it can be clearly seen many of the above mentioned managerial dimensions have also serious implications for the patients.

During this research it was detected that after the HTP it has become easier for the patients to get health care services, nevertheless, the quality of the services they get has deteriorated. One of the main reasons for this is the obligation that public hospitals have to maintain their financial survival and to this end they do face situations where they have to prioritize cost-effectiveness over quality. Moreover as a result of performance-based payments there occurred an increase in the number of unnecessary tests and operations and an environment which has made doctors work over-capacity and thus cause deterioration in the quality of the services provided.

It was found out that there has not been any change in the length of waiting times mainly because of the fact that chain of referral system has not been put into practice yet.

It is the patients who were formerly covered by the SSK that have ameliorated their position the most with the adoption of the HTP compared to the other group of patients in terms of their reach to health care services. Patients who were formerly covered by the Retirement Fund (Emekli Sandığı) now do have the option to go to private hospitals.

However HTP has made health care become more like a commodity and loose its public service character. Health care service is less a “right” of the citizen as reach to health care is more linked to the condition that compulsory premiums are paid. In addition to the compulsory premiums, patients are asked to make more out of pocket payments or pay contribution fees throughout their journey within the health care system. They are also asked to pay difference fees if they choose to go to private hospitals.

8.3.3 Effects of HTP on the Health Workforce

Performance-based payments have been the most cited drawbacks of HTP for the health workforce. It has been criticized for various aspects such as forcing health care workforce work overcapacity, destroying solidarity among them and creating ethical problems for health care professionals.

In addition to this, full-time employment of doctors working in public hospitals and legislations regulating working procedures of self-employed doctors have also caused serious problems for the working conditions of the doctors who are said to be "forced to become the cheap labor for the private hospitals."[142] With the law on full time employment of doctors, now it is possible for the Ministry of Health to charge professionals working in medical schools with various other duties (SES 2011: 13). It has also been reported that there has been a serious increase in the number of contracted personnel since 2002 (SES 2011: 15).

One final remark can be that although it was promised to be so, there have not been any serious steps towards making hospitals managed through more participatory procedures nor there had been sufficient attempts to get participation of health workforce in the preparation and conduct of HTP reforms.

8.3.4 Effects of HTP on the Conceptualization of Health Care Services

HTP has brought about a change in the conceptualization of health care services where health is conceptualized less a right derived from being a citizen of this country and more as a commodity which is provided and purchased within the competitive market.

In this regard and as one of the repercussions of the public management, attitude towards patients has also changed towards seeing them as customers where related practices such as patient choice or more contribution payments have also been adopted.

Moreover as it has been touched upon in the related sections, it is expected that HTP reforms would bring about a change in the state-citizen relations and in this regard new citizenship practices would emerge; which should also be considered among the important legacies of the transformation in health care system.

[142] Butakın (2011)

CHAPTER 9

CONCLUSION

Aim of this study was to conceptualize the transformation in the health care system in Turkey where the main focuses were on the changes attempted in its organizational and financial set-up, which were thought to have serious impacts and implications for various aspects of the health care system. In its efforts towards understanding these impacts, the dissertation referred to the British NHS – particularly to its way of reforming itself - as the model from which inferences were made to help apprehend the Turkish transformation better.

In line with this orientation certain arguments and hypothesis were put forward which in the end took the research to a point where quite valuable findings were attained. To recapitulate these arguments and the notable findings that this research has revealed about them, the following concluding remarks are worth making:

First of all, it is quite evident that health care reforms in general and HTP of Turkey in particular should be conceptualized within the context of the neoliberal restructuring process. Although Turkey can be considered to be a bit late in undertaking the health pillar of this general transformation, together with all its complementary reforms and outcomes, HTP constitutes one of the most critical reform attempts that should be considered within the neoliberal restructuring of the public sector.

Secondly, although there are numerous typologies to help classify health care systems, it has been detected that they are not sufficient alone to explain the health care systems attempted and brought about by the transformation projects. At this point it is the hybrid model approach which helps out. Hybrid models are quite compatible with the neoliberal restructuring process which in fact can be considered both as the end products of and also the tools produced by this process. That is to say neoliberal transformation has been making use of hybrid models which help ease the transformation in question besides producing them. As has been the case in many

health reform programs, this holds true for the HTP which has brought about a hybrid model carrying strong characteristics from the Beveridge, the Bismarckian and the Liberal Models. Since it is difficult to conceptualize the change that has been brought about by the HTP with the mainstream health system typologies it is necessary to refer to (or devise) hybrid models where the National Health Insurance (NHI) model seems a useful one to utilize.

Thirdly, this dissertation emphasized and found out that health care reforms mainly targeted organizational and financial set-ups where organizational reforms were usually carried out under the banner of 'decentralizing the system' no matter they may also brought about (re)-centralization. It was also detected that organizational and financial reforms were interrelated among themselves that change in one of them highly affected the change in the other. The dissertation went a step further and claimed that it was the financial set up which was primarily targeted by the health care reforms and that organizational reforms either serve for their success or emerge as a result of them. Moreover it was argued that it was these two aspects from which the most prominent legacies of the transformation arise and that was why health reforms mainly targeted them and that was why this study insisted on focusing mainly on these two aspects in its efforts towards understanding the HTP. While analyzing the HTP these arguments were detected to hold true for the Turkish health care reforms.

Fourthly, it was argued and found out that HTP reforms highly resembled the English NHS - particularly its way of reforming itself. While acknowledging the various differences between the two countries, common points between their health care reforms were detected and inferences were drawn from the English case for the incipient Turkish case, which are thought to be quite enlightening in conceptualizing the HTP reforms and their future implications.

Fifthly, serious effort was made to understand and demonstrate the repercussions of the HTP on the Turkish health care system. In this regard, effects of the HTP on economic, political, managerial, clinical, equity and conceptual (cultural) aspects of the health care system were analyzed. In so doing besides using the available secondary data which shed light on these issues, a research was conducted in a public

hospital with the aim of seeing what has changed in practice after the HTP. Both the primary data obtained from this research and other available data showed that many serious changes have already occurred with the reforms undertaken so far.

As has been declared several times in this study, HTP has not yet been fully adopted. It is an on-going process and its impacts will get intensified with full implementation of all of its components. In fact, it was this on-going and incremental characteristic of the HTP which made things a bit though throughout this study as there was always the need to be alerted about the recent changes and to reflect them on the relevant sections of the dissertation. Nevertheless, it can be said that each and every reform attempt provided quite supportive input for the arguments put forward by this dissertation. A similar development occurred at the very end of this study, when the writing process was almost finished: a Statutory Decree[143] which has brought about another bundle of changes to the health care system was issued. Changes brought about by this last legal document are again complying with the previsions made about the HTP while setting out for this research. Since they are last minute reforms providing supportive input for the arguments put forward in this dissertation, this concluding chapter would be the most appropriate place to cite them very briefly. In this regard, the following can be quoted as the highlights of the Statutory Decree in question:

re-organization in the activities of the Ministry of Health whose planning and coordinating activities are emphasized vis a vis the ones related to its direct provision of services; establishment of Health Free Zones; creation of Health Campuses together with Public-Private-Partnership (PPP) Model; creation of Public Hospital Unions System together with the Hospital League Table System; creation of Council of Health Professions (Sağlık Meslekleri Kurulu) having critical authorities on health professionals such as deciding on their temporary or permanent dismissal from the profession; making Public Hospital Unions free to employ contracted personnel and the Ministry of Health to recruit foreign professionals; setting compulsory service for the doctors getting their medical specialty; asserting full implementation of the

[143] Resmi Gazete (2011b) Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions), No: KHK/663, 02.11.2011.

Family Practice System throughout the country by changing the name of the related Law; annulling the Article No. 1 of the Law on Turkish Medical Association which read as "...profession of a doctor (tabiplik) is performed and developed in public and individual interest.." thus implying a change in the conceptualization of health care services by challenging its public character; and setting up the Pharmaceuticals and Medical Devices Institute of Turkey (Türkiye İlaç ve Tıbbi Cihaz Kurumu) which will have its public personality and deal with regulating the related markets and advertorial activities of the related products.

As it can be clearly seen, this recent Statutory Decree has brought about changes in both the organizational and financial set-up of the health care system which are also highly inter-related among themselves that an organizational change definitely has implications for the financial set-up and vice versa. Moreover, it is quite evident that these newly-adopted changes will add to and further the economic, political, managerial, clinical, equity and conceptual impacts of the HTP that were discussed in the above sections.

Although their official adoption have just been attained, changes brought about by this Statutory Decree and their possible impacts were already discussed in the above sections as they were the reforms expected to follow when the philosophy, orientation and the course of the HTP so far were considered. Therefore, here, they will not be elaborated on once again. However, it is important that their implementation be watched carefully to capture their future repercussions.

Last but not the least, it should be asserted that this study could be deemed to have undertaken its mission if it has been able to draw the general framework and the put forward the findings for its arguments. In this regard it can be said that analyzing health care reforms and particularly the HTP from a political science and public administration perspective and in this context providing a rather integrated approach to the study of health care reforms and their impacts while acknowledging the role of the neoliberal restructuring process and other related theories could be considered as one of the important contributions of this study to the literature. In addition to this, its attempt at clarifying long-lasting confusion in defining what decentralization refers to in health care services; its emphasis on the use of the hybrid model approach in

understanding and explaining health care reforms and its attempt to find out the common points between the HTP and the NHS's way of reforming itself and making inferences from the latter for the former can be considered some of the other contributions to be credited.

Nevertheless, pertaining to the on-going character of the HTP which is expected to bring about further changes and to the novelty of the subject to the researchers from social and political science backgrounds, particularly to those in Turkey, health care reform in general and HTP and the arguments put forward in this dissertation in particular point to a promising fertile field for further research which can be taken as an open call for interested researchers and for the author herself for further studies.

BIBLIOGRAPHY

ABGS (2011) Council Decision of 18 February 2008 on the principles, priorities and conditions contained in the Accession Partnership with the Republic of Turkey and repealing Decision 2006/35/EC, http://www.abgs.gov.tr/files/AB_Iliskileri/Tur_En_ Realitons/Apd/turkey_apd_2008.pdf (last accessed on 08.01.2011).

Ağartan, T. (2007) "Sağlıkta Reform Salgını" in Ç. Keyder, N. Üstündağ, T. Ağartan and Ç. Yoltar (eds,), **Avrupa'da ve Türkiye'de Sağlık Politikaları – Reformlar, Sorunlar, Tartışmalar**, İstanbul: İletişim Yayınları.

Aksoy, Ş. (2003) "Yeni Sağ ve Devletin Değişimi" in B. Aykaç, Ş. Durgun and H. Yayman (eds.), **Türkiye'de Kamu Yönetimi**, Ankara: Yargı Yayınevi.

Aktan, C. C. ve Işık, A. K. (2006) Halk Sağlığı ve Temel Sağlık Hizmetleri Sunumunda Devletin Hizmet Sunma Kapasitesinin Arttırılması, http://www.canaktan.org/ekonomi/saglik-degisim-caginda/anasayfa-saglikek.htm (last accessed on 05.03.2011).

Alban, A. and Christiansen, T. (1995) The Nordic Lights: New Initiatives in Health Care Systems. Odense, Denmark: Odense University Press quoted in "Health in Developing Countries." International Encyclopedia of the Social Sciences. Ed. William Darity, Jr. 2nd ed. Vol. 3. Detroit: Macmillan Reference USA, 2008. 441-444. Global Issues In Context.

Alp, A. (2009a) Grip Olan Hastaneye Gidemeyecek!, http://www.hurriyet.com.tr/yasasinhayat/12495530.asp?gid=229 (last accessed on 16.09.2009).

Alp, A. (2009b) Sağlam Vatandaşa Anjiyo ve By-pass Yapıyorlar, http://www.hurriyet.com.tr/ekonomi/12451375.asp (last accessed on 10.09.2009).

Anderson, O.W. (1972) *Health Care: Can there be Equity? The United States, Sweden and England*, quoted in Nolte, E., McKee, M. and Wait, S. (2005) "Describing and Evaluating Health Systems" in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Arrowsmith, J. and Mosse, P. (2000) Health Care Reform and the Working Time of Hospital Nurses in England and France *European Journal of Industrial Relations* 2000; 6; 283.

Ataay, F. (2007) *Kamu Hastane Birlikleri Tasarısı Üzerine Değerlendirme*, Ankara: Türk Tabibleri Birliği Yayınları.

Ataay, F. (2006) *Neoliberalizm ve Devletin Yeniden Yapılandırılması- Türkiye'de Kamu Reformu Üzerine İncelemeler*, Ankara: De Ki.

Ateş, M. (2011) *Sağlık Sistemleri* İstanbul: Gerekli Kitap.

Atkinson, S. (2007) "Approaches to Studying Decentralization in Health Systems" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Atun, R. (2007) "Privatization as Decentralization Strategy" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Avrupa Birliği Bakanlığı (2011a) National Programme 2003 – (2003 Yılı Ulusal Programı) http://www.abgs.gov.tr/index.php?l=1&p=196 (last accessed on 28.01.2012).

Avrupa Birliği Bakanlığı (2011b) National Programme 2008 – (2008 Yılı Ulusal Programı) http://www.abgs.gov.tr/index.php?p=42260&l=1 (last accessed on 28.01.2012).

Axelsson, R., Marchildon, G. P. and Repullo-Labrador, J. R. (2007) "Effects of Decentralization on Managerial Dimensions of Health Systems" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Baggott, R. (2007) *Understanding Welfare: Social Issues, Policy and Practice - Understanding Health Policy* Bristol: The Policy Press.

Balcı, A. (2005) *Kamu Hizmetleri ve Yerinden Yönetim: Sağlık Hizmeti Sunumunun Yeniden Yapılandırılması*, İstanbul: Atlas Yayın Dağıtım.

Bankauskaite, V. and Saltman, R. B. (2007) "Central Issues in the Decentralization Debate" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Bayer, Y. (2011) Çapa-Cerrahpaşa'dan 450 Profesör Ayrıldı, http://www.hurriyet.com.tr/yazarlar/19189384.asp (last accessed on 08.11.2011).

Bedirhanoğlu, P. and Yalman, G. L. (2010) "State, Class and the Discourse – Reflections on the Neoliberal Transformation in Turkey" in A. Saad-Filho and G. Yalman (eds.) **Economic Transitions to Neoliberalism in Middle Income Countries**, London: Routledge.

Belek, İ. (2009) *Sağlığın Politik Ekonomisi- Sosyal Devletin Çöküşü*, İstanbul: Yazılama Yayınevi.

Bieling, H-J. (2011) "European Integration and Social Policy Reform" in İ. Eren-Vural (ed.), **Converging Europe – Transformation of Social Policy in the Enlarged European Union and in Turkey**, Ashgate Publishing.

Blank, R. and Burau, V. (2006) Setting Health Priorities Across Nations: More Convergence than Divergence? *Journal of Public Health Policy* 2006, 27, 265-281.

Bossert, T.J. (1998) Analyzing the decentralization of health systems in developing countries: decision space, innovation, and performance, *Social Science and Medicine* 47(10): 1513–27 quoted in Peckham, S., Exworthy, M. and Greener, I (2005) Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) July 2005, http://www.sdo.nihr.ac.uk/files/adhoc/67-final-report.pdf (last accessed on 05.10.2009).

Burns, D., Hambleton, R. and Hoggett, P. (1994) *The Politics of Decentralisation.* quoted in Peckham, S., Exworthy, M. and Greener, I (2005) Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) July 2005, http://www.sdo.nihr.ac.uk/files/adhoc/67-final-report.pdf (last accessed on 05.10.2009).

Butakın, K. (2011) Doktorlar Bayrak Açtı, http://haber.gazetevatan.com/doktorlar-bayrak-acti/384838/1/Gundem (last accessed on 22.06.2011).

Cole, A. and G. Jones (2005) Reshaping the State: Administrative Reform and New Public Management in France *Governance: An International Journal of Policy, Administration, and Institutions* Vol. 18, No. 4, October 2005, pp. 567-588.

Conyers, D. (1984) Decentralization and Development: A Review of the Literature, *Public Administration and Development 4: 187-97* quoted in Hutchcroft, P. D. (2001) Centralization and Decentralization in Administration and Politics: Assessing Territorial Dimensions of Authority and Power *Governance: An International Journal of Policy and Administration* vol. 14, No. 1, January 2001, pp. 23-53.

Dışişleri Bakanlığı (2011) National Programme 2001- (AB Müktesebatının Üstlenilmesine İlişkin Türkiye Ulusal Programı 2001) http://www.mfa.gov.tr/sub.tr.mfa?03fb894d-294d-4eff-84ef-460c6ddb6e0e (last accessed on 22.01.2011).

Demirci, B. (2008) *Health Technology Assessment: The Case of UK and Lessons to be Derived for the Incipient Turkish Case,* Unpublished Ms Dissertation, UCL, London.

Dictionary.com (2009a) Reform, http://dictionary.reference.com/browse/reform (last accessed on 25.5.2009).

Dictionary.com (2009b) Transform,http://dictionary.reference.com/browse/transform (last accessed on 25.5.2009).

Dieppe, P. (2005) "Research on Health and Health Care" in A. Bowling and S. Ebrahim (eds.) **Handbook of Health Research Methods – Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Dowling (1997) quoted in Baggott, R. (2007) Understanding Welfare: Social Issues, Policy and Practice -Understanding Health Policy Bristol: The Policy Press, p. 152.

DPT (2010) Five-Year Development Plans (Kalkınma Planları), http://ekutup.dpt.gov.tr/plan/plan.asp (last accessed on 29.09.2010).

Enthoven, A. C. (2000) In Pursuit of an Improving National Health Service, *Health Affairs* 19(3): 102-19 quoted in Magnussen, J., Tediosi, F. and Mihalyi, P. (2007) "Effects of Decentralization and Recentralization on Economic Dimensions of Health Systems" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), Decentralization in Health Care – Strategies and Outcomes, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Ersoy, M., Şengül, H. T., Tunç, G., Yoloğlu A. C. (der.) (2006) *Sağlıksızlığın Kentleşmesi – Ankara ve Diyarbakır Kentlerinde Sağlık Sorunları Üzerine Bir Araştırma*, ODTÜ Kentsel Politika Planlaması ve Yerel Yönetimler Anabilim Dalı 2004 – 2006 Yılları Stüdyo Çalışması Yayın No: 10, Ankara – Aralık 2006.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*, Cambridge: Polity Press.

EUR-Lex (2006) Consolidated Versions of the Treaty on European Union and the Treaty Establishing the European Community, http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:321E:0001:0331:EN:PDF (last accessed on 18.01.2011).

EUROPA (2011) Activities of the European Union - Public Health, http://europa.eu/pol/health/index_en.htm (last accessed on 01.01.2011).

European Commission (2004a) *Proposal for a Directive of the European Parliament and of the Council on Services in the Internal Market.* COM 2004.2. Final. 13 January 2004. Brussels, European Commission.

European Commission (2004b) Communication from the Commission - *Modernising Social Protection for the Development of High-Quality, Accessible and Sustainable Health Care and long-term Care: Support for the National Strategies Using the "Open Method of Coordination"*. COM 2003.304. Final. Brussels, European Commission.

European Commission (2004c) Communication from the Commission - follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union, COM (2004) 301 final. Brussels, European Commission.

Eurpean Commission (2003) Green Paper on on Services of General Interest. 21 May 2003. COM. Final. Brussels, European Commission.

European Commission (2001) The Internal Market and Health Services: Report of the High Level Committee on Health. 17 December. Brussels, European Commission.

European Parliament (2010) European Parliament's Committee on the Environment, Public Health and Food Safety, *General Overview of the Public Health Sector in Turkey in 2006*, http://www.europarl.europa.eu/comparl/envi/pdf/expert_panels/public_health_panel/public_health_in_turkey_by_reig_and_valverde.pdf (last accessed on 12.06.2010).

Evrensel (2008) Kriz Sağlıkçıları Hasta Ediyor, Evrensel Gazetesi 24.12.2008, http://www.evrensel.net/v2/haber.php?haber_id=42579 (last accessed on 08.02.2009).

Field, M.G. (1973) The Concept of the 'health system' at the macrosociological level, *Social Science & Medicine, 7: 763-85* quoted in Nolte, E., McKee, M. and Wait, S. (2005) "Describing and Evaluating Health Systems" in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Figueras, J., Saltman, R. B. and Sakellarides, C. (1999) "Introduction" in R. B. Saltman, J. Figueras and C. Sakellarides (eds.) **Critical Challenges for Health Care Reform in Europe,** Philadelphia: Open University Pres.

Fitzgerald and Reeves (1999) quoted in Baggott, R. (2007) Understanding Welfare: Social Issues, Policy and Practice -Understanding Health Policy Bristol: The Policy Press, p. 149.

Gazetevatan.com (2009a) Sağlık Harcamalarına Fren, http://w9.gazetevatan.com/haberdetay.asp?detay=&tarih=07.09.2009&Newsid=258070&Categoryid=2) (last accessed on 07.09.2009).

Gazetevatan.com (2009b) İlaç Harcamaları Kısılacak!, http://haber.gazetevatan.com/haberdetay.asp?detay=Ilac_harcamalari_kisilacak&tarih=13.09.2009&Newsid=259071&Categoryid=1 (last accessed on 13.09.2009).

Giaimo, S. and Manow, P. (1999) Adapting the Welfare State – The Case of Health Care Reform in Britain, Germany and the United States *Comparative Political Studies* Vol. 32, No. 8, December 1999, pp. 967-1000.

Gülten, G. (2011), 9.5 Milyon Yeşil Kart'a 'Test' Yapılacak, http://haber.gazetevatan.com/95-milyon-yesil-karta-test-yapilacak/386414/41/Saglik (last accessed on 01.07.2011).

Haas, P. M. (1992) Introduction: Epistemic Communities and International Policy Coordination *International Organization* vol. 46 no. 1, winter 1992, pp.1-35.

Harvey, D. (2003) *The New Imperialism*, New York: Oxford University Press.

Hambleton, R., Hoggett, P. and Razzaque, K. (1996) *Freedom Within Boundaries. Developing effective approaches to decentralisation* quoted in Peckham, S., Exworthy, M. and Greener, I (2005) Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) July 2005, http://www.sdo.nihr.ac.uk/files/adhoc/67-final-report.pdf (last accessed on 05.10.2009).

Hassenteufel, P. (2001) Liberalisation Through the State. Why is the French Health Insurance System Becoming so British? *Public Policy and Administration* Vol. 16, No. 4, Winter 2001.

Health for All Network (2010) What is the Health for All Network?, http://independent.livjm.ac.uk/healthforall/whatishfa3.htm (last accessed on 17.09.2010).

Hix, S. (2005) *The Political System of the European Union*, 2nd Ed., New York: PalgraveMacmillan.

HurriyretEgitim.com (2011) Üniversitelerde Sözleşmeli Öğretim Üyeliğine Geçiliyor, http://www.hurriyetegitim.com/haberler/17.10.2011/universitelerde-sozlesmeli-ogretim-uyeligine-gecili.aspx , 17.10.2011 (last accessed on 31.10.2011).

Hutchcroft, P. D. (2001) Centralization and Decentralization in Administration and Politics: Assessing Territorial Dimensions of Authority and Power *Governance: An International Journal of Policy and Administration* vol. 14, No. 1, January 2001, pp. 23-53.

İhlas Haber Ajansı (2009) Sağlık Bakanı Recep Akdağ, İngiltere Ziyaretinden Memnun, http://www.yorumla.net/saglik/379092-saglik-bakani-recep-akdag-ingiltere-ziyaretinden-memnun.html (last accessed on 22.12.2009).

Kammerling and Kinnear (1996) quoted in Baggott, R. (2007) Understanding Welfare: Social Issues, Policy and Practice -Understanding Health Policy Bristol: The Policy Press, p. 152.

Kaplan, Z. (2007) İlaç ve Tıbbi Cihaz Kurumu Yasası, http://www.ced.org.tr/v2/ecz-zafer-kaplan/ilac-ve-tibbi-cihaz-kurumu-yasasi (last accessed on 30.03.2011).

Kartal, M., Özbay, H. and Erişti, H.E. (2004) *SHA – Based Health Accounts in 13 OECD Countries: Country Studies – Turkey – National Health Accounts 2000,* OECD Health Technical Papers No. 13, Paris: OECD, http://www.oecd.org/dataoecd/7/49/33696739.pdf (last accessed on 20.01.2011).

Keating, M. and Hooghe, L. (2001) "Bypassing the Nation State? Regions and the EU Policy Process" in Jeremy Richardson (ed.) **European Union – Power and Policy-Making**, London: Routledge.

Keyder, Ç. (2007) "Giriş" in Ç. Keyder, N. Üstündağ, T. Ağartan and Ç. Yoltar (eds.) **Avrupa'da ve Türkiye'de Sağlık Politikaları – Reformlar, Sorunlar, Tartışmalar**, İstanbul: İletişim Yayınları.

Kinnunen, J., Danishevski, K., Deber, R. B. and Tulchinsky, T. H. (2007) "Effects of Decentralization on Clinical Dimensions of Health Systems" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Koivusalo, M., Wyss, K. and Santana, P. (2007) "Effects of Decentralization and Recentralization on Equity Dimensions of Health Systems" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Köker, M. (2009) Sağlıkta İngiliz sistemiyle 70 bin yataklı hastane, http://www.tumgazeteler.com/?a=2364616 (last accessed on 22.12.2009).

Kutzin, J., Ibraimova, A., Jakab, M. and O'Dougherty, S. (2009) Bismarck Meets Beveridge on the Silk Road: Coordinating Funding Sources to Create a Universal Health Financing System in Kyrgyzstan *Bull World Health Organ* 5 May 2009; 87: 549-554.

Lee, S.Y. and Chang-Bae Chun (2006) The National Health Insurance as One Type of New Typology: The Case of South Korea and Taiwan, www.bris.ac.uk/...sang-yi_Lee_&_Chang-Bae_Chun_paper.doc (last accessed on 20.10.2009).

Lee, S-Y., Chun, C-B., Lee, Y-G. and Seo, N. K. (2008) The National Health Insurance System as one Type of New Typology: the Case of South Korea and Taiwan *Health Policy* 85 (2008) 105- 113.

Leys, C. (2011) "Sağlık ve Kapitalizm" in L. Panitch and C. Leys (eds.) **Kapitalizmde Sağlık Sağlıksızlık Semptomları – Socialist Register 2010**, İstanbul: Yordam Kitap.

Leys, C. (2007) "Piyasa ile Politika Arasında Sağlık Hizmetlerinin Konumu" in Ç. Keyder et al. (eds.), **Avrupa'da ve Türkiye'de Sağlık Politikaları – Reformlar, Sorunlar, Tartışmalar**, İstanbul: İletişim Yayınları.

Lister, J. (2008) *Sağlık Politikası Reformu – Yanlış Yolda mı Gidiyoruz?- Küresel "Sağlık Reformu" Endüstrisinin Eleştirel Klavuzu*, İstanbul: İNSEV Yayınları.

Loeppky, R. (2011) "Kusursuz Servet: Sağlık Endüstrisinde Sermaye Birikimi" in L. Panitch and C. Leys (eds.) **Kapitalizmde Sağlık Sağlıksızlık Semptomları – Socialist Register 2010**, İstanbul: Yordam Kitap.

Long, M. J. (1994) *The Medical Care System: A Conceptual Model*, quoted in Nolte, E., McKee, M. and Wait, S. (2005) "Describing and Evaluating Health Systems" in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Longman English Dictionary 1995, London: Longman.

Magnussen, J., Tediosi, F. and Mihalyi, P. (2007) “Effects of Decentralization and Recentralization on Economic Dimensions of Health Systems” in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Maino, F., Blomqvist, P., Bertinato, L., Bohigas, S., Garrido, R. M. U. and Shishkin, S. (2007) “Effects of Decentralization and Recentralization on Political Dimensions of Health Systems” in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

McPake, B., Kumaranyake, L. and Normand, C. (2002) *Health Economics: An International Perspective*, quoted in Nolte, E., McKee, M. and Wait, S. (2005) “Describing and Evaluating Health Systems” in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Medihaber (2011) Akdağ; Devlet Hastaneleri Yerine Şehir Hastaneleri, http://www.medihaber.net/2011/09/18/akdag-devlet-hastaneleri-yerine-sehir-hastaneleri/ (last accessed on 18.09.2011).

Medikalproje.com (2011) Sağlık Kampüslerinde İngiltere Modeli Daha Yakın, http://www.medikalproje.com/default.asp?pg=news&i=4615&lng=1 (last accessed on 30.03.2011).

Mills, A. (1990) “Decentralization Concepts and Issues: A Review” in A. Mills, J. P. Vaughan, D. L. Smith and I. Tabibzadeh (eds.) **Health System Decentralization – Concepts, Issues and Country Experience**, Geneva: WHO.

Mills, A. And Ranson, M. (2001) The Design of Health Systems in M. Merson, R. Black and A. Mills (eds.) *International Public Health, Diseases, Programs, Systems, and Policies* quoted in Nolte, E., McKee, M. and Wait, S. (2005) “Describing and Evaluating Health Systems” in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Ministry of Health of Turkey (2011) *Health Statistics Yearbook 2010*, http://www.tusak.saglik.gov.tr/saglik_istatistikleri_yilligi_2010.pdf (last accessed 19.08.2011).

Mossialos, E. and Dixon, A. (2007) "Funding Health Care: An Introduction" in E. Mossialos, A. Dixon, J. Figueras and J. Kutzin (eds.) **Funding Health Care: Options for Europe**, New York: Open University Pres.

Nalçacı, E., Hamzaoğlu, O. and Özalp, E. (2006) *Eleştirel Sağlık Sosyolojisi Sözlüğü*, Nazım Kitaplığı, İstanbul: Kayhan Matbaacılık.

Nemec, J. and Kolisnichenko, N. (2006) Market-Based Health Care Reforms in Central and Eastern Europe: Lessons After Ten Years of Change *International Review of Administrative Sciences* Vol. 72(1): 11-26.

Nolte, E., Wait, S. and McKee, M. (2006) *Investing in Health – Benchmarking Health Systems*, London: The Nuffield Trust.

Nolte, E., McKee, M. and Wait, S. (2005) "Describing and Evaluating Health Systems" in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

OECD (2011a) *OECD Health Data 2011- How does Turkey Compare*, http://www.oecd.org/dataoecd/46/5/38980477.pdf (last accessed on 11.07.2011).

OECD (2011b) *OECD Health Data 2011 – Frequently Requested Data*, http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html (last accessed on 11.07.2011).

OECD (2011c) *Members and Partners*, http://www.oecd.org/document/25/0,3746, en_36734052_36761800_36999961_1_1_1_1,00.html (last accessed on 25.01.2011).

OECD (2011d) *About OECD*, http://www.oecd.org/pages/0,3417,en_36734052_ 36734103_1_1_1_1_1,00.html (last accessed on 25.01.2011).

OECD (2010) *OECD Health Data 2010 - How Does Turkey Compare?*, http://www.oecd.org/dataoecd/46/5/38980477.pdf (last accessed on 26.10.2010).

OECD (2009) *Health at a Glance 2009: OECD Indicators*, http://www.oecd.org/ document/0,3746,en_2649_201185_46462759_1_1_1_1,00.html (last accessed on 29.06.2011).

OECD (2000) *A System of Health Accounts*, http://www.oecd.org/dataoecd/41/4/1841456.pdf (last accessed on 27.12.2009).

OECD (1997) *Managing Across Levels of Government*, http://www.oecd.org/dataoecd/10/14/1902308.pdf (last accessed on 01.10.2009).

OECD (1995) *Governance in Transition – Public Management Reforms in OECD Countries*, OECD Publishing.

Öniş, Z. and C. Bakır (2007) Turkey's Political Economy in the Age of Financial Globalization: The Significance of the EU Anchor *South European Society & Politics* Vol. 12, No.2, June 2007, pp. 147-164.

Palier, B. (2005) *La Réforme des Systèmes de Santé*, Paris: Presses Universitaires de France.

Peckham, S., Exworthy, M. and Greener, I (2005) *Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) July 2005*, http://www.sdo.nihr.ac.uk/files/adhoc/67-final-report.pdf (last accessed on 05.10.2009).

Pollitt, C. and G. Bouckaert (2004) *Public Management Reform – A Comparative Analysis*, New York: Oxford University Press.

Resmi Gazete (2011a) Statutory Decree No. 650, Date. 26.08.2011, (Adalet Bakanlığının Teşkilat Ve Görevleri Hakkında Kanun Hükmünde Kararnamenin Değiştirilerek Kabulü Hakkında Kanun İle Bazı Kanun Ve Kanun Hükmünde Kararnamelerde Değişiklik Yapılmasına Dair Kanun Hükmünde Kararname, Karar Sayısı: Khk/650, Resmi Gazete Tarih: 26 Ağustos 2011, Sayı : 28037).

Resmi Gazete (2011b) Statutory Decree on Organization and Functions of the Ministry of Health and Associated Institutions (Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname), KHK/663, 02.11.2011, http://www.resmigazete.gov.tr/eskiler/2011/11/20111102m1.htm (last accessed on 03.11.2011).

Resmi Gazete (2010) Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği, Tarih: 25 Mart 2010, Sayı : 27532 (Mükerrer), http://www.resmigazete.gov.tr/eskiler/2010/03/20100325M1-1.htm (last accessed on 10.03.2011).

Roberts, M. J., Hsiao, W., Berman, P. and Reich, M. R. (2008) *Getting Health Reform Right- A Guide to Improving Performance and Equity*, New York: Oxford University Pres.

Roemer, M. I. (1991) *National Health Systems of the World*, quoted in Nolte, E., McKee, M. and Wait, S. (2005) "Describing and Evaluating Health Systems" in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

Rondinelli, D.A., Nellis, J.R. and Cheema, G.S. (1983) *Decentralization in Developing Countries: A review of Recent Experience*, Washington: World Bank.

Sağlık Aktüel (2010) By-Law on Green Card (Ödeme Gücü Olmayan Vatandaşların Tedavi Giderlerinin Devlet Tarafından Karşılanması ve Yeşil Kart Uygulaması Hakkında Yönetmelik) Resmi Gazete No: 21314, http://www.saglikaktuel.com/haber/yesil-kart-uygulamasi-hakkinda-yonetmelik-13690.htm (last accessed on 10.03.2011).

Sağlık Bakanlığı (2011a) Sağlıkta Dönüşüm Programına Destek Sağlıkta Dönüşüm Projesi, http://www.pydb.saglik.gov.tr/node/69 (last accessed on 23.01.2011).

Sağlık Bakanlığı (2011b) Sağlık Bakanı Prof.Dr.Recep Akdağ "Teke Tek" Programına Katıldı, http://www.saglik.gov.tr/TR/belge/1-12422/saglik-bakani-profdrrecep-akdag-teke-tek-programina-kat-.html (last accessed on 30.03.2011).

Sağlık Bakanlığı (2011c) Law on Pilot Implementation of Family Medicine, 5258 sayılı Aile Hekimliği Pilot Uygulaması Hakkında Kanun, 24.11.2004 tarih ve 25650 sayılı Resmi Gazete, http://www.ailehekimligi.gov.tr/index.php?option=com_content&view=category&layout=blog&id=54&Itemid=213 (last accessed on 13.03.2011).

Sağlık Bakanlığı (2011d) By-Law on the Pay-Rolls for Family Doctors (Aile Hekimliği Uygulaması Kapsamında Sağlık Bakanlığınca Çalıştırılan Personele Yapılacak Ödemeler ile Sözleşme Usul ve Esasları Hakkında Yönetmelik, 24.12.2010, No : 2010/1237), http://www.ailehekimligi.gov.tr/index.php?option=com_content&view=article&id=924:aile-hekimlii-uygulamas-kapsamnda-salk-bakanlnca-caltrlan-personele-yaplacak-oedemeler-le-soezleme-usul-ve-esaslar-hakknda-yoenetmelik&catid=42:yoenetmelikler&Itemid=223 (last accessed on 20.08.2011).

Sağlık Bakanlığı (2010) Basic Law on Health Services (Sağlık Hizmetleri Temel Kanunu, Kanun no: 3359), http://www.saglik.gov.tr/TR/Genel/BelgeGoster.aspx?F6E10F8892433CFF71BE64510F6C8BC9C663EB3BA2011BDE (last accessed on 21.01.2010).

Sağlık Bakanlığı (2009) National Health Program of Turkey in its Alignment with the EU Acquis-(Avrupa Birliği Müktesebatının Üstlenilmesine İlişkin Türkiye Ulusal Sağlık Programı), http://www.saglik.gov.tr/TR/BelgeGoster.aspx?F6E10F8892433CFF7A2395174CFB32E1DA0F7D5833632EE9 (last accessed on 18 february 2009).

Sağlık Bakanlığı (2003) Health Transformation Programme (Sağlıkta Dönüşüm Programı), http://www.saglik.gov.tr/TR/BelgeGoster.aspx?F6E10F8892433CFF7A2395174CFB32E19ABF9BBCF4C02FA1 (last accessed on 17.12.2008).

Türkiye Gazetesi (2004) Sağlıkta Sınıfı Geçemiyoruz, www.tumgazeteler.com/?a=250477 (last accesssed on 20.05.2004).

Saltman R. B., Bankauskaite, V. and Vrangbaek, K. (2007) "Introduction: The Question of Decentralization" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

SES (2011) *2010 Yılı Sağlık Raporu*, http://www.ses.org.tr/index.php (last accessed on 15.04.2011).

SGK (2010) Guideline on the Grading of Private Hospitals (Özel Hastaneler ile Vakıf Üniversite Hastanelerinin Puanlandırılması ve İlave Ücret Alınması Hakkında Yönerge) – (Date: 29.01.2010) http://www.sgk.gov.tr/wps/wcm/connect/755d1e8041388f1ba24abb4a37026f07/puanlandirma_yonergesi.pdf?MOD=AJPERES (last accessed on 31.03.2011).

Smith et al. (2001) quoted in Resmi Gazete (2010) Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği, Tarih: 25 Mart 2010, Sayı : 27532 (Mükerrer), http://www.resmigazete.gov.tr/eskiler/2010/03/20100325M1-1.htm (last accessed on 10.03.2011), p. 135.

Socialist Health Association (2011) Reform of the National Health Service, http://www.sochealth.co.uk/news/NHSreform.htm (Socialist Health Association of England) (last accessed on 10.06.2011).

Socialist Health Association (2010) Social Insurance and Allied Services - Report by Sir William Beveridge (The Beveridge Report), http://www.sochealth.co.uk/history/beveridge.htm (last accessed on 20.01.2010).

Soyer, A. (2007) *AKP'nin Sağlık Raporu*, İstanbul: Evrensel Basım Yayın.

Soyer, A. (2003) 1980'den Günümüze Sağlık Politikaları *Praksis (*9) 2003, 301-319.

Stone, D. (2001) Think Tanks, Global Lesson-Drawing and Networking Social Policy Ideas *Global Social Policy* vol. I (3): 338-360.

Şengül, T. (2007) "Planlama Aygıtından Planlama Alanına: Siyaset Planlama İlişkisini Yeniden Düşünmek" in **Planlama, Siyaset, Siyasalar – 6. Türkiye Şehircilik Kongresi Bildiriler Kitabı**, Ankara: BRC.

Şengül, H. T. (2001) *Kentsel Çelişki ve Siyaset – Kapitalist Kentleşme Süreçleri Üzerine Yazılar*, İstanbul: WALD.

Tallis (2004) quoted in Baggott, R. (2007) Understanding Welfare: Social Issues, Policy and Practice -Understanding Health Policy Bristol: The Policy Press, p. 135.

TBMM (2011a) Law on the Full-Day Employment of Health Personnel – Üniversite ve Sağlık Personelinin Tam Gün Çalışmasına ve Bazı Kanunlarda Değişiklik Yapılmasına Dair Kanun- (Law No: 5947; Date: 21.01.2010)- http://www.tbmm.gov.tr/kanunlar/k5947.html (last accessed on 20.03.2011).

TBMM (2011b) Draft Law on the Pilot Implementation of Union of Public Hospitals (Kamu Hastane Birlikleri Pilot Uygulaması Hakkında Kanun Tasarısı) http://www2.tbmm.gov.tr/d23/1/1-0439.pdf (last accessed on 29.03.2011).

TBMM (2010a) Constitution of the Turkish Republic (1961) (Türkiye Cumhuriyeti Anayasası 1961), http://www.tbmm.gov.tr/anayasa/anayasa61.htm (last accessed on 16.07.2010).

TBMM (2010b) Constitution of the Turkish Republic (Türkiye Cumhuriyeti Anayasası 1982), http://www.anayasa.gen.tr/1982ay.htm (last accessed on 16.07.2010).

TBMM (2010c) Constitution of the Turkish Republic http://www.tbmm.gov.tr/anayasa/anayasa_2010.pdf (last accessed on 05.01.2011).

TBMM (2010d) Law on the Foundation, Coordination and Duties of Development Agencies – Kalkınma Ajanslarının Kuruluşu, Koordinasyonu ve Görevleri Hakkında Kanun- (Kanun No: 5449, Tarih: 25.01.2006), http://www.tbmm.gov.tr/kanunlar/k5449.html (last accessed on 18.12.2010).

TBMM (2009) Basic Law on Public Administration (Kamu Yönetiminin Temel İlkeleri ve Yeniden Yapılandırılması Hakkında Kanun) (Kamu Yönetimi Temel Kanunu), Kanun No: 5227, http://www.tbmm.gov.tr/kanunlar/k5227.html. (last accessed on 18.02.2009).

TCMB (2011) IMF Letter of Intents - IMF Niyet Mektupları ve Stand-by Anlaşmaları, http://www.tcmb.gov.tr (last accessed on 29.01.2011).

Tıp Dünyası (2009) Sağlıkta Dönüşüm Programından Sağlıkta Dönüşüm Problemine (15 Şubat 2009, Sayı: 160) http://www.ttb.org.tr/TD/TD160/index.pdf (last accessed on 14.04.2009).

TRT Haber (2011) Danıştay'ın Tam Gün Yasası Kararı, http://www.trt.net.tr/haber/HaberDetay.aspx?HaberKodu=909bd9e9-9152-4502-85ae-4490d83b5803 (last accessed on 04.07.2011).

TÜİK (2010) Resmi İstatistik Programı Bilgi Sistemi, http://www.tuik.gov.tr/rip/temalar/2_5.html (last accessed on 14.10.2010).

Tünay, M. (2002) Türk Yeni Sağının Hegemonya Girişimi *Praksis* (5) 2002, 177-197.

Türk Sağlık-Sen Raporu quoted in Evrensel (2008) Bütçe Yetersiz, Evrensel Gazetesi, 24.12.2008, http://www.evrensel.net/v2/haber.php?haber_id=42579 (last accessed on 08.02.2009).

Türk Tabipleri Birliği (2011a) Circular on the Provision of Ambulatory Services (Acil Sağlık Hizmetlerinin Sunumu ile İlgili Başbakanlık Genelgesi, 2008/13) http://www.ttb.org.tr/mevzuat/index.php?option=com_content&task=view&id=594&Itemid=35 (last accessed on 30.03.2011).

Türk Tabipleri Birliği (2011b) Draft Law on the Establishment and Responsibilities of the Pharmaceuticals and Medical Devices Institute – Türkiye İlaç ve Tıbbi Cihaz Kurumu Kuruluş ve Görevleri Hakkında Kanun Tasarısı- http://www.ttb.org.tr/ekler/ilac_kurum_taslak.pdf (last accessed on 30.03.2011).

Türk Tabipleri Birliği (2010) 224 Sayılı Kanun, http://www.ttb.org.tr/index.php/component/content/article/15-genel/54-224-sayili-kanun (last accessed on 16.09.2010).

Türk Tabipleri Birliği (2009) Law on Social Insurance and General (Universal) Health Insurance- (Sosyal Sigortalar ve Genel Sağlık Sigortası Kanunu) Kanun No: 5510, Resmi Gazete: 16.06.2006- 26200, http://www.ttb.org.tr/mevzuat/index.php?option=com_content&view=article&id=413:sosyal-sortalar-ve-genel-saik-sortasi-kanunu-5510&catid=1:yasa&Itemid=28 (last accessed on 19.05.2010).

Türk Tabipleri Birliği (2008) Law on Social Security Institution (Sosyal Güvenlik Kurumu Kanunu) - Kanun No: 5502- Resmi Gazete: 20.05.2006- 26173- http://www.ttb.org.tr/mevzuat/index.php?option=com_content&task=view&id=401&Itemid=28 (last accessed on 19.05.2010).

UKAF – United Kingdom Accreditation Forum http://www.ukaf.org.uk/HQS.htm (last accessed on 25.11.2010).

UKAS (2011) About UKAS, http://www.ukas.com/about-accreditation/about-ukas/default.asp (last accessed on 15.03.2011).

United Nations (2010) Universal Declaration of Human Rights, http://www.un.org/en/documents/udhr/index.shtml#a25 (last accessed on 16.01.2010).

Üstündağ, N. and Ç. Yoltar (2007) "Türkiye'de Sağlık Sisteminin Dönüşümü: Bir Devlet Etnografisi" in Ç. Keyder et al. (eds.), **Avrupa'da ve Türkiye'de Sağlık Politikaları – Reformlar, Sorunlar, Tartışmalar**, İstanbul: İletişim Yayınları.

Üstüner, Y. (2000) Kamu Yönetimi Kuramı ve Kamu İşletmeciliği Okulu *Amme İdaresi Dergisi* Cilt 33 Sayı 3 3 Eylül 2000 s. 15-31.

Vrangbaek, K. (2007) "Towards a Typology for Decentralization in Health Care" in R. B. Saltman, V. Bankauskaite and K. Vrangbaek (eds.), **Decentralization in Health Care – Strategies and Outcomes**, European Observatory on Health Systems and Policies Series, Glasgow: Open University Press.

Walker, D. (2002) In Praise of Centralism: a new critique of localism. Catalyst Forum working paper. http://editiondesign.co.uk/catalyst/pubs/pub7.html quoted in Peckham, S., Exworthy, M. and Greener, I (2005) Decentralisation, Centralisation and Devolution in Publicly Funded Health Services: Decentralisation as an Organisational Model for Health Care in England – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) July 2005, http://www.sdo.nihr.ac.uk/files/adhoc/67-final-report.pdf (last accessed on 05.10.2009).

Walshe, K., Smith, J., Dixon, J., Edwards, N., Hunter, D. J., Mays, N., Normand, C. And Robinson, R. (2004) "Primary Care Trusts: Premature Reorganization, with Mergers, may be Harmful?" *British Medical Journal Editorial*, quoted in Lister, J. (2008) Sağlık Politikası Reformu – Yanlış Yolda mı Gidiyoruz?- Küresel "Sağlık Reformu" Endüstrisinin Eleştirel Klavuzu, İstanbul: İNSEV Yayınları.

Walshe (2003) quoted in Baggott, R. (2007) Understanding Welfare: Social Issues, Policy and Practice -Understanding Health Policy Bristol: The Policy Press, p. 148.

Weinerman, E. R. (1971) Research on Comparative Health Service Systems, *Medical Care, 9: 272-90*, quoted in Nolte, E., McKee, M. and Wait, S. (2005) "Describing and Evaluating Health Systems" in A. Bowling and S. Ebrahim (eds.), **Handbook of Health Research Methods: Investigation, Measurement and Analysis**, Berkshire: Open University Press.

WHO (2011a) *Country Cooperation Strategy at a Glance for Turkey* http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_tur_en.pdf (last accessed on 23.01.2011).

WHO (2011b) *National Health Accounts for Turkey,* http://www.who.int/nha/country/tur/en/ (last accessed on 23.01.2011).
WHO (2011c) *Turkey: Health Profile*, http://www.who.int/gho/countries/tur.pdf (last accessed on 23.01.2011).

WHO (2011d) *Turkey: Selected Basic Statistics,* http://www.euro.who.int/en/where-we-work/member-states/turkey/selected-basic-statistics (last accessed on 23.01.2011).

WHO (2011e) Biennial Collaborative Agreement between the Ministry of Health of Republic of Turkey and WHO/Europe 2010-2011, http://www.euro.who.int/__data/assets/pdf_file/0020/101909/TUR1011.pdf (last accessed on 23.01.2011).

WHO (2011f) Declaration of Alma-Ata – International Conference on Primary Health Care, 6-12 September 1978, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (last accessed on 03.03.2011).

WHO (2011g) About WHO http://www.who.int/about/en/ (last accessed on 20.01.2011).

WHO (2009a) *Decentralization*, http://www.euro.who.int/observatory/Glossary/TopPage?phrase=decentralization (last accessed on 01.10.2009).

WHO (2009b) Constitution of the World Health Organization, Forty-fifth edition, Supplement, October 2006, http://www.who.int/governance/eb/who_constitution_en.pdf (last accessed on 23. 11.2009).

WHO (2007) *Everybody's Business – Strengthening Health Systems to Improve Health Outcomes-WHO's Framework for Action*, http://www.searo.who.int/LinkFiles/Health_Systems_EverybodyBusinessHSS.pdf (last accessed on 08.12.2009).

WHO (2006) *Highlights on Health in Turkey in 2005* http://www.euro.who.int/__data/assets/pdf_file/0018/103608/E88394.pdf (last accessed on 23.01.2011).

WHO (2000) *The World Health Report 2000 – Health Systems: Improving Performance* http://www.who.int/whr/2000/en/ (last accessed on 23.12.2009).

World Bank (2011) *Turkey Health Transformation and Social Security Reform Project*, http://siteresources.worldbank.org/TURKEYEXTN/Resources/361711-1286352604360/ECATRHealthTransformationandSocialSecurity.pdf (last accessed on 23.01.2011).

World Bank (2004) *World Development Report 2004* http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2003/10/07/000090341_20031007150121/additional/310436360_20050005033644.pdf (last accessed on 24.01.2011).

World Bank (1993) World Development Report – Investing in Health http://econ.worldbank.org/external/default/main?pagePK=64165259&theSitePK=469382&piPK=64165421&menuPK=64166093&entityID=000009265_3970716142319 (last accessed on 05.03.2009).

WTO (2011a) *Horizontal Commitments of Turkey*, http://tsdb.wto.org/simplesearch.aspx?id=196&name=Turkey&sc=hc (last accessed on 23.01.2011).

WTO (2011b) *Sector Specific Commitments*, http://tsdb.wto.org/simplesearch.aspx?id=196&sc=8 (last accessed on 23.01.2011).

Yalman, G.L. (2002a) "The Turkish State and Bourgeoise in Historical Perspective: A Relativist Paradigm or A Panoply of Hegemonic Strategies" in N. Balkan and S. Savran (eds.), **The Politics of Permanent Crisis: Class, Ideology and State in Turkey**, New York: Nova Science Publishers Inc.

Yalman, G. L. (2002b) Tarihsel Bir Perspektiften Türkiye'de Devlet ve Burjuvazi: Rölativist Bir Paradigma mı Hegemonya Stratejisi mi? Hegemonya Projeleri Olarak Devletçilik, Kalkınmacılık ve Piyasa *Praksis* (5) 2002, 7-23.

Yenimahalleli-Yaşar, G. (2008) Türkiye'de 1980 Sonrası Sağlık Politikalarında Gözlenen Neoliberal Dönüşüm ve Sonuçları Üzerine Değerlendirmeler *Mülkiye* 2008 Cilt: XXXII Sayı: 260 s: 157-192.

Yıldırım, K. (2010) "Sağlıkta Dönüşüm Sürecinde AKP'nin 'muhalif ama hegemonik' Dili", http://www.sendika.org/yazi.php?yazi_no=32702, 11.09.2010 (last accessed on 13.09.2010).

APPENDIX A

TURKISH SUMMARY

Sağlık konusu toplumların hayatında yüzyıllardır önemli ve popüler bir yere sahip olmuştur. Şüphesiz ki konunun insan için "yaşamsal" olması ve dolayısıyla onların oluşturduğu toplumların devamı ve bir anlamda varlık nedeni olması bunda çok önemli bir rol oynamıştır. Ancak konuya daha politik ve sosyo-ekonomik açıdan yaklaşacak olursak, modern devletin ortaya çıkışı ve gelişimi ile sağlık konusunun siyasi ve ekonomik bir boyut kazandığını ve modern devletin önemli bir iktidar ve meşruiyet alanı haline geldiğini söyleyebiliriz.

Kapitalizmin gelişim süreci içerisinde, sağlık en önemli ve aynı zamanda da en çok manipüle edilen kamu sektörlerinden birisi haline gelmiştir. Diğer nedenlerin yanında bu durum özellikle kapitalizmin geçirdiği aşamalarla yakından ilgilidir ve bunlardan doğrudan etkilenmiştir. Söz konusu süreçte, refah devleti ve kapitalizmin bugüne kadar geçirmiş olduğu döngüsel krizler ve bunlara cevaben sistemin yeniden yapılanma çabaları genelde kamu sektörünü, özel olarak da sağlık sektöründeki dönüşümleri yakından ilgilendiren konular olarak özellikle dikkat çekmektedir.

Sağlık sektöründe son yıllarda iyice gündeme yerleşen reform çalışmalarını da bu kapsamda değerlendirmek son derece yerinde olacaktır. Bu bağlamda 1980'li yıllardan bu yana devam etmekte olan neoliberal yeniden yapılanma süreci ve bunun sağlık reformları ile olan ilgisi doğru analiz edilmelidir. Zira söz konusu dönemde, gerek dünyada gerekse de Türkiye'de, diğer kamu sektörlerindeki sürece benzer şekilde, sağlık alanında yürütülmekte olan dönüşüm projelerinin arkasındaki temel belirleyicilerin başında neoliberal yeniden yapılanma dinamikleri gelmektedir. Sağlıkta dönüşüm projeleri bu bağlamda ele alınınca, sağlıkla ilgili pek çok konunun yalnız politika yapanların gündeminde geniş yer tutması değil, sıradan vatandaşların günlük hayatlarında giderek daha çok yer almaya başlaması da daha anlaşılır hale gelmektedir, ki bu durum en genel haliyle neoliberal yeniden yapılanmanın getirdiği

sağlık hizmetlerinde artan metalaştırma sürecinin doğal bir uzantısı olarak değerlendirilebilir. Belli bir takım farklılıkları göz önünde tutulmakla beraber, Türk sağlık sisteminde yaşanmakta olan dönüşümü, genel neoliberal dönüşüm perspektifinden okumanın bizi daha "sağlıklı" değerlendirmelere götüreceği iddiası bu çalışmanın temel tezlerinden birisidir.

Sağlık sistemlerinde yaşanan dönüşüm süreçleri derinlemesine incelendiğinde bunların çok ciddi sosyo-ekonomik, siyasi, yönetimsel, klinik ve kültürel sonuçları olduğunu görülmektedir. Dolayısıyla sağlıkta dönüşüm projeleri, yalnızca tıp biliminin değil aynı zamanda ilgili birçok sosyal bilim dalının da hassasiyetle incelemesi gereken konulardır. Bu bağlamda, konuya siyaset bilimi ve kamu yönetimi perspektifinden kapsamlı bir şekilde bakacak çalışmalar son derece önem arz etmektedir. Bu çalışmanın hayata geçirilmesinin arkasında yatan temel nedenlerden birisi de, bu alandaki boşluğa da bir katkı sunması düşüncesiyle, sağlıktaki dönüşüm çabalarına siyaset bilimi ve kamu yönetimi perspektifinden bakmaya çalışıp yukarıda sözü edilen etkilerini bu çerçeveden değerlendirmeye çalışmaktır.

Türk Sağlık Sistemi'ndeki neoliberal dönüşümün en son ve en radikal halkası olan Sağlıkta Dönüşüm Programı (SDP)[144] 2003 yılından bu yana hayata geçirilmektedir. SDP, Türk Sağlık Sistemi'nin sosyo-ekonomik, siyasi, yönetimsel, klinik ve kültürel boyutlarına yönelik ciddi değişiklikler getirmiştir ve getirmeye devam etmektedir. Sağlıkta Dönüşüm Programı çerçevesinde, Türkiye'deki sağlık sistemini dönüştürmeye yönelik olarak hayata geçirilen ve geçirilmeye devam edilen reformları ve özellikle de bu reformların sözü edilen etkilerini anlamaya çalışma gayesi bu çalışmanın yapılmasında belirleyici olmuştur.

Buraya kadar anlatılanların ışığında, bu çalışmanın temel amacının Türkiye'deki sağlık sisteminin geçirmekte olduğu dönüşümü ve bu dönüşümün sağlık sisteminin temel bileşenleri ve özellikleri üzerindeki etkisini anlamak olduğu söylenebilir. Söz konusu dönüşümü incelerken, çalışma esas olarak sağlık sisteminin organizasyonu (yerelleştirilmesi[145]) ve finansmanına yönelik dönüşüm faaliyetlerine

[144] Sağlık Bakanlığı (2003)

[145] Hem genel olarak sağlık reformlarında hem de Sağlıkta Dönüşüm Programı özelinde, sağlık sisteminin organizasyonuna yönelik reformlar çoğunlukla sistemin "yerelleştirilmesi" başlığı ile sunulur ve yerelleştirilmiş bir sağlık sisteminin önemine vurgu yapılır. Ancak bu çalışmada da

odaklanmaktadır. Bunun nedeni, dönüşümün en önemli hedefinin bu iki alan olduğu ve esas olarak bu alanlardaki düzenlemelerin sağlık sisteminin sosyo-ekonomik, politik, yönetimsel, klinik ve kültürel özelliklerine yönelik ciddi değişiklikler getirdiği tezidir. Çalışma, Türk Sağlık Sistemi'ndeki dönüşümü anlamaya çalışırken, İngiliz Ulusal Sağlık Sistemi (National Health Service) (NHS)'ye – özelikle bu sistemin reforme edilme biçimine - başvurmakta ve bu modelden yapılacak çıkarımların Türk Sağlık Sistemi'ndeki dönüşümü anlamada önemli kolaylıklar sağlayacağını söylemektedir.

Çalışmanın amacını ve kapsamını daha somut bir biçimde ortaya koyabilmek için, öne sürülen ve çalışmanın süresi ve sınırları elverdiği ölçüde doğrulanan argümanları şu şekilde sıralamak mümkündür:

1. *Hem genel olarak sağlık reformları hem de özel olarak Sağlıkta Dönüşüm Programı neoliberal yeniden yapılanma perspektifi çerçevesinde değerlendirilmelidir.*

Bilindiği gibi neoliberal yeniden yapılanma sebepleri ve sonuçları olan bir süreçtir. Kapitalist sistemin döngüsel krizlerinden olan 1970 krizi bu süreci başlatan en temel neden olarak alınabilir. Bu krizi aşabilmek için geliştirilen ve uygulamaya konulan neoliberal politikalar dünyanın hemen her yerinde devletin ve kamu hizmetlerinin neoliberal çerçevede yeniden yapılandırılması ile sonuçlanmıştır ve sonuçlanmaya devam etmektedir. Bu çerçevede geliştirilen Yeni Kamu İşletmeciliği Yaklaşımı neoliberal yeniden yapılanma sürecinde gerçekleştirilen reformların genel çerçevesini çizmek ve temel prensiplerini ortaya koymak suretiyle sürece önemli katkı sunmuştur.

Devletin ve kamu hizmetlerinin neoliberal perspektifle yeniden yapılandırılması sürecinde en fazla hedeflenen sektörlerin başında sağlık hizmetleri gelmiştir ve gelmektedir. Çalışmada etraflıca tartışıldığı üzere, gerek sektörün büyüklüğü gerekse de yapısal özellikleri itibariyle sağlık sektöründe yaşanan dönüşüm ve yeniden yapılanma faaliyetlerinin söz konusu sağlık sisteminin ekonomik, siyasi, yönetimsel, klinik, eşitlik ve kavramsal/kültürel boyutları üzerinde ciddi etkileri olmaktadır.

---

gösterildiği üzere, pratikte bu her zaman böyle olmamakta, sağlık sisteminin organizasyonuna yönelik dönüştürme faaliyetlerinde yerelleştirme çoğu zaman merkezileştirme, yeniden merkezileştirme (re-centralization) ya da bölgeselleştirme (regionalization) faaliyetleri ile birlikte - eş zamanlı ya da peş peşe olacak şekilde - gerçekleşmektedir.

Dikkatli bir şekilde incelendiğinde, diğer kamu hizmetlerindeki reformlarda da olduğu gibi, sağlık alanındaki reformları hem neoliberal yeniden yapılandırma süreçlerinin bir sonucu hem de bu süreçlerin dönüşümü sağlayıp kolaylaştırması amacıyla geliştirdiği araçları olarak görmek mümkündür. Bu nedenle sağlık reformlarını incelerken neoliberal yeniden yapılandırma süreçlerinin analizi temel referans noktalarından biri olarak ele alınmalı ve reformların bu süreçle ve Yeni Kamu İşletmeciliği gibi ilgili diğer yaklaşımlarla olan bağlantısı iyi kurulmalıdır. Bu çalışma bunu yapmayı hedeflemiştir.

Türkiye'deki sağlık sistemini dönüştürme faaliyetlerine bakıldığında, sistemin ve ülkenin kendine özgü bir takım özellikleri dikkate alınmak kaydıyla (örneğin, reformların hayata geçirilebilme ve uygulanabilme zamanlarında diğer ülkelere göre geriden takip etme gibi), bunları da neoliberal yeniden yapılandırma süreçleri çerçevesinde okumak mümkündür ve konu hakkında doğru sonuçlara ulaşabilmek de ancak bu yöntemle mümkündür.

Ulusal Sağlık Sisteminin kurulmaya başlanıp ulusal düzeyde sağlık politikalarının yapılmaya başlandığı erken Cumhuriyet döneminden bu yana sağlık sistemini reforme etmeye yönelik pek çok adım atılmıştır. 1980'lerden itibaren neoliberal yeniden yapılandırma süreçleri Türkiye'de etkisini göstermeye başlamıştır ve sağlık sektörü de diğer sektörler gibi bu süreçten nasibini almaya başlamıştır. 1990'larda bu yönde bir dizi reform önerileri gündeme gelmiş ancak bunların büyük bir çoğunluğu sonuçlandırılamamıştır. Sağlık sistemini neoliberal çizgide dönüştürmeye yönelik atılan en ciddi adım 2000'li yılların başında gelmiştir. 2003 yılında başlatılan ve halen devam etmekte olan Sağlıkta Dönüşüm Programı (SDP)'yi 1980'lerde başlayan Sağlık Sistemini neoliberal çizgide dönüştürme projesinin en radikal ve en kapsamlı – ve bir ölçüde de gecikmiş- en son halkası olarak değerlendirmek yanlış olmayacaktır. SDP'nin Türkiye'deki Sağlık Sisteminin ekonomik, siyasi, yönetimsel, klinik, eşitlik ve kavramsal/kültürel boyutlarına getirdiği ve getirmekte olduğu değişiklikler incelendiğinde, bu projenin sağlık sisteminin neoliberal yeniden yapılandırılması süreci içerisindeki önemi açıkça ortaya çıkmaktadır.

Sonuç olarak bir kez daha tekrar etmek gerekirse, gerek dünya genelindeki sağlık reformlarını gerekse Türkiye'deki sağlık sisteminin dönüşümünü doğru anlayıp değerlendirebilmek için devletin ve kamu hizmetlerinin neoliberal yeniden

yapılandırılması süreçleri temel referans noktalarından biri olarak alınmalı ve sürecin işleyişi hakkında bilgi sağlayan Yeni Kamu İşletmeciliği gibi ilgili yaklaşımlarla birlikte dikkatle değerlendirilmelidir.

2. *Neoliberal yeniden yapılanma çerçevesinde dönüşüme tabi tutulan sağlık sistemlerini anlayabilmek için "hibrit model" yaklaşımı oldukça açıklayıcı ve yardımcı bir rol oynamaktadır.*

Hibrit model yaklaşımı her şeyden önce reform süreçleri sonucunda ortaya çıkan yeni sağlık sistemlerini tanımlamada açıklayıcı bir kavramsal çerçeve sunması açısından önemlidir. Zira reform sonrası değişikliğe uğrayan sağlık sistemlerini klasik sağlık sistemleri sınıflandırması ile açıklamak pek de mümkün olamamaktadır.

Hibrit modeller yaratmak ve bu modellerden faydalanmak neoliberal yeniden yapılanma süreçlerinin ve onun tamamlayıcısı olan Kamu İşletmeciliği yaklaşımıyla gerçekleştirilen reformların sık sık başvurduğu bir durumdur. Hibrit modellerin, söz konusu dönüşümümün gereklerine ve iniş çıkışlarına cevap verebilecek, dolayısıyla daha az sorunlu bir dönüşüm yaşanmasını sağlayabilecek son derece işlevsel araçlar oldukları artık kabul görmüş bir bilgidir ve bu reformlar çerçevesinde uzun süredir uygulanma alanı bulmaktadır. Sonuç olarak hibrit modeller için neoliberal dönüşümün hem kolaylaştırıcıları hem de bu dönüşümün sonuçlarıdır denilebilir. Bu bağlamda Türkiye'de 2003 yılından bu yana yürütülmekte olan Sağlıkta Dönüşüm Programı ile ortaya çıkmakta olan yeni sağlık sisteminin de neoliberal dönüşümün ruhuna uygun olacak ve bu dönüşümü kolaylaştıracak şekilde hibrit bir özellik göstermekte olduğunu söylemek yanlış olmayacaktır.

Sağlık sistemlerini açıklamak amacıyla ortaya konmuş bir takım sınıflandırmalar mevcuttur. Bunlardan en çok kullanılanı, Klasik Sınıflandırma olarak adlandırılan ve sağlık sistemlerini Beveridge Model, Bismarkçı Model, Liberal Model ve Semashko Model olarak gruplandıran sınıflandırmadır. Bu sınıflandırmadan yola çıkarak, neoliberal dönüşüm geçiren sağlık sistemleri, özellikle de Türkiye'deki reform çalışmalarının ortaya çıkarmakta olduğu model anlamlandırılmaya çalışıldığında, bu çalışmada üzerinde durulan "hibrit model sağlık sisteminin" Beveridge Model üzerine Bismarkçı Modelin ve ondan biraz daha fazla olacak şekilde Liberal Modelin özelliklerinin eklendiği bir yapıya karşılık geldiği söylenebilir. Hatta bir adım daha

ileri gidilip, söz konusu ülkelerde yaşanan her bir reform teşebbüsünün sağlık sistemlerine liberal modelden daha fazla motifler kattığı söylenebilir.

Türkiye'de, SDP ile birlikte sağlık sisteminde ortaya çıkmakta olan ve sağlıkta neoliberal dönüşümün hem sonucu hem de bu dönüşümün bir gerekliliği ve kolaylaştırıcısı olan hibrit modeli, daha somut olarak şu şekilde ifade edebiliriz: SDP sonrasında sağlık sisteminin genel bütçeden finansmanına dayanan mevcut Beveridge Model özelliklerinin üzerine eklenen zorunlu prim ödemeye dayalı Bismarkçı özellikler; sağlık hizmetlerinin sunumunda özel hizmet sağlayıcılarının, piyasa mekanizmalarının, cepten ödemelerin ve işletme mantığını ön plana çıkaran hastanelerin belirleyici olduğu Liberal modelin özellikleri ile birleşmiş ve ortaya sözü edilen hibrit model çıkmıştır.

3. Sağlık hizmetlerinin organizasyonu (yerelleştirilmesi) ve finansmanı, neoliberal yeniden yapılandırma çerçevesinde gerçekleştirilen sağlıkta dönüşüm projelerinin en temel iki hedefidir.

Sağlık reformlarına yakından bakıldığında, reformların aslında iki ana hedefi olduğu görülür: birincisi sağlık sisteminin örgütlenme biçimini değiştirmek, ikincisi de sistemin finansman yapısını dönüştürmek. Dolayısıyla sağlık reformlarını doğru kavrayabilmek, bu iki alanda getirilen düzenlemeleri yakından takip etmeyi ve doğru değerlendirmeyi gerektirir.

Sağlık sisteminin organizasyonu ve finansmanına yönelik reformlar birbirleri ile yakından ilgilidir. Birçok durumda bir alanı dönüştürmeye yönelik bir reform hareketi diğer alanda da ciddi değişikliklere yol açmaktadır. Aslına bakılırsa son tahlilde şu yargıya varmak hiç de yanıltıcı olmayacaktır: sağlık reformlarındaki nihai amaç, söz konusu sağlık sisteminin finansman yapısını dönüştürmektir; sistemin örgütlenme biçimini değiştirmeye yönelik düzenlemeler de nihayetinde bu amaca hizmet etmek içindir. Zira sağlık sisteminin finansman yapısında ciddi bir dönüşüm gerçekleştirilebilmesi, sistemin örgütlenme yapısında gerekli reformların yapılmasını gerekli kılmaktadır. Bu durum neoliberal yeniden yapılanma çerçevesinde gerçekleştirilen reformlara bir nevi arka plan sağlayan ve yerelleşme ve maliyet-verimlilik hesaplarını öne çıkaran Yeni Kamu İşletmeciliği yaklaşımı ile de uyumludur.

Sistemin örgütlenme yapısına yönelik reformların lafzına bakıldığında, en çok gündeme getirilen kavramların başında sistemin yerelleştirilmesinin (decentralization) geldiği görülmektedir. Her ne kadar bu bağlamda öne çıkan kavram yerelleşme olsa da, işin pratiğine bakıldığında bunun duruma ve ilgili konunun gereklerine göre merkezileşme (centralization) - yeniden merkezileşme (re-centralization) ya da bölgeselleşme (regionalization) pratikleri ile iç içe geçmiş bir yerelleşme süreci olduğu görülmektedir. Yani, sağlık reformları, söz konusu sağlık sisteminin yerelleştirilmesinin önemine ciddi vurgu yapsalar da, pratikte olan, konunun durumuna ve dönüşümün gereklerine göre, merkezileşme, yeniden merkezileşme ya da bölgeselleşme pratikleri ile birlikte (eş zamanlı) ya da bunları takip eden bir yerelleşme sürecidir. Bu durum yukarıda açıklanan hibrit model yaklaşımı ile de uyumluluk arz etmektedir. Buna ek olarak, sağlıkta dönüşüm süreçlerinde, sağlık sisteminin organizasyonunda yerelleşme yaşanırken, sistemin finansmanda merkezileşme çabalarının gündeme gelmesi gibi, daha geniş bir boyutta iç içe geçmiş hibrit yapılar da mümkün olmaktadır.

Buraya kadar anlatılanları, Türkiye'de yürütülmekte olan Sağlıkta Dönüşüm Programı (SDP) bağlamında gözlemek mümkündür.

Yakından incelendiğinde, SDP reformlarının en temel iki hedefinin sağlık hizmetlerinin organizasyonu ve finansmanı olduğu görülmektedir. Yukarıda sözü edilen mantıktan hareketle, Türkiye'de de, sağlıkta dönüşümün nihai hedefinin sağlık sisteminin finansman yapısını değiştirmek olduğu, sistemin organizasyonuna yönelik reform çabalarının da bu amaca ulaşmak için hayata geçirilmekte olduğunu söyleyebiliriz. Örneğin, sistemi daha adem-i merkeziyetçi yapmaya dönük çabalar arasında sayılan idari ve mali yönden özerk kamu hastaneleri yaratma çabasının son kertede sistemin finansmanına dönük ciddi değişiklikleri beraberinde getirmekte olduğu açıkça görülmektedir.

Yine benzer şekilde, Türkiye'deki reform sürecinde de yerelleşme vurgusu oldukça ön plandadır ve sağlık hizmetlerinin organizasyonuna yönelik reform çabalarında en çok değinilen konuların başında gelmektedir. Ancak pratikte yaşanan, dönüşümün gereklerine uygun olacak şekilde, merkezileşme (centralization) - yeniden merkezileşme (re-centralization) ya da bölgeselleşme (regionalization) pratikleri ile iç içe geçmiş bir yerelleşme sürecidir. SDP, bir yandan sağlık sistemindeki aşırı

merkeziyetçi yapıdan şikâyet edip Sağlık Bakanlığı'na sağlık hizmetlerinin doğrudan sunumunda olabildiğince az rol verilmesi gerektiğini savunup idari ve mali yönden özerk hastanelerin kurulmasına ön ayak olurken, bir yandan da çıkarılan son Kanun Hükmünde Kararname[146] ile Sağlık Bakanlığı'ndaki merkezi bürokrasinin rolünü artırmaktadır. Yine aynı Kanun Hükmünde Kararname ile bölge düzeyinde kurulan Bölge Hastane Birlikleri, adem-i merkezileşme ve yerelleşme pratiklerinin bir arada yaşandığı sürece, bölgeselleşme pratiklerini de eklemiş bulunmaktadır. Yukarıda değinildiği gibi bu şekil bir hibrit yapılanma hem neoliberal dönüşümün gereklerine ve onun tamamlayıcısı olan Yeni Kamu İşletmeciliği yaklaşımına uygun bir durumdur hem de bu sürecin bir sonucudur. Benzer bir hibrit modelin ortaya çıkması durumu, daha makro bir düzeyde de gerçekleşmektedir. Şöyle ki, sistemin organizasyon yapısı belli ölçüde daha adem-i merkeziyetçi bir yapıya kavuşturulurken, finansman yapısında ciddi anlamda merkezileştirme adımları atılmaktadır. Örnek vermek gerekirse, SDP, Sağlık Bakanlığı'na, sağlık hizmetlerinin doğrudan sunumunda son derece sınırlı roller vermekte ve bu anlamda idari ve mali yönden özerk hastaneleri ön plana çıkarmakta iken, hemen her konuda son sözü söyleme yetkisine sahip Sosyal Güvenlik Kurumu'nun kurulması ile, sağlık hizmetlerinin finansmanını oldukça merkeziyetçi bir yapıya kavuşturmaktadır.

Bütün bunlardan hareketle, Türkiye'de yürütülmekte olan Sağlıkta Dönüşüm Programını anlama çabasında olan bu çalışma, esas olarak SDP'nin, sistemin organizasyon ve finansman yapısına yönelik olarak ortaya koyduğu reformlara odaklanma yolunu benimsemiştir. Zira dönüşümün en kritik unsurları bu iki alanda ortaya atılan ve hayata geçirilen reformlardan çıkmıştır ve çıkmaktadır.

4. İngiliz Ulusal Sağlık Sistemi (National Health Service) (NHS)[147], özellikle bu sistemin reforme edilme biçimi, Türkiye'deki sağlık sisteminin dönüşümünü anlamada önemli bir modeldir. Sağlıkta Dönüşüm Programı ile önerilen ve hayata geçirilen pek çok yenilik, İngiliz Ulusal Sağlık Sistemi'yle, özellikle bu sistemin reforme edilme biçimiyle önemli benzerlikler göstermektedir. Bu bağlamda, iki ülke arasındaki farklılıkların bilincinde olmakla beraber, refomlar konusunda oldukça yol

[146] Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Resmi Gazete 2011).

[147] Ulusal Sağlık Sistemi (NHS) ibaresi, genel olarak Birleşik Krallık'ta kamunun sunduğu sağlık hizmetlerini tanımlamak için kullanılmaktadır. Bu çalışma, NHS'den söz ederken, tüm Birleşik Krallık'ta yürütülen sağlık hizmetlerini değil, NHS'nin İngiltere'deki uygulamalarını kast etmekte ve İngiltere'deki sağlık hizmetleri üzerine yoğunlaşmaktadır.

kat etmiş olan İngiliz Sağlık Sistemi'nden, halen reform sürecinden geçmekte olan Türk Sağlık Sistemi için çıkarımlar yapmak mümkündür ve faydalıdır.

İngiltere, 1980'lerde başlayan neoliberal dönüşüm süreçlerine öncülük eden ülkelerin başında gelmekteydi. Bu bağlamda gerçekleştirilen kamu reformlarına teorik çerçeve sağlayan Yeni Kamu İşletmeciliği yaklaşımının en belirgin ve en çok konuşulan örnekleri de yine o yıllarda bu ülkede hayata geçirilmeye başlanmıştır. Bu reformlar neoliberal dönüşüm süreçlerinden geçen diğer ülkeler tarafından da örnek alınmıştır. Ulaştırmadan eğitime birçok alanda gerçekleştirilen neoliberal reformlar, sağlık hizmetleri alanında da kendini göstermiş, İngiliz Ulusal Sağlık Sistemi de dönüşümün gerektirdiği biçimde reform sürecine tabi tutulmuştur ve diğer alanlarda olduğu gibi bu alanda da İngiltere diğer ülkelere örnek model olmuştur.

Yukarıda anlatıldığı üzere, Türkiye'de sağlık sektöründe gerçekleştirilmekte olan dönüşümü doğru anlayabilmek, onu, neoliberal dönüşüm ve onun kamu sektöründeki tamamlayıcısı olan Yeni Kamu İşletmeciliği Okulu perspektifinde uygun bir yere oturtmakla mümkündür. İngiltere'nin neoliberal dönüşüm ve Yeni Kamu İşletmeciliği ekseninde gerçekleştirilen reformlardaki öncü rolü göz önüne alındığında, politika transferi veya politika benzeşmesi (convergence) yoluyla bu ülkenin sağlık alanında yaptığı reformların Türkiye'deki reformlara da örnek teşkil ettiğini söylemek yerinde bir yaklaşım olacaktır. Zaten İngiliz Ulusal Sağlık Sistemi, özellikle de bu sistemin reforme edilme yöntemleri incelendiğinde, Türkiye'de gerçekleştirilmekte olan Sağlıkta Dönüşüm Programı ile pek çok noktada benzerlikler gösterdiği açıkça görülmektedir. Buradan hareketle İngiliz Ulusal Sağlık Sistemi'nden, özellikle onun kendini reforme etme biçiminden, ona göre nispeten yolun başında (en azından yapılan reformların sonuçlarını görebilmek açısından) sayılabilecek Türkiye'deki reform süreçleri hakkında çıkarımlar yapmak mümkündür ve son derece faydalıdır.

Bu durum yine yukarıda açıklanan ve genelde neoliberal çerçevede gerçekleştirilen sağlık reformlarını, özelde de Türkiye'deki Sağlıkta Dönüşüm Programı'nı anlamada kolaylık sağlayan hibrit model yaklaşımı ile de uyumludur. Hatırlanacağı gibi bu çalışmada kullanılan hibrit model, İngiliz tarzı Beveridge Model üzerine Bismarkçı ve özellikle de Liberal Model özelliklerinin eklenmesi ile oluşan bir modele karşılık gelmekteydi. Bu çerçevede hibrit model yaklaşımı, İngiliz Ulusal Sağlık Sistemi'nin

reforme edilme süreçlerini ve bu süreçte ortaya çıkan sistemi anlamada son derece yararlı bir araç sunmaktadır. Zira söz konusu sistem de, her bir reform adımından sonra, örnek gösterildiği Beveridge Model özelliklerine bilhassa Liberal Model'den gelen etkilerin sonucunda daha hibrit bir yapıya kavuşmuştur.

İngiliz Ulusal Sağlık Sistemi ve reformları ile Türkiye'deki Sağlıkta Dönüşüm Programı arasındaki benzerliklere birkaç örnek vermek gerekirse: herkesi kapsam altına alan ulusal sağlık sigortası sistemi, sağlık sistemi içinde bir iç pazar kurulması ve ona uygun olarak hizmet sağlayıcısı/hizmet satın alıcısı ayrımının yerleştirilmesi ve sistem içinde rekabet koşullarının oluşturulması, aile hekimliği sistemi ve (henüz Türkiye'de yürürlüğe konulmamış olsa da) kademeli sevk zinciri sistemi, idari ve mali yönden özerk kamu hastanelerinin kurulması, hastanelerin ve diğer sağlık hizmeti sunan birimlerin işletmeleştirilmesi ve kamu hizmeti prensibi yerine işletmecilik ilkelerini benimsemelerinin sağlanması, kamu-özel-ortaklığı (public-private partnership) yöntemi ile yapılan sağlık kampüsleri, sağlıkta artan özel yatırımlar ve daha fazla oranda sağlık hizmetinin özel sektör sunucuları tarafından sağlanması ve teşvik edilen ve artan özel sağlık sigortacılığı ilk etapta sayılabilecekler arasındadır.

İngiliz Ulusal Sağlık Sistemi ve onun kendini reforme etme biçiminden Türkiye'deki reform sürecine yönelik yapılacak çıkarımlar ve alınacak dersler konusunda ilk akla gelenler şunlardır: Bu reformlar sonucunda Türkiye'deki sağlık hizmetleri daha piyasaya açık hale gelecek ve kamu hizmeti olma mantığından uzak bir çerçevede sunulacak; sistemde düzenleyici kurumlar ve uygulamalar daha ağırlıkta olacak; kendilerini idari ve mali yönden idare etme sorumluluğu verilen kamu hastaneleri kamu hizmeti sunma misyonundan daha da uzaklaşıp kâr odaklı çalışan, birbirleriyle yarışan işletmeler haline gelecek ve bu durum sağlık hizmetlerine erişimdeki eşitsizlikleri artırırken kendi başlarının çaresine bakmak durumunda kalan hastaneleri daha da zor duruma düşürecektir; sağlık sektörü daha politize bir alan haline gelecektir.

Sonuç olarak İngiliz Ulusal Sağlık Sistemi'ni, özellikle de onun geçirmiş olduğu reform sürecini incelemek Türkiye'de sağlık alanında yaşanan dönüşümü ve onun ortaya koyduğu ve koyacağı sonuçları anlamada son derece yararlı olacaktır.

5. Gerçekleştirilmekte olan dönüşüm, Türkiye'deki sağlık sisteminin ekonomik, politik, yönetimsel, klinik, eşitlik ve kültürel özelliklerine yönelik ciddi değişiklikler getirmektedir ve söz konusu alanlarda, dönüşüm dolayısıyla ortaya çıkmakta olan değişiklikler birbirlerinden bağımsız değil bilakis birçok durumda birbirleriyle yakından ilişkilidir.

Dönüşümün ekonomik alandaki etkilerine örnek vermek gerekirse, Sağlıkta Dönüşüm Programı'nın yürürlüğe konmasından bu yana toplam sağlık harcamaları, kişi başına yapılan toplam sağlık harcamaları, kişi başına yapılan cepten sağlık harcamaları, sosyal güvenlik sistemine genel bütçeden yapılan transferler ve sağlık hizmeti sunucularına Sosyal Güvenlik Kurumu tarafından yapılan ödemeler ciddi oranda artmıştır.

Sağlıkta Dönüşüm Programı'nın, sağlık sisteminin siyasi yönüne yaptığı etkilere verilecek en çarpıcı örneklerden biri kamu-özel-ortaklığı (public-private-partnership) yöntemiyle kurulan sağlık kampüsleri projesidir. Bu model, sağlık hizmetlerinin örgütlenmesi ve finansmanı alanlarında yeni ilişki biçimlerinin ve yeni bir takım düzenleyici faaliyetlerin ortaya çıkmasının yolunu açmıştır. Söz konusu yeni ilişki biçimlerinde özel hukuk, özel yatırımlar ve sözleşmeye dayalı ilişkiler kamu yatırımları ve sağlık hizmetlerinin kamusal olma özelliğini bir hayli gölgede bırakmıştır. Sağlık alanında bir hayli güçlü yeni aktörlerin ortaya çıkması (Örneğin, Sosyal Güvenlik Kurumu ve özel hastaneler, sistemin işleyişinde, eski dönemin güçlü aktörlerinden olan Sağlık Bakanlığı ve Tabipler Birliği gibi kuruluşlara göre daha güçlü bir pozisyon elde etmişlerdir.), 2005 yılından bu yana yabancı yatırımların sayısındaki artış, 2002 yılından bu yana özel hastanelerin sayısında yaşanan çarpıcı artış ve özel sektöre aktarılan kamu kaynaklarındaki artış, Sağlıkta Dönüşüm Programı'nın, sağlık sistemin siyasi boyutları üzerinde yarattığı etkilere verilebilecek diğer önemli örneklerdendir. Bu etkilerin sistemin ekonomik, sosyal, kültürel vb. diğer alanlarında da ciddi etkileri olduğu açıktır.

Sağlıkta Dönüşüm Programı'nın sistemin yönetimsel boyutları üzerinde yaptığı etkileri en iyi özetleyecek örnek, söz konusu dönüşümün genel olarak tüm sağlık sisteminde, özel olarak da kamu hastanelerinde işletme mantığını ve prensiplerini egemen kılmaya çalışmasıdır. Sağlık sistemi içerisinde yaratılan iç pazar (internal market) mekanizması ve onun tamamlayıcıları olan sağlık sunucusu ve sağlık

hizmeti satın alıcısı ayrımının (provider/purchaser split) ve birbirleriyle rekabet ilişkisi içerisinde olan idari ve mali yönden bağımsız kamu hastanelerinin kurulması, sisteminin yönetimsel boyutlarına dair ciddi değişiklikler getirmektedir. Kuşkusuz bütün bu değişiklikler sağlık çalışanları ve hastalar başta olmak üzere sistemin bütün paydaşları için son derece önemli değişiklikler öngörmektedir. Söz gelimi, performansa dayalı ödeme sistemi sağlık çalışanlarının çalışma koşulları, sundukları hizmetin niteliği ve aralarındaki dayanışma ve etik davranış kodları üzerinde çok ciddi etkileri gündeme getirmiştir. Benzer bir şekilde işletme mantığının hâkim kılınmaya çalışıldığı kamu hastaneleri de kamu yararı prensibi yerine kârlılık ve verimlilik gibi ilkelere ağırlık verince vatandaşlar sağlık hizmetlerine ulaşmada hem daha fazla cepten ödeme yapma hem de aldıkları hizmetin kalitesinin eskiye göre daha düşük olması sonucuyla karşı karşıya kalmışlardır. İdari ve mali yönden özerklik verilen ve bu anlamda kendi kendilerini idare etmeleri beklenen kamu hastaneleri de bütün bu olumsuzlukların yanında bir de borçlanma ve hatta iflas gibi sorunlarla baş etmek zorunda kalmışlardır.

Dönüşümün, sistemin klinik boyutları üzerinde yaptığı etkileri değerlendirmek belli durumlarda eğer istatistiki veri mevcutsa biraz daha kolay olabilmektedir. Örneğin, 2002 yılından bu yana, hastanelere yapılan toplam başvuru sayısında önemli bir artış olduğu tespit edilmiştir. Burada özel hastanelere yapılan toplam başvuru sayısındaki artışın ise çok çarpıcı olduğu görülmüştür[148]. Sağlıkta Dönüşüm Programının uygulamaya konulmasından sonra kişi başına düşen hastaneye başvuru sayısı veya yapılan ameliyat sayılarındaki artışlar ya da ortalama yaşam süresi ve bebek ölüm oranlarındaki iyileşmeler de dönüşümün klinik sonuçları üzerinde bir fikir verebilmektedir. Yine benzer şekilde, 100.000 kişiye düşen doktor sayısı (ki bu rakam hâlâ Avrupa ortalamasının altındadır) ya da performans sistemi ve işletmeleşen devlet hastaneleri sayesinde sağlık çalışanlarının (özellikle doktorların) klinik otonomilerinde (clinical autonomy) meydana gelen gerileme, Sağlıkta Dönüşüm sürecinin Türkiye'deki sağlık sisteminin klinik boyutlarına yönelik nasıl ciddi sonuçlar doğurduğuna dair önemli ipuçları vermektedir.

[148] 2002 yılında Sağlık Bakanlığı'na bağlı hastanelere yapılan toplam müracaat sayısı 109.793.198 iken bu sayı 2010 yılında 235.172.924'e ulaşmıştır. 2002 yılında 5.697.170 olan özel hastanelere yapılan toplam müracaat sayısı da 2010 yılında 47.712.540'a yükselmiştir (Ministry of Health of Turkey (2011: 97, Table 8.1)).

Sağlıkta Dönüşüm Programı'nın sağlık hizmetlerinin eşitlik boyutuna dair de çok önemli sonuçları vardır. Her ne kadar eskiye oranla sağlık hizmetlerine ulaşım görece daha kolay bir hale getiriliyorsa da, sunulan hizmetin kalitesi buraya kadar bir kısmı sayılan nedenlerden ötürü düşmektedir ve sonuç olarak hizmete ulaşımda eşitlik ilkesi konusu giderek daha sorunlu hale gelmektedir. Sağlıkta Dönüşüm Programı'nın ana bileşenlerinden olan Genel Sağlık Sigortası uygulamasıyla tüm vatandaşlara zorunlu olarak prim ödeme yükümlülüğü getirilmiştir. Yani vatandaş için sağlık hizmetlerinden yararlanabilmenin ön koşulu yapılacak gelir testine göre belirlenecek primi ödemiş olmaktır. Ödenen prim karşılığında alınan sağlık hizmetleri de temel sağlık paketleri şeklinde sunulmakta ve bu paketin kapsamı ve Sosyal Güvenlik Kurumu tarafından karşılanan oranlar yine bu Kurum tarafından değişikliğe tabi tutulabilmektedir. Vatandaş, Genel Sağlık Sigortası kapsamında sunulan sağlık hizmetlerinden yararlanırken muayene katılım payı, ilaç katılım payı, ilave ücret ödemeleri adı altında birçok noktada cepten ödeme yapmak durumunda kalmaktadır. Bütün bunlar sağlık hizmetlerinden yararlanmada eşitlik açısından ciddi sorunlara işaret etmektedir. Buna sağlık hizmetlerinin sunumunda gözlenen bölgesel eşitsizlikler de eklenince durum daha da karmaşıklaşmaktadır. Bazı yazarlara göre her ne kadar Sağlıkta Dönüşüm Programı ile sosyal güvenlik kurumlarına bağlı olan gruplar arasında eskiden mevcut olan hiyerarşi ortadan kaldırılmış ve herkes Genel Sağlık Sigortası ve Sosyal Güvenlik Kurumu kapsamında benzer norm ve prosedürlere tabi tutulmuş olsa da, prim ödemiş/ödememiş olma ya da yeni sistemin olanakları hakkında yeterli bilgiye sahip olma/olmama gibi ayrımlar üzerinden sağlık hizmetlerinden yararlanmada mevcut olan eşitsizlikler devam etmektedir ve bunun en yoğun hissedildiği kesimler de işsizler, düşük gelirliler ve kadınlar olmaya devam etmektedir. (Üstündağ ve Yoltar 2007: 91-92).

Dönüşümün en önemli sonuçlarından biri de sağlık hizmetlerinin kavramsallaştırılması ve kültürel alandaki yeri ile ilgili yarattığı etkiler açısından meydana gelmiştir. Aslına bakılırsa bir yandan buraya kadar sayılan bütün sonuçlar bu alandaki değişime katkı bulunmuştur denebileceği gibi bir taraftan da sağlık hizmetlerinin kavramsallaştırılmasındaki bu dönüşüm bu sonuçları getirmiştir de denebilir. Sağlık hizmetlerinin kamu hizmeti olma özelliğinin giderek geri plana düşürülmesi ve rekabetçi bir pazarda alınıp satılan bir hizmet olarak gündeme

gelmesi, bu konuda önemle üzerinde durulması gereken bir noktadır. Yine yakın zamanda çıkarılan bir Kanun Hükmünde Kararname[149] ile, ilgili kanundan "doktorluk mesleğinin kamu yararına yapılan bir hizmet olduğu" ibaresinin çıkarılması da sağlık hizmetlerinin kavramsallaştırılması ve bunun toplumdaki kültürel algılara yansıması açısından son derece çarpıcı bir gelişmedir. Bu konuda verilebilecek bir başka örnek de, "devlet hastaneleri"nin isimlerinden "devlet" ibaresinin kaldırılıp bunların "şehir hastaneleri" olarak adlandırılması yönünde gündeme getirilen projedir. Sağlık hizmetlerinin kavramsallaştırılmasında ve bunun toplumdaki kültürel algıda yaratacağı değişikliklerin ne ölçüde yerleşip benimseneceğini, ilgili aktörlerin bu değişime karşı geliştirecekleri tutum ve dönüşümü yürütenlerin bu konuda gösterecekleri çaba belirleyecektir.

Sağlıkta Dönüşüm Programı'nın burada sayılan sonuçlarını daha somut bir biçimde görebilmek için Ankara'daki bir kamu hastanesinde gözlem, ilgili aktörlerle görüşme ve doküman analizi yöntemleri kullanılarak bir araştırma yapıldı. Bu araştırmada esas olarak bir hastanın hastaneye başvuru sürecinden taburcu olma aşamasına kadar geçirdiği süreçler üzerinden Sağlıkta Dönüşüm Programı'nın getirdiği değişiklikleri analiz etmek amaçlandı. Sonuçta araştırmadan elde edilen birincil verilerin bu tezde ortaya konulan argümanları, çizilen teorik çerçeveyi ve Sağlıkta Dönüşüm Programı'nın sonuçlarına dair yapılan tartışmaları son derece destekler nitelikte olduğu görüldü. Örnek vermek gerekirse, dönüşümün hastaneleri nasıl işletmeleştirdiği, Sosyal Güvenlik Kurumu'nun idari ve mali yönden bağımsız olduğu söylenen hastaneler üzerinde nasıl etkin bir kontrol gücüne sahip olduğu ve sağlık hizmetlerinden yararlanmak isteyen vatandaşların doktor, hastane ve Sosyal Güvenlik Kurumu ile nasıl bir ilişki içinde olduğu bu araştırma sayesinde somut bir biçimde görülmüş oldu.

Tezde kullanılan diğer araştırma yöntemlerinden de kısaca bahsetmek gerekirse, öncelikle bu çalışmanın esas olarak nitel bir araştırma olduğu ifade edilmelidir. Bağımsız değişkeni Sağlıkta Dönüşüm Programı – özellikle onun sağlık sisteminin organizasyonu ve finansmanına yönelik düzenlemeleri – bağımlı değişkeni ise bu düzenlemelerin Türkiye'deki sağlık sisteminin ekonomik, siyasi, yönetimsel, klinik, eşitlik ve kültürel yönleri üzerindeki etkileri olarak özetlenebilir. Çalışma belli

[149] Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Resmi Gazete 2011).

bölümlerinde (örneğin, İngiliz Sağlık Sistemi'nin incelendiği bölüm) betimleyici araştırma özellikleri taşırken belli bölümlerinde de (örneğin, İngiliz Sağlık Sistemi'nden Türkiye'deki sağlık reformları hakkında çıkarımlar yaparken) açıklayıcı araştırma özellikleri göstermektedir. Belge analizi yöntemi çalışmanın en çok başvurduğu tekniklerin başında gelmektedir. Makale, kitap, yasa metinleri, reform önerileri, kanun tasarıları, mahkeme kararları, gazete yazıları, internet kaynakları ve benzeri birçok kaynak araştırma boyunca kullanılmıştır. İlgili olan durumlarda ve verilerin mevcudiyeti ölçüsünde (özellikle Sağlıkta Dönüşüm Programı'nın sayılan alanlardaki etkileri tartışılırken) istatistiki verilerden de yararlanılmıştır. Çalışmada hem birincil hem de ikincil kaynaklar kullanılmıştır. Mevcut ikincil kaynakların istenilen bilgiye ulaşmada yeterli olmadığı durumlarda, yukarıda sözü edilen hastane araştırmasında olduğu gibi, gözlem ve mülakat gibi tekniklerin kullanıldığı saha araştırması yöntemine de başvurulmuştur. Belge analizi yönteminin yanı sıra, belge yorumlama yöntemi de çalışmanın belli bölümlerinde (örneğin, yerelleşmenin, sağlık hizmetlerinin organizasyonu ve sunumunda nasıl anlaşıldığı ve uygulandığı konusu tartışılırken) kullanılmıştır. Betimleyici tarihsel analiz, çalışmanın kullandığı bir başka yöntemdir. Türkiye'deki sağlık sisteminin kuruluşu, gelişimi ve geçirdiği reform süreçleri incelenirken bu yöntem kullanılmıştır. Çalışma bu şekilde betimleyici tarihsel analiz yaparken eleştirel tarihsel analiz yapma gibi bir iddia ortaya koymamıştır. Ancak bu durum çalışmanın hem sözü edilen kısımla ilgili olarak hem de çalışmanın bütününde eleştirel bir yöntem benimsememiş olduğu anlamına gelmemelidir. Bilakis, gerek sağlıkta yaşanan dönüşümün devam etmekte olan bir süreç olması, gerekse de bu zamana kadar hayata geçirilmiş reformların hali hazırda ortaya koymuş olduğu ciddi değişiklikler göz önüne alındığında, çalışma, eleştirel yaklaşımın gerekliliğine inanmış ve bunu mümkün olan her yerde kullanmaya çalışmıştır. İngiliz ve Türk Sağlık Sistemlerini ve onların geçirmekte oldukları dönüşüm süreçlerini analiz eden çalışmanın, örnek olay incelemesi yöntemini kullandığı da görülmektedir. Burada, özellikle Türkiye'deki dönüşümün devam etmekte olan bir süreç olmasından ve iki ülke arasındaki bazı diğer farklılıklardan kaynaklı olarak, tam anlamıyla bir karşılaştırmalı çalışma yapmanın mümkün olamadığını da belirmekte yarar var. Ancak yine de iki reform süreci arasındaki benzerliklerin ortaya konulması ve reform sürecinde Türkiye'ye göre bir hayli yol kat etmiş olan İngiliz Sağlık Sistemi'nden Türkiye'deki dönüşüme yönelik çıkarımlar yapılmış olması bu çalışmanın literatüre

en önemli katkılarından biri olmuştur. Son olarak, Türkiye'de sağlık alanında yaşanan dönüşümü siyaset bilimi ve kamu yönetimi perspektifinden inceleyen bu çalışmanın; sağlık sistemleri ve reformları konusunu çok boyutlu ve çok disiplinli çalışılması gereken bir konu olarak ele alan ve konuya farklı disiplinlerden yapılacak katkıları hararetle destekleyen Sağlık Hizmetleri Araştırması (Health Services Research) (HSR) disiplini tarafından da benimsenip destekleneceği öngörüsünün burada not edilmesi önemlidir.

Sağlıkta Dönüşüm Programı tamamlanmış ve tümüyle yürürlüğe konmuş bir program değildir. Aksine son derece dinamik ve 2003 yılında başlatılmış olmasına rağmen hâlâ devam etmekte olan bir süreçtir. Bu çalışmanın en zor yanlarından birisi, her an yeni bir gelişmeyle, bazen yeni uygulamaların bir öncekiyle çeliştiği, çoğu kez bir ileri iki geri gibi bir anlayışla yürütülen reformlar karşısında çalışmanın güncellenmesini sağlamaktı. Öyle ki, tezin yazım sürecinin sonlandığı noktada çıkarılan bir Kanun Hükmünde Kararname[150] - her ne kadar bu tezde ortaya konmuş olan argümanları destekleyen değişiklikleri getirmiş olsa da[151] – tezin kurgusunu ve şeklini bozmamak adına sonuç bölümünde tartışılabilmiştir.

Bugüne kadar uygulamaya geçirilen kısımlarıyla sağlık alanında son derece radikal değişimlere imza atmış olan Sağlıkta Dönüşüm Programı tüm bileşenleri ile yürürlüğe girdiğinde Türkiye'deki sağlık sisteminin son derece farklı bir noktaya taşınmış olacağı muhakkaktır. Dönüşümün etkileri esas olarak o zaman daha derinden hissedilecektir. Bu çalışma, Sağlıkta Dönüşüm Programı'nın bugüne kadar vâkıf olabildiğimiz, hayata geçirilmiş ya da geçirilmesi kuvvetle muhtemel olarak beliren bileşenleri ve bunların ekonomik, siyasi, yönetimsel, klinik, eşitlik ve kavramsal etkileri üzerinde olabildiğince detaylı bir analizi olabildiğince eleştirel bir perspektiften yapmaya çalışmıştır. Ancak söylendiği gibi Sağlıkta Dönüşüm Programı henüz tüm parçaları hayata geçirilmemiş, devam etmekte olan bir süreçtir. Dolayısıyla süreç ve getireceği sonuçlar ciddi bir şekilde incelenmeye devam edilmelidir.

[150] Sağlık Bakanlığı ve Bağlı Kuruluşların Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname (Resmi Gazete 2011).

[151] Sağlık Bakanlığı'nın görev ve yetkilerinin yeniden düzenlenmesi; Kamu-Özel-Ortaklığı ile Sağlık Kampüslerinin kurulması; Sağlık Serbest Bölgelerinin kurulması; Kamu Hastane Birliklerinin kurulması; Hekimliğin kamu yararına yapılan bir hizmet olduğu ibaresinin ilgili kanundan çıkarılması; Türkiye İlaç ve Tıbbi Cihaz Kurumu'nun kurulması gibi birçok önemli değişiklik bu Kanun Hükmünde Kararname ile uygulamaya konmuştur.

Çalışma, Türkiye'de sağlık alanında gerçekleştirilen reformları, özellikle de 2003 yılından bu yana yürütülmekte olan Sağlıkta Dönüşüm Programı'nı, siyaset bilimi ve kamu yönetimi perspektifinden inceleyip sağlık reformu konusunda bu anlamda bütünlükçü bir yaklaşım ortaya koymayı hedeflemiştir. Bu bağlamda, bu çalışmada, Sağlıkta Dönüşüm Programı ve sonuçlarına dair ortaya konulan argümanlar, bulunan sonuçlar ve yapılan analizlerin siyaset bilimi ve kamu yönetimi perspektifinden yapılması bu çalışmanın sağlık reformlarını sosyal bilimler alanından inceleyen literatüre getirdiği katkıların başında sayılabilir. Buna ek olarak, sağlık hizmetlerinde yerelleşme konusunda yıllardır süregelen kavram karışıklığını gidermeye yönelik yapılan çalışma, sağlık reformlarını anlamada hibrit model yaklaşımını kullanmanın önemine yapılan vurgu ve İngiliz Ulusal Sağlık Sistemi ve özelikle bu sistemin reforme edilme biçimi ile Türkiye'de gerçekleştirilen dönüşüm arasındaki benzerlikleri görüp Türkiye için çıkarımlar yapma çabası yine bu çalışmanın literatüre yaptığı katkılar arasında sayılabilir.

Sağlıkta Dönüşüm Programı'nın devam etmekte olan bir süreç olması, bugüne kadar hayata geçirilen ve bundan sonra gerçekleştirilmesi planlanan reformların sağlık sistemine getirmekte olduğu son derece önemli değişiklikler ve konunun Türkiye'de sosyal bilimler, özellikle siyaset bilimi ve kamu yönetimi alanlarında çalışan araştırmacılar tarafından görece yeni ele alınmaya başlanıyor olması, sağlıkta yaşanan dönüşümün ve bu çerçevede bu çalışmada ortaya konulan argümanların ve yapılan analizlerin, yapılacak yeni çalışmalar için hem bu satırların yazarına hem de konuyla ilgilenen diğer araştırmacılara son derece verimli bir araştırma alanı için açık bir davet olarak alınabilir.

APPENDIX B

CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Demirci, Bengi
Nationality: Turkish (TC)
Date and Place of Birth: 20 December 1978, Rize
e-mail: bengidemirci@gmail.com

EDUCATION

Degree	Institution	Year of Graduation
PhD	Middle East Technical University, Political Science and Public Administration	2012
MSc	University College London, Public Policy	2008
MSc	Middle East Technical University, European Studies	2003
BS	Middle East Technical University, Political Science and Public Administration	2001
High School	Rize Anatolian High School	1996

WORK EXPERIENCE

Year	Place	Enrollment
2002-Present	Middle East Technical University, Department of Political Science and Public Administration	Research Assistant

FOREIGN LANGUAGES

Advanced English, Intermediate French

AREAS OF RESEARCH INTEREST

Health Policy and Reform, Public Administration and Reform, Public Policy, Organizational Theory, Urban Politics, Local Government, European Integration, Governance in the EU.

SELECTED WRITINGS

1. Demirci, B. (2008) Health Technology Assessment: The Case of UK and Lessons to Be Derived for the Incipient Turkish Case, *unpublished MS Thesis submitted to School of Public Policy, University College London*

2. Demirci, B. (2007) Hizmette Halka Yakınlık (Subsidiarity) İlkesinin AB'de Algılanışı ve Son Reform Çalışmaları Bağlamında Türk Kamu Yönetimi Sistemine Yansımaları in Şinasi Aksoy and Yılmaz Üstüner (eds.) *Kamu Yönetimi – Yöntem ve Sorunlar*, Ankara: Nobel.

3. Demirci, B. (2005) A Brief Outlook on the Health and Education Services in France and England with a View to Making Comparisons with the Recent Decentralization Attempt in Turkey, in Guiseppe Burgio (ed.) *Europe as an Item on the Identity Card: Conceptualization of European Identity by the European Academy and Public*, September 2005, Metu Press.

4. Demirci, B. (2003) The Principle of Subsidiarity in European Governance in Guiseppe Burgio (ed.) *European Integration in the View of Young Researchers***,** September 2003, Metu Press.

5. Demirci, B. (2003) The Principle of Subsidiarity within the European Union Context, *unpublished MS Thesis Submitted to the Graduate School of Social Sciences, Center for European Studies, METU.*

PROFESSIONAL EXPERIENCE

Research Visits:

- L'Institut d'études Politiques de Paris, FRANCE (May 2007 – one month).
- Cardiff University, UK (May 2005 – one nonth).
- University of Leeds, UK (May 2003 – one month).

Conference Organization:

- Member of the Organizing Committee for the 3rd Public Administration Forum, Ankara, 2005).

Conference Presentation:

- Demirci, Bengi, “Hizmette Halka Yakınlık (Subsidiarity) İlkesinin AB’de Algılanışı ve Son Reform Çalışmaları Bağlamında Türk Kamu Yönetimi Sistemine Yansımaları”, III. Kamu Yönetimi Forumu –Kamu Yönetimi: Yöntem ve Sorunlar, ODTÜ-Ankara, 17-18 Kasım 2005.

SCHOLARSHIPS AND HONOURS

- ÖYP Scholarship for one year research abroad (UCL, UK – September 2007 – September 2008).
- METU/CES Scholarship for one month research abroad (L'Institut d'études Politiques de Paris, FRANCE – May 2007).
- EUROPEAN COMMISSION – METU/CES Scholarship for one month research abroad (CARDIFF UNIVERSITY, UK – May 2005).
- EUROPEAN COMMISSION – METU/CES Scholarship for one month research abroad (UNIVERSITY OF LEEDS, UK - May 2003).
- High Honour Student Awards 8 times during B.S. Education.
- Top Scoring Graduate Award in High School (1996).

METU LIBRARY

APPENDIX C

TEZ FOTOKOPİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü ☐

Sosyal Bilimler Enstitüsü ☐

Uygulamalı Matematik Enstitüsü ☐

Enformatik Enstitüsü ☐

Deniz Bilimleri Enstitüsü ☐

YAZARIN

Soyadı: DEMİRCİ
Adı : BENGİ
Bölümü : SİYASET BİLİMİ VE KAMU YÖNETİMİ

TEZİN ADI (İngilizce) : TRANSFORMATION IN THE ORGANIZATIONAL AND FINANCIAL SET-UP OF THE HEALTH CARE SYSTEM IN TURKEY - ITS REPERCUSSIONS AND SIMILARITIES WITH THE ENGLISH MODEL

TEZİN TÜRÜ : Yüksek Lisans ☐ Doktora ☐

1. Tezimin tamamı dünya çapında erişime açılsın ve kaynak gösterilmek şartıyla tezimin bir kısmı veya tamamının fotokopisi alınsın. ☐
2. Tezimin tamamı yalnızca Orta Doğu Teknik Üniversitesi kullancılarının erişimine açılsın. (Bu seçenekle tezinizin fotokopisi ya da elektronik kopyası Kütüphane aracılığı ile ODTÜ dışına dağıtılmayacaktır.) ☐
3. Tezim bir (1) yıl süreyle erişime kapalı olsun. (Bu seçenekle tezinizin fotokopisi ya da elektronik kopyası Kütüphane aracılığı ile ODTÜ dışına dağıtılmayacaktır.) ☐

Yazarın imzası ..... Tarih .....